Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 30 September at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Teams Live Event

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION: Reducing Restrictive Practice's: National Collaborative **Louise Summers, Matron CAMHS Inpatient**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 29 July 2020	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	SM	Attached	Noting
(b)	Learning from Deaths – Mortality Review Q1	NH	Attached	Noting
(c)	Complaints Deep Dive into Staff Attitude (Action from Complaints Annual report at May Board)	SL	Attached	Noting
(d)	View of Members & Governors Report (election information)	SS	Attached	Noting
(e)	NHS Workforce Disability Equality Standard	SL	Attached	Approval
(f)	NHS Workforce Race Equality Standard Data	SL	Attached	Approval
(g)	Urgent actions to address Health Inequalities in NHS provision and outcomes	SL	Attached	Approval
7	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework	SM	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Charitable Funds Committee Assurance Report Part 1 & Part 2 and Terms of Reference	NT	Attached	Noting
	(iii) Finance & Performance Committee	ML	Attached	Noting

	(iv) Quality Committee	AS	Attached	Noting
	(v) People, Innovation & Transformation Committee	ARQ	Attached	Noting
(c)	EU Exit	NL	Attached	Noting
(d)	Engagement with Board of Directors Policy & Procedure	SM	Attached	Approval
(e)	**Risk Assurance Reports**			
	(i) COVID-19	SM	Attached	Noting
	(ii) Ligature Risk Report Q2	SM	Attached	Noting
8	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	SM	Attached	Approval
(b)	PHSO and HSE Steering Group	AD	Attached	Noting
(c)	EPRR Core Standards	SM	Attached	Noting
(d)	Review of SFI's and Standing Orders	SM	Attached	Approval
9	**OTHER**			
(a)	Use of Corporate Seal	SM	Attached	Noting
(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
10	**ANY OTHER BUSINESS**	All	Verbal	Noting
11	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
12	**DATE AND TIME OF NEXT MEETING** Wednesday 25 November 2020 - Virtual at 10:00			
13	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 27 January 2021 at 10:00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 29 July 2020
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Sally Morris (SM)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Mark Madden (MM)	Executive Chief Finance Officer
Andy Brogan (AB)	Executive Chief Operating Officer / Deputy CEO
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Strategy and Transformation
Dr Milind Karale (MK)	Executive Medical Director
Janet Wood (JW)	Non-Executive Director
Nigel Turner (NT)	Non-Executive Director
Alison Davis (AD)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director

In Attendance:

Faye Swanson (FS)	Director of Compliance and Assurance/ Trust Secretary
Angela Horley (AH)	PA to Chief Executive, Chair and NEDs (minutes)
Tina Bixby (TB)	Assistant Trust Secretary
Chris Jennings (CJ)	Assistant Trust Secretary
John Jones	Lead Governor
Dr Fiona McDowall (FM)	Consultant Old Age Psychiatrist (Item 082/20 only)
Tracy Reed (TR)	Clinical Lead for End of Life Care (Item 082/20 only)

SS welcomed Board members, Governors, members of the public and members of staff that were viewing the live broadcast. The meeting commenced at 12:31.

080/20 APOLOGIES FOR ABSENCE

Apologies were received from Rufus Helm, NED.

081/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

082/20 PRESENTATION: END OF LIFE OUR COMMITMENTS AND ACHIEVEMENTS

TR advised that the Trust had undertaken a recruitment process 18 months ago for a Trust wide clinical End of Life Lead with sessional medical support. The Trust's End of Life Framework and implementation plan was then revised to align with the national strategy. TR advised that the priority is for fair access to services for all those in our care recognised as end of life, irrespective of care setting. A number of resources for staff and patients have been made available including an intranet page for staff and information leaflets for patients and loved ones.

FM advised that there is robust governance in place including an End of Life care subcommittee chaired by the Executive Nurse, with membership from across the Trust. The quality and governance in relation to EOL also overlaps with membership of the Mortality and Deceased Patient

Review Groups. FM advised that there are policies, guidance and standard operating procedures in place to support best practices in end of life care.

TR reported that the Trust EOL services had been rated in 2018 as 'requires improvement', however as a result of the continued focussed efforts, this had improved to 'Outstanding' in 2019. TR advised that there have been a number of mechanisms put in place to support staff: there are now 42 EOL Champions across the Trust and this continues to grow; forums are held four times a year to support shared learning and best practice; competency framework is in place for all end of life care champions and there are partnership approaches for shared learning.

The Trust was invited to formulate and participate in a National Audit around Care at End of Life; as well as promoting 'Dying Matters' awareness.

The Covid-19 pandemic has been a challenging time, but services have acted quickly to be compliant with national guidance. A set of slides has been created for staff to ensure best practice and support patients with Covid-19 as well as podcasts to support clinical practice.

TR and FM concluded that there was an ongoing journey in regards to End of Life Care, however they were proud of the achievements and progress to date, stating that we owe our patients the opportunity to live well and to die well.

SS thanked TR and FM for their insightful presentation, noting the positive journey from a CQC rating of 'requires improvement' to 'outstanding'. SS acknowledged that Covid-19 had added additional pressure to services and thanked all for their continued dedication to ensuring our patients receive quality care.

NH thanked TR and FM, stating that they both embody the Trust values by being open and sharing learning across the system by being empowered and promoting the EOL agenda across the whole organisation and demonstrating compassion and passion in their clinical leadership.

ARQ echoed SS and NH's sentiment, acknowledging that end of life care is a sensitive service. Referring to the much improved CQC rating, ARQ queried what advice could be given to other services within the Trust. TR commented that passion and belief in the services are very important. TR stated that with EOL care, there is only one opportunity to get it right and so it is important that services demonstrate patient centred care and work in partnership with other services, not in silos. FM added that the EOL Champions meeting is a powerful forum and provides a voice to feed into governance process across the Trust.

ML commented that during a meeting with TR in her role as Staff Governor, TR had given a powerful description of challenges faced during the Covid-19 pandemic including enabling access to medication and providing training to colleagues during the crisis. ML praised TR for her clinical leadership and recognised her commitment and hard work. ML queried whether there was any learning from the use of digital platforms. TR responded that Microsoft Teams had been very helpful in communicating with staff. EOL podcasts are recorded and available for staff to view at any time which provides reassurance to deliver care. TR acknowledged that some training does require face to face and does not translate well via online platforms, but the team are looking at new ways of working, bearing in mind the benefits that the digital age can bring. FM advised that Covid-19 patients are isolated and technology had been an invaluable tool to allow contact in different ways.

JW added her congratulations for the fantastic progress in such a short period of time; JW stated that during service visits, patients and staff speak highly of the help and support the EOL team offers to help patients diagnosed as end of life.

AS stated that it was a privilege to act as the lead NED for end of life services. AS queried how services address the cultural differences and challenges regarding end of life, also querying how training and learning can be embedded. TR advised that the Team work closely with the Trust Chaplaincy Team and an action for this year is to improve links with community organisations. TR added that Covid-19 has added challenges, but cultural beliefs have been respected as much as possible while keeping in line with national Covid-19 guidance.

SM commented that there is a reason that this service was rated as Outstanding by the CQC; stating that the service focusses on delivering a patient centred service. A high number of compliments are received regarding EOL care. This is a very difficult time for families, and it is pleasing that there is recognition for the extra mile that our staff go to in providing care to patients at this difficult time. SM stated that she was proud of the recognition from the CQC that this service so rightly deserves.

083/20 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 27 May 2020 were agreed as an accurate record of discussions held subject to one typographical error:

- Page 3 – 61 mental health complaints should read 261.

084/20 ACTION LOGS AND MATTERS ARISING

The action log was reviewed and it was noted that there is one outstanding action that is due in September.

There were no other matters arising that were not on the action log or agenda.

The Board discussed and approved the Action Log.

085/20 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.

The Board received and noted the Chair's Report.

086/20 QUALITY AND PERFORMANCE SCORECARD

SM presented the Quality and Performance Scorecard advising that due to the Covid-19 pandemic, full performance reporting has been suspended leaving focus on hotspots and national indicators. Information for all other indicators continues to be captured and monitored by other teams and services and where possible via live dashboards and reports. It is expected however, that full reporting will resume gradually in August.

One new hotspot has been identified at the end of June 2020, Timeliness of Data Entry. There were no hotspots which are Oversight Framework indicators for June 2020 identified and no hotspots were identified in the EPUT Safer Staffing Dashboard for June 2020.

SM advised that the Quality Account is no longer a part of Quality and Performance reporting. The Quality Account action plan is now held and reported by members of the Quality Committee.

The Board of Directors received and noted the report.

087/20 PLACE ANNUAL REPORT

MM presented the results of the 2019 Patient Led Assessment of the Care Environment (PLACE), advising that the Trust is required to undertake a mandatory annual review assessing the quality of the hospital environment. PLACE is intended to put the perspective of the Service User at the centre of the assessment process. Teams of PLACE assessors evaluate the care environment reporting on how well the Trust is performing against the published criteria. MM noted a disappointing reduction in two categories and advised that action plans are now in place to address concerns. MM highlighted that there had been a reduction in score for disability access, however this remained within acceptable levels; MM also noted a decline in the national average in respect to this area.

JW queried whether the removal of dormitory accommodation would help to address the Privacy, Dignity and Wellbeing category. MM confirmed that this was not discussed during the assessment as focus had centred on whether the environment was welcoming and had sufficient space for patients and relatives to spend time together.

ARQ noted that the report advised that charitable funds had been used to improve the environment and queried why this would not be funded from existing Trust budgets. MM confirmed that the Trust funds the decorating of the environment, but charitable funds are used to enhance the environment with items that are over the 'standard' such as artwork.

AD noted that the food and hydration category had seen a decline and queried whether the Trust will look to other organisations that have had higher success. MM confirmed that the issues raised include the availability of hot meals at lunchtime, availability of finger food and snacks throughout the day and how frequently the menu cycles are updated. The Trust is carrying out a review of its external food provider in November 2020 during which these issues will be considered and changes to the overall specification could be made. MM highlighted that any changes to the specification would need business case approval from the Trust Board.

The Board of Directors received the contents of the report.

088/20 LEARNING FROM DEATHS – MORTALITY REVIEW SUMMARY OF Q4

NH presented the Mortality Review Summary advising that the Trust is nationally mandated to report to the public Board meetings on a quarterly basis.

NH confirmed that the deaths in scope were within the statistical control limits and was comparable to the same period the previous year. NH advised that an increase in deaths in nursing homes had been noted in March, following which a detailed review was commissioned.

Monitoring of deaths within the Trust has continued throughout the Covid-19 pandemic in order to ensure timely identification of any possible problems in care. This is demonstrated by the improvement in timeliness of consideration via the Deceased Patient Review Group process. However, progressing long term learning from mortality review in Q4 has been limited as the Trust has focussed capacity on essential activity during the pandemic response. As such it has not been possible to progress developmental work arising from mortality review since the last report to the Board was prepared; however this work has recently been recommenced.

NH advised that learning themes continue to be noted. MK added that weekly online learning sessions had been implemented which had been well attended.

AS reminded colleagues that much of the terminology and methodology used with the report is mandated nationally. AS provided assurance that the Quality Committee review information regarding mortality review and learning from deaths and look at each case as an individual and not a statistic.

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

089/20 MENTAL HEALTH ACT ANNUAL REVIEW

NH presented a summary of Mental Health Activity, advising that there had been an increase in the use of Section 2s and a decrease in the use of Section 3s, demonstrating the use of least restrictive practice. NH advised the ethnicity of detainees is being looked into following the Dr Wesley review which found that there is an over representation of BAME nationally. However, EPUT was found to be under-represented.

NH also advised that during the Covid-19 pandemic, the use of digital technology including Microsoft Teams has been incorporated. There is recognition that when tested against other organisations, EPUT are seen as proactive with digital tribunals taking place.

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

090/20 INFECTION CONTROL ANNUAL REPORT

NH presented the annual report, taking the opportunity to acknowledge the IPC team and the responsiveness of the team during this unprecedented time.

NH was pleased to note the improvement in the uptake of the flu vaccination, stating that there was a national expectation that 100% uptake will be achieved in the coming year. ARQ understood the government's desire for 100% uptake, however noted that this had been an area that the Trust had struggled with in the past. ARQ queried whether there was learning from other Trusts that could be shared. NH advised that one challenge in delivering vaccinations to staff across the Trust was the large geography and multiple sites covered. The Trust has put in place multiple flu clinics and peer vaccinators to attempt to cover as wide an area as possible. The IPC team are also working tirelessly to dispel myths around the flu vaccine and promote the positive benefits of receiving a vaccination.

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

091/20 SAFEGUARDING ANNUAL REPORT

NH presented the annual Safeguarding Report which has been set up to look at how the legislation in relation to Safeguarding is used within EPUT and to consider how practice can be improved to ensure best standards of care at all times. Whilst a number of achievements have been accomplished this year, the Trust continues to challenge itself so that the quality of services is developed and improved. NH advised that as a result of the Covid-19 virus, the year had ended with the service adapting the way it delivers its business, including offering new ways of working that enhance the service offered.

NH advised that following the cancellation of the annual safeguarding conference, a webinar option was being explored.

SS noted that training was an ongoing challenge and was encouraged to see an increase on update of level one safeguarding training against the benchmark. SS queried whether strategies were in

place to improve the uptake of training. NH advised that a key issue in compliance was a change in guidance, with training becoming more focussed. Online training packages have been developed and it is hoped that this will enable training to be more readily available to clinicians and improve compliance.

The Board of Directors:

1. **Considered the issues and hotspots and where appropriate the mitigating actions as identified within the report.**
2. **Noted the Trust's position in relation to national trends and action being taken.**
3. **Were made aware of matters of concern with regards to safeguarding and actions being taken.**

092/20 BOARD ASSURANCE FRAMEWORK

SM presented the Board Assurance Framework as at July 2020 highlighting the following:

- SM provided assurance that the Covid Risk Register was reviewed every two weeks.
- The report covers June and July 2020, SM confirmed that the Executive Team had discussed and approved the identified risks and associated risk score.
- As at July there were 18 risks on the BAF, with one risk recommended for de-escalation to the Corporate Risk Register; this is in light of the review of Corporate Objectives due to the Covid-19 pandemic resulting in the risk no longer being relevant to the revised objectives.
- There were 22 risks on the Corporate Risk Register, with one risk recommended for closure.
- SM confirmed that this is a live document which is regularly reviewed and updated.

ML advised that a deep dive of CIP had been undertaken at the Finance and Performance Committee where challenges in delivering recurrent CIP were discussed. ML suggested a review of wording and mitigation of BAF41 in light of recent conversations and the need to focus on ongoing and future sustainability.

AD noted the potential risk around low secure services for young people and queried whether there was a continuing challenge regarding availability around the country. SM confirmed that this was a national problem, commissioners are actively trying to source availability within the system. However, a number of providers have withdrawn from the market as they were unable to provide this service.

Action:

1. **Review of BAF41 wording and mitigation in light of recent conversations held at F&P committee, where the challenges in delivering recurrent CIP was discussed.**

The Board of Directors:

1. **Reviewed the risks identified in the BAF 2020/21 July summary and approved the risk scores taking account of actions taken by EOSC at its June meeting.**
2. **Approved the de-escalation of BAF32 Quality Improvement to the Corporate Risk Register.**
3. **Approved a reduction in score of BAF34 Staffing for Transformation.**
4. **Noted the CRR July summary table, including actions taken by EOSC at its June meeting.**
5. **Approved the closure of CRR1 in Section 5.**
6. **Noted the proposed risks for assessment and escalation to eh EOSC August 2020 in Section 3.**
7. **Did not identify any further risks for escalation to the BAF, CRR or Risk Registers.**

093/20 STANDING COMMITTEES

(i) Finance and Performance Committee

The Board of Directors:
1. **Received and noted the report.**
2. **Confirmed acceptance of assurance provided.**
3. **Approved the revised Terms of Reference for the Committee**

(ii) Quality Committee

AS advised that as a result of the BAF risk around restraint within the Trust, a deep dive had been undertaken. This was an intensive piece of work. Restraints across the Trust predominantly take place with Children and Adolescent services.

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

(iii) People, Innovation and Transformation Committee – Including Terms of Reference

ARQ advised of an inaccuracy within the report – paragraph 3 Digital Service Change, a report would be presented to the PIT committee and not the Board in July 2020.

The Board of Directors:
1. **Noted the contents of the report.**
2. **Confirmed acceptance of assurance given in respect of risks and actions identified.**
3. **Ratified the Terms of Reference.**

094/20 RISK ASSURANCE REPORTS

i) Covid 19

SM reported that there are currently no patients with confirmed cases of Covid-19 within EPUT services. SM advised that learning identified through the Covid-19 process, including looking at how services have worked differently, will be essential if a second wave takes place.

SM shared an example of good practice during the pandemic, advising that the Psychology department had produced leaflets on how to cope after contracting Covid-19. Acute partners have been distributing these leaflets to patients. SM advised that this was a well written document and CCGs had indicated their satisfaction with the quality of the document.

ML agreed that there was a vast amount of learning from this unprecedented situation and noted the Trust was working with region and partners regarding reset and recovery. ML queried when it may be likely that learning can be pulled together for continue conversation regarding collective changes that they system may wish to make. SM advised that Phase 3 planning was underway and suggested that a report be discussed at the next Board Development Session.

JW referred to the weekly live staff event which received a number of positive comments each week and queried whether a formal staff feedback / survey had been considered. SM confirmed that informal feedback had been received, however SL and the Wellbeing Team will pick this up further. Consideration is being given to a formal staff questionnaire. SM advised that region had indicated that they had been impressed by the Trust's engagement with staff during the pandemic.

ACTION:

1. **Phase 3 planning to be included on agenda for Board Development session for discussion.**

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

ii) Flow and Capacity

AB advised that this report provided assurance on the inpatient capacity and bed occupancy position. AB confirmed that there had been a lot of work undertaken regarding flow and capacity and transformation prior to Covid-19 which had begun to have an impact. Due to the Covid-19 pandemic, a reduction in demand had been seen and out of area placements had reduced. As lockdown restrictions begin to ease, the Trust is now beginning to see an increase in demand for services. AB advised that with the phase 3 recovery plan, the Trust has identified that to comply with social distancing guidance, inpatient areas aim to maintain up to 85% capacity. The full impact of the pandemic is unknown, but services are already beginning to see an increase in the severity of clinically unwell presentations which will put further pressure on capacity and occupancy.

ARQ queried whether there was a contingency plan to keep occupancy to 85%, recognising that there is an anticipated second wave and surge in mental health expected. AB advised that potential plans and solutions are being explored, including utilising space available across the Trust, however there may be staffing and resource implications as a result. AB reiterated that there are several options to consider how to meet potential demand.

NL advised that region have requested a model be developed to meet a potential surge in demand as part of the reset and recovery work that is taking place across the system. NL confirmed that this model includes making available additional inpatient capacity. NL commented that good gatekeeping and the use of digital technology are also included as part of this model. NL acknowledged that to remain at 85% capacity may be challenging and potentially result in further pressure on out of area placements.

SS thanked AB and NL for this update, acknowledging that this was an ongoing process.

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

iii) Female patients with Personality Disorders

AB advised that following identification of an increased number of female patients with a personality disorder being admitted to inpatient environments, operational inpatient and professional leads have taken a holistic approach to the controls and mitigation focussing on service developments, workforce, training, therapeutic offer, environments and digital support. AB provided assurance the currently the numbers of female patients with personality disorders admitted to inpatient service is within manageable limits, however should the Trust continue to experience high numbers of this cohort of patients, the ward environment may become more volatile and difficult to manage, resulting in a risk to patient safety and length of stay. A number of service developments are available to support service users within the community therefore preventing and providing an alternative to admission. Workforce and training has also been reviewed and strengthened as well as further digital support being made available. In addition, all EUPD admissions are discussed on daily SITREPs so that the risk and activity can be shared across female treatment wards. The Trust wide roll out of '10 ways to improve

safety' and 'flow and capacity' principals will also support that admissions for females with personality disorder are within manageable limits.

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

iv) No Force First

NH advised that it is the Trust ambition to become a 'no force first' organisation and had been successful in reducing the number of restraints across the Trust in the previous year. Since the onset of the pandemic, it was recognised that this would likely negatively impact those in care due to several factors – lockdown measures resulting in visiting restrictions, reduction of leave for patients and requirements to isolate. Further to this, acuity of presenting patients may be influenced by fears and anxieties related to the pandemic as well as avoidance of therapeutic engagement in the community. These factors may lead to increased violence and aggression and potentially increase restrictive interventions. Actions have been undertaken to counteract the pandemic specific risk during this period, with focus on mitigating risk continuing to be strong and progress continuing to be made. Medical, Psychological and Occupations Therapy leads have met to develop each discipline's agenda in contributing to collaborative work. Psychology are leading on the introduction of trauma informed care, Occupational Therapists are engaged with activities and supporting techniques to alleviate boredom, anxiety and stress which are all factors related to increasing challenging behaviour. A Restrictive Practice Steering Group is in place as a forum to implement the agenda and cascade learning.

ARQ noted that within the report it had been identified that prone restraint was used as a means to exit seclusion. NH advised that it is recognised through TASI training that there are options on how to exit seclusion safely. NH also confirmed the Trust is exploring the introduction of safety pods.

SS noted the clear ambition around reducing restraint and the cultural change to drive this forward. SS sought assurance that the Board would be kept appraised of the ambition to reduce restraints by 20% year on year. NH advised that the Quality Committee would review to see progress. Nationally this is a challenge for a number of Trusts. NH added that a national benchmark is available and so progress will be monitored and compared nationally.

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

095/20 MENTAL HEALTH AND COMMUNITY HEALTH SERVICES TRANSFORMATION

NL advised that as the Trust begins to return to business as usual. A number of project managers redeployed during the Covid-19 pandemic are now returning their focus to the transformation programme. The Trust continues to work with commissioners regarding the Personality Disorder Business Case and an issue around funding has been identified which is being discussed.

NL confirmed that community projects had also been impacted by the Covid-19 pandemic with Mountnessing Court and the Cumberlege Intermediate Care Centre (CICC) being temporarily relocated to Brentwood Community Hospital. NL advised that there is a national shortage of qualified nursing staff, and as such skill mix and competencies were being reviewed to identify innovative ways of delivering services.

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

096/20 CQC UPDATE

SM presented the report which provided an update on the activities that are being undertaken within the Trust to maintain compliance with CQC standards, and support the Trust's ambition of achieving an outstanding rating by 2022.

SM advised that it was proposed that any outstanding actions as a result of the previous CQC inspection be transferred to a 'reset' action plan. These actions have reset focus on outcomes was presented and approved at the Quality Committee. The Executive CQC Steering Group agreed that the 'Towards Outstanding' working group reconvene with the first meeting taking place on 24 July.

SS thanked SM for advising of the renewed focus on outstanding actions.

The Board of Directors:

1. **Received and noted the content of the report.**
2. **Agreed the closure of the original CQC action plan with actions being transferred to the Reset Action Plan.**
3. **Approved the Reset Action Plan**

097/20 PHSO AND HSE STEERING GROUP

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

098/20 QUALITY ACCOUNT 2019/20 – INTERIM VERSION FOR PUBLICATION

NH advised that the Quality Account is usually due for publication formally by the end of June each year, however due to Covid-19 this has been delayed and submission is advised by NHSE/I by 15 December 2020. EPUT has worked to its normal timetable in producing this Quality Account and will publish an interim version in July, with a Council of Governors Statement but without partner statements. The CEO has written to partners with the revised timetable for final publication. Partner statements will be added in November prior to final approval by the Board of Directors.

The Board of Directors:

1. **Noted the EPUT (Interim) Quality Account for 2019/20 formally approved at Extraordinary Board on 24 June 2020 for publication on the public website.**

099/20 USE OF CORPORATE SEAL

The Corporate Seal has not been used.

100/20 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

101/20 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.

102/20 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SS reflected on discussions held and noted that the Trust values of being Open, Compassionate and Empowered were evident throughout the EOL presentation, noting the journey of the team and focus to ensure patients receive a quality service at a difficult time, leaving a lasting legacy with people and their families at the end of life.

AD stated that there is a national acknowledgement that Covid-19 can affect those from a BAME background and suggested it was important that the Trust were cognisant of differences that may be identified through national surveys and implement learning wholeheartedly. SL acknowledged that there was a common theme in that diversity runs through the organisation and was proud that the Trust considered equality and diversity in everything that we do.

103/20 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

Board members confirmed that they had remained present during the meeting and heard all discussions.

104/20 ANY OTHER BUSINESS

There was no other business.

105/20 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 29 July 2020, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

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

106/20 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 14:40.

Appendix 1: Governors / Public / Members Query Tracker (Item 106/20)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	In terms of the quality target of 7%, the Trust is currently achieving 39% which may indicate that the target is set too low?	SL advised that 7% is a minimum standard and not a target. The Trust achieves 40% so this shows that the organisation absolutely believes in the value that is brought by those with lived experience.
John Jones	Corporate RR48 Consultant cover in NE missed target – what is being done to remedy this?	MK advised that recruitment to medical staff in NE Essex has been a challenge. ET have approved initiatives to make the position more attractive. In the interim a locum has been secured at Peter Bruff and as such there is now a full complement of medical staff in place.
John Jones	CRR57 achieved a target score of 6, this doesn't sit with the staff survey results?	SL advised that this risk has a risk factor of 6. The Trust is introducing a culture of training and have strong engagement networks which all helps to build a strong culture in the organisation.
Pippa Crockett	Item 6D **Mental Health Act Annual Report.** 98/391 **HOTSPOTS** "Currently the Mental Health Act Administration team are unable to renew Section 3 on the PARIS clinical system."....."..*planned update of PARIS* due in Nov 2020" ..."....this has been placed on the Risk Register. (??) + ...how are Section 3 renewals (? In North Essex) recorded in the meantime? + Why the apparent delay in sorting out this problem?	NH confirmed that this was due to a software issue that has now been resolved. The issue had been raised and added to the Corporate Risk Register. NH confirmed that as this was a software issue, there had been no impact on section three renewals.

Anonymous	With regard to the environmental look of wards, units and out patients areas both Brockfield House and Basildon MHU patients and OT have created great environmental spaces this could roll out so the areas are updated	Thanks for this feedback. I will ask my Estates and Facilities colleagues to link in with these areas
Paula Grayson	In this Board meeting, many references were made to detailed discussions in sub committees. As Governors, we hold our NEDs to account by listening today and reading minutes of sub committees. Some sub committees met and scrutinised key reports such as Safeguarding, Mental Health Act and IPC annual reports. There is minimal evidence of active debate in the notes from the sub committees. Please can future notes contain more evidence?	Thanks Paula ... I will pick this up for the assurance reports it may be that the reports because presented twice to the committee for debate and approval.
Paula Grayson	There are a number of good practices cited in the early pages of the Quality Account which are for the future. What is the time scale? When will we have feedback about the ambitions being realised please?	I will also raise this to those involved and leading the agendas, we are planning to ascertain our timescales for reporting as delayed to CV19
Anonymous	Aspects of language needs to be addressed also earlier discussion took place on disability access we need to change this to in total access or accessibility	Mark I apologise if my use of language was incorrect during my PLACE presentation and will reflect your comment in future presentation. Regards

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 29 Jul 2020)

Lead	Initials	Lead	Initials	Lead	Initials
Andy Brogan	AB	Nigel Leonard	NL	Amanda Sherlock	AS
Alison Davis	AD	Manny Lewis	ML	Nigel Turner	NT
Natalie Hammond	NH	Mark Madden	MM	Janet Wood	JW
Rufus Helm	RH	Sally Morris	SM	Trust Secretary	TS
Milind Karale	MK	Alison Rose-Quirie	ARQ		
Sean Leahy	SL	Sheila Salmon	SS		

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session . SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	
July 092/20 (1)	Review of BAF41 wording and mitigation in light of recent conversations held at F&P Committee, where challenges in delivering recurrent CIPs were discussed.	TS	September	Wording updated.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
July 094/20 (1)	Phase 3 Reset and Recovery Planning to be included on agenda for Board Development Session for discussion.	TS	September 2020	Added to the Board Seminar Agenda for November 2020	Completed	
May 068/20 (1)	Board Assurance Framework – Review BAF9 risk in light of review of data for Q1	NH	July 2020	Risk reviewed. Satisfied that progress is being made to mitigate. No Force First Assurance report provided to Board on the 29th July..	Completed	
March 026/20 (1)	Quality Health to explore lack of correlation in questions relating to staff being pleased with the quality of care they are able to provide and the Friends and Family Test responses in relation to recommending the Trust as a place to work or a place for family or friends to receive treatment.	Quality Health SL	May 20	Quality Health have provided a response which has been shared with ARQ. A further Board Seminar Session Plan on 2019 staff survey results will be scheduled as part of the Covid Recovery Plan in future months. Workforce Transformation will also assess results and set local improvement plans.	Completed	
March 026/2020 (2)	SL, ARQ and Quality Health to discuss results in further detail.	SL/ARQ	May 20	On-going discussions in July at the People, Innovation and Transformation Committee	Completed	
March 040/20	AD to check with NL whether the Covid outbreak will impact the ongoing HSE/ PHSO Investigation.	AD/NL	May 20	Our lawyers have confirmed that the Covid19 outbreak has impacted on the HSE progress with responding to the points of clarity requested by EPUT. As soon as an update is received we will reconvene the Task and Finish group and update the Board accordingly.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 023/20 (ii)	Provide the outcome of the deep dive referred to in performance report in respect of older people's readmissions to P. Ecclestone	MK	~~Feb20~~ ~~Mar 20~~ May 20	A higher rate of readmission in the north and west of the Trust is likely due to patients being discharged to acute hospitals and readmitted. In the South East patients are marked on leave whilst transferred to acute. MK to explore why there is not a consistent approach across the Trust. ET discussed and requested operations to agree consistent approach. SW/LW agreed practice should be standardised based on current approach in north Essex.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
September 174/19	Update on progress with implementing the QI framework to be provided to the Board.	NH	~~Mar 20~~ May 20	Governance arrangements to support implementation of the QI Framework are in place. A sub-committee has been formed with agreed terms of reference. Driving the agenda at Directorate level are QI Hubs. Specialist services and mental health are working with clear terms of reference and identified projects and are supporting the development of QI Hubs across community and corporate services. The sub-committee has reviewed the Framework and action plan in light of current challenges and have tightened arrangements to embed QI across the organisation; the changes will be considered by the Quality Committee in June 2020. This is supported by a comprehensive action plan. A training strategy has been drafted providing a framework to build capacity and competency in relation to QI at a range of levels. A tiered approach has been proposed building competency at a range of levels with an aim to train 500 staff during 2020/21. The intranet has a section on QI, and this is under development to make it a platform for staff to access information in relation to training, QI tools and methodology, opportunities and QI projects. The actions relating to the QI ambitions of the frameworks are caveated in relation to the current pandemic and ensuing impact on resource and capacity and innovative ways to deliver are being designed.		
March 034/2020	Weekly WebEx video conference to be scheduled for NEDs and members of the Executive Team, to ensure NEDs are kept up to date of the current situation and actions taken.	SM	May 20	Weekly WebEx call scheduled and invitations sent to NEDs and members of the Executive Team.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 004/20	ARQ to visit the Perinatal Service	ARQ	Mar 20	Visited on 20 February.	Completed	
January 004/20	CB to be invited to Mortality Committee to agree how the perinatal suicide agenda is incorporated into the Trust's Suicide Prevention Strategy	NH	Mar 20	Actioned	Completed	
January 005/20	Clarify progress with development of dashboards as referenced in the Quality Priorities update in the Performance Report .	NH	Mar 20	There is now a dashboard against each priority that can be measured. Ward level dashboards are also in place and training has been undertaken in this respect by both matrons and ward managers.	Completed	
January 007/20	There is a need to agree which standing committee will take responsibility for detailed monitoring and discussion in respect of Cardio Metabolic Assessment (CMA).	AS/ML	Mar 20	AS advised Finance and Performance.	Completed	
January 007/20	Drop in RTT performance in south Essex to be investigated.	MM	Mar 20	FS confirmed that there had been confusion as to which RTT target had been referred to, however SEE data had been reviewed with no variation noted. FS reported however that a slight underperformance is noted in the report presented to Board this month.	Complete	
January 007/20	CMA deep dive report considered at Finance and Performance Committee in January to be circulated to Board members.	MM	Mar 20	Finance and Performance assurance report presented to January Board. Chair of Finance and Performance Committee gave praise for the work carried out on the CMA. It was noted that a further audit would be carried out on the CMA.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 008/20	Confirmation to be provided of the timescale for completing ligature risk reduction works to bedroom and bathroom doors and soap/towel dispensers.	MM	Mar 20	Door Top Alarms to be fitted to communal bathroom and shower room doors started 24/02 and are to be completed by mid-April. All bedroom door top alarm installation has been completed in accordance with ligature policy standards. Soap/towel dispensers to be trialled at Basildon MHU week commencing 9th March having been initially tested at AFC. If this testing in a live ward is successful then the revised fittings will be rolled out to all locations in a programme lasting 4 months.	Completed	
January 009/20	A detailed report of the financial implications of the nursing establishment review be provided to the Finance and Performance Committee.	NH	Mar 20	Establishment Review paper will be presented to F&P on 19 March 2020.	Completed	
January 010/20	Content and format of mortality / learning from deaths report to be reviewed/ improved to focus on learning and simpler presentation of data.	NH	Mar 20	Data presentation has now been simplified with more focus on learning. Quality Committee have been asked to comment on the new format at their next meeting on 13 March prior to it being presented to the Board.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 012/20	Confirm whether CMA is a CQUIN and if so, what is the financial implication of non-achievement.	NL	Mar 20	The answer is that the full CMA CQUIN ended last financial year. This year there is CQuin that followed on with part of it, Alcohol and Tobacco, assessment and follow up/referral on for treatment, and this one we are highly likely to fully achieve because we have surpassed the requirements every quarter, with Q4 to go. In the very unlikely event we missed the target the financial implication would be 28k based on today's figures, but these figures improve every day and the financial implications consequently improve every day.	Completed	
January 012/20	Identify learning from EU Exit planning and present this to the Board of Directors.	NL	Mar 20	On agenda for Board meeting March 20. FS to develop this	Completed	
January 012/20	Board seminar discussion regarding transformation to be scheduled.	FS/NL	Mar 20	Included on Agenda for Seminar 29 April 2020.	Completed	
January 023/20 (i)	Confirm current data and forecast for achieving target of 20% reduction in prone restraint to J.Jones	NH	Feb 20	Current data confirmed with J Jones. Reduction currently stands at 14% of all restraints and 6% specifically on prone although we are awaiting updated data from Performance following the introduction of safety pods etc.	Completed	
October Public Q	Share CQC guidance regarding long term segregation with PE and have discussion following the Board meeting.	NH	November 2019	CQC guidance sent to PE 20 November. NH and PE discussed issue at the COG meeting 13 November	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 200/19	The timescale for developing the suicide prevention and QI dashboards to be confirmed.	NH/ MM	November 2019	Quality Account content reviewed in respect of suicide prevention dashboard as misleading. By August 2019 a suicide prevention dashboard will be in place to track and monitor progress on the ten key parameters for safer mental health services. Revised wording now: By August 2019 a suicide prevention action plan will be in place to track and monitor progress on the ten key parameters for safer mental health services. Action plan in place supported by work streams to ensure delivery. New separate action (with Mar 20 timescale) is: Dashboard to be developed against action plan to monitor delivery at service level. QI dashboard: Quality Account action is - By September 2019 to have in place a dashboard against all quality priorities. Update: Dashboard is in place against a number of priorities with further work scheduled for roll out against all areas.	Completed	
October 207/19	Future transformation progress reports to explore workforce risks and mitigation in more detail.	NL/SL	November 2019	Transformation report presented November has focus on workforce issues	Completed	
September 174/19	Quality Committee Terms of Reference to be revised to reflect establishment of new QI and Innovation sub-committee.	AS/NH	November 2019	TOR revised and approved by Quality Committee 14 November 2019	Completed	
July 149/19	Quality Committee to be provided with an update on implementation of the LD Improvement Standards.	AS/NH	November 2019	Quality Committee 14 November received update	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 209/19	CQC Update – the Board delegated authority to the Quality Committee to approve the CQC action plan as a result of the Well Led Inspection held July/August 2019, prior to submission on 20 November 2019.	AS/NH	November 2019	Draft action plan considered by Quality Committee 14 November 2019. Final action plan approved by Chairs action and submitted to CQC by deadline of 20 November 2019. Presented to Board of Directors at agenda item 9a.	Completed	
July 150/19	Ensure that any target dates missed within Quality Priorities include an explanation in future reports.	NH	September 2019	Update 25/9: Addressed in report presented to September Board of Directors.	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

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**	

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Service Visits
- CEO and Executive Director Departures
- NED Departure
- CEO Transition
- Executive Team Changes
- Council of Governors
- Joint AO for Mid and South Essex STP

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
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 £**			
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
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
30 September 2020

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

This report provides a summary of key activities and information to be shared with the Board and stakeholders and an update on governance developments within the Trust.

2.0 CHAIR'S REPORT

2.1 Coronavirus / Covid-19

The situation regarding the Covid-19 pandemic continues to change rapidly, with infection rates rising on a national scale and tightened control measures. The Trust has put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is being updated frequently as the situation develops further. The Trust is fully engaged with regional and national planning to respond to this situation. The Non-Executive Directors and I have been kept fully briefed during this extraordinary time by the Chief Executive and Executive Team. I and the Board wish to extend our thanks to our dedicated staff who have continued tirelessly and with exemplary resolve to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 Chair and NED Service Visits

Due to the ongoing Covid-19 Pandemic and the enforced lockdown by Government, in order to compress the risks associated with cross infection and to protect patients and staff, the Board of Directors took the decision to cancel all non-essential service visits. Whilst these will be restored at the earliest safe opportunity, I am pleased to advise however, that with the increasing use of digital technology, we have piloted two 'virtual' NED visits using Microsoft Teams. 'Virtual' visits of the Veteran's Service and Clifton Lodge have taken place, with further 'virtual' visits to services to be scheduled. This innovative approach is being evaluated and it is hoped that future visits can include Governor participants.

2.3 CEO and Executive Departures

On behalf of the Board of Directors, as we bid a fond farewell, I would like to extend our heartfelt thanks and best wishes to Sally Morris (CEO), Andy Brogan (COO and DCEO) and Mark Madden (CFO). Sally and Mark are retiring and we particularly wish them long and fulfilling retirements as they each embark on their new life chapters. Andy has decided to return to his nursing leadership roots and we sincerely congratulate him on his new role as Executive Nurse at St Andrews. Of course each of them individually, and as a collective, will be much missed. They have given dedicated service and exemplary leadership over many years.

2.4 NED Departure

NED Nigel Turner's tenure has also come to an end, with Nigel leaving the Trust on 30 September. On behalf of the Board, I would like to extend our sincere thanks and appreciation to Nigel for his contribution to the Trust during the past three years over the length of his appointed term of office and we wish him well in his future endeavours. Nigel's role as the Chair of the Charitable Funds Committee will be taken-up by Rufus Helm. This will be formally approved at the next meeting of the Committee.

2.5 CEO Transition Arrangements

I am delighted that our new CEO, Paul Scott, formally joined us on 24 August. Paul has spent his first few weeks with the Trust undertaking a robust induction process, including visiting many services across the organisation. Paul has shared that he has found these visits informative and positive, and has greatly enjoyed meeting many of our enthusiastic, dedicated staff. Paul has received a comprehensive handover by Sally and officially takes the reins as Chief Executive and Accountable Officer on 01 October.

2.6 Executive Appointments

CFO: I can confirm that the recruitment process for a new Executive Chief Finance Officer delivered a strong outcome. Trevor Smith was successfully appointed and joined us on 18 September, which has allowed a comprehensive handover with Mark before his retirement. Trevor will formally take up the reins of the CFO on 01 October,

COO: Following the news that Andy Brogan is returning to his nursing roots at St Andrews, a decision was taken to open the position as an interim development opportunity to our existing Directors in the Trust. Initially this is anticipated as a 6 month appointment, which will allow our new CEO, Paul Scott to consider his future Board structure, whilst at the same time, having someone in post to lead and deliver our operational services. I am delighted to announce that following an open process Alex Green has been appointed as Interim COO. Alex is currently Director of Health and Care Delivery for West Essex at EPUT and Essex County Council and brings a wealth of experience to the role, having worked in health and social care for more than 25 years. Alex will take over the interim role on the 24 October when Andy leaves the organisation on the 23 October. Congratulations Alex!

2.7 Council of Governors

I am delighted to note that the outcome from the recent round of Governor elections is extremely positive with a mix of re-election of experienced Governors coupled with new Governors coming into our Council.

In Essex Mid and South, Keith Bobbin has been re-elected, along with new Governors; Emmanuel Jessa and Liz Rotherham. North East Essex and Suffolk have two new Governors; David Rolph and David Short. West Essex sees the return of Brian Arney and Pippa Ecclestone and one new Governor Jean Juniper. Finally, our Staff Constituencies; Tracy Reed was re-elected as a Clinical Governor along with a new Governor Jared Davis. Lara Brooks and Reverend Paul Walker are our new Staff Non-Clinical Governors – welcome aboard!

We greatly look forward to working with the refreshed Council as we move forward.

2.8 Joint Accountable Officer and STP Lead for Mid and South Essex STP

I was pleased to be a member of the interview panel for the role of Joint Accountable Officer and STP Executive Lead for Mid and South Essex. Our incoming CEO Paul Scott chaired one of the stakeholder panels. High calibre candidates were interviewed and the successful candidate will be announced in due course.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Our Standing Financial Instructions

Please see attached a copy of the updated standing financial instructions which was updated on 1 September 2020 which sets the purpose, scope, roles and responsibilities and payments. **For Information: Link**

3.2 Time to Deliver Real Change for People with a Learning Disability and Autistic People
The report asks for help with the ongoing underfunding of services available for people who have learning disabilities and autistic.
For Information: Link

3.3 NMC Sets Out Plans To Safely Resume Fitness To Practise Hearings
The NMC will resume fitness to practice hearings on 14 September 2020. Safety measure will be put in place to include staggered start times for physical hearings whilst some will be virtual depending on the complexity of the case.
For Information: Link

3.4 New Framework Launched To Help NHS And Public Sector Organisations Manage Cyber Threats
The new framework will assist in giving the NHS confidence from cyber security.
For Information: Link

3.5 Prevalence Data For 21 Common Conditions Published Today
The report is made up of information voluntarily provided and shows that mental health is one of the key conditions.
For Information: Link

3.6 Immigration Skills Charge Is A Burden For NHS Trusts.
The NHS relies on staff from other countries to maintain staffing levels which has cost NHS Trusts over £15 million pounds.
For Information: Link

3.7 Positive Developments on Inspections
The CQC is aiming to adopt a more streamlined and easier way of carrying out Trust inspections.
For Information: Link

3.8 Health And Care Inspections Should Not Resume Until After Winter – NHS Confederation
A letter sent to the health and social care secretary asks them to consider a lighter approach until after the winter so as not to increase the burden on health leaders and their teams.
For Information: Link

3.9 Reintroduction Of CHC (Continuing Healthcare) Assessments With Effect From 1 September 2020
The Department of Health and Social Care has released the new guidance of continuing Healthcare
For Information: Link

3.10 CQC Transitional Regulatory Approach
CQC inspections will resume in September 2020 taking an approach from Emergency Support Framework and aims to contact every social care provider by March 2021.
For Information: Link

3.11 Funding Boost For Clinical Placements Growth And Teaching
£15m is going to be available to increase clinical placements in the NHS to help with undergraduate programs starting in September.
For Information: Link

3.12 New HEE Fellowships Will Help NHS Staff Shape The Digital Healthcare Revolution

The recruitment for this commences 01.09.2020 – 30.09.2020 and 5 successful candidates will be given time to design and deliver health projects and initiatives allowing them to lead digital health transformations for NHS staff and patients.
For Information: Link

3.13 Coping With The Expected Surge In Children's Services Referrals
As life return to normal there is likely to be a rise in children's referrals due to concerns raised and safeguarding. It is expected that numerous caseloads may have suffered during this period and that some will children will be experiencing mental health issues for the first time.
For Information: Link

3.14 HEE Launches New Learning Resources To Prevent Suicide And Self-Harm
As part of World Suicide Prevention HEE has launched a new online service which will be free to access and anyone caring for or is feeling suicidal can access this service.
For Information: Link

3.15 Developing NHS-Led Lead Provider Collaboratives: Faqs To Support You
The role is to help in improving mental health services and a 10 FAQ guide to help you process a successful collaborative.
For Information: Link

3.16 Be Aware Of The Signs Of Abuse And Neglect In Adult Care Homes, Says NICE
A new guideline will help residents, family members and staff visiting care homes to assist in recognising the warnings signs and what steps they need to take if they suspect there is neglect.
For Information: Link

3.17 Creating the Workforce of the Future
Please see the report below asking that "employer hubs" be set up to bring NHS organisations together with colleges providing recruitment of students to the NHS.
For Information: Link

3.18 Mental Health Services Monthly Statistics Performance June, Provisional July 2020
Please see a copy of the report below which was published on 10 September 2020.
For Information: Link

3.19 **Community Services Statistics for Children, Young People and Adults May 2020**
Please see a copy of the report below which was published on 10 September 2020.
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: 6a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

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

Purpose of the Report

The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance "hotspots". 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 5 (August 2020).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed the hotspots in detail for August 2020.

Two hotspots (variance against target/ambition) have been identified at the end of August 2020 and are summarised in the Quality and Performance Reporting Hotspots Scorecard.

- Timeliness of Data Entry
- CPA Reviews

There are no Hotspots which are Oversight Framework indicators for August 2020.

There are no hotspots in the EPUT Safer Staffing Dashboard for August 2020.

This CQC Reset action plan is summarised in the CQC Scorecard. There is one hotspot identified for Overarching actions, with one action past timescale for August 2020. This action is:

- The trust must review their risk management systems to prevent overly restrictive wards, ensure blanket restrictions are reduced and review the use of prone restraints.

In August 2020 there remains one hotspot identified within the Finance scorecard which is Cost improvement Programmes. The CIP Programme continues to be affected by the

Summary of Key Issues
response to COVID-19 and the emergency finance regime. The Trust focus is on the Recurrent savings in preparation for the emergency finance regime ending. 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	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF6 BAF9 BAF10 BAF13 BAF20 BAF32 BAF33 BAF34 BAF35 BAF36
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 £**			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

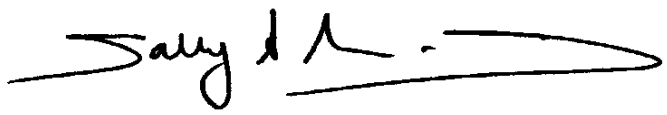
Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme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

CRHT	Crisis Resolution Home Treatment Team	OT	Outturn
CWP	Connecting with People	YTD	Year To Date
EIP	Early Intervention in Psychosis	PHSO	Public Health Service Ombudsman
FEP	First Episode of Psychosis	PICU	Psychiatric Intensive Care Unit
FFT	Friends and Family Test	RAG	Red-Amber-Green
RWB	Recovery & Well-Being Team	RTT	Referral to Treatment
RD	Recovery Date		

Supporting Documents and/or Further Reading

Board Integrated Quality & Performance report

Lead



Name Sally Morris
Job Title Chief Executive

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
August 2020

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.

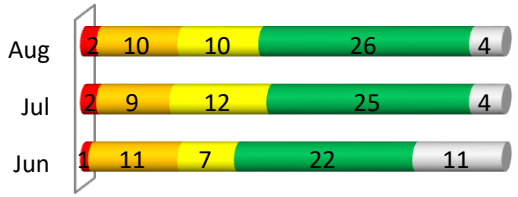
How is data presented?

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	Emerging Risk EPUT is performing under target in current month/ Emerging Trend	Hot Spot 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	Trend Depicts current trend and colour coded accordingly

SECTION 1 - Performance Summary

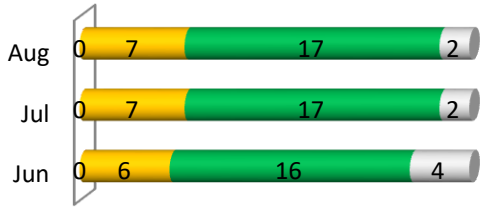
Hotspots Summary of Quality and Performance Indicators (Pg 6)



August Hotspots

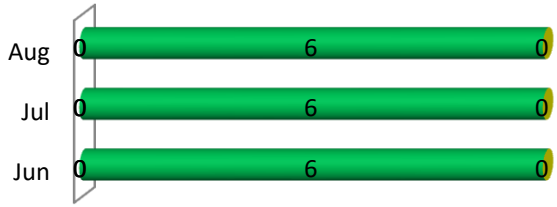
- 2.1 Timeliness of Data Entry (Pg 6)
- 2.3 CPA Reviews (Pg 7)

Summary of Oversight Framework Indicators (Pg 8)



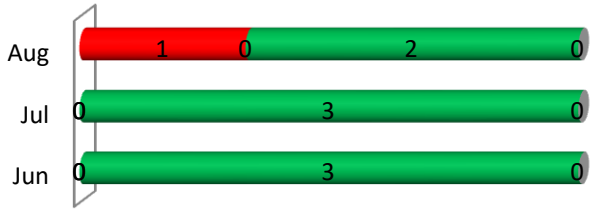
No hotspots are identified within the Oversight Framework.

Summary of Safer Staffing Indicators (Pg 19)



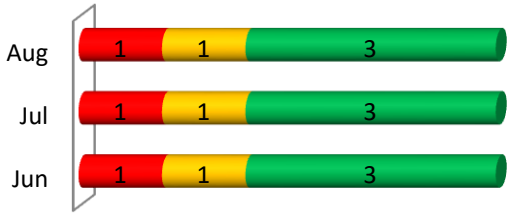
No hotspots identified within the Safer Staffing scorecard.

CQC Summary (Pg 21)



One hotspot identified within the CQC Summary for Overarching actions:
• The trust must review their risk management systems to prevent overly restrictive wards, ensure blanket restrictions are reduced and review the use of prone restraints.

Finance Summary (Pg 23)



August Hotspots

- Cost improvement Programmes

SECTION 2 - EPUT Quality and Performance Reporting Hot Spots Scorecard

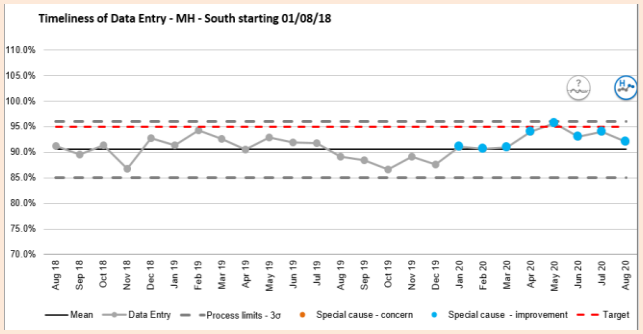
For Note:

- MH Serious Incidents: In August there were 6 Mental Health serious incidents within the Trust, this represents no change from our position in July and overall EPUT is continuing to see a reducing trend.
- CHS Serious Incidents: Zero Community Health serious incidents were reported in August and year to date, and there is no significant trend following analysis.

Click here to return to Summary

<table>
<tr><th colspan="8">Effective Indicators</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M5</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td rowspan="2">2.1 Timeliness of Data Entry

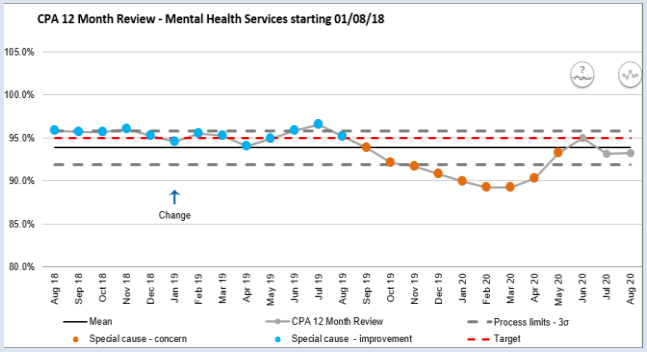
Committee: FPC
Indicator: Local
Data Quality RAG: TBC</td><td colspan="7">Hotspot
Timeliness of Data Entry has been highlighted as a hotspot risk as Mobius MH data is below target at 92.0% in August.

Data Entry MH services (on Mobius) achieved 92.0% in August 20 against target of 95%. In August there were seven (out of 11) MH and one (out of two) Specialist MH Services below target. The following services were below 90%:
• Memory Service
• Other Teams (This includes but is not limited to services relating to Speech Therapy, Psychology, Psychotherapy, OT, and Day Care)
• Forensic Community
Late data entry has a significant impact on trust reported performance and internal figures being at variance with national figures.</td></tr>
<tr><td>2.1.2 Timeliness of data entry - Continuation Sheets Completed (Mobius)
Target 95%</td><td>92.0%</td><td>●</td><td>Above Target = Good
 
</td><td>●</td><td>Special Cause of improving nature due to achieving (H)igher values</td><td></td></tr>
</table>

<table>
<tr><th colspan="8">Effective Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M5</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><th></th><th></th><th>Perf</th><th>RAG</th><th></th><th></th><th></th><th></th></tr>
<tr><td rowspan="2">2.3 CPA Review

Committee: Quality
Indicator: National
Data Quality RAG: Amber</td><td colspan="7">Hotspot
CPA Reviews has been highlighted as a hotspot as performance continues to be below target. Since April 2020 this indicator has seen marked recovery following the decline in performance from July 2019. Significant efforts are being made to continue this recovery. This performance has been noted by all Commissioners.

Compliance for August 20 remains below 95% target at 93.3%. There were 12 Teams in the South, five Teams in Mid, four Teams in NE and two Teams in West below target.</td></tr>
<tr><td>People on CPA will have a formal CPA review within 12 months

Target 95%</td><td>93.3%</td><td></td><td>Above Target = Good
 
</td><td></td><td>Performance remains inconsistent</td><td></td></tr>
</table>

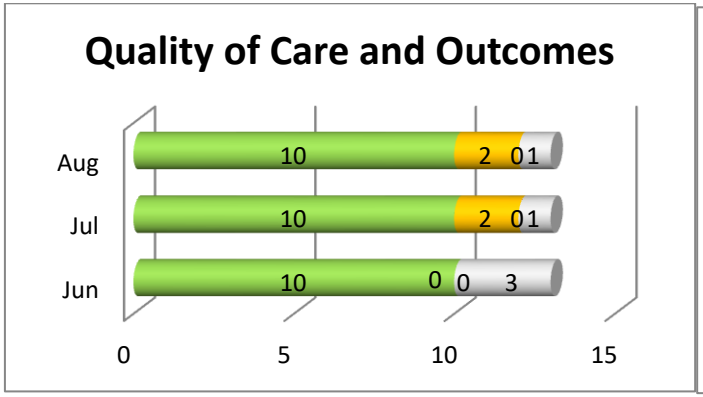
[Click here to return to Summary]

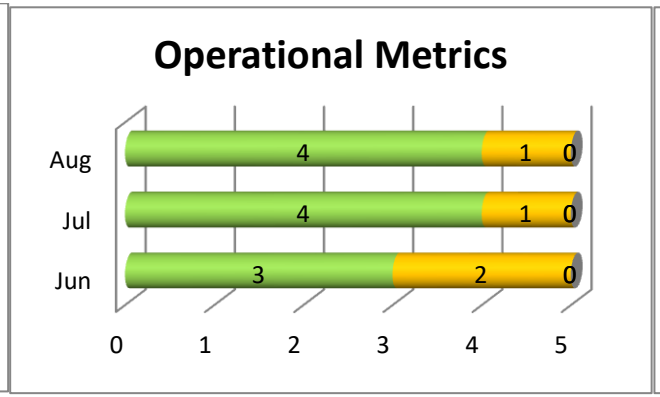
SECTION 3 – Oversight Framework

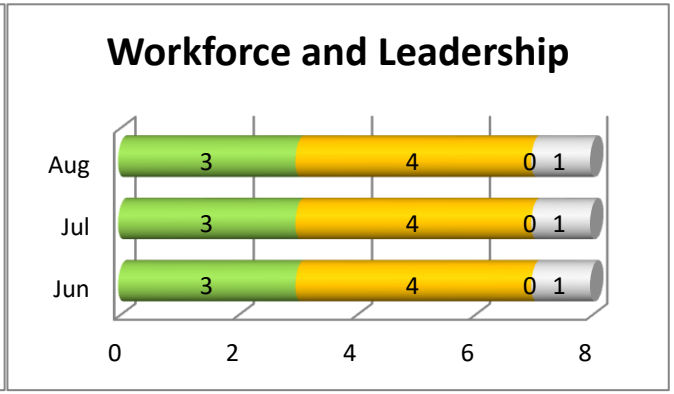
Click here to return to Summary

Summary

Following the revision to the national Oversight Framework in August 2019, not all indicators have been issued with a target. Where there is a national target or benchmark this has been used to assess if potentially an emerging risk (colour coded Amber) or risk (colour coded red). The Oversight Framework highlighted that an indicator will be a cause for concern only if below targets set for 2 months therefore indicators have only been indicated as a risk if below for 2 months.





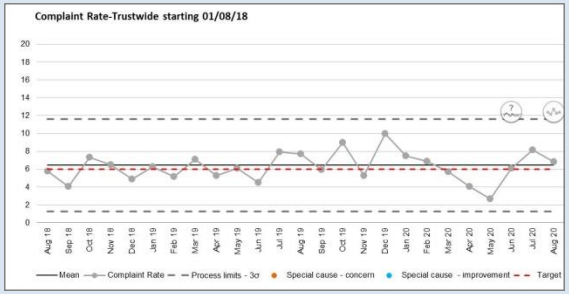


Hotspots

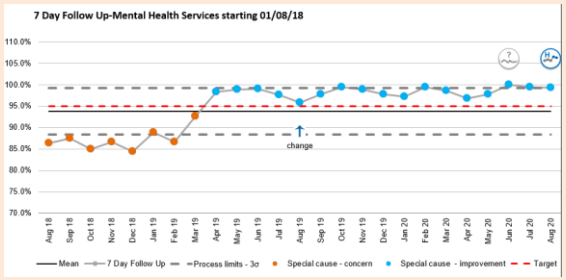
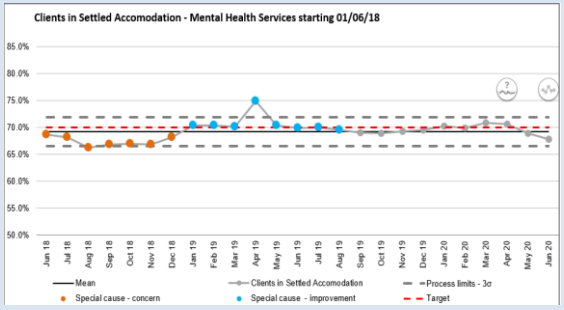
There are no Oversight Framework hotspots identified for August 2020.

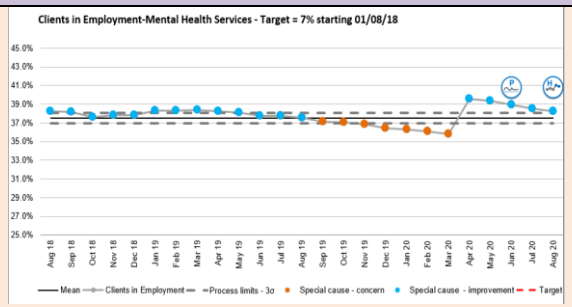
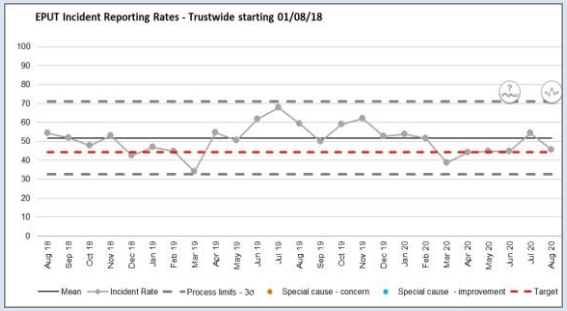
Emerging Risks (4 emerging risks)

- Complaint Rate
- Clients in Settled Accommodation
- Out of Area Placements
- Staff Survey indicators (4 indicators)

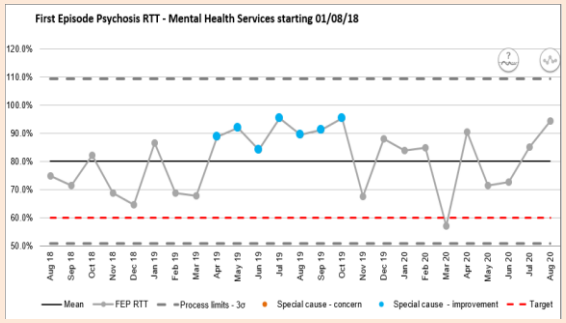
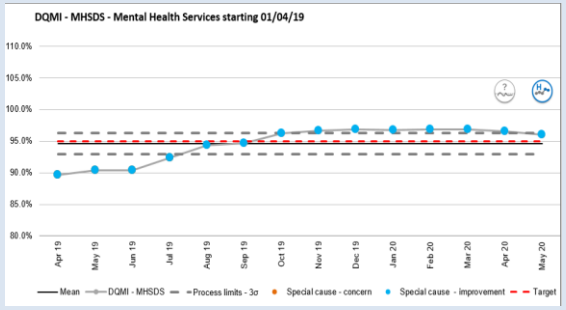
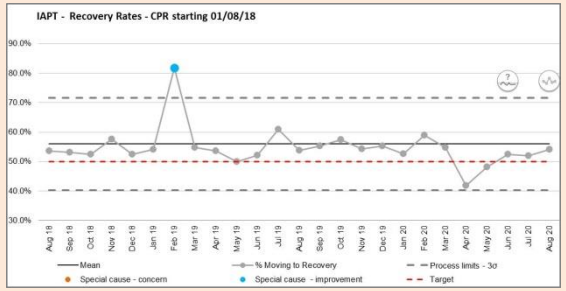
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	Achieved overall “Good” with Outstanding for Caring Oct 2019			N/A
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	Written Complaint Rate (no target set)	6.8	●	Below Target = Good 	●	Performance remains inconsistent	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) **Target 74%**		●		●	Indicator suspended nationally over Covid period	N/A
1.1 Never Event Committee: Quality	Occurrence of a Never Event in last 6 months (no target set)	0	●	Year to Date 0	●	Monitored over six-month rolling period	N/A

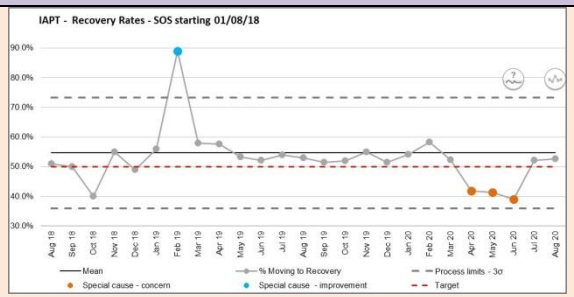
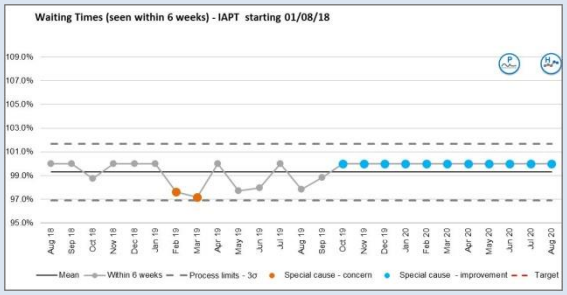
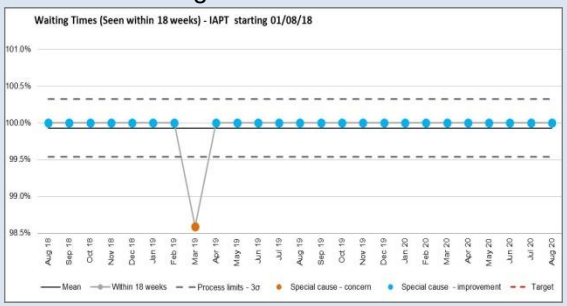
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2019/20 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 Patient MH Survey Data Quality RAG: **Green**	CQC community mental health survey (no target set)		●	EPUT achieved the same or better in all 11 domains in the 2019 survey	●	Action plan in place and all actions within timescales	N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG: **Green**	Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 88.3%**		●	100% of responses were rated Very Good or Good.		Very low number of Responses for August. 15 total for MH	N/A

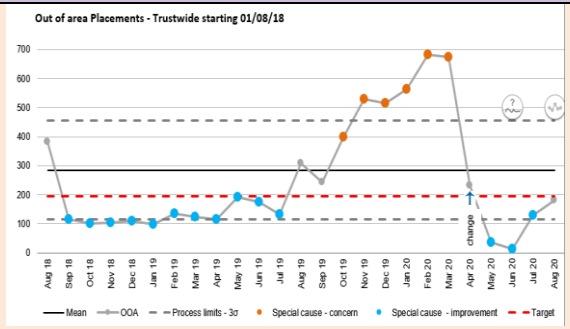
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.3.2 Patient FFT CHS Committee: Quality Data Quality RAG: **Green**	Community scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 96%**		●		●	Very low number of Responses for August. 6 total for CHS	N/A
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Green**	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	99.4%	●	Below Target = Good 	●	Special Cause of improving nature due to (H)igher values	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	% clients in settled accommodation (no target set) **LA Target 70%**	65.4%	●	Trend above Target = Good 	●	Reduction in Paris data noted (64.1% in August). Special cause of concern due to 5 months of decline.	N/A
2.5 Employment	% clients in employment (no target set) **LA Target 7%**	38.2%	●	Trend above Target = Good	●	Assurance indicates consistently (P)assing target.	N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**							
1.8 Patient Safety Incidents Committee: Quality Data Quality RAG: **Amber**	Potential under-reporting of patient safety incidents **Target >44.33**	45.4	●	Trend above Target = Good 	●	No significant trend noted however performance is inconsistent. CQC Insight Report August 2020: Jul 19 – Jun 20 Potential Under Reporting of Incidents shows EPUT with a ratio of 0.4, in line with National average of 0.2.	N/A
1.15 Under 16 Admissions Committee: FPC Data Quality RAG: **Green**	Admissions to adult facilities of patients under 16 years old	0	●	Zero admissions in June and YTD.	●		N/A

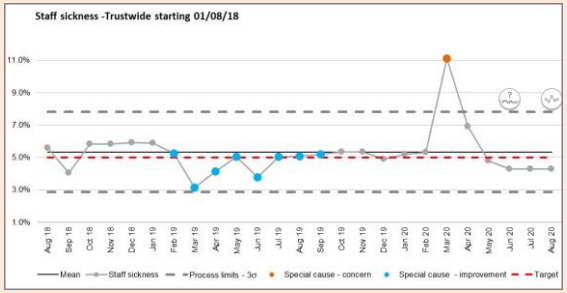
Click here to return to Summary

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	>56% of people with a first episode of psychosis (FEP) begin treatment with a NICE-recommended care package within two weeks of referral	94.4%	●	Trend above Target = Good 	●	Target change effective April 20 (from 56% to 60%) 1 / 18 Breached in August : 1 / 7 West Essex CCG Teams are currently experiencing issues with clients reluctant to engage via Video Calls during COVID19 pandemic	N/A
2.2 DQMI Committee: FPC Data Quality RAG: TBC **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	96.0%	●	Trend above target = good 	●	Latest published figures are for May 20	Dec 20
2.16.3/4 IAPT Recovery Rates Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 54.1%	●	Trend above target = Good 	●	In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	Part of Reset Plan
		SOS 52.6%	●	Trend above target = Good	●	The IAPT service for Southend saw a higher than usual and more sustained rate of self-discharges mid therapy (Apr-Jun). This was due to patient concerns around Covid-19.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
							
2.16.5/6 IAPT Waiting Times Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%	●	Trend above target = Good 	●	Consistently passing target	N/A
		ii) 100%	●	Trend above target = Good 	●		
4.5 Out of Area Placements	Continued reduction in Out of Area Bed days to 0 by 2020/21	180	●	Below Target = Good	●	In August EPUT placed 13 new clients out of Area (ten Adult & three PICU), ten remain (eight Adult & two PICU) OOA at the end of August. 11 patients were repatriated in August (seven Adult & four PICU). The total Occupied bed days for all out of area placements in August was	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Data Quality RAG: **Amber**						180. OOAP's for locked Rehab patients have been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area, this was discussed and agreed at ET in July 2020.	

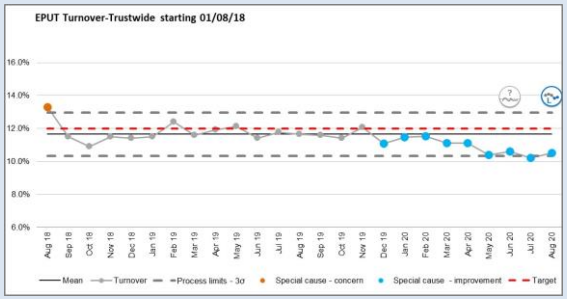
<table>
<tr><th colspan="8">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M5
Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>5.3.1 Staff Sickness

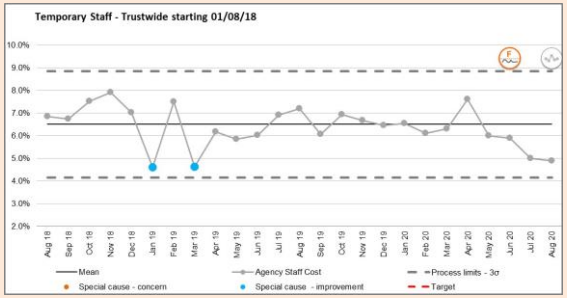
Committee: FPC
Data Quality RAG: TBC</td><td>Sickness Absence consistent with MH Benchmark 6%
EPUT Target <5.0%</td><td colspan="2">July 4.3%
August Draft 4.3%</td><td></td><td>Below Target = Good
 
</td><td></td><td>July* sickness absence is below the target of <5% at 4.3%.

*Please note sickness is reported in arrears to allow entry in to ESR. August is represented as a draft only.</td><td>N/A</td></tr>
<tr><td>5.2.2 Turnover

Committee: FPC
Data Quality RAG: Blue</td><td>Staff turnover rates (no target set)

(Benchmark 2017/18 MH 12%/CHS 12.1%)

EPUT Target <12%</td><td colspan="2">10.5%</td><td></td><td>Below Target = Good
 
</td><td></td><td>Special Cause of improving nature of lower pressure due to (L)ower values.</td><td>N/A</td></tr>
<tr><td>5.7.3 Temporary Staff

Committee: FPC
Data Quality RAG: Blue</td><td>Proportion of temporary staff Agency staff costs (no target set)</td><td colspan="2">4.9%</td><td></td><td>Below Target = Good
 
</td><td>N/A</td><td>No significant trend noted</td><td>N/A</td></tr>
<tr><td>5.5 Staff Survey</td><td>Place to Work of Receive Treatment</td><td colspan="5">Recommendation of the organisation as a place to work or receive treatment

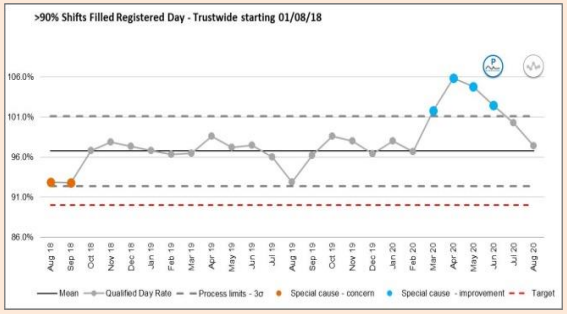
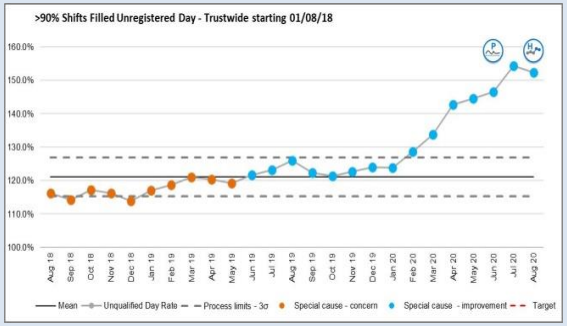
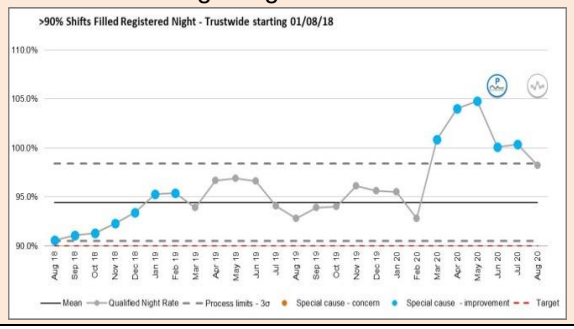
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>C21a Care of patients / Service users is my organisations top priority</td><td>74.3%</td><td>76%</td><td>Better than last year.</td><td></td></tr>
<tr><td>C21c I would recommend my organisation as a</td><td>58.9%</td><td>62.4%</td><td>Worse than average</td><td></td></tr>
</table></td><td></td></tr>
</table>

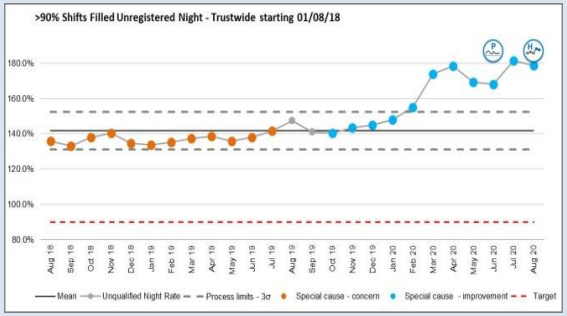
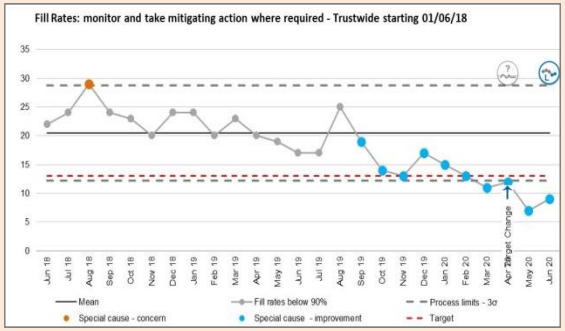
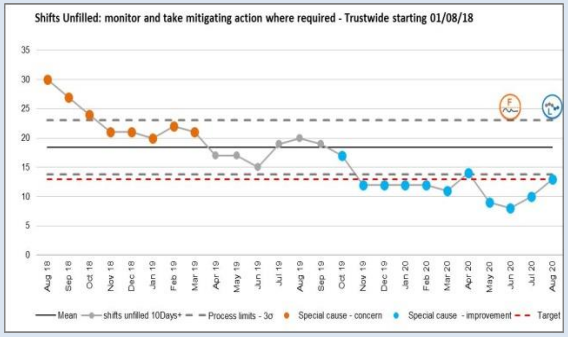
<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M5
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="4">Committee: FPC
Data Quality RAG:
Green</td><td></td><td colspan="5"><table>
<tr><td>place to work</td><td></td><td></td><td></td><td></td></tr>
<tr><td>C21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation</td><td>60.8%</td><td>67.52%</td><td>Below average</td><td>●</td></tr>
</table></td><td></td></tr>
<tr><td>Harassment, Bullying and Abuse</td><td colspan="5">Support and compassion average rating of:
• % experiencing harassment, bullying or abuse from staff in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Safe Environment – Bullying & Harassment (high is better)</td><td>7.9</td><td>8.2</td><td>Below Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)</td><td>12%</td><td>10.8%</td><td>Above Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)</td><td>18.4%</td><td>16.3%</td><td>Above Average</td><td>●</td></tr>
</table></td><td></td></tr>
<tr><td>Team Work</td><td colspan="5">Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team’s effectiveness
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>73.7%</td><td>Better than average and better than last year.</td><td>●</td></tr>
<tr><td>Q4i The Team I work in often meets to discuss the team’s effectiveness</td><td>68.5%</td><td>69.1%</td><td>Below Average better than last year</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern</td><td></td></tr>
<tr><td>Inclusion</td><td colspan="5">Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leader
or other colleagues in the last 12 months
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>82.4%</td><td>85.1%</td><td>Below Average</td><td>●</td></tr>
<tr><td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td><td>8.1%</td><td>6.4%</td><td>Above average</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern</td><td></td></tr>
<tr><td></td><td colspan="5">Inclusion (2)
The BME leadership ambition (WRES) re executive appointments.
Trusts in lowest third across the sector will represent a concern</td><td></td></tr>
</table>

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
		WRES data publishing this month: Later this month EPUT will be publishing its latest Workforce Race Equality Standard (WRES) data, followed by a presentation at the Board meeting on 30th September. The figures show a positive story, as EPUT has improved in a number of areas, but further work is still needed to improve the experiences of our Black, Asian and minority ethnic colleagues. EPUT's action plan for the next year will re-emphasise our zero-tolerance of racism in all its forms.					

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	97.4%	●	Trend above target = good 	●	The following wards were below target in August: Adult: Ardleigh & Gosfield Nursing Homes: Rawreth & Clifton Lodge Older: Ruby & Beech – Rochford CAMHS: Larkwood & Poplar Specialist: Dune	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	152.4%	●	Trend above target = good 	●	No wards were below target in August	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	98.2%	●	Trend above target = good 	●	The following wards were below target in August: Older Adult: Kitwood, Henneage, & Gloucester Nursing Homes: Rawreth Court & Clifton Lodge Adult: Gosfield Specialist: Dune	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	178.8%	●	Trend above target = good 	●	The following ward was below target in August: Adult: Kelvedon	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	13	●	Below Target = Good 	●	The following wards had fill rates of <90% in August: Adult: Ardleigh, Gosfield & Kelvedon Older Adult: Beech, Gloucester, Henneage, Kitwood, & Ruby Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Dune CAMHS: Larkwood & Poplar	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	13	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in August: Adult: Ardleigh, Kelvedon & Gosfield Older Adult: Beech – Rochford, Kitwood, & Hennage Nursing Homes: Clifton Lodge & Rawreth Court CAMHS: Longview, Larkwood, & Poplar Specialist: Dune & Edward House	

SECTION 5 – CQC

Click here to return to summary page

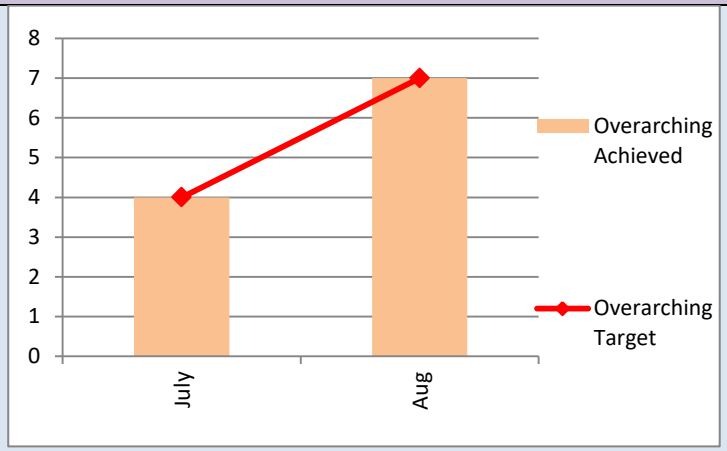
At the Executive CQC Steering Group on 2nd June the Trust CQC action plan was discussed in detail and it was agreed this needed to be revised to ensure it was fully reflective of the current position. Following this discussion and review, the Trust has developed a reset of the original action plan, which aims to resolve the remaining issues identified by the CQC from the inspection and to ensure actions have been fully embedded in practice and facilitates change. The action plan has been developed with consideration of all previous actions taken and those that remained open to ensure these continued to be taken forward to address the original issues identified.

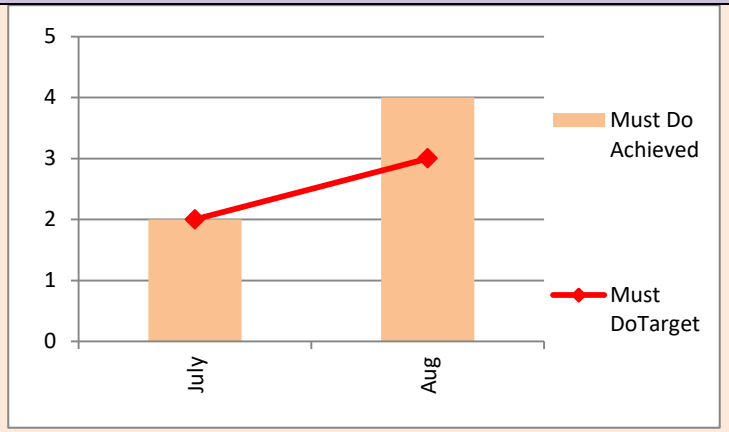
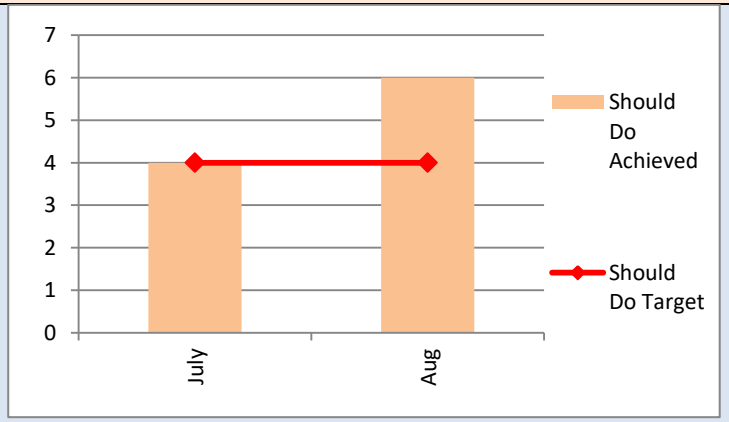
It should be recognised that tremendous learning and innovation has occurred as part of responding to the pandemic that will contribute to the Trust's outstanding ambition and as such the reset of the action plan has taken some of these changes into new actions to reflect on the practice changes that took place during Covid19 and to identify the different actions needed going forward.

At the Trust CQC engagement meeting on the 10th June; the plans for the reset approach were shared with the CQC, it was agreed to be a pragmatic approach and one which the CQC would endorse.

As at the end of June 2020, all 223 internal actions on the original action plan were closed. 13 internal actions were considered still relevant therefore transferred onto the reset action plan, some with some minor adjustments in order to fully meet the CQC issues identified. 3 internal actions were previously closed, however following review, were re-opened due to the current measures not being sufficient to cover the issue originally highlighted by the CQC. 4 internal actions were closed as it was identified that the actions would not be progressed and new actions developed; within the reset action plan, to address the final areas remaining from the original issues identified.

The Reset Action plan consists of 32 Internal Actions to ensure the remaining 14 CQC Requirement Actions are fully met.

RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Over-arching Actions	There will be 0 CQC Overarching Must Do and Should Do actions past timescale	At the end of August 1 action is past timescale		1 CQC Overarching action is past timescale at the end of August 2020, , which is identified below: • M2. M3. M4. S3. The trust must review their risk management systems to prevent overly restrictive wards, ensure blanket restrictions are reduced and review the use of prone restraints. - 1 Action

RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of August 0 actions were past timescale		0 CQC Must Do actions were past timescale at the end of August 2020.
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	At the end of August 0 actions were past timescale		0 CQC Should Do actions were past timescale at the end of August 2020.

SECTION 6 - Finance

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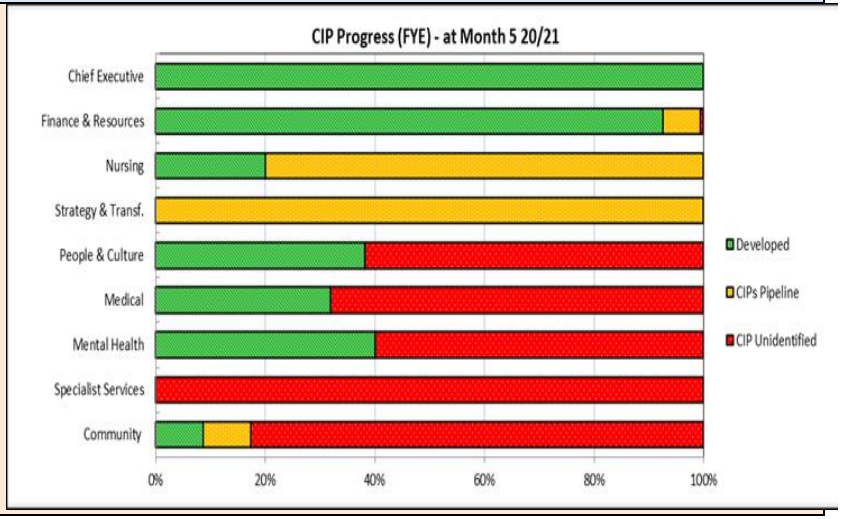
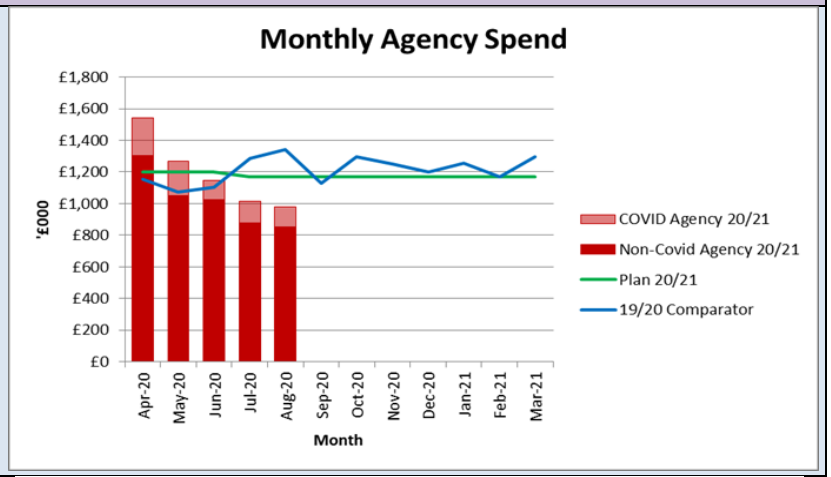
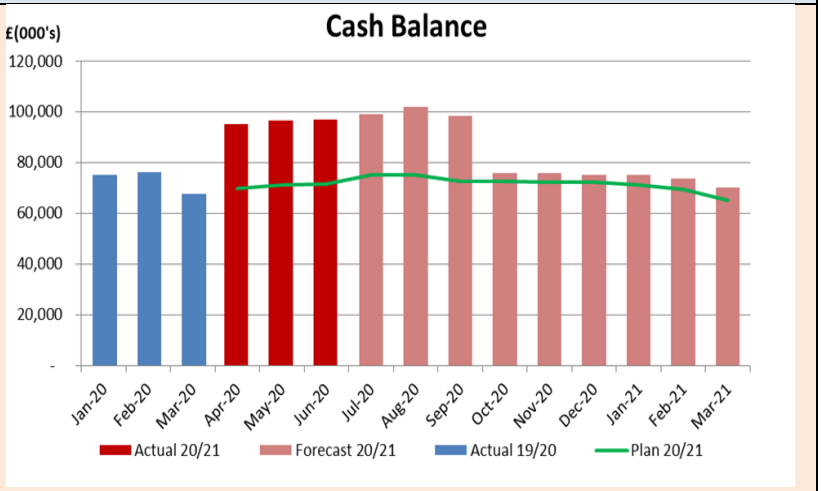
RAG	Ambition / Indicator	Position	Trend
Financial Risk Rating / Use of Resources	NHS Improvement's metric of financial risk	Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime and currently NHSI is not monitoring Trust's against the Use of Resources Rating.	
Year to Date Operating Deficit	Operating Income and Expenditure	Due to the COVID pandemic, the Trust continues to operate under an Emergency Financial Regime which has been extended to Month 6, in addition block income arrangements have been extended to Month 7. The Trust's draft Continuing Operating performance at the end of Month 5 - August 2020 is break-even (£0). The draft 20/21 plan submitted in March 2020, forms the basis of the budgets the Trust is currently reporting against internally. During the Emergency Financial Regime, all NHS provider organisations reporting a deficit will receive Top Up Payments to adjust their reported position to breakeven. The financial arrangements for the second half of the second half of the year are still being finalised	
Cost Improvement Programmes	Planned improvement in productivity and efficiency	The Trust's CIP target for 20/21 is £11.7m, including 19/20 recurrent CIP shortfall brought forward of £5.1m. The CIP Programme is affected by the response to COVID-19 and the Emergency Financial Regime. As at Month 5 Recurrent savings of £5.0m has been identified; £4.2m is delivered and £2.7m actioned in the general ledger. In Year savings of £7.2m have been identified; £6.5m is delivered and £4.9m actioned in the general ledger. The Trust focus must be on the Recurrent savings for when the emergency finance regime ends.	

RAG	Ambition / Indicator	Position	Trend
Agency Costs	Control of Agency Costs	The Trust's Agency target for 2020/21 is £14,118k. The total expenditure at the end of Month 5 on Agency Staff was £5,955k against the Trust plan of £5,933k giving an adverse variance of £22k. The impact of COVID expenditure in Month 5 was £849k. The 19/20 comparator is last years agency spend.	
Cash Balance	Cash Balances	The cash balance at the end of August is £98,562k compared to an adjusted plan of £71,752k. This variance largely relates to the impact of the current cash regime, whereby the Trust received an additional block payment in April. NHSI have confirmed that the current NHS block income arrangements will remain in force until the end of month 7 at least. For the forecast cash position, the Trust has not factored in any block income during month 8 with payments reverting to monthly contract payments thereafter.	

END

						Agenda Item No: 6b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**				**30 September 2020**	
Report title:	Learning from Deaths – Mortality Review Summary of Quarter 1 2020/21 information					
Executive Lead:	Prof Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Project Co-ordinator					
Report discussed previously at:	Mortality Data Group (18/08/20) Mortality Review Sub-Committee (27/08/20) Quality Committee (17/09/20)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	
Risk Rating	**Low**		**Medium**		**High**	✓

Purpose of the Report

The attached report presents:

- Information relating to deaths in scope for mortality review for Q1 2020/21 (1st April – 30th June 2020) together with updated information for 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.

Information	✓
Discussion	
Decision	

Recommendations / Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – ie the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. The Annexes to the report present the data outlined in the report in the nationally prescribed dashboard format. The report also contains additional information over and above national requirements in order to provide the Board of Directors with information relating to actions being taken in response to trends identified from the data and assurances in terms of the timeliness of review processes.

There were 90 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q1. This is significantly higher than any previous quarter since the Trust has commenced monitoring and reporting mortality data. The most significant increase occurred in April 2020 (in which there were 59 deaths in scope). The increase has been investigated and further details are included in the attached report. Death numbers returned to levels consistent with previous quarters in May and June 2020.

Of the 90 deaths, 29 were inpatient deaths and 22 were nursing home deaths. Of these 51 deaths, 44 deaths have been confirmed as due to natural causes. Five causes of death are currently under determination and two have been denoted as unknown.

The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This is being kept under review and will be taken into account in determining new arrangements to implement the national Patient Safety Incident Response Framework (PSIRF).

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

The Mortality Review Sub-Committee also reviews data on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. There are no issues of note / concern to report for Q1.

Monitoring of deaths within the Trust has continued throughout the COVID-19 pandemic in order to ensure timely identification of any possible problems in care. The last report to the Board of Directors noted that the progression of long term learning from mortality review had been limited due to capacity being focussed on essential activity during the pandemic response. Developmental learning and action has now recommenced as capacity allows. Details of learning are included in the attached report.

The COVID-19 Deaths Review Working Group has undertaken a data analysis of all deaths of patients reported on the Datix system who had tested positive for COVID-19 and considered learning emerging. This has been discussed in detail at the Mortality Review Sub-Committee.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are being delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework	
Are any existing risks in the Board Assurance Framework affected?	Yes
If yes, insert relevant risk	Delivering the requirements of the national guidance on mortality review requires significant action and has potentially significant capacity implications.
Do you recommend a new entry to the Board Assurance Framework is made as a result of this report?	No

Corporate Impact Assessment:			
Impact on CQC Regulation Standards, Commissioning Contracts, 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 £**	NA
Governance Implications			✓
Impact on Patient Safety /Quality			✓
Impact on Equality & Diversity			
Equality Impact Assessment (EIA) Completed?	No	**If YES, EIA Score**	NA

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

Supporting Documents &/or Further Reading

Attached - Report on Mortality Information and Learning from Deaths for Q1 2020/21
Annex A – 2020/21 Dashboard (national reporting format)
Annex B – 2019/20 Dashboard (national reporting format)
Annex C – 2018/19 Dashboard (national reporting format)
Annex D – 2017/18 Dashboard (national reporting format)

"National Guidance on Learning from Deaths" *Quality Board March 2017*
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-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

Executive Lead

Natalie Hammond
Executive Nurse

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 1 2020/21

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q1 2020/21 (1st April – 30th June 2020);
- Updated information relating to deaths in scope for mortality review in 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Board of Directors.

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

2.0 BACKGROUND AND CONTEXT

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

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q1 2020/21 (and updated data for previous years) as at the day the report was prepared (ie 9th September 2020).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

3.1 The scope of deaths included within this report is in line with the scope defined in the Trust's Mortality Review Policy.

3.2 The Mortality Review Sub-Committee also monitors the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. The data for Q1 has been considered by the Mortality Review Sub-Committee and there are no issues of note or concern to report.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

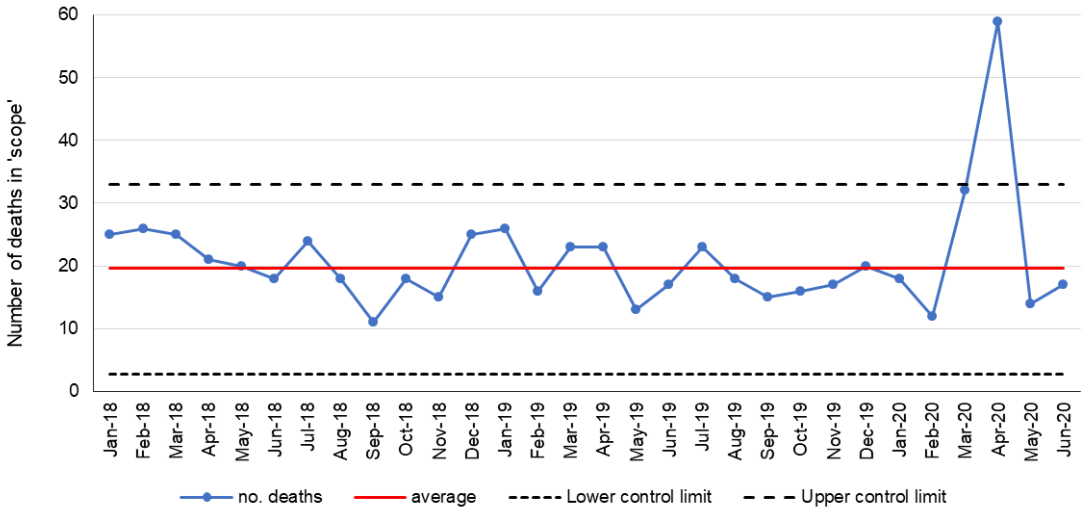
4.1 There were **90 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q1 2020/21**. This total number of deaths is significantly higher than any quarter since mortality data has been reported, with the significant increase being in April 2020 (n. 59). Death numbers returned to levels consistent with previous quarters in May and June 2020. Further investigation has been undertaken to understand the significant increase in deaths in scope of the Mortality Review Policy in April 2020. Further information is given at paragraph 4.3 below.

Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	2018/19 Q1 Total	2018/19 Q2 Total	2018/19 Q3 Total	2018/19 Q4 Total	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	2019/20 Q3 Total	2019/20 Q4 Total	Total 2019/20	April 2020	May 2020	June 2020	2020/21 Q1 Total
Deaths in scope	**248**	**59**	**53**	**58**	**65**	**235**	**53**	**56**	**57**	**62**	**228**	**59**	**14**	**17**	**90**

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope in April 2020 significantly exceeded the control limits, returning to within the control limits in May and June 2020. Further detail relating to this is included in paragraph 4.3 below.

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



4.3.1 There were 29 inpatient deaths in Q1 (of which 20 were in April). 15 of these deaths were sadly of patients with confirmed COVID-19. One of these deaths occurred on a North Essex Mental Health Older People's ward, one occurred on a South Essex Community Health Services ward and 13 occurred on West Essex Community Health Services (WECHS) wards. One of the Trust's WECHS wards was repurposed during the height of the pandemic to provide additional capacity to which the acute Trust could transfer COVID-19 positive patients for end of life care. There were therefore 14 inpatient deaths in Q1 which were due to other causes; this is broadly in line with numbers experienced in previous quarters. 12 of these deaths have been confirmed as natural causes with two causes of death under determination. It is important that the Trust is mindful in future quarters, when considering any benchmarking, of the impact of exceptional circumstances in Q4 / Q1 related to COVID-19.

4.3.2 The increase in the number of deaths in the two Trust managed nursing homes experienced in Q4 continued into Q1, with there being 22 deaths in Q1. A rapid review of all deaths occurring in the two nursing homes from January – May 2020 was undertaken by the Trust's Consultant in Public Health Medicine and Consultant in Older Peoples Mental Health Services in order to understand the position and identify any learning. The outcomes of this review have been considered by the Trust's COVID-19 Gold Command and Mortality Review Sub-Committee and appropriate actions are being taken forward to strengthen the Trust's position should a second wave of the pandemic be experienced.

4.3.3 Of the 51 inpatient (n.29) and nursing homes (n. 22) deaths, 44 deaths have been confirmed as due to natural causes. Five causes of death are currently under determination and two have been denoted as unknown.

4.4 A working group has been established to review all deaths of patients reported on the Datix system who had tested positive for COVID-19. This group has undertaken a data analysis of all deaths which have occurred to date with a view to identifying any trends for further exploration / assisting with the identification of immediate learning. The outcomes have been discussed in the Mortality Review Sub-Committee. Deaths of patients who tested positive for COVID-19 and which fall within the scope of the Trust's Mortality Review Policy have continued to be considered via the Deceased Patient Review Group in accordance with normal Trust mortality governance.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

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

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

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

Grade of review / investigation	2017/18 total	2018/19 Q1 total	2018/19 Q2 total	2018/19 Q3 total	2018/19Q Q4 total	2018/19 total	2019/20 Q1 total	2019/20 Q2 total	2019/20 Q3 total	2019/20 Q4 total	2019/20 total	Apr 2020	May 2020	Jun 2020	2020/21 Q1 total
Grade 1 Deceased Patient Review Group	148	41	30	31	45	147	32	26	35	46	139	41	7	7	55
	60%					63%					61%				61%
Grade 2 Case Note Review	11	6	4	5	4	19	6	3	2	4	15	2	0	1	3
	4%					8%					7%				3%
Grade 3 Critical Incident Review	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0
	0.5%					0%					1%				0%
Grade 4 Serious Incident Investigation	88	12	19	22	16	69	15	26	14	10	65	7	5	5	17
	35%					29%					28%				19%
Final grade under determination	0	0	0	0	0	0	0	1	5	2	8	9	2	4	15
	0%					0%					4%				17%
TOTAL	248	59	53	58	65	235	53	56	57	62	228	59	14	17	90

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (60% 2017/18, 63% 2018/19, 61% thus far 2019/20 and 61% thus far 2020/21); or
- being investigated as Grade 4 serious incident investigations (35% 2017/18, 29% 2018/19, 28% thus far 2019/20 and 19% thus far in Q1 2020/21).

5.3 There has been limited use of the Grade 2 clinical case note review option (only 4% in 2017/18, 8% in 2018/19, 7% thus far in 2019/20 and 3% thus far in Q1 2020/21). This is being kept under review and is being taken into account in development of the arrangements to be put in place in the Trust to implement the national Patient Safety Incident Response Framework (PSIRF).

5.4 Positive progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with only 17% of deaths in Q1 2020/21 and 4% of deaths in 2019/20 (13% in previous quarterly report) requiring the grade of review to be determined.

5.5 Progress in terms of completion of reviews / investigations is as follows:

Level of review	Progress	2017/18		2018/19		2019/20		YTD 2020/21	
Grade 1 (DPRG)	**Complete**	148	100%	147	100%	139	100%	55	100%
	In progress	0	0%	0	0%	0	0%	0	0%
Grade 2 (CNR)	**Complete**	10	91%	13	68%	5	33%	0	0%
	In progress	1	9%	6	32%	10	66%	3	100%
Grade 3 (CIR)	**Complete**	1	100%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	1	100%	0	0%
Grade 4 (SI)	**Complete**	88	100%	69	100%	59	91%	10	59%
	In progress	0	0%	0	0%	6	9%	7	41%
Under determin-ation	**Complete**	0	0%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	8	100%	15	100%
TOTAL	**Complete**	247	99%	229	97%	203	89%	65	72%
	In progress	1	1%	6	3%	25	11%	25	28%

5.6 Case Note Reviews constitute all reviews still in progress for 2017/18 and 2018/19 deaths. There has been steady progress with completing Case Note Reviews this quarter as and when capacity has allowed – a total of 5 have been considered and closed via the Deceased Patient Review Group since the last report to the Board of Directors.

5.7 Reviews / investigations have already been completed for 72% of deaths in Q1. The significant increase in the timeliness of consideration via the Deceased Patient Review Group has continued with virtual Group meetings being held throughout the pandemic to ensure timely review of deaths within scope of the Mortality Review Policy. Thanks are extended to members of the Group for their continued work in this respect under difficult circumstances.

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

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

Score	*2017/18 (Number)	*2017/18 (as a %)	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)
6 - definitely less likely than not	112	84%	189	80%	156	68%	57	63%
5 - slight evidence	14	10%	21	9%	19	8%	1	1%
4 - not very likely	3	2%	11	5%	8	3%	0	0%
3 - probably likely	1	1%	6	3%	3	1%	0	0%
2 - strong evidence	0	0%	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	4	3%	8	4%	42	18%	32	36%

* Note: Problems in care scores only assigned for deaths from 1st October 2017

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

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

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

7.1 Annexes A - C of this report detail the number of deaths that have been referred into the programme. Assurances can be given that all deaths meeting the criteria for referral to the LeDeR programme have been referred.

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

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

8.1.2 Learning themes from Q1 have included risk assessments and care plans; administration; recording of information; transfers of care; disengagement; integrated working; communication with primary care; and discharge planning from inpatient services.

8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

8.2.1 The progression of long term learning from mortality review has been recommenced following limited progress the previous quarter due to the need to focus capacity on essential activity during the pandemic response.

8.2.2 Since the last report to the Board of Directors, the Mortality Review Sub-Committee has considered the outcomes of the following mortality thematic reviews:

- Serious Incident deaths 2018/19 (high level data analysis and quality of investigations / reports)
- Follow up medications management review of Nursing Homes deaths 2018/19
- Non-serious incident deaths of patients with Severe Mental Illness 2018/19

8.2.3 The reviews highlighted a number of areas of good practice and overall high standards of care. Some recommendations for improvements were made from the reviews and these are being taken forward.

9.0 CONCLUSIONS AND FUTURE ACTIONS

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

10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

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

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

September 2020

ANNEX A – MORTALITY DATA DASHBOARD 2020/21

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

Trust	EPUT	**Total Deaths in Scope:**
Month	Sep-20	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
		• All community Learning Disability deaths (detailed on sheet 2)
		• All community deaths meeting Serious Incident criteria
Year	2020-21	* Deaths subject to a complaint / claim
		* Deaths subject to a serious staff concern
		* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	90	8	82	47	0	0	3	0	0	10	7	15	0	0	0	0	1	49	32
YTD		**90**	**8**	**82**	**47**	**0**	**0**	**3**	**0**	**0**	**10**	**7**	**15**	**0**	**0**	**0**	**0**	**1**	**49**	**32**
2020-21	Q2																			
YTD		**90**	**8**	**82**	**47**	**0**	**0**	**3**	**0**	**0**	**10**	**7**	**15**	**0**	**0**	**0**	**0**	**1**	**49**	**32**
2020-21	Q3																			
YTD		**90**	**8**	**82**	**47**	**0**	**0**	**3**	**0**	**0**	**10**	**7**	**15**	**0**	**0**	**0**	**0**	**1**	**49**	**32**
2020-21	Q4																			
Total 2020-21		**90**	**8**	**82**	**47**	**0**	**0**	**3**	**0**	**0**	**10**	**7**	**15**	**0**	**0**	**0**	**0**	**1**	**49**	**32**

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

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

Trust	EPUT
Month	Sep-20
Year	2020-21

Learning Disability Deaths

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

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

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

ANNEX B – MORTALITY DATA DASHBOARD 2019/20

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

Trust	EPUT
Month	Sep-20
Year	2019-20

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	24	0	3	3	0	0	15	0	0	0	0	0	1	5	31	8
YTD		53	**8**	45	24	0	3	3	0	0	15	0	0	0	0	0	1	5	31	8
2019-20	Q2	56	3	53	23	0	1	2	0	0	26	0	1	0	0	3	4	9	31	6
YTD		109	11	98	47	0	4	5	0	0	41	0	1	0	0	3	5	14	62	14
2019-20	Q3	57	11	46	24	0	0	2	0	1	12	2	5	0	0	0	2	4	24	16
YTD		166	**22**	144	71	0	4	7	0	1	53	2	6	0	0	3	7	18	86	30
2019-20	Q4	62	8	54	38	0	1	3	0	0	6	4	2	0	0	0	1	1	40	12
Total 2019-20		228	30	198	109	0	5	10	0	1	59	6	8	0	0	3	8	19	126	42

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

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

Trust	EPUT
Month	Sep-20
Year	2019-20

Learning Disability Deaths

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

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

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

ANNEX C – MORTALITY DATA DASHBOARD 2018/19

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

Trust	EPUT	**Total Deaths in Scope:**
Month	Sep-20	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria
Year	2018-19	* Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	59	7	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
YTD		59	**7**	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
2018-19	Q2	53	11	42	19	0	3	1	0	0	19	0	0	0	0	3	3	4	30	2
YTD		112	18	94	53	0	7	3	0	0	31	0	0	0	0	5	3	7	74	5
2018-19	Q3	58	4	54	27	0	3	2	0	0	22	0	0	0	0	0	5	6	41	2
YTD		170	**22**	148	80	0	10	5	0	0	53	0	0	0	0	5	8	13	115	7
2018-19	Q4	65	10	55	35	0	3	1	0	0	16	0	0	0	0	1	3	8	42	1
Total 2018-19		235	32	203	115	0	13	6	0	0	69	0	0	0	0	6	11	21	157	8

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

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

Trust	EPUT
Month	Sep-20
Year	2018-19

Learning Disability Deaths

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

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

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

ANNEX D – MORTALITY DATA DASHBOARD 2017/18

Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT	**Total Deaths in Scope:** • All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria Plus from Q3: * Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)
Month	Sep-20	
Year	2017-18	

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	6	0	1	0	16	0	0	0	0	1	2	5	40	1
YTD		172	31	141	68	0	9	0	1	0	63	0	0	0	0	1	2	5	40	1
2017-18	Q4	76	9	67	41	0	1	1	0	0	24	0	0	0	0	0	1	9	55	2
Total 2017-18		248	40	208	109	0	10	1	1	0	87	0	0	0	0	1	3	14	95	3

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

Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT	**Learning Disability Deaths**
Month	Sep-20	
Year	2017-18	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	13	0	12	0	0	0	0	0	1	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		13	0	12	0	0	0	0	0	1	0	0							
2017-18	Q2	9	3	9	0	0	0	0	0	0	0	0							
YTD		22	3	21	0	0	0	0	0	1	0	0							
2017-18	Q3	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
YTD		31	12	30	0	0	0	0	0	1	0	0	0	0	0	0	0	9	0
2017-18	Q4	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
Total 2017-18		40	21	39	0	0	0	0	0	1	0	0	0	0	0	0	0	18	0

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

	Agenda Item No: 6c

SUMMARY REPORT	**BOARD OF DIRECTORS PART ONE**	**30 September 2020**

Report Title:	Complaints Deep Dive into Staff Attitude					
Executive/Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Pam Madison former Head of Complaints					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**	

Purpose of the Report		
This report provides the Board of Directors with an overview of the complaints received for Mid and South Essex during 2019/20.	**Approval**	
	Discussion	√
	Information	√

Recommendations/Action Required

The members of the Board of Directors are asked to:

1. Note and discuss the report.

.

Summary of Key Issues

Total of 114 complaints received during 2019/20 for Mid and South Essex – higher than other areas.
Breakdown of bases and services.
Geographical comparisons.
No causes for concern identified in data.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experience and outcomes	√
SO 2: Achieve top 25% performance	√
SO 3: Valued system leader focused on integrated solutions	√

Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

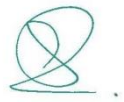
Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	√
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

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	0
Involvement of Service Users/Healthwatch	√
Communication and consultation with stakeholders required	√
Service impact/health improvement gains	√
Financial implications: **Capital £**	0

			Revenue £ **Non Recurrent £**
Governance implications			√
Impact on patient safety/quality			√
Impact on equality and diversity			0
Equality Impact Assessment (EIA) Completed?	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PHSO	Parliamentary and Health Service Ombudsman		
STP's	Sustainability and Transformation Partnerships		
EPUT	Essex Partnership University NHS Foundation Trust		

Supporting Documents and/or Further Reading

Lead
 **Sean Leahy** **Executive Director of People and Culture**

Agenda Item: 6c
Board of Directors
30 September 2020

1. Background

Following the presentation of the Complaints Annual Report, 2019/20 at the Board of Directors meeting on May 27th, 2020, it was noted by a Non-Executive Director that the Mid and South Area had received considerably more complaints than the other areas of the Trust. It was, therefore, suggested that a deep dive be undertaken to ascertain the reason for this variance. This report sets out the findings of that work.

As noted in the Complaints Annual Report, the reporting mechanism was changed during the financial year of 2019/20, to reflect the Sustainability and Transformation Partnerships (STP's), therefore, comparisons to previous years data was not included.

To recap, Mid and South Essex received 114 complaints, North East Essex 61 complaints and West Essex 15 complaints. These complaints related to Mental Health Integrated Services only, as Medical and Specialist Services are reported Trust-wide, separately under their own headings, as are the Community Healthcare Services. (see Complaints Annual Report, page 5)

Combining North East and West figures accounts for 76 complaints, there is a clear and substantial gap between those and the Mid and South figure of 114 complaints. A total of 7 complaints were either withdrawn or not investigated due to consent issues, leaving 107 complaints which received a full investigation.

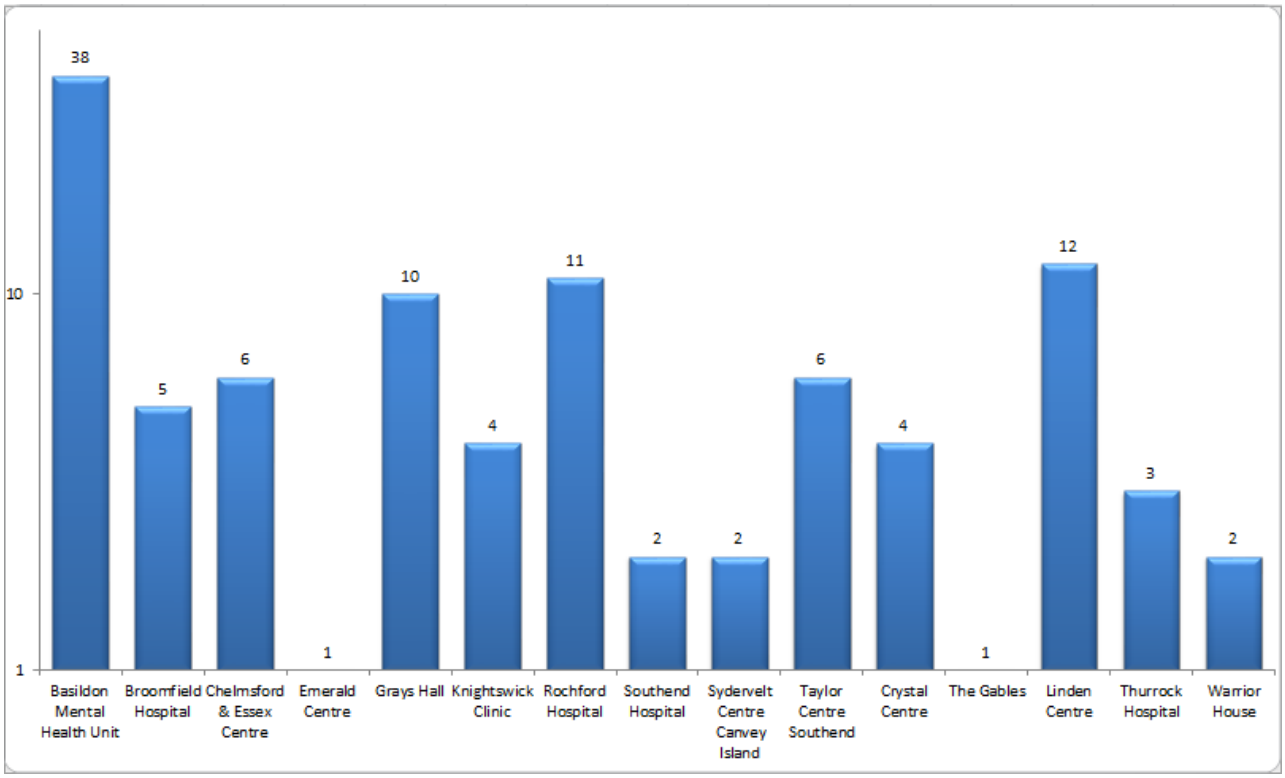
However, splitting out the services for 2018/19 into the STP areas shows that Mid and South Essex received 123 complaints for that year, of which 7 were subsequently withdrawn, giving a total of 116 complaints. To contextualise this, Mid and South Essex received fewer complaints during 2019/20 than the previous year, by 9. In summary, the figures over the two years were virtually the same, so does not indicate a trend for 2019/20.

Mid and South Essex covers a large geographical area and includes older adult wards, acute treatment wards, mental health assessment units as well as several mental health community services. Mental Health Liaison Services are also based in Southend, Broomfield and Basildon Hospitals.

2. Complaints Received

The 107 complaints were received for 15 different bases and 21 different services, covering 7 subjects and 33 sub subjects. Looking at the graph below, it shows that the majority, by some margin, were for the Basildon Mental Health Unit (38). This was followed by the Linden Centre, Chelmsford (12). However, it should be noted that both of these units contain several different services such as Acute Treatment Wards, Health Based Places of Safety as well as being bases for several Mental Health Community Services.

Graph 1, bases



2.1 Complaints received by Service

Table 1 illustrates the number of complaints received by services. Community Mental Health Teams, Acute Treatment wards and The Mental Health Assessment Unit, Basildon received just over half of all complaints.

Table 1

Service	Complaints received		Service	Complaints received
Access & Assessment	**1**		Mental Health Assessment Unit (MHAU)	**10**
Acute Treatment Wards	**17**		Mental Health Liaison	**8**
Administration	**2**		Older Adult Inpatient	**8**
Assertive Outreach Team	**3**		Perinatal Service	**1**
Community MH Teams (CMHT)	**27**		Psychiatric Intensive Care Unit (PICU)	**7**
Crisis Resolution Home Treatment Team (CRHTT)	**1**		Psychology	**4**
Dementia Memory service	**2**		Psychotherapy	**1**
Eating disorders	**1**		Recovery Team	**4**
First Response Team	**3**		Specialist Mental Health Team	**3**
Home Treatment Service	**2**		Support & Treatment for Early Psychosis	**1**
Improving Access to Psychological Services (IAPT)	**1**		**Total**	**107**

6 teams received between 7 and 27 complaints, which on the face of it appears a lot, but is consistent with previous year's data. The tables below show the breakdown of the teams.

Table 2 Breakdown of Teams

The Basildon Mental Health Assessment Unit received 10 complaints. The remaining 5 teams are broken down by services.

Community Mental Health Teams – 27 complaints	
Basildon CMHT	3
Basildon Intensive Outreach Team	2
Basildon Recovery & Wellbeing	2
First response Team	3
Grays Hall CMHT	3
Thurrock Recovery & Wellbeing	1
Intensive Outreach Knightswick Clinic	1
Recovery & Wellbeing Knightswick Clinic	3
First response East	1
Older people CMHT Sydervelt Centre	2
Southend Recovery & Wellbeing	6

Acute Treatment Wards – 17 complaints	
Cedar Ward, Rochford Hospital	5
Kelvedon Ward, Basildon MHU	3
Finchingfield Ward, Linden Centre	3
Gallywood Ward, Linden Centre	3
Thorpe Ward, Basildon MHU	3

Mental Health Liaison Teams – 8 complaints	
Basildon Hospital	1
Broomfield Hospital	5
Southend Hospital	2

Older Adult Inpatient – 8 complaints	
Beech Ward, Rochford Hospital	2
Ruby Ward, Crystal Centre	3
Gloucester Ward, Rochford Hospital	3

Psychiatric Intensive Care (PICU) – 7 complaints	
Hadleigh Unit, Basildon MHU	5
Christopher Unit, Linden Centre	2

Table 3 Teams with 5 complaints and above (total 31)

Basildon MHAU	10
Southend Recovery & Wellbeing	6
Cedar Ward Rochford	5
Hadleigh Unit (PICU)	5
Mental Health Liaison, Broomfield Hospital	5

3. Categories and Outcomes from Complaint Investigations

3.1 Basildon Mental Health Assessment Unit

The 10 complaints were received for the following categories:

Communication x 1, partially upheld. Discharge arrangements x 2, 1 partially upheld and 1 not upheld. Environment, ligature safety x 1, not upheld. Medication x 1, partially upheld. Physical care x 1, not upheld. Staff Attitude x 4, 3 partially upheld, 1 not upheld.

3.2 Southend Recovery & Wellbeing

The 6 complaints were for the following categories:

Assessment & Treatment x 1, not upheld. Communication x 1, partially upheld. Confidentiality breach x 1, not upheld. Staff Attitude x 2, both partially upheld. Unhappy with Treatment x 1, partially upheld.

3.3 Cedar Ward, Rochford Hospital

The 5 complaints were received for the following categories:

Security (patient belongings) x 1, partially upheld. Staff Attitude x 3, all partially upheld. Unhappy with treatment x 1, upheld.

3.4 Hadleigh Unit, PICU

The 5 complaints were received for the following categories:

Assault/Abuse x 1, not upheld. Assessment & Treatment x 1, partially upheld. Mental Health Act Detention x 1, partially upheld. Staff Attitude x 1, partially upheld. Staffing levels x 1, partially upheld.

3.5 Mental Health Liaison – Broomfield Hospital

The 5 complaints were received for the following categories:

Discharge Arrangements x 2, both partially upheld. Staff Attitude x 3, all partially upheld.

4. In Conclusion

Looking at the breakdowns above, the main reason for the complaints received, has been around staff attitude as referenced in the Complaints Annual Report. Assurance is given that all staff attitude complaints are shared with named staff's line managers as well as the Director of the services involved. The findings of the complaint investigation will determine the best course of action for the named member of staff. This could be further training, monitoring through supervision or taking forward through the Trust's Conduct and Capability Policy. Due to the rise in staff attitude complaints during 2019/2020, all such complaints are being proactively monitored with a view to understanding the reason for the upward trend and how this might be ameliorated during 2020/2021.

As stated at the beginning of the report, Mid and South Essex covers a large area of Essex, with Southend, Chelmsford and Basildon having substantial populations. Taking into account the complaints received, related to 15 different bases and 21 different services the findings are not unexpected. The number of complaints is commensurate with the respective populations. North

and West Essex have smaller populations that are covered by EPUT Mental Health Services so it is not surprising that they receive fewer complaints.

Mid and South Essex also had 11 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), North and West Essex had 4 and 2 referrals respectively. Again, this is relative to the number of complaints received from each area and is commensurate with the overall number of complaints and populations.

Mid and South Essex received fewer complaints in 2019/20 than the previous year; as with all complaints, the numbers received, and the content of the concern, for all areas are continuously monitored for emerging trend or themes. 37% of the total number of complaints received for Mid and South Essex, came from relatives or friends of patients either under EPUTS care at the time, or having previously received care and treatment from the Trust.

Assurance is given to the Board that all complaints received are analysed for any emerging trends and themes on a weekly, monthly and quarterly basis. Any immediate causes of concern are escalated to Executive Directors to take forward. The Complaints Department also liaises with the Compliance, Human Resources and Estates Departments as necessary to highlight any recurring concerns.

Report Author

Pam Madison, former Head of Complaints

On behalf of Sean Leahy, Executive Director of People and Culture

		Agenda Item No: 6d
SUMMARY REPORT	**BOARD OF DIRECTORS MEETING PART 1**	**30 September 2020**

Report Title:	**Council of Governors Elections and Membership**					
Executive/Non-Executive Lead:	**Professor Sheila Salmon, Chair**					
Report Author(s):	**Tina Bixby, Assistant Trust Secretary**					
Report discussed previously at:	-					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides an update on the recent elections to the Council of Governors for EPUT.	**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

Elections and appointments to the Council of Governors commenced on the establishment of the Trust in 2017. The Governors were elected in 2017 for a mix of terms of 2 and 3 years. Elections were also held in June 2019.

Due to the impact of COVID and guidance from NHSE/I on reducing workloads of the NHS FT's the Trusts elections were delayed from June 2020 until August 2020 which resulted in a short period of time; 21 June -1 September where we had vacancies on the Council. The risk assessment by the Trust Secrete highlighted that no major council decisions were due in that period.

Four Prospective Governor Workshops, led by Faye Swanson were held virtually during June 2020. Elections commenced on 5 August with 27 candidates applying for 11 vacancies, voting closed on 28 August 2020, with the results being declared on 2 September 2020.

Elections were held in four constituencies:

- Staff
  Clinical – 2 vacancies
  Staff Non-Clinical – 2 vacancies
- Essex Mid and South -3 vacancies
- North East Essex and Suffolk – 1 vacancy
- West Essex and Hertfordshire – 3 vacancies

Councillor Bob Massey replaced Councillor Andy Wood as the Appointed Governor for Essex County Council.

There are 30 Governors in total on the Council and no vacancies.

The report on voting is attached at appendix 1. The current membership of the Council of Governors is attached at appendix 2.

The turnout for the Staff Non Clinical Governor election was 17.4%. The Clinical Staff turnout was 10.1% which may reflect that clinical staff are less likely to access emails or their PC as

regularly as non-clinical staff.

The average turnout for the Public Governor elections across three constituencies was 8.1%, slightly higher than the 6.85% for the elections in 2019.

The Governor induction programme is reviewed each year, It was previously delivered over 3 sessions in 2019. As part of the programmes annual review it was decided that a Governor Workbook would be beneficial for new Governors. The workbook principle is a blend of the NHS Provider Statutory guide and the Prospective Governor work book which is issued to any Governor considering making a nomination. The workbook enables Governors to read about their role at their own pace, a reference tool for throughout their term of office and some particle working examples. Due to the current social distancing rules the programme will be delivered over 6 Modules The first 'Initial Welcome' Module for newly elected Governors, was held on 4 September 2020. The second Module was held on 16 September and was open to all Governors and was very well attended. Module 3 'Welcome to our Services' is scheduled for 16 October 2020 and Module 4 and 5 will be facilitated by NHS Providers in November and December and covers the statutory requirements of being a Governor. Module 6 'Working together' is planned for early 2021.

A continuing rolling programme of training, learning and development for Governors is being planned that will support the Board's responsibility to ensure that Governors are equipped with the skills and knowledge required to discharge their duties.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

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
Appendix 2

Lead

Professor Sheila Salmon
Chair

Report of Voting

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ELECTION TO THE COUNCIL OF GOVERNORS

CLOSE OF VOTING: 5PM ON 28 AUGUST 2020

CONTEST: Public: Essex Mid & South

The election was conducted using the single transferable vote electoral system.
he following candidates were elected (in order of election):

ELECTED
Elizabeth ROTHERHAM
Emmanuel JESSA
Keith BOBBIN

Number of eligible voters		1,979
Votes cast by post:	32	
Votes cast online:	119	
Total number of votes cast:		151
Turnout:		7.6%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		151

CONTEST: Public: North East Essex & Suffolk

The election was conducted using the single transferable vote electoral system.
The following candidate was elected:

ELECTED
David ROLPH

Number of eligible voters		610
Votes cast by post:	20	
Votes cast online:	29	
Total number of votes cast:		49
Turnout:		8.0%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		49

CONTEST: Public: West Essex & Herts

The election was conducted using the single transferable vote electoral system.
he following candidates were elected (in order of election):

ELECTED
Pippa ECCLESTONE
Jean JUNIPER
Brian ARNEY

Number of eligible voters		720
Votes cast by post:	20	
Votes cast online:	44	
Total number of votes cast:		64
Turnout:		8.9%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		64

CONTEST: Staff: Clinical

The election was conducted using the single transferable vote electoral system.
he following candidates were elected (in order of election):

ELECTED
Tracey REED
Jared DAVIS

Number of eligible voters		4,263
Votes cast by post:	29	
Votes cast online:	401	
Total number of votes cast:		430
Turnout:		10.1%
Number of votes found to be invalid:		3
Total number of valid votes to be counted:		427

CONTEST: Staff: Non-Clinical

The election was conducted using the single transferable vote electoral system.
he following candidates were elected (in order of election):

ELECTED
Lara BROOKS
Paul WALKER

Number of eligible voters		1,726
Votes cast by post:	17	
Votes cast online:	283	
Total number of votes cast:		300
Turnout:		17.4%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		300

The result sheets for each election form the Appendix to this report. They detail:-

- the quota required for election
- each candidate's voting figures, and
- the stage at which successful candidates were elected.

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the election:-

a) was sent the details of the election and

b) if they chose to participate in the election, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and CES is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for 12 months.

Ciara Hutchinson
Returning Officer
On behalf of Essex Partnership University NHS Foundation

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COUNCIL OF GOVERNORS as at 1 Sept 2020

ELECTED GOVERNORS

Public: Essex Mid & South (9)
Keith Bobbin
Dianne Collins
Mark Dale
Jim Dean
Emmanuel Jessa
Sam Rakusen
Tanya Robertson
Elizabeth Rotherham
Judith Woolley

Public: North East Essex & Suffolk (3)
Peter Cheng
David Rolph
David Short

Public: Milton Keynes, Bedfordshire, Luton & Rest of England (2)
Paula Grayson
John Jones

Public: West Essex & Hertfordshire (5)
Brian Arney
Pippa Ecclestone
Jean Juniper
Kate Shilling
Michael Waller

Staff: Clinical (4)
Marianne Evans
Nosi Murefu
Jared Davis
Tracy Reed

Staff Non Clinical (2)
Lara Brooks
Paul Walker

APPOINTED GOVERNORS

Anglia Ruskin/Essex Universities	Dr Ruth Jackson
Essex County Council	Cllr Bob Massey
Thurrock Council	Cllr Sue Shinnick
CVS Essex	Diane Fairfield
Southend on Sea Council	Cllr Laurie Burton

Agenda Item No: 6e

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 September 2020

Report Title:	**NHS Workforce Disability Equality Standard Data Analysis**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director – People and Culture					
Report Author(s):	Gary Brisco – Equality Advisor Jo Debenham – Head of Staff Engagement Chris Jennings and Lorraine Mitchell – D&MH Equality Network Co-Chairs					
Report discussed previously at:	D&MH Staff Equality Network sessions Equality & Inclusion Committee Executive Operational Committee Workforce Transformation Committee					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the annual report for the Workforce Disability Equality Standard and sets out the experience of our staff with disabilities compared to our non-disabled staff across a range of metrics.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Discuss the contents of the report.
2 Agree the proposed Action Plan to address gaps.
3 Make general recommendations for improving the equality and inclusion of staff with disabilities and mental health conditions at EPUT.
4 Agree to the publication of the paper internally and externally.

Summary of Key Issues

This report is the second year of the Workforce Disability Equality Standard (WDES) and the second year of EPUT. Out of ten metrics there has been only been deterioration for one (M3) but there is still a significant amount of work to do to bring the experience of staff with disabilities (including long term, hidden and mental health conditions) in line with that of their non-disabled counterparts.

The report also shows that we are not comparing well nationally – and we are worse than the national picture for five out of the ten metrics. Although it should be noted that these are only by small margins.

The Trust needs to take action now to ensure that staff with disabilities are not:

- More likely to experience harassment, bullying or abuse from members of the public or their managers.
- More likely to enter formal capability processes.
- Underrepresented at senior levels within the Trust.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	√
SO 2: Achieve top 25% performance	√
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	√
If yes, insert relevant risk	5
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 £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			√
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	**NO**

Acronyms/Terms Used in the Report			
WDES	Workforce Race Equality Standard		
D&MH	Disabilities and Mental Health		
M3	Metric 3 on the WDES		

Supporting Documents and/or Further Reading
WDES Report 2019 and Appendices WDES Action Plan 2019/20

Lead

Sean Leahy
Executive Director – People and Culture

Appendix A: Breakdown and Results of WDES Metrics 1 - 10

Key	
Symbol	Meaning
▲ ▼	An Increase / Decrease from WDES 2019 Data (Improvement)
▲ ▼	An Increase / Decrease from WDES 2019 Data (Decline)
-	No Increase / Decrease from WDES 2019 Data

METRIC 1 – PERCENTAGE OF DISABLED STAFF IN EACH BAND COMPARED TO THE OVERALL WORKFORCE.

This metric compares the data for disabled and non-disabled staff across all pay bands and grades.

Fig 1 - NON CLINICAL POSTS

Cluster	Bandings / Type	Disabled	Non-Disabled	Unknown	Total	Same / Higher or Lower than overall Workforce 3%	Comparison to NHS National Score 2019 (3.6%)
C1	1-4	(54) 4% ▲	(946) 65%	(453) 31%	1453	Higher	Higher
C2	5-7	(7) 2% ▲	(221) 65%	(111) 33%	339	Lower	Lower
C3	8a / 8b	(3) 5% ▲	(42) 65%	(19) 30%	64	Higher	Higher
C4	8c +	0%	(27) 59%	(19) 41%	46	Lower	Lower

Figure 1 shows that for non-clinical posts, bands 8c and above have under-representation of disabled staff.

Fig 2 - CLINICAL POSTS

Cluster	Bandings / Type	Disabled	Non-Disabled	Unknown	Total	Same / Higher or Lower than overall Workforce 3%	Comparison to NHS National Score 2019
C1	1-4	(56) 3%▲	(1336) 73%	(437) 24%	1829	Same	Higher (2.9%)
C2	5-7	(91) 4% -	(1447) 65%	(679) 31%	2217	Higher	Higher (2.9%)
C3	8a / 8b	(8) 3% ▲	(145) 58%	(99) 39%	252	Same	Higher (2.9%)
C4	8c +	(1) 3% -	(17) 45%	(20) 53%	38	Same	Higher (2.9%)
C5	Consultants	0% -	(58) 58%	(42) 42%	100	Lower	Lower (0.8%)
C6	Career Grade	0% -	(29) 60%	(19) 40%	48	Lower	Lower (1.2%)
C7	Trainees	0% -	(58) 73%	(22) 27%	80	Lower	Lower (1.94%)

Figure 2 shows that for clinical posts, Consultants, Career Grades and Trainees all have under-representation of disabled staff.

METRICS 2 – 10

Fig 3 – Summary of WDES Metrics 2020

Met.	Type	Description	EPUT		NHS 2019	
			2019	2020	Score	Compared
1	**Workforce Data**	Percentage of Disabled staff in the workforce	**3%**	**3%**	**See Fig 1 and 2**	
2		Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. *(lower scores are better)*	**1.24**	**0.95 ▼**	**1.23**	**Better than national score**
3		Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. *(A figure above one means this is higher)*	**0***	**1.41 ▲**	**1.1**	**Worse than national score**
4a I	**Staff Survey Results 2019**	Percentage of Disabled staff compared to non-disabled staff experiencing harassment bullying, or abuse from patients, relatives and public in last 12 months. *(Lower %'s are better)*	**41%**	**39% ▼**	**33.8%**	**Worse than national %**
4a II	**22% of staff survey respondents said that they had a disability or long term health condition**	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers in last 12 months. *(Lower %'s are better)*	**23%**	**20% ▼**	**19.8%**	**Worse than national %**
4a III		Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from colleagues in last 12 months. *(Lower %'s are better)*	**28%**	**26% ▼**	**26.8%**	**Better than national %**
4b		Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. *(Higher %'s are better)*	**49%**	**52% ▲**	**47.8%**	**Better than national %**
5		Percentage of Disabled staff compared to non-disabled staff believing the Trust provides equal opportunities for career progression or promotion. *(Lower %'s are better)*	**75%**	**75% -**	**75.3%**	**Better than national %**
6		Percentage of Disabled staff compared to non-disabled staff feeling pressure from their manager to come to work despite not feeling well enough to perform their duties. *(Lower %'s are better)*	**31%**	**30% ▼**	**32.0%**	**Better than national %**
7		Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. *(Higher %'s are better)*	**36%**	**38% ▲**	**37.2%**	**Better than national %**
8		Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work. *(Higher %'s are better)*	**70%**	**72% ▲**	**72.4%**	**Worse than national %**
9		The staff engagement score for Disabled staff, compared to non-disabled staff. *(Lower scores are better)*	**6.5**	**6.5 -**	**6.64**	**Better than national %**
9b		Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	**Narrative available in 2019 Report**	**Narrative available below**	**-**	
10	**Board Membership**	Percentage difference between Board membership & overall workforce.	**-3%**	**-3% -**	**2.1%**	**Worse than national %**

** For Metric 3 in 2018/19, out of the 9 staff who went through the formal capability process, there were no disabilities recorded or none-disclosed on ESR, resulting in a score of 0.*

METRIC 9b YOUR TRUST TAKEN ACTION TO FACILITATE THE VOICES OF DISABLED STAFF IN YOUR ORGANISATION?

Trusts that answer YES to this question must provide at least one practical example within this report. For EPUT these examples are as follows:-

- An Equality Champion Scheme that includes staff with lived experience of mental and physical health conditions, involved in providing feedback and advice across the Trust.
- EPUT Endorsed as a Mindful Employer and Disability Confident Employer.
- A Disability and Mental Health Staff Network which specifically has Mental Health within its title to ensure mental health conditions and disabilities are given equal weighting when providing support.
- Trust Events aimed at people with disabilities and mental health conditions, offering support and guidance as well as endorsement and attendance from the Trust Board.
- Lived experience videos share staff lived experience and how colleagues can support these conditions (including ADHD, Dyslexia, Dyspraxia and Cochlear Implants for hearing impairments).
- Promotion and intranet articles for disability and mental health events including Deaf Awareness Week, Disability History Month and Purple Tuesday
- Mental Health Awareness training sessions provided in the Trust.
- Delivering 'Positive Cultures' sessions across the Trust dealing with cultural differences and how to recognise, support and celebrate these factors including disability, mental wellbeing and invisible conditions.
- Staff Inductions now contain guidance on supporting disability and mental health in the workplace, including reasonable adjustments and managing discrimination against those with disabilities and mental health conditions.
- Easy to read guide on how to update disability status on ESR.
- Equality and Inclusion intranet pages advising how staff can make sure that their accessibility needs are supported by the Trust (including in an emergency) as well as micro-aggressions against disability and mental health.
- Regular articles encouraging staff to update their ESR status.

METRIC 10 - PERCENTAGE DIFFERENCE BETWEEN THE ORGANISATIONS BOARD MEMBERSHIP AND ITS OVERALL WORKFORCE. (Lower Figure is better)

Executive Membership
Executive Membership includes members that sit on the BOD e.g. Executive Medical Director or Executive Finance Director. The Trust has 3% disabled workforce and 0% of its Executive Members has declared a disability. **The % difference between the Executive Membership and its overall workforce is -3%**

Board Membership
Board membership includes all voting members of the board irrespective of whether they are executive or non-executive.

The Trust has 3% disabled workforce and 0% of its 15 voting board members has declared a disability. **The % difference between the Board Voting Membership and its overall workforce is -3%**

Essex Partnership University
NHS Foundation Trust

APPENDIX B: WORKFORCE DISABILITY EQUALITY STANDARD
ACTION PLAN - 2020 - 2021

This document supports the first Workforce Disability Equality Standard Report which was approved at Trust Board on [approval date].

Key:
Green: Delivered
Blue: On track/good progress
Amber: Slippage likely/not critical
Red: Slippage/critical

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
Metric 1 Percentage of staff in AfC pay-bands for medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. (Full Breakdown in Report, 3% of Staff declare that they have a disability within the workforce)	**Improvement** as percentage of Disabled Staff increased in all Non-Clinical Posts and some Clinical Posts.	Review job evaluations and specification process involving the Disability and Mental Health Networks to identify any barriers and develop improvements.	Involvement of the D&MH Network will establish if there barriers or disproportionality in the job description and evaluation processes	Rachel Laverty (HR Business Partner) Freya Whiting (Head of Organisational Development / Medical Workforce) D&MH Network Co-Chairs	February 2021		

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
Metric 2 Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. 2019: 1.24 2020: 0.95	**Improvement** as score has decreased from 2019	Roll out EPUT Talent Management Programme and have a member of OD attend the D&MH Network to present details of this program.	Strong talent management will identify someone's potential and then align them to the coaching and development they need in order to progress. Indirectly increasing the pool of internal recruitment and success at interview.	Nicky Reeves OD Manager	December 2020		
		Review process for Job Interview Guarantee Programme and ensure that this is being used appropriately to shortlist staff	To explore how many staff are appointed from Job Interview Guarantee Programme and discuss areas for improvement.	Jodie Russell Head of Resourcing D&MH Network	February 2021		
Metric 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. 2019: 0 2020: 1.41	**Decline** as likelihood has increased since 2019	Quarterly thematic review of formal capability procedure for D&MH Staff (including recommendations for improvement) by the Human Resources Department	Investigate possible themes associated with D&MH staff and formal capability procedures. Further actions will be noted as a result of this work in updates.	Kelly Gibbs, Associate Director of HR	Quarterly throughout WDES 2020-21 Reporting Period		
		ER activity Report quarterly into Workforce Transformation Group and shared with D&MH network including deep dive disciplinary data by area.	To identify those areas were D&MH staff more likely to enter formal processes and work with Operational Leads and HR to create recommendations and put interventions in place.				
		Above process reflected in the Trust's Conduct & Capability Procedure	To ensure fairness and equity across all D&MH investigations.		January 2021		
Metric 4 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/Service users, their relatives or other	**Improvement** as rates decreased across all three categories with an increase in these issues being reported	Anti-Bullying Ambassadors Scheme to run an additional Cohort to recruit and train further members, and will approach the D&MH Network for Volunteers	Bullying is significant for D&MH and there should be D&MH representation in the Anti-Bullying Advisors. ABAs are advocates of positive cultures and have the skills and power to challenge poor behaviour – signposting staff and escalating staff concerns.	Jo Debenham Head of Staff Engagement Charlotte Thomas Staff Engagement Manager	October 2020		

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **2019 – 2020** i) 41% - 39% ii) 23% - 20% iii) 28% - 26% b) 49% - 52%	by staff.	Trust Board and Very Senior Managers to join Reverse Mentoring Scheme if they have not already taken part	Leaders are accountable and should understand learning from D&MH mentors	Anthea Hockley Associate Director, Workforce Development and Learning	October 2020		
Metric 5 Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. 2019-2020: 75%	**No Change** this figure remains static from 2019	Introduction of Career Lounges targeted at D&MH staff. OD representative will attend the D&MH Network to discuss this and how it will benefit these groups.	Develop a better understanding of why these groups may not be accessing Non Mandatory training and Continuous Professional Development	Freya Whiting Head of OD	December 2020		
Metric 6 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to	**Improvement** as this has decreased	Anti-Bullying Ambassadors, Staff Engagement Champions and Equality Champions to be trained to know more about how they can support people in these situations.	Providing Training to these groups of staff across the Trust increases this knowledge in our workforce, and allows for easier signposting and support of those affected.	Gary Brisco Equality Advisor	December 2020		

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
come to work, despite not feeling well enough to perform their duties. 2019: 31% 2020: 30%		Article on Trust Intranet with information for Staff who may find themselves in this situation.	Online article allows staff affected but who do not want to discuss this in the Trust to find guidance and information		October 2020		
Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. 2019: 36% 2020: 38%	**Improvement** as this has increased in the Trust	Relaunch Trust Staff Recognition Scheme, whilst also analysing successful candidates to identify if this is in line with the proportion of disabled staff in the Trust.	Ensuring that we promote the successes of staff with disabilities or mental health conditions at the same rate as staff who are not from these groups and remove possible unconscious bias.	Jo Debenham Head of Staff Engagement	October 2020		
Metric 8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. 2019: 70% 2020: 72%	**Improvement** as this has increased in the Trust	To review staff members who have had reasonable adjustments put in place and request that they share their story to raise awareness.	Highlighting good practice stories of reasonable adjustments put in place for staff will raise awareness of this process and allow this to happen across the Trust.	Gary Brisco Equality Advisor	Throughout WDES 2020-21 Reporting Period		
		Carry out 6 monthly review of grievances against refusal to implement reasonable adjustments including identifying hotspot areas present to Disability Network	Reduce trust grievances and formal processes against the Trust for refusals.	Kelly Gibb Associate Director of HR	December 2020		
		Finalise Reasonable Adjustments Passport as part of renewed Employee Wellbeing and Sickness and Absence Policy	This document will allow those with reasonable adjustments to feel that they can take these with them as they progress within the company.	Kelly Gibbs, Associate Director of HR	December 2020		
		Review HR processes for implementing Reasonable adjustments Present to Dsiability Network.	Speed up processes and reduce the perception in some areas that reasonable adjustments can be seen as a problem .	Kelly Gibb Associate Director of HR	December 2020		

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
Metric 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) 2019 – 2020: 6.5	**No Change** this figure remains static from 2019 Examples included in WDES Report 2020-21	Recruit Staff Engagement Champions to ensure that their membership has over 3% representation from staff members with disabilities or mental health conditions.	Staff Engagement Champions will be better able to understand the needs of these groups if they have members sharing their lived experience.	Jo Debenham Staff Engagement Manager	February 2021		
Metric 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board. WDES Metrics 2019 – 2020: -3%	**No Change** percentage difference remains at -3%	Any recruitment processes for Board or the Executive Team will have a staff representative for Disability and Mental Health on the panel.	A D&MH representative would reduce the risk of unconscious bias, as well as an understanding of Disability and Mental Health concerns and issues.	Executive Director for People & Culture Trust Secretary Office	Throughout WDES 2020-21 Reporting Period		
		Request Board to ensure their details on the Electronic Staff Record are up-to-date.	Board and ET involvement shows senior level investment and promotes psychological safety in the Trust via role-modelling.	Trust Board and Executive Team	December 2020		
GENERAL WDES ACTIONS	Build upon 2019-20 Board Level support	Increase involvement of Board and Executive Team in Disability and Mental Health Network Events	Board and ET involvement shows senior level investment and promotes a positive culture in the Trust via role-modelling.	Gary Brisco, Equality Advisor	Throughout WDES 2020-21 Reporting Period		

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
	Improve Staff Survey Response Rate from Staff with Disabilities	Encouragements from the D&MH Network Chair throughout the Staff Survey Period and updates from Communications.	Increasing involvement of Staff from this group gives us a clearer picture of the employees represented by the WDES and where support is needed.	Staff Eng, Comms, D&MH Network, Equality Advisor	Throughout WDES 2020-21 Reporting Period		
	Continue to share good news and lived experience stories through the lived experience library and through communication channels.		Lived Experience gives others an understanding and compassion for the barriers and challenges faced by staff.	Gary Brisco Equality Advisor	Throughout WDES 2020-21 Reporting Period		
	Infographic produced about the WDES to raise awareness and understanding of the disparities faced		User-Friendly way to communicate the results.	Jo Debenham Staff Engagement Manager	September 2020	Attached	
	Provide a quarterly update on progress against the WDES		Show progress against the action plan – highlight key work and identify risks to achievement.	Jo Debenham Head of Staff Engagement	Quarterly throughout WDES 2020-21 Reporting Period		
	Provide 10 Sensory Awareness Training sessions from Essex Cares across the year with funding from NHS Charities COVID-19 Grant		These will be provided to key staff members to ensure that they are trained to understand, support and care for those with sensory losses	Gary Brisco Equality Advisor D&MH Network	June 2021		
	Run regular campaigns throughout the year to encourage more staff to declare/update their disability status on ESR (Currently 30% of our workforce disability status is unknown)		To produce a more realistic Disablity % for the Trust and reduce the 'not-known' category	Gary Brisco Equalities Adviser	Quarterly		
	Complete a Post-Covid Equality Impact Assessment following on from the original Covid Impact Assessment . Share with Senior Leadership team with advice for considerations.		To identify the impact of covid on disabled staff.	Gary Brisco Equalities Adviser	December 2020		

EPUT 2020 Workforce Disability Equality Standard (WDES) Progress

Essex Partnership University NHS Foundation Trust

Helping to improve the treatment of disabled staff and eliminate discrimination

(*National figure data listed below has been taken from the WDES Annual Report 2019)

Indicator 1

The total number of disabled staff in the workforce (3%) has stayed the same since 2019.

Indicator 2

The likelihood of disabled staff being appointed from shortlisting across all posts has improved since 2019. Last year 1.24, this year 0.95. Better than the national score of 1.23.

Indicator 3

More disabled staff have entered the formal capability process. Last year 0, this year 1.41. Worse than the national score of 1.1.

Indicator 4

The percentage of disabled staff experiencing harassment, bullying or abuse in the last 12 months from the following has improved:

- **Patients, relatives and public - Last year 41%, this year 39%. Worse than the national percentage of 33.8%**
- **Managers - Last year 23%, this year 20%. Worse than the national percentage of 19.8%.**
- **Colleagues - Last year 28%, this year 26%. Better than the national percentage of 26.8%.**

More disabled staff are reporting harassment, bullying or abuse. Last year 49%, this year 52%. Better than the national percentage of 47.8%.

The total number of staff survey respondents that said they had a disability or long term health condition was 21%.

21%

Indicator 5

The percentage of disabled staff believing the Trust provides equal opportunities for career progression & promotion has stayed the same since 2019 (75%). Better than the national percentage of 75.3%.

Indicator 6

Less disabled staff are feeling pressure from their manager to come to work despite not feeling well enough to perform their duties. Last year 31%, this year 30%. Better than the national percentage of 32.0%

Indicator 7

More disabled staff are satisfied with the extent to which their organisation values their work. Last year 36%, this year 38%. Better than the national percentage of 37.2%.

Indicator 8

The percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work has improved. Last year 70%, this year 72%. Worse than the national percentage of 72.4%

Indicator 9

The staff engagement score for disabled staff has stayed the same since 2019 (6.5). Better than the national score of 6.64.

Has the Trust taken action to facilitate the voices of disabled staff? Narrative is available in the 2020 WDES report on the intranet, go to: 'Working Here' > 'Equality & Inclusion' > 'Disability & Mental Health Network > 'WDES'

Yes

Indicator 10

There has been no change in the percentage of disabled board members this year (-3%). Worse than the national percentage of 2.1%.

See what we are doing about the indicators on the intranet, go to: 'Working Here' > 'Equality & Inclusion' > 'Disability & Mental Health Network' > WDES - click here or ask your manager.

		Agenda Item No: 6f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**NHS Workforce Race Equality Standard Data Analysis**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director – People and Culture					
Report Author(s):	Jo Debenham – Head of Staff Engagement David Uzosike – WRES Expert and BAME Staff Equality Network Chair					
Report discussed previously at:	BAME Staff Equality Network Equality & Inclusion Committee Workforce Transformation Committee Executive Operational Committee					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the annual report for the Workforce Race Equality Standard and sets out the experience of our BME workforce compared to our White across a range of metrics.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

Trust Board are asked to:

- Discuss the contents of the report and note the lack of progress across three of the metrics.
- Agree the proposed Action Plan to address gaps.
- Make general recommendations for improving the experience of Black Asian and Minority Ethnic Staff at EPUT.
- Agree to the publication of the paper internally and externally.

Summary of Key Issues

It is really positive to see improvements across 5 out of 9 metrics this year and it is reassuring to see improvements in the metrics around Bullying and Harassment amongst staff and from managers.

We expect a steady progression over time on each metric and this year's results are to be celebrated with 5 of the metrics showing improvements this year. Much more positive than a year previous where only 2 metrics improved. However disciplinary, career development and bullying from patients and the public have not improved and will require strong focus this year.

The Trust needs to take action now to reverse this negative experience in order to improve engagement levels of BAME staff and ultimately all of our patients and service users.

Relationship to Trust Strategic Objectives

SP 1: Continuously improve service user experiences and outcomes	√
SP 2: Achieve top 25% performance	√
SP 3: Valued system leader focused on integrated solutions	√

Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	√
If yes, insert relevant risk	5
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 £**			
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			
WRES	Workforce Race Equality Standard		
BAME	Black, Asian & Minority Ethnicity (Staff)		
HR	Human Resources		

Supporting Documents and/or Further Reading
WRES Report 2019 & Appendices WRES Action Plan 2019/20

Lead

Sean Leahy
Executive Director – People and Culture

NHS WORKFORCE RACE EQUALITY STANDARD DATA ANALYSIS

EPUT YEAR 3

1 Purpose of Report

The purpose of this report is to share progress with the Trust and Board on the experiences of our Black, Asian and Minority Ethnicity Staff (BAME) workforce compared to our White workforce. It sets out our current position, progress since the last report and the proposed actions for the next 12 months to address the gaps in racial equality.

This is year 3 of the Workforce Race Equality Standard for EPUT – Year 6 overall.

It seeks Board level and senior support in driving the WRES and overall Equality agenda forward within Essex Partnership Trust.

2 Executive Summary

The report summarises each of the 9 metrics' progress since last year as well as how we compare nationally. A summary of our progress is set out at Appendix One. Appendix Two is a visual infographic of our position.

This report is written in partnership with the EPUT BAME network and Chair, and the EPUT Frontline Representative. It has also been discussed at the BAME Staff Network, Workforce Transformation Committee, Executive Operational Committee and Equality Committee. The action plan attached at Appendix 3 sets out what actions will be taken to address the gaps in the next 12 months from September 2020 when the paper is launched.

The assessment is date stamped 31 March 20 and Bank Staff are included in our figures because we believe they are an integral part of our workforce.

It is really positive to see improvements across 5 of the metrics this year and it is reassuring to see improvements in the metrics around Bullying and Harassment amongst staff and from managers. But there is still much work to do to improve the experience of our BAME staff and we are optimistic that a stronger focussed action plan and strong partnership working with our BAME network will lead to continued improvement next year.

3 Our Work since last year

Some of the key work towards improving our BAME experience in the last action plan included:

- The completion of the 1st round of Reverse Mentoring including a celebratory event.
- Implementation of a mandate to have a BAME representative on all B8a and above interviews and Interview Skills Training for a pool of BAME Representatives
- Recruiting Manager Interview pack strengthened to include rationale for including BAME reps on panels.
- Template Equality Questions included in all Appointing Manager recruitment packs with a recommendation that at least one equality question is asked (All Bands)
- Trial of a Disciplinary Decision Making tool.
- Regular reporting of Employee Relations Activity including BAME prevalence in disciplinaries.

- Review and Update of the Conduct & Capability Training to include WRES and Unconscious Bias.
- Talent Hub created Autumn 2019.
- Introduction of an Anti-Bullying Ambassador Programme which includes BAME Anti-Bullying Ambassadors.
- A review of Senior Leadership team and extension to Band 7.
- Programme of Senior Leadership Development including Equality and Inclusion.
- Two new sessions on the Management Development Programme including 'Equality' and 'WRES and BAME Issues'.
- Positive Cultures session been delivered across Teams which includes Cultural awareness.
- WRES board development session held Autumn 2019 with Head of Staff Engagement and WRES Expert.
- Black History Month celebration and BAME role model profiling.
- Participation in the national WRES FRONTLINE PROGRAMME with an EPUT employee Sylvia Impraim.
- Violence and Aggression Task and Finish Group with BAME Representative.
- Thriving BAME staff Network.
- BAME Network Chair Role with Funded Administrative Support and 2 days PM protected time.
- Investment in a Full Time Permanent Equality Adviser.
- Trained Mediators to support disputes at work including some from a BAME background.
- EPUT Equality Champions Conference July 2019.
- Specific Covid-19 Sessions for BAME staff.
- Letter of support for All BAME Staff during Covid-19.

4 Breakdown of BAME staff in bands.

Appendix 4 shows a breakdown of BAME staff in our Band 8 positions. Appendix 5 shows performance compared to nationally set trajectories for senior recruitment.

Currently 16% of our Bands 8A – 8D are held by BAME staff. This compares to 15% last year.

Individual bands have increased in 5 – stayed the same in 6 and reduced in 4 – B1 B8c B8d and Other.

5 Conclusion

We are really pleased to see positive movement in many of the Metrics this year – a real improvement on the year previous. However much work is still needed to improve the experience of our BAME workforce and it is disappointing to see such little progress in two of the key metrics around access to CPD and staff entering the Disciplinary process. There will have to be close scrutiny this year in order to ensure that for the first time since the merger these metrics improve.

It cannot be the case that our BAME workforce are allowed to have such lower levels of staff engagement – or application of our Trust values.

We must now focus on not only improving the individual metrics, but look overall at how we are addressing the issues faced by our BAME workforce. The action plan will go some way to doing this but it should be noted that it is not a full set of actions being taken to address racial inequalities – rather those that are agreed to address these metrics.

6 Action Planning

The action plan is attached at Appendix 3. These are those action specific to the WRES metrics and do not include our wider response to Equality and Race as set out in the NHS People Plan. We believe these priorities will have a positive impact on the experience of BAME staff. It will have a strong focus on HR Processes, disciplinary activity and continuous professional development.

Key Features include:-

- Focussed unconscious Bias Training to be made available via the STPs Autumn 2020.
- The support and funding for a new EPUT WRES Expert when the next national cohort launches.
- Strengthened Management Development and Senior Leadership around WRES and actions to address race inequalities.
- Further Cohorts of Anti-Bullying Ambassadors to include the BAME workforce.
- All Conduct and Capability Processes to be reviewed before proceeding to formal stage.
- A drill down into disciplinary activity across all stages of the process.
- Trust Board and Senior Leadership Development Programme in partnership with CQ Cultural Intelligence Jennifer Izekor.

7 Action Required

Executive Operational Committee are asked to:

- Approve the report for publication and wide promotion internally and externally
- Agree the Action Plan.
- Make recommendations for any further actions which will improve the experience of our BAME staff.

Report prepared by

Name **Jo Debenham**
Job Title **Head of Staff Engagement**
Date **September 2020**

Name **David Uzosike**
Job Title **BAME Network Chair (Acting)**
Date **September 2020**

On Behalf of:

Name **Sean Leahy**
Job Title **Executive Director - People and Culture**

Appendix 1 - 2020 Workforce Race Equality Standard Data EPUT Progress

Ind No	Type	Description	EPUT 2019 score	EPUT 2020 score	EPUT Direction 2020	National 2019 report	EPUT Comp to National
1	Workforce Data	% BME staff in the workforce *Higher = Better*	24%	26%	▲	19.7%	▲
2		Likelihood of white staff being appointed from shortlisting compared to BME staff across all posts *Lower = Better*	1.27	0.91	▼	1.46	▼
3		Likelihood of BME staff entering formal disciplinary process compared to White staff *Lower = Better*	2.10	2.73	▲	1.22	▲
4		Likelihood of White staff accessing non-mandatory training and CPD compared to BME staff *Lower = Better*	1.63	2.10	▲	1.15	▲
5	Staff Survey Results 2018	% BME staff experiencing harassment bullying abuse from patients relatives and public in last 12 months *Lower = Better*	36%	39%	▲	30%	▲
6		% BME staff experiencing harassment bullying abuse from staff in last 12 months *Lower = Better*	28%	25%	▼	29%	▼
7		% BME staff believing the Trust provides equal opportunities for career progression & promotion *Higher = Better*	71%	74%	▲	70%	▲
8		In last 12 M have you personally experienced discrimination at work from Manager or Team *Lower = Better*	16%	13%	▼	15%	▼
9	Board Membership	Difference between BME Board membership & overall workforce *Lower = Better*	17%	17%	–	8.4%	▲

- WRES data for all trusts in England
- Indicator 5 National Report named EPUT as a trust where practice may be worse
- Indicator 8 National Report named EPUT as a trust where practice may be worse

EPUT 2020 Workforce Race Equality Standard (WRES) Progress

Essex Partnership University NHS Foundation Trust

Helping to improve the treatment of BAME staff and eliminate discrimination

Indicator 1

The total number of BAME staff in the workforce has increased to 26% compared to 24% in 2019.

2%

increase in our overall BAME workforce this year.

EPUT are doing better than the national average.

Indicator 2

More BAME staff are being appointed from the shortlisting stage across all posts.

EPUT are doing better than the national average.

Indicator 3

The likelihood of BAME staff entering the formal disciplinary processes, compared with White staff has increased since 2019. Last year 2.10, this year 2.73.

Indicator 4

The likelihood of White staff accessing non-mandatory training/CPD, compared with BAME staff has increased since 2019. Last year 1.63, this year 2.10.

Indicator 5

More BAME staff are experiencing harassment, bullying and abuse from patients, relatives and public in the last 12 months. Last year 36%, this year 39%.

Indicator 6

Fewer BAME staff are experiencing harassment, bullying and abuse from other staff in the last 12 months - (25% compared to 28% in 2019).

EPUT are doing better than the national average.

Indicator 7

More BAME staff are believing the Trust provides equal opportunities for career progression & promotion - (74% compared to 71% in 2019).

EPUT are doing better than the national average.

Indicator 8

Fewer BAME staff said they have personally experienced discrimination at work from their manager or team in the last 12 months - (13% compared to 16% in 2019).

EPUT are doing better than the national average.

Indicator 9

The difference between BAME board membership and the overall workforce has stayed the same since 2019.

See what we are doing about the indicators on the intranet, go to: 'Working Here' > 'Equality & Inclusion' > 'WRES' or ask your manager

Essex Partnership University
NHS Foundation Trust

WRES 12 MONTH ACTION PLAN
1 October 2020 – 30 September 2021
Updates 31 December 2020/31 March 2021 /30 June 2021 /30 September 2021

This document supports the Workforce Race Equality Standard Report approved at Trust Board 30 *September 2020*

'OPEN COMPASSIONATE EMPOWERING'

Metric No	Result	Action Required	Rationale/intended outcome	Lead	Due Date	Quarterly Progress update	Ranking
1. Percentage of BME staff in Bands 1-9, VSM (compared with the percentage of BME staff in the overall workforce	**IMPROVED** since last year and better than national average.	Analyse job evaluation by BME Data and identify any hotspots	Establish any barriers and disproportionality in the JE process.	Jodie Russell Head of Resourcing	January 2021		

WRES ACTION PLAN 2020 – 2021

		CQ Cultural Intelligence Programme applied to: Trust Board Senior Leadership Pilot Group Staff Engagement and Equality Champions ½ day workshop	Commitment at senior level to becoming an inclusive and representative employer improving understanding of cultural intelligence and awareness in decision making. CQ for BAME Advisory Group to enhance talents and maximise opportunities.	Sean Leahy Executive Director of People and Culture BAME Network Chair & Network	Autumn 2020		
		Trust Board and VSMs to join Reverse Mentoring Scheme if they have not already taken part	Leaders are accountable and should understand learning from BAME mentors	Anthea Hockly Head of Learning	November 2020		
		Produce a separate report on EPUT Ambition Modelling for Band 8 in line with recommendations made by NHS E & I for EPUT	Improve BAME representation and inclusion at most Snr levels of the Trust	Sean Leahy Executive Director for People & Culture Head of Staff Engagement.	October 2020		
2. Relative likelihood of White staff being appointed from shortlisting	**IMPROVED** since last year and better than national average.	Roll out EPUT Talent Management Programme (Cross refer to Organisational Development Plan)	Strong talent management will identify someone's potential and then align them to the coaching and development they need in order to progress. Indirectly increasing the pool of internal recruitment and success at interview.	Freya Whiting Head of OD	Q3 December 2020		

		Targeted recruitment adverts at under-represented areas e.g. Allied Health Professionals.	Increase BAME representation	Head of Resourcing BAME Network Chair & Network	Quarterly		
3. Relative likelihood of BME staff entering the formal disciplinary process, compared to White	**IMPROVED** since last year and better than national average.	Just and learning culture approach introduced.1/4 review of Suspensions and Cases – discussion with BME network and Head of Resourcing.	Gives focus and structure to identifying issues with putting staff through to formal processes	Associate Director of HR BAME Network Chair & Network	Quarterly		
		ER activity Report quarterly into Workforce Transformation Group and shared with BAME network including deep dive disciplinary data by area	To identify those areas more likely to enter formal processes – and work with Leaders and HR to ascertain why their rates are higher – putting interventions in place.		Quarterly		
		Disciplinary Decision Making Tool used and any BAME cases include a discussion with BAME network before proceeding to formal process (NB Any case information is redacted and anonymized)	Review any potential disparity or bias compared to other case and identify any potential race or bias issues with a view to reducing the number of BAME cases entering formal Disciplinary Process.		Immediate		
		Above process reflected in the Trusts **Conduct & Capability Procedure**	To ensure fairness and equity Across all BAME investigations.		December 2020		
		Review of Grievance Activity by BAME in conjunction with BAME network	Identify any bias in grievance processes and put measures in place to reduce.	Kelly Gibb Associate Director of HR	October 2020		

4. Relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff	**WORSE** than last year. Worse than the national picture.	Reverse mentoring – second cohort to run		Anthea Hockly Head of Learning and Development	November 2020		
		Talent Management Programme – promote with BAME network and get engagement			End of Q3		
		Apprenticeships – promote apprenticeship opportunities to the BAME network with the aim of increasing uptake to the appropriate percentage for the staff group.			End of Q3		
		Succession planning Leadership Development – appraisal audit to look at how succession planning is covered. 10% target and focus on BAME staff.	Improve BAME staff accessing personal development and non-mandatory training and encouraging career progression		31 October 2020		
		Promotion of National Leadership Academy programmes to BME staff (Stepping Up, Ready Now etc.			immediate		
		Coaching Lounges – set up for BAME staff. Aim to get 20 staff undertaking coaching.		Freya Whiting Head of OD	December 2020		
		Create a scholarship with targets attached for BAME staff accessing learning and development.		Anthea Hockly Head of Learning and Development	December 2020		
		Audit ALL BAME Staff regarding their access to NM Training and CPD. This needs to be extended to ask all BAME staff about career opportunities and aspirations.	Gain intelligence on the barriers to accessing to allow targeted actions.				

		Identify the highly populated bands and carry out targeted work with each of the BME People it applies to who have been at the top of their band for 5+ years (this will applyto ALL EPUT staff not just BME)	Supports career progression discussion and identifies reasons why they are not progressing.		October 2020		
5 % BME staff experiencing harassment bullying abuse from **patients relativ es and public** in last 12 months	**WORSE** than last year. Better than the national picture	Develop Work stream with Security Management Team and Operational Leads including Operational Leads and Police.	V&A is part of our Client Group. However working with Clients to reduce accelerated/aroused behaviour can reduce poor behaviour and aggression towards staff.	Jo Debenham Head of Staff Engagement Debby Stevens Security Management Specialist.	October 2020		
		LSMS team to deliver their zero tolerance / Violence and Aggression workshop to the BAME network.	To raise awareness for them and BME staff that may approach them for support.	Debby Stevens David Uzosike	January 2021	Currently awaiting details of the new LSMS Replacement as existing post holder moving to a new internal role.	
		Quarterly report on % of patient related incidents by BME v White presented to BAME network for discussion	Regular discussion with BME staff around the issues and what the Trust is doing to address.	Debby Stevens Security Management Specialist Jo Debenham Head of Staff Engagement.	Quarterly		

		Each Senior Leader to hold one 'Through my eyes' focus group to learn more about the experience of BAME staff in their area of responsibility. Stories to be anonymised and discussed at Operational SLTs with responses and actions fed through the communication channels	Leaders should have awareness of what happens in their area of responsibility and be able to give assurance that they are responding and making positive changes. Getting comfortable with the uncomfortable	Operational SMTs	January 2021		
		Carry out Quality Improvement Project in identified areas (including St Aubyns Centre) with the aim of reducing violence from Patients and improving staff morale and experience.	Address the root causes of Violence and Aggression from Patients and improve staff and patient experience	Jo Debenham Head of Staff Engagement Debby Stevens LSMS Specialist	October 2020		
		Review ACT resilience Coaching content to include information about how to deal with someone who is abusing/being racist/poor behaviour.	Equip staff with skills and strategies to cope with abusive patients.	Greg Wood	December 2020		
		Review and update display of Zero Tolerance Posters in all In Patient Areas of the Trust	Send out a clear message that poor behaviour will not be tolerated	Debby Stevens LSMS Specialist	January 2021		
6% BME staff experiencing harassment bullying abuse from **staff** in last 12 months	**IMPROVED** since last year and better than national average.	Anti-Bullying Ambassadors Scheme to run an additional Cohort	Bullying is significant for BAME and there should be BAME representation in the Network. ABAs are advocates of positive cultures and have the skills and power to challenge poor behaviour – signposting staff and escalating concerns.	Jo Debenham Head of Staff Engagement Charlotte Thomas Staff Engagement Manager	November 2020		

		HRBPs to work with Directorates on local actions to tackle Bullying	Issues are different for each area as set out in staff survey results and issues should be managed locally.	HRBPs Matt Cope Rachel Laverty Debbie Prentice	Quarterly update required for this report.		
7 BME staff believing the Trust provides equal opportunities for career progression & promotion	**IMPROVED** since last year and better than national average.	Introduction of Career Lounges targeted at BAME staff.	Get to the root cause of why BAME staff are not accessing NMT and CPD	Freya Whiting Head of OD	October 2020		
8 In last 12 M have you personally experienced discrimination at work from Manager or Team	**IMPROVED** since last year and better than national average.	Anti-Bullying to continue to be a feature of SLT events.	Anti-Bullying on grounds of Race must remain high profile and leaders held to account – therefore skills and awareness is vital.	Sean Leahy Executive Director People and Culture Freya Whiting OD Manager	Quarterly SLT events.		
9 Difference between Board membership & overall workforce	**No Change.**	Increasing BME representation at Senior Levels Target Set (TBC) Recruitment Processes for Board Roles to have BAME representation on Panel and actively encourage BAME applications.	Reflective of population served and local workforce	Trust Secretary Office Sean Leahy Executive Director for People & Culture	Subject to instigation of recruitment processes.		

GENERAL	Continue to share **good news** and lived experience stories through the lived experience library and through communication channels.	Lived Experiencegives others an understanding and compassion for the barriers and challenges faced by BAME staff.	Gary Brisco Equalities Adviser BAME Network	Quarterly update		
	Infographic produced about the WRES to raise awareness and understanding of the issue of Race and poor experience	User Friendly way to communicate the results.	Jo Debenham Head of Staff Engagement	Complete.		
	Train 1 EPUT employee as a **WRES Expert**.	Champion and challenge the implementation of the WRES and National Regional and Local Expert. Access to network of learning and experience of applying the WRES across the UK Increases WRES skill set within the organisation	Jo Debenham Head of Staff Engagement	Subject to national launch of next Cohort.	EPUT have lodged a request with the national WRES team for a place.	
	Review **Engagement Champion** Network BAME representation.	Network should be representative of the underlying workforce	Sean Leahy Executive Director People and Culture Jo Debenham Head of Staff Engagement	December 2020		
	Act on the results of **local Pulse Survey** and extract by BAME responses	Real-time live up to date information from BAME staff which can be acted on quickly and locally.	Jo Debenham Head of Staff Engagement Operational Leads HRBPs	Launches August 2020 October 2020		

	Ensure EPUT has 100% Compliance for BAME Risk Assessment Processes and identify patterns and trends reported into the Workforce Transformation Group for discussion and action.	Safety of our BAME staff and need to identify risks and provide assurance that their wellbeing and safety is provided for	Associate Director of HR	August 2020		
	Network closely with other local organisations STPs and Partners around the BAME agenda.	Share learning and good practice and problem solve together where appropriate.	ALL			
	Work with the BAME network and devise a communication Plan for BAME staff. To include role model articles	Raise awareness and profile of BAME staff at EPUT in a positive encouraging way.	Head of Communications	October 2020		
	Cross refer to the Trust Wide NHS People Plans for 'Belonging' Actions arising out of the National People Plan	Ensure the wider people plan inclusion actions are monitored and governed to address racial inequalities.	All	Quarterly		

Key: Green: Delivered Blue: On track/good progress/Not Due Gold: Slippage likely/not critical Red: Slippage/critical

WRES ACTION PLAN 2020 – 2021

Appendix 4 – BAME Breakdown overall and Band 8 Breakdowns

Fig 1 - EPUT BME Breakdown ALL BANDS 19 v 20

Bands	BME 2019	BME 2020
Bands 1	15%	14%↓
Bands 2	39%	39%↔
Bands 3	22%	22%↔
Bands 4	8%	9%↑
Bands 5	29%	32%↑
Bands 6	21%	21%↔
Bands 7	19%	19%↔
Bands 8a	13%	17%↑
Bands 8b	14%	19%↑
Bands 8c	10%	8%↓
Bands 8d	11%	4%↓
Bands 9	0%	0%↔
VSM	7%	7%↔
Medical & Dental	63%	65%↑
Other	7%	6%↓
Total	**24%**	**26%**

24% + = Over Representation
18%-23% = Similar Representation
0=18% = Under representation

This section shows that our overall % of BAME staff in the Band 8s has increased this year.

It also shows that the overall % of BME staff in our workforce has increased by 2% which is really positive.

This table shows that our individual bands have increased in 5 – stayed the same in 6 and reduced in 4 – B1 B8c B8d and Other.

Fig 2 - % BME staff overall at EPUT – 3 year comparison

2017	Last Year 2018	This Year 2019	NATIONAL PICTURE*
19.5%	22% ▲	24% ▲	19%▲

Fig 2 - Breakdown of Band 8 by BME representation.

Band	2017	2018	2019	2020
8a	12.5%	15%↑	13%↓	17%↑
8b	11.5%	16%↑	14%↓	19%↑
8c	10%	19%↑	10%↓	8%↓
8d	7%	10%↑	11%↑	4%↓

This year 2 out of 4 B8 grades have increased their BAME representation

APPENDIX 5 – Trajectory Chart for increasing BAME representation at Senior Level.

	2019 Goal	2019 Actual	Gap	2020 Goal	2020 Actual	Gap
8a	36	29	-7	37	37	0
8b	16	13	-3	16	18	+2
8c	6	5	-1	7	3	-4
8d	2	2	0	2	1	-1
9	0	0	0	0	0	0
VSM	1	1	0	1	1	0

Note * Figures taken from document 'Model Employer: Increasing black and minority ethnic representation at senior levels across Essex Partnership University NHS Foundation Trust'

Presented by the national wres team as a suggested commitment to improv ing BAME representation across the Trust – full report av ailable for reference here

		Agenda Item No: 6g
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Urgent Actions to address Health Inequalities**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director – People and Culture					
Report Author(s):	Jo Debenham – Head of Staff Engagement					
Report discussed previously at:	None					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Purpose of the Report		
The purpose of this report is to share with the Board our intentions around addressing patient inequalities at Essex Partnership NHS Trust and the wider system.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note and discuss the approach to addressing health inequalities
2 Agree to the Executive Director of People & Culture acting as the Lead for Health inequalities.

Summary of Key Issues

The Phase 3 letter sent to all Trusts on 31 July 2020 included tackling health inequalities as one of the priorities for Trusts. This paper summarises our priorities over the next 12 months to tackle health inequalities. Full details of our response to Phase 3 are contained within a separate Reset and Recovery Paper.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	√
SO 2: Achieve top 25% performance	√
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	√
If yes, insert relevant risk	5
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 £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			√
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	**NO**

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Appendix 1 – Summary of Key Priorities
Appendix 2 – Infographic

Lead

Sean Leahy
Executive Director – People and Culture

Agenda Item: 6g
Board of Directors
30 September 2020

URGENT ACTIONS TO ADDRESS INEQUALITIES IN NHS PROVISION & OUTCOMES SUMMARY PAPER

1 Purpose of Report

The purpose of this report is to share with the Board our intentions around addressing patient inequalities at Essex Partnership NHS Trust and the wider system.

2 Executive Summary

The Phase 3 letter sent to all Trusts on 31 July 2020 included tackling health inequalities as one of the priorities for Trusts. This paper summarises our priorities over the next 12 months to tackle health inequalities. Full details of our response to Phase 3 are contained within a separate Reset and Recovery Paper.

3 Background

Covid-19 has further exposed some of the health and wider inequalities that persist in our society and the virus itself has had a disproportionate impact on certain sections of the population, including those that are deprived, Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations.

It is essential that recovery is planned in a way that inclusively supports those in greatest need and that sufficient attention is given to the fact that this is a case of people dying. It is serious and we must take our responsibilities seriously.

It is vital that as a Healthcare provider we work collaboratively with our internal and external stakeholders to address the inequalities and hold track of progress.

4 Summary of key priorities

Appendix 1 sets out our response to the Health Inequalities element of the Phase 3 letter issued to all Trusts. It is presented in priority order and does not include non-relevant areas (e.g. Maternity services). It will be monitored through the Equality & Inclusion Committee and Board lead for Equality & Inclusion.

5 General Actions to address health inequalities.

In addition to the above there is a wide range of work underway – reflected in our Equality Delivery System but summarised here as follows:-

- Collaborative working to monitor patient experience
- Refreshed and strengthened Equality Impact Assessment Process and Guidance

- Equality Committee Sub Group capturing good practice Patient Equality Initiatives and outreach
- Quality Improvement Programme focus on E&I and increased impact assessment
- Review of current E&I resource for the organisation
- Collaborative working with East of England, NHS England & Improvement, and Integrated Care Systems
- Strengthened E&I Committee with strengthened Equality Staff Network voice
- Leadership Development E&I Programme in place including Cultural Intelligence Autumn 2020.
- Increased focus on community engagement (more detail at appendix 3).

The diagram at Appendix 2 sets out in further detail the key elements of our longer term approach to addressing patient inequalities.

8 Action Required

Trust Board are asked to:

1. Note and discuss the approach to addressing health inequalities
2. Agree to the Executive Director of People & Culture acting as the Lead for Health inequalities.

Report prepared by

Jo Debenham
Head of Staff Engagement

For and on behalf of
Sean Leahy
Executive Director of People & Culture
September 2020

Appendix 1 – Summary of actions to address Health Inequalities

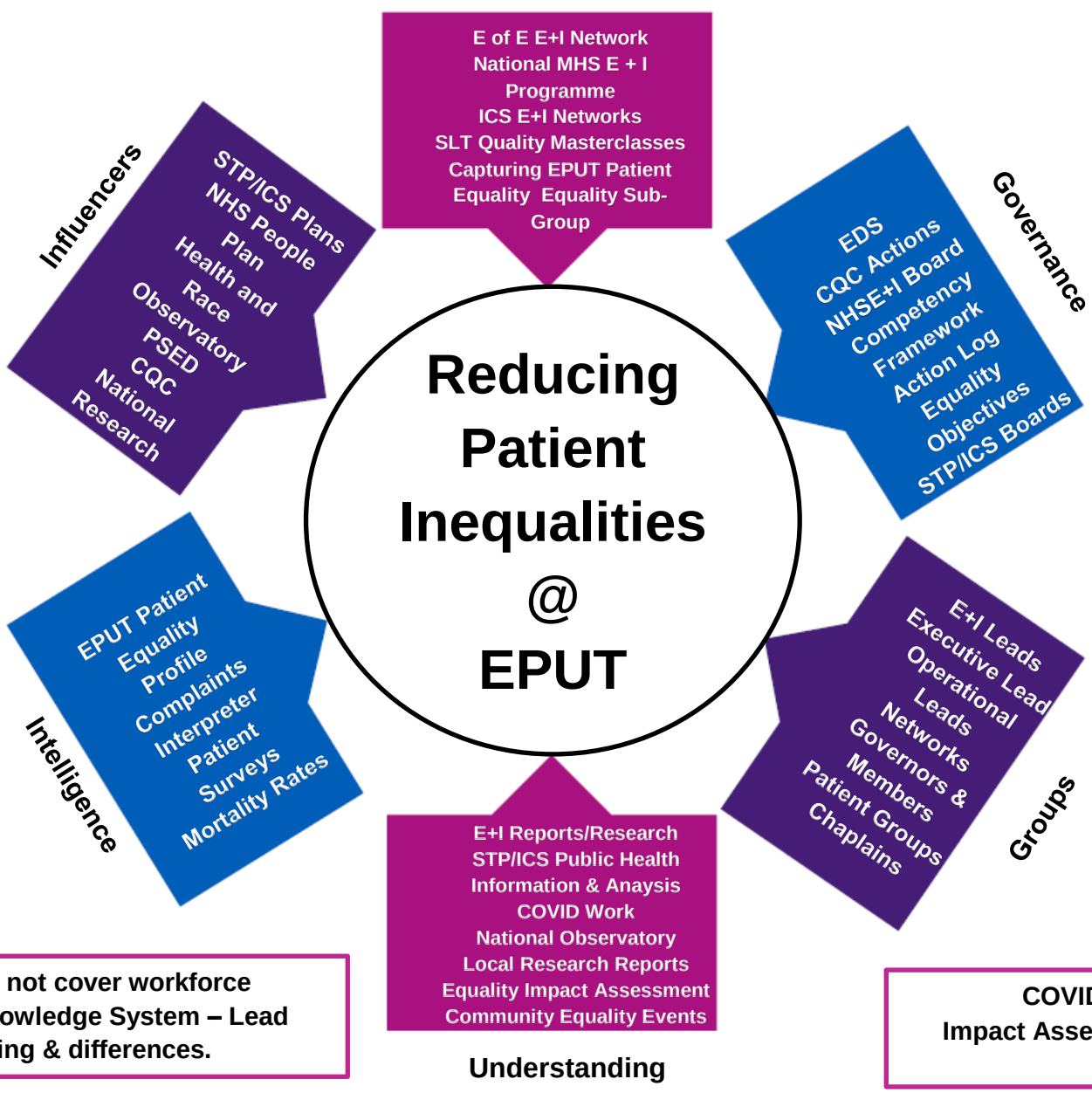
Expectation	EPUT Intention
Health Inequalities and Prevention	
Named executive Board member responsible for tackling inequalities in place in September in every NHS organisation	Complete subject to Board Approval
Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. (starting with emergency, outpatient and elective care – including cancer referrals and waiting times)	Support the new central performance monitoring systems for EPUT services and ensure the information forms a key part of local operational plans.
Develop **digitally enabled care pathways in ways which increase inclusion**, reviewing who is using new digitally enabled care pathways by 31 March *(starting with virtual outpatients and digitally enabled mental health)*	Refer to the IM&T Strategy and Group
Protect the most vulnerable from Covid-19, with **enhanced analysis and community engagement**, to mitigate the risks associated with relevant protected characteristics and social and economic conditions and better engage those communities who need most support.	System Level response with MSE – Meeting Associate Director of Mental Health Commissioning Mid and South Essex Health and Care Partnership October 2020 See Appendix 3
Each NHS board to publish an action plan showing how over the next five years its Board and Senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.	Contained within the WRES Workplan (deadline 31.10.20)
All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December	In Progress.
Workforce Inequalities	
Urgent action to **address systemic inequality** that is experienced by some of our staff, **including BAME staff.**	Cross refer to: WDES Action Plan WRES Action Plan Equality Delivery System 20/21
Local People Plans –role in both reducing inequalities and local economic recovery	EPUT People and Culture Action Plan

Essex Partnership University
NHS Foundation Trust

Reducing Patient Inequalities at EPUT

EPUT Trust Board

EPUT E + I Committee



Does not cover workforce Acknowledge System – Lead working & differences.

COVID Impact Assessment

Ensure datasets are complete - to underpin an understanding and response to inequalities. All organisations should proactively review and ensure the completeness of data by 31st December.

Appendix 3 - Engaging with Communities to reduce inequalities.

There will be an increased focus on community engagement as follows:-

- Working with the ICS System Groups to identify System wide community groups and then working in partnership with local councils, commissioners and health care providers.
- Stronger focus on Inclusion at Patient User Groups and Forums.
- Promotion of EPUT services and how to get involved through local community spots including sports centres and cafes using newspapers posters and leaflets.
- EPUT service delivery and planning to include representatives from local communities and groups.
- Increased Public Surveying about access and barriers to our services.
- Tapping into locally organised events and having an EPUT presence to engage with community groups.
- Increasing Volunteers from our local community to work with us and steer our services.
- Development of locally based health initiatives using co-production between communities and EPUT healthcare leaders.
- Increased use of Social Media to engage with local communities on specific inclusion work.
- Annual Equality sessions with the local community to rate how we are delivering equality.
- Work with the EPUT Equality Networks to ascertain local community links – bringing in speakers to support specific equality issues in the community.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	Board Assurance Framework 2020/21 as at September 2020					
Executive/Non-Executive Lead:	Sally Morris, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive Operational Sub-Committee 18 August and 22 September 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report presents the Board of Directors with an overview of the Board Assurance Framework, Corporate Risk Register, and Covid-19 Gold Risk Register for 2020/21 covering the two month period August and September (Q2) as at 30 September 2020	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 September summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its August meeting.
2 Approve the escalation of BAF23 EU Exit Operational Preparedness to the BAF (2.1).
3 Approve the new risk for the Corporate Risk Register (2.2).
4 Note the CRR September summary table (Appendix 2) including actions taken by EOSC at its August meeting.
5 Approve the proposal for Key Performance Indicators in relation to the BAF (Appendix 3).
6 Identify any further risks for escalation to the BAF, CRR or risk registers.

Summary of Key Issues

- This report covers two months of reporting to EOSC and the September summary includes reference to any changes made by EOSC in August 2020.
- As at September there are 21 risks on the Board Assurance Framework and 23 on the Corporate Risk Register.
- Q2 BAF action plans were reviewed by EOSC, Finance and Performance and Quality Committees in September. PIT will review their BAF action plans at their next meeting
- People and Culture DRR summary and Chief Executive DRR summary were reviewed by EOSC in August and September respectively

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	All
If yes, insert relevant risk	See report
Do you recommend a new entry to the BAF is made as a result of this report?	Yes – EU Exit

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	CRR	Corporate Risk Register
HSE	Health and Safety Executive	CAMHS	Child and Adolescent Mental Health Service
PICU	Psychiatric Intensive Care Unit	CQC	Care Quality Commission
DRR	Directorate Risk Register	CIPs	Cost Improvement Plans
EU	European Union	NELFT	North East London Foundation Trust
STP	System Transformation Programme	TOR	Terms of reference
QI	Quality Improvement	STARS	Specialist Treatment & Recovery Service
OD	Organisational Development	SPC	Statistical Process Control
NHSI & NHSE/I	NHS Improvement NHS England/Improvement	SEECHS	South East Essex Community Health Services
CCG	Clinical Commissioning Group	WECHS	West Essex Community Health Services
SLT	Senior Leadership Team	SMT	Service Management Team
SDIP	Service Development and Improvement Plan	QIPP	Quality, Innovation, Productivity and Prevention
CEO	Chief Executive Officer	BAU	Business as usual
ACT	Acceptance and Commitment Therapy	RAG	Red Amber Green
SI	Serious Incident	Q&S	Quality and Safety
PHSO	Parliamentary Health Service Ombudsman	HSSC	Health Safety and Security Committee
MH/LD	Mental Health/Learning Disabilities	EFA	Estates and Facilities Alert
SITREP	Situation Report	HBPOS	Health based place of safety
NEP	North Essex Partnership	TFO	Trust Fire Officer
CICC	Cumberlege Intermediate Care Centre	ITT	Information Technology and Telephony
HSCN	Health and Social Care Network	PIR	Provider Information Request

Supporting Documents and/or Further Reading

Appendix 1 – Summary of BAF September 2020
Appendix 2 – Summary of CRR September 2020
Appendix 3 – Proposal for KPIs for BAF

Lead

Sally Morris
Chief Executive Officer

Agenda item 7a
Board of Directors
30 September 2020

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 SEPTEMBER 2020

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2020/21 as at 30 September 2020.

UPDATE AS AT SEPTEMBER 2020

1. Board Assurance Framework 2020/21

The Board Assurance Framework (BAF) provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key aims agreed by the Board of Directors. The full BAF and CRR spreadsheets are available on request.

There are currently 21 risks on the BAF. Appendix 1 provides a summary of BAF risks as at September 2020 (and notes of any changes made in August 2020), including mapping of risks against the 5 x 5 scoring matrix and movement on scoring from October 2018 to September 2020.

2. Recommendations for Escalation and New Risks

2.1 Escalation to BAF

In light of the increasing likelihood of a 'no deal' EU Exit EOSC is recommended to escalate BAF23 EU Exit Operational Preparedness back up to the BAF.

2.2 New risks for Corporate Risk Register

From West Essex Community Health Services:
"If GPs do not carry out home visits on their end of life care patients then additional work is given to community staff in visiting patients and sending videos to GPs to avoid coroner involvement in unexpected deaths, resulting in a poor experience for patients and low morale of staff."
Suggested score 4 x 4 = 16

3. BAF Action Plans

Potential risks on the BAF should (in most cases) have a detailed risk mitigation action plan. BAF Action Plans were reviewed by EOSC September 20, and relevant risks reviewed and scrutinised by Quality Committee and Finance and Performance Committee in September 2020. PIT will review their risks at their next meeting. The table below breaks these down by action plan status for August and September. BAF action plans are available on request.

August 2020		**September 2020 Q2**	
Action plans in place		**Action plans in place**	
BAF4	Fire Safety	BAF4	Fire Safety
BAF10	Ligature Reduction	BAF10	Ligature Reduction
BAF36	Female patients with PD	BAF36	Female patients with PD
BAF9	No force first	BAF9	No force first
BAF34	Staffing new services/ care pathways	BAF34	Staffing for new services/ care pathways
BAF38	Emergency planning for Covid19	BAF32	Quality improvement
BAF20	Adult inpatient capacity	BAF48	Capacity for Mortality Reporting/ Review
BAF31	Skills and capacity	BAF31	Skills and capacity
BAF44	Learning from Covid19 (to develop)	BAF20	Adult inpatient capacity
No action plans required		BAF35	Culture of fairness and learning
BAF40	Organisational objectives	BAF44	Learning from Covid19
BAF45	CQC - reset action plan	**No action plans required**	
BAF42	Financial plan	BAF47	Limiting bed occupancy to 85%
BAF35	Culture of fairness and learning	BAF40	Organisational objectives
BAF41	CIPs (linked to financial plan)	BAF38	Emergency planning for Covid19
BAF43	Surge planning	BAF43	Surge planning

August 2020			September 2020 Q2	
BAF46	Young people with complex care needs		BAF46	Young people with complex care needs
BAF15	HSE (linked to BAF10)		BAF15	HSE – linked to BAF10 Ligatures
			BAF45	CQC - reset action plan approved
			BAF41	CIPs
			BAF42	Financial plan
			BAF49	Executive Leadership

4. Corporate Risk Register

4.1 August 2020

There were 22 risks on the Corporate Risk Register in August.

4.2 September 2020 (Q2)

There are currently 23 risks on the Corporate Risk Register. The summary table of CRR risks is attached as Appendix 2. Table 1 gives a summary of each risk (including notes of any changes made in August 2020), and Table 2 shows the mapping of risks against the 5 x 5 scoring matrix.

5. Covid-19 Risk Register

The C19 risk register is updated every two weeks as far as practicable and is circulated to Executive Directors via Gold Command for review. The Non-Executive Director responsible for emergency planning receives the risk register at the same time. A summary document for Gold risks is appended to each CEO report on Covid19 presented to Board.

6. Directorate Risk Registers

A full risk profile has been undertaken with the Operational Services Directorate and work is progressing to update the Directorate Risk Registers accordingly.

Work is progressing on producing Directorate Risk Register summaries so that these can be presented instead of the spreadsheets. Directorate objectives continue to be added to Risk Registers with senior leads assessing any new risks.

The People and Culture Directorate Risk Register was reviewed by EOSC at its meeting on 18 August, and Chief Executive Directorate Risk Register was reviewed by EOSC at its meeting on 22 September.

7. Key Performance Indicators

Initial key performance indicators for the Board Assurance Framework were developed and presented in the Risk Management and Assurance Annual Report to the Audit Committee. Further work has been carried out to develop targets for these KPI's and the proposal for these is attached as Appendix 14 for approval.

8. Recommendations

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 September summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its August meeting.
2 Approve the escalation of BAF23 EU Exit Operational Preparedness to the BAF (2.1).
3 Approve the new risk for the Corporate Risk Register (2.2).
4 Note the CRR September summary table (Appendix 2) including actions taken by EOSC at its August meeting.
5 Approve the proposal for Key Performance Indicators in relation to the BAF (Appendix 3)
6 Identify any further risks for escalation to the BAF, CRR or risk registers.

Report prepared by**:** On behalf of:

Susan Barry, Head of Assurance

Sally Morris, Chief Executive

Table 1 – BAF 2020/21 Summary of Risks as at September 2020

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF32	If EPUT does not drive quality improvement through innovation then maintaining 'Good' rating and moving towards an 'Outstanding' rating may be difficult resulting in potential stagnation of services and falling behind in whole system transformation	NH	• Re-escalated to BAF from CRR at August EOSC • Action plan reviewed • There are currently six actions on the BAF action plan (attached as Appendix 2) • Five actions are completed including one that is ongoing • One action is due for completion this month	Risk score unchanged Current Risk Score 4 x 4 = 16	Target September 20 4 x 3 = 12	Learning Oversight PIT Above threshold	PIT 1 June (Oct/Nov 20)
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Sally Morris supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF4	If EPUT fire safety systems and processes are not suitable and sufficient there is a potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form or restrictions, forced closure of premises, fines, and prosecution / custodial sentencing for 'Responsible' persons	MM	• Seven actions on BAF Action Plan (attached as Appendix 3) • One action is completed and ongoing • Six actions are in progress, two with amended timescales • BDO audit rated as Moderate Assurance, in the main there are appropriate procedures and controls in place to mitigate the key risks. Some recommendations have already been actioned. Review and focus on fire warden training and fire training in general. Report to be presented to HSSC September.	Risk score unchanged Aug and Sept Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC, EOSC and Board Fire Safety Group Above threshold	Finance and Performance June 2020 (Sept 20)

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF10	If EPUT fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services. Linked to BAF15 HSE	SM (FS) supported by MM	• There are 42 actions on the BAF action plan (ligature reduction work plan) (attached as Appendix 4) • 21 actions completed • Nine actions are due to be completed this month • 20 actions in progress to timescale or not due yet (including the nine above) • One action is overdue (retrospective review of serious incident action plans to demonstrate that they are completed and have had learning shared)	Risk score unchanged Aug and Sept Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC Quality Committee EERG LRRG Above threshold	Quality Committee June 20 (Sept 20)
BAF9	If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience	NH	• 19 actions on BAF Action Plan (attached as Appendix 5) • 12 actions completed • Three actions are due for completion this month • Five actions in progress to timescales (including the three above) • Two actions are overdue (review personal support plans to ensure learning from Covid-19 pandemic is captured EPUT wide, review approach to restrictive interventions and identify actions to support continued reduction and delivery of framework)	Risk score unchanged Aug and Sept Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Restrictive Practice Steering Group Above threshold	Quality Committee June 20 (Sept 20)
BAF38	If EPUT does not implement effective emergency planning arrangements for managing the Covid19 outbreak in line with national and local requirements then the ability to deliver services is reduced resulting in a lack of containment of the pandemic.	NL	• This risk is at threshold but remains on the BAF whilst Covid19 continues with our associated command structure in place • No change to incident level 3 and control with Region • Command meetings reduced together with C19 incident box monitoring	Risk score unchanged Aug and Sept Current Risk Score 5 x 2 = 10	Target Ongoing during Covid19 crisis 5 x 2 = 10	Board of Directors Covid19 Command Structure At threshold	Live Action Log maintained daily through Command Structure

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF40	If EPUT uses all its resources and capacity to manage the C19 pandemic then it may not achieve its organisational objectives for 2020/21 resulting in a potential stagnation of risks and an impact on our position in the wider health economy	SM (FS)	• Managed through regular monitoring of the BAF, CRR and other risk registers • Directorate Objectives for 2020/21 were approved by EOSC July 2020 and continue considered in respect of risk registers • The situation with Covid19 has stabilised and risks are being monitored through standing committees	Risk score unchanged in August and decreased in Sept Current Risk Score 4 x 4 = 12	Target March 2021 4 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold	No Action Plan required
BAF15	If EPUT does not take actions to satisfy HSE investigations into the actions taken by former NEP in respect of patient safety then failings may be identified in the system in place prior to merger resulting in prosecutions and / or fines being imposed	SM (FS)	• No separate action plan but linked to BAF10 ligature reduction BAF action plan/ligature reduction work plan • The HSE and PHSO Steering Group continue to meet and oversee actions required to support EPUT's defence of any potential charges brought by the HSE. Lawyers have been appointed • Discussions are continuing with HSE and the timetable for next steps will be notified shortly	Risk score unchanged Aug and Sept Current Risk Score 5 x 4 = 20	Target date changed from June to ~~August~~ October 2020 5 x 2 = 10	Quality Committee Above threshold	No Action Plan required
BAF36	If EPUT continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety and length of stay.	AB supported by NH / SM (FS)	• Eight actions on BAF Action Plan (attached as Appendix 6) • Two actions completed • Two actions in progress and due this month • Four actions overdue and awaiting updates (increased provision of activities and therapeutic offer, introduction of psychology assistant posts on wards with high level PD/trauma, new trauma/PD pathway to support inpatient services, all inpatient staff to have Mentalisation/ Stabilisation training)	Risk score unchanged Aug and Sept Current Risk Score 5 x 3 = 15	Target date changed from July to September 2020 5 x 2 = 10	Directorate SMT Mid/South Essex funding agreed Above threshold	Quality Committee June 20 (Sept 20)

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF45	If EPUT does not prepare for an anticipated CQC inspection in 2020 then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating	SM (FS)	• CQC Executive Steering Group is monitoring • As at end of August 2020 16 (50%) of internal actions have been reported as complete with a slippage reported of two (6%) internal action – (1) undertake option appraisal to determine the solution to allow patients access to their bedrooms on older people's inpatient wards; (2) identify what is required following Dementia Friendly Review of the dementia wards	Risk score unchanged Aug and Sept 4 x 3 = 12	Target March 2021 4 x 2 = 8	CQC Exec Steering Group Above threshold	Quality Committee June 2020 (Sept 20)
BAF46	If EPUT is unable to secure low secure and other placements for young people with complex care needs then an increase in restraints and assaults may be seen resulting in potential harm to patients and staff	AB	• An internal EPUT action plan is not required as we are participating in the system wide clinical reference group and its associated workstreams. • The clinical design group for clinical care models continues • Actions logs and feedback are used to monitor this risk in conjunction with Specialist Services	Risk score unchanged Aug and Sept Current risk score 4 x 4 = 16	Target March 2021 4 x 2 = 8	SMT Above threshold	No action plan required
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Sally Morris supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
BAF48	If EPUT has insufficient capacity within the Quality, Risk, Information and Medical Teams then Governance, Data Collation, Analysis and Mortality Review processes (respectively) may become unsustainable resulting in delays in producing mortality reports and reviews	NH supported by SM MM MK	• Action plan attached for approval as Appendix 7 • There are five actions on this action plan • One action is completed but requires ongoing monitoring	Initial and current risk score 4 x 4 = 16	Target March 2021 4 x 2 = 8	Mortality Review Steering Committee F&PC Board Above threshold	F&PC (Sept 20)
Corporate Objective 3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12							

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF31	If EPUT does not have the skills, and capacity to deliver high quality services then the ability to achieve top 25% performance is reduced	SL supported by All Execs	• There are nine actions on BAF31 action plan attached as Appendix 8 • Four actions are completed • Five actions are in progress to timescale (some timescales extended due to Covid19)	Risk score unchanged Aug and Sept Current Risk Score 5 x 3 =15	Target ~~July~~ Dec 20 4 x 3 = 12	WTG Quality Committee Above threshold	Quality Committee (Sept 20)
BAF35	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating	SL NH	• This risk is monitored through the People Plan, WRES, Communications and PSIRF implementation plan • A two hour session is being held at the October Board Development session to feedback on EPUT's People Plan	Risk score unchanged Aug and Sept Current Risk Score 4 x 3 = 12	Target March 21 4 x 2 = 8	Workforce Transformation Group PIT F&PC Regular reporting of data in place Mortality Review Sub-Committee Learning Oversight Group Above threshold	No action plan required
BAF20	If EPUT has insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services delivered as well as the Trust meeting its statutory financial duties	AB	• There are now ten actions on BAF20 (linked also to BAF47) (attached as Appendix 9) • Five actions have been completed • Two actions in progress are due for completion this month • Three further actions in progress require target dates • Out of area placements remain challenging	Risk score unchanged Aug and Sept Current Risk Score 5 x 3 = 15	Target date changed from June to March 21 due to Covid19 4 x 2 = 8	Reporting to SMT CQC action plan monitored by EOSC Above threshold	F&PC (Sept 20)

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF41	If recurrent CIPs for 2020/21 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	MM (financial monitoring) supported by all Executive Leads	The Trust's Cost Improvement target for 20/21 is £11.6m, including 19/20 £5.1m recurrent shortfall brought forward • Full recurrent delivery of the 20/21 CIP target must be delivered and focus needs to be on the full year recurrent CIP for the Trust due to the current financial regime • **M5** £4,210k FYE CIP schemes agreed and £811k of pipeline schemes remain deliverable • This leaves FYE unidentified balance of circa £6.6m • The 2020/21 CIP Deep Dive reviewed at FPC last month concluded a number of actions which finance, supported by Executive Directors, will be required to work on in the coming months. The main focus will be to recurrently address the 19/20 recurrent CIP shortfall brought forward, of £5.1m, in advance of setting baseline budgets for 2021/22 • Finance continuing to meet and set up further meetings with Directors/ Service Leads to discuss progressing schemes identified, and identify schemes to meet the unidentified target • Emerging risk is the unknown and unconfirmed terms of settlement for the second half of 2020/21 • In operational services CIPs is being taken forward internally, with a different approach linked more to transformation rather than top slicing budgets. To be discussed within SMT.	Risk score unchanged Aug and Sept Current Risk Score 4 x 4 = 16	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	MM	• EPUT continues to operate under a National NHS Emergency Finance Regime as a result of C19. This is expected to change in M7 and a review of this risk will take place • During the first four months of 2020/21 all NHS providers reporting a deficit will receive top up payments to adjust their reported position to breakeven • In August 2020 the Trust recorded a deficit of £4,545k before top up income, including year to date Covid-19 costs of £6,554k. Cash is £26.8m above plan at **M5** • Continued discussions with system regarding allocation of Covid funding for M7-12. Early indications are that there will be a system shortfall.	Risk score unchanged Aug and Sept Current Risk Score 4 x 3 = 12 Score will increase to 4 x 4 = 16 In October upon agreement by EOSC (recommended by Deputy CFO)	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AB	• EPUT is now into Phase 3 planning with Region following the letter from Simon Stevens. A national submission is required by 27 September. • A heavily financial and activity oriented draft system plan was submitted by the 1 September deadline • Flow and capacity lead has developed a surge plan in conjunction with winter planning • For community health services there remain many unknowns related to side effects from Covid19, and those coming out of intensive care and off ventilators • There remains a need to look at activity levels arising from Covid19	Risk score unchanged Aug and Sept Current Risk Score 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold	PIT 1 June 20 (Oct/Nov 20)
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Sally Morris supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF44	If EPUT does not fully capture, review and embed learning from the C19 experience then this may have an adverse impact on Phase 3 planning resulting in missed opportunities in transformation	NL	• Action plan developed and attached as Appendix 10 for approval	Risk Score unchanged Aug and Sept Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Above threshold	PIT (Oct/Nov 20)
BAF47	If EPUT limits bed occupancy to 85% on mental health inpatient wards to facilitate social distancing requirements then modelling suggests there will be a shortfall in beds resulting in delays to admissions or an increase in out of area placements	AB	• New risk approved at EOSC August 20 • To be linked to reset and recovery group for action planning – agreed by operational services • This is linked to BAF20 action plan	Initial and current risk score 4 x 4 = 16	Target date March 21 4 x 2 = 8	Reset and Recovery Board EOSC Above threshold	Action plan linked to BAF20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF49	If EPUT does not have robust plans in place for changes in Executive leadership then public and partner confidence may be lost resulting in a challenge to reputation and place as system leader	SM supported by all Executives	• New risk approved at EOSC Aug 20 • Monitored closely – no action plan required • Robust mitigating actions in place ○ Strong handover plans in place for new CEO and ECFO including handover with partners ○ Good communications plan to ensure public and partner confidence is maintained during the transition period ○ Interim leadership arrangements in place for COO with Operations Director stepping up into role	Initial and current risk score 4 x 3 = 12	Target date Dec 20 4 x 2 = 8	Chair & NEDS Board CoG Above threshold	No action plan required
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF34	If EPUT is unable to recruit new / additional staff to deliver new services and care pathways then the success of new services may be impacted or existing services may not be able to retain staff	SL/ AB	• There are 13 actions on BAF action plan (attached as Appendix 11) • 12 actions completed • 1 action in progress and ongoing • Operations continue to focus on retention of staff • There remain issues with international recruitment at this time • Review recruitment related to transformation so far, which may contribute to reducing the score on this risk – awaiting update	Risk score unchanged Aug and Sept Current Risk Score 4 x 3 = 12	Target date changed from July to October 2020 4 x 2 = 8	F&PC PIT Above threshold	PIT 1 June 2020 (Oct/Nov 20)

Table 2: Mapping of risks against 5 x 5 scoring matrix

		RISK RATING				
		Consequence				
		1	2	3	4	5
Likelihood	1					
	2					BAF38
	3				BAF35 BAF40 BAF42 BAF9 BAF44 BAF45 BAF34 BAF49	BAF4 BAF20 BAF31 BAF36 BAF10
	4				BAF41 BAF46 BAF47 BAF48 BAF32	BAF15 BAF43
	5					

Table 3: Movement on scoring – 2 year period from October 2018 to September 2020 (rolling two year period)

Risk ID	Initial Score	Oct 18	Nov 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
BAF1	20	8 ↓		C		L		O		S		E		D		C		R		R				
BAF3	12	12↔	12↔				C		L		O		S		E		D							
BAF4	15	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF5	12	12↔	12↔	12↔	12↔	12↔	C			L			O			S			E			D		
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Me	rg	ed	Wi	th	BAF	35		
BAF9	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔
BAF10	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔
BAF12	12	16↔	16↔	16↔	16↔	16↔	C		L		O		S		E		D							
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓	Cl	os	ed	
BAF14	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C	L	O	S	E	D	TO	C	R	R			
BAF15	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔
BAF16	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C		L	O		S		E		D			
BAF18	15	20↔	20↔	20↔	20↔	20↔	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Cl	os	ed	
BAF20	12	20↓	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF21	15	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	C		R		R							
BAF22	16	16↔	16↔	16↔	9↓	9↔	9↔	9↔	9↔	9↔	9↔	9↔	C	L	O		S		E		D			
BAF23	15	15↔	15↔	20↑	20↔	12↓	8↓	CL	OS	E	D	20↑	20↔			C		R		R				
BAF24	16	16↔				C		L		O		S		E		D								
BAF25	16	16↔	16↔	12↓	12↔	8↓	C		L		O		S		E		D							
BAF26	16	16↔	12↓	8↓	8↔	C		L		O		S		E		D								
BAF27	16	16↔	16↔	16↔	12↓	12↔	C		L		O		S		E		D							
BAF28	16	New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C	L		O		S		E		D			
BAF29	12		New	12	8↓	C		L		O		S		E		D								
BAF30	12					New	12	12↔	12↔	12↔	12↔	12↔	C	L	O		S		E		D			
BAF31	16					New	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔

BAF32	16					New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔*	16↔	16↔
BAF33	12										New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓	Cl	os	ed	
BAF34	16											New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔
BAF35	16											New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔
BAF36	15													New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF37	15															New	15	15↔	Cl	o	s	e	d	
BAF38	15																New	15	15↔	15↔	15↔	15↔	15↔	15↔
BAF39	20																New	16	Cl	o	s	e	d	
BAF40	12																		New	12	16↑	16↔	16↔	12↓
BAF41	16																		New	16	16↔	16↔	16↔	16↔
BAF42	12																		New	12	12↔	12↔	12↔	12↔
BAF43	20																		New	15	20↑	20↔	20↔	20↔
BAF44	12																			New	12	12↔	12↔	12↔
BAF45	12																			New	12	12↔	12↔	12↔
BAF46	16																				New	16	16↔	16↔
BAF47	16																						New 16	16↔
BAF48	16																						New 16	16↔
BAF49	15																						New 15	15↔

Note: Risks closed for over two years removed from table

Appendix 2

CRR 2020/21 Summary of Risks as at September 2020

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Sally Morris supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
CRR 51	If EPUT staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience	AB	• Reports from West and Mid and South Mental Health show marked decreased in incidents. • The view from P&C Directorate leads is that they retain the risk on the DRR(s) for monitoring purposes but close it on the Corporate Risk Register • The view from Operations is that this remains a corporate risk and the score should remain unchanged	Risk score unchanged in Aug and Sept 3 x 3 = 9	3 x 2 = 6 July 2020	EOSC Above threshold
CRR 58	If EPUT's in-patient wards do not fill shifts consistently to a minimum of 90% then safer staffing is not fulfilled resulting in poor patient experience, low staff morale and non-compliance with standards	AB	• Continues to be monitored due to CQC profile • Unfilled shifts highlighted in performance reports are not aligned with acuity and occupancy. Low occupancy may mean that the ward is still well managed even with unfilled shifts • The view of Operations is that twice daily sitreps ensure that wards are safely staffed • This is not an issue for Community Health Services • Specialist Services and Mental Health have negligible vacancies and with the recent over-recruitment the review next month should show an improvement. This will happen after aspirant nurses receive their PIN numbers.	Risk score unchanged in Aug and Sept 4 x 2 = 8	4 x 2 = 8 March 2021	Sitreps Quality Dashboard/ CQC compliance Board At threshold

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 61	~~If the HSE CQC considers recent inpatient deaths as part of its case against the Trust, there is a risk that EPUT's mitigation case may be impacted, potentially resulting in the HSE taking increased regulatory or legal action against the Trust, with associated reputational damage~~ If the CQC investigates recent inpatient deaths then EPUT may receive additional scrutiny during its upcoming inspection resulting in its rating not being improved with the associated reputational damage	AB/ SM	• No contact has been made by the HSE in respect of recent inpatient deaths in relation to its existing case against EPUT and the CQC have raised no concerns to date • Leave at threshold as a precautionary measure • Since April 2015 there has been a memorandum of understanding between the CQC and HSE to the effect that health and safety enforcement action in respect of service users will be conducted by the CQC. This has not changed health and safety legislation in itself. A caveat to this is corporate manslaughter, investigated by the Police and governed by a separate statute.	Risk score unchanged in Aug and Sept 5 x 2 = 10	5 x 2 = 10 July 2020	HSE Steering Group At threshold
CRR 65	If the Trust is unable to achieve the ECTAS standards at The Linden Centre and The Lakes then the service becomes unsustainable resulting in a risk to the quality of services provided	MK	• An update is to be provided to the Clinical Directors' Meeting on the situation regarding ECT and ECTAS accreditation • Recommended by MK to increase the score as EPUT holds two of the three sites in England without ECTAS accreditation	Risk score increased in Aug and unchanged in Sept 4 x 4 = 16	4 x 2 = 8 September 2020	MMT Above threshold
CRR 11	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	NH/ MK	• Reviewing Suicide Prevention Strategy by September 2020 • A campaign of awareness will be held between 10 September and 10 October • In addition an action on identifying learning from suicide prevention training awareness and response is due for completion August 2020 • Further to the above a meeting took place 13 August relating to the schedule of business for suicide prevention and action plan deliverables	Risk score unchanged in Aug and Sept 4 x 3 = 12	4 x 2 = 8 March 21	Quality Committee and sub-Committees Above threshold
CRR 39	If EPUT does not drive improvement through clinical research then an outstanding rating may not be possible resulting in the Trust not reaching its aspiration in the desired timeframe	MK	• Face to face research activity has been suspended at EPUT due to Covid19 • NIHR funded staff were redeployed to acute Trusts to assist with Covid19 research and most team members have returned to EPUT • An Assessment and Prioritisation Panel has been set up to review the safety and feasibility of re-opening each study in the light of Covid19 • Usual NIHR performance targets will not be applicable for this financial year due to Covid19	Risk score unchanged in Aug and Sept 3 x 3 = 9	3 x 2 = 6 March 2021	Research and Innovation MMT NIHR Clinical Trials Performance (CTP) Team Above threshold

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 16	If violence and aggression is not managed there is a risk of severe harm or death, as well as impacting on reputation and staff survey results.	SM	• General workplace risk assessments are in place • Environmental aspects are reviewed to minimise violence and aggression • Violence and aggression task and finish group continues to meet quarterly • Trial of body worn cameras completed with evaluation showing positive staff response • Ongoing work with Essex Police has resulted in improved responses and investigations and a better relationship • Staff are better supported with positive feedback • New lone worker devices in place with more staff using them • Patient acuity is high meaning that this is always going to be a risk	Risk score unchanged in Aug and Sept 4 x 3 = 12	4 x 2 = 8 March 21	Internal audit HSSC Staff survey Task & Finish Group Above threshold
CRR 56	If blanket (global) restrictions continue to be operated in in-patient mental health services, then the experience of patients will be impacted and the CQC rating of the Trust / in-patient services is unlikely to improve	AB NH	• Risk assessments are being carried out on wards. • 5 steps to managing global restrictions in inpatient wards has been introduced • Work is currently ongoing within Older People's wards • EPUT's response to managing higher occupancy levels as a result of C19 pandemic and winter pressures may result in a decision to introduce rules to enforce social distancing on inpatient wards as well as staggered mealtimes. This could result in an interpretation of 'blanket restrictions' • This is deemed important for staff and patients during this unprecedented time	Risk score unchanged in Aug and Sept 3 x 4 = 12	3 x 2 = 6 March 21	Restrictive Practice Group Quality Committee Above threshold
CRR 64	If there are ~~further~~ new serious inpatient patient safety incidents then there is a risk that the Trust could be subject to increased regulatory scrutiny with respect to clinical care and governance processes, impacting the Trust's reputation and CQC rating	AB/ SM	• The occurrence of a never event in the last six months is zero • This is closely aligned to BAF10 Ligatures and remains high risk • Close scrutiny by LRRG is in place	Risk score unchanged in Aug and Sept 4 x 3 =12	4 x 2 = 8 March 21	Ligature Risk Reduction Group HSSC Above threshold

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 48	If substantive consultant cover cannot be maintained in adult North Essex mental health wards then there will an increase in use of locums resulting in increased costs and potential impact on quality of care	MK	• The situation is now more complex and activity has increased with cover being maintained by locum and agency	Risk score unchanged in Aug and Sept 5 x 4 = 20	3 x 2 = 6 Mar 21	Medical Staffing Committee Above threshold
CRR 68	If EPUT does not complete annual General Workplace Risk Assessments then its statutory requirement is not met resulting in non-compliance with CQC well led standards	SM supported by all Executives	• Risk Management Team has sent out all templates for completion of annual General Workplace Risk Assessments • Low compliance with return of GWPRAs is being experienced • The Risk and Compliance Directorate is reviewing the processes for undertaking GWPRA's • Operations Directors indicated that this had not been escalated to them for action	Initial and current risk score 4 x 4 = 16	4 x 2 = 8 October 20	HSSC Quality Committee Above threshold
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Sally Morris supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
CRR 40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	MM	• Whilst this is at threshold, during Covid-19 the NHS remains vulnerable to hacking. • There is a need to upgrade Windows 10 by October – this was delayed due to Covid19. Licences have now been ordered.	Risk score unchanged in Aug and Sept 4 x 2 = 8	4 x 2 = 8 March 20	Cyber Essentials Accreditation SMOG SMT At threshold
CRR 53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	NL	• Phase 1 completed • Phase 2 completed • Phase 3 Cherrydown and Kelvedon Ward refurbishments design team reviewing current floor plan to include assisted bathroom • An application has been made to Region for central funding to support Phase 3	Risk score unchanged in Aug and Sept 3 x 4 = 12	4 x 2 = 8 December 21	Capital Group PIT EOSC Above threshold

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 34	If there are insufficient suicide prevention trainers and staff are not trained effectively in suicide prevention then there is a risk that staff may not have the necessary skills to safely support a suicidal patient, resulting in self-harm or suicide.	NH MK	• Ligature and training compliance figures have been reviewed and are decreasing; an improvement is required • This training is not mandatory and an improvement trajectory is being set for specific staff to complete the training as the current uptake is an issue	Risk score unchanged in Aug and Sept 3 x 3 = 9	3 x 2 = 6 March 21	Quality Committee Suicide Prevention Group Above threshold
CRR 49	If access and assessment services receive high levels of referrals which do meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	AB	• Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • By April 21 EPUT will have more control over referrals from IAPT into core services • Community transformation is a phased model • Operations leads are reviewing the wording of this risk and cross referencing with surge planning	Risk score unchanged in Aug and Sept 3 x 3 = 9	3 x 2 = 6 July 20	CCG QCPM Board CCGs Above threshold
Corporate Objective 3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CRR 14	If EPUT staff morale is low then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	• Staff engagement champions scheme • Anti-bullying ambassadors scheme • Staff equality networks • Encourage operations engagement • Review and refresh communication strategies	Risk score unchanged in Aug and Sept 4 x 3 = 12	4 x 2 = 8 March 2021	Workforce Transformation Group Above threshold
CRR 57	If EPUT fails to embed equality and diversity into its culture and conversation then staff and patient experience may be negative resulting in a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Execs	• There are 300 Equality Champions in EPUT and as part of Be You week a dedicated training session for Equality Champions is being launched on 15 Sept • As part of staff induction training Equality, Inclusion, Bullying and Harassment training will take place on 16 September • Be You week 14 September – staff being encouraged to 'Be You' in the workplace sharing things that are important to them • Workforce Disability Equality Standard (WDES) in place for 2020/21 • Inequalities Executive Lead will be agreed before 1 October	Risk score increased in August and unchanged in September 3 x 4 = 12	3 x 2 = 6 March 21	Equality and Inclusion Committee PIT Board EOSC Above threshold
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CRR 45	If the revised mandatory training policy requirements are not achieved this could impact on the Trust's ability to maintain a 'good' rating.	SL supported by all Execs	• Face to face courses restarted in the middle of July with restricted numbers following Covid19 guidance and this is impacting on the compliance figures • There is a backlog of staff requiring training from the Covid19 period • Compliance levels are decreasing • Prioritisation during Covid19 did not prove effective • Risk added to all Directorate Risk Registers	Risk score Increased in August and unchanged in September 4 x 4 = 16	4 x 2 = 8 March 21	Training and Development Group Above threshold
CRR 69	If STPs and Commissioners continue to increase a variation of demands on EPUT corporate services then numerous reports and datasets may be in play resulting in a strain on capacity and resources	SM supported by NL and MM	• New risk approved at EOSC August 2020 • From a project management perspective EOSC have agreed some non-recurrent investment to support this work • A central co-ordination point is being established within Strategy and Transformation Directorate	Initial and current risk score 4 x 3 = 12	4 x 2 = 8 March 21	Standing Committees EOSC Board Above threshold
CRR 28	If mental health clinical activity is not entered into patient admin systems on a timely basis this could impact on monitoring and reporting key performance measures which could result in breaches on regulatory or contractual requirements	AB/ MK	• Timeliness of data entry is still identified as a concern • Works within Operations Mental Health is currently ongoing	Risk score unchanged in Aug and Sept 5 x 3 = 15	4 x 2 = 8 September 20	SMT Performance reports Above threshold
CRR 30	If data entry is incorrect, late or recorded on paper then managers may not have sufficient information for decision making, data from paper records cannot be reported on, impacting on contractual obligations and the risk of financial penalties	MM	• DQMI – additional national requirements introduced which reduced compliance in M3 • Compliance is now at 97% and target has been met • There are additional issues around inequalities as outlined in the Clare Murdoch letter and we are looking at our population and reporting accordingly	Risk score unchanged in Aug and Sept 4 x 3 = 12	4 x 2 = 8 July 20	Internal Audit CCG Assurance IGSC Above threshold
CRR 52	If EPUT, as the lead in the consortium, is unable to manage overruns or delays in the implementation of HSCN, then this may weaken relationships with partners resulting in a threat to reputation and a financial cost pressure	MM	• Migration is almost completed • At threshold but continues to be monitored	Risk score unchanged in Aug and Sept 4 x 2 = 8	4 x 2 = 8 June 20	C19 Command At threshold

Appendix 2

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 36	If the provision of primary care services in different areas of the Trust includes a range of varying models then this presents an associated challenge to corporate services in providing performance management information and responding to data requests, resulting in a resource and capacity issue impacting on contract requirements and financial sustainability	MM	• This risk was reviewed with the Directorate and remains a risk for ITT services whilst returning to business as usual, the demands of which may increase the score at some point. • A broader risk was added as CRR69 to reflect the pressures on all corporate services • Consistency is required across the different areas and this remains an issue	Risk score unchanged in Aug and Sept 4 x 3 = 12	4 x 2 = 8 March 2021	Above threshold
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Sally Morris supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						

Table 2: Mapping of risks against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				CRR58 CRR40 CRR52	CRR61
	3			CRR51 CRR34 CRR39 CRR49	CRR11 CRR16 CRR30 CRR14 CRR36 CRR64 CRR57 CRR68 CRR69	CRR28
	4			CRR65 CRR53	CRR45 CRR56	CRR48
	5					

Appendix 3

DRAFT PROPOSAL FOR RISK REGISTER KPIs – SEPTEMBER 2020

1. Introduction

The 2018/19 EPUT Risk Maturity Report from internal auditor BDO made the following recommendation for continuous improvement: 'Identify KPIs in order to measure the effectiveness of risk management activity at the Trust. This can include the proportion of risks operating at the target level and/or the overall effectiveness of risk management (current risk versus target risk).'

Management response to this recommendation was accepted on the basis that it would be undertaken subject to capacity and prioritisation of governance related actions. The Trust agreed to review the example KPIs provided by BDO as the basis for moving this recommendation forward. In addition, the Audit Committee wished to see a difference in the Annual Report to the regular monthly reports presented to Executive Operational Sub Committee and the Board of Directors. As a result the Annual Report was enhanced and the KPIs were introduced within that report, with work on targets to follow.

This paper sets out a proposal for introducing KPIs with targets to the Board Assurance Framework and to incorporate these into regular monthly and/or quarterly reporting.

2. KPIs for Board Assurance Framework

Following a number of Board Development sessions at which risk appetite was considered there was not a consensus on taking this forward but rather more emphasis on the target risk score and completion. This has been a consideration during 2020/21 when reviewing and updating risk registers. In light of this it was felt that KPIs could be developed to enhance the effectiveness of target risk scores and their completion dates. Any risk on the Board Assurance Framework that has an action plan will have a target completion date determined by the latest date on the action plan.

KPI ref	KPI	Target
KPI 1	Percentage of risks with action plans completed by target completion date	90%
KPI 1a	Number of risks open with action plans fully completed	Information only
KPI 1b	Number of risks with open action plans	Information only
KPI 1c	Number of risk with no action plan	Information only
KPI 1d	Number of risks closed / de-escalated in Month (YTD)	Information only
KPI 1e	Number of new risks added to BAF in month (YTD)	Information only
KPI 2	Percentage of stagnant risks (no movement from initial risk score)	<30%
KPI 2a	Percentage of risks which have increased	<10%
KPI 2b	Percentage of risks which have decreased	60%
KPI 3a	Percentage of current risks on BAF for over 12 months	<40%
KPI 3b	Percentage of current risks on BAF for over 24 months	<30%
KPI 3c	Percentage of current risks on BAF for over 12 months (excluding known ongoing risks)	0%

3. Recommendations

- Approve the proposal to introduce KPI's into the Board Assurance Framework reporting process

Susan Barry
Head of Assurance

Nicola Jones
Associate Director of Risk and Compliance

		Agenda Item No: 7bi
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Board of Directors Audit Committee Assurance Report**					
Executive/Non-Executive Lead:	Janet Wood, Chair					
Report Author(s):	Carol Riley, Audit Committee Secretary					
Report discussed previously at:	Assurance Reports provided to the Board following Audit Committee Meetings.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides: Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 To note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To request further action/information as required.

Summary of Key Issues

- Minutes of meeting held on the 21 August 2020
- Internal Audit Progress Report 2019/20
- LCFS Progress Report
- External Audit
- Annual Review of SFIs and Detailed Scheme of Delegation
- Review of Standing Orders for the Practice and Procedure of the Board of Directors
- Review of the Scheme of Reservation & Delegation
- LSMS Annual Report and Clinical Audit Annual Report
- Audit Committee Chair's Annual Report 2019/20 (Attached at Appendix 1)
- Draft Charity Accounts for 2019/20
- Finance Procedure
- Waiving of Standing Orders
- Impaired Debt Write Offs

Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
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 £**			Nil
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	No

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
 **Janet Wood** **Chair of Audit Committee**

Agenda Item: 7bi
Board of Directors
30 September 2020

EPUT

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 16 September 2020

The Audit Committee met on the 16 September 2020 and approved the minutes of the meeting held on 21 August 2020. These minutes are available to Board members on request.

At the meeting held on 16 September 2020 the following matters were discussed:

1. **Internal Audit**

Internal Audit Progress Report 2019/20
There were no final reports issued.

LCFS Progress Report

Risk Assessment
A full risk/actions assessment was provided to the Committee.

Referrals
An update was provided with regards to the current ongoing investigations.

2. **External Audit**

Draft Letter to Council of Governors
The draft 2019/20 Letter to the Council of Governors was approved

3. **Annual Review of SFI and Detailed Scheme of Delegation**
The Committee approved the changes to the above and agreed to recommend the SFIs and DSoD to the Board for approval.

4. **Review of Standing Orders for the Practice and Procedure of the Board of Directors**
The Committee approved the minor changes to the above and agreed to recommend the Standing Orders to the Board for approval.

5. Review of the Scheme of Reservation & Delegation (SoRD)
The Committee approved the changes to the above and agreed to recommend the SoRD to the Board.

6. **Annual Reports**
The LSMS Annual Report and the Clinical Audit Annual Report were discussed and noted.

7**. Audit Committee Chair's Annual Report for 2018/19**
The above report was discussed and noted. The report is attached at appendix 1.

8. **Draft Charity Accounts for 2019/20**
The Committee approved the submission for the above accounts to the external auditors.

9. **Finance Procedure - Approval of Operating Cash Management Policy**
There were minor changes to the above. The main change to the above policy was to remove the reference to NHS Protect and this has now been replaced with the NHS Counter Fraud Authority.

10. **Waiver of Standing Orders**
There were no waivers during the period of August 2020

11. **Impaired Debt Write Offs**
There were no waivers during the period of August 2020

3.0 MANAGEMENT OF RISK

The Audit Committee is not responsible for managing any of the Trust's significant risks (as identified in the Board Assurance Framework).

4.0 NEW RISKS

There are no new risks that the Audit Committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

5.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the summary of the meeting held on 16 September 2020.
2. Confirm acceptance of assurance given in respect of risk.
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee

APPENDIX 1

		Agenda Item No: 11
SUMMARY REPORT	**AUDIT COMMITTEE PART 1**	**16 September 2020**

Report Title:	**Audit Committee Chair's Annual Report for the Accounting Period April 2019 to March 2020**					
Executive/Non-Executive Lead:	Janet Wood					
Report Author(s):	Janet Wood					
Report discussed previously at:	-					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

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 2019/20 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 two areas which required additional input from the Committee.

They were:

- NHSCFA Engagement Meeting
- COVID19 and remote working

NHSCFA Engagement Meeting

In February the Executive Chief Finance & Resources Officer, the Local Counter Fraud Specialist and myself met with the Senior Quality & Compliance Inspector from the NHS Counter Fraud Authority (NHSCFA). This was the first meeting with NHSCFA for the Trust. The meeting covered the year 2018/19 a considered fraud referrals, cases investigated, sanctions and losses identified and recovered. Following the visit NHSCFA provided a report with recommendations which was presented and discussed at the Audit Committee. The recommendations were accepted and implemented.

COVID-19 and remote working

In mid-March the country went into lockdown as a result of the COVID-19 critical incident and the Trust moved to remote working where appropriate. The Audit Committee received an assurance report at the end of March detailing the business continuity arrangements being taken by Finance to maintain essential duties during the COVD-19 pandemic**.** The Annual Report and Accounts deadlines were also pushed back by a month. Audit Committee meetings have been held successfully via MS Teams and the Internal Audit Programme has been refreshed Internal Audit Programme to reflect challenges and risks associated with COVID and trust reset.

Regular Work and Other Issues

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 letter 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
- 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 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 and quality. The Audit Committee Chair also meets regularly with both sets of Auditors for private discussions.

Relationship to Trust Strategic Priorities	
SP 1: Continuously improve patient safety, experience and outcomes	
SP 2: Attract, develop, enable and retain high performers	
SP 3: Achieve 25% performance	✓
SP 4: Co-design and co-produce service improvement plans	

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

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: 7bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Charitable Funds Committee**					
Executive/Non-Executive Lead:	Nigel Turner, Non-Executive Director					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

To provide assurance to the Board that the duties of the Charitable Funds Committee have been appropriately complied with and to approve the Terms of Reference.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. To note the contents of the report
2. Approve the Terms of Reference for the Charitable Funds Committee
3. Approve the IT Lending Library bid for £28,700 which is in excess of the Charitable Funds Committees delegated approval limit.
4. To confirm acceptance of assurance given in respect of risks and actions identified
5. To request further action/information as required.

Summary of Key Issues

The Committee approved the minutes of the meeting held on 1st October 2019.

The value of the Charity was £1,016,362 as at the end of June 2020. The review undertaken on the administration charge from the Trust to the Charity was reviewed by the Committee and it was agreed to reduce this from £27,240 to £26,788, saving £452 per annum. Further savings of £1,099 were noted on system costs due to changes in the financial system used to support the Charity.

To date, the Charity has received a grant from NHS Charities Together of £70,000 which has been allocated to the provision of wobble / wellbeing spaces for staff, a death in service fund and physiotherapy services.

The Committee reviewed further bids received against NHS Charities Together funding and it was agreed to submit bids totalling £50,000 for potential grant funding. Of the six bids approved for funding, one was in excess of the £10,000 delegated approval limit of the Committee. As such, the Board of Directors are asked to approve a bid for £28,700 in respect of the provision of an IT Lending Library to help ensure any economically disadvantaged clients were able to make use of and access online interventions, websites, apps and webinars as part of our services.

The Committee approved the commencement of the annual general bidding round for 2020/21 with a return date for bids of mid-September 2020.

The Terms of Reference and associated work plan for the Committee were reviewed and are recommended to the Board for approval.

The Committee is not responsible for managing any significant risks on the Board assurance framework and has not identified any new risks to be included.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
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 £**			Nil
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
Attached Report Appendix 1 – Terms of Reference

Lead
Nigel Turner **Chair of Charitable Funds Committee**

Agenda Item No: 7bii
Board of Directors
30 September 2020

ASSURANCE REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

1. Purpose of Report

This report is provided to the Board of Directors by the Chair of the Charitable Funds Committee. It is designed to provide assurance to the Board of Directors that the duties of the Charitable Funds Committee have been appropriately complied with and risks that may affect the achievement of the organisations objectives are being managed effectively.

2. Executive Summary

The Charitable Funds Committee met on the 23 July 2020 and approved the minutes of the meeting held on the 1 October 2019. These are available to Board members via Content Locker.

At the meeting held on 23 July 2020, the following matters were discussed

1. **Report of the Financial Trustee**
   The value of the Charity as at the end of June 2020 was £1,016,362. It was noted, however, that the value of the fund had reduced to £876,011 at the end of March 2020 largely due to a deterioration in the financial markets – primarily due to impact of the global pandemic – and the resulting unrealised losses on investments. During the period of April 2020 to June 2020, the Charity increased in value to £1,016,362, which included £70,255 from investment gains and a grant of £70,000 from NHS Charities Together.

2. **Administration Charge**
   The Committee reviewed the deep dive exercise that had been undertaken on the administration charges made by the Trust to the Charity.

   The historic charges over the last seven years are shown below. The values for SEPT and NEPT have been combined to show comparative values.

	EPUT (and predecessor trusts)						
	2019/20*	**2018/19**	**2017/18**	**2016/17**	**2015/16**	**2014/15**	**2013/14**
	£'000	£'000	£'000	£'000	£'000	£'001	£'002
Year end fund value	876	1,010	1,438	1,569	1,917	1,909	1,786
Trust recharge	27	27	27	32	33	33	34
System cost	-	2	2	2	1	2	2
Admin fee	27	29	29	34	34	35	36
	3.1%	2.9%	2.0%	2.2%	1.8%	1.8%	2.0%
Other	-	-	-	1	-	-	-
Audit fee	2	2	6	5	7	6	5
Support cost	30	31	35	40	41	41	41
	3.4%	3.1%	2.4%	2.5%	2.1%	2.1%	2.3%

** unaudited accounts*

There is a significant fixed element to the cost of administering the Charity, which is reflected by the consistency in the Administration fee over the years regardless of the size of the Charity's funds. It should be noted that with the exception of the March 2020 reduction that reflected the impact of COVID-19 on the financial markets, the reduction in the funds' value is mainly the result of reassignment to other organisations following the loss of services to other providers.

This deep dive exercise identified a reduction in the Trust recharge from £27,240 to £26,788, and a saving of £452 per annum, which was approved.

In addition, a further saving of £1,099 per annum on system costs was noted whereby the department have moved away from a standalone charitable funds system that incurred additional licence and maintenance costs. All reporting for the Charity is now via the main finance system.

The revised 2020/21 Administration Fee of £26,788 represents 2.6% of the value of the fund at June 2020.

Finally, it should be noted that the Charity current maintains over 100 individual funds within the overall fund value. This is the result of benefactors often requesting that their donations are spent on a particular ward or service.

3. **Communications Plan**
   The updated communications plan was discussed and noted. It was agreed to continue to focus on raising funds for the general fund.

4. **NHS Charities Together**
   It was noted that, to date, the Charity has received a grant of £70,000 from the national NHS Charities Together fundraising. This has been allocated to the creation of wobble / wellbeing spaces for staff, a death in service fund for the next of kin of our staff who have unfortunately died as a result of COVID and the provision of a physiotherapy service for all staff for a 12 month period.

   The Charity also has an option to bid for further funds up to a maximum of £50,000. Consequently, via Silver Command, bids were invited from staff and have been reviewed by the Committee. The Committee agreed to put forward a number of bids to NHS Charities Together totaling £50,000, including the establishment of an IT Lending Library for our patients, support to our Equality Networks (BAME, LGBTQ+, Disability, Faith) and physical health improvements for our patients.

   Of the above bids, one is in excess of the Charitable Funds Committees delegated approval limit of £10,000 and as such, the Board of Directors are asked to approve a bid totaling £28,700 in respect of the provision of an IT Lending Library to help ensure any economically disadvantaged clients are able to make use of and access online interventions, websites, apps and webinars as part of our services

5. **Annual General Bidding Round 2020/21**
   The Committee reviewed the available general funds as at the end of June 2020 and agreed to commence the annual general bidding round with a closing date for bids to be received on mid-September 2020.

6. **Terms of Reference / Work Plan**
   The Terms of Reference for the Committee were reviewed, together with the associated Work Plan. The main change was to align the number of members to two Non-Executives and two Executive Directors, which is how the Committee had previously been agreed to operate in late 2018. A copy of the Terms of Reference is attached as Appendix 1.

Management of Risk
This Committee is not responsible for managing any of the Trusts' significant risks (as identified in the Board Assurance Framework).

New Risks
There are no new risks that the committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

3. Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the Terms of Reference for the Charitable Funds Committee
3. Approve the IT Lending Library bid for £28,700 which is in excess of the Charitable Funds Committees delegated approval limit.
4. Confirm acceptance of assurance given in respect of risks and actions identified
5. Request any further information or action.

Nigel Turner
Chair of Charitable Funds Committee

Appendix 1

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE
DRAFT TERMS OF REFERENCE

1. AUTHORITY

1.1 The Charitable Funds Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings

1.2 The Charitable Funds is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by this Committee

1.3 The Charitable Funds Committee is authorised by the Board of Directors to instruct the in-house legal advisors and other professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions

1.4 The Charitable Funds Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

1.5 These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.

2. ROLE

2.1 The remit of this Committee and delegated limits are contained within the Scheme of Delegation

2.2 The Charitable Funds Committee is responsible for ensuring the appropriate investment of charitable funds in accordance with the Trustee Act 2000

2.3 This Committee will carry out the functions delegated to it by the Trust as a Corporate Trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund 1053793. The Corporate Trustee, through its Board of Directors, has delegated the day to day management of this charitable fund to this Committee. The delegated functions to this Committee are in accordance with section 11 of the Trustee Act 2000

2.4 The Committee shall at all times operate in a manner not inconsistent with the fiduciary duties of the Corporate Trustee which broadly include (but not limited to):

- Spend funds only in furtherance of the stated charitable objects
- Provide proper infrastructures to ensure funds are managed efficiently and effectively
- Maintain a proper distinction between the Corporate Trustee's responsibilities as a trustee and its other functions
- Act in accordance with the conditions for which a donation is made and charity law
- Deal with charitable funds at all time in accordance with the Declaration/s of Trust and not mix them with the general funds of the Corporate Trustee.

3. FUNCTIONS

3.1 The Committee will review and recommend investment policy for charitable funds in line with any spending policy approved by the Board of Directors

3.2 Review delegated authority to Investment Brokers

3.3 Regularly review investment activities and performance for charitable funds

3.4 Review and appoint Investment Brokers and Investment Institutions for charitable funds, as and when required.

3.5 Approve day to day expenditure up to limits specified in the detailed Scheme of Delegation and in line with the spending priorities and criteria set out by the Board of Directors

3.6 Oversee the amalgamation or disaggregation of funds in line with organisational reconfigurations and other changes to service provision and in line with all or any policies, budget and spending priorities set out by the Board of Directors

3.7 Comply with its obligations in relation to corporate governance as advised by the Trust Secretary

3.8 To comply with the Charitable Funds Policy and Procedure and related documents approved by the Board of directors in the discharge of its functions under these terms of reference

3.9 To ensure it co-operates with the People, Innovation and Transformation Committee and Audit Committee, as appropriate

3.10 To receive and recommend approval of the charitable funds accounts by the Board of Directors

3.11 To ensure implementation of the funding decisions made by the Board of Directors in accordance with the Trust's objectives

3.12 To comply with procedures and policies which ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate as directed by the Board of Directors

3.13 To create an Annual Working Plan setting out proposed actions, priorities and objectives within the remit of its delegated authority and against which its performance is to be evaluated on an annual basis in accordance with paragraph 12 below.

4. SUB COMMITTEES AND SUB-GROUPS

None

5. MEMBERSHIP

- Two (2) Non-Executive Directors (one of which shall be the Chair of this Committee)
- Executive Chief Finance Officer
- Executive Director of Strategy and Transformation

6. IN ATTENDANCE (as required)

- Officers of the Charitable Fund holders
- Head of Financial Accounts
- Independent advisors

7. ATTENDANCE AT MEETINGS

Members should attend 75% of the meetings each year.

8. SUPPORT TO COMMITTEE

PA to the Executive Chief Finance & Resources

9. QUORUM

The quorum necessary for the transaction of business is one (1) Non-Executive Director and one (1) Executive Director.

10. FREQUENCY OF MEETINGS

Meetings shall be called as required, but at least twice a year.

11. REPORTING AND MINUTES

11.1 Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval

11.2 The Committee will report in writing to the Board of Directors after each meeting advising the Committee has met and the decisions it has made. If requested to do so it will provide further information to the Board of Directors including the terms of any advice it has received and considered

11.3 In the bi-annual reports under paragraph 11.2 above the Committee shall indicate the value of each fund, value of any investments and highlight any areas of risk

11.4 The Charitable Funds Committee will provide to the Board an annual self-assessment report including highlighting areas for improvement.

12. MONITORING OF EFFECTIVENESS	12.1 These terms of reference shall be reviewed by the Board of Directors at least annually. The Charitable Funds Committee shall undertake an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors and in achieving the Trust's objectives. The Charitable Funds Committee shall report to the Board of Directors on the results of this review.
13. DATE ORIGINALLY APPROVED	03 April 2017
14. REVIEWED	1 November 2018 23 July 2020
15. NEXT REVIEW DATE	July 2021

		Agenda Item No: 7 (b)iii
SUMMARY REPORT	**BOARD OF DIRECTORS PART I**	**30 September 2020**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis Chair of the Finance and Performance Committee Sally Morris Chief Executive Officer					
Report Author(s):	Janette Leonard Director of ITT, Business Analysis and Reporting					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides: • Assurance to the Board of Directors that the Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action.

Summary of Key Issues

The Committee considered the following key issues:

Quality & Performance Report (including contractual exceptions performance)
The committee noted the following:

The Trust had identified 2 hotspots in both month 4 and 5 listed below. No new hotspots have been identified in August and no hotspots from last month have been downgraded at the end of August.

- Timeliness of Data Entry
- CPA Review

The Director of Operations reported that both hotspots are being investigated through a deep dive process where issues have been identified around patients not being discharge from CPA off the system hence the number of CPA reviews not being met as these patients are still being counted in the baseline. This work will continue and the systems will be updated by the operational teams.

Data compliance is being monitored by operational services and they have raised some issues around some services where they think there may be duplication. This will be investigated and reported back in next month's report.

Contract Reporting

Due to the current COVID-19 crisis the Trust previously agreed with commissioners a reduction to reporting requirements for 3 months. Full reporting has now resumed.
The CPNs previously issued by Commissioners on First Response Seen Within 28 Days and Community MH Service Users on CPA with a Care Plan continue to be suspended.
One additional CPN (Risk Assessments within 4 Hours) has now been removed by the CCG following the past 5 consecutive months of target attainment.

Financial Performance Report

Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime. We will **not** be reporting against all five of the finance key metrics whilst the Emergency Financial Regime is in place. The Emergency Financial is extended to month 6, the initial M1-6 arrangement of block income has been extended to M7, however there is no confirmation regarding true-ups. We are clear a new financial regime will be in place from Month 7 for the rest of the financial year.

Month 5 financial position:

Financial Position: Deficit of £4.6m including all COVID related expenditure. NHS accounting rules for at least the first 6 months are that Trusts will receive a top up to bring it back to Break Even. We have therefore accrued income to match the deficit and will expect a cash top up of an equal value.

COVID Spend: The Trust incurred further expenditure of c£1.3m in August (c£6.6m year-to-date). This is causing the deficit in Month 5 and will therefore be reimbursed through the monthly top up payments.

CIP Position: £11.7m 20/21 target. For Month 5 Recurrent savings of £5.0m has been identified and £4.2m of Recurrent savings is delivered, c£2.5m of Recurrent savings has been actioned in the General Ledger. Full delivery of the 20/21 recurrent savings target must be achieved.

Agency Spend: Trust target for 20/21 is £14.1m and currently above target. The total expenditure at the end of Month 5 on Agency Staff was £5,955k against the Trust plan of £5,933k giving an adverse variance of £22k. The cumulative impact of COVID expenditure as at Month 5 was £849k.

CAPEX: Against the Trust's revised CDEL for the year of £10,031k, the Trust is reporting a year to date net underspend of £270k mainly due to anticipated net spend profile being slightly above actual spend.

Cash: £26.8m above plan. The cash balance at the end of August is £98,562k compared to an adjusted plan of £71,752k. This variance is mainly due to the impact of the current cash regime, whereby the Trust received an additional block payment in April. For the forecast cash position, the Trust has factored an additional block income in month seven which is in line with the latest guidance and payments reverting to monthly contract payments thereafter.

UoRR: Due to COVID-19 and the Emergency Financial Regime, NHSI is not monitoring against this metric.

Future Planning Issues:

- The Trust has received notification from the centre and Mid & South STP that the reset plan for 20-21 will cover M7-12; the initial draft was submitted to NHSE/I on 3rd September and the final plan is due to be submitted by 24th September 2020.

- The Trust also has to produce a separate reset plan for Mental Health; this will also be incorporated into a Mid & South STP plan. The initial draft was submitted to NHSE/I on 3rd September and the final plan was submitted on 24th September 2020.

Sub Committee Reports

The Committee received 9 sets of Executive Operational Sub-Committee part one minutes for noting:

- 7th July 2020
- 14th July 2020
- 21 July 2020
- 28th July 2020
- 4th August 2020
- 11 August 2020
- 18th August 2020
- 25th August 2020
- 1st September 2020

Policies for Approval

The following Policies and Procedures were approved by the Committee

- Business Costs Policy & Procedure Extension

- Adverse Weather Policy & Procedure Extension

- Employee Wellbeing Policy & Procedure

National Staff Survey Results

The Head Staff Engagement on behalf of the Executive Director of People and Culture presented the NHS Staff Survey 3 year trajectory information.

The Committee discussed the data set and supported the follow up actions.

Governance development Plan & Deloittes Well Led Review

The Trust has agreed a Governance Development Plan each year to continually enhance the arrangements that are in place in light of changing requirements or identified need. An updated plan was presented to the Committee. These plans are reviewed and updated at the end of each month.

The Committee supported the updated Governance Development Plan 2020/21 and the Deloitte Well Led Action Plan September 2020.

Board Assurance Framework Action Plans Q2

There are nine BAF risks assigned to the Finance and Performance Committee for oversight and scrutiny.

The Committee reviewed and agreed the BAF action plans and agreed that the action plans mitigated the identified risks.

Any Risks or Issues

Any risks or issues that need to be:

There were no risks or issues identified.

Any other Business

There was no other business

Relationship to Trust Strategic Objectives	
SP 1: Continuously improve patient safety, experience and outcomes	✓
SP 2: Achieve 25% performance	✓
SP 3: Co-design and co-produce service improvement plans	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
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 £**			
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

Manny Lewis
Chair of Finance & Performance Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Agenda Item 7(b)iii
Board of Directors
30 September 2020

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 5, August 2020 was 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

The Committee considered the following key issues:

Quality & Performance Report (including contractual exceptions performance)
The committee noted the following

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

The Trust had identified 2 hotspots in both month 4 and 5 listed below. No new hotspots have been identified in August and no hotspots from last month have been downgraded at the end of August.

- Timeliness of Data Entry
- CPA Review

The Director of Operations reported that both hotspots are being investigated through a deep dive process where issues have been identified around patients not being discharge from CPA off the system hence the number of CPA reviews not being met as these patients are still being counted in the baseline. This work will continue and the systems will be updated by the operational teams.

Data compliance is being monitored by operational services and they have raised some issues around some services where they think there may be duplication. This will be investigated and reported back in next month's report.

Contract Reporting

Due to the current COVID-19 crisis the Trust previously agreed with commissioners a reduction to reporting requirements for 3 months. Full reporting has now resumed.
The CPNs previously issued by Commissioners on First Response Seen Within 28 Days and Community MH Service Users on CPA with a Care Plan continue to be suspended.
One additional CPN (Risk Assessments within 4 Hours) has now been removed by the CCG following the past 5 consecutive months of target attainment.

3.0 Financial Performance Report

Financial Performance Report

Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime. We will **not** be reporting against all five of the finance key metrics whilst the Emergency Financial Regime is in place. The Emergency Financial is extended to month 6, the initial M1-6 arrangement of block income has been extended to M7, however there is no confirmation regarding true-ups. We are clear a new financial regime will be in place from Month 7 for the rest of the financial year.

Month 5 financial position:

Financial Position: Deficit of £4.6m including all COVID related expenditure. NHS accounting rules for at least the first 6 months are that Trusts will receive a top up to bring it back to Break Even. We have therefore accrued income to match the deficit and will expect a cash top up of an equal value.

COVID Spend: The Trust incurred further expenditure of c£1.3m in August (c£6.6m year-to-date). This is causing the deficit in Month 5 and will therefore be reimbursed through the monthly top up payments.

CIP Position: £11.7m 20/21 target. For Month 5 Recurrent savings of £5.0m has been identified and £4.2m of Recurrent savings is delivered, c£2.5m of Recurrent savings has been actioned in the General Ledger. Full delivery of the 20/21 recurrent savings target must be achieved.

Agency Spend: Trust target for 20/21 is £14.1m and currently above target. The total expenditure at the end of Month 5 on Agency Staff was £5,955k against the Trust plan of £5,933k giving an adverse variance of £22k. The cumulative impact of COVID expenditure as at Month 5 was £849k.

CAPEX: Against the Trust's revised CDEL for the year of £10,031k, the Trust is reporting a year to date net underspend of £270k mainly due to anticipated net spend profile being slightly above actual spend.

Cash: £26.8m above plan. The cash balance at the end of August is £98,562k compared to an adjusted plan of £71,752k. This variance is mainly due to the impact of the current cash regime, whereby the Trust received an additional block payment in April. For the forecast cash position, the Trust has factored an additional block income in month seven which is in line with the latest guidance and payments reverting to monthly contract payments thereafter.

UoRR: Due to COVID-19 and the Emergency Financial Regime, NHSI is not monitoring against this metric.

Future Planning Issues:

- The Trust has received notification from the centre and Mid & South STP that the reset plan for 20-21 will cover M7-12; the initial draft was submitted to NHSE/I on 3rd September and the final plan is due to be submitted by 24th September 2020.

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Policies for Approval

The following Policies and Procedures were approved by the Committee

- Business Costs Policy & Procedure Extension
- Adverse Weather Policy & Procedure Extension
- Employee Wellbeing Policy & Procedure

National Staff Survey Results

The Head Staff Engagement on behalf of the Executive Director of People and Culture presented the NHS Staff Survey 3 year trajectory information.

The Committee noted that the Staff Survey Annual Work was significantly affected by Covid-19 and there have been delays in the communication and action planning processes. Whilst the usual annual plan for staff survey was significantly affected this year the following actions have taken place:-

- Results shared at Executive Team (March 2020)
- Staff Survey Presentation to Trust Board March 2020
- HR Business Partners have developed localised action plans to be monitored by Workforce Transformation Committee
- Staff Survey results publicised to staff (low level)
- Continuation of relevant work streams such as Anti-Bullying, Anti-Violence, Health and Wellbeing and Engagement.

The Committee discussed the data set and supported the follow up actions.

Governance development Plan & Deloittes Well Led Review

The Trust has agreed a Governance Development Plan each year to continually enhance the arrangements that are in place in light of changing requirements or identified need. The updated Governance Development Plan for 2020/21 should be viewed in the context of a live and rolling plan linked to continuous improvement within the Trust. It is reviewed and updated at the end of each month.

Four governance priorities were agreed by F&PC in June 2020:

•Being an 'outstanding' well led organisation
•Being compliant with the NHSFT Licence conditions
•Ensuring that internal governance systems are effective
•Having effective communication systems in place that support staff in undertaking their role and promote understanding of the Trust with its stakeholders.

Governance development actions have been collated from self-assessments carried out to support current compliance requirements (self-certification, code of governance, annual reporting); actions identified in response to the Deloitte well led review 2019 and actions identified in 2019/20 that have not been completed. Some dates have been updated due to Covid-19.

One action has been removed as aspirational and two actions have been merged(crossed through for ease of reference)

The Committee supported the updated Governance Development Plan 2020/21 and the Deloitte Well Led Action Plan September 2020

Board assurance Framework Action Plans Q2

There are nine BAF risks assigned to the Finance and Performance Committee for oversight and scrutiny.

The following risks all have action plans:

- BAF4 Action Plan Fire Safety 2020/21 (RR = 15)
- BAF48 Substantive Capacity for Mortality Reporting and Review (RR=16)
- BAF20 Adult Mental Health Capacity and Bed Occupancy (RR=15)

There are risks relevant to Finance and Performance Committee that are not required to have action plans:

- BAF38 Emergency Planning arrangements for Covid19 – covered by command structure
- BAF40 Organisational objectives during Covid19 – command structure, EOSC, Board and Standing Committee monitoring of risks
- BAF41 Financial plan impact on CIPs – covered by performance reporting
- BAF42 Financial plan during Covid-19 – covered by performance reporting
- BAF47 Limiting bed occupancy – linked to BAF20 and covered off by that action plan
- BAF49 Executive Leadership – mitigated by handover plans, communications plan and interim leadership arrangements

The Committee reviewed and agreed the BAF action plans and agreed that the action plans mitigated the identified risks.

Any Risks or Issues

There are no risks and Issues identified.

Any other Business

There was no other business

Report prepared by:

Janette Leonard
Director of ITT, Business Analysis and Reporting
On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**7biv**

Report Title:	**Board of Directors Quality Committee Assurance Report**					
Executive/Non-Executive Lead:	**Amanda Sherlock, NED and Chair of Quality Committee**					
Report Author(s):	**Natalie Hammond, Executive Nurse**					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	x	**Level 3**	

Purpose of the Report		
This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality, are being managed effectively.	**Approval**	
	Discussion	x
	Information	x

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 risks and actions identified
3 Request further action/information as required.

Re

At the meeting held on 17 September 2020, the Quality Committee:

- Received a patient story that highlighted the impact of high quality family liaison support. In February 2020 the Access and Assessment team in West Essex were notified that a 64 year old gentleman known to them had sadly ended his life. The Patient Safety team allocated a Family Liaison Officer to support the family both pre post and during the coronial process and Trust investigation process. Feedback from the gentleman's family and Trust representative at the Inquest was extremely positive stating that the level of engagement had been exceptional. The Family Liaison Officer responded very positively to the feedback received.

Received the following reports:

- Quality Strategy Review & Academy Update Report
- Perfect Ward Update
- Combined Assurance Report for all reporting Sub-Committees
- Restrictive Practice Update Report
- CQC Assurance Report
- Medicines Management Annual Report
- Learning Disabilities Update Report
- Q1 2020/21 Mortality Data and Learning Report
- HSSC Annual Report
- Patient & Carer Experience Framework
- Ligature Risk Management
- Suicide Prevention Strategy and Implementation Plan Update
- Q2 BAF Action Plan Report
- SIRO Annual report

The Committee reviewed the following policies:

- CLP73 Clinical Coding Policy and Procedure
- CP41 Dress Code and Uniform Policy Extension

Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme

The Committee identified the following as areas of good practice:

- Patient Story and the work undertaken by Family Liaison Officers
- The themed seminars around patient safety and suicide risk.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	X
SO 2: Achieve top 25% performance	x
SO 3: Valued system leader focused on integrated solutions	x

Which of the Trust Values are Being Delivered	
1: Open	x
2: Compassionate	x
3: Empowering	x

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
Do you recommend a new entry to the BAF is made as a result of this report?	

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Committee		
BAF	Board Assurance Framework		

Supporting Documents and/or Further Reading

Lead

Amanda Sherlock
NED and Chair of the Quality Committee

Agenda Item 7biv
Board of Directors Meeting
September 2020

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust's agreed assurance system, the report is designed to provide assurance to the Board that:

- Risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- The Committee is discharging its terms of reference and delegated responsibilities effectively.

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 24 July 2020 were approved at the meeting held on 17 September 2020

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 17 September 2020

2.2.1 Patient Story:

Received a patient story that highlighted the impact of high quality family liaison support. In February 2020 the Access and Assessment team in West Essex were notified that a 64 year old gentleman known to them had sadly ended his life.

The Patient Safety team allocated a Family Liaison Officer to support the family both pre post and during the coronial process and Trust investigation process. Feedback from the gentleman's family and Trust representative at the inquest was extremely positive stating that the level of engagement had been exceptional. On reflection the Family Liaison Officer noted the following points:

- Her previous experience of a patient whom she had worked with closely and the impact of their death on both her and the family had given her significant insight and empathy regarding the situation for the family with whom she carried out the family liaison role
- The family themselves were receptive to developing a relationship with her
- She made sure that the family had easy access to communicating with her on a regular basis and any questions were followed up promptly. The Family Liaison Officer responded very positively to the feedback received.

2.2.2 Quality Strategy Review & Academy Update Report:

The Committee received a report giving an update into delivery against the Quality Strategy, development of the Quality Academy and the steps being taken to embed quality improvement and innovation across the organisation. Assurance was given that training programmes are due to run in a virtual capacity building QI capabilities across the Trust. The Committee noted that the Quality Strategy was currently under review and that it was expected that it would be closer aligned with quality

improvement, innovation and research and how these would support patient safety outcomes. A further workshop had taken place and a task and finish group had been initiated to develop a business proposal against a 'strawman' model discussed during the workshop. Assurance was given from the Non-Executive lead that the workshop had resulted in some useful discussion around the model and the first task and finish group had taken place.

2.2.3 Perfect Ward Update:
The Committee received a verbal update in relation to Perfect Ward. During the pandemic it had been agreed through Trust governance arrangements that ward teams under pressure would not be required to complete the audits on the Perfect Ward app. This meant that in some areas the app was not being used to provide assurance. However, during the period, work was undertaken to ensure that audits contained on the app were fit for purpose and a number of revisions have been made and new audits developed. All ward teams have been requested to recommence undertaking the audits on the app and the numbers of individuals using the app are steadily increasing. Regular reports are being produced to show the number of audits being undertaken and escalation processes for any actions not showing compliance.

2.2.4 Combined Assurance Report for all reporting Sub-Committees:
The Committee was presented with a report that gave assurance from all sub-committees accountable to the Quality Committee. It was noted that all sub-committees had virtual arrangements in place and were meeting on a regular basis. The Committee was advised of the following risks/hotspots and assured of actions being taken to mitigate risks:

Restrictive Practices BAF9 (No Force First) – A review of global restrictions has been undertaken across inpatient areas. All restrictions have been escalated and risk assessment and recording processes are in place. The Committee noted that COVID-19 appears to have some impact in relation to greater acuity of patients and admission of individual's previously unknown to Trust services.

Information Governance - A patient record requested via the Access to Records process cannot be located. It was last tracked out to a member of staff in 2017 and the staff member has now left the Trust. A Datix has been raised and an investigation underway.

Assurance was given in relation to new IT working practices introduced as a result of the pandemic. Policy has been updated to allow the recording of MS Teams Meetings with strict rules around consent, retention, storage and deletion of all recordings and guidance has been issued in relation to confidentiality with large scale home working.

MHA and Safeguarding - In relation to MHA there were two outstanding items: submission of the Associate Hospital Managers Assurance and BAF action plan for oversight and scrutiny. There are plans in place to address both of these. In relation to safeguarding there were no outstanding actions or hotspots.

Concern was raised by the Medical Director regarding one break in process regarding administration of the Mental Health Act. It was agreed that an assurance report should be provided to the next MHA and Safeguarding Sub-Committee giving assurance that there is an action plan in place to ensure mitigation of risk. In addition a request was made by non-executives that the MHA plan should be referred to internal audit for review.

Clinical Governance – The results of the MEWS audit had been noted as a risk due to a lack of evidence of staff escalating when there is a high score. Assurance was given that MEWS are recorded on charts but this is not evident in patient records. Work is being undertaken to resolve the issue.

Physical Health – It has been observed that coronavirus may cause a rise in pressure ulcers and falls. A deep dive has been undertaken and lessons learnt will be shared with the Physical Health Sub-Committee and disseminated through lunchtime learning sessions. There is a potential for misidentification of delirium and dementia, with delirium under-reported in many clinical areas. The Committee is taking steps to ensure that staff are clear about identifying the two conditions and following the correct pathways.

Health, Safety & Security – Three risks have been identified for escalation; general workplace risk assessment, increase in incident reporting in Specialist Services and CAMHS and radiator covers increasing ligature risk. The Committee noted that these issues had been brought to the Committee's attention in other reports to give assurance that work was being undertaken to mitigate any risks.

Patient Experience and Carer – A hotspot was noted in respect of the number of complaints rising when compared to 2019/20. Further review reported that although EPUT was slightly higher than the national rate, it was not a reason for concern.

Research and Innovation – regular face to face research activity remains suspended but it is mitigated by clear guidance from the NIHR to prioritise urgent public health research.

Learning and Oversight – A number of hotspots have been identified; however assurance was given that actions have been taken to mitigate risk. Hotspots identified are as follows: suicide prevention training uptake which is currently being addressed as a quality priority with the offer of virtual training and learning events, staffing levels on female wards which has been addressed on a temporary basis and subject to a more detailed review, staffing limitations within SI team which has been resolved following successful recruitment to all vacant posts, learning from COVID-19 deaths, challenges around individuals isolating on wards, recurrent concerns from SI investigations identified disengagement as a key factor in incidents.

Multi-Professional Education – a hotspot was noted in relation to student redeployment, however it was noted that standard student placements will recommence. The Committee was assured that the level of appointment of newly qualified nurses was double that of previous years.

2.2.2 Restrictive Practice Update Report:
The Committee received a report regarding a change management approach taken across inpatient services to change practice with the aim of reducing restrictive interventions particularly prone restrain, blanket restrictions and IM injection sites. The Committee sought assurance that steps were being taken to maintain engagement with frontline staff and share learning. It was noted that the change approach had been owned by front line teams and the outcomes had been driven by individual teams identifying areas of improvement in their areas. There are plans in place to maintain engagement with teams and a number of learning events are planned. It was agreed by the Committee that sharing the learning on one of the lunchtime learning sessions would be welcomed.

2.2.3 CQC Assurance Report:
The Committee noted the action plan in relation to the CQC Unannounced Inspection (July – August 2019) was reset at the end of August 2020 and was confirmed by the

Executive Team on 15 September 2020. The Committee was advised in line with Care Quality Commission (Registration) Regulations 2009: Regulation 15, notification is being prepared for Chair approval in relation to change in CEO, CFO and nominated individual. The CQC had published the CQC Mental Health Insight Report on 23 August 2020, analysis was undertaken and key changes highlighted.

2.2.4 Medicines Management Annual Report:

The Committee received the report that gave assurance on progress in relation to medicines management and optimization during 2019/20. The report included a high level analysis of how the Trust spends resources on drugs for mental health and learning disability services it also contains the Accountable Officer for Controlled Drugs report on use of drugs. The Committee sought assurance on a number of issues and requested that a summary of key issues highlighting any hotspots and celebrating wins be summarised in the front of future reports.

2.2.5 Learning Disability Standards Update Report:

The Committee received the report but were unable to obtain further assurance due to none attendance of the author.

2.2.6 Q1 2020/21 Mortality Data and Learning Report:

The Committee received a detailed report relating to deaths in scope for mortality review for Q1 2020/21 (1 April – 30 June 2020) together with updated information for 2019/20, 2018/19 and 2017/18 and learning that has been identified within the Trust as a result of a mortality review undertaken since the last update to the Quality Committee.

The Committee welcomed the change in format following their request at a previous meeting. It was noted that there were 90 deaths which fell within scope for mortality review. This is significantly higher than any previous quarter since the Trust commenced monitoring and reporting mortality data, largely due to COVID-19 related deaths in April 2020. Of the 90 deaths, 29 were inpatient deaths and 22 were nursing home deaths. Of these 51 deaths, 44 deaths were confirmed as due to natural causes. Five causes of death are currently under determination and two have been denoted as unknown. The Committee noted that the report indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group had continued and a COVID-19 Deaths Review Working Group had been formed to undertake a data analysis of all deaths reported on the Datix system who had tested positive for COVID-19 for further learning.

The Committee approved presentation of a shortened report to the Trust Board in the public session in September 2020.

2.2.7 HSSC Annual Report:

The Committee received the report of the Health, Safety and Security activity undertaken in the year 2019 – 20. The Committee was assured that the organization was taken appropriate actions required to fulfil the statutory Health & Safety requirements.

2.2.8 Patient and Carer Experience Framework:

The Committee received the Framework that sets out the Trust's commitment to ensure people with lived experience are able to influence the way the Trust delivers its services. A key suggestion made was to rename the Framework to Patient and Carer Experience in recognition of the importance of the carers role and experience. It was noted that a new action plan will also be developed to ensure the pledges set

out are met. The Committee challenged the simplicity of the content but was assured that it was co-produced with patients and carers and fully represented their views. The Committee approved the Framework.

2.2.9 Ligature Risk Management:
The Committee received the report that gave an update of the actions that are underway and those planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. The Committee was assured that the focus on mitigating risk continues to be strong and progress continues to be made and acknowledged that managing ligature risk associated with the physical environment must be considered in the wider context of care provision. Challenge was initiated for confirmation that there are processes in place to ensure that all actions previously identified in relation to ligature had been actioned and continued to be reviewed. The Committee acknowledged the importance of this agenda and reinforced the need for continued review of the strategy and action planning to assure high levels of patient safety. Questions were raised in relation to Mental Health Act oversight and it was agreed that a report would be prepared to give assurance of the mitigation of risk.

2.2.10 Suicide Prevention Strategy and Implementation Plan Update:
The Committee received a progress report outlining progress in relation to the Suicide Prevention Strategy. It was noted that significant progress had been made and recognition was given that the suicide prevention events had been extremely successful.

2.2.11 Q2 BAF Action Plan Report:
The Committee was presented with a report that set out the action plans that mitigate BAF risks. It was noted that there are eight BAF risks assigned to the Quality Committee for oversight and scrutiny and it was noted that they have been reviewed following the COVID-19 pandemic. The Committee reviewed and accepted assurance of the risks.

2.2.12 Senior Information Risk Officer Annual Report:
The Committee considered a report which set out the activities and achievements of the Information Governance Team during the period April 2019 – September 2020 and received assurance/ progression developments within the Information Governance agenda. The report noted compliance with legislative and regulatory requirements relating to the handling of information and ongoing improvement to managing risks to information.

2.3 The Committee approved the following policy and procedure:

- CLP73 Clinical Coding Policy and Procedure
- CP41 Dress Code & Uniform Policy Extension noting that adaptions were being put in place to ensure staff protection in light of COVID-19.

2.4 Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- No risks or issues to be raised with other outstanding committees
- Mental Health Act referred to the Audit Committee linked to the internal audit programme

The Committee identified the following as areas of good practice:

- Patient Story and the work undertaken by Family Liaison Officers
- The themed seminars around patient safety and suicide risk

Report prepared by:
Natalie Hammond
Executive Nurse

On behalf of:
Amanda Sherlock
Non-Executive Director Chair of the Quality Committee

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Agenda Item No: 7b (v)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 September 2020

Report Title:	**People, Innovation & Transformation Committee Assurance Report**					
Executive/Non-Executive Lead:	Dr Alison Rose-Quirie Non-Executive Director Chair of THE People, Innovation & Transformation Committee					
Report Author(s):	Nigel Leonard Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the identification and/or achievement of the organisation's objectives 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 given in respect of risks and actions identified.
3 Request further action/information as required.

Summary of Key Issues

The People, Innovation & Transformation Committee met on 26 August 2020, and discussed the following key issues:

- Committee Work Plan
- Reset and Recovery Phase 3
- Innovations Update
- The New People Plan
- Strategic Objectives Review 2019/20
- Contract Negotiation and Tender Submissions Update

Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered

1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF18
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:			Nil
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	No

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
None

Lead

Dr Alison Rose-Quirie
Non-Executive Director
Chair of the People, Innovation & Transformation Committee

Agenda Item: 7b (v)
Board of Directors
30 September 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisation's objectives are being managed effectively.

EXECUTIVE SUMMARY

People, Innovation & Transformation Committee 26 August 2020
The People, Innovation & Transformation Committee met on 26 August 2020, where Committee members had a successful and positive debate on a number of key areas.

The following matters were considered:

1. **Committee Work Plan**
   Committee members received a report providing the proposed work plan for the period August 2020-March 2021, and were invited to provide feedback on the report by 4 September 2020.

2. **Reset and Recovery Phase 3**
   Committee members received a PowerPoint presentation providing an update on Phase 3 of the Covid-19 Reset and Recovery, and were invited to provide feedback on this update by 4 September 2020.

3. **Innovations Update**
   Committee members received a report providing details of the digital innovations completed during the Covid-19 pandemic. The most prominent projects included:

   - Mental Health Crisis 24/7 – NHS111
   - Oxehealth Digital Care Assistant
   - Covid Response video consultation solutions
   - Alcove Carephone

   The report also identified work currently underway for 2020/21 using digital technology to improve patient safety and support staff in delivering care, including:

   - Shared Record
   - Extension of Oxehealth across more wards
   - Electronic Prescribing and Medicines Administration System
   - Rollout of Microsoft 365
   - Lifelight blood pressure, pulse and breathing rate technology
   - APP wound management application
   - Alexa Homecare
   - Cyber Essentials Plus security software
   - Cardio metabolic/physical health care checks software
   - Smart Wards boards

4. The New People Plan

Committee members received a presentation providing an update on the NHS National People Plan, and the Trust's response to its requirements.

Committee members received assurance that the HR team were currently analysing the potential challenges for EPUT, and drafting a People & Culture Framework and Action Plan for 2020-21. This included aligning EPUT deadlines to the requirements of NHSE/I.

The People Plan would be explored further during an upcoming Board Seminar session, and discussed again at the next People, Innovation and Transformation Committee meeting.

5. Strategic Objectives Review 2019/20

Committee members received a report outlining the end of year position in relation to the Trust's Strategic Objectives for 2019/20.

This confirmed that, of the nine Corporate Objectives agreed, four had been fully achieved; four had been partially achieved; and one would be carried into the 2020/21 financial year.

Committee members were invited to provide feedback on the report by 4 September 2020.

6. Contract Negotiation and Tender Submissions Update

Committee members received a report providing an update on the status of business development activities undertaken during the period 5 March to 17 August 2020, and the future development pipeline, along with an update on contract negotiations.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting of the People, Innovation & Transformation Committee held on 26 August 2020.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Request further action/information as required.

Report produced by:
Nigel Leonard
Executive Director of Strategy & Transformation

On behalf of:
Dr Alison Rose-Quirie
Non-Executive Director
Chair of the People, Innovation & Transformation Committee

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**EU Exit Operational Preparedness**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Corporate Governance and Strategy					
Report Author(s):	Nicola Jones, Deputy Director of Compliance and Assurance					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report presents the Board of Directors with an update on current operational preparedness requirements for EU Exit and assurance on EPUT's response to these.	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Trust Board is recommended to:

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

Summary of Key Issues

- EU Exit Operational Preparedness workstream was initiated in 2019 but suspended over the Covid 19 pandemic
- EU Exit is being recommended for escalation back onto the Board Assurance Framework at the end of September
- The Department of Health and Social Care issued guidance on operational preparedness requirements in December 2018 that was considered in full by EPUT at the time of publication
- A comprehensive provider self assessment was completed. The trust was able to meet the majority of requirements. The attached report details those areas where further action/ clarification is required.

The Trust Senior Responsible Officer (SRO) for EU Exit has requested that the EU Exit work stream be re-established. This will be done through the following steps:

- Re-establish EU Exit Task and Finish Group
- Review any national changes to guidance
- Consider learning and Trust changes following Covid 19
- Escalate EU Exit back onto the BAF
- Revise the BAF action plan

Relationship to Trust Strategic Objectives	
SP 1: Continuously improve patient safety, experience and outcomes	✓
SP 2: Attract, develop, enable and retain high performers	✓
SP 3: Achieve top 25% performance	✓
SP 4: Co-design and co-produce service improvement plans	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF23
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 £**			
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			
EU	European Union	NHSE	NHS England
BAF	Board Assurance Framework	FT	Foundation Trust
BCP	Business Continuity Plan	SFI	Standing Financial Instructions
IT	Information Technology	OJEU	Official Journal of the European Union
ET	Executive Team	TED	Tenders Electronic Daily
A&E	Accident and Emergency	HR	Human Resources
SRO	Senior Reporting Officer	CEO	Chief Executive Officer
IMP	Investigational medicinal product	EEA	European Economic Area
CIPs	Cost improvement programmes	DHSE	Department of Health Sciences Education
CCG	Clinical commissioning group		

Supporting Documents and/or Further Reading
EU Exit Report attached below

Lead
 Nigel Leonard Executive Director of Corporate Governance and Strategy

Agenda item 7c
Board of Directors
30 September 2020

EPUT

EU Exit Operational Preparedness

1.0 PURPOSE OF THE REPORT

This report presents the Trust Board of Directors with an update on current operational preparedness requirements for EU Exit and assurance on EPUT's response to these.

2.0 BACKGROUND

The Department of Health and Social Care published EU Exit Operational Readiness Guidance on 21 December 2018, developed and agreed with NHS England and Improvement. It lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a 'no deal' exit. This is to ensure that organisations are prepared for, and can manage, the risks in such a scenario.

The Guidance summarises the Government's contingency plans and covers actions that all health care organisations should take in preparation for EU exit. As a result organisations are advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. Actions in the guidance cover seven areas of activity in the health and care system that the Department is focussing on in its 'no deal' exit contingency planning:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

All providers must consider and plan for the risks that may arise due to a 'no deal' exit.

3.0 Initial Response

In response to the need for operational readiness a number of actions were taken by EPUT (as detailed below). The EU Exit preparations and working group were put on hold due to the Covid 19 pandemic.

3.1 Board Assurance Framework

The potential risk associated with EU Exit was added to the Board Assurance Framework with an initial risk score of consequence 5 x likelihood 3 = risk score 15. An initial action plan was developed to support mitigation of potential risk at that time. This risk was downgraded over the height of the Covid 19 pandemic but has been recommended for re-escalation.

3.2 Task and Finish Group

A Task and Finish Group was established led by Nigel Leonard, Executive Director of Corporate Governance and Strategy, also identified as EPUT's Senior Responsible Officer (SRO) for EU Exit.

The Task and Finish Group is supported the Compliance and Assurance team. In addition the following departments are represented:

- Finance
- ITT
- Legal and planning
- Risk
- Procurement
- Medicines Management
- Research and Development
- HR and workforce
- Communications
- Contracts and service development

The Task and Finish Group was suspended due to the Covid 19 pandemic and it is planned for this to be re-established in Q3 20/21.

3.3 Data Collection and Self Assessment

The national data collection template was comprehensively completed as far as possible and returned to NHS England by the deadline of 24 January 19.

The Trust was able to confirm that it met the majority of requirements for preparedness that NHSE has identified but there is action required to respond to the following requirements (although most actions require clarification by NHSE):

- Assessment of potential increases in demand associated with the wider impacts of a no deal exit (the trust has sought further clarification from NHSE on planning assumptions for this)
- Undertake testing of existing business continuity plans against EU Exit risk assessment scenarios (the trust is awaiting further information from NHSE regional office on this)
- Communication of trust EU Exit preparation actions to the wider health community (the trust has sought clarification on expectation regarding this)
- Review of capacity and activity plans as well as annual leave, on call and command and control arrangements around 29 March 2019 (the trust has sought clarification on expectation regarding these actions as it is not believed that the potential risk will materialise on that specific day)
- Recording of costs incurred in complying with guidance (none over and above effort involved as part of existing roles has been identified to date but clarification regarding expectation has been sought from NHSE)
- Ensure advice is being followed on data protection in a no deal scenario (clarification is being sought from NHSE regarding this)
- Develop contingency plans with Local Health Resilience Partnerships and share with commissioners (the trust has not been asked by the LHRP to do this)
- Consider implications for further staff shortages caused by EU Exit across the health and social care system (the trust has sought clarification on expectation as information is needed from local authorities on which the trust can carry out a risk assessment)
- Completion of local risk assessment to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU Nationals (this is underway)
- Incorporate EU exit workforce planning risk into existing business continuity plans (this is underway)

- Be in a position to confirm that the trust has suffici8ent resources to update planning/ processes based on further guidance provided by the Department (the trust has sought clarification on expectation)
- Pharmacists and emergency planning staff to meet at a local level to discuss and agree local contingency and collaboration arrangements (NHSE to confirm the local collaboration arrangements expected in light of other contingency measures already in place)

4.0 NEXT STEPS

The Trust Senior Responsible Officer (SRO) for EU Exit has requested that the EU Exit workstream be re-established. This will be done through the following steps:

- Re-establish EU Exit Task and Finish Group
- Review any national changes to guidance
- Consider learning and Trust changes following Covid 19
- Escalate EU Exit back onto the BAF
- Revise the BAF action plan

5.0 RECOMMENDATIONS

The Trust Board of Directors is recommended to:

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

Prepared by:
Nicola Jones
Deputy Director of Compliance and Assurance

On behalf of:

Nigel Leonard
Executive Director of Corporate Governance & Strategy

		Agenda Item No: 7(d)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Engagement with the Board of Directors Policy & Procedure**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive Officer					
Report Author(s):	Chris Jennings Assistant Trust Secretary					
Report discussed previously at:	Council of Governors 23 September 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides a policy and procedure for the Council of Governors engagement with the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report.
2 Approve the Engagement with the Board of Directors Policy & Procedure for presentation to the Board of Directors.

Summary of Key Issues

The Council of Governors Engagement with the Board of Directors policy and procedure outlines the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The policy and procedure also describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.

The procedure was originally developed following the compliance review against the (Monitor) Code of Governance. The original document has now been reviewed and amended, including adding an additional section following the development of other procedures for the Council of Governors. The amended policy and procedure was approved by the Council of Governors on the 23 September 2020 for presentation to the Board of Directors.

The policy and procedure is attached to this report as Appendix 1 for approval.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
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 £**			
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: Engagement with the Board of Directors Policy & Procedure

Lead
Sally Morris **Chief Executive Officer**

THE COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

PROCEDURE REFERENCE NUMBER:	CPG56
VERSION NUMBER:	001
~~REPLACES SEPT DOCUMENT~~	~~CP56~~
~~REPLACES NEP DOCUMENT~~	~~n/a~~
KEY CHANGES FROM PREVIOUS VERSION	n/a
AUTHOR:	~~Cathy Lilley,~~ Trust Secretary
CONSULTATION GROUPS:	Council of Governors Governance Committee, Council of Governors, Board of Directors
IMPLEMENTATION DATE:	
AMENDMENT DATE(S):	n/a
LAST REVIEW DATE:	n/a
NEXT REVIEW DATE:	September 2023
APPROVAL BY COUNCIL OF GOVERNORS	
APPROVAL BY BOARD OF DIRECTORS	~~7 March 2018~~
~~RATIFICATION BY FINANCE & PERFORMANCE COMMITTEE~~	
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PROCEDURE SUMMARY
This Procedure and associated Policy outlines the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.
The Trust monitors the implementation of and compliance with this Policy in the following ways:
This Procedure will be subject to a three year review and implementation will be monitored by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	
~~Essex MH&LD~~		
~~CHS~~		

The Director responsible for monitoring and reviewing this Procedure is the ~~Executive Director of Corporate Governance~~Chief Executive Officer

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COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

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COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

Assurance Statement

The purpose of this Procedure is to ensure a process is in place for engagement between the Council of Governors and the Board of Directors as well as when the Council of Governors need to engage with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence or the welfare of the Trust in line with the requirement A.5.6 of (Monitor's) NHSE/I *NHS Foundation Trust Code of Governance* (July 2014).

1.0 INTRODUCTION

1.1. This Procedure has been developed by the Council of Governors to take account of the recommendations in (Monitor's) NHSE/I *NHS Foundation Trust Code of Governance* (July 2014) provision A.5.6 to address engagement between the Council of Governors (Council) and the Board of Directors (Board)

1.2. This Procedure outlines the mechanisms by which the Council and the Board will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council has concerns about:

1.2.1. the performance of the Board of Directors
1.2.2. compliance with the Trust's provider licence
1.2.3. other matters related to the overall wellbeing of the Trust

1.3. The resolution of disputes between the Council and the Board is also covered in SO 9 of the Council's Standing Orders and SO 14.4 of the Board's Standing Orders

1.4. The relationship between the Council and the Board is also covered under SO 10 of the Council's Standing Orders and SO 15 of the Board's Standing Orders.

2 SCOPE

2.1 Informal, formal and frequent communication between the Council and the Board are an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides

2.2 Directors and Governors are expected to act in such a manner as to comply with this Procedure

3.0 ENGAGEMENT

3.1 A duty of the Council is to hold the NEDs individually and collectively to account for the performance of the Board

~~3.2 The relationship between the Council and Board is covered under sections 10 and 15 of the Council and Board Standing Orders respectively~~

Comment [JC(EP1]: Removed due to repetition

3.3 Governors and Board Directors should have the opportunity to meet at regular intervals with Governors feeling comfortable in asking questions regarding the management of the Trust and Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community

3.4 The relationship between the Council and Board is critical and should be based on the Trust's values (open, compassionate and empowering) as well as respect, candour and trust. There are a number of ways an open and constructive relationship can be achieved between the two; these are not limited to the examples below:

- Receiving the agenda and minutes of Board meetings and requesting any specific papers.
- Minutes of Part 1 Board of Director meetings and a summary of discussions for Part 2 Board of Director meetings.
- Governors are invited to attend Board meetings and have the opportunity to ask questions of the Board on the agenda items
- Receiving quarterly finance, quality and performance update reports at Council meetings and asking questions on and/or challenging their content
- The attendance of the CEO, other Executive and Non-Executive Directors at Council meetings and using these opportunities to ask them questions as required.
- Confidential briefing session by the CEO prior to the quarterly Council meeting with opportunity to ask questions
- Attending Annual Members Meeting
- NEDs/Governors informal meetings and local constituency meetings.
- Involvement of Governors at Quality visits with Executive and Non-Executive Directors
- Establishment of joint working groups, e.g. Membership Framework Task & Finish Group; Appointment of Auditors Working Group
- Briefing session by the ECFO on the annual ~~report~~ accounts
- Receiving the annual report and accounts and asking questions on their content
- Receiving performance appraisal information for the Chair and other NEDs (through the Council's Remuneration Committee)
- Receiving information/being kept up to date on issues or concerns likely to generate adverse media (or in response to media coverage) and providing Governors with the opportunity to raise questions or seek information or assurances
- Receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions, and questioning Directors on these (in the first instance through the Governors Significant Transactions Group)
- Receiving relevant development sessions/workshops/briefings by Board Directors as appropriate ensuring that Governors are equipped with the skills and knowledge they require to fulfil their role
- Involvement of Governors in the Trust's strategy and planning process through attendance at the Trust's stakeholder planning event and also through a meeting of the Governors Strategic Planning Working Group
- Chair's report on the activities of the NEDs at each Council meeting
- Reports from the chairs of Board standing committees highlighting the work and key issues reviewed by the committee on an annual rolling basis
- Views of Governors on the performance of the Chair are fed through the Senior Independent Director
- Your Voice meetings for members and the public in each of the Trust's constituencies.

4.0 RAISING CONCERNS

4.1 Governors should raise concerns through existing channels as outlined in section 3,0 of this procedure. Any concerns raised will be recorded and monitored via the relevant committee (when raised formally) or via a Governor Requested Action Log (when raised informally).

4.2 Governor(s) should not raise concerns that are not supported by evidence. In raising their concerns, Governors will need to demonstrate the following:

4.2.1 any written statement must be from an identifiable person(s) who must sign the statement and indicate that they are willing to be interviewed about its content

4.2.1 other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

Newspaper or other media articles will not be accepted as prima facie evidence but may be accepted as supporting evidence.

4.3. The CEO as the Accounting Officer will routinely present reports on performance, finance and compliance at Board and Council public meetings. Any Governor or member of the public in attendance may also raise any concerns relating to the performance, finance and/or compliance through the Chair at these meetings at the time, so that issues can be addressed without delay

4.4 If the above does not address the concerns of the Governor(s), para 19.3 of the Trust's Constitution may be invoked. The clause states that the Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties.

4.5 While recognising the key role of the Chair in providing the link between the Council and the Board, if concerns are identified and persist, any Governor(s) who have concerns covered by this Policy should:

4.5.1 in the first instance, consult the Trust Secretary for advice and guidance and who will seek to resolve the matter informally. The Trust Secretary will advise the Governor(s) on the issues raised and whether it is appropriate to take their concerns to the Chair

4.5.2 the advice of the Trust Secretary, however, is not binding upon the Governor(s) concerned who retain at all times the right to raise the matter with the Chair directly

4.5.3 if the above steps fail to resolve the matter or contacting the Trust Secretary or Chair (in the case of his/her own performance) was felt inappropriate, the Governor(s) should contact the SID to address the concerns

4.6 The Chair will investigate all concerns brought to him/her by Governors involving the Chief Executive and/or other Board members. The investigation will include a review of the evidence offered and discussions with Trust officers as appropriate.

4.7 As soon as practicable after the conclusion of the investigation, the Chair and Trust Secretary (or SID) will meet with the Governor(s) to discuss the findings. This meeting has three possible outcomes:

4.7.1 Governor(s) are satisfied their concerns were unjustified and withdraw them unreservedly; in this case no further action is required

4.7.2 Governor(s) are satisfied their concerns have been resolved during the course of the investigation. The Chair will write a report on the concerns and the actions taken and present this at a closed session of the next scheduled meeting of the Council. If the majority of those Governors present at the meeting agree that the matter is resolved, then no further action is required. However, should a majority of the Council in attendance disagree, then the process for escalation described in section 5 will be initiated

4.7.3 The matter is not resolved to the satisfaction of the Governors. The Chair will call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution to consider the matter further. The meeting may choose either to take no further action or, if the majority of those Governors present and voting agree, to initiate the escalation process described in Section 5. The Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties

4.8 The minutes of the meeting(s) shall record the outcome of the discussions

5.0 ESCALATING CONCERNS

5.1 Where the matter is not resolved following the the completion of steps outlined in section 4 then the following actions will be taken.

5.2 The SID takes over the lead role from the Chair. ~~.~~ Should the SID be unavailable or prevented from participating because of a conflict of interest, then the Council may choose any other Non-Executive Director to fulfil the role

5.3. The first duty of the SID is to establish the facts of the concern. This will be accomplished by reviewing the evidence offered by Governors, the process of the investigation and any documentation produced, and also by meetings/interviews with Governors and any Trust officers involved. In carrying out this process the SID will seek the agreement of all interested parties and will have the authority to commission whatever legal or other advice is required following internal protocols

5.4 Once the facts are established to the SID's satisfaction, the SID will make a decision on the course of action to be followed in the best interests of the Trust and will describe the reasons for that decision in a written report. In the first instance, the SID will present the decision and the report to Governors and to interested parties within the organisation.

5.5 The Chair will the, at the SID's request, call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the SID to present his/her report and decision, and for the Council to give its response. Three outcomes are possible:

5.5.1 The Council accepts the SID's decision. No further action is necessary

5.5.2 The Council does not accept the SID's decision but chooses not to escalate the matter further. No action is prescribed by this Policy but the Council may choose to keep the matter under review at future meetings

5.5.3 The Council votes to make a formal notification to NHS England / Improvement through the Lead Governor under the terms of guidance from NHSE/I

5.6 The timescale for completion of this process from raising the concern to receipt of the response should be no more than 14 calendar days unless there are exception circumstances resulting in agreement to an extension which is acceptable to all parties.

6.0 DISAGREEMENTS BETWEEN THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

6.1 It is important that the Council of Governors discusses and agrees with the Board how it will undertake its 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, as set-out in section 10.1 of the Standing Orders.

6.2 The Board of Directors must ensure the Council of Governors is provided with all information and involvement where a statutory decision is required by the Council is required.

6.3. For any statutory decisions to be made by the Council of Governors, a report will be presented establishing the context and process followed and make a recommendation to the Council of Governors.

6.4 The Council of Governors should consider and discuss any recommendation made prior to approving or not approving the recommendation.

6.5 If the Council of Governors does not approve the recommendation, the Trust Secretary must ask the Council to provide a rationale and record this in the minutes of the Council of Governors.

6.6. The Trust Secretary will report to the Board of Directors that the recommendation has not been approved by the Council of Governors and provide the rationale provided.

6.7. The Board of Directors will determine if the non-approval of the recommendation creates a significant risk to the Trust and if so, ~~invoke~~request the Senior Independent Director (SID) to undertake mediation.

6.8. The SID will meet with Governors who did not approve the recommendation to understand the rationale and try to find a way forward.

6.9 Following mediation by the SID, the Board of Directors will decide the next steps to be taken, including re-presenting the resolution to the Council of Governors.

7.0 DISPUTES

7.1 Where a Governor is declared ineligible or disqualified from office or his term of office as a Governor has been terminated (other than a consequence of his own resignation) and that person disputes the decision, he shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive. The Chair and Chief Executive ~~who~~ shall use their best endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief

Executive shall not be entitled to rescind or vary the decision which has already been taken.

END

		Agenda Item No: 7ei
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Sally Morris Chief Executive					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Board with assurance in relation to the actions taken in response to the Covid 19 pandemic.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 risk register and mitigations (Appendix 1).
4. Request any further information and or action.

Summary of Key Issues

The country has now been dealing with the corona virus outbreak for 7 months. The Trust's arrangements continue to be in place and are working effectively. This report provides assurance across the following areas :-

- Details on the Command structure operating within the Trust
- The impact to date on the Trust and its patients
- Communications arrangements
- Major risks and actions taken

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	✓

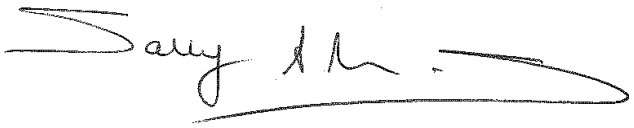
Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	✓
BAF 38 EPR arrangements for Covid 19	
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			✓
Governance implications **The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.**			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading
Visit the Government website: https://www.gov.uk/coronavirus

Lead
 **Sally Morris** **Chief Executive**

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

PURPOSE OF REPORT

The purpose of this report is to provide the Board of Directors with an update on how the Trust continues to respond to the Covid 19 pandemic, and with assurance that the actions being taken are mitigating the risks identified. This is the fourth report to be presented to the Board.

BACKGROUND

The Level 4 National Incident which was declared on 30th January 2020 was changed to Level 3 on 31st July 2020. This means that rather than the NHS being under direct control from the centre (which was exercised through the Regions), it is now under Regional control. In reality this means no change to how the pandemic is being managed. Despite the relaxation of many lockdown processes the NHS continues to maintain the original distancing arrangements of 2m and the wearing of face masks in all clinical and hospital settings. Whilst operating in a "reset and recovery" phase, given the recent upturn in Covid cases and the implementation of stricter restrictions it can be assumed that the NHS is likely entering a 2nd wave.

COMMAND STRUCTURE

The Gold, Silver and Bronze Command now meet twice a week, but will shortly step up in frequency as national daily sitrep reporting is increasing. The (virtual) Incident Control room is still operational 7 days a week, from 9am until 5pm during the week and from 9 – 4pm at weekends to receive and cascade information and guidance, manage daily sitreps required, oversee the SPOC for test and trace, identify and send staff for testing and receive and cascade swab results. The hours the Incident Control Room operates are due to be extended as the 2nd wave progresses. Decisions made by Gold continue to be communicated to all staff through the Covid Brief which is published on Monday and Thursday when Gold Command meets and on Tuesday following the Live briefing.

The Covid Risk Register is regularly reviewed and updated by Gold & Silver Command. In addition, the Chairs from each of the Trust's five staff equalities networks attend the Silver Command meetings to ensure that no staff group is adversely affected by decisions made, or recommendations submitted to Gold Command.

IMPACT TO DATE

Covid 19 is still having an impact on the Trust and its patients, and we are starting to see an increase in staff off sick with Covid, although not as many isolating. At the time of writing this report we have 17 staff off sick with Covid, and 50 self-isolating (compared to 14 sick and 209 self isolating 2 months ago). Good infection control procedures and use of PPE means that we were Covid free from mid July until recently when we currently have 1 patient diagnosed with Covid. (The patient was admitted with Covid and is being isolated whilst receiving mental health support).

I can advise that no further patients have passed away due to Covid in our wards since the

last report, meaning we have sadly lost 18 patients since the crisis began (2 in Mental Health services and 16 in Community beds). All of these patients were elderly and had underlying health conditions.

The costs associated with Covid and their treatment up until the end of September will be covered from the top up funding we understand. However, costs incurred in relation to Covid for the next 6 months of the year will need to be funded from the system financial envelope which was shared with STPs/ICSs mid September. We are currently reviewing how this will impact on the Trust.

COMMUNICATIONS

The weekly Live event which is hosted by the Chief Executive with the Executive Directors enables staff to hear first hand the key events of the week and allows them to ask any questions directly to the Executive Directors. These questions reflect the issues that are causing the greatest concern amongst staff. Early on the majority of questions were about PPE and its availability, this then moved to testing (especially antibody testing), then to what Covid secure meant and where it was available etc. This has assisted management in identifying where additional communication was necessary and helped to assure staff on relevant issues.

As noted in previous reports the Non-Executive Directors continue to receive a weekly briefing via Microsoft Teams from the Chief Executive, as well as ad hoc briefings when necessary.

The Trust continues to use Microsoft Teams to undertake all of its corporate meetings on a virtual basis and recently successfully held its Annual Members Meeting and Staff Quality Awards over Teams Live.

RISKS

In the July 2020 paper a number of risks/hotspots were identified: -

i) Infection & Prevention Control within the Trust
ii) Availability of PPE
iii) Care Home Testing
iv) Return to work and social distancing
v) Mental Health Surge

The risks are constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. From this it can be seen that major risks currently facing the Trust are: -

Care Home Testing
The risk here relates to Trust staff visiting Care Homes and in particular the lack of clarity around policy and processes for testing staff as visitors to Care Homes, and availability of tests for these staff.

Return to work and Social Distancing Covid
The Trust has continued to support a large number of staff to work from home, whilst at the same time preparing our accommodation to be “Covid Secure” wherever possible. The Trust had seen an increase in the number of staff coming in to work, however with the recent government announcement encouraging staff to work from home this trend will need to reverse. The learning from the 1st wave of Covid is of the importance to support staff who are working at home to maintain their good mental health and well being, as well as

supporting staff who still need to come into work in order to undertake their roles.

Mental Health Surge

The anticipated surge in mental health demand has materialised and in addition we appear to be in a 2nd wave of Covid. Our inpatient services are experiencing pressure whilst we are trying to manage capacity to allow for appropriate social distancing on the wards. With the increased prevalence of Covid in the community it is essential that patients who are admitted have the results of their Covid test before they can be allowed to mix with other patients.

LEARNING

To be an outstanding Trust it is important that we are also a learning organisation. Last month we reported on a wide range of activities that had been taking place during the Covid pandemic. These are identified below :-

- Establishment of COVID-19 Deaths Review Working Group, reporting to mortality review sub-committee
- Data analysis of ALL deaths of patients under the care of EPUT at the date of death, including analysis of rates of increase between Jan - May 2019 and Jan - May 2020. Significant increases evident across many services.
- Rapid review of deaths in the Trust managed Nursing Homes Jan - May 2020 undertaken by Consultant in Public Health and Consultant Psychiatrist (Older People), including review of clinical records.
- Commissioned review of all Serious Incident deaths (including suicides) from March to ascertain direct / indirect impact of COVID-19 factors (eg breakdown of normal support arrangements, social isolation etc).
- Incorporation of staff support offering into reflective learning.
- Learning emerging from all activity being collated for sharing at meetings with acute trusts.

The learning we have gathered from the above areas is assisting us in preparing for the 2nd surge in Covid that we are starting to experience.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report,
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3. Note the Covid 19 risk register and mitigations
4. Request any further information and or action

Report compiled by:

Sally Morris
Chief Executive

Appendix 1

Covid Gold Command Risk Register Summary of Risks as at September 2020

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 19	If EPUT does not manage Infection and Prevention Control (IPC) during Covid-19 then infections may increase resulting in a negative impact on the pandemic	NH	• IPC guidance updated September 20	Reduced Risk Score 4 x 2 = 8	4 x 2 = 8 Ongoing for duration of crisis	Command Structure IPC Board Assurance Framework - EPUT response At threshold
CVG 20	If EPUT has insufficient PPE available then the spread of the Covid-19 virus to staff and patients cannot be fully contained resulting in EPUT not being able to deliver a service.	NH	• Weekly stock check taking place in line with national - two to three weeks supplies in place • Trust has 6 months stock of FFP3 • Trust is currently reviewing dispensers to facilitate single mask dispensing on entry to unmanned sites	Reduced Risk Score 4 x 2 = 8	4 x 2 = 8 Ongoing for duration of crisis	Gold, Silver and Bronze Command Structure Board of Directors Monitored daily - live action log Regular auditing of stock Letter to CEOs stating that staff without PPE will not be forced to treat patients Mutual aid - 30,000 masks from MSE and 10,000 via emergency NSDR route At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	• FFP3 mask fit testing sessions available during August, primarily for community based staff but also open to inpatient staff who have not been tested. Successful fit tests in the community will result in staff being issued with a mask and gown. Slots must be booked in advance. • People have been trained across the Trust but are returning to clinical duties • As part of research study 4 additional staff have been trained to fit test and will be offering additional fit test sessions during September • Circa 1200 staff have been fit tested New gaps identified • With services ramping up staff are not being released for Fit Testing • Trainers returning to clinical duties • Notification has been received that supplies of certain masks will need to be removed from stock as they meet their expiry dates. This will require re-fit testing staff that were previously confirmed as being able to use that particular mask as no new stocks will be provided. Plans are being put in place to schedule this process.	No change to Risk Score 4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Command Structure Above threshold
CVG 35	If EPUT does not implement guidance on face masks and face coverings from 15 July in all buildings then people with mild or no respiratory symptoms may transmit the virus to others resulting in a further spread of Covid-19	NH	• 67 Buildings Covid Secure • Updated IPC guidance in Sept 20 providing advice on where face coverings/masks are advised to be worn, additional posters will be displayed in the Trust areas where this is necessary • IPC visits being undertaken to gain assurance	Reduced Risk Score 4 x 2 = 8	4 x 2 = 8 Ongoing for duration of crisis	Command Structure At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 37	If EPUT is unable to ensure that premises are Covid-19 secure then community based services cannot restart resulting in further delays in service delivery	SM/ MM	• 150 risk assessments submitted to date including some additional risk assessments for same building. • 67 buildings have achieved Covid secure status Covid Secure premises are communicated and listed on InPut • Regularly updating IPC guidance and advising staff on any new or updated national guidance • Developing signage and posters guiding staff on requirements upon entering buildings New Gaps and Actions • Updated guidance requires a recovery piece of work to be undertaken to review and re-issue Covid-secure risk assessments previously completed and those approved for buildings that have a combination of both clinical and non-clinical staff • Ambiguous understanding of the guidance regarding the requirement for face coverings to be worn in buildings that have a combination of both clinical and non-clinical staff • Development of additional signage and consideration of video to explicitly explain to staff the changes • Requirement to dispel the myths that Covid Secure means no masks • Random spot checks to ensure compliance	Reduced Risk Score 4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Command Structure Above threshold
CVG 10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	MM	No delays identified, the Trust will be able to maintain our target.	Reduced Risk Score 3 x 2 = 6	3 x 2 = 6 Jul-20	Command Structure At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 34	EPUT staff are not identified as a contact of a positive patient when working in the community through the PHE track and trace system. Other means of patient identification of positive Covid status must therefore be obtained (To be rephrased as if, then, resulting in statement)	NH	• Staff have been risk assessed as well as each service • High risk areas identified and mitigation in place	Reduced Risk Score 4 x 2 = 8	4 x 1 = 4 Jul-20	Command Structure Above threshold
CVG 38	If EPUT is unable to maintain the provision of self-testing kits for staff due to delays by the Local Authority and/or Public Health England then weekly testing for staff visiting care homes cannot take place resulting in non-compliance with national requirements and an outbreak affecting staff and patients	NH	• staff that are in this group have been given guidance to access postal tests via the national Pillar 2 route whilst a longer term bulk delivery solution is being sought by the DHSC • DIPC is a member of the Essex TCG for key worker testing so that EPUT's position is escalated at this system meeting.	No change in risk Score 4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Command Structure Above threshold
CVG 39	If EPUT does not maintain its bed occupancy levels below the target of 85% then its ability to manage a Covid-19 or other outbreak is impacted resulting in the potential for unsafe admission or discharges	AB	• Mitigating actions have been developed for each ward type to manage bed occupancy	No change in risk score 4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Command Structure Above threshold
CVG 40	If EPUT does not have clarity on the definition of aerosol generating procedures then staff may not follow the correct guidance resulting in potential infection and spread of Covid-19	NH	• Existing internal guidance is in place • Specific issue identified regarding oral cavity suction has been escalated to NHSE/I, whilst waiting for clarification interim EPUT guidance issued New gaps identified • Conflicting advice has caused a lack of clarity • AGP guidance issued nationally has limitations as does not cover all clinical procedures • Awaiting pan-Essex approach which will include local authorities and schools	No change in risk score 4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH	• Weekly reports to Gold Command on C19 training data • Live briefings taking place as training • Working group in place of HR business partners and workforce development to ensure training analysis, uptake and recording takes place New action • Training evaluation underway on the courses that have been offered	No change in risk score 5 x 3 = 15	5 x 2 = 10 Ongoing for duration of crisis	Command Structure Above threshold
CVG 32	If EPUT does not develop a systematic application of a risk reduction framework to protect its vulnerable workers then those staff may be disproportionately affected by increased morbidity and mortality from Covid-19 resulting in EPUT breaching its duty of care in securing the health, safety and welfare of its employees	SL	As at 2nd September 2020 • 98% all staff risk assessed • 99% at risk staff risk assessed • 99% BAME staff risk assessed	Reduced Risk Score 4 x 2 = 8	4 x 2 = 8 Jul-20	Command Structure At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 14	If EPUT does not manage its cyber security then systems may be interrupted or compromised resulting in a failure of business continuity	MM	• Cyber Essentials Accreditation achieved, full Cyber Essentials Plus Accreditation planned for October 2020 • ITT Security Procedure approved in relation to Microsoft Teams • Secure boundaries across HSCN now implemented to strengthen system-wide security Updates to gaps Identified • Director of ITT raising six cyber security issues with CEO - implementation of the mitigations are part of the Cyber security plan • Few unsupported systems actively being displaced and identified on risk register. Mitigation steps in place to minimise exposure to internet and Trust network. • Windows 7 upgrade work has continued programme due to be complete in next 4 weeks Less than 60 instances remain and are being tracked down • Exploration of NHS Secure boundary with support from EPUT's HSCN provider and forms part of the Essex COIN HSCN programme	Reduced Risk Score 4 x 3 = 12	5 x 2 = 10 Ongoing for duration of crisis	Command Structure Above threshold Six issues covered off with centre and copied to CEO

Table 2: Mapping of risks against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			CRR57	CRR58 CRR40 CRR52	CRR61
	3			CRR51 CRR1 CRR34 CRR39 CRR49	CRR11 CRR16 CRR56 CRR30 CRR14 CRR45 CRR36 CRR64	CRR28
	4			CRR65 CRR53		CRR48
	5					

		Agenda Item No: 7eii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Ligature Risk Management**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Catriona King Ligature Risk Coordinator					
Report discussed previously at:	Quality Committee 17th September 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Trust Board of Directors with an overview of the action that is underway currently and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in-patient estate.

Approval	
Discussion	✓
Information	

Recommendations/Action Required

The Trust Board of Directors is asked to:

- Discuss the contents of this report.
- Identify any further actions required.

Summary of Key Issues

The report provides a summary of:

- Assurance on current risk management systems.
- Governance arrangements in place.
- Enhancements to risk management systems that have taken place.
- Ligature risk assessment policy and procedure implementation.
- Action taken to achieve risk reduced environmental standards.
- Staff training.
- CQC new inspection criteria

Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered

1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF 15 BAF10
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			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
BAF	**Board Assurance Framework**	**LRRG**	**Ligature Risk Reduction Group**

Supporting Documents and/or Further Reading
Ligature Report

Lead
Sally Morris **Chief Executive**

Agenda Item: 7eii
Board of Directors
30th September 2020

EPUT

LIGATURE RISK MANAGEMENT

1.0 Introduction

This report provides the Trust Board of Directors with an update of the action that is underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture. The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Board Assurance Framework (ref BAF10). An action plan is in place to mitigate this potential risk. Regular reports on the action that has been taken have been provided to the Board of Directors since April 2017, most recently in July 2020. This report aims to assure Board members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and progress continues to be made, Board members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning. It also has to be recognised that the Trust's inpatient environments (consistent with many providers of mental health services) will rarely be entirely free of fixed ligature points because most were not designed to mitigate the potential risks being identified currently and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 Independent Assurance

Care Quality Commission (CQC)
As previously reported the CQC carried out an inspection of Trust services in July / August 2019 and the report of findings confirmed that whilst "staff knowledge and management of ligature risks had improved since the last inspection" there were still some actions to be taken in regards to:

- Reviewing governance arrangements for ligature risk assessment and management (Must Do)
- Reviewing the management of ward and garden blind spots (Should Do)
- Ensuring staff fully assess the ward environment for ligature risks and blind spots (Should Do)

The previous report advised the Trust developed a detailed action plan in response to the CQCs inspection findings which aimed to resolve the issues identified and to ensure action was fully embedded in practice and facilitated change. The action plan identified 15 internal actions to meet the one 'Must do' and the two 'Should dos' requirement notices as described above. All 15 actions have been fully addressed. A summary of the actions were provided in the ligature report in May 2020.

Internal Audit

Previously the committee were advised that BDO, the Trust's internal independent auditors carried out testing of the Trust's implementation of its ligature risk management policy and procedures in August 2019 and their findings were shared with the Trust in November 2019. The detail of the auditor's findings was included in the January 2020 ligature report.

The 2020 audit is currently being undertaken with the draft repot due to be issued in November 2020.

CQC New Inspection Criteria
On the 20th August the CQC issued an update for NHS MH Trusts from Dr Kevin Cleary, Deputy Inspector Mental Health and Community Services.

The update highlighted that "there is still significant variation in the quality and safety of mental health services across the country, but where organisations have adopted a collaborative approach and Quality Improvement (QI) methods using a defined methodology, there has been real progress."
However, the CQC "remain very concerned about a lack of improvement in some estates and the absence of a sense of urgency that change is needed in these organisations".

The update highlighted that there are still incidents where high risk ligature points have been "identified but no effective action has been taken to manage the ligature points". We are often told that the mitigation is a variation on "staff to be more vigilant" and that the issue is on the capital projects register. However, leaving such an issue on the capital projects register for a prolonged period when they have been identified as requiring urgent resolution, risks serious harm to patients."

A new 2020 brief guide for inspection teams has been published for CQC inspectors and the CQC have confirmed that as part of their Well Led inspections they will:

- Look at the Capital Projects Allocation for each organisation and the prioritisation of the allocation.
- Explore the non-executive directors' understanding of the estates' risks and how these impact on the safety and quality of care.
- Consider the degree to which the quality and finance sub-committees of the board have considered individual notified estates risks e.g. ligature points and the actions that they have subsequently taken.
- Look at the pathway from ward to board of risk information about estates.
- Critically assess the transparency and openness of board papers dealing with quality and safety that are in the public domain.
- Seek confirmation that trusts have environmental risk assessment policies that comply with the alerts listed above and the wider guidance summarised in our brief guide for inspection teams.

As part of CQC inspections of wards the CQC will:

- Discuss concerns about patient safety with staff and people using the service.
- Assess the degree to which concerns raised about safety and quality are listened to and acted upon.
- Determine the effectiveness of ligature audits and **their mitigations**, including an assessment of the human factors involved in their mitigations and their impact upon staff. By this we mean the relationship between staff, the equipment they use in the workplace, and the environment in which they work.

Work is underway to review the EPUT position against the CQC well lead criteria above. A report will be presented to the next Trust Board in November with an assessment against the letter and any actions that need to be taken forward

3.0 Governance

The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Chief Operating Officer. The group reports to the Health Safety and Security Committee and ensures:

- Ligature risk assessment inspections are robust with appropriate control measures in place
- The Trust remains compliant with all regulatory or legislative requirements and Safety Alerts
- Risks that are identified are managed and escalated as required.
- Governance structures of the Trust are appropriate and effective.

The Estates Expert Reference Group, chaired by the Executive Chief Finance Officer, has continued to meet at least monthly to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

4.0 Enhancements to Risk Management Arrangements Requirements

4.1 Estates and Facilities/National Patient Safety Alerts

There has been on safety alert in 2020 relating to ligature "NatPSA/2020/001/NHSPS Ligature & ligature point risk assessment tools and policies". The alert was issued in March 2020 and had 3 required actions. All actions have been completed.

4.2 Learning

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. Learning is shared through a range of methods including:

- Internal safety alerts
- Ligature Risk Reduction Group
- Trust Communications
- Training Sessions

4.3 Policy and Procedure

As previously advised the Ligature Risk Assessment and Management Policy and Procedure was launched in April 2019. Following a six month implementation period the policy was reviewed in October 2019. Additional reviews have been undertaken as follows since the last report to the Board of Directors:

- Appendix 1, ligature risk assessment tool has been reviewed in line with NatPSA/2020/001/NHSPS Ligature & ligature point risk assessment tools and policies alert. Colour coding system to differentiate between a noncompliance with a standard (red) and damage to the fixing (yellow) the revised tool will be presented to HSSC in September 2020.
- Appendix 9, fixture and fittings standards: the Trust's standards have been updated to take into account learning from safety alerts and incidents (both national and local).
- An additional appendix (appendix 10) Risk Management Ligature Assessment Standard Operating Procedure (SOP) has been developed, the SOP describes the process for preparing, completing and issuing the ligature risk assessment tool and report in line with the Ligature Risk Management Policy and Procedure.
- Appendix 5, Procurement, Storage and Maintenance of Ligature Cutters has been reviewed following learning from an incident. All wards must have at least one of either the ResQhook or Barrington LC1.
- Inclusion of Medical Staff when available in the ligature risk assessment process.

4.2.2 Ligature Risk Assessment

As previously advised an inconsistency of ligature risk assessments carried out in wards with the same layout was identified as a potential risk earlier in the year. A review of the risk assessments in place in those wards was completed to ensure the same risks are identified and risk mitigation is consistent. The outcome of this review was presented to the Ligature Risk Reduction Group (LRRG) in April 2020; an action plan has been developed and is being monitored by the LRRG.

4.3 Co-production

As previously advised two ligature risk assessments of inpatient wards have included a person with lived experience in the assessment team. A protocol is in place to carry out this activity safely. Unfortunately there has been limited progress with this initiative since the last report, initially due to availability of persons with lived experience, and later due to the pandemic and the pausing of on-site inspections. The patient experience and risk team have worked together and inspections with people with lived experience are planned for this month.

4.4 Board Assurance Framework (BAF10)

The BAF is included in the Quality Committee papers and details ongoing ligature risk reduction work. BAF10 is reviewed on a monthly basis via HSSC.

5.0 Ligature Incident Data

Ligature incident dashboards on Datix have been developed and have been rolled out to all mental health, LD and specialist service ward managers. The dashboard identifies all ligature incidents both with and without an anchor point by date, ward, secure fixture used and items used. This gives staff a real time picture of incident activity relating to ligature incidents to quickly identify any emerging trends for action.

A bi-monthly 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. The report details incidents from April 2017 to current reporting period for the group.

6.0 Policy and Procedure Implementation

Ligature risk assessment inspections continue to be completed in line with policy on a bi-annual or annual inspection programme for all inpatient areas as follows:

- Medium and Low Secure Services – 6 monthly
- Acute Admission Wards – 6 monthly
- Health Based Place of Safety (HBPoS) – 6 monthly
- Psychiatric Intensive Care Unit (PICU) – 6 monthly
- Assessment Units – 6 monthly
- Young Person Units – 6 monthly
- Older Adult Functional Wards – 6 monthly
- Learning Disability In-patient Services – 6 monthly
- Older Adult Organic Wards – Annually
- Rehabilitation Wards - Annually

A Ligature Inspections Dashboard is in place which provides a monitoring tool for all assessments undertaken and the plan for future inspections. This details inspections that could not be undertaken due to the pandemic. GOLD command agreed that risk assessments should be paused to protect risk and estates staff and to minimise the risk of bringing infection into the

wards. Where a risk assessment was due during the pandemic, a table top review was undertaken instead, led by risk management with input from the estates department and ward representative as required.

Potential ligature risks identified in risk assessments are where possible removed and replaced with a reduced ligature design at the earliest opportunity. Where this is not possible local mitigation plans are required to be confirmed and the risk highlighted on the ward heat map.

Action required following a ligature risk assessment is recorded and monitored on a database held by the Risk Team through to completion. Detailed assurance is provided to the Quality Committee to ensure any overdue actions are followed up.

The Board were advised previously of ligature assessment scrutiny audits being undertaken by the Compliance Team, these are designed to test compliance with policy and procedure but also to provide coaching and support to frontline staff to help them assess and manage risk appropriately. Due to the pandemic these audits were paused, this process has been reviewed and is now incorporated into the 6 monthly ligature inspections and is part of the ligature risk assessment tool.

Compliance checks within the risk team continue to ensure all ligature risk assessment tools and reports are completed correctly and in line with policy and the newly developed SOP.

7.0 Risk Reduced 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.

8.0 STAFF TRAINING

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package (launched in March 2018 and reviewed December 2019) "Preventing Suicide by Ligature" on an annual basis. The training package details:

- Definitions relating to the management of ligature
- Background and trends in suicide and self-harm
- Ligature hazards and risks and there management
- Principles of good practice in the prevention of suicide
- Emergency procedures and equipment
- Policy and procedures, related training and links.

Compliance with training as of the 4th May 2020 was 94% (901 out of 955 staff identified have completed it). This is a stable percentage of 94% as previously reported, despite an increase in the number of staff requiring training.

Work is ongoing to secure ligature risk assessment training (initially) for the main inspection team, TIDAL Training have been approached and are undertaking a scoping exercise to take the training forward for 15 EPUT staff, preliminary date November 2020.

9.0 Conclusion

The summary of information provided in this report is by its nature only potentially a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

It is hoped that the information provides sufficient assurance that the Trust continues to take mitigating the risk of ligature seriously.

10.0 Action Required

The Board of Directors is asked to:

- Discuss the contents of this report
- Identify any further actions required

Report Prepared By:
Catriona King
Ligature Risk Coordinator

On behalf of:
Sally Morris, CEO
September 2020

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30th September 2020**

Report Title:	**CQC Update**					
Executive/Non-Executive Lead:	Sally Morris, Chief Executive					
Report Author(s):	Amanda Webb, Compliance Officer					
Report discussed previously at:	Executive Committee (in part) 15th September Quality Committee (in part) 17th September					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report

This report provides:

- An update on progress working Towards Outstanding
- An overview of new CQC Ligature focused inspections
- An update on progress with implementing actions arising from the CQC Well Led Inspection of the Trust in July – August 2019
- An update on changes required to CQC registration
- An overview of the EPUT Insight Report published by the CQC - August 2020

Approval	✓
Discussion	
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.
2 Identify any further action that is required to be taken.

Summary of Key Issues

- **Towards Outstanding:** Details are provided outlining progress made against the next stage of the CQC compliance Programme.

- **Preparing for Annual Inspection:** The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections. The CQC have not yet announced when they will be returning to routine inspections. The CQC have notified organisations that they have concerns nationally around Ligature management processes and will be undertaking Ligature focuses inspections/reviews.

- **Internal Compliance Regime:** Due to Covid-19, internal CQC inspection visits to services are to remain on hold however details are provided around current tasks the compliance team will be undertaking.

- **CQC Reset Action Plan:** As at the end of August 2020, 17 (55%) internal actions have been reported as complete with a slippage reported of 1 (3%) internal action. Following further review the CQC Action Plan and CQC Reset Action Plan developed following the CQC Unannounced Inspection (July-August 2019) have now addressed the CQC concerns and therefore the CQC Action plan has now been confirmed as closed.

- **EPUT Registration Requirements:** The Trust is required to notify the CQC, in advance, of any changes to its Directors or CQC Nominated Individual. Therefore the notifications are currently being prepared for:

  - Change in CEO and Change in Nominated Individual

- Change in CFO
- Change in Executive Operational Director

- **CQC Insight Report (August 2020):** Analysis has been undertaken for the indicators included in the August 2020 report and there are no significant changes

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF45
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 £**			
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		
EERG	Estates Expert Reference Group		

Supporting Documents and/or Further Reading
CQC Compliance Update

Lead
Sally Morris, **Chief Executive**

Agenda Item 9a

Agenda Item: 8a
Board of Directors
30th September 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1.0 Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

2.0 Ownership and Leadership

2.1 'Towards Outstanding'

As previously reported it was agreed that the trust would take forward the next stage of our compliance programme through a new ambitious working group '*Towards Outstanding'* to focus on 4 key themes (learning lessons; equalities; data quality and restrictive practice) that we believe could make the difference to the quality of our services and lead to improved ratings. Due to Covid-19, the Towards Outstanding meetings were suspended until July 2020.

The 'Towards Outstanding' working group has been established with a wide ranging membership representing different services and professional groups. The working group is focusing on 8 key areas where practice has the potential to contribute towards an outstanding rating for the Trust:

- Patient Experience
- Learning Lessons
- Restrictive Practice
- IT Innovation
- Bed Management
- Equality and Diversity
- Suicide Prevention
- Data Quality

For each key area different ambitions have been identified and the working group generates ideas on where outstanding practice is already in place and how we can extend further.

3.0. Preparing for Annual Inspection

3.1. CQC Update

The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections however it may be necessary to still use some of its inspection powers in a very small number of cases where risks are identified and as such focused inspections at short notice may take place. The CQC has not yet announced when it will be returning to routine inspections.

3.2. Ligature Inspection Criteria

On the 20th August the CQC issued an update for NHS MH Trusts from Dr Kevin Cleary, Deputy Inspector Mental Health and Community Services.

The update highlighted that "there is still significant variation in the quality and safety of mental health services across the country, but where organisations have adopted a collaborative approach and Quality Improvement (QI) methods using a defined methodology, there has been real progress."

However, the CQC "remain very concerned about a lack of improvement in some estates and the absence of a sense of urgency that change is needed in these organisations".

The update highlighted that there are still incidents where high risk ligature points have been "identified but no effective action has been taken to manage the ligature points". We are often told that the mitigation is a variation on "staff to be more vigilant" and that the issue is on the capital projects register. However, leaving such an issue on the capital projects register for a prolonged period when they have been identified as requiring urgent resolution, risks serious harm to patients."

A new 2020 brief guide for inspection teams has been published for CQC inspectors and the CQC have confirmed that as part of their Well Led inspections they will:

- Look at the Capital Projects Allocation for each organisation and the prioritisation of the allocation.
- Explore the non-executive directors' understanding of the estates' risks and how these impact on the safety and quality of care.
- Consider the degree to which the quality and finance sub-committees of the board have considered individual notified estates risks e.g. ligature points and the actions that they have subsequently taken.
- Look at the pathway from ward to board of risk information about estates.
- Critically assess the transparency and openness of board papers dealing with quality and safety that are in the public domain.
- Seek confirmation that trusts have environmental risk assessment policies that comply with the alerts listed above and the wider guidance summarised in our brief guide for inspection teams.

As part of CQC inspections of wards the CQC will:

- Discuss concerns about patient safety with staff and people using the service.
- Assess the degree to which concerns raised about safety and quality are listened to and acted upon.
- Determine the effectiveness of ligature audits and **their mitigations**, including an assessment of the human factors involved in their mitigations and their impact upon staff. By this we mean the relationship between staff, the equipment they use in the workplace, and the environment in which they work.

Work is underway to review the EPUT position against the CQC well lead criteria above. A report will be presented to the next Trust Board in November with an assessment against the letter and any actions that need to be taken forward

4.0 Progress with Existing Action Plans

4.1. CQC Unannounced Inspection (July – August 2019)

The reset action plan was developed with the aim to resolve the final issues identified by the CQC from the inspection and to ensure action has been fully embedded in practice and facilitates change. The reset action plan has been developed with consideration of all previous actions taken and those that remained open to ensure these continued to be taken forward to address the original issues identified.

The reset action plan identified 31 individual actions to deliver the 6 "Must Do and 8 "Should do" actions identified by the inspection that required further progress. One further internal action has been identified as the action plan has progressed to ensure all issues have been fully resolved and a total of 32 internal actions have now been identified.

Action Type	Must Do / Should Do Actions				Specific Actions That Address Must Do/Should Do Actions			
	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale
Combined Must and Should Do	6	0	6	0	10	7	2	1
Must Do	3	1	2	0	12	4	8	0
Should Do	5	2	3	0	10	6	4	0
TOTAL	**14**	**3 (21%)**	**11**	**0**	**32**	**17 (55%)**	**14**	**1**

As reported to the Quality Committee on the 17th September, at the end of August 2020, 17 (55%) internal actions have been reported as complete with a slippage reported of 1 (3%) internal action. Detail of the action where timescale had slipped is outlined below:

M3. The trust must ensure that blanket restrictions like locking patients' bedroom doors are reduced and regularly reviewed. (Wards for Older People)

Undertake option appraisal to determine the solution to allow patients access to their bedrooms on older people's inpatient wards - Discussed at Exec CQC Steering Group the limited progress with this action. Agreed to make contact with other Trusts to establish how this is addressed. Review original findings and detail of AIMS accreditation for any guidance in this area. The review has been undertaken and it was agreed at the Executive CQC Steering Group that the actions taken have addressed the original issues raised and therefore this action is now closed.

Following a further review of all remaining open actions, confirmation was received at the Executive CQC Steering Group on the 25th September, that the CQC Action Plan and CQC Reset Action Plan developed following the CQC Unannounced Inspection (July-August 2019) have now addressed the CQC concerns and therefore the CQC Action plan has now been confirmed as closed.

5.0 Internal Compliance Regime

Internal CQC Inspections

Due to Covid-19, internal CQC inspection visits to services were suspended. It was agreed at Silver and Gold Command that internal CQC inspections could resume from September 2020 with a change in process to carry out as much of the inspection as possible remotely.

The Compliance Team is currently developing a calendar of visits focusing on areas where actions for improvement were identified and areas that achieved outstanding.

6.0 CQC Registration Changes

Under the Care Quality Commission (Registration) Regulations 2009: Regulation 15, the Trust is required to notify the CQC, in advance, of any changes to its Directors or CQC Nominated Individual. CQC can prosecute for a breach of this regulation therefore the notifications are currently being prepared, for:

- Change in CEO – Sally Morris to Paul Scott
- Change in Nominated Individual. – Sally Morris to Paul Scott
- Change in CFO – Mark Madden to Trevor Smith
- Change in COO – Andy Brogan to Alex Green

7.0 CQC Insight Report August 2020

The CQC published the Mental Health Services Insight Report for EPUT on the 23rd August 2020. The document provides an update on the data currently held by the CQC in relation to the Trust and develops a profile which may be used to target any inspections or instigate an inspection if a risk is seen to be developing.

The report identified that they have not been able to refresh 21 indicators based on the Mental Health Services Data Set (MHSDS), their MHA visits and data CQC receives from providers therefore they have continued to suspend the indicators because the analysis was not sufficiently timely.

The following indicator is highlighted in the report as showing improvement:

- Proportion of Health Care Workers with direct patient care that have been vaccinated against seasonal influenza (%)'. Performance has been recorded as 62.0% for the data range Sep 19 - Feb 20.

The following indicator is highlighted in the report as having declined:

- Whistleblowing alerts received by the CQC that have been open for at least 10 weeks'. Performance has been recorded as 1 or more Aug 20.

The report confirms that the CQC have suspended the indicator Detained patient deaths: Trusts flagging for risk in the number of suicides of patients detained under the Mental Health Act (all ages) due to database migration. This will be re-introduced as soon as possible.

8.0 Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Compliance Officer

On behalf of:

Sally Morris
Chief Executive

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 8b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**PHSO and HSE Steering Group Assurance Report**					
Executive/Non-Executive Lead:	Alison Davis, Non-Executive Director / Chair of the PHSO Steering Group					
Report Author(s):	Gill Brice, Associate Director of Planning					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the PHSO and HSE Steering Group. This is a Task and Finish Group established by the Board to oversee the work relating to the PHSO and HSE requests for information.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the summary of the meetings held on 29 July 2020.
2. Confirm acceptance of assurance given in respect of the actions identified.

Summary of Key Issues

The PHSO & HSE Steering Group met on 29 July 2020. The following items were discussed:

- Action Log
- PHSO Action Plan
- HSE Investigation
- PACAC Assurance Statement

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF 15
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:			Nil
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	No

Acronyms/Terms Used in the Report			
PHSO	Parliamentary and Health Service Ombudsman	HSE	Health and Safety Executive
PACAC	Public Administration and Constitutional Affairs Committee		

Supporting Documents and/or Further Reading

Lead
Alison Davis **Non-Executive Director / Chair of the PHSO & HSE Steering Group**

Agenda Item: 8b
Board of Directors
30 September 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PHSO and HSE STEERING GROUP

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of PHSO and HSE Steering Group. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisations objectives are being managed effectively.

EXECUTIVE SUMMARY

PHSO and HSE Steering Group meeting of 29 July 2020
The PHSO and HSE Steering Group met on 29 July 2020. The Steering Group had a robust and thorough discussion on a number of key areas. The following matters were considered:

1. **Steering Group Action Log**
   Updates were received and slippage was identified in relation to narrative regarding the Perfect Ward report, compliance with TASI training due to Covid-19 and a review of other organisation's care plan templates.

2. **Final PHSO Action Plan**
   No slippage was noted on the action plan. Proposals on compliance testing for a number of the completed actions was discussed and agreed. It was agreed that the current version of the action plan would be sent to Operational Services for discussion at their next meeting.

3. **HSE Investigation**
   No slippage was noted on the action plan.

4. **PACAC Assurance Statement**
   Updates on the actions outlined were noted by the Group.

5. **Risks**
   A risk was noted in respect of the Compliance Team having the capacity to complete the proposed testing, and the timeframe for completion.

ACTION REQUIRED

The Board of Directors is asked to:
1. Note the summary of the meeting held on 25 June 2020.
2. Confirm acceptance of assurance given in respect of the actions identified.

Report produced by:
Gill Brice
Associate Director of Planning

On behalf of:
Alison Davis
Non-Executive Director / Chair of the PHSO and HSE Steering Group

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report title:	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2020					
Executive Lead:	Sally Morris (CEO)					
Report Author(s):	Debby Stevens, EPRR Lead					
Report discussed previously at:	Executive Operational Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	
Risk Rating	**Low**		**Medium**		**High**	✓

Purpose of the Report

This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2020. This report was submitted to EOSC on 22nd September 2020 and was discussed at a core standards assurance meeting on 23rd September 2020, in line with the national EPRR assurance timetable for information and confirmation of the self-assessed fully compliant rating.	**Information**	✓
	Discussion	
	Decision	✓

Recommendations / Action Required

The Board of Directors is asked to:

- Note the information contained within this report
- Approve and note the rating received from NHS England as fully compliant with all standards

Summary of Key Issues

The NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Framework 2015 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.

On 24th August 2020, the Trust received a communication from the regional EPRR team at NHSE/I (East) informing the Trust of the proposed EPRR core standards assurance process for 2020 which is delayed and reduced, due to the COVID19 Pandemic.
Trusts were asked to focus on the three areas below:

1) Progress made by organisations that were reported as partially or non-compliant in the 2019/20 process
2) The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic
3) Inclusion of progress and learning in winter planning preparations.

Although the key focus would be on partially or non- complaint organisations NHSE/I also wanted to seek assurance that the 2019/20 rating of full compliance is unchanged for EPUT.

The Trust remains fully compliant with a total of 54 out of the 54 standards applicable to mental health and community care trusts.

The 2020/21 ‘assurance’ meeting was attended by the EPRR lead via Microsoft Teams, on Wednesday 23rd September 2020, which confirmed that the Trust remains complaint with the previous year’s core standards and the demonstrates lessons learnt from the Trust’s COVID19 response.

The organisational rating will be submitted, as part of the Regional response, to the national

NHS England EPRR team, after approval at board, which will in turn prepare an assurance report for the NHS England Board. This will ultimately inform assurances to central government.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are being delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework	
Are any existing risks in BAF affected?	No
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment:			
Impact on CQC Regulation Standards, Commissioning Contracts, 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 £**	NA
Governance Implications			✓
Impact on Patient Safety /Quality			✓
Impact on Equality & Diversity			
Equality Impact Assessment (EIA) Completed?	No	**If YES, EIA Score**	NA

Acronyms / Terms used in the report	
CBRN	Chemical, Biological, Radiological, Nuclear
EPRR	Emergency Preparedness, Resilience and Response
EPUT	Essex Partnership University NHS Foundation Trust
HAZMAT	Hazardous materials
HSSC	EPUT Health, Safety and Security Committee
NHSE/I	NHS England & Improvement

Supporting Documents &/or Further Reading
National Core Standards Return Report APPENDIX 1 – Draft National EPRR Core Standards Return 2020 APPENDIX 2 – Core Standards Annual Assurance Review Return

Executive Lead
Sally Morris, CEO

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE NATIONAL CORE STANDARDS RETURN 2020

1.0 INTRODUCTION

1.1 This report presents the draft Emergency Preparedness, Resilience and Response (EPRR) national core standards return 2020.

2.0 CONTEXT

2.1 The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2015 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.

2.2 On 24th August 2020, the Trust received communication from the regional EPRR team at NHS England (East) informing the Trust of the EPRR national core standards process for 2020-21. Due to the ongoing pandemic NHSE/I advised that the normal annual process would be excessive, due to preparing for a further wave of COVID19, as well as the upcoming seasonal pressures and the operational demands of restoring services.

2.3 Given the current situation and tight timescales, The Trust was advised the amended process for 2020/21 would be focusing on the three areas listed below;

- Progress made by organisations that were reported as partially or non-compliant in the 2019/20 process and fully compliant Trusts remained so for the current year.
- The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic
- Inclusion of progress and learning in winter planning preparations.

2.4 NHSE/I have given CCG's a central role in this year's core standards. They will be holding assurance meetings with each Trust to confirm they have undertaken a comprehensive and thorough review on the above three areas.

2.5 EPUT's assurance meeting with NHSE/I will be held on Wednesday 23rd September 2020.

2.6 CCG EPRR teams will provide a regional report to the National team providing assurance of processes and learning, and an update on Providers continued compliance from the 2019 core standards.

3.0 SELF-ASSESSMENT SUBMISSION

3.1 The 2019 self-assessment was undertaken by the individuals within the Trust responsible for EPRR. This self-assessment, which is required to be submitted to NHS England (East), assessed the Trust as being fully compliant with a total of 54 out of the 54 standards applicable to mental health and community care trusts. This self-assessment results in an overall rating of "Fully Compliant" for the organisation. This was agreed during the 'confirm and challenge meeting with the regional EPRR

team in September 2019. This self- assessment rating remains true for EPUT for the 2020 core standards.

3.2 The definitions of the ratings, given in the national guidance, are as follows:

Not compliant	Not compliant with the core standard and in line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard but the organisations EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with the core standard.

4.0 Assurance meeting with CCG

The Trust's EPPR officer met with the EPRR lead of CCG on Wednesday 23rd September 2020. At this meeting, the Trust presented the evidence available to demonstrate compliance with the standards and to evidence learning from COVID19 management. At NHSE/I's request the Trust has supplied the CCG with copies of the Trust's major incident plan and corporate business continuity plan.

5.0 COVID19 MANAGEMENT & LESSONS LEARNT

5.1 Command Management

The Trust commenced a COVID committee from 13th February 2020 which was held on a weekly basis. Key stakeholders from across the Trust were involved at this early stage. The committee was escalated to daily meetings on the 2nd March 2020.

On the 16th March 2020 EPUT declared a major incident due to the ongoing COVID incident.

EPUT initiated the Gold / Silver and Bronze command structure with each command meeting being held daily (7 days a week). In addition a small incident response team was implemented, chaired by the Director of Compliance and Assurance (Deputy EPRR SRO) to oversee and manage the day to day running of the incident.

The deputy EPRR SRO (deputised by Associate Director of Risk and Compliance) chaired the daily Silver Command and provided the link into Gold Command meetings that were chaired by the Chief Executive (deputised by the Deputy CEO). The meetings were for a period of time each morning, however further command meetings could be reconvened at any stage if required. A number of Bronze Command groups were initiated chaired by the service Directors.

A loggist was put in place for the gold command meeting. They used a log book, however this had to be driven between the rostered staff and for sign off.

For Silver Command actions agreed were recorded on the Silver Command Action log.

Due to the nature of the pandemic, and the UK lockdown requirements, on 24th March 2020 virtual incident rooms were set up within the Trust via WebEx and subsequently Microsoft Teams. All stakeholders including the incident response team, worked predominantly remotely to managing the situation.

5.2 Notifications Management

EPUT set up a dedicated COVID 19 email address as the central information point for receiving information into the Trust. The EPRR officer and the incident control team monitored the EPUT C19 email box on a rota basis, to address and ensure compliance with all actions, required returns and enquiries into the organisation.

The EPRR officer held a central database of all correspondence received and logged any action taken.

All email notifications were considered for relevance by the incident control team who took expert advice from Bronze and Silver Command members. Where applicable notifications were taken to Silver Command for Information, Action or Decision. These were then escalated to Gold Command where appropriate or disseminated to Bronze Command where appropriate.

The Incident control team action manager, or a deputy, attended Silver and Gold Command noting any internal actions required to be taken. These were noted on a central Silver command action log. The internal action log was regularly compared against the COVID email database to ensure compliance with all required action.

The incident control team also produced and maintained a register noting all decisions and service changes made for any future assurance requirements.

Over the Covid 19 pandemic there have been a number of different national submissions required. These have been a mix of daily, weekly and via different portals/information systems. Responsibility for the content of the submissions was allocated to the appropriate Silver Command member. The submissions were made by a small rostered team.

A standard operating procedure was drafted to manage the EPUT C19 email and national submission requirements. The Incident control team met on a weekly basis to review working practices, raise concerns and ensure the smooth management of the Trust's response.

5.3 Staff Communication and Support

Over the Covid 19 pandemic it has been essential to keep staff fully informed and up to date with current guidance. To achieve this EPUT initiated a full communication framework.

To ensure all staff are fully briefed and information shared within the Trust as timely as possible, the Trust's communications team sent out daily briefings on situational information and changes of guidance.

The Trust developed a COVID Internet page where all COVID related information is kept including all guidelines, links to training and links to staff support.

The Trusts Executive Team held weekly all staff "Live" briefings virtually overall Microsoft Teams'. This new approach to communication has been extremely successful and enabled staff to ask questions directly to the CEO and Executive Directors throughout the session. The sessions were recorded and available to be watched by all staff that were unavailable at the live session time.

Being a mental health Trust we were fully aware of the impact of COVID on our staff. A confidential COVID staff helpline was introduced and wellbeing apps were encouraged to be

used. All staff were encouraged to access support through the daily briefings, live briefings and through the COVID intranet page.

5.3 Service Provision

Where possible EPUT has maintained the provision of services taking an adaptive approach to meet current needs and the national lockdown.

Due to the national lockdown EPUT made changes to how community services could be provided. All teams initiated their Business Continuity Plans and the Trust IM&T Directorate identify and established new ways of undertaking virtual care where face to face appointments were not possible. Various different systems have been used depending on clinical need including Microsoft Teams for group work, Accurx system for one to one sessions and the Trust used the attendanywhere system for the waiting room for sessions.

In response to local need at the start of the crisis some of EPUT community health beds were reconfigured to assist the local economy. EPUT Mental Health inpatient services undertook robust clinical risk assessments and worked with partners working to the removal of red tape allowing patients to be discharged to ease capacity and flow.

In preparation for the lockdown the Trust extended staffs ability to work from home. The IT Team ensured a range of equipment was available for staff to enable home working with full access to all systems accessed in a Trust building. A full range of risk assessments were undertaken with staff including DSE, Covid Personal Risk Assessment and Working at Home Questionnaire.

5.4 Lessons Learnt

The COVID 19 pandemic has been an unprecedented event within the NHS of a sustained major incident taking place over a period of months. Most NHS major incident planning and learning from past incidents focuses on immediate response to a limited time crisis. Due to the unusual nature of this event significant new ways of working were needed. The key areas of learning (so far) from this event are:

- Conducting the incident command response via Microsoft Teams allowed flexibility to the control of the incident, ability to continue to respond through a lockdown situation while still maintaining a form of business as usual.
- Utilising Microsoft Teams gave a better attendance at meeting/committees. This has removed the need for all attendees to travel to the same location opening up the opportunity for more people to attend.
- Utilising Microsoft Teams allowed meetings to be more focused. Meetings were incident specific. There was better engagement with all involved parties.
- Microsoft Teams, Accurx and attendanywhere have given an alternative way of providing a service to patients. These digital methods are becoming the new norm and in some cases this is a better form of support and treatment for patients.
- The command meetings were opened up to key stakeholders and members of the BAME, Equality and Spiritual Care networks to ensure all groups within the Trust had a voice within the Trust command structure.
- The Incident Control team underpinned the management team and provided continuity to the Trust's response. This insured the structure ran smoothly and these individuals had thorough knowledge of the Trusts response instead of a selected few.
- COVID all staff briefings and the COVID internet page have ensured staff were provided with timely and relevant information.
- The Live staff weekly briefings have allowed staff to interact directly with the CEO and Executive Directors, ask questions and raise concerns and receive an immediate

response. The live briefings have been very popular with staff and staff have highlighted that this format for briefings works really well and want this to continue not just for COVID

- The dedicated COVID staff support helpline has been an excellent initiative to support staff and has been commissioned by other local organisations.
- The pandemic has shown that most corporate/support services are able to fulfil their roles from home, as well if not better, than previously. Staff sickness and requested care needs were able to be met, whilst allowing staff to continue to perform their roles. Staff required to self-isolate have still been able to continue to provide their service and support from home.
- EPUT Central C19 email box ensured one place all COVID notifications came to within the organisation.
- The Trust received guidance, actions and information via many means (via three different CCG ICC's and directly from NHSE/I to different places within the Trust, such as directly to the CEO, Director of Nursing and the Trusts ICC). This caused complications in monitoring the Trusts responses, due to receiving some requests to individuals or receiving it a number of different times. The Trust believes it would be more beneficial that requests should be sent centrally to allow the responses to be collated centrally.
- The process of a physical log book for gold command is required to be review. A potential solution is to PDF an online log book after each meeting to ensure decisions are logged, held securely and cannot be altered, but remains accessible to all.

The Trusts approach to reset and recovery is Adapt / Adopt / Abandon to ensure that an open mind is kept in deciding what new practices worked well, to ensure this work is continued and is improved upon instead of reverting to previous business as usual methods.

6.0 NEXT STEPS

Subject to approval by the Trust Board of Directors in September, the return will be formally submitted to NHS England (East). The organisational rating will then be submitted, as part of the Regional response, to the national NHS England EPRR team which will in turn prepare an assurance report for the NHS England Board. This will ultimately inform assurances to central government.

The Trust will further embed COVID 19 lessons learnt into ongoing working practices in preparation to a second wave and/or winter pressure surges.

7.0 ACTION REQUIRED

The Board of Directors is asked to:

- Note the information contained within this report;
- Consider the draft Emergency Preparedness, Resilience and Response national core standards return 2020 for EPUT – attached at **APPENDIX 1**;
- Note the 2020 Core Standards Annual Assurance Review Return – Attached at **APPENDIX 2**;
- Seek clarity / comment where required; and
- Note the lessons learnt from the first wave of COVID19

Report prepared by: Debby Stevens

On behalf of: Sally Morris, CEO
September 2020

Please select type of organisation: **Mental Health Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	13	13	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	7	7	0	0
Total	54	54	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Total	20	20	0	0

Overall assessment:	Fully compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. 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. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**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. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**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 of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	Policy and Procedure	Fully compliant		EPRR Lead	Every 3 Years	Reviewed 2020
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	BCP/ P&P	Fully compliant		Operational Leads	Every 2 years	All Trust services have robust BCP's in place
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	BCP	Fully compliant		HR Lead	Every 2 years	Corporate and back office Staff have capabilty to work remotely. Consultations can be held remotely via various ITT systems.
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	BCP	Fully compliant		Operational Leads	Every 2 years	Consultations can be held remotely via various ITT systems.
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Policy and Procedure	Fully compliant		EPRR Lead	Every 3 years	Communication with Multi Agencies
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	BCP	Fully compliant		Estates and Facilities Lead	Every 2 years	Communication with Multi Agencies- Supplies of Grit stored on site
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result	Emails	Fully compliant		EPRR Lead	Ad Hoc	Communication from the EPRR team who will send MET office circulation to staff, intranet messagges and ticker messages when required.
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	P &P and BCP	Fully compliant		EPRR Lead/ Head of Estates	Every 3 years	Head of Estates has plans and contacts with Extenal providers and water suppliers for regular and ad hoc drainage issues.
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	LRF Plan	Fully compliant		EPRR Lead	N/A	N/A

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
10	**Severe Weather response**	**Warning and informin**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Comms Plan	Fully compliant		Comms Lead	Every 2 years	N/A
11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	P&P and BCP's	Fully compliant		EPRR Lead/ Head of Estates	Every 2 years	Estates are aware and monitor areas of concern
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Risk Register	Fully compliant		Assuanrance Manager	Monthly	N/A
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	BCP	Fully compliant		EPRR Lead	N/A	N/A
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Exercise	Fully compliant	Trustwide annual exercise held later part of 2019 to cover extreme weather- Snow/ice with after flooding	EPRR Lead	Annual	Trustwide annual exercise held later part of 2019 to cover extreme weather- Snow/ice with after flooding
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	BCP	Fully compliant		Assurance Manager	Monthly	N/A
Domain: long term adaptation planning											
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	P&P/BCP	Fully compliant		EPPR/Head of Estates	Every 2 years	N/A
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	P&P/BCP/Heatwave audit 8B	Fully compliant		EPPR/Head of Estates	Every 2 years	Heatwave audit completed 2019 further reviewed 2020.
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	BCP	Fully compliant		Head of Estates	Every 2 years	N/A
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	P&P/BCP	Fully compliant		EPRR Lead/ Head of Estates	Every 2 years	N/A
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	P&P/BCP	Fully compliant		EPRR Lead/Head of Estates	Every 2 years	New Project work is discussed at Estates project meetings and any adaption plans are considered

Overall assessment:										
Ref	**Domain**	**Standard**	**Detail**	**Evidence - examples listed below**	**Organisation Evidence**	**Self assessment RAG** **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Exercise	Fully compliant	Trustwide annual exercise held later part of 2019 to cover extreme weather- Snow/ice with after flooding	EPRR Lead	Annual	Trustwide annual exercise held later part of 2019 to cover extreme weather- Snow/ice with after flooding

East of England Regional EPRR Annual Assurance Report 2020/21

Organisational Information

Organisation Name	Essex Partnership University NHS Foundation Trust		
Organisation Type	Mental Health and Community Services	ODS Code	
Date of Return	23rd September 2020		

01. Progress of partially or non-compliant organisations

01a What was the organisational rating for 2019/20?	Fully compliant
If your organisation was partially or non-compliant:	
01b What would the organisation rating to be for 2020/21?	
01c Does the CCG EPRR Lead & AEO agree with this rating?	
If your organisation remains partially or non-compliant:	
01d Does the organisation have a robust improvement plan?	
01e Has this improvement plan been agreed with the board?	
01f Has this improvement plan been agreed with the CCG?	

02. Identification and application of learning from the first wave of the Covid-19 pandemic

02a Has the organisation commenced identifying learning from the first wave?	Yes
02b Has the organisation commenced embedding learning from the first wave?	Yes
02c Has the organisation worked with partner organisations to ensure system wide learning?	Yes

03. Incorportating progress and learning in to winter planning arrangements

03a Has the organisation commenced planning for Winter 2020/20?	Yes
03b Has the organisation incorporated learning from Covid-19 response in to its winter plans?	Yes
03c Has the organisation engaged with the system winter planning lead?	Yes
03d Has the organisation commenced planning for EU Exit?	Yes

04. Approval

Completed By	Debby Stevens	Job Title	EPRR lead
Email Address	d.stevens2@nhs.net	Contact Number	01268 739862
Approved By	Nicola Jones	Job Title	AD of Compliance and
Email Address	nicola.jones26@nhs.net	Contact Number	01268 739742

04a Has a structured conversation been held with the CCG?	Yes
04b What date was the structured conversation undertaken?	23/09/2020
04c Has this assurance been reviewed by the board?	
04d Has the board approved this return?	
04e What date did the board approve this return?	

		Agenda Item No: 8(d)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Review of SFI's and Standing Orders**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive Officer					
Report Author(s):	Chris Jennings Assistant Trust Secretary					
Report discussed previously at:	Audit Committee 16 September 2020 Council of Governors 23 September 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation and Detailed Scheme of Delegation for formal approval by the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report.
2 Approve the Standing Orders For The Board Of Directors
3 Approve the Standing Financial Instructions
4 Approve the Scheme of Reservation and Delegation
5 Approve the Detailed Scheme of Delegation

Summary of Key Issues

Annual review of the Standing Orders For The Practice and Procedure of the Board of Directors, Standing Financial Instructions (SFI's), Scheme of Reservation and Delegation (SoRD) and Detailed Scheme of Delegation (DSoD) has been completed.

Copies of all documents are attached, with proposed changes tracked, at Appendices 1-4. A summary of changes proposed within each document is provided below:

Appendix 1 Standing Orders For The Practice And Procedure Of The Board Of Directors

- **Provision 2.9.1 Appointment and Powers of Vice-Chair**
  The reference paragraph 28.3 and 28.4 of the Trust Constitution have been removed as these paragraphs refer to the removal of a Non-Executive Director from office, rather than the removal of the Vice-Chair from that position.

Appendix 2 Standing Financial Instructions

- Removing reference to the Strategy and Planning Committee and replacing with the People, Innovation and Transformation Committee.
- Provided further clarity that the term Director includes all staff who report directly into an Executive Director irrespective of whether they have Director in the title.

Appendix 3 Scheme of Reservation and Delegation

- **Section 5.6** has been amended to include reference to the Appointment of the Acting Chair.
- **Section 7.27.3** refers to the CEO ensuring register(s) of interest is maintained. However, in **Section 5.14.1** the Trust Secretary is delegated to "compile and maintain" registers including registers of interest. Therefore, Section 7.27.3 has been amended to reflect the

responsibility to maintain register of interests is delegated to the Trust Secretary.

- **Section 8.16.1** amended to refer to the Local Counter Fraud Specialist (LCFS) rather than the Local Security Management Specialist (LSMS).
- **Section 17.2** changed delegated authority relating to ensuring staff are made aware of the Gifts & Hospitality policy from the ECFO to the CEO.
- **Section 9: Major Incident Plan:** This section has been added to the document following the Covid-19 pandemic. The section provides that in the event of a Business Continuity, Critical or Major Incident being declared leading to the activation of the Major Incident Plan (RM14) a Major Incident Response Team (MIRT) will be established consisting of a Gold Command. The delegated powers have been given to the Gold Commander (who would be either the CEO or Deputy CEO) rather than Gold Command as it is not a Standing Committee of the Board.

Appendix 4 Detailed Scheme of Delegation

- Removing reference to the Strategy and Planning Committee and replacing with the People, Innovation and Transformation Committee.
- Expanding existing sections for the accepting of gifts and hospitality and the associated declarations and conflicts of interest. This section has been aligned to the Trusts Conflicts of Interest, Gifts and Hospitality Policy (CP80) that was approved by the Finance and Performance Committee in February 2020.
- Remove a duplication around establishments (section 14 a / b and c)
- Provide further clarity around staffs entitlement to carry forward annual leave in excess of 10 days where there have been periods of maternity or long term sickness.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
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 £**			
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			
SOs	Standing Orders	SFI's	Standing Financial Instructions
SoRD	Scheme of Reservation & Delegation		

Supporting Documents and/or Further Reading
Appendix 1: Standing Orders for the Board of Directors Appendix 2: Standing Financial Instructions (SFI's) Appendix 3: Scheme of Reservation & Delegation (SoRD) Appendix 4: Detailed Scheme of Delegation (DSoD)

Lead
Sally Morris **Chief Executive Officer**

Essex Partnership University
NHS Foundation Trust

Appendix 1

STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE BOARD OF DIRECTORS

POLICY REFERENCE NUMBER:	TB01
VERSION NUMBER:	0043
~~**REPLACES SEPT DOCUMENT**~~	
~~**REPLACES NEP DOCUMENT**~~	
KEY CHANGES FROM PREVIOUS VERSION	~~As recommended following legal advice~~Minor amendments
AUTHOR:	Trust Secretary
CONSULTATION GROUPS:	Board of Directors Audit Committee Council of Governors CoG Governance Committee ~~Executive Operational Sub-Committee~~
IMPLEMENTATION DATE:	01 April 2017
AMENDMENT DATE(S):	08 November 2017 (Chair's action) August/September 2018 September 2019, September 2020
LAST REVIEW DATE:	September ~~2019~~2020
NEXT REVIEW DATE:	September ~~2020~~2021
APPROVAL BY BOARD OF DIRECTORS	September ~~2019~~2020
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POLICY SUMMARY

The purpose of the Standing Orders for the Board of Directors is to set out the practice and procedures of the Board 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 Board of Directors will be undertaken by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	
~~Essex MH&LD~~		
~~CHS~~		

The Chief Executive is responsible for monitoring and reviewing this policy

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INTRODUCTION

Regulatory Framework

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1 April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act) by Monitor - Independent Regulator of NHS Foundation Trusts.

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 and the Health & Social Care Act 2012.

The Trust's Standing Orders and wider governance arrangements are further supported by various policies and procedures and for financial matters, by the Standing Financial Instructions (SFIs), Detailed Scheme of Delegation (DSoD), and associated finance procedures. Certain powers are reserved to be exercised by the Board only, others are delegated to individual Executive Directors and/or committees of the Board. These are covered by the Scheme of Reservation & Delegation of Powers of the Board. (SoRD).

The principal place of business of the Trust is at The Lodge, Lodge Approach, Runwell Chase, Wickford SS11 7XX.

As a public benefit corporation the Trust has the power to act as a corporate Trustee of charitable funds. Under section 11 of the Trustee Act 2000 the Trust can appoint a Charitable Funds Committee and delegate its functions to it. This power includes appointing a committee whose members are not members of the Board of Directors. The Trust has appointed a Charitable Funds Committee which operates in accordance with these Standing Orders and its terms of reference (as approved by the Board of Directors) and the relevant guidance from the Charity Commission.

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting of the Board of Directors 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 Chief Executive and the Trust Secretary)

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 and 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 & 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 **Budget** means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust

1.2.6 **Chair of the Board** or **Chair of the Trust** or **Chair** 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 the meeting or is otherwise unavailable

1.2.7 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution

1.2.8 **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources

1.2.9 **Committee** means a committee appointed by the Board of Directors

1.2.10 **Committee members** means persons formally appointed by the Board of Directors to sit on or to chair specific committees

1.2.11 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act

1.2.12 **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

1.2.13 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution

1.2.14 **Deputy Chief Executive** means the officer of the Trust appointed under paragraph 30 of the constitution

1.2.15 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.2.16 **Executive Chief Finance Officer** means the Chief Finance Officer of the Trust

1.2.17 **Executive Director** means a member of the Board of Directors appointed under paragraph 31 of the constitution

1.2.18 **Licence** means the Trust's provider licence (no 120163) issued by Monitor on 1 April 2017 (and reissued on 11 October 2017)

1.2.19 **Member** means a person registered as a member of one of the constituencies as set out in paragraph 5 of the constitution

1.2.20 **Monitor** means the body corporate known as Monitor, as part of NHS Improvement (now known as NHS England / Improvement), as provided by Section 61 of the 2012 Act

1.2.21 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting

1.2.22 **Nominated Officer** means an officer charged with the responsibility for discharging specific task under the Scheme of Reservation & Delegation

1.2.23 **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

1.2.24 **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust

1.2.25 **SFIs** means the Standing Financial Instructions of the Trust

1.2.26 **Scheme of Reservation & Delegation** is the Trust's scheme of reservation and delegation of powers approved by the Board of Directors

1.2.27 **SOs** means these Standing Orders (for the Board of Directors)

1.2.28 **Trust** means Essex Partnership University NHS Foundation Trust

1.2.29 **Trust headquarters** means The Lodge, Lodge Approach, Runwell Chase, Wickford SS11 7XX

1.2.30 **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.2.31 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution

1.2.32 **Working days** means a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday

1.3 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. THE BOARD OF DIRECTORS

2.1 The general duty of the Board and of each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate Trustee

2.3 The powers of the Trust shall be exercisable by the Board. The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the SoRD and have effect as if incorporated into these SOs

2.5 **Patients Forum Representatives**
The Trust will continue to be subject to the general duty to involve patients, and to seek assurance that the appropriate process has been adhered to in line with national guidance

2.6 **Composition of the Board**
In accordance with paragraph 25 of the constitution, the composition of the Board of the Trust shall be:

- A Non-Executive Chair
- Not less than five and not more than eight other Non-Executive Directors
- Not less than four and not more than eight Executive Directors

so that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive.

2.7 **Appointment and Removal of the Chair and other Non-Executive Directors**
In accordance with paragraph 28 of the constitution and guidance issued by Monitor, the Chair and the other Non-Executive Directors are appointed (and removed) by the Council at a general meeting of the Council

2.8 **Terms of Office of the Chair and other Non-Executive Directors**

2.8.1 The Chair and Non-Executive Directors shall be appointed with terms and conditions of office as decided by the Council at a general meeting taking account of Monitor's governance guidance

2.8.2 The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years

2.8.3 The Chair and Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director

2.8.4 The Chair and Non-Executive Directors may in exceptional circumstances serve longer than six years subject to annual re-appointment and subject to external competition if recommended by the Board and approved by the Council. In establishing that the Non-Executive Director continues to be independent, the Chair will take into account Monitor's guidance and conduct an evidence-based evaluation

2.8.5 Any reappointment after the second term of office for the Chair and Non-Executive Directors shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence

2.9 **Appointment and Powers of Vice-Chair**

2.9.1 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 his place ~~in accordance with paragraphs 28.3 and 28.4 of the constitution~~

Comment [JC(EP1]: This has been removed as the reference to the Constitution isfor the removal of the Chair / NED and not the removal of the person from this position.

2.9.2 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

2.9.3 In the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust

2.9.4 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 2.9

2.9.5 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair and be entitled to exercise all the rights and powers conferred upon the Chair by the constitution including but without limit those set out in these SOs and in the SOs of the Council until a new Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in these SOs shall, so long as there is

no Chair able to perform his duties, be taken to include references to the Vice-Chair

2.10 **Appointment and Removal of the Chief Executive**

2.10.1 In accordance with the constitution paragraph 31.1, the Non-Executive Directors of the Trust will appoint (and remove) the Chief Executive

2.10.2 The appointment of the Chief Executive requires the approval of the majority of the Council at a meeting of the Council in accordance with paragraph 31.2 of the constitution

2.11 **Appointment and Removal of Executive Directors**

In accordance with the constitution paragraph 31.3, all Executive Directors (excluding the Chief Executive) are to be appointed (and removed) by a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors.

2.12 **Appointment of the Deputy Chief Executive**

In accordance with paragraph 30.4 of the constitution, the Board of Directors Nominations Committee, which shall comprise all of the Non-Executive Directors, may nominate one of the Executive Directors to be the Deputy Chief Executive.

2.13 **Joint Executive Directors**

2.13.1 Where more than one person is appointed jointly to an Executive Director post, those persons shall count for the purpose of SO 2.6 (composition of the Board) as one person (save that the Executive positions of registered Medical Practitioner or registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions) in accordance with paragraph of 31.4 of the constitution

2.13.2 Where such an arrangement is in force, both individuals shall be able to attend a meeting of the Board provided that at any meeting of the Board they may only count as one individual for the purposes of the quorum and may only exercise one vote between them

2.13.3 Where the two individuals disagree as to how to vote at a Board meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both

2.13.4 The presence of either or both persons shall count as the presence of one person for the purposes of SO 30.17 (Quorum)

2.14 **Appointment and Removal of the Senior Independent Director**

2.14.1 The Board shall (following consultation with the Council) appoint one of the Non-Executive Directors as the Senior Independent Director in accordance with paragraph 30.3 of the constitution, for such period not exceeding the remainder of the individual's term of office as a Non-Executive Director

2.14.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board (following consultation with the Council) may thereupon appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of this Standing Order.

2.15 **Trust Secretary**

The Chair and Chief Executive shall appoint a Trust Secretary to act independently of the Board, to provide advice on corporate governance issues to the Chair and the Board, and to monitor the Trust's compliance with the regulatory framework, the constitution and the SOs.

2.16 **Role of the Chief Executive**

2.16.1 The Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business

2.16.2 The Chief Executive reports to the Chair and the Board

2.16.3 The Chief Executive is the Accounting Officer and shall be responsible for ensuring the discharge of obligations under all relevant financial directions and guidance issued by NHS FT regulators or any other relevant body

2.17 **Role of the Executive Chief Finance Officer**

2.17.1 The Executive Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems

2.17.2 The individual shall be responsible, along with the Chief Executive, for ensuring the discharge of obligations under all relevant financial requirements, conditions or notices issued by NHS FT regulators or any other relevant body.

2.18 **Role of Executive Directors**

Executive Directors shall exercise their authority within the terms of these SOs, SFIs and the SoRD

2.19 **Role of the Chair**

2.19.1 The Chair shall be responsible for the leadership of the Board (and Council), and chair all Board (and Council) meetings when present

2.19.2 The Chair must ensure effectiveness in all aspects of the Board's role and lead on setting the agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues

2.19.3 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board (and Council) in a timely manner with all the necessary

information and advice being made available to the Board (and Council) to inform the debate and ultimate decisions.

2.19.4 The Chair is responsible for ensuring that the Board and the Council work effectively together

2.20 **Role of Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

3. MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press**

3.1.1 The meetings of the Board shall be open to members of the public and the press in accordance with paragraph 34.1 of the constitution

3.1.2 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 Board will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 18E of Schedule 7 of the 2006 Act, the Board of Directors 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"

3.1.3 The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as detailed in SO 3.1.2 above

3.1.4 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press 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 Board and such agreement not to be unreasonably withheld

3.1.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Board and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting

3.2 **Calling Meetings**

3.2.1 Ordinary meetings of the Board shall be held at such times and places as the Board may determine

3.2.2 Meetings of the Board are convened by the Trust Secretary, by order of the Chair. Not less than one-third of the Directors can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary

3.2.3 The Trust shall hold meetings of the Board at least six times in each calendar year

3.3 **Notice of Ordinary Meetings**

3.3.1 The Trust Secretary shall give to all Directors at least ten (10) working days written notice of the date and place of every ordinary meeting of the Board

3.3.2 Agendas will be sent to Directors 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 or extraordinary business under SO 3.4 or SO 3.5.

3.3.3 A notice or other document(s) to be served upon a Director under these SOs shall be manually delivered or sent by post to the Director at his usual 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

3.3.4 A notice or other document(s) where manually delivered or sent by post shall be presumed to have been served on the next working day following the day of delivery and where sent by email at the time at which the email is sent

3.3.5 Failure to serve notice and supporting papers on any Director shall not affect the validity of an ordinary meeting

3.3.6 Save in the case of urgent meetings, for each meeting of the Board a public notice of the date, time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's head office and on the Trust's internet site for general access at least three working days before the meeting

3.3.7 Before holding a meeting, the Board must send a copy of the agenda of the meeting to the Council

3.4 **Notice of Extraordinary Meetings**

3.4.1 At the request of the Chair or by at least one-third of the whole number of members of the Board, the Trust Secretary shall send a written notice to all Directors within 10 (ten) working days of receipt of such a request specifying the date and place to discuss the specified business

3.4.2 If the Trust Secretary does not send notice a meeting of the Board within ten (10) working days of receiving a request from the Chair or a requisition from not less than one-third of the Directors pursuant to SO 3.4.1, the Directors who made the requisition may convene the meeting themselves by giving written notice to all Directors; this notice must be signed by all of the Directors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

3.5 **Notice of Urgent Meetings**

3.5.1 At the request of the Chair or not less than one-third of Directors, the Trust Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Trust Secretary shall give Board members as much notice as is possible in light of the urgency of the request

3.5.2 If the Trust Secretary fails to call such a meeting, then the Chair or at least one-third of the whole number of Board members shall call such a meeting

3.5.3 In the case of a meeting called under SOs 3.4 and 3.5, the notice shall be signed by the Chair or at least one-third of the whole number of Board members

3.5.4 No business shall be transacted at the meeting called under SOs 3.4 and 3.5 other than that specified in the notice. Agendas will be sent to Board members three working days before the meeting and supporting papers shall accompany the agenda, save in the case of urgent meetings

3.5.5 In the case of a meeting called under SOs 3.4 and 3.5 failure to serve such a notice on more than three Directors will invalidate the meeting

3.6 **Setting the Agenda**

3.6.1 The Board 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

3.6.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 (ten) 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 seven (7) working days before a meeting may be included on the agenda at the discretion of the Chair

3.6.3 Before holding a meeting, the Trust Secretary must send a copy of the agenda of the Board meeting to the members of the Council and may be sent in any manner permitted under SO 3.3.5 and 3.3.6

3.7 **Petitions**

Where a petition has been received by the Trust not less than ten (10) working days before a meeting of the Board, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting

3.8 **Chair of Meeting**

3.8.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent (and provided the Chair has waived the requirement for the Chair or Vice-Chair to be present under SO 3.17), the Non-Executive Directors present shall nominate a Chair for the meeting from their number and who has no conflict of interest

3.8.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Non-Executive Directors present shall nominate, shall preside

3.9 **Motions**

3.9.1 **Notices of Motion:** A Director desiring to move or amend a motion shall send a written notice thereof at least ten (10) 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

3.9.2 **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

3.9.3 **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 (6) calendar months shall bear the signature of the Board member who gives it and also the signature of four other Board members, to include at least one non-executive director and one executive director. Such notice shall be sent at least ten (10) working days before the meeting to the Chair, who shall insert in the agenda for the meeting. When any such motion has been disposed of by the Board, it shall not be possible for any Board member other than the Chair to propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate

3.9.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto

3.9.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Director to move:

(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 Director who has not previously taken part in the debate

3.9.6 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

3.10 **Chair's Ruling**

Statements of Directors made at meetings of the Board 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

3.11 **Voting**

3.11.1 Subject to the following provisions of this clause, questions arising at a meeting of the Board shall be decided by a majority of votes. Each Director shall have one vote:

(a) in the event of joint Executive Directors, SO 2.13 shall apply. In case of an equality of votes the Chair shall have a second casting vote
(b) no resolution of the Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present

3.11.2 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

3.11.3 A paper ballot may also be used if a majority of the Directors present so request in which case any person attending by telephone, teleconference, video or computer link shall cast their vote verbally (such verbal vote to be recorded in the minutes)

3.11.4 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained

3.11.5 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot)

3.11.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote

3.11.7 Directors may participate (and vote) in Board meetings by telephone, teleconference, video or computer link with the prior agreement of the Chair; participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting

3.11.8 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director and has a responsibility to consult with the Executive Director if available. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director, but has a responsibility to consult with the Executive Director if possible and to ensure their views are included within the debate, prior to the vote taking place. An officer's status when attending a meeting shall be recorded in the minutes

3.12 **Minutes**

3.12.1 The minutes of the proceedings of a meeting shall be drawn up by the Trust Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it

3.12.2 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

3.12.3 Minutes shall be retained in the Trust Secretary's office

3.12.4 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by any applicable guidance

3.12.5 As soon as practicable after holding a Board meeting, the Trust Secretary must send a copy of the approved minutes of the meeting to the members of the Council of Governors

3.12.6 Where Directors have concerns that cannot be resolved about the running of the Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes. On resignation, a Director should provide a written statement to the Chair for circulation to the Board, if they have any such concerns

3.13 **Informal Meetings and Meetings as a Committee**

3.13.1 The Chair should hold meetings with the Non-Executive Directors without the Executives Directors present

3.13.2 Led by the Senior Independent Director, the Non-Executive Directors should meet without the Chair present, at least annually, to appraise the Chair's performance, and on other such occasions as are deemed appropriate

3.13.3 Notwithstanding anything in these SOs, the Directors may meet informally or as a committee of the Board 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

3.14 **Amendment of Standing Orders**

3.14.1 These SOs may be amended without the need to amend the constitution. These SOs may be amended only if:

(a) a notice of motion under SO 3.9.1 (Notices of Motion) has been given
(b) not fewer than half of the total number of Non-Executive Directors vote in favour of the amendment
(c) at least two-thirds of Directors are present
(d) the amendment proposed does not contravene a statutory provision or direction made by Monitor

3.14.2 For the avoidance of doubt, SO 3.17 (Quorum) shall not apply to the variation of the SOs and the higher quorum required in SO 3.15 (Variation and Amendment of Standing Orders) shall be reached

3.15 **Record of Attendance**

3.15.1 The names of the Chair, Directors and all others present at the meeting (other than members of the public and media) who are present at a meeting of the Board shall be recorded in the minutes

3.15.2 A meeting of the Board refers to officers being physically present and officers being present via the use of technology, as defined in SO 3.17.5 and 3.18

3.16 **Quorum**

3.16.1 Seven (7) Directors including not less than two (2) Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive) and not less than two (2) Non-Executive Directors (one of whom must be the Chair or the Vice-Chair) shall form a quorum provided that a meeting shall be quorate if:

(a) the Chief Executive has waived the requirement for the Chief Executive or the Deputy Chief Executive to be present; and
(b) the Chair has waived the requirement for the Chair or the Vice-Chair to be present

3.16.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum

3.16.3 If a Director 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 (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the 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

3.16.4 The above requirement for at least two (2) Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee)

3.16.5 Board Directors may participate (and vote) in its meetings by telephone, teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

3.17 **Meetings: Electronic Communication**

3.17.1 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

3.17.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board or of a standing committee or sub-committee of the Board shall be regarded for all purposes as being present and personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication

3.17.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair is physically present

3.17.4 Meetings held in accordance with this SO are subject to SO 3.16 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting

3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 The NHS Act 2006 provides for all the powers of the Trust to be exercised by the Board on its behalf. It also states that the Board may delegate any of its powers to a committee of Directors or to an Executive Director

4.2 Subject to such requirements, conditions, notices or guidance as may be given by Monitor, the Board may make arrangements in these SOs for the exercise, on behalf of the Board, of any of its functions by either a committee or an Executive Director

4.3 In each case subject to such restrictions and conditions as the Trust thinks fit

4.4 Where a function is delegated (as detailed in the Trust's SoRD, i.e. delegation to committees or officers) the Trust retains full responsibility

4.5 **Emergency Powers**

The powers which the Board has retained to itself within these SOs may in emergency situations be exercised by the Chief Executive or in his absence, the Deputy Chief Executive, provided that prior to taking such action, the Chief Executive has consulted with and gained the agreement of the Chair or in his absence, the Vice-Chair. Where time permits the Chair should contact all Board members in writing to allow the opportunity for objection. The exercise of such powers by the Chief Executive shall be reported to the next formal meeting of the Board held in public for ratification

4.6 **Delegation to Committees and Officers**

4.6.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with statute and such requirements, conditions, notices or guidance as may be given by Monitor. The constitution and terms of reference of these committees and their specific executive powers shall be approved by the Board

4.6.2 The Board may delegate certain functions of the Trust to an Executive Director

4.6.3 The Chief Executive shall prepare a detailed SoRD identifying the functions to be delegated to either an Executive Director or a committee of the Board. The proposals shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the detailed SoRD that shall be considered and approved by the Board as indicated above

4.6.4 Nothing in the SoRD shall restrict or limit the responsibility of the Executive Chief Finance Officer to provide information and advice to the Board in accordance with any statutory requirements, but subject to his discharge of these statutory requirements, the Executive Chief

Finance Officer shall be accountable to the Chief Executive for the performance of his role

4.6.5 The arrangements made by the Board as set out in the SoRD shall have effect as if incorporated in these SOs

4.7 **Non-compliance with the Standing Orders**
Full details of any non-compliance with these SOs together with the circumstances around the non-compliance shall be reported by the relevant Executive Director immediately to the Chair and the Chief Executive and to the next formal meeting of the Board for action and ratification. All staff have a duty to disclose any potential or impending non-compliance to their Executive Director, who in turn has a duty to report to the Chief Executive and the Chair as soon as possible.

5. COMMITTEES

5.1 The National Health Service Act 2006 states that:

5.1.1 The Board shall appoint an Audit Committee of Non-Executive Directors to perform such monitoring, reviewing and other functions as appropriate in accordance with this SO and the constitution paragraph 43

5.1.2 The Board shall appoint a Remuneration Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors in accordance with SO 2.10 and 2.11 and the constitution paragraph 37

5.2 Subject to the NHS Act 2006 and the regulatory framework and any such guidance as may be issued by Monitor, the Board may appoint standing committees of the Board (ref SO 4.6 Delegation to Committees and Officers)

5.3 The SOs of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. 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 term “member” 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 in public

5.5 Each such standing committee (including their sub-committees and working groups) shall have terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by Monitor. Such terms of reference shall have effect as if incorporated into the SOs.

5.6 Committees are authorised to establish sub-committees which shall operate as working groups and shall have no delegated executive powers from the Board or a committee of the Board

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted

5.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by Monitor and/or the law, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the regulations and directions made by Monitor and/or the law

5.9 The committees established by the Board are attached at Appendix A of the SOs

5.10 The Board may change the committees, without requirement to amend these SOs

5.11 A Board member or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board shall resolve that it is confidential

5.12 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests**

6.1.1 All Board members have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with interests of the Trust. Any Director who has an interest in a matter that he/she is required to declare in accordance with paragraph 36 of the Trust's constitution shall declare such interest to the Board and:

(a) shall withdraw from the meeting and play no part in the relevant discussion or decision; and
(b) shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

6.1.2 Details of any such interest shall be recorded in the Register of Interests of Board members. At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes. Any changes in interests should be declared in accordance with the requirements of paragraph of the Trust's constitution

6.1.3 Any Board member who fails to disclose any interest required to be disclosed under the preceding clause must permanently vacate their office if required to do so by a majority of the remaining Board

members and (in the case of a Non-Executive Director) by the requisite majority of the Council

6.1.4 Board members' directorships of companies which may conflict with their management responsibilities should be published in the Trust's annual report. As the Trust maintains a Register of Interests which is open to the public, the disclosure in the annual report may at the discretion of the Board, be limited to a comment on how access to the information in that Register may be obtained

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision

6.1.6 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Trust Secretary

6.2 **Register of Interests**

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members. In particular the Register will include details of all Directorships and other interests which have been declared by both Executive and Non-Executive Board members in accordance with paragraphs 36 and 40 of the Trust's constitution

6.2.2 The Trust Secretary will keep these details up to date by means of an annual review of the Register in which any changes to the interests declared during the preceding 12 (twelve) months will be incorporated. It is the responsibility of each member of the Board to provide an update to the Trust Secretary of their register entry if their interest changes

6.2.3 The Register will be available to the public and the Chief Executive 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

6.3 **Register of Gifts and Hospitality**

6.3.1 A Register of Gifts and Hospitality will be maintained by the Trust Secretary for Board members and staff

6.3.2 The Register will be published on the Trust's website in line with regulatory requirements.

7. CONFLICT OF INTEREST AND PECUNIARY INTEREST

7.1 **Disclosure of Interest**

Subject to the following provisions of this SO, if a Board member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall disclose that interest to the Board and/or meeting as soon as he becomes aware of it

7.2 **Conflict of Interest**
During the course of a Board meeting (or other meeting) if a conflict of interest is disclosed, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision

7.3 The Board may exclude the Director from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration

7.4 Any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director shall not be treated as a pecuniary interest by the Trust for the purpose of this SO

7.5 For the purpose of this SO, a Board member shall be treated, subject to SO 7.7, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.5.1 he, or a nominee of his, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.5.2 he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and, in the case of sibling, parent, child, cohabiting spouse or civil partner or person living together with them as partner, the interest of one shall, if known to the other, be deemed for the purposes of this SO to also be an interest of the other.

7.6 A Board member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.6.1 of his membership of a company or other body, if they have no beneficial interest in any securities of that company or other body

7.6.2 of an interest in any company, body or person with which he is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter

7.7 In the event that the Board member having an indirect pecuniary interest in a contract (including a proposed contract or other matter) by virtue of holding securities of the company concerned, then for the Board member to be able to participate in the consideration or discussion of the contract (or other matter), and vote on any question with respect to it, the following requirements need to be met:

7.7.1 If one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total nominal value of issued share capital of the company concerned; or

7.7.2 If more than one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total issued share capital of that class

However, it remains the responsibility of the individual to disclose his interest

7.8 This SO applies to a committee or sub-committee or a joint committee of the Board as it applies to the Board and applies to any such committee or sub-committee as it applies to a Director.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 All Board members must comply with the Trust's standards of business conduct policy as amended from time to time.

8.2 All Board members should comply with this SO 8, Appendix B national guidance contained in HSG 1993/5 *Standards of Business Conduct for NHS Staff*, the S*tandards for members of NHS boards and Clinical Commissioning Group governing bodies in England (November 2012)* included in Appendix C, the Trust's Counter Fraud Policy and Procedure and any such guidance issued by Monitor or the Department of Health and Social Care from time to time

8.3 **Interest of Officers in Contracts**

8.3.1 If it comes to the knowledge of an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein

8.3.2 An Officer should also declare to the Chief Executive in accordance with Trust procedure, any other employment, business or other relationship of theirs, or of a spouse/partner/other family member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust

8.3.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff, in accordance with Trust procedure

8.4 **Canvassing of, and Recommendations by, Board Members in Relation to Appointments**

8.4.1 Canvassing of Board members of the Trust or of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the contractor for such appointment. The contents of this provision of the SO shall be included in application forms or otherwise brought to the attention of contractors

8.4.2 A Board member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this clause of this SO shall not preclude a Board member from giving written testimonial of a contractor's ability, experience or character for submission to the Trust

8.4.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.5 **Relatives of Board Members or Officers**

8.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Board member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal

8.5.2 Every Board member and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Board member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made

8.5.3 On appointment, Board members (and prior to acceptance of an appointment in the case of officer Board members) should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust

8.5.4 Where the relationship to a Board member of the Trust is disclosed, SO 7 applies.

9. TENDERING AND CONTRACT PROCEDURE

9.1 **Duty to comply with Standing Orders and Standing Financial Instructions**

The procedures to be followed by the Trust in relation to all contract opportunities with the Trust and for awarding all contracts with the Trust shall comply with the SOs, SFIs, the financial limits specified in the detailed SoRD, and the Trust's Tendering & Quotation Policy and Procedure.

9.2 **Legislation Governing Public Procurement**

9.2.1 The Trust shall comply with the Public Contracts Regulations 2015 (the "Regulations") as applicable and any European Union (EU) Directives relating to EU procurement law having direct effect in England (the "Directives") and any other duties derived from EU Treaty ("Treaty Obligations") and any other duties derived from the UK common law ("Common Law Duties") and where applicable The National Health Service (Procurement, Patient Choice and Competition)(No.2) Regulations 2013 (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in those SOs as "Procurement Legislation"). The Procurement Legislation as from

time to time amended shall have effect as if incorporated in these SOs and the Trust's Standing Financial Instructions

9.2.2 The Trust should consider obtaining support from the NHS Supply Chain and/or the Cabinet Office where relevant and/or any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures)

9.2.3 The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity

9.2.4 When procuring services, the Trust should have regard to the requirements of the Public Services (Social Value) Act 2012 and its supporting regulations and guidance, as amended.

9.3 **Guidance on Procurement and Commissioning**

9.3.1 The Trust should have regard to all relevant guidance issued in relation to the conduct of procurement practice, including but not limited to:

(a) the Department of Health's "*Capital Investment Manual*" and "Estate Code" in respect of capital investment and estate and property transactions save where either has been superseded by later published guidance;
(b) policies and procedures in place for the control of all tendering activity, and
(c) in the case of management consultancy contracts the Department of Health guidance "*The Procurement and Management of Consultants within the NHS*" or any successor guidance issued by the Department of Health and Social Care;

or any successor to such guidance issued from time to time.

9.4 **Formal Competitive Tendering**

9.4.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any Procurement Legislation or as otherwise set out in the Trust's Tendering and Quotation Policy and Procedure and/or the DSoD

9.4.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive (except in (c) to (f) below) where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the minimum procurement

threshold for the purposes of the Regulations or any figures set by the Board, (this figure to be reviewed annually); or

(b) the supply is proposed under special arrangements negotiated by the DHSC or NHS England and ~~NHS~~ Improvement (NHSE/I) , to the extent that these arrangements comply with the Regulations and utilising them will not cause the Trust to breach any of its obligations arising pursuant to any Procurement Legislation, in which event the said special arrangements must be complied with; or

(c) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender and the relevant tests set out in the Regulations for such instances have been met; or

(d) specialist expertise is required and is available from only one source; or

(e) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate, in deciding if this provision can be relied on, the relevant/corresponding provision in the Regulations will need to be satisfied; or

(f) there is a working benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering, in deciding if this provision can be relied on the relevant/corresponding provision in the Regulations will need to be satisfied; or

(g) provided for in the Capital Investment Manual; or

(h) the supply of goods or services is covered by an NHS Framework Agreement or other Public Sector framework available to the trust, and the price is certain (i.e. quoted)

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure

Where it is decided that competitive tendering is not applicable and should be waived by virtue of (c) to (f) above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Executive Operational Committee. All such waivers should also be reported at the next available meeting of the Audit Committee

9.4.3 Except where SO 9.4.2, or a requirement under SO 9.2, applies, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required

9.4.4 Tendering procedures are set out in the Trust's Tendering & Quotation Procedure.

9.5 **Quotations**

9.5.1 Quotations are required where formal tendering procedures are waived under SO 9.4.2 (a) or (c) and where the intended expenditure is reasonably expected to exceed the financial limit specified in the DSoD

9.5.2 Where quotations are required under SO 9.5.1 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board

9.5.3 Quotations should normally be in writing, (subject to limits specified in SFIs and occasions when verbal quotes can be obtained)

9.5.4 All quotations should be treated as confidential and should be retained for inspection. A written record of verbal quotations should also be retained

9.5.5 The Chief Executive or the nominated officer (via the DSoD) should select the quotations which gives the best quality and value for money. If this is not the lowest cost then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record

9.5.6 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or the nominated officer, possible or desirable to obtain competitive quotations
(b) the goods/services are required urgently.

9.6 **Where tendering or competitive quotation is not required**

9.6.1 The Trust shall use NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

Competitive quotations should be sought for all expenditure in excess of the limit specified in the DSoD. However, there are a number of approved instances when three competitive quotes need not be sought as follows:

(a) Sole Supplier **-** specialist expertise is required and is available from only one source
(b) Agency/Consultancy Staff **-** where the goods/services purchased are staffing expertise or agency staff or expenditure in relation to training or training courses
(c) Part order of a tendered contract
(d) Specialist training course

(e) Specialist research

(f) NHS Framework Agreement or other Public Sector framework available to the trust – if the supply of goods or services is on a national framework agreement, and the price is certain (i.e. quoted).

A waiver form needs to be completed if one of these instances does not apply.

In the event that three competitive quotations cannot be obtained and none of the above reasons apply. This decision then needs to be reported to the next available meeting of the Audit Committee

9.6.2 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11).

9.7 **Private Finance/Procure 22**

The Trust may consider using PFI/Procure 22 when considering a capital procurement. When the Board proposes that PFI/Procure 22 be considered:

9.7.1 The Chief Executive shall demonstrate that the scheme represents value for money and genuinely transfers risk to the private sector

9.7.2 The proposal must be specifically agreed by the Board

9.7.3 Trust competitive tendering/quotations procedures should apply where necessary.

9.8 **Contracts**

9.8.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

(a) these SOs;
(b) the Trust's SFIs;
(c) EU Directives and other statutory provisions;
(d) any relevant and mandatory directions including Monitor's guidance on Risk Evaluation for Investment Decisions, the DoH's Capital Investment Manual, Estate Code and guidance on the Procurement and Management of Consultants;
(e) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.8.2 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.9 **Personnel and Agency or Temporary Staff Contracts**
The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

9.10 **Legally Binding Contracts (LBC) for the Provision of Healthcare**
Legally binding contracts for the supply of healthcare services shall be drawn up in accordance with legal advice, best practice and where possible use the NHS Standard model contract. These legally binding contracts will be administered by the Trust.

9.11 **Cancellation of Contracts**
Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

9.11.1 if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or

9.11.2 if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

9.11.3 if in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916, the Bribery Act 2010 and any other appropriate legislation.

9.12 **Determination of Contracts for Failure to Deliver Goods or Material**
There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

9.12.1 such default; or

9.12.2 in the event of the contract being wholly determined the goods or materials remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have

been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.13 **Contracts involving Funds Held on Trust** shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

10. DISPOSALS

10.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

10.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer

10.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust

10.1.3 items to be disposed of with an estimated sale value of less than £5,000

10.1.4 items arising from works of construction, demolition or site working, which should be dealt with in accordance with the relevant contract

10.1.5 land or buildings concerning which DoH or other statutory body guidance has been issued but subject to compliance with such guidance.

11. IN-HOUSE SERVICES

11.1 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

11.1.1 Specification group, comprising the Chief Executive or nominated officer/s and specialist

11.1.2 In-house tender group, comprising a nominee of the Chief Executive and technical support

11.1.3 Evaluation team, comprising normally a specialist officer, a supplies officer and the Executive Chief Finance Officer or their nominated representative. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team

11.2 All groups should work independently of each other. No officer is able to sit on both the in-house tender group and the evaluation group

11.3 The evaluation team shall make recommendations to the Executive Operational Sub-Committee and/or the Board, in accordance with the Trust's DSoD.

12. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal**
The common seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents**

12.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Chief Executive or Executive Chief Finance Officer

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Executive Chief Finance Officer (or an officer nominated by him and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Directorate).

12.3 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. The report shall detail the description of the document, the date of sealing and the names of persons who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

13. SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee with delegated authority.

14. MISCELLANEOUS

14.1 **Standing Orders to be given to Board Members and Officers**
It is the duty of the Chief Executive to ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

14.2 **Documents having the standing of Standing Orders**
SFIs, DSoD and the SoRD shall have effect as if incorporated into SOs.

14.3 **Review of Standing Orders**
SOs shall be reviewed annually by the Board. The requirement for review extends to all documents having the effect as if incorporated in SOs.

14.4 **Dispute Resolution**

14.4.1 Where there is a dispute between the Board of Directors and the Council of Governors, the procedure set out in the *Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance* should be referred to and followed

14.4.2 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

14.4.3 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

14.4.4 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.

15. RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

15.1 The Council has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its Licence. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the Trust. The Council is responsible for representing the interests of Trust members and the public and staff in the governance of the Trust. Governors must act in the best interests of the Trust and should adhere to its values and code of conduct. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty

15.2 Governors should discuss and agree with the Board how they will undertake these and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and

emerging good practice. Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts 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

15.3 Board members are to present to the Council at a general meeting the annual accounts, any report of the auditor on them, and the annual report

15.4 The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). The Trust will comply with the NHS Foundation Trust Annual Reporting Manual. The Council may request that a matter which relates to the annual accounts or forward planning for the Trust is included on the agenda for a meeting of the Board

15.5 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 nominated Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.

15.6 The annual report should include a statement from the Board on how performance evaluation of the Board, its committees and its Directors is conducted and the reason why the Trust adopted a particular method of performance evaluation

15.7 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 work hard 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 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

15.8 If the Council does not accept the Audit Committee's recommendation, 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

15.9 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors

15.10 In accordance with section A 1.1 of Monitor's *Code of Governance* (February 2014) the roles and responsibilities of the Council of Governors are set out in Appendix D.

16 OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, THE STANDING FINANCIAL INSTRUCTIONS, THE PROVIDER LICENCE AND THE NATIONAL HEALTH SERVICE ACT 2006

16.1 **Specific Policy Statements**
These SOs must be read in conjunction with the following policy statements and documents which shall have effect as if incorporated in these SOs:

16.1.1 the Standards of Business Conduct and Conflicts of Interest Policy for Trust staff

16.1.2 the Code of Conduct for Board Members

16.1.3 the Staff Disciplinary and Appeals Procedures

16.1.4 the SFIs adopted by the Board in accordance with all financial regulations, directions and guidance issued by Monitor and any other relevant body

16.1.5 the SoRD approved by the Board

16.1.6 Tendering and Quotations Procedure

16.1.7 the Trust's Counter Fraud Policy and Procedure

16.2 **Specific Guidance and Legislation**
These SOs must be read in conjunction with any directions and guidance issued by Monitor, the Department of Health and Social Care and any other relevant body and in accordance with the following:

- National Health Service Act 2006
- Health and Social Care Act 2012
- DH Caldicott Guardian Manual 2010 (and any subsequent versions)
- Human Rights Act 1998
- Freedom of Information Act 2000 and relevant guidance from the Information Commissioner Office
- Equality Act 2010
- Information Governance Toolkit July 2010 (and any subsequent versions)
- Bribery Act 2010
- Data Protection Act 1998 and relevant guidance from the Information Commissioner's Office
- Monitor's Code of Governance (December 2013) (and any subsequent versions)
- any other relevant legislation and guidance as applicable from time to time.

16.3 **Potential Inconsistency**

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in SO 16.2 above (the Legislation), 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.

Appendix A

COMMITTEES OF THE BOARD OF DIRECTORS

1. **Audit Committee**
2. **Charitable Funds Committee**
3. **Finance & Performance Committee**
4. ~~**Strategy and Planning Committee**~~**People, Innovation & Transformation Committee**
5. **Remuneration and Nominations Committee**
6. **Quality Committee**

Appendix B

STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF

1. Prevention of Corruption – Bribery Act 2010

1.1 The Trust has a responsibility to ensure that all Directors (and staff) are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

(a) bribing, or offering to bribe, another person (section 1);
(b) requesting, agreeing to receive, or accepting a bribe (section 2);
(c) bribing, or offering to bribe, a foreign public official (section 6);
(d) failing to prevent bribery (section 7)

1.2 All Directors (and staff) are required to be aware of the Bribery Act 2010 and should also refer to the remaining provisions in this Appendix B for further guidance in relation to this duty as well as any other national guidance.

2. NHS staff are expected to abide by the seven principles of public life (Nolan) at all times:

2.1 **SELFLESSNESS**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends

2.2 **INTEGRITY**: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties

2.3 **OBJECTIVITY:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

2.4 **ACCOUNTABILITY:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office

2.5 **OPENNESS:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

2.6 **HONESTY:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

2.7 **LEADERSHIP**: Holders of public office should promote and support these principles by leadership and example.

3. IMPLEMENTING THE GUIDING PRINCIPLES ABOVE:

Gifts

3.1 With the exception of items of little value (less than £5025) such as diaries, calendars, flowers and small tokens of appreciation (including seasonal gifts), which may be accepted, all offers of gifts should be declined. In cases of doubt, advice should be sought from your line manager. A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value. Any personal gift of cash or cash equivalents (e.g. tokens) must be declined whatever its value. All Directors (and staff) should report immediately all offers of unreasonably generous gifts to the Trust Secretary and return promptly any unacceptable gifts, with a letter politely explaining the terms of this policy and stating that you are not allowed to accept them.

Hospitality

3.2 Hospitality will be in accordance with Trust's policy on hospitality and sponsorship.

Raising concerns

3.3 It is the duty of every member of the Board (and staff) to speak up about genuine concerns in relation to criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and the cover up of any of these in the workplace. The Trust has a whistle-blowing policy that sets out the arrangements for raising and handling staff concerns. The procedure for reporting specific concerns relating to fraud are described below at 3.5.

Freedom to Speak Up

3.4 The Trust's Freedom to Speak Up Guardian is contactable by email and telephone and contact details are available on the Trust's intranet for all staff needing to raise a concern about patient or staff safety. For example, matters may be raised such as unsafe patient care; unsafe working conditions; inadequate induction or training for staff; lack of, or poor, response to a reported patient safety incident or a bullying culture across a team.

Counter fraud

3.5 All Directors (and staff) are required not to use their position to gain financial advantage. The Trust is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. The Trust's Directors (and staff) should inform the Executive Chief Finance Officer immediately, unless the Executive Chief Finance Officer is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken

3.6 The Trust's Directors (and staff) can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides

an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

3.7 Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The Executive Chief Finance Officer will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised

3.8 The Trust's Directors (and staff) should not ignore their suspicions, investigate themselves or tell colleagues or others about their suspicions.

Preferential treatment in private transactions

3.9 Individual Directors must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. (This does not apply to concessionary agreements negotiated with companies by the Directors, or by recognised staff interests on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts

3.10 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to the standards set out in Appendix B and are encouraged to also follow the professional standards set out in the Ethical Code of the Chartered Institute of Purchasing and Supply.

Favouritism in awarding contracts

3.11 Fair and open competition between prospective contractors or suppliers for all contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

3.11.1 no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.

3.11.2 each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

3.11.3 the Trust should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

3.12 The Trust will wish to ensure that all invitations to potential contractors to tender for NHS and non-NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

3.13 No Directors should engage in outside employment that may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area; the Trust will be responsible for judging whether the interests of patients could be harmed.

Intellectual property

3.14 The Board of Directors should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by the Trust's employees in the course of their duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Directors should build appropriate specifications and provisions into the contractual arrangements that they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases

3.15 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles

3.16 In the case of collaborative research and evaluative exercises with manufacturers, the Trust should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under their contract of

employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Standards of business

3.17 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to these standards; and

3.17.1 maintain the highest standard of integrity in all business relationships

3.17.2 reject any business practice which might reasonably be deemed improper

3.17.3 never use their authority or position for their own personal gain

3.17.4 enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way

3.17.5 foster the highest standards of professional competence amongst those for whom they are responsible

3.17.6 optimise the use of resources which they have influence over for the benefit of the organisation

3.17.7 comply with both the letter and the intent of: - the law of countries where the contracts are executed or as otherwise stated in the contracts - Chartered Institute of Purchasing and Supply guidance on professional practice

3.17.8 declare any personal interest that might affect, or be seen by others to affect, their impartiality or decision making

3.17.9 ensure that the information they give in the course of the work is accurate

3.17.10 respect the confidentiality of information they receive and never use it for personal gain

3.17.11 strive for genuine, fair and transparent competition

3.17.12 not accept inducements or gifts, other than items of small value such as business diaries or calendars

3.17.13 always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision

3.17.14 remain impartial in all business dealing and not be influenced by those with vested interests.

Appendix C

STANDARDS FOR MEMBERS OF NHS BOARDS AND CLINICAL COMMISSIONING GROUP GOVERNING BODIES IN ENGLAND

standards-for-memb
ers-of-nhs-boards-an

Appendix D

ROLES AND RESPONSIBILITIES OF THE COUNCIL OF GOVERNORS

The roles and responsibilities of the Council which are to be carried out in accordance with the constitution and the Trust's licence include:

General Duties

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. To represent the interests of the members of the Trust and the interests of the public.

Non-Executive Directors, Chief Executive and Auditor

3. To approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council

4. To approve the appointment and removal of the Chair and the Non-Executive Directors. The Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board

5. To approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the Remuneration Committee of the Council. All Non-Executive Directors and elected Governors should be submitted for re-appointment or re-election at regular intervals. The performance of Executive Directors should be subject to regular appraisal and review. The Council should ensure planned and progressive refreshing of the Non-Executive Directors

6. To set the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors on the recommendations of the Remuneration Committee of the Council. The Council should consult external professional advisers to market-test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive Director

7. To approve the appointment of a candidate as Chief Executive of the Trust recommended by the Non-Executive Directors

8. To approve the criteria for the appointment, removal and re-appointment of the auditor

9. To approve the appointment, removal and re-appointment of the auditor on the recommendation of the Audit Committee

Strategy Planning

10. To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate

11. To collaborate with the Board in the development of the forward plan

12. Where the forward plan contains a proposal that the Trust will carry out activity other than the provision of goods and services for the purpose of the NHS in England, to determine whether the proposal will interfere in the fulfilment by the Trust of its principal purpose and notify its determination to the Board

13. To approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the Trust

14. To approve entering into any significant transactions (as defined by the Board from time to time) in accordance with the 2006 Act and the constitution

15. To approve proposals from the Board for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

16. 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

17. 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

18. To prepare and from time to time review the Trust's membership engagement strategy and policy

19. To notify Monitor, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, if these concerns cannot be resolved at local level

20. To report to the members annually on the performance of the Council

21. To promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy

22. To seek the views of stakeholders and feed back to the Board.

Essex Partnership University
NHS Foundation Trust

Appendix 2

STANDING FINANCIAL INSTRUCTIONS

POLICY NUMBER	FP10
VERSION NUMBER	3
REPLACES SEPT DOCUMENT	SEPTFP10
REPLACES NEP DOCUMENT	NEP Standing Financial Instructions
KEY CHANGES FROM PREVIOUS VERSION	Not applicable
AUTHOR	Head of Financial Accounts
CONSULTATION GROUPS	Audit Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 18 (GDPR), September 2018, September 2019, September 2020
LAST REVIEW DATE	~~September 2018~~September 2019
NEXT REVIEW DATE	September ~~2020~~2021
APPROVAL BY	Audit Committee
RATIFIED BY	Not applicable
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POLICY SUMMARY
THIS DOCUMENT PROVIDES A BUSINESS AND FINANCIAL FRAMEWORK WITHIN WHICH ALL OFFICERS OF THE TRUST ARE EXPECTED TO WORK. THIS DOCUMENT SHOULD BE READ IN CONJUNCTION WITH THE TRUST'S CONSTITUTION, SCHEME OF DELEGATIONS AND SUPPORTING FINANCE PROCEDURES. FAILURE TO COMPLY CAN RESULT IN DISCIPLINARY ACTION.
The Trust monitors the implementation of an compliance with this policy in the following ways:
INTERNAL AUDIT WORKPLAN EXTERNAL AUDIT WORKPLAN LOCAL COUNTER FRAUD SPECIALIST AUDIT COMMITTEE

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance & Resources Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

CONTENTS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

FOREWORD:

These Standing Financial Instructions (SFIs) together with the Essex Partnership University NHS Foundation Trust's (the NHSFT) Constitution, and Standing Orders, provide a business and financial framework within which all Executive Directors, Directors, Non-Executive Directors and officers of the NHS Foundation Trust will be expected to work. All Executive Directors, Non-Executive Directors, Directors and other members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These documents fulfil the dual role of protecting the interests of the NHSFT and protecting staff from any possible accusation that they have acted less than properly.

In addition to the Standing Orders and SFIs, there is a Detailed Scheme of Delegation, a Schedule of Decisions Reserved to the Board, Finance Procedures and locally generated rules and instructions. Existing Finance Procedures, Procedure Notes and locally generated rules and instructions shall apply until these are revised (except where specifically overruled by these SFIs).

The SFIs have been formally adopted by the Board of Directors, and shall have effect as if incorporated in the standing orders.

Any queries regarding the contents of this document should in the first instance be raised with the Finance Manager responsible for your area.

Executive Chief Finance Officer
September ~~2019~~2020

1 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the NHSFT. They are designed to ensure that financial transactions are carried out in accordance with the law, Government policy and the requirements of NHS Improvement (NHSI), in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved for the Board and the Scheme of Delegation adopted by the Board of Directors.

1.1.2 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They are not intended to provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All Trust wide financial policies and procedures must be approved by the Audit Committee on the recommendation of the Executive Chief Finance Officer.**

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Executive Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar and comply with the provisions of the Trust's Standing Orders.

1.1.4 FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER THAT COULD RESULT IN DISMISSAL.

1.1.5 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Chief Finance Officer at the earliest opportunity.

1.1.6 The NHSFT may be responsible for providing shared financial and other corporate services to other NHS organisations.

The specific services to be provided will be defined in legally binding contracts between the NHSFT and the receiving organisation. Where these contracts do not cover a specific matter, the NHSFT's Standing Orders, Standing Financial Instructions and Scheme of Delegation will take precedence.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Financial Directions made under the Acts shall have the same meaning in these instructions; and

(a) **"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. For the Trust, this is the Chief Executive;

(b) **"Board of Directors" or "Board"** means the Trust Chair, Executive and Non-Executive directors of the NHSFT collectively as a body in accordance with the constitution;

(c) **"Board Member"** means Executive or Non-Executive Director including the Trust Chair and Chief Executive.

(d) **"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the NHSFT;

(e) **"Budget Holder**" means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

(f) "**Chairman / Chair of the Board / Trust Chair"** is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the NHSFT as a whole. The expression of "Trust Chair" shall be deemed to include the Vice-Chair if the Trust Chair is absent from the meeting or otherwise unavailable;

(g) **"Chief Executive"** means the chief officer and accounting officer of the NHSFT;

(h) **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the NHSFT within available resources;

(i) **"Committee"** means a sub-committee of the Board of Directors;

(j) **"Constitution"** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act;

(k) **"Council of Governors"** means the Council of Governors of the NHSFT as described in the constitution of the NHSFT;

(l) **"Deputy Chief Executive"** means the Officer of the Trust nominated by the Chief Executive to act as their Deputy;

(m) **"Director"** means a Director of a service who does not hold Executive Director status, and therefore is not a member of the Board of Directors. This includes staff at Director level and who directly report into an Executive Director but may not have Director explicitly stated in their job title, eg Deputy Chief Finance Officer.

(n) **"Executive Chief Finance Officer"** means the chief financial officer of the Trust;

(o) **"Executive Director"** means a member of the Board of Directors who holds an executive office of the NHSFT;

(p) **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable;

(q) **"Legal Adviser"** means the properly qualified person appointed by the NHSFT to provide legal advice;

(r) **"Monitor"** means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;

(s) **"NHSI"** means the office or an officer of NHS Improvement

(t) **"Nominated Officer"** means an officer charged with the responsibility of discharging specific tasks under the Scheme of Reservation and Delegation;

(u) **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the NHSFT and is appointed by the Council of Governors;

(v) **"NHS Act"** means the National Health Service Act 2006 as amended by the Health and Social Act 2012

(w) **"NHSFT" or "Corporation"** means the Essex Partnership University NHS Foundation Trust constituted as a public benefit corporation in accordance with the National Health Service Act 2006;

(x) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust. This also includes employees of third parties contracted and seconded from other organisations when acting on behalf of the NHSFT;

(y) **"Principle Purpose"** means the delivery of goods and services for the purposes of the health service in England, as per Section 164 of the Health and Social Care Act 2012**.**

1.2.2 Wherever the title Chief Executive, Executive Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them or act on their behalf.

1.2.3 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.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Reservation of Powers to the Board document.

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Board of Directors.

1.3.3 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accounting Officer accountable to Parliament, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Trust Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.4 The Chief Executive and the Executive Chief Finance Officer will delegate specific responsibilities, but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that systems and processes are in place so that the Board of Directors and other employees are notified and understand their responsibilities within these Instructions.

1.3.6 The Executive Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

(d) advising the Board of Directors regarding the financial performance, legality and vitality of the Trust

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Chief Finance Officer include:

(e) the provision of financial advice to other members of the Board of Directors and employees;

(f) the design, implementation and supervision of systems of internal financial control; and

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the NHSFT may require for the purpose of carrying out its statutory duties.

1.3.7 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the NHSFT;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Finance Procedures and the Schemes of Delegation.

1.3.8 Any contractor or employee of a contractor who is empowered by the NHSFT to commit the NHSFT to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Executive Chief Finance Officer.

2 AUDIT

2.1 AUDIT COMMITTEE

The National Health Service Act 2006 specifies that auditors of NHSFTs shall comply with the directions of Monitor under paragraph 24 (5) of Schedule 1 to the Act with respect to the standards, procedures and techniques to be adopted.

2.1.1 In accordance with Standing Orders (and as set out in the National Health Service Act 2006) the Board of Directors shall formally establish an Audit Committee, comprising of Non-Executive Directors, with clearly defined formal terms of reference. The role of the Audit Committee will be to provide an independent and objective review of governance and assurance processes and arrangements.

2.1.2 The Board of Directors shall satisfy itself that the Chairman and members of the Audit Committee have recent and relevant financial experience or have appropriate training.

2.1.3 The Audit Committee must assess the work and fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable.

2.1.4 The Audit Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the external auditors. If the work has been satisfactory and the charges reasonable, the Council of Governors may re-appoint the auditors for the following year without the need for a formal selection process. However, in line with National Audit Office Audit Code and the Local Audit and Accountability Act 2014 (LAAA), the NHSFT will undertake a market-testing exercise for the appointment of the external auditors at least once every 5 years.

2.1.5 Where the Audit Committee considers there is evidence of ultra vires transactions, improper acts, or other important matters that the committee feel it is justified to escalate, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to Monitor having been raised with the Executive Chief Finance Officer and Accounting Officer.

2.1.6 The Executive Chief Finance Officer and the Audit Committee shall be involved in the selection process when/if an audit service provider is changed.

2.2 EXECUTIVE CHIEF FINANCE OFFICER

2.2.1 The Executive Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the purpose, authority and responsibility of internal audit is formally defined by the NSHFT in the Terms of Engagement with regard to professional best practice;

(c) deciding at what stage to involve the police in cases of misappropriation, in consultation with the LSMS, and other irregularities not involving fraud or corruption. Where fraud and corruption is suspected and in consultation with the Local Counter Fraud Specialist, any irregularities should be investigated as appropriate.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear opinion on the effectiveness of internal financial control, risk management and organisational controls;
(ii) major internal control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

(e) Ensuring that the Chief Internal Auditor delivers an annual audit opinion on the effectiveness of the system of internal control.

2.2.2 The Executive Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the NHSFT;

(c) the production of any cash, stores or other property of the NHSFT under a member of the Board and employee's control; and

(d) explanations concerning any matter under investigation.

2.3 AUDIT

(A) ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will, in accordance with recognised professional best practice and as included in the agreed plan for the year, review, appraise and report upon:

(a) the extent to which the achievement of the NHSFTs objectives are monitored;

(b) the extent of compliance with, and the financial effect of risk associated with, relevant established policies, plans and procedures;

(c) the adequacy, efficiency and application of financial and other related management controls;

(d) the suitability and effective usage of financial and other related management data;

(e) the extent to which the NHSFT's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

(f) Internal Audit will produce an annual audit opinion on the effectiveness of the systems of internal control

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Chief Finance Officer must be notified immediately. (See also SFI 13 – Disposals and Condemnations, Losses and Special Payments).

2.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the NHSFT.

2.3.4 The Chief Internal Auditor shall report directly to the Executive Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take the necessary remedial action within a reasonable period shall be reported to the Executive Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit the Chief Internal Auditor shall have access to report directly to the Audit Committee.

2.3.5 The Chief Internal Auditor shall co-ordinate internal audit plans and activities with line managers of the function being audited, external audit and other review agencies to ensure the most effective audit coverage is achieved and publication of effort is minimised.

2.3.6 The NHSFT will provide the Chief Internal Auditor with every facility and information which is reasonably required for the purposes of the functions under the terms of engagement.

(B) EXTERNAL AUDIT:

2.3.7 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors (also refer to 2.1.4 above).

2.3.8 The initial appointment must be made as soon as possible and no later than the end of the first period for which the NHSFT will be preparing accounts.

2.3.9 The NHSFT must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the NAO Code of Audit Practice and the Local Audit and Accountability Act 2014 (LAAA).

2.3.10 The external audit responsibilities (in compliance with the requirements of Monitor and NHSI) are as follows:

1. to be satisfied that the accounts comply with the directions provided including compliance with the NHS Foundation Trust Annual Reporting Manual and the DH Group Accounting Manual (where relevant)
2. to be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts
3. to be satisfied that proper practices have been observed in compiling the accounts
4. to be satisfied the quality report has been prepared in accordance with the detailed guidance issued by NHSI
5. to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources
6. to comply with any directions given by NHSI as to the standards, procedures and techniques to be adopted, i.e. to comply with the NAO Code of Audit Practice and LAAA 2014.
7. to consider the issue of a public interest report
8. to certify the completion of the audit
9. to express an opinion on the accounts
10. to refer the matter to NHSI if the NHSFT, or an officer or Board Director of the NHSFT, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.
11. to read the monthly / quarterly reports required under NHSI's Single Oversight Framework, the quality report, annual report and comparing the information to ensure there are no material inconsistences;
12. to review reports arising from Care Quality Commission planned and responsive reviews of the NHSFT and any consequent action plans developed by the NHSFT.

2.3.11 External auditors will ensure that there is a minimum of duplication of effort between themselves and relevant regulators. The auditors will discharge this responsibility by:

1. reviewing the statement made by the Chief Executive as part of the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the NHSFT

2. reviewing the results of the work of relevant assurors, for example the Care Quality Commission, to determine if the results of the work have an impact on their responsibilities
3. undertake any other work that they feel necessary to discharge their responsibilities

2.3.12 The NHSFT will provide the external auditor with every facility and all information which they may reasonably require for the purposes of their functions under Part 1 of the 2006 Act

2.3.13 The NHSFT shall forward a report to NHSI within 30 days (or such shorter period as may be specified) of the external auditor issuing a public interest report in terms of Schedule 5 paragraph 3 of the Act. The report shall include details of the NHSFT's response to the issues raised within the public interest report.

2.4 FRAUD, BRIBERY AND CORRUPTION

2.4.1 In line with their responsibilities, the Trust's Chief Executive and Executive Chief Finance Officer shall monitor and ensure compliance with best practice on prevention of fraud, bribery and corruption.

2.4.2 The Executive Chief Finance Officer shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust's Executive Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

2.4.4 The Executive Chief Finance Officer is responsible for providing detailed procedures to enable the NHSFT to minimise and where possible, eliminate fraud and corruption. These procedures are included in the NHSFT's Fraud and Bribery Policy which sets out action to be taken by persons detecting a suspected fraud and responsibilities for investigating it.

2.4.5 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the NHSFT is accountable to, through:

1. encouraging prevention;
2. promoting detection; and,
3. ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

2.4.6 Proven instances of fraud, theft and corruption shall normally be dealt with as gross misconduct under the NHSFT's disciplinary policies and procedures.

2.4.7 It is expected that all officers shall act with utmost integrity, ensuring adherence to all relevant regulations and procedures. This responsibility has been delegated to the Executive Chief Finance Officer who will produce and issue these to the appropriate Directors and managers who should in turn ensure that all staff have access to these.

2.4.8 The Executive Director with the portfolio of Human Resources is responsible for ensuring that steps are taken at recruitment stage to establish, as far as possible, the previous record of potential officers in terms of their propriety and integrity.

2.4.9 Staff are expected to act in accordance with the NHSFT's Standing Orders, Standing Financial Instructions and the Standards of Conduct (outlined in HRPG27a Appendix 2).

2.4.10 The Bribery Act 2010 replaced the "Prevention of Corruption Acts 1906 and 1916" with new corporate and individual offences of bribery. The Executive Chief Finance Officer is responsible for ensuring that all staff and contractors are made aware of the Act and implementing procedures designed to ensure compliance with the Act by the Trust and staff. Any breach of the Act may result in criminal proceedings being commenced.

2.4.11 Non-Executive Directors are subject to the same standards of accountability and are required to declare and register any interest which might potentially conflict with those of the NHSFT.

2.4.12 The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls, and evaluate the implication of fraud on the system of risk management, control and governance, reported to the Audit Committee.

2.4.13 Staff employed by the NHSFT are encouraged to raise any concerns they may have regarding suspected fraud and/or corruption (Please refer to the Fraud and Bribery Policy and the NHSFT's Raising Concerns (Whistle Blowing) Policy). They can do this through:

1. their line manager;
2. Internal Audit;
3. the Executive Chief Finance Officer;
4. The NHSFT's Local Counter Fraud Specialist; or,
5. the NHS National Fraud Hotline.

2.4.14 Any abuse of the procedures, such as unfounded or malicious allegations, will also be subject to full investigation and appropriate disciplinary action where appropriate.

2.5 SECURITY MANAGEMENT

2.5.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with best practice on NHS security management.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.5.3 The Trust shall consider the need for a nomination of a Non-Executive Director to be responsible to the Board for NHS security management.

2.5.4 The Trust shall prepare a Security Policy that sets out measures to protect staff, visitors, premises and assets.

2.5.5 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Executive Director with the lead for Security Management and the appointed Local Security Management Specialist (LSMS).

3 ANNUAL PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 PREPARATION AND APPROVAL OF ANNUAL PLANS AND BUDGETS

3.1.2 The Chief Executive will compile and submit to the Board of Directors an Operational Plan in a format prescribed by NHSI which takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans. The Operational Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan;

(c) and, have due regard to the views of the Council of Governors, including confirmation by the Council of Governors that they are satisfied that any activities undertaken by the NHSFT for non-primary purposes will not to any significant extent, interfere with the fulfilment of their principle purpose or other functions.

3.1.3 Prior to the start of the financial year the Executive Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets to the Board of Directors for approval. These budgets may subsequently be amended as a result of the preparation of the Operational Plan, and any such changes should be reported to the Board at the earliest opportunity. Such budgets will:

(a) include income, revenue operational expenditure and capital expenditure which will:

(i) be in accordance with the aims and objectives set out in the Operational Plan;
(ii) accord with workload and manpower plans;
(iii) take account of capital receipts, as well as plans set out in the Trust's Operational and Strategic Plans.

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the limits of available funds; and

(d) identify potential risks, and mitigating strategies.

3.1.4 The Executive Chief Finance Officer shall monitor financial performance against budget and the operational plan, including activity, workforce and other targets. These shall be periodically reviewed, and reported to the Board of Directors at every ordinary meeting of the Board.

3.1.5 All budget holders must provide information as required by the Executive Chief Finance Officer to enable budgets, plans, estimates and forecasts to be compiled.

3.1.6 The Executive Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage resources successfully.

3.1.7 The Board of Directors must take appropriate action to manage and overcome, where possible, any potential operational deficit and decide on the appropriate use of any forecast operational surplus.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and will normally form part of individual job descriptions. Through the annual budget setting and approval process, budget holders will be set:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Executive Chief Finance Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) Detailed monthly financial reports to the Executive Operational Committee and Finance and Performance Committee, and monthly financial assurance reports to the Board of Directors. Finance reports to the Executive Operational Committee and Finance and Performance Committee will be in a format agreed with the Executive Chief Finance Officer and may include the following:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) summary cash flow and forecast year-end position;

(iii) capital project spend, projected outturn against plan and fixed asset disposals;
(iv) explanations of any material variances that explain any movement from the plan at the end of the current month position;
(v) performance against NHSI monitoring ratings currently in force (eg, Use of Resources Risk Rating) ~~(for the purpose of monitoring returns to NHSI)~~;
(vi) Any changes to key financial assumptions underpinning the operational and strategic plans;
(vii) The use of working capital facilities and the management of working capital (if applicable);
(viii) Debtor and Creditor days against assumptions in forecasts;
(ix) Other key balance sheet performance as required:
(x) Details of any corrective action where necessary and the Chief Executive's and/or Executive Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed in excess of available resources as approved by the Board of Directors, without the approval of the Chief Executive and,

(d) ensuring compliance with the systems of budgetary control established by the Executive Chief Finance Officer.

(e) budgetary virements are only undertaken in line with the Detailed Scheme of Delegation

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operational Plan and the Strategic Plan as authorised by the Board of Directors.

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3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 11.)

3.5 FINANCIAL PERFORMANCE AND MONITORING:

3.5.1 The Chief Executive is responsible for ensuring that:

1. financial performance measures have been defined and are monitored;
2. reasonable targets have been identified for these measures;
3. a robust system is in place for managing performance against targets;
4. reporting lines are in place to ensure overall performance is managed;
5. arrangements are in place to manage/respond to adverse performance; and,
6. relevant financial information is submitted to the statutory authorities and other relevant organisations (eg STP's).

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Executive Chief Finance Officer, on behalf of the NHSFT, will:

(a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSI may, with the approval of the Treasury direct;

(b) ensure that, in preparing annual accounts, the NHSFT complies with any directions given by NHSI with the approval of the Treasury as to:

1. the methods and principles according to which the accounts are to be prepared; and
2. the information to be given in the accounts.

(c) ensure that a copy of the annual accounts and annual report and any report of the external auditor on them, are laid before Parliament and that copies of these documents are sent to NHSI as required in the Annual Reporting Manual for Foundation Trusts.

4.2 The NHSFT will prepare a combined annual report and accounts as required by paragraph 26 of Schedule 1 of the Act. This will be presented to the Board of Directors for approval and received by the Council of Governors at a public meeting. A copy will be forwarded to NHSI. The report will give:

(a) Information on any steps taken by the NHSFT to ensure (taken as a whole) the actual membership of its public constituency is representative of those eligible for such membership;
(b) Information explaining the impact of any non-primary purpose income on the delivery of goods and services for their principle purpose (i.e. the delivery of goods and services for purposes of health services in England); and
(c) Any other information required by NHSI.

5 BANK ACCOUNTS – ALSO REFER TO SFI 10: EXTERNAL BORROWING AND INVESTMENTS.

5.1 GENERAL

5.1.1 The Executive Chief Finance Officer is responsible for managing the NHSFT's banking arrangements and for advising the NHSFT on the provision of banking services, operation of accounts, financing and working capital facilities.

5.1.2 The Board of Directors shall approve the banking arrangements, financing and working capital facilities.

5.2 BANK ACCOUNTS AND WORKING CAPITAL FACILITIES

5.2.1 The Executive Chief Finance Officer is responsible for:

(a) bank accounts, financing and working capital facilities;

(b) establishing separate bank accounts for the NHSFT's non-exchequer funds;

(c) reporting to the Board of Directors when working capital facilities are committed, liquidity headroom calculations, details of potential drawdown's and when accounts are overdrawn;

5.3 BANKING PROCEDURES

5.3.1 The Executive Chief Finance Officer will prepare detailed instructions on the operation of bank accounts that must include:

(a) the conditions under which each bank account is to be operated;
(b) those authorised to sign cheques or other orders drawn on the NHSFT's accounts and limitations on single signatory payments
(c) Committed working capital facility approved by the Board of Directors to be operated under the terms and conditions agreed with the bank and approved by the Board of Directors;

5.3.2 The Executive Chief Finance Officer must advise the NHSFT's bankers in writing of the conditions under which each account will be operated.

5.3.3 All funds shall be held in accounts in the name of the NHSFT. No officer other than the Executive Chief Finance Officer shall open any bank account in the name of the NHSFT.

5.4 TENDERING AND REVIEW

5.4.1 The commercial banking arrangements of the Trust should be reviewed at regular intervals by the Executive Chief Finance Officer to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business, where appropriate.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Executive Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The Executive Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Executive Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in-kind such as subsidised goods or loans of equipment) is considered, the NHSFT's policies on these matters shall be followed.

6.2.2 In receiving cash payments, the Trust should adhere to the maximum value for a single transaction as specified in the Money Laundering Regulations.

6.2.3 All employees must inform the Executive Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Executive Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Executive Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of

safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the NHSFT.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor “IOUs.”

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Chief Finance Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the NHSFT is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the NHSFT from responsibility for any loss. A senior officer within each area responsible for holding cash, in discussion with the finance department, should ensure there are suitably secure arrangements in place to minimise the risk of loss.

6.5 INCOME FROM NON-PRINCIPAL PURPOSES

6.5.1 The Executive Chief Finance Officer is responsible for monitoring and reporting to the Board of Directors that the NHSFT is complying with its obligation under that the Health and Social Care Act 2012 that the total income derived from its principal purpose (i.e. the delivery of goods and services for the purposes of the health service in England) is greater than its total income from the provision of goods and services for "any other purposes" including the provision of private healthcare.

6.5.2 The Executive Chief Finance Officer is responsible for ensuring that the approval of the Council of Governors is obtained when it is proposed to increase by 5% or more the proportion of income derived from the provision of goods and services for non-primary purposes.

7 CONTRACTS WITH COMMISSIONERS:

7.1 The Chief Executive supported by the Directors holding the portfolios of Finance, Operational Services and Contracting, are responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the Operational and Strategic Plans.

7.2 Contracts with commissioners shall be devised to minimise risk. The contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract should be considered.

7.3 In carrying out these functions, the following should be taken into account:

1. activity (e.g. bed days, attendances, etc. attached to the legally binding contracts);
2. payment terms and conditions;
3. billing systems and cash flow management;
4. any other matters of a financial nature;
5. the contract negotiation process and timetable;
6. the provision of contract data;
7. monitoring arrangements;
8. amendments to contracts;
9. discretion to use spare capacity; and
10. any other matter relating to contracts such as joint responsibility for the delivery and achievement of CIPs, QIPPs etc.
11. any requirements of the NHS Constitution.

7.4 Regular reports detailing actual performance against signed contracts should be provided to the Board of Directors by the Directors holding the portfolios of Finance and Performance.

7.5 As required by the NHSFT's Terms of Authorisation, the NHSFT will maintain a public and up-to-date schedule of Commissioner Requested Services.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

8.1 REMUNERATION AND TERMS OF SERVICE

8.1.1 In accordance with Standing Orders, the Board of Directors shall establish a Remuneration Committee for Executive Directors with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will:

a) advise the Board of Directors of their decisions in relation to the remuneration and terms of service for the Chief Executive and Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms;

b) monitor and evaluate the performance of the Chief Executive and Executive Directors

8.2 STAFF APPOINTMENTS

8.2.1 No Executive Director or employee may engage, or re-engage employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

8.2.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees covered under the national Agenda for Change pay rates.

8.3 PROCESSING PAYROLL

8.3.1 The Executive Director with responsibility for Workforce and Payroll, together with support from the Executive Chief Finance Officer where appropriate, is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.3.2 The Executive Director with responsibility for Workforce and Payroll, together with support from the Executive Chief Finance Officer where appropriate, will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the NHSFT.

8.3.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the relevant Executive Directors instructions and in the form prescribed by the Executive Director with responsibility for Workforce and Payroll; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement.

(d) Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director with the portfolio of Human Resources must be informed immediately.

8.3.4 Regardless of the arrangements for providing the payroll service, the Executive Director with responsibility for Workforce and Payroll shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4 CONTRACTS OF EMPLOYMENT

8.4.1 The Board of Directors shall delegate responsibility to the Executive Director holding the portfolio of Human Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

8.5 PAYMENTS TO INDIVIDUALS WHO ARE NOT EMPLOYEES OF THE TRUST

8.5.1 The Executive Chief Finance Officer is responsible for issuing instructions to managers concerning:

(a) Making payments of agency invoices
(b) Making payments to self-employed individuals

(c) Making payments to limited companies
(d) Additional compliance requirements to be followed in assessing the employment status of individuals who are not employees of the Trust.

9 NON PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services; and

(b) the maximum approval value for each manager and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the NHSFT. In so doing, the advice of the NHSFT's adviser on supply shall be sought, and policies and procedures on procurement are to be followed at all times. Where this advice is not acceptable to the requisitioner, the Executive Chief Finance Officer (and/or the Chief Executive) shall be consulted.

9.2.2 The Executive Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

9.2.3 The Executive Chief Finance Officer will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;
(b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;
(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment;

- VAT is appropriately accounted for.

(iii) A timetable and system for submission to the Executive Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Where material (and not agreed under the terms of the contract or licensing arrangements), prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages i.e. cashflows must be discounted to NPV using the base rate specified by the Executive Chief Finance Officer.

(b) the appropriate Executive Director must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the NHSFT if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(c) the Executive Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Executive Chief Finance Officer;

(c) state the NHSFT's terms and conditions of trade; and

(d) only be issued to, used by or electronic access granted, to those duly authorised by the Chief Executive,

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Executive Chief Finance Officer and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are actioned as per the NHSFT's procedures on Losses;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement and comply with the latest Public Sector Procurement Directives. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(c) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) hospitality as per the Trust's policy

(d) no requisition/order is placed for any item or items which cannot be accommodated within total available resources;

(e) all goods, services, or works are ordered on an official order except those detailed on the 'PO Exceptions List' which is maintained by the Purchasing Department. This includes for example: purchases from petty cash, purchase cards, agency payments for staff and utility invoices where it is deemed that alternative control mechanisms are in place. The Executive Chief Finance Officer or their nominated Deputy should review the 'PO Exceptions List' on an annual basis and ensure, where possible, these are minimised;

(f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Executive Chief Finance Officer;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Chief Finance Officer ; and

(k) petty cash records are maintained in a form as determined by the Executive Chief Finance Officer.

9.2.7 The Chief Executive and Executive Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

10 EXTERNAL BORROWING AND INVESTMENTS

10.1 The Executive Chief Finance Officer will be responsible for the management of the NHSFT's cashflow.

10.2 EXTERNAL BORROWING

10.2.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the NHSFT's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The Executive Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest.

10.2.3 Any application for new borrowing will only be made by the Executive Chief Finance Officer or by an officer so delegated by them. The Board of Directors is required to approve the acceptance of all external borrowing agreements.

10.2.4 The Executive Chief Finance Officer will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by Monitor.

10.2.5 Assets supporting Commissioner Requested Services (CRS) shall not be used as collateral for borrowing. Non-Commissioner Requested assets will be eligible as security for a loan.

10.3 INVESTMENTS

10.3.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by Monitor in accordance with the NHSFT's Operating Cash Management Policy.

10.3.2 The Executive Chief Finance Officer is responsible for advising the Board of Directors on investment strategy and shall report periodically to the Board of Directors concerning the performance of investments held.

10.3.3 The Executive Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained as specified in the NHSFT Operating Cash Management Policy.

11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The Chief Executive, supported by the Executive Chief Finance Officer:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is prepared in accordance with the detailed scheme of delegation issued by the Chief Executive on the advice of the Executive Chief Finance Officer and approved by the Board of Directors. Where the financial value outlined in the detailed scheme of delegation is met, the Chief Executive supported by the Executive Chief Finance Officer shall ensure that a business case (in line with the guidance contained within the Capital Accounting manual and Risk Evaluation for Investment Decisions guidance issued by Monitor) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(b) that the Executive Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and where required is submitted to the Board of Directors in accordance with the scheme of delegation;

(c) business cases requiring legal and tax expertise have been subjected to appraisal by the NHSFTs legal and tax advisor or the most appropriate legal and tax advice.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Executive Chief Finance Officer will ensure there are processes in place for their management.

The Executive Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Executive Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.4 The approval of a capital programme by the Board of Directors shall not constitute approval for the initiation of expenditure on any scheme. The approval of the capital programme by the Board of Directors will include the approval of broad allocations to IT, Safety and Ligature, Backlog Maintenance, and Equipment for example, as well as allocations to specific schemes subject to option appraisals/business cases being prepared.

The initiation of expenditure will be approved by the Executive Chief Finance Officer, the Chief Executive, or the People, Innovation and Transformation ~~Strategy and Planning Committee~~ as per the limits specified in the detailed scheme of delegation. Each manager responsible for any scheme will be granted;

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.1.5 The Executive Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 **PRIVATE FINANCE**

11.2.1 The Trust may test for PFI when considering capital procurement. When the Trust proposes to use finance that is to be provided other than through its contracts, the following procedures shall apply:

(a) The Executive Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board.

11.3 **PROCURE 22**

11.3.1 NHS ProCure 22 has been developed by the Department of Health with the objective of promoting better capital procurement in the NHS.

11.3.2 The Trust may consider P22 as a possible procurement route when considering building projects above the amount specified in the scheme of delegation.

11.3.3 When the Board proposed, or is required, to use the P22 procurement route, the following should apply:

(a) The Chief Executive and Executive Chief Finance Officer shall demonstrate that the use of P22 represents the best combination of value for money, project delivery time, and build quality, when compared with alternative procurement routes.

(b) The proposal must be specifically agreed by the Board.

The selection of a Principle Supply Chairman Partner (PSCP) must be carried out in accordance with Department of Health guidelines

11.4 ASSET REGISTERS

11.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.4.2 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

11.4.3 The NHSFT must not dispose of any property that supports a Commissioner Requested Service (CRS) without the agreement of the Trust's main commissioner and notification to NHSI, where Monitor has given notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. This includes the disposal of part of the property or

granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.4.4 The Executive Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in the statement of financial position against balances on fixed asset registers.

11.4.5 All land and buildings should undergo an interim revaluation every third year, and a formal revaluation every five years, in accordance with guidance issued by Monitor. Investment properties are revalued on an annual basis.

11.4.6 The value of each asset shall be depreciated using agreed methods and asset lives.

11.4.7 The Executive Chief Finance Officer of the Trust shall calculate and charge capital charges in the form of depreciation and PDC dividends, to the Trust's expenditure budget each month. The Executive Chief Finance Officer shall ensure PDC dividends are paid to HM Treasury in accordance with guidance.

11.4.8 The Board of Directors may approve the disposal of non-CRS assets to raise funds for the development of services.

11.5 SECURITY OF ASSETS

11.5.1 The overall control of fixed assets is the responsibility of the Chief Executive, as advised by the Executive Chief Finance Officer for the accounting aspects and for the physical management and control

11.5.2 Asset control procedures must be approved by the Executive Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to / approved by the Deputy Chief Finance Officer or Executive Chief Finance Officer and noted to / approved by the Audit Committee as per the Detailed Scheme of Delegation.

11.5.4 Whilst each employee and officer has a responsibility for the security of property of the NHSFT, it is the responsibility of the Board of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to the property of the NHSFT as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5 Any damage to the NHSFT's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.5.6 Where practical, assets should be marked as NHSFT property.

12 STORES AND RECEIPT OF GOODS

12.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2 Subject to the responsibility of the Executive Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to employees by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees, subject to such delegation being entered in a record available and approved by the Chief Executive and the Executive Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

12.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

12.4 The Executive Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.5 Stocktaking arrangements shall be agreed with the Executive Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Chief Finance Officer.

12.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Executive Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Executive Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.8 For goods supplied via the NHS Supplies central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

13 DISPOSALS, CONDEMNING, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNING

13.1.1 The Executive Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemning, and ensure that these are notified to managers. The NHSFT must not dispose of CRS property without the approval of the Trust's commissioners and without informing Monitor, if Monitor has given notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. These procedures shall comply with all appropriate Standing Orders and SFI's in addition to the requirements specified in the NHSFTs Policies and Procedures manual.

13.1.2 When it is decided to dispose of an NHSFT asset, the head of department or authorised deputy will determine and advise the Executive Chief Finance Officer of the estimated market value of the item, taking account of professional advice valuations where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Executive Chief Finance Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Chief Finance Officer.

13.1.4 Officers shall satisfy themselves as to whether or not to condemn, where evidence of negligence and shall report such evidence to the Executive Chief Finance Officer who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Executive Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Executive Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Executive Chief Finance Officer must immediately inform the

police, following consultation with the LSMS, if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Chief Finance Officer must inform the Local Counter Fraud Specialist.

13.2.3 The Executive Chief Finance Officer must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

13.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Chief Finance Officer must immediately notify:

(a) the Board of Directors

(b) the Local Security Management Specialist; and

(c) the External Auditor.

13.2.5 The approval of the writing-off of losses is as per the limits set out in the detailed scheme of delegation.

13.2.6 The Executive Chief Finance Officer shall be authorised to take any necessary steps to safeguard the NHSFT's interests in bankruptcies and company liquidations.

13.2.7 For any loss, the Executive Chief Finance Officer should consider whether any insurance claim could be made.

13.2.8 The Executive Chief Finance Officer shall maintain a Losses and Special Payments Register.

14 INFORMATION TECHNOLOGY

14.1 The Executive Director with the portfolio for ITT, and who is responsible for the accuracy and security of the computerised data of the NHSFT, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the NHSFT's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation 2016;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system (including those obtained by external agency arrangements) and that such computer audit reviews as they may consider necessary are being carried out.

14.2 The Executive Chief Finance Officer, in conjunction with the ITT department, shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible NHS bodies, directors and employees will send to the Executive Director with the portfolio for ITT:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.4 The Executive Director with the portfolio for ITT shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the

security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.5 Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director with the portfolio for ITT shall periodically seek assurances that adequate controls are in operation.

14.6 Where computer systems have an impact on corporate financial systems the Executive Chief Finance Officer, shall satisfy themselves that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Finance staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

15 PATIENTS' PROPERTY

15.1 The NHSFT has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Executive Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.4 The NHSFT will maintain a separate account for patients' money, which will be opened and operated under arrangements agreed by the Executive Chief Finance Officer. Any income relating to patients money which may temporarily be included within exchequer funds, will be reconciled and reported separately on a regular basis.

15.5 In all cases where property of a deceased patient is of a total value in excess of £10,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £10,000 or less, forms of indemnity shall be obtained.

15.6 Staff should be informed, on appointment, by the appropriate senior manager of their responsibilities and duties for the administration of the property of patients.

15.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16 FUNDS HELD ON TRUST (CHARITABLE FUNDS)

16.1 Standing Orders state the NHSFT'S responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the NHSFT, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust.

16.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom.

16.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

16.4 The over-riding principle is that the integrity of each fund must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.5 The Board of Directors hereby nominates the Executive Chief Finance Officer to have primary responsibility to the Board of Directors for ensuring that Funds Held On Trust (Charitable Funds) are administered in line with our Standing Orders, Charity Commission guidance and other statutory provisions. The Executive Chief Finance Officer will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of all Trust Funds for the discharge of the Board of Directors responsibilities as Corporate Trustees.

17 ACCEPTANCE OF GIFTS BY STAFF AND DECLARATIONS OF INTEREST

17.1 The acceptance of gifts, hospitality or consideration of any kind from contractors or other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The NHSFT's standards of business conduct guidance, (copy available from the Executive Chief Finance Officer), must be followed, and the Chief Executive notified immediately so that appropriate action can be taken.

17.2 The Executive Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff.

17.3 The Trust Secretary should review the Register of Interests for the Trust on an annual basis to tie in with the disclosures within the annual accounts.

17.4 The Register of Interests should also be referred to, prior to any major contracts in excess of £500,000 being awarded.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive, and the relevant Executive Director, shall be responsible for maintaining archives for all documents required to be retained.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

19 INSURANCE AND RISK MANAGEMENT

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured; and

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing the Annual Governance Statement within the Annual Report and Accounts.

19.3 The Board of Directors shall decide if the NHSFT will insure through the risk pooling schemes administered by NHS Resolution (formerly the NHS Litigation Authority) or self insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decide not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.4 The Executive Chief Finance Officer is required to consider and make proposals to the Board of Directors regarding insurance. In addition, the Executive Chief Finance Officer will consider the use of top-up building insurance to the NHS Resolution risk pooling scheme where appropriate.

19.5 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Executive Directors holding the portfolios of Insurance and Risk Management shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The

Executive Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.6 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Executive Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Executive Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

19.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Executive Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. NEW BUSINESS / INCOME OPPORTUNITIES

20.1 The Chief Executive will ensure that there are processes in place to oversee the management of New Business Development and Income Generation opportunities. Such processes must ensure compliance with the Trust's terms of authorisation and adherence to NHSI's Single Oversight Framework and mandatory reporting requirements. The Trust's processes will also adhere to best pratice guidance including Risk Evaluation for Investment Decisions (REID) or any subsequent guidance that may be issued by NHSI.

20.2 The Board of Directors will ensure there is a governance framework in place to scrutinise and consider any new iniatitives which contain one or more of the following characteristics:

- an equity component;
- significant reputational risk;
- potential to destabilise the Trust's core business;
- the inclusion of material contingent liabilities.

20.3 In the event a 'significant transaction' is being considered, then the Council of Governors also need to be involved in the approval process. The term 'significant transaction' is as per NHSI's definition detailed in the Single Oversight Framework, plus any other transaction in excess of a £10 million threshold and which has an overall risk rating (based on the Trust's risk management framework) which in the reasonable opinion of the Board of Directors, is considered to be significant.

20.4 The People, Innovation and Transformation Committee ~~Strategy and Planning Committee~~ shall be chaired by a Non-Executive Director and comprise both Executive and Non-Executive Directors. The remit of this Committee will include:

- to establish the overall methodology, processes and controls of the Trust's investments and marketing initiatives/opportunities;
- to ensure that robust processes are followed;
- to ensure that Council of Governors approval has been obtained for any investment that would increase the proportion of income from non-principle purposes by 5% or more;
- to evaluate, scrutinise and monitor significant investments and marketing initiatives / opportunities.
- to ensure appropriate safeguards are in place for the investment of exchequer funds and review treasury management activities and performance.

20.5 The committee will also be responsible for consideration of investments or marketing initiatives / opportunities:

- where a change to the Trust's corporate structure is required (for example establishment of subsidiary vehicle);
- there is potential significant risk associated with the project in accordance with REID or established best practice guidelines.

20.6 The initial evaluation of any initial marketing opportunities and to engage in any tender processes may be delegated by the Board of Directors to the Executive Operational Committee, and / or the People, Innovation and Transformation Committee ~~Strategy and Planning Committee~~ in accordance with approved limits.

20.7 Approval of new contracts in relation to new business opportunities will be the responsibility of the Board of Directors unless delegated to the Executive Operational Committee within approved limits.

Appendix 3

FP12 – SCHEME OF RESERVATION & DELEGATION (SoRD)

SCHEME OF RESERVATION & DELEGATION (SoRD)

POLICY REFERENCE NUMBER	FP12
VERSION NUMBER	004
KEY CHANGES FROM PREVIOUS VERSION	New template used. Tables made consistent resulting in changes to document references. Addition of section delegating authority as part of the Major Incident Plan.
AUTHOR	Trust Secretary
CONSULTATION GROUPS	Audit Committee Board of Directors
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 2018, September 2019, September 2020
LAST REVIEW DATE	September 2020
NEXT REVIEW DATE	September 2021
APPROVAL BY	September 2020
RATIFICATION BY	Board of Directors
COPYRIGHT	

POLICY SUMMARY
The purpose of the Scheme of Reservation & Delegation (SoRD) is to set out the powers reserved to the Board of Directors and those that the Board has delegated. It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply. The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust

The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the SoRD will be undertaken by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

CONTENTS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

1.0 INTRODUCTION

1.1 (Monitor) NHSE/I *NHS Foundation Trust: Code of Governance* requires that there should be a formal schedule of matters reserved for decision by the Board of Directors (Board).

1.2 This document sets out the powers reserved to the Board and those that the Board has delegated.

1.3 The Board remains accountable for all of its functions, including those which have been delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to perform its monitoring role.

1.4 All powers of the NHS Foundation Trust (Trust), which have not been retained as reserved by the Board or delegated to a committee of the Board, will be exercised on behalf of the Board by the Chief Executive (CEO) or another Executive Director (ED).

1.5 The National Health Service Act 2006 (the Act) designates the CEO of the Trust as the Accounting Officer. The Act states that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. The Accounting Officer has the personal duty of signing the Trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

1.6 The CEO is ultimately accountable to the Board and has overall executive responsibility for the Trust's activities

2.0 PURPOSE

2.1 The purpose of this document is to set out the powers reserved to the Board and those that the Board has delegated. It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply.

2.2 The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.3 The Board reserves certain matters to itself which are set out in the SoRD which is the schedule of matters reserved to the Board.

2.4 The Detailed Scheme of Delegation (DSoD) identifies any functions which the CEO will perform personally and those delegated to other EDs or officers. All powers delegated by the CEO can be reassumed by him/her should the need arise.

2.5 The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.6 In the absence of a Director or officer to whom powers have been delegated, those powers shall be exercised by that Director or officer's superior. If the CEO is absent, powers delegated to him/her may be exercised by the Deputy CEO or in his/her absence by the ED who is formally acting up as CEO. Formal acting-up status shall be confirmed in writing by either the CEO or the Chair. If the Executive Chief Finance Officer is absent powers delegated to him/her may be exercised by the Deputy Chief Finance Officer.

2.7 The key documents in the corporate governance framework include:

- Standing Financial Instructions (SFIs)
- Detailed Scheme of Delegation (DSoD)
- Constitution
- Standing Orders (SOs) for the Board of Directors

3.0 DECISIONS RESERVED TO THE BOARD OF DIRECTORS

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
Constitution	General Enabling Provision	3.1	3.1.1	The Board is responsible for ensuring on-going compliance by the Trust with its licence, its Constitution, mandatory guidance issued by NHS Improvement (NHSI), the Independent Regulator for Foundation Trusts, relevant statutory requirements and contractual obligation
			3.1.2	The Board may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors
			3.1.3	Any functions of the Trust that have been reserved to the Board shall be exercised by the Board on behalf of the Trust or may be delegated by the Board to a committee of Directors or to an Executive Director
			3.1.4	All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual standing committees, sub-committees, Directors or officers
N/A	Regulation & Control	3.2	3.2.1	Approve Standing Orders For The Practice and Procedures of the Board of Directors (SOs) and a schedule of matters reserved to the Board (Scheme of Reservation & Delegation – SoRD), Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business, including the ability to suspend, vary or amend SOs
			3.2.2	Ratify any urgent decisions taken by the Chair and/or CEO
			3.2.3	Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which a member of the Board may remain

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			involved with the matter under consideration
			3.2.4 Approve the corporate structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity, this will comprise of details of the structure of the Board and its committees and sub-committees. Organisational structures below ED are the responsibility of the CEO who may delegate this function as appropriate
			3.2.5 Delegate executive powers to be exercised by committees or sub-committees or joint committees of the Board and approve the committee structure of the Board including associated terms of reference and the required accountability arrangements
			3.2.6 Receive and consider reports from committees of the Board and, where relevant, approve any recommendations made by the committees
			3.2.7 Approve governance arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust
			3.2.8 Approve the Trust's banking arrangements
			3.2.9 Ratify any urgent or emergency decisions taken by the Chair and/or CEO in accordance with SO (Emergency Powers) of the SOs
			3.2.10 Consider instances of failure to comply with SOs and take action where appropriate
			3.2.11 Approve the disciplinary procedures for officers of the Trust
			3.2.12 Approve the systems and processes for escalating and resolving quality issues, including the escalation of such issues to the Board where appropriate
			3.2.13 Ensure there are adequate systems and processes maintained to measure and monitor the Trust's effectiveness, efficiency and

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				economy as well as the quality of its healthcare delivery (including systems and processes to ensure effective financial decision-making, management and control)
			3.2.14	Establish standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
			3.2.15	Call meetings of the Board
			3.2.16	Approve the minutes of the proceedings of Board meetings
			3.2.17	Review the Constitution and SOs annually
N/A	**Committees**	3.3	3.3.1	Appoint and disestablish committees that are directly accountable to the Board
			3.3.2	Establish terms of reference and reporting arrangements for all Board committees
			3.3.3	Ratify the appointment/removal of Board committee members
			3.3.4	Receive reports from committees including those which the Trust is required by its constitution, or by the regulator or by the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action thereon
			3.3.5	Confirm the recommendations of the Board's committees where the committees do have executive powers
N/A	**Strategy, Business Plans and Budgets**	3.4	3.4.1	Define the strategic aims of the Trust with due regard to the views of the Council of Governors (Council)
			3.4.2	Approve proposals for ensuring the quality and safety and for applying the principles and standards of clinical governance as set out by relevant bodies (including the Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions) of services provided by the Trust.

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			3.4.3 Approve and monitor the Trust's programme of risk management which must identify risks and liabilities, evaluate them and ensure adequate responses/actions are in place and monitored 3.4.4 Approve outline and final business cases for Capital Investment over the agreed thresholds detailed in the SFIs 3.4.5 Approve annual budgets. 3.4.6 Ensure plans take timely and appropriate account of quality of care considerations. 3.4.7 Approve the annual plan and forward plan (also known as the Trust's Five Year Plan) 3.4.8 Consider a merger, acquisition, separation or dissolution of the Trust (such an application may only be made with the approval of more than half the members of the Council of Governors (CoG)). 3.4.9 Consider a significant transaction as defined in the constitution. A significant transaction may only be entered into if approved by more than half of the Governors voting at a meeting of the Council 3.4.10 Approve proposals for acquisition, disposal or change of use of land and/or buildings over the agreed thresholds detailed in the SFIs 3.4.11 Approve PFI proposals 3.4.12 Approve the appointment of bankers and the opening of bank accounts 3.4.13 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature as set out in the Detailed Scheme of Delegation 3.4.14 Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the CEO and Executive Chief Finance Officer (ECFO) for losses and

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				special payments previously approved by the Board
			3.4.15	Approve individual compensation payments in accordance with Trust Detailed Scheme of Delegation (DSoD)
			3.4.16	Approve proposals for action on litigation against or on behalf of the Trust as per the financial limits set out in the Detailed Scheme of Delegation/
			3.4.17	Review the use of NHS~~LA~~ Resolution risk pooling schemes.
			3.4.18	Approve proposals for ensuring equality and diversity in both employment and the delivery of services
Constitution	Audit	3.6	3.6.1	Approve the appointment (and where necessary dismissal) of internal auditor (the recommendation in respect of the external auditors is made by the Audit Committee to the Council)
Audit Committee			3.6.2	Receive an annual report from the Audit Committee
Constitution	Annual Reports and Accounts	3.7	3.7.1	Approve the Annual Report and Accounts for the Trust
			3.7.2	Approve the Charity Accounts for the Trust
			3.7.3	With regard to the views of the Council, prepare the information as to the Trust's forward plan in respect of each financial year to be given to NHSE/~~I~~
			3.7.4	Present to the Council at a general meeting, the annual accounts, any reports of the auditors on them and the annual report
N/A	Monitoring	3.8	3.8.1	Receive such reports, as the Board sees appropriate from committees in respect of their exercise of powers delegated as well as from members of the Board and officers of the Trust in order to continually appraise the affairs of the Trust
			3.8.2	All returns required by NHSE/I and the Charity Commission will be reported, at least in summary, either in a specific report to the Board or by a committee report
			3.8.3	Receive reports from the ECFO on financial performance and requirements of NHSE/I, and the Director with the portfolio for other

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			areas of performance 3.8.4 Approve the making of declarations in accordance with statutory requirements and /or at the request of NHSI 3.8.5 Monitor the delivery of business plans (including any changes to such plans) and receive internal and where appropriate external assurance on such plans and their delivery

4.0 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

The Board may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board from time to time taking into account where necessary the requirements of the regulator and/or the Charity Commission (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with the SOs, Board committees may not delegate executive powers to sub-committees.

A list of committees together with their terms of reference shall be maintained by the Trust Secretary.

The Board has delegated decisions/duties to the following committees:

SoRD Ref	Committee	Decisions / Duties Delegated by the Board to Committees
4.1	Audit Committee	Terms of Reference
4.2	Charitable Funds Committee	Terms of Reference
4.3	Finance & Performance Committee	Terms of Reference
4.4	~~Strategy and Planning Committee~~ People, Innovation & Transformation Committee	Terms of Reference
4.5	Remuneration & Nominations Committee	Terms of Reference
4.6	Quality Committee	Terms of Reference

5.0 SCHEME OF DELEGATION DERIVED FROM THE CONSTITUTION

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
4. Powers	~~NA~~ Board of Directors	5.1	5.1.1	All the powers of the Trust shall be exercised by the Board on behalf of the Trust
			5.1.2	Any of these powers may be delegated to a committee of Directors or to an ED
13. Annual Members Meeting	Trust Secretary	5.2	5.2.1	The Trust shall hold an annual meeting of its members which shall also be open to members of the public
14. Council of Governors	Trust Secretary	5.3	5.3.1	The Trust is to have a Council of Governors that will comprise of both elected and appointed Governors
18.3. Council of Governors Skills & Knowledge	Chair Trust Secretary	5.4	5.4.1	The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such
23.1. Council of Governors Travelling Expenses	~~N/A~~ Trust Secretary	5.5	5.5.1	The Trust may pay travelling expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust.
30.1. Appointment of the Vice Chair	Chair Council of Governors	5.6	5.6.1	The Chair shall be entitled to advise the Council of the NED who is recommended by the Board for appointment as the Vice-Chair
30.2. Appointment of the Acting Chair				
30.4. Appointment of the Senior Independent Director	Board of Directors	5.7	5.7.1	The Board shall, following consultation with the Council, appoint one of the NEDs as the SID
30.5. Appointment of Deputy CEO	Remuneration & Nomination Committee	5.8	5.8.1	Appoint one of the EDs to be the Deputy Chief Executive in line with agreed procedure
31.1. Appointment	Chair	5,9	5.9.1	The NEDs shall appoint or remove the CEO. The appointment

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
and Removal of CEO	Non-Executive Directors			shall require the approval of a majority of the COG present at a meeting of the COG
31.3. Appointment and Removal of Other Executive Directors	Remuneration & Nomination Committee	5.10	5.10.1	A Committee consisting of the Chair, CEO and the other NEDs shall appoint or remove other EDs
19.2. Council of Governors Meetings (Exclusion)	Chair	5.11	5.11.1	The Chair may exclude any person from a meeting of the Council/Board if that person is interfering with or preventing the proper conduct of the meeting
34.1. Board of Directors Meetings (Exclusion)				
34.2. Board of Directors Meetings	Trust Secretary	5.12	5.12.1	Send a copy of the agenda to the Council prior to holding a Board meeting
			5.12.2	Send a copy of the minutes of a Board meeting to the Council (as soon as reasonably practicable)
37.2. Remuneration & Terms of Office	Remuneration & Nomination Committee	5.13	5.13.1	Decide the remuneration and allowances and other terms and conditions of office of the CEO and other EDs
38 / 39 / 40. Registers	Trust Secretary	5.14	5.14.1	Compile and maintain including admission/removal from registers including: • Register of members • Register of members of the Council of Governors • Register of interests of Governors • Register of Directors • Register of interests of Directors
			5.14.2	Make the above registers available to the public in line with the conditions in the constitution

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
41, Documents Available for Public Inspection	Trust Secretary	5.15	5.15.1	The Trust shall make the following documents available for inspection by members of the Trust/members of the public free of charge at all reasonable times: • Constitution • Latest annual accounts, including any report of the auditor on them • Latest annual report • Documents relating to a special administration of the Trust
43. Audit Committee	Audit Committee	5.16	5.16.1	Perform such monitoring, reviewing and other functions for an Audit Committee as are appropriate
44. Accounts	CEO (Accounting Officer)	5.17	5.17.1	The Trust shall prepare in respect of each financial year annual accounts in line with regulatory requirements
45.1. Annual Report	Board of Directors	5.18	5.18.1	Prepare an annual report for submission to NHSE/I
45.2 – 45.7. Forward Plan	Board of Directors	5.19	5.19.1	Prepare the forward plan having regard to the views of the Council
47. Instruments	Board of Directors	5.20	5.20.1	Authorise use of the seal
48.1. Constitution Amendments	Board of Directors	5.21	5.21.1	Make amendments to the constitution (subject to more than half the Council and Board approving amendments)
Annex 5. Model Election Rules	Board of Directors	5.22	5.22.1	Retention and public inspection of election documents (para 57.1) – these will be destroyed after one year unless otherwise directed by the Board
			5.22.2	Consent (or not) to the application for inspection of certain documents relating to an election (para 58)
Annex 9. Significant Transactions	Strategy & Planning Committee	5.23	5.23.1	Assess the significance of the overall risk of a transaction that exceeds the definition as detailed in section 1 of Annex 9 Significant Transactions of the constitution

6.0 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM (AUGUST 2015)

Comment [JC(EP1]: Added reference to make it easier in the future to confirm references are up to date.

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
1.	CEO	6.1	6.1.1 The National Health Service Act 2006 (the 2006 Act) designates the CEO of an NHS FT as the Accounting Officer 6.1.2 The Board has agreed that to support the Accounting Officer to discharge his/her duties the following functions will be delegated as identified below
3.	CEO	6.2	6.2.1 The Accounting Officer has the duty to prepare the accounts in accordance with the 2006 Act 6.2.2 An Accounting Officer has the personal duty of signing the NHS FT's accounts 6.2.3 By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.
5.	CEO	6.3	6.3.1 Regardless of the source of the funding, the Accounting Officer is responsible to Parliament for the resources under their control.
7. General Responsibilities of the Accounting Officer	CEO Director with Portfolio for People Management ECFO	6.4	6.4.1 Responsible for the overall organisation and management 6.4.2 Responsible for staffing of the Trust 6.4.3 Responsible for the Trust's procedures in financial and other matters 6.4.4 Ensure there is a high standard of financial management in the Trust as a whole 6.4.5 Ensure the financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
			6.4.6 Ensure financial considerations are fully taken into account in decisions on Trust policy proposals
8-11: Specific Responsibilities of the Accounting Officer	ECFO	6.5	Responsible for ensuring: 6.5.1 the propriety and regularity of the public finances for which he/she is answerable 6.5.2 the keeping of proper accounts 6.5.3 prudent and economical administration 6.5.4 the avoidance of waste and extravagance 6.5.5 the efficient and effective use of all the resources in their charge
	CEO		6.5.6 personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content as prescribed by NHSE/I in accordance with the Act
	ECFO		6.5.7 comply with the financial requirements of the Trust's provider licence 6.5.8 ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the Trust) 6.5.9 ensure that the resources for which the Accounting Officer is responsible are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
	ECFO or Director with Portfolio for Estates		6.5.10 ensure that assets for which the Accounting Officer is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
	ECFO		6.5.11 ensure that any protected property (or interest in) is not

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
			disposed of without the consent of NHSE/I
	CEO		6.5.12 ensure that conflicts of interest are avoided, whether in the proceedings of the Board, Council or in the actions or advice of the Trust's staff, including the Accounting Officer
	ECFO		6.5.13 ensure that in the consideration of policy proposals relating to the expenditure for which the Accounting Officer is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board
	CEO		6.5.14 ensure that there are effective management systems appropriate for the achievement of the Trust's objectives, including financial monitoring and control systems, have been put in place 6.5.15 ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the Trust), including a critical scrutiny of output and value for money • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively
	CEO ECFO		6.5.16 ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				in the Government Internal Audit Standards
12 – 15: Advice to the Board	CEO ECFO	6.6	6.6.1	Ensure that appropriate advice is tendered to the Board and the Council on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the PAC, transactions for which they are accountable
	CEO		6.6.2	The Board and the Council of an NHS FT should act in accordance with the requirements of propriety or regularity. If the Board, Council or the Chair is contemplating a course of action involving a transaction which the Accounting Officer considers would infringe these requirements, the Accounting Officer should set out in writing his/her objection to the proposal and the reasons for this objection. If the Board, Council or Chair decides to proceed, the Accounting Officer should seek a written instruction to take the action in question. The Accounting Officer should also inform NHSE/I of the position, if possible before the decision is taken or in any event before the decision is implemented, so that Monitor, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that the Accounting Officer is overruled, the instruction must be complied with, but the Accounting Officer's objection and the instruction itself should be communicated without undue delay to the Trust's external auditors and to NHSE/I. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction
			6.6.3	If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to the Accounting Officer's

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				wider responsibilities for economy, efficiency and effectiveness, it is the Accounting Officer's duty to draw the relevant factors to the attention of the Board and the Council and to advise them in whatever way he/ she deems appropriate. If the advice is overruled, and the proposal is one which the Accounting Officer would not feel able to defend to the PAC as representing value for money, the Accounting Officer should seek a written instruction before proceeding. NHSE/I should be informed of such an instruction, if possible before the decision is implemented. It will then be for Monitor to consider the matter, and decide whether or not to intervene
			6.6.4	If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 2 and 3 above before the decision is taken, the Accounting Officer must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards
16 -20: Appearance before the Public Accounts Committee	CEO	6.7	6.7.1	Appear before the PAC furnishing the PAC with an explanation of any indications of weaknesses in the matters covered by the paragraphs of the Accounting Officer Memorandum headed *The Specific Responsibilities of an NHS FT accounting Officer* to which the PAC's attention may have been drawn/ about which it may wish to question the Accounting Officer and ensuring the accuracy of evidence furnished. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence. In practice, the Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his/her accountability
21 -23: Absence of	CEO	6.8	6.8.1	The Accounting Officer should ensure that he/she is generally available for consultation, and that in any temporary period of

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
an Accounting Officer				unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the Trust who can act on his/her behalf if required
	Board of Directors		6.8.2	If it becomes clear to the Board that the Accounting Officer is so incapacitated that he/she will be unable to discharge these responsibilities over a period of four weeks or more, the Board should appoint an acting Accounting Officer, usually the Deputy CEO, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted
	Acting Accounting Officer		6.8.3	The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time to submit them to the Minister, the NHS FT may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

7.0 SCHEME OF DELEGATION FROM THE STANDING ORDERS FOR THE BOARD OF DIRECTORS

Comment [JC(EP2]: Minor change to wording

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
1.1.	Chair	7.1	7.1.1	Save as otherwise permitted by law, the Chair has the final authority in interpretation of SOs (as advised by the CEO and the Trust Secretary)
2.4. Board of Directors	~~NA~~ Board of Directors	7.2	7.2.1	The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Scheme of Reservation & Delegation (SoRD) and have effect as if incorporated into the

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				SOs
2.9 Vice-Chair appointment 2.9.5. Acting Chair appointment	Board of Directors	7.3	7.3.1 7.3.2	Recommend the appointment of the Vice-Chair / Acting Chair to the Council In the absence of the Chair, the Vice-Chair / Acting Chair will act as the Chair of the Trust
2.10 CEO appointment	Chair Non-Executive Directors	7.4	7.4.1	Appoint (and remove) the CEO subject to approval by Council of Governors
2.11 Executive Directors appointment	Remuneration & Nomination Committee	7.5	7.5.1	All EDs (excluding the CEO) to be appointed (and removed) by a Committee consisting of the Chair, CEO and other NEDs
2.12 Deputy CEO appointment	Remuneration & Nomination Committee	7.6	7.6.1	Appoint one of the EDs to be the Deputy Chief Executive in line with agreed procedure
2.14 Senior Independent Director appointment	Board of Directors	7.7	7.7.1	Appoint one of the NEDs as the SID in consultation with the Council
2.15 Trust Secretary appointment	Chair CEO	7.8	7.8.1	Appoint a Trust Secretary
2.16 Role of the Chief Executive Officer	Chair CEO	7.9	7.9.1	Implement the decisions of the Board in the running of the Trust's business. The CEO is the Accounting Officer (see dedicated section in terms of specific delegated responsibilities)
2.17 Role of the Executive Chief Finance Officer	ECFO ECFO CEO	7.10	7.10.1 7.10.2	Responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems Responsible for the discharge of obligations under all relevant financial directions and guidance issued by Monitor or any other relevant body
2.19. Role of the Chair	Chair	7.11	7.11.1	Responsible for the leadership of the Board (and Council) and chair all Board (and Council) meetings when present

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			7.11.2	Ensure effectiveness in all aspects of the Board's role
			7.11.3	Lead on setting agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues
			7.11.4	Ensure key and appropriate issues are discussed by the Board in a timely manner with all necessary advice being available to inform debate and decisions
			7.11.5	Responsible for ensuring that the Board and Council work effectively together
2.20. Role of the Non-Executive Directors	Non-Executive Directors	7,12	7,12,1	May exercise collective authority when acting as members of or when chairing a committee of the Board which has delegated powers
3.1 / 3.2 / 3.3.~~3~~ / 3.4.2 / 3.5 Board meetings	Board of Directors	7.13	7.13.1	For special reasons including commercial confidentiality, may exclude members of the public and press
			7.13.2	Determine times and places for ordinary meetings of the Board
			7.13.3	Not less than one-third of Directors (or the Chair) can requisition the Trust Secretary to call a meeting by giving written notice
			7.13.4	If the Trust Secretary does not send a notice of a meeting of the Board within ten working days of receiving an order from the Chair or a requisition from more than one-third of Directors, the Directors who made the requisition may convene the meeting
			7.13.5	The Chair or at least one-third of the Board may call an extraordinary or urgent meeting if the Trust Secretary fails to call such a meeting
	Chair or Board of Directors		7.13.6	Request in writing to the Chair a matter to be included on the agenda at least ten working days before the meeting
3.2.2 / 3.3 / 3.4 / 3.5 Meetings	Trust Secretary	7.14	7.14.1	Meetings of the Board are convened by order of the Chair, or more than one-third of Directors who give written notice to the Trust Secretary

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			7.14.2	Issue notice of meetings
			7.14.3	Issue notice of and calling of extraordinary meetings and urgent meetings
			7.14.4	Send agendas to Directors not later than three working days before the meeting; supporting papers, wherever possible, will accompany the agenda save in the case of the need to conduct urgent business
			7.14.5	Display at the Trust's head office and website a public notice of the date, time and place of the meeting including the public part of the agenda at least three working days before the meeting (save in the case of an urgent meeting)
			7.14.6	Send a copy of the agenda to the Council before the Board meeting
3.6 / 15.1 Setting the agenda	Chair or Board of Directors	7.15	7.15.1	Can determine certain matters to be included on every agenda for an ordinary meeting
			7.15.2	Include petition if received not less than 10 working days before a meeting
3.8 Chair of meeting	Chair Vice Chair / Acting Chair Non-Executive Directors	7.16	7.16.1	Chair all Board meetings and associated responsibilities
			7.16.2	Chair meeting if the Chair of the Trust is absent from a meeting
			7.16.3	If the Chair and Deputy Chair are absent (or disqualified from participating) a NED as nominated by other NEDs, will preside
3.9 Motions	Directors	7.17	7.17.1	Move or amend or withdraw or rescind a motion
3.10 Chair's Ruling	Chair	7.18	7.18.1	Give final ruling on questions of order, relevancy, and regularity and other matters of meetings
3.11 Voting	Directors	7.19	7.19.1	Have one vote (with the exception of joint EDs)
	Chair		7.19.2	Determine voting method (oral/show of hands)
	Directors		7.19.3	A majority of Directors present can request a paper ballot
			7.19.4	Request voting (other than by paper ballot) to be recorded to show how each Director present voted/abstained
	Officer		7.19.5	Entitled to vote if appointed formally by the Board to act up for an ED during a period of incapacity/vacancy

Comment [JC(EP3]: The original reference 15.7 was not correct. Changed to 15.1

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	Chair		7.19.6	Has a second or casting vote in the event of equality of votes
3.12 / 3.1~~6~~ 5Minutes	Trust Secretary	7.20	7.20.1	Ensure meetings are minuted and submitted for agreement at the next meeting where they will be signed by the person presiding at it
			7.20.2	Record the names of the Chair, Directors and all others present at the meeting (other than members of the public and media)
			7.20.3	Retain minutes
			7.20.4	Circulate minutes including sending approved minutes to Council of Governors and make public
	Directors		7.20.5	Ensure minutes record any concerns that cannot be resolved about the running of the Trust or a proposed action
3.13 Informal and committee meetings	Chair	7.21	7.21.1	Hold meetings with NEDs without EDs present
	Senior Independent Director		7.21.2	Meet with the NEDs without the Chair present at least annually to appraise the Chair's performance and on other such occasions as deemed appropriate
	Board of Directors		7.21.3	May meet informally or as a Board committee at any time
3.14. Amendments of Standing Orders	Board of Directors	7.22	7.22.1	May amend SOs without the need to amend the constitution
3.1~~7~~6 Quorum	CEO	7.23	7.23.1	Waive requirement for CEO or Deputy CEO to be present at a meeting
	Chair		7.23.2	Waive requirement for Chair or Vice-Chair to be present at a meeting
4. Exercise of functions by delegation	CEO	7.24	7.24.1	Prepare a detailed Scheme of Reservation & Delegation identifying the functions to be delegated to either an ED or a committee of the Board for approval by the Board
	Board / Directors		7.24.2	Formal delegation of executive powers to committees which it has formally constituted; however, the Trust retains full responsibility
	CEO / Deputy CEO		7.24.3	The powers which the Board has retained to itself within the SOs may in emergency situations be exercised by the CEO or in his/her absence, the Deputy CEO, provided that prior to taking such action,

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				the CEO has consulted with and gained the agreement of the Chair
4.7 Non-compliance with Standing Orders	All Executive Directors	7.25	7.25.1	Disclosure of full details of any non-compliance with SOs shall be reported to the Chair and CEO as soon as possible and to the next formal meeting of the Board for action and ratification
	All Staff		7.25.2	Duty to disclose any potential or impending non-compliance with the SOs to their ED who in turn has a duty to report to the CEO and the Chair as soon as possible
5 Committees	Board of Directors	7.26	7.26.1	Appoint an Audit Committee of Non-Executive Directors.
			7.26.2	Appoint a Remuneration Committee of Non-Executive Directors
			7.26.3	Appoint standing committees of the Board
			7.26.4	Approve the appointments to each committee formally constituted
			7.26.5	Standing committees to have terms of reference and powers, and be subject to such conditions, such as reporting back to the Board, as the Board decides
	Standing Committees		7.26.6	Standing committees may establish sub-committees that do not have delegated executive powers from the Board or committee of the Board
6 Declarations / Register of Interest	Directors	7.27	7.27.1	Statutory duty to avoid a situation in which they have a direct or indirect interest that conflicts (or may conflict) with the interests of the Trust
			7.27.2	Declare interests to the Board that are required to be declared (under constitution) and ensure an update is provided if their interests change
	~~CEO~~ Trust Secretary		7.27.3	Ensure Register(s) of Interests is maintained
	Trust Secretary		7.27.4	Take reasonable steps to bring the existence of the Register to the attention of the local population and publicise arrangements for viewing it
			7.27.5	Keep the Register of Interests up-to-date by means of an annual review in which any changes to interests declared in the preceding

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				12 months will be incorporated
6.3 Register of gifts and hospitality	Trust Secretary	7.28	7.28.1	Maintain a register of gifts and hospitality for Board members and staff
			7.28.2	Publish on Trust's website in line with regulatory requirements
7 Conflict of interest and pecuniary interest	Directors ~~Board~~ Standing Committees	7.29	7.29.1	Disclose any pecuniary interest (as defined in SOs) in any contract/proposed contract/other matter and is present at a meeting at which the contract/other matter is being considered
			7.29.2	Withdraw from a meeting if a conflict of interest is disclosed
			7.29.3	SO also applies to a committee/sub-committee/joint committee of the Board
8 Standards of Business Conduct Policy	Staff Directors	7.30	7.30.1	Comply with the Trust's Standards of Business Conduct Policy at all times
			7.30.2	Comply with national guidance contained in ~~HSG 1993/5~~ *NHSE/I Standards of Business Conduct policy ~~for NHS Staff~~* (ref Appendix B of SOs), *the Standards for Members of NHS Boards and CCG Governing Bodies in England (Nov 2013)* (ref Appendix C of SOs), Trust's ~~Counter Fraud Policy and Procedure~~ Policy for Fraud and Bribery, and any such guidance issued by NHSI or the DHSC from time to time.
8.3 Interests of officers in contracts	Staff	7.31	7.31.1	Disclose any pecuniary interest in a contract to which they are a party (or has been or is proposed to be)
	Staff Directors		7.31.2	Disclose to the CEO any other employment, business or other relationship of theirs or of a spouse/partner/other family member that conflicts or might reasonably be predicted that could conflict with the interests of the Trust
	Staff		7.31.3	Declare interests/employment/relationships on a Register of Interests for staff
8.5 Relatives of Board members or officers	Staff Directors	7.32	7.32.1	Disclose whether they are related to any other Board member or holder of any office in the Trust
			7.32.2	Disclose to the CEO any relationship between themselves and a

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				candidate for staff appointment of whose candidature the Board member or staff member is aware
			7.32.3	On appointment Board members should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust
	CEO		7.32.4	CEO to report any disclosures under 7.32.2 to the Board of Directors
9 Tendering and contract procedure	CEO	7.33	7.33.1	Where it is decided that competitive tendering is not applicable and should be waived, the reasons should be documented and reported by the CEO to the Executive Operational Sub-Committee and to the next available meeting of the Audit Committee
	CEO or Nominated Officer		7.33.2	Responsible for selecting quotations which gives the best quality and value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record
	CEO ECFO		7.33.3	Competitive quotations should be obtained. Where this is not possible and none of the reasons apply (under SO 9.6.1), the CEO and ECFO can waive this requirement. The decision needs to be reported to the Audit Committee
	CEO		7.33.4	Responsible for ensuring best value for money can be demonstrated for all services provided under contract or in-house
	CEO Board of Directors		7.33.5	Demonstrate that a PFI/Procure22 scheme represents value for money and genuinely transfers risk to the private sector
	Board of Directors		7.33.6	Approve PFI/Procure22 proposal
	CEO Nominated Officer		7.33.7	Endeavour to obtain best value for money in relation to contracts
			7.33.8	CEO will nominate an officer to oversee and manage each contract on behalf of the Trust
			7.33.9	CEO will nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts
			7.33.10	Competitive tendering or quotation procedures will not apply to the

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				disposal of any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the CEO or nominated officer
	Evaluation ~~Team~~ Panel		7.33.11	Make a recommendation to the Executive Operational Sub-Committee and/or Board of Directors in relation to in-house services and in accordance with the DSoD
12. Custody of Seal and Sealing of Documents	Trust Secretary CEO ECFO	7.34	7.34.1	Keep the common seal of the Trust in a secure place and maintain a register of sealing
	CEO ECFO		7.34.2	Authorise the fixing of the Trust Seal to documents
	CEO ECFO Executive Directors (not within the originating directorate)		7.34.3	Approve and sign all building, engineering, property or capital documents
	Board of Directors		7.34.4	Receive a report of all sealings at least quarterly
13. Signature of Documents	CEO or Nominated Executive Director	7.35	7.35.1	Approve and sign all documents which will be necessary in legal proceedings involving the Trust, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to another executive director for the purpose of such proceedings
			7.35.2	Sign where authorised by resolution of the Board on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub- committee or standing committee with delegated authority
14. Standing Orders	CEO	7.36	7.36.1	Ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs

Comment [JC(EP4]: This is referred to as an Evaluation Panel in FP07

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
14.4. Dispute Resolution	SID	7.37	7.37.1	Make all reasonable efforts to mediate a settlement to a dispute that involves the Chair
	Trust Secretary		7.37.2	Deal with any membership queries and other similar questions including any voting or legislation issues in the first instance
15. Council of Governors	Board of Directors	7.38	7.38.1	Present to the Council at a general meeting the annual accounts, any report of the auditor on them, and the annual report
			7.38.2	Explain in the annual report their responsibility for preparing the annual report and accounts and the approach to quality governance
			7.38.3	Comply with Annual Reporting Manual including stating they consider the annual report and accounts as fair, balanced and understandable and provide the necessary information so that the Trust's performance, business model and strategy can be assessed; as well as approach to quality governance.
	External Auditor		7.38.4	Statement about reporting responsibilities
	Audit Committee		7.38.5	Agree with the Council the criteria for appointing, reappointing and/or removing external auditors

8.0 SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFI'S)

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
1.1.2	Audit Committee	8.1	8.1.1	Approval of all Trust wide financial procedures and financial control procedures
1.1.3	ECFO	8.2	8.2.1	Advice on interpretation or application of SFIs
1.1.5	Board of Directors Staff	8.3	8.3.1	Disclosure of non-compliance with SFIs as soon as possible to the ECFO; ECFO to report to the Audit Committee
1.3.3	CEO	8.4	8.4.1	Responsible as the accounting officer to ensure financial targets and obligations are met and have overall responsibility for the

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			system of internal control.
1.3.4	CEO ECFO	8.5	8.5.1 Accountable for financial control but will, as far as possible, delegate their detailed responsibilities
1.3.5	CEO	8.6	8.6.1 To ensure systems and processes in place so that all Board members, officers and employees, present and future, are notified of and understand SFIs
1.3.6	ECFO	8.7	Responsible for: 8.7.1 Implementing the Trust's financial policies and co-ordinating corrective action 8.7.2 Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented 8.7.3 Ensuring that sufficient records are maintained to explain Trust's transactions and financial position 8.7.4 Providing financial advice to members of Board and staff 8.7.5 Design, implement and supervise systems of internal financial control 8.7.6 Maintaining such accounts, working papers, etc., as are required for the auditors to carry out their statutory duties
1.3.7	All Board Members & Employees	8.8	8.8.1 Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions, and Financial Procedures. and Schemes of Delegation
1.3.8	CEO	8.9	8.9.1 Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply
2.1.1	Audit Committee	8.10	8.10.1 Provide independent and objective view on Governance and assurance processes and arrangements
2.1.2	Board of Directors	8.11	8.11.1 Members of the Audit Committee have recent and relevant financial

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				experience or have appropriate training
2.1.3	Audit Committee	8.12	8.12.1	Assess the work and fees of external audit on an annual basis to ensure that the work is of a high standard and that fees are reasonable
2.1.4	Audit Committee	8.13	8.13.1	Recommend to the Council of Governors re: the appointment/re-appointment of external auditors
2.1.5	Chair of Audit Committee	8.14	8.14.1	Where there is evidence of ultra vires transactions, improper acts and other important matters these should be raised at Board Meetings. Exceptionally, refer to Monitor any matters of concern, having raised it with the Chief Executive Accounting Officer and Executive Chief Finance Officer
2.1.6 2.2.1	ECFO	8.15	8.15.1	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed)
2.2.1	ECFO	8.16	8.16.1	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption, in consultation with ~~LSMS~~ Local Counter Fraud Specialist
2.3.1	Chief Internal Auditor	8.17	8.17.1	Review, appraise and report in accordance with best practice
2.3.1 2.3.2	Chief Internal Auditor	8.18	8.18.1 8.18.2	Produce an annual audit opinion on the effectiveness of the systems of internal control Raise with the ECFO immediately any matter which involves or thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity
2.3.3	Chief Internal Auditor	8.19	8.19.1	Attend audit committee meetings
2.3.4	Chief Internal Auditor	8.20	8.20.1	Report directly to the ECFO and refer audit reports to Auditees as appropriate
2.3.6	ECFO	8.21	8.21.1	Provide Internal Auditors and External Auditors with information

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
2.3.12				
2.3.7	Council of Governors	8.22	8.22.1	Appoint external auditors
2.3.9	Audit Committee	8.23	8.23.1	Ensure external auditors appointed by the Council meet the criteria set by ~~Monitor~~ (Monitor) NHSE/I
2.3.13	ECFO	8.24	8.24.1	Forward to (Monitor) NHSE/I within 30 days any public Interest report issued by auditors
2.4	CEO ECFO	8.25	8.25.1	(Monitor) NHSE/I and ensure compliance with on fraud and corruption including the appointment of the Local Counter Fraud Specialist
2.5	CEO	8.26	8.26.1	(Monitor) NHSE/I and ensure compliance with best practice on NHS security management, including the appointment of the Local Security Management Specialist
3.12	CEO	8.27	8.27.1	Compile and submit to the Board an Operational Plan which takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans and in the format specified by (Monitor) NHSE/I. The annual business plan will contain: • a statement of the significant assumptions on which the plan is based • details of major changes in workload, delivery of services or resources required to achieve the plan • and have due regard to the views of the Council, including confirmation by the Council that they are satisfied that any activities undertaken by the Trust for non-primary purposes will not to any significant extent interfere with the fulfilment of their principle purpose or other functions
3.13 3.14	ECFO	8.28	8.28.1 8.28.2	Submit budgets to the Board for approval Monitor performance against budget, submit to the Board financial

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			estimates and forecasts
3.1.6	ECFO	8.29	8.29.1 Ensure adequate training is delivered on an on-going basis to budget holders
3.1.7	Board of Directors	8.30	8.30.1 Take appropriate action to manage and overcome any potential operational deficit and decide on the appropriate use of any forecast operational surplus
3.2.1	CEO	8.31	8.31.1 Delegate budget to budget holders
3.2.2	CEO Budget Holders	8.32	8.32.1 Must not exceed the budgetary total or virement limits set by the Board
3.3.1	ECFO	8.33	8.33.1 Devise and maintain systems of budgetary control and reporting
3.3.2	Budget Holders	8.34	Ensure that: 8.34.1 no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board 8.34.2 approved budget is not used for any other than specified purpose subject to rules of virement no permanent employees are appointed in excess of available resources as approved by Board or Director without the approval of the CEO 8.34.3 ensure that there is compliance with the system of budgetary control established by the ECFO 8.34.4 budgetary virements between divisions are only undertaken in line with the Detailed Scheme of Delegation 8.34.5 budgetary virements between commissioning contracts should not be undertaken
3.3.3	CEO	8.35	8.35.1 Identify and implement cost improvements and income generation activities in line with the Operational Plan
3.5.1	CEO	8.36	Submit to (Monitor) NHSE/I, as per the ~~compliance framework~~ Oversight Framework: 8.36.1 financial performance measures have been defined and are monitored 8.36.2 reasonable targets have been identified for these measures

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			8.36.3	a robust system is in place for managing performance against targets
			8.36.4	reporting lines are in place to ensure overall performance is managed
			8.36.5	arrangements are in place to manage/respond to adverse performance
			8.36.6	relevant financial information is submitted to the statutory authorities and other relevant organisations (e.g. STP's).
4.1	ECFO	8.37	8.37.1	Preparation of annual accounts.
5.1.1	ECFO	8.38	8.38.1	Managing banking arrangements, including provision of banking services, financing, working capital facilities, reporting on accounts and working capital facilities, operation of accounts, preparation of instructions for operating accounts and list of cheque signatories
5.1.2	Board of Directors	8.39	8.39.1	Approve banking arrangements, financing and working capital facilities
5.4	ECFO	8.40	8.40.1	Commercial banking arrangements reviewed at regular intervals
6.	ECFO	8.41	8.41.1	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash
6.2.2	All Employees	8.42	8.42.1	Duty to inform ECFO of money due from transactions which they initiate/deal with
6.5	ECFO	8.43	8.43.1	Monitoring and reporting to the Board of Directors that the Trust is complying with its obligation under the Health and Social Care Act 2012 that the total income derived from its principal purpose is greater than its total income from the provision of goods and services for 'any other purpose' and seeking Council of Governors approval when it is proposed to increase by 5% or more the proportion of income received from non-primary purposes

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
7.1 7.2	CEO	8.44	8.44.1	Ensure the Trust enters into suitable Legally Binding Contracts (LBC) with service commissioners for the provision of NHS services, devised to minimise risk
7.4	CEO Directors holding portfolios of Finance, Integrated Clinical Services and Contracting	8.45	8.45.1	Ensure that regular reports are provided to the Board detailing actual performance against signed LBCs
7.5	ECFO	8.46	8.46.1	Maintain a public and up-to-date schedule of Commissioner Requested Services as required by the Trust's Terms of Authorisation
8.1.1	Board of Directors	8.47	8.47.1	Establish a NEDs' Remuneration Committee for EDs
8.1.3	Board Remuneration and Nomination Committee ~~for ED's~~	8.48	8.48.1	Report in writing to the Board of Directors its advice and its bases about remuneration and terms of service of directors
8.2.1	CEO delegated to Executive Directors	8.49	8.49.1	Approval of variation to funded establishment of any department
8.2.2	CEO delegated to Executive Directors	8.50	8.50.1	Appointment of staff, including agency staff
8.3.1 8.3.2	CEO delegated to Executive Directors	8.51	Payroll: 8.51.1 8.51.2 8.51.3 8.51.4 8.51.5	specifying timetables for submission of properly authorised time records and other notifications final determination of pay and allowances making payments on agreed dates agreeing method of payment issuing instructions (as listed in SFI 8.3.2)
8.3.3	Nominated Managers*	8.52	8.52.1 8.52.2	Submit time records in line with timetable Complete time records and other notifications in required form

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			8.52.3	Submitting termination forms in prescribed form and on time
8.3.4	ECFO	8.53	8.53.1	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies
8.4	Executive Director with Portfolio of People Management Nominated Managers*	8.54	8.54.1	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation
			8.54.2	Deal with variations to, or termination of, contracts of employment
8.5	ECFO	8.55	8.55.1	Issue instructions to staff regarding procedures to be followed when payments are to be made to individuals who are not employees of the Trust
9.1	CEO	8.56	8.56.1	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. (Please see attached Detailed Scheme of Delegation)
9.1.3	CEO	8.57	8.57.1	Set out procedures on the seeking of professional advice regarding the supply of goods and services
9.2.1	Requisitioners*	8.58	8.58.1	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought
9.2.3	ECFO	8.59	8.59.1	Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed
			8.59.2	Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			8.59.3 Be responsible for the prompt payment of all properly authorised accounts and claims 8.59.4 Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable 8.59.5 A timetable and system for submission to the ECFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment 8.59.6 Instructions to employees regarding the handling and payment of accounts within the Finance Department 8.59.7 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
9.2.4	Appropriate Executive Director ECFO Budget Holder	8.60	8.60.1 Make a written case to support the need for a prepayment 8.60.2 Approve proposed prepayment arrangements 8.60.3 Ensure that all items due under a prepayment contract are received (and immediately inform ECFO if problems are encountered)
9.2.5	CEO	8.61	8.61.1 Authorise who may use and be issued with official orders.
9.2.6	Managers Officers	8.62	8.62.1 Ensure that they comply fully with the guidance and limits specified by the ECFO
9.2.7	CEO ECFO	8.63	8.63.1 Ensure that Standing Orders are compatible with Department of Health requirements re building and engineering contracts. ~~(until such time as guidance is issued by Monitor)~~ 8.63.2 Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with any relevant guidance published by the Department of Health and / or NHSE/I. ~~with the guidance contained within CONCODE and ESTATECODE (until such time as guidance is issued by (Monitor) NHSE/I).~~ The technical audit of these contracts shall be the responsibility of the relevant Director.

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
10.1	ECFO	8.64	8.64.1 Trust's cash flow management
10.2	ECFO	8.65	External borrowing: 8.65.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The ECFO is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest 8.65.2 Any application for new borrowing will only be made by the ECFO or by an officer so delegated by him/her 8.65.3 The ECFO will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by (Monitor) NHSE/I 8.65.4 Assets supporting Commissioner Requested Services shall not be used as collateral for borrowing. Non Commissioner Requested assets will be eligible as security for a loan
10.3	ECFO	8.66	Investments 8.66.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by (Monitor) NHSE/I 8.66.2 The ECFO is responsible for advising the Board on investment strategy and shall report periodically to the Board concerning the performance of investments held 8.66.3 The ECFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained as specified in the Trust Operating Cash Management Policy
11.1.1 11.1.2	CEO	8.67	Capital investment programme: 8.67.1 ensure that there is adequate appraisal and approval process for

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				determining capital expenditure priorities and the effect that each has on business plans
			8.67.2	responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost
			8.67.3	ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences
			8.67.4	ensure that a business case is produced for each proposal in line with limits approved by the Board of Directors
11.1.2	ECFO	8.68	8.68.1	Certify professionally the costs and revenue consequences detailed in the business case for capital investment
11.1.3	CEO ECFO	8.69	8.69.1	Issue procedures for management of contracts involving stage payments
	ECFO		8.69.2	Assess the requirement for the operation of the construction industry taxation deduction scheme
			8.69.3	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure
11.1.4	Executive Operational Committee CEO ECFO ~~Investment & Planning Committee~~ People, Innovation & Transformation Committee	8.70	8.70.1	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Approval will be granted in line with limits in detailed scheme of delegation.
11.1.5	ECFO	8.71	8.71.1	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes
11.2	ECFO	8.72	8.72.1	If required, demonstrate that the use of private finance/Procure 22

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
11.3				represents value for money
	Board of Directors		8.72.2	Proposal to use PFI/Procure 22 must be specifically agreed by the Board
11.4.1	CEO	8.73	8.73.1	Maintenance of asset registers (on advice from ECFO)
11.4.4	ECFO	8.74	8.74.1	Responsibility for ensuring that commissioner requested property is not disposed (unless agreed with main commissioner and informed to (Monitor) NHSE/I)
11.4.5	ECFO	8.75	8.75.1	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
11.4.9	ECFO	8.76	8.76,1	Calculate capital charges in accordance with Monitor requirements.
11.4.10	Board of Directors	8.77	8.77.1	Approve the use of non-commissioner requested assets for the development of services
11.5.1	CEO	8.78	8.78.1	Overall responsibility for fixed assets
11.5.2	ECFO	8.79	8.79.1	Approval of fixed asset control procedures
11.5.4	All Senior Staff	8.80	8.80.1	Responsibility for security of Trust assets including notifying discrepancies to ECFO, and reporting losses in accordance with Trust procedure
12.2	CEO	8.81	8.81.1	Delegate overall responsibility for control of stores (subject to ECFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Please see attached Detailed Scheme of Delegation)
	ECFO		8.81.2	Responsible for systems of control over stores and receipt of goods
	Designated Pharmaceutical Officer		8.81.3	Responsible for controls of pharmaceutical stocks
	Designated Estates Officer		8.81.4	Responsible for control of stocks of fuel oil and coal
12.3	Nominated Officers*	8.82	8.82.1	Security arrangements and custody of keys
12.4	ECFO	8.83	8.83.1	Set out procedures and systems to regulate the stores
12.5	ECFO	8.84	8.84.1	Agree stocktaking arrangements
12.6	ECFO	8.85	8.85.1	Approve alternative arrangements where a complete system of

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				stores control is not justified
12.7	ECFO	8.86	8.86.1	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items
	Nominated Officers*		8.86.2	Operate system for slow moving and obsolete stock, and report to ECFO evidence of significant overstocking
12.8	CEO	8.87	8.87.1	Identify persons authorised to requisition and accept goods from NHS Supplies
13.1.1	ECFO	6.88	8.88.1	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers
13.2.1	ECFO	6.89	8.89.1	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft
13.2.2	All Staff	6.90	8.90.1	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CEO and ECFO
	ECFO		8.90.2	Where a criminal offence is suspected ECFO must inform the police if theft or arson is involved, following consultation with LSMS. In cases of fraud and corruption ECFO must inform the relevant Operational Fraud Team in line with SoS directions and consult with the Counter Fraud Specialist where appropriate.
13.2.3	ECFO	6.91	8.91.1	Notify NHS Protect and External Audit of all frauds
13.2.4	ECFO	6.92	8.92.1	Unless trivial, notify Board of Directors, Local Security Management Specialist & External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness
13.2.5	Board of Directors	6.93	8.93.1	Approve write off of losses (within limits delegated by Trust)
13.2.7	ECFO	6.94	8.94.1	Consider whether any insurance claim can be made
13.2.8	ECFO	6.95	8.95.1	Maintain losses and special payments register
14.1	Executive Director with Portfolio of Information &	6.96	8.96.1	Responsible for accuracy and security of computerised data

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
	IT		
14.2	ECFO in conjunction with Executive Director with Portfolio of Information & IT	6.97	8.97.1 Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation
14.3	Relevant Officers	6.98	8.98.1 Send proposals for general computer systems to ED with portfolio of IT
14.4 14.5	Executive Director with Portfolio of Information & IT	6.99	6.99.1 Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review 6.99.2 Seek periodic assurances from the provider that adequate controls are in operation
14.6	Executive Director with Portfolio of Information & IT	6.100	Where computer systems have an impact on corporate financial systems satisfy themselves that: 6.100.1 systems acquisition, development and maintenance are in line with corporate policies 6.100.2 data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists 6.100.3 ECFO and staff have access to such data 6.100.4 Such computer audit reviews are being carried out as are considered necessary
15.2	CEO	6.101	6.101.1 Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
15.3	ECFO	8.102	8.102.1 Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients
15.6	Departmental Managers	8.103	8.103.1	Inform staff of their responsibilities and duties for the administration of the property of patients
16.5	ECFO	8.104	8.104.1	Primary responsibility to the Board of Directors for Charitable Funds as Financial Trustee
17.2	~~ECFO~~ CEO	8.105	8.105.1	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
17,3	Trust Secretary	8.106	8.106.1	Review Register of Interests on an annual basis to link in with disclosures of annual report
18.1	CEO	8.107	8.107.1	Maintaining archives for all documents required to be returned
19.1	CEO	8.108	8.108.1	Risk management programme
	Boards of Directors		8.108.2	Approve and monitor risk management programme
19.3	Board of Directors	8.109	8.109.1	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self- insure should be reviewed annually
19.4	ECFO	8.110	8.110.1	Consult NHS Resolution in case of doubt as to the power to use commercial insurers
19.6	Director with Portfolio of Insurance & Risk Management ECFO	8.111	8.111.1	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution, the Director holding the portfolio of Insurance and Risk Management shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ECFO shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the ECFO shall ensure that the

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The ECFO will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed
19.7	ECFO	8.112	8.112.1	Ensure documented procedures cover management of claims and payments below the excess amount (currently £10K for LTPS and £3K for PES claims) as defined by NHSR
20.1	CEO	8.113	8.113.1	Ensure there are processes in place to oversee the management of new business development and income generation opportunities, and ensuring compliance with the Terms of Authorisation, Risk Assessment Framework and available best practice guidance
20.2	Board of Directors	8.114	8.114.1	Ensure there is a governance framework in place to scrutinise and consider new initiatives as necessary
20.3	Council of Governors	8.115	8.115.1	Ensure involvement in the approval process of all 'significant transactions' as per Monitors definition in the Risk Assessment Framework, any transactions in excess of £10m and a significant overall risk rating based on the Trust's risk management framework
20.5	Strategy & Planning Committee	8.116	8.116.1	Consideration of investment, initiatives or opportunities where a change to the Trust's corporate structure is required or potential significant risk

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Detailed Scheme of Delegation document.

9.0 MAJOR INCIDENT PLAN

In the event of a Business Continuity, Critical or Major Incident being declared leading to the activation of the Major Incident Plan (RM14) a Major Incident Response Team (MIRT) will be established consisting of a Gold Command. Delegated powers will be given to the Gold Commander who will be the CEO or Deputy CEO.

END

Appendix 4

DETAILED SCHEME OF DELEGATION

POLICY NUMBER:	FP11
VERSION NUMBER:	4
REPLACES SEPT DOCUMENT:	
REPLACES NEP DOCMENT:	
AUTHOR:	Head of Financial Accounts
CONSULTATION GROUPS:	Audit Committee
IMPLEMENTATION DATE:	April 2017
AMENDMENT DATE(S):	September 2020
LAST REVIEW DATE:	April 2017, September 2018, November 2018, September 2019
NEXT REVIEW DATE:	September 2021
APPROVAL BY AUDIT COMMITTEE:	September 2020
RATIFICATION BY BoD:	

POLICY SUMMARY
THIS DOCUMENT PROVIDES A BUSINESS AND FINANCIAL FRAMEWORK WITHIN WHICH ALL OFFICERS OF THE TRUST ARE EXPECTED TO WORK. THIS DOCUMENT SHOULD BE READ IN CONJUNCTION WITH THE TRUST'S CONSTITUTION, STANDING FINANCIAL INSTRUCTIONS, SCHEME OF DELEGATIONS AND SUPPORTING FINANCE PROCEDURES. FAILURE TO COMPLY CAN RESULT IN DISCIPLINARY ACTION.
The Trust monitors the implementation of an compliance with this policy in the following ways:
INTERNAL AUDIT WORKPLAN EXTERNAL AUDIT WORKPLAN LOCAL COUNTER FRAUD SPECIALIST AUDIT COMMITTEE

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DETAILED SCHEME OF DELEGATION

BM	Budget Managers
HoE	Head of Estates / Property Management
CE	Chief Executive
DCE	Deputy Chief Executive
ECFO	Executive Chief Finance Officer
DCFO	Deputy Chief Finance Officer
HoFM	Head of Financial Management
HoFA	Head of Financial Accounts
DHoFA	Deputy Head of Financial Accounts
HoP	Head of Purchasing
AD	Assistant / Deputy Directors or direct report to a Director
Dir	Director or direct report to Executive Director (but not a formal member of the BoD)
ED	Executive Director
EoC	Executive Operational Committee
BoD	Board of Directors
~~SPC~~ PIT	People, Innovation and Transformation Committee
FPC	Finance and Performance Committee
CPPG	Capital Projects Programme Group

The above titles may change as restructures are undertaken. Equivalent job titles may need to apply in terms of the authority being delegated and where this is uncertain, approval from the finance department should be sought.

In the event that staff to which authority has been delegated are absent, then approval / authority reverts to line manager or equivalent (and related) post.

All limits quoted are assumed to include VAT irrespective of whether this is reclaimable or not.

DETAILED SCHEMEOF DELEGATION

			AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1	**MANAGEMENT OF BUDGETS**			
	a	At individual budget level (pay and non pay)	BM	SFI Section 3 / FP03-01 Budgetary Control
	b	At service level	AD, Dir or ED	
	c	For the totality of services covered by the Assistant Director (or equivalent) or Service Director	Dir, ED or CE	
	d	For all other areas (including, but not limited to, utility bills, phone bills, inter-NHS invoices, lease car invoices, which may be charged to a delegated budget or control account)	DCFO / HoFM / HoFA / DHoFA	
	e	Approving expenditure up to an increase of 10% on the tender price or £20k whichever is the lower.	DCFO / Dir / ED	
	f	Approving expenditure as above, but up to a maximum of £100k.	CE	
	g	Approving expenditure as above, but over £100k	BoD	
2.1	**NON-PAY REVENUE AND CAPITAL EXPENDITURE – REQUISITIONING, ORDERING AND PAYMENTS OF GOODS AND SERVICES**			
	a	i) Up to an individuals authorised signatory limit but not exceeding £4,999	Other Staff	SFI Section 9 / FP01-03 Requisitioning of Goods and Services
		ii) Requisitions / invoices up to £9,999	BM	
		iii) Requisitions / invoices up to £24,999 or up to individuals authorisation limit (whichever is lowest)	AD	
		iv) All requisitions / invoices from £25,000 to £49,999	Dir / ED	

	v) All requisitions / invoices from £50,000 to £99,999	DCFO and ED	
	vi) All requisitions / invoices from £100,000 to £249,999	ECFO or CE	
	vii) All requisitions / invoices from £250,000 to £999,999	ECFO and CE	
	viii) All requisitions / invoices over £1 million	Reserved for Board and verification against Register of Interest	
	ix) Placing official orders on receipt of a signed valid requisition up to £249,999	HoP	
	x) Placing official orders on receipt of a signed valid requisition over £250,000	HoP and CE / ECFO / DCFO / HoFM / HoFA	
b	Non-pay expenditure in excess of allocated resources and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a).	Dir, ED or CE	
2.2	**BUDGET VIREMENTS**		
a	**Virements within a cost centre / directorate**		SFI Section 3 / FP03-01 Budgetary Control
	i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	
	ii) Within pay / non-pay lines above £100,000 and all transfers between pay and non-pay lines	Dir or ED	
b	**Virements between directorates**		
	i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	
	ii) Within pay / non-pay lines above £100,000 and all transfers between pay	Dir or ED	

	and non-pay lines		
3	**CAPITAL EXPENDITURE**		
	a Approval of the release of funds to individual capital schemes from the capital allocations approved by BoD as part of the Operational / Annual Plan each year and ability to vire between capital allocations,		SFI Section 11
	i) Up to £999,999	CE or ECFO	
	ii) Over £1,000,000	PIT	
	b Approval of any new capital allocations not included in Operational Plan, and any requests which exceed total capital allocated in Operational Plan	PIT	
	c Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations.	ECFO / DCFO / Lead Director for estates / HoE	
	d Financial monitoring and reporting on all capital scheme expenditure.	ECFO / DCFO	
	e Leasing of equipment and other assets, where the overall value (average value X number of years) is:		
	i) Up to £49,999	ED	
	ii) Up to £999,999	CE or ECFO	
	iii) Over £1 million	CE and ECFO	
4	**REQUIREMENTS FOR QUOTATION, TENDERING AND CONTRACT PROCEDURES FOR EXPENDITURE / INCOME PROPOSALS, WHETHER CAPITAL OR REVENUE, PURCHASES OR DISPOSALS**		

In line with EU terms, limits are based on the value for the length of the contract. In the interest of ensuring that a wide range of contractors have the opportunity to submit competitive tenders, each competitive tender should provide for the opportunity for at least one contractor to bid that has not tendered within the preceding 12 months. Contracts will be advertised on the 'Contract Finder' website in line with current DH limits. The use of framework agreements should be considered where appropriate. All quotes and Bid Request/Option Appraisal/FBC should be appended to order when raised.		SFI Section 11 / Standing Orders Section 9
a Obtaining a minimum of 3 written quotations for all goods/services over £10,000 and up to £24,999.		
b Obtaining a minimum of **3 written quotations** for goods/services from £25,000 to £99,999 including a clear auditable selection process and Bid Request form recommended by CPPG where applicable		
c i) Invite a minimum of 5 bidders (where available) to submit written competitive tenders for goods/services from £100,000 to £999,999 (in line with EU limits) and Options Appraisal form recommended by CPPG where applicable		
ii) Invite a minimum of 5 bidders (where available) to submit competitive tenders for goods / services above £1,000,000 (in line with EU limits) and Full Business Case recommended by CPPG where applicable		
d New business developments and Income Generation opportunities. The ability to approve tender submissions where;		SFI Section 20
i) Annual Tender price up to 2.5% of Trust annual income.	CE and ECFO	
ii) Annual Tender price between 2.5% and 5% of Trust annual income	PIT	
iii) Annual Tender price on Sole Supplier cumulatively on a number of different	BoD	

	projects above 5% of Trust annual income. iv) All transactions deemed to be significant in terms of a deminimus limit of £10m (per annum) and the Trusts risk management framework (and in addition to above delegated approval) require involvement of Council of Governors		
	e Approval of contract in reference to new business ventures	BoD	
5	**SETTING OF FEES AND CHARGES** (subject to 4e for new business / tender opportunities)		
	a Overseas visitors, income generation and other ad-hoc patient related services	ECFO and Operational ED's	SFI Section 6 and 7
	b Price of NHS Contract Charges for all NHS legally binding contracts be they block, cost per case, cost and volume or spare capacity	CE and ECFO	
6	**ENGAGEMENT OF STAFF NOT ON THE ESTABISHMENT**		
	a Booking of medical locums	Medical Director / Deputy Medical Director	HR40 Deployment of Temporary Workers Policy
	b Booking of nursing agency staff	Executive Nurse / ED Operations / Operational Directors	
	c Booking of AHP agency staff	ED Operations / Operational Directors	
	d Booking of all other agency staff	ECFO / DCFO	
	e Breaching of agency cap and thresholds	ED	
7	**EXPENDITURE ON CHARITABLE AND ENDOWMENT FUNDS**		

a	Up to £5,000 per request or up to individuals charitable fund authorised limit	Fund Manager or nominated deputy	SFI Section 16 / FP09/03 Charitable Funds
b	Up to £5,000 per request	Fund / Service Director	
c	Up to £10,000 per request	Charitable Fund Committee	
d	Above £10,000 per request or above authorisation limit	BoD	
e	Overall financial management of Charitable Funds	Financial Trustee	
f	Overall management of Charitable Funds	BoD	
8	**AGREEMENT / LICENSES OF TRUST OWNED PROPERTIES**		
a	Extensions to existing leases	ECFO / Lead Director for Estates / HoE	FP05/01 Leasing Procedure
b	Letting of premises to outside organisations	ECFO and CE	
c	Approval of rent based on professional assessment	ECFO	
d	Preparation and signature of all tenancy agreements / licences for all staff subject to Trust Policy on accommodation to staff	HoE / Lead Director for Estates	
9	**CONDEMNING AND DISPOSAL**		
a	Items of equipment which are obsolete, obsolescent, redundant, irrepairable or cannot be repaired cost effectively:		SFI Section 13 / FP05/02 / RMPG13c
	i) Individual items not on the asset register	BM / Facilities	
	ii) Individual items on the asset register up to £10,000	DCFO (& noting to Audit	

		Committee)	
	iii) Individual items on the asset register up to £100,000	ECFO (& noting to Audit Committee)	
	iv) Individual items on the asset register above £100,000	Audit Committee (& noting to BoD)	
	b Land and buildings which are surplus to Trust requirements or held for sale	BoD (as detailed in Operational / Annual Plan)	
10	**DEBTOR WRITE OFFS / OTHER WRITE OFFS / LOSSES AND SPECIAL PAYMENTS**		
	a Up to £10,000 per item	DCFO (& noting to Audit Committee)	SFI Section 13 / FP09/01
	b Between £10,000 and £99,999	ECFO (& noting to Audit Committee)	
	c Over £100,000 per item	Audit Committee (& noting to BoD)	
	d Special Severance Payments (irrespective of value)	HM Treasury	
	e Financial remedy to a complaint:		CPG2 (Appendix 2)
	i) A direct quantifiable loss of up to £50	Director	
	ii) A direct quantifiable loss of over £50 / All non-quantifiable losses	ECFO, NED & Lead Director for Complaints	
	iii) All financial remedies approved by the Ombudsman	Director / ED for relevant service	
11	**REPORTING OF INCIDENTS TO THE POLICE**		

	Where a criminal offence is suspected of a non-fraud nature	Dir / AD / Managers, ECFO, DCFO or nominated deputy	SFI Sections 2 and 13
12	**PETTY CASH DISBURSEMENTS**		
a	Expenditure up to £100	Petty Cash Holder	
b	Expenditure in excess of £100	Approval of CE / ECFO / DCFO	
c	Reimbursement of clients money	Welfare & Cashier Officer	
13a	**RECEIVING GIFTS**		
a	Gifts from current or potential suppliers / contractors:		
i)	Low cost branded promotional items (eg pens / post-its) up the value of £6 can be accepted and do not need to be declared	All staff	
ii)	Anything else should be declined whatever their value	All staff	
b	Gifts from other sources (eg patients, families, service users):		
i)	All cash and vouchers to individuals to be declined	All staff	
ii)	Modest gifts of less than £50 can be accepted and need not be declared	All staff	
iii)	Gifts over £50 can be accepted on behalf of the Trust (not by individual) with the approval of the Service Director and must be declared	Director & Declaration Form	
13b	**ACCEPTING HOSPITALITY**		
a	Meals and Refreshments:		

	i) Under £25 can be accepted and need not be declared	All staff	
	ii) Between £25 and £75 can be accepted and must be declared	All staff & Declaration Form	
	iii) Over £75 are to be routinely declined	All staff	
	Iv) In exceptional circumstances, over £75 can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
b	Travel and Accommodation:		
	i) Modest offers related to attendance at events can be accepted and must be declared	All staff & Declaration Form	
	ii) In exceptional circumstances, other offers which go beyond modest or are of the type the Trust would not usually offer can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
13c	**OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)**		
a	Outside employment	All staff & Declaration	
b	Shareholdings and other ownership issues	All staff & Declaration	
c	Patents / intellectual property rights	All staff & Declaration	
d	Loyalty interests	All staff & Declaration	
e	Accepting sponsorship	Director in conjunction with Trust Secretary	
f	Sponsored research	Research & Innovations Department HR Department	CPL19

	g Sponsored posts h Clinical private practice	All staff & Declaration	CP48 / CPG48
13d	**DONATIONS TO EPUT CHARITY**		
	a From current / potential suppliers should be declined	All staff	Charitable Funds Policy & Procedure
	b In exceptional circumstances, such donations can be accepted with the approval of the Service Director and must be declared	Director & Declaration Form	
	c Other donations / legacies can be accepted	All staff	
13e	**OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)**		
	At every stage of procurement, steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. Records will be kept that show a clear audit trail of how conflicts have been identified and managed. Conflicts of interest must be declared.	All staff & Declaration	CP8 / CPG8
14	**IMPLEMENTATION OF INTERNAL / EXTERNAL AUDIT AND LCFS RECOMMENDATIONS**	Directors	SFI Section 2
15	**MAINTENANCE AND UPDATE OF TRUST FINANCIAL PROCEDURES**		
	a Approval of finance policies and procedures	Audit Committee	
16	**INVESTMENT OF FUNDS**		
	a Investment of Exchequer Funds (day to day) b Investment of Charitable Funds	DCFO Charitable Funds Committee	SFI Section 5 SFI Section 16 / FP09/03a (appendix 1)
17	**PERSONNEL AND PAY**		SFI Section 8
	~~a~~ ~~Authority to fill unfunded post on the establishment with permanent staff~~	Directors or nominated	HR57 / HRPG57

~~b~~		~~Authority to appoint staff to post not on the formal establishment~~	deputies CE and ECFO for resource allocation	
a		**Additional Increments** The granting of additional increments to staff within budget	Deputy Director of HR / Remuneration Committee	HR57 / HRPG57
b		**Upgrading and Regrading** All requests for upgrading / regrading shall be dealt with in accordance with Trust Procedure and there shall be no provision beyond this for regrading of posts	ED responsible for People Management	Job Matching and Evaluation Policy and Procedure HR15 / HRPG15
c		**Establishments**		
	i)	Additional staff to the agreed establishment with specifically allocated finance	AD	
	ii)	Additional staff to the agreed establishment without specifically allocated finance	CE and ECFO	
d		**Pay**		
	i)	Authority to complete standing data forms effecting pay, new starters, variations and leavers	Deputy Director for HR or nominated deputy / Directors / BM or Manager with delegated authority	
	ii)	Authority to complete and authorise positive reporting forms / finalise rotas in Health Roster	AD / Directors / BM or Manager with delegated authority	
	iii)	Authority to authorise overtime	AD / Directors / BM or Manager with delegated	

			authority	
e		**Travel and Subsistence Expenses**		
	i)	Authority to approve up to three months following month in which expense was incurred	AD / BM or Manager with delegated authority	
	ii)	Authority to approve if over three months following month in which expense was incurred	ECFO and Deputy Director for HR	
f		**Leave**		
	i)	Approval of annual leave	Line / Departmental Manager	
	ii)	Approval of carry forward of annual leave up to a maximum of 7 days	AD	
	iii)	Approval of carry forward of annual leave up to a maximum of 10 days	Director	
	iv)	Approval of carry forward of more than 10 days of annual leave where there has been no long term absence in the year	Remuneration Committee	
	v)	Approval of carry forward of more than 10 days of annual leave where there has been absence due to maternity / long term sickness	AD / BM / Director or Manager with delegated authority	Employee Wellbeing & Management of Sickness Absence (HR26 / HRPG26b), Maternity & Adoption, Paternity, Parental Leave & Shared Leave Procedure (HRPG24b)
	vi)	Compassionate leave (see HR Policy for limits)	AD	Leave Policy HR24 / Special Leave Procedure HRPG24c

	vii)	Special leave arrangements including paternity and carers leave (see HR Policy for limits)	AD / Director	Special Leave Procedure HRPG24c
	viii)	Leave without pay	Director	Special Leave Procedure HRPG24c
	ix)	Medical staff leave of absence	Medical Director & CE	
	x)	Time off in lieu	Approval in line with departmental guidance	Time Off In Lieu Policy & Procedure HR47 / HRPG47
	xi)	Maternity leave – paid and unpaid	Automatic approval with guidance	Leave Policy HR24 / HRPG24b
g		**Sick Leave**		
	i)	Reinstatement of half pay in accordance with S14.9 of AfC terms and conditions of service	Director in conjunction with Director responsible for People Management	Employee Wellbeing & Management of Sickness Absence Policy / Procedure HR26 / HRPG26b
	ii)	Return to work part time on full pay to assist recovery	Director in conjunction with Occupational Health Department	
	iii)	Extension of sick leave on full pay or half pay in accordance with Section 14.12 of AfC terms and conditions	Director responsible for People Management and CE	
h		**Extended Study Leave or Study Leave Outside the UK**		
	i)	Study leave outside the UK	Relevant Remuneration Committee & Workforce Development Approval	Whitley Council / NHS T&Cs (AFC) & CE / Study Leave

			Panel	Policy HR18
	ii)	Medical staff study leave (UK)	Workforce Development Approval Panel	Trainee & Trust Grade Doctors Procedure HRPG18c
	iii)	All other study leave (UK)	Workforce Development Approval Panel	Study Leave Policy & Procedure HR18 / HRPG18a/b
	iv)	General study leave	Line Manager	
i		**Relocation Expenses**		
		Authorisation of payment of relocation expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		HR57 / HRPG57
	i)	Up to £8,000	Director	
	ii)	Over £8,000	CE	
j		**Grievance Procedure**		
		All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a HR Advisor must be sought when the grievance reaches the level of a Director.	Director for People Management	HR2 / HRPG2a / HRPG2b
k		**Authorised ~~Car and~~ Mobile Phone Users**		
	~~i)~~	~~Requests for new posts to be authorised as car users~~	~~Director~~	
	ii)	Requests for new posts to be authorised as mobile telephone users	Director (plus Director for IT)	
l		**Renewal of Fixed Term Contract**	Director in accordance	HR57 / HRPG57

			with Recruitment & Retention Policy (HR57)	
	m	**Redundancy**	Director responsible for People Management & ET in accordance with Staff Affected by Organisational Change Policy	Organisational Change Policy and Procedure HR1 / HRPG1a
	n	**Ill-Health Retirement** Decisions to pursue retirement on the grounds of ill-health	AD in conjunction with Occupational Health and HR Department	HR26 / HRPG26b
	o	**Dismissal**	In accordance with Trust Procedure	HR27 / HRPG27a/ HRPG27b/ HR26/ HRPG26b
18	**AUTHORISATION OF NEW DRUGS**			
	a	With additional implications of up to £4,999 per annum (compared with existing therapy)	Medicines Management Group	
	b	With additional implications of over £5,000 per annum (compared with existing therapy)	ET	
19	**AUTHORISATION OF SPONSORSHIP DEALS**			
	a	Authorisation of clinical sponsorship deals	CE, Medical Director, Medicines Management Group	CLP51
	b	Authorisation of other sponsorship deals	Director / ED / CE	
20	**AUTHORISATION OF RESEARCH PROJECTS**		Research Governance Group	

21	**AUTHORISATION OF CLINICAL TRIALS**	Research Governance Group	
22	**INSURANCE POLICIES AND RISK MANAGEMENT**	CE and ECFO	
23	**PATIENTS AND RELATIVES COMPLAINTS**		
a	Overall responsibility for ensuring that all complaints are dealt with effectively	Lead Director for Complaints	CP2
b	Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	AD	
c	Medico-legal complaints – co-ordination of their management	Lead Director for Clinical Negligence / Insurance	
24	**RELATIONSHIPS WITH PRESS**		
a	Non-emergency general enquiries		CP51
i)	Within hours	Head of Communications	
ii)	Outside hours	Director on Call	
b	Emergency enquiries		
i)	Within hours	Head of Communications	
ii)	Outside hours	Director on Call	
25	**INFECTIOUS DISEASES AND NOTIFIABLE OUTBREAKS**	Duty Officer / Director on Call / ED for Operations	

26	**EXTENDED ROLE ACTIVITIES**		
	Approval of nurses to undertaken duties / procedures which can properly be described as beyond the normal scope of Nursing Practice	CE, Medical Director and Executive Nurse	
27	**PATIENT SERVICES**		
	a Variation of operating and clinic sessions within existing numbers,		
	i) Outpatients	EDs in consultation with Medical Director	
	ii) Other	EDs in consultation with Medical Director	
28	**FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE**		
	Professional recognition, honorary contracts and insurance of medical staff	Director	
	Work experience students	Director	
29	**REVIEW OF FIRE PRECAUTIONS**	Fire Safety Officer	
30	**REVIEW OF ALL STATUTORY COMPLIANCE LEGISLATION AND HEALTH AND SAFETY REQUIREMENTS, INCLUDING CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH**	Health and Safety Manager	
31	**REVIEW MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AUTHORITY (MHRA) AND DRUG ALERTS ISSUED BY THE CENTRAL ALERTING SCHEME**	Chief Pharmacist / Accountable Officer for Controlled Drugs	
32	**REVIEW COMPLIANCE WITH ENVIRONMENTAL REGULATIONS (EG THOSE RELATING TO CLEAN AIR AND WASTE DISPOSAL)**	HoE and AD's	

33	**REVIEW OF TRUSTS COMPLIANCE WITH THE DATA PROTECTION AND FREEDOM OF INFORMATION ACTS**	Lead AD / Lead Director for Data Protection & FOI	
34	**MONITOR PROPOSALS FOR CONTRACTURAL ARRANGEMENTS BETWEEN THE TRUST AND OUTSIDE BODIES**	Lead Director for Contracting	
35	**REVIEW THE TRUSTS COMPLIANCE WITH ACCESS TO RECORDS ACT**	Lead Director for Information	
36	**REVIEW OF THE TRUSTS COMPLIANCE CODE OF PRACTICE FOR HANDLING CONFIDENTIAL INFORMATION IN THE CONTRACTING ENVIRONMENT AND THE COMPLIANCE WITH SAFE HAVEN PER EL(92)60**	Lead Director for Information	
37	**THE KEEPING OF A DECLARATION OF INTERESTS REGISTER**	Trust Secretary / ED	SO Section 6
38	**ATTESTATION OF SEALINGS IN ACCORDANCE WITH STANDING ORDERS AND USE OF SEAL**	Trust Chair & CE	SO Section 12
39	**THE KEEPING OF A REGISTER OF THE USE OF THE TRUST SEAL**	Trust Secretary	SO Section 12
40	**THE KEEPING OF THE HOSPITALITY REGISTER**	CE and Directors for their respective services	
41	**RETENTION OF RECORDS**	Lead Director for Information	SFI Section 18
42	**CLINICAL AUDIT**	Quality Committee	
43	**OPENING OF TENDERS**		SO Section 9
	a Responsibility for ensuring conflict of interest forms are completed	Contracts Department	
	b Responsibility for reviewing audit trail of current and closed tenders	Contracts Department	

44	**CARRY OUT DUTIES RELATING TO FRAUD AND CORRUPTION**	Local Counter Fraud Specialist / ECFO	
45	**AUTHORISING, MANAGING AND PROCESSING CLINICAL NEGLIGENCE AND INSURANCE CLAIMS**		
	a Day to day management of clinical negligence and insurance claims	Lead Director for Clinical Negligence / Insurance	
	b Authorisation of payments for clinical negligence and insurance claims,		
	i) Up to £10,000	Lead AD	
	ii) Up to £50,000	Lead Director for Clinical Negligence / Insurance	
	iii) Above £50,000	As per limits in section 2.1	
46	**LEASE / SALARY SACRIFICE CARS**		
	a Authority to designate posts eligible for lease cars involving a Trust contribution (Standard or Senior Manager schemes)	Director	
	b Requisitions and ordering of leased vehicles on receipt of authorisation from manager	DCFO / HoFA / HoFM / DHoFA	
	c Payment of invoices and signing of contracts	DCFO / HoFA / HoFM / DHoFA	
47	**LEGAL SERVICES**		
	Authority to engage any of the Trust's panel law firms	Persons authorised in legal protocol	

DETAILED SCHEMEOF DELEGATION

		Agenda Item No: 9a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 September 2020**

Report Title:	**Use of Corporate Seal**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Angela Horley PA to CEO, Chair and NEDs					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	**x**	**Level 2**		**Level 3**	

Purpose of the Report		
This report updates the Board of Directors of when the Trust Corporate Seal has been used.	**Approval**	
	Discussion	
	Information	X

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The EPUT Corporate Seal has been used on the following occasions this month:

- ADSI – for 12 car parking spaces that the Trust leases and support Pride House. Lease is for three years
- Report on Lease – 12 Doolittle Mill, Froghall Road, Bedfordshire

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	x
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

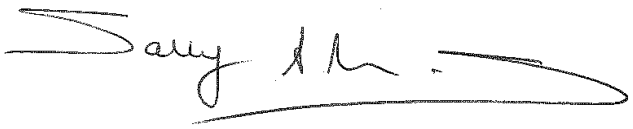
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	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

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

Acronyms/Terms Used in the Report

Supporting Documents and/or Further Reading

Lead



Sally Morris
Chief Executive