Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 29 September at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	Presentation Mental Health Family Group Conference Service Dr Lynn Prendergast, Associate Director, Social Care			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 28 July 2021	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Mental Health Act Annual Report 2020/21	NH	Attached	Approval
(c)	Workforce Disability Equality Standard (WDES) Report 2021	SL	Attached	Approval
(d)	NHS Workforce Race Equality Standard (WRES) Report 2021	SL	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2020/21	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Charitable Funds Committee	AS	Attached	Noting
	(iii) Finance & Performance Committee	ML	Attached	Noting
	(iv) Quality Committee	RH	Attached	Noting
9	**RISK ASSURANCE REPORTS**			

	(i) COVID-19 Assurance Report	PS	Attached	Noting
	(ii) Ligature Risk Management Q1	PS	Attached	Noting
	(iii) EPUT Winter Planning 2021-22	NL	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	Mid & South Essex Community Collaborative - Transition to Decision-Making Form	PS/JWi	Attached	Approval
(b)	New Strategic Objectives and Accountability Framework	PS/TS	Attached	Approval
11	**REGULATION AND COMPLIANCE**			
(a)	Review of SFIs and Standing Orders	TS	Attached	Approval
(b)	CQC Compliance Update	PS	Attached	Noting
(c)	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2021	PS	Attached	Noting
(d)	CP15 – Code of Conduct for Members of the Board of Directors	JD	Attached	Approval
(e)	Chair and Chief Executive Officer: Division of Responsibilities	SS	Attached	Approval
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Not Used	Approval
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** Wednesday 24 November 2021 at 10:00			
16	**DATE AND TIME OF FUTURE MEETINGS** 26 January 2022 at 10.00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 28 July 2021
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Major Projects
Dr Milind Karale (MK)	Executive Medical Director
Alex Green (AG)	Executive Chief Operating Officer
Janet Wood (JW)	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
Mateen Jiwani (MJ)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
James Day	Interim Trust Secretary
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Administrator
Simon Covil	Director of Finance (Deputising for Trevor Smith)
Janette Leonard	Director of ITT (Deputising for Trevor Smith)
Alisdair Bovaird	Support to Independent Inquiry
David Short	Public Governor
Dianne Collins	Public Governor
John Jones	Public Governor
Keith Bobbin	Public Governor
Pippa Ecclestone	Public Governor
Stuart Scrivener	Public Governor
Dr Judith Friedman	Consultant Clinical Psychologist
Pam Madison	Public Governor
Judith Wooley	Public Governor
Victoria Green	CQC

SS welcomed the Board members, Governors and members of the public who had joined this virtual meeting. SS advised that Victoria Green from the CQC was in attendance as an observer and introduced AB who had been appointed to support the independent inquiry as an independent consultant to demonstrate openness and bring scrutiny and challenge to the Trust's engagement.

The meeting commenced at 10:02

077/21 APOLOGIES FOR ABSENCE

Apologies were received from Trevor Smith and Rufus Helm.

078/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

Signed: …… Date: ……

In the Chair

079/21 PRESENTATION: HERE FOR YOU

JF advised that the Here For You service was a confidential staff support service that was available for Health and Social Care colleagues and third sector organisations across Herts and Essex and was available 24 hours a day, seven days a week. There had been a 123% increase in calls / contacts to the service since June following a broadened outreach offer. There have been 707 in reach calls since January and outreach work has connected with 2683 people. The dedicated website continues to have an increased number of 'hits' month on month.

The service uses a variety of engagement methods including webinars, training programmes, pop up events, reflective practice groups and drop in sessions. The team is a multi-disciplinary team and funding has now been agreed for full establishment.

Main themes identified from engagement with individuals thus far includes:

- Burnout
- Compassion fatigue
- Moral injury
- Low mood / depression
- Anxiety regarding organisational changes
- Pandemic specific social anxiety

While themes from team engagement are:

- Loss of team identify / fragmentation
- Varying levels of productivity, lack of resources and a lack of clear communication
- Bullying from avoidance to stigmatising use of OH and return to work challenges

Feedback from webinars has suggested that those attending have been happy with the webinar experience and are likely to recommend to colleagues.

JF stated that in terms of delivery considerations, there is varying integration of Here for You by the ICS system and there is a lack of security of long term funding.

SS thanked JF for the informative presentation on this worthwhile service provided to our staff and Health and Social Care and voluntary sector colleagues.

AG noted the phenomenal activity levels that have been seen and the wider strategic learning regarding how we work with partners across systems.

NH congratulated the team and stated that a mark of success is hearing about the service being spoken about and recommended by system partners, and agreed that the challenge is how to maintain this level of staff to support going forward with the uncertainty of longer term funding.

MJ agreed that this was an interesting presentation and suggested there was scope for technology resources to be utilised in different ways, scaling out resource for low lying members and focussing face-to-face interactions for those with complex needs. However, MJ noted that this was a consideration for the future as we begin to know more about the anticipated wave of MH issues following the pandemic. JF advised that following the first wave of the pandemic, brochures and videos were produced regarding the impact of Covid which were bite size pieces given help and advice as to how to deal with issues. JF stated that there is an element of 'people power' and bringing resources to people but confirmed that the use of technology was being explored.

ARQ was impressed by how the team had engaged and broken the stigma of 'reaching out' enabling a preventative approach to develop.

In response to a query, JF confirmed that Moral Injury was the sense of having to carry out a role against your moral code, giving an example of nurses working on Covid wards feeling that there was potentially as much dignity for dying patients due to infection risks as a result of the pandemic. ARQ thanked JF for this a powerful example.

ARQ asked how links were initiated with other initiatives across the Trust, for example Freedom to Speak Up, and how they can interlink to address underlying issues. ARQ also queried how the impact and results of the service were measured. JF confirmed that the service worked with SL and team to pull together evidence of the impact of the service and the tie-in element of what we do for our staff. SL stated that the service had been extremely powerful and helpful for our workforce. SL continued that triangulation work is happening alongside data from the Freedom to Speak Up service. System feedback has also been extremely positive in relation to this service.

SS noted the phenomenal situation that had led to the development of this system wide service and stated that it was a real exemplar of providing support to our staff and the system.

LL noted the positive feedback in terms of the service and queried whether there was scope to use this model in a system-wide or national setting. SL responded that JF had created a model for a commercial product notwithstanding that this is a relatively new service that is being given the chance to build, grow and develop.

080/21 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 26 May were agreed as an accurate reflection of discussions held. ML referred to a query raised by JJ relating to Out of Area Placements. MK highlighted that there is a detailed report within the Quality and Performance Scorecard regarding this; however MK reported that currently there are 23 OOAPs with a target to reach zero by September 2021. This target remains and has been reviewed at the Finance and Performance Committee.

081/21 ACTION LOGS AND MATTERS ARISING

The action log was reviewed as follows:

- 033/21 – this action is linked to the HR review. There is a lot of work being undertaken following this review and as such, this action has been deferred to November 2021.
- 040/21 – as above. Action deferred to November 2021.

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

The Board discussed and approved the Action Log.

082/21 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.

SS advised that in line with the Trust's priority and focus on patient safety, a new Board Safety Oversight Group had been established and would be held monthly chaired by ARQ.

SS highlighted and congratulated Tower Ward for achieving the Gold Standard Framework (GSF) Accreditation for end of life care. Tower Ward were the first mental health unit in the country to achieve this accreditation.

SS was also pleased to advise that she and the NEDs has recommenced service visits and hoped to soon recommence the 15-step visits programme with governors.

The Board received and noted the Chair's Report.

083/21 CEO REPORT

PS highlighted the following key messages:

- There is a lot to celebrate as we continue with and adapt the vaccination project to meet the changing needs.
- Covid is still with us and as a result of the increase in the Delta variant, Gold Command has been stepped up to meet twice weekly.
- EPUT are formalising partnerships at both local and regional level including an East of England Specialist Services partnership and a collaborative between the three physical community health providers in Mid and South Essex.
- PS and the Chair have been engaging with leaders of the voluntary and charitable sector to explore how EPUT can contribute more in this area.
- Services continue to experience tremendous pressure and staff are fatigued after the past 18 months however EPUT continues to support staff in many ways, with the Here for Your Service a shining example.
- The Executive Team have identified four key areas for our priority focus: Safer Staffing, Culture of Learning, Ligature Risk Assessment and Observation and Engagement. These four key areas of priority focus are overseen by the Executive Safety Oversight Group (ESOG) and the newly established Board Safety Oversight Group.

The Board received and noted the CEO's Report.

084/21 QUALITY AND PERFORMANCE SCORECARD

NH provided the following update from a safety perspective:

- We continue to reinforce the Safety Strategy and the four key areas of priority focus with resources in place to support each area.
- We have an ambition to reduce the use of bank and agency staff and move bank staff to substantive positions, working towards our safety ambitions with tools to manage this safety.
- Oxehealth pilot programme is due for completion in September.
- Observation and engagement process is subject to daily and weekly review and a significant improvement in compliance has been noted.
- To enhance work being undertaken in regard to ligature management, a dedicated project office support will work alongside our Patient Safety Ligature Coordinator that will sit in our estates and facilities team. The focus will be to ensure all required remediation works are planned and delivered.
- Director of Patient Safety has developed a PID around the Culture of Learning and NH was excited to see this develop and flourish.
- Restrictive practice had been challenging due to the pandemic and more environmental restrictions, however an improvement has been seen in terms of prone restraint.
- A process for a full learning debrief to take place regarding prone restraint has been established to review and drill down into the detail and look at alternative methods.
- A reduction has been seen in Falls of 20% year on year.
- There have been zero incidents of pressure ulcers reported year to date.

AG provided the following update in regards to performance:

- There are 24 performance and quality indicators within target.
- There are 7 inadequate indicators (variance against target / ambition) identified at the end of June 2021.
- In June a service user that was under 18 was admitted via a S136 suite due to a lack of tier 4 beds available within the system. AG provided assurance that the service user was transferred to an appropriate facility within 24 hours.
- The positive trend in out of area placements had continued with 20 service users repatriated in month. There are currently 23 out of area placements with 12 considered inappropriate due to contracting arrangements. AG confirmed that we are on track to meet out zero OOAP ambition by September.
- Occupancy rates were 98.2%, outside the national benchmark of 94%.

SC provided the following update in regards to finance:

- The current revenue position shows at M3 year to date £0.1m deficit against a breakeven year to date plan.
- Year to date capital spend is in line with planned expectations. Progress on delivery of profiled plans will require continued in year monitoring.
- Sufficient cash resources are in place to meet trading operations.
- There is a continued drive to accelerate recruitment to deliver MHIS schemes.
- H2 allocations and funding settlements remain uncertain. Block contracts to continue in H2 with a national expectation that efficiency requirements will be more demanding in H2.
- The EOE Provider Collaborative is due to go live in October. A paper is to be submitted to the Audit Committee to unpick the financial flows in the agreement.
- EPUT are continuing to work with ICS colleagues regarding financial sustainability.

SL provided the following update in terms of HR:

- SL stated that as an Executive Team there is a commitment to be open, transparent and accessible.
- The current vacancy rate is 6.4% against a target of 12%.
- The current turnover rate is 9.5% against a target of 12%.
- There were 85 staff members joining the organisation in May and 72 new starters in June 2021. This has decreased from April. 45 staff left the Trust in April 2021 and 34 in June 2021. The Trust has seen a reduction in leavers since the previous report.
- Staff have the opportunity to feedback to the Executive Team via a variety of channels and forums including 'The Grill' with engagement champions, Leadership L30 and L100 meetings.
- A commitment to transfer bank and agency spend to substantive roles has not been an easy task but a dedicated team are in place to work on this and a full establishment review will take place in the coming months.

MK advised that in terms of Quality and Safety, the roll out of Storm suicide prevention training continues and lunchtime learning sessions also continue to ensure learning and sharing of good practice.

ARQ noted the impact of the appointment of the Director of Patient Safety as per NH's update and queried how the 'lessons learned' log is to be actioned on the ground. NH agreed that the Director of Patient Safety had made a positive impact since joining the Trust and brought a wealth of knowledge and experience to the role. The Director of Patient Safety had commenced a robust induction programme including visits to services across the organisation and was a member of the ESOG meeting. As previously mentioned the Director of Patient Safety had developed a PID in regards to Culture of Learning and was undertaking some exiting work with the Ministry of Defence to share learning and ensure we embed change in a positive way. The

lessons log is in progress and will be a live document where solutions are shared as part of a network of communication.

LL noted that prone restraints had increased during the pandemic and queried whether there was any learning to be tracked as a result.
NH responded that it was anticipated that as the pandemic took hold that restrictive practices would increase due to the impact of deprivation of liberty measures caused by the Covid 19 restrictions on those most challenged. A rapid collaboration with ward staff to look at the immediate solution was implemented as well as prone critical debriefing sessions to look at work done with moral compassion. This had yielded some good results against a background of increased pressure. A pilot of alternative methods of exit seclusion is underway, from which we anticipate some good results.

ARQ referred to the current occupancy rate of 98.2% against the national benchmark of 94% and queried the impact of this on KPIs.
AG advised that this had been compounded by multiple issues including the drive to reduce out of area placements. Each repatriation is considered on an individual basis, and whilst this drives down the OOAP figures, it increases occupancy onwards. The mix of patients is also important, with each ward reviewed individually as well as looking at the Essex-wide position. AG continued that there are a number of actions taking place:

- Work on 'red to green' ensuring every day a patient is with us adds value and therapeutic benefit.
- Work on purposeful admissions – being clear why patients are admitted and that each inpatient admission is beneficial to patient recovery as well as identifying an expected length of stay.
- There have been challenges regarding discharge and a small number of patients with a longer than expected length of stay.
- Work with district and county councils is taking place regarding access pathways and there is some fantastic joined up work taking place within the system as to how we support discharge in a timely way.

ML noted the high bank and agency usage within CAMHS services and asked that given the known correlation between temporary staff and consistency of care, what risks do we carry in those areas? AG referred to the previously mentioned challenge and ambition to enable the transfer of temporary staff to permanent positions that was currently taking place. It is acknowledged that there is a high level of activity in CAMHS in particular having arisen since the pandemic began; this was a risk from increased activity combined with a lack of provision in alternative settings. This has resulted in high levels of observation and engagement requiring additional staff. A daily executive 'stand up' and daily sit reps are taking place with clear escalation routes in place.

AS acknowledged the pressures across all services and the additional stress the pandemic has brought; AS noted that the Board had heard that staff are tired and queried where we can assess that we are asking the right questions in terms of impact and how we triangulate the plethora of data and experience and how this is cascaded. AS continued that it is important that we balance the various risks and focus on key priorities and measure outcomes. SL responded that staff are managing huge change and transformation, coping with working in different ways with people presenting differently, and there is a sense that we are waiting for the next wave. SL suggested that as a Board, system and region, we do not tell staff they are tired but appreciate that they are working exceptionally hard and support them through this challenging time.

JW referred to the point around the level of financial uncertainty continuing for this financial year and queried how we engage and influence within the system, regional and national teams. SC advised that there are a number of collaboratives in place across the system with finance leads meeting

regularly regarding the position and run rate exercises as well as there being two deep dives into expenditure taking place. The Trust is engaged in local discussions and system working.

ARQ sought clarity / assurance around the three following issues:

- Vacancy rate of 6.4%, stating that staff continue to report being stretched and teams understaffed.
- National issue regarding isolating following contact from the NHS Track and Trace team – where are we in terms of our staff that are contacted?
- The report refers to 4000 temporary staff positions – how many are our staff already and what is the actual number of new staff?

In response to the concern regarding the Track and Trace contact, NH confirmed that if an individual was contacted and could still work remotely then this would be encouraged; however, in exceptional circumstances there is potential to request that staff do not self-isolate following contact. This is a convoluted process in which we would need to understand fully the patient and staff cohort to ensure that no one is put at risk. NH reiterated that this would be in exceptional circumstances and a process / matrix for clear decision making was being developed as well as a request made to the national team for further clear guidance.

ML referred to page 10 of the report in which a proposal to change the metric in time to hire data and did not agree with this proposal. SL acknowledged that there are two distinct metrics to be recorded – time to hire from approval of vacancy to offer and time to onboard from approval of vacancy to commencement in post.

PS reiterated that this was a very challenging time but huge achievements have been made and we have the drive and ambition to move forward in a compassionate way.

The Board of Directors received and noted the report.

085/21 BOARD CHAMPIONS – NED AND EXEC LEADS REQUIREMENTS

SS advised that she and PS had reflected and updated the NED and Exec Lead structure to reflect recent Executive and Non-Executive changes as well as committee chair changes. Following a suggestion from Governors, this also included a restraint champion and a champion role for AHP – this is not a mandatory requirement but it was agreed that this role would be beneficial.

SS noted that NHSE are considering mandating a board champion role for Privacy and Dignity; this will be reviewed if needed following the outcome being determined.

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

086/21 INFECTION PREVENTION AND CONTROL ANNUAL REPORT

NH presented the IPC annual report, which provided assurance that the Trust provides a robust, proactive and effective IPC service. This report also provides assurance that the Trust is compliant with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

NH highlighted the essential support that the IPC had given to teams across the organisation during the pandemic to alleviate fears and support staff during real and extreme pressure. NH extended her thanks and praise to the IPC team. NL echoed NH's sentiment and acknowledged the IPC team's input to the initiation of the Covid 19 vaccination programme.

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

087/21	LEARNING FROM DEATHS MORTALITY REVIEW Q4 REPORT 2020/21

NH presented the Q4 report on Learning from Deaths Mortality Review advising that there had been a significant increase in deaths in scope, which had coincided with the peak of the second wave of the Covid 19 pandemic. NH noted the significant system support EPUT had put in place including repurposing wards and community beds for end of life Covid 19 patients. NH continued that this had deeply impacted staff and reiterated the importance of the Here for You service.

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

088/21	DUTY OF CANDOUR ANNUAL REVIEW

NH presented the Duty of Candour Annual Review reporting that the Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2020/21. NH noted that in March 2021, the CQC updated the guidance to meet the requirements of the regulation and circumstances to which it must be applied.

NH advised that the duty of candour requirements are referred to in both the Patient Safety Incident Response Framework and the EPUT Patient Safety Incident Response Plan. The Trust's PSIRP was reviewed following the updated guidance and no changes were required. The EPUT Being Open Policy is currently under review to reflect both the implementation of PSIRF and the updated duty of candour guidance.

AS queried whether there is an active process to seek feedback from families, NH confirmed that there is no formalised process, but the Engagement Officer engages with families and collects feedback offered. AS considered incorporating this into our evaluation methodology.

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

089/21	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

NL presented the EPPR Annual Report highlighting the breadth of work and the connections between the Trust and the system. There is considerable scope for this piece of work and the team have been extremely active during the pandemic.

A firm process is in place along with active connectivity with local resilience forums. The volunteer function has also helped the Trust to obtain a significant number of volunteers during the pandemic, in particular at vaccination centres.

JW as Board Champion for EPPR extended thanks to NL and all within the EPRR team for their huge effort over the past year and noted the significant learning that had been captured whilst in the 'command structure' during the pandemic.

In response to a query from LL, SL confirmed that the Executive Team have implemented principles of working for all staff following learning from the pandemic.

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

090/21	DISCIPLINARY (CONDUCT) POLICY AND PROCEDURE

ML was disappointed that there was no contextual reference to the equality dimension in terms of disciplinary procedures and suggested that some contextual guidance would be beneficial. SL advised that this policy and procedure had been developed in line with guidance from NHSE but acknowledged the point.

ARQ also suggested that guidance for managers in circumstances where it is believed that allegations have been made maliciously may be beneficial.

The Board of Directors:

1. **Reviewed and discussed the Disciplinary (Conduct) Policy and Procedure.**
2. **Requested consideration be given to further development and articulation of the equalities element and guidance for managers as discussed.**
3. **Approved in principle the Disciplinary (Conduct) Policy and Procedure**

ACTION:

1. **Further development and articulation of the equalities element and guidance for managers when it is believed an allegation to be malicious to be included. (SL)**

091/21 BOARD ASSURANCE FRAMEWORK

PS advised that work continues to reset the BAF with an anticipated launch date of September 2021. During this reset it is anticipated that there will be a consolidation of a number of risks.

PS presented the BAF report which provided the EPUT Board with an overview of the BAF and Corporate Risk Register as at 28 July covering the two month period June and July 2021.

There are 17 risks on the BAF with recommendations in the report taking this to 15. It was noted that actions / decisions made at the ET Subgroup at the June meeting were as follows:

- Approved separation of risks relating to staff recovery (BAF62 amended) and recovery of services (new BAF65).
- Approved closure of BAF41 CIPs 2020/21 (end of financial year) and approval of new risk BAF66 Efficiencies 2021/22.
- Approved closure of BAF57 HSE (risk materialised)
- Noted the request from May Board that BAF64 remains at 5 x 4 = 20
- Noted Project Initiation Document in train for BAF58 Clinical Activity (record-keeping) project aligned to patient safety PMO
- Noted the following summaries for June 2021 – BAF, CRR, Covid-19 and Mass Vaccinations
- Noted review and scrutiny of action plans by Standing Committees – Quality, Finance and Performance and People, Innovation and Transformation
- Noted Q1 Key Performance Indicators Approved proposal for Electronic Risk Register
- Reviewed and approved Terms of Reference for ET Sub-Group

In terms of CAMHS, it was noted that the service remains under significant pressure with a significant risk in terms of staffing; work continues to address and mitigate this risk and Tier 4 inpatient units have been temporarily closed to admissions.

ML commended PS and the Executive Team for the way in which the BAF is reviewed rigorously and it is clear that this is a dynamic process. ML was pleased to see that the impact of morale is reflected as well as the challenge to the recovery of services post Covid.

SS was encouraged by system wide working, stating that relationships are strong and robust to enable us to continue to move ahead to manage extremely complex services.

The Board of Directors:

1. **Noted the progress on the BAF refresh and actions from the Board Development Session on risk appetite.**
2. **Noted progress on procurement of an electronic risk register.**
3. **Noted assurances to the Executive Team and the Audit Committee.**
4. **Reviewed the risks identified in the BAF 2021/22 July summary and approved the risk scores including recommended changes outlined, taking account of actions by the BAF ET Sub Group at its June meeting.**
5. **Approved the BAF risk closures and amendments iterated in the key issues and main report.**
6. **Noted the July Key Performance Indicators.**
7. **Reviewed the risks identified in the CRR 2021/22 July summary, including actions taken by BAF ET Sub Group at its June meeting.**
8. **Approved the CRR risk closures and amendments iterated in key issues and main report.**
9. **Did not identify further risks for escalation to the BAF, CRR or Directorate Risk Registers.**

092/21 STANDING COMMITTEES

(i) Audit Committee

JW highlighted that the following reports had been finalised and issued with the following assurance:

- Ligature Risks Site Visits – Design (substantial) and Operational Effectiveness (moderate).
- Data Security and protection Toolkit – Moderate assurance.

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

(ii) Finance and Performance Committee

ML thanked the commitment of the Consultants for the excellent work undertaken against the KPI for clients waiting longer than 12 months. ML stated that this is an exemplar of how MDT teamwork can help to tackle system issues and / or data accuracy issues. SS agreed that clinical leadership is essential.

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

(iii) Quality Committee

AS noted that the June Quality Committee was not quorate, however any actions were taken as 'Chairs Action'.

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

093/21 RISK ASSURANCE REPORTS

i) Covid 19 Assurance Report

PS stated that as we move into a new phase of the pandemic, the control / command structure remains in place. This has been upgraded to two meetings per week. There are currently three Covid positive patients and one outbreak within our inpatient services.

An announcement has been made of a national statutory inquiry into the Covid 19 response, EPUT are preparing for this by ensuring that all documentation is well organisation.

MJ suggested that there may be claims made against organisations by staff that may have contracted Covid 19 in the work place and therefore the Trust should consider and prepare for this.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Confirmed acceptance of assurance given in respect of actions identified to mitigate risks.**
3. **Approved the BAF38 Emergency Planning**
4. **Noted the Covid 19 Gold Risk Register and summary mitigations.**
5. **Did not request any further information or action.**

ii) EU Exit

NL advised that the requirement for highlighting any areas of concern relating to EU Exit on the Daily Sit Rep return to NHSEI has now ended and is no longer discussed in the Gold/Silver commands. This indicates that due to the lessening impact of EU Exit, reduction of notifications and reducing risks there are no significant concerns at a regional level following the transitions period of EU Exit at this time. Key messages and correspondence will continue to be monitored by the Emergency Planning team and cascaded to relevant parties for information or action as required. The Task and Finish Group can be stood up immediately should this be required.
The Executive Team BAF Sub-Group agreed the recommendation to reduce the risk score to threshold and close due to the lessening impact of EU Exit, reduction of notifications and reducing risks. This recommendation is on the Board agenda for 28th July 2021.

The Board of Directors received and noted the contents of the report, including approving the suggested approach to the risk score.

094/21 STRATEGIC INITIATIVES

i) Digital Strategy Refresh

JL presented the paper which provided the Board with information on the updated position and progress towards a new EPUT digital strategy. JL advised that with the finalisation of the ICS digital strategies, now is the time to move forward to ensure that digital is woven into the transformation of EPUT to allow it to continue to be an enabler for change. The Trust was successful in obtaining national funding through the Digital Aspirant Seed funding programme to support digital transformation. With this financial support, the IMT Team commissioned independent advice and support which has worked with all three Essex ICSs on a digital maturity model. JL confirmed that the final draft of the strategy is expected to be presented to the Executive Team by November 2021.

JL advised that a recent review of HIE technology had identified that technology used by the Trust is good which means that we can now move and drive forward in a review of clinical systems. We are engaging with suppliers with a view to look at MH system requirements going forward.

SS noted that there was a big stem of work in progress with more to come. JW was pleased to see progress and queried whether there would be additional system money

available. JL confirmed that in the first instance there is circa £5m for mental health which is match-funded.

LL noted the great start to this work and stated that in order to achieve its full potential this needs to be embedded at an operational level. For true transformation, this needs to be intertwined and LL would like to see this go beyond and get a strategy as an iterative process and engage with colleagues on the front line.

JL advised that the reason for the delay in moving forward was waiting for the new organisational strategy to be completed and agreed that we need to ensure connections and work closely with clinicians to identify what can help on the front line. JL confirmed that this is part of a fully integrated programme.

PS agreed that we need to work hard to focus our strategy on the services we provide. We are in a good place for digital to move forward and ensure connectivity and influence with the system wide digital agenda.

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

095/21 REGULATION AND COMPLIANCE

i) CQC Update

PS presented the update which provided 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.

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

ii) Safe Working of Junior Doctors Annual Report Covering April – June 2021

MK presented the report which provided assurance that doctors in training are safely rostered and that their working hours are in compliance with the Terms and Conditions of the Service.

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

096/21 USE OF CORPORATE SEAL

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

097/21 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

098/21 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.

099/21 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SL reflected that equalities and inequalities of the population and workforce are being considered in all decisions across the Trust as common practice. SS also reflected that this could be demonstrated by the challenge to further articulate this within the Disciplinary policy and procedure as discussed previously.

100/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that all Board members had remained present during the meeting and heard all discussions.

101/21 ANY OTHER BUSINESS

i) Board Oversight Safety Group

SS advised that as mentioned previously, a Board Oversight Safety Group had been established to formalise scrutiny and challenge anchored in to the Board. NH welcomed ARQ to the lead role of this group and also recognised other NEDs that were part of this group and the strong links this ensured between the Quality Committee and Audit Committee. The inaugural meeting is due to take place imminently and will provide an opportunity to continue to drive this important agenda across the organisation. ARQ advised that the TOR for this group were near completion and would be approved at the first group due to be held on 03 August; ARQ welcomed the opportunity for further board oversight, scrutiny and challenge in regards to this important agenda.

JD thanked JW as Audit Chair, AS as SID and RH as Quality Committee Chair for their participation on this Board oversight group.

There was no other business.

102/21 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 29 September 2021, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

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

103/21 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:47.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 103/21)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	On Board Champions at page 16 of 19 concerning Privacy and Dignity. There is no NED allocated. Does the Board consider it might be helpful to have an independent (NED) oversight to promote this important area?	Discussed during the meeting.
John Jones	On Agenda item 7.f, Emergency Preparedness, at 11.4 on page 14 of 17. A Power Outage on 5th April shows significant consequences listed following an incident at The Lakes and this chaos was tripped by what could have been avoided. Have these been corrected and lessons learned such that these can be transferred to all other sites?	NL responded Estates Colleagues and EPRR Team have looked into in detail. This power outage occurred due to an electricity provider off site cutting the power and the generator kicked in. Learning from this incident was that estates are looking at a potential device to send an alert when generators are activated. Normally the electricity provider would also make a correction, however this was a unique circumstance as they had incorrectly believed this was a redundant line. There are some business continuity plans to be put in place and the operational process to be adjusted.
John Jones	On Board Assurance Framework (BAF4) there is mention of backlog maintenance at Robin Pinto and Wood Lea Clinic. Is funding allocated and what work has been identified?	Anthony Flaherty: We will be carrying out compartmentation works through our backlog maintenance programme at Woodlea and Robin Pinto this year. Although this does not explicitly say that funding is available Stephen's view is that this means it is funded as it is in the backlog maintenance programme 2021/22.
Pippa Ecclestone	**CEO Report….performance scorecards** 5 areas requiring improvement' remain unchanged from last month - these include **Essex STaRS.** Could you give further detail on the issues that 'require improvement' here?	AG responded that IAPT had been impacted nationally by the lockdown and had seen access and recovery rates impacted. AG provided assurance that performance is significantly better and a recovery plan is in place as well as investment in IAPT to manage the surge. There is a concertina effect of people not having appointments during the pandemic however we are now in a stage of recovery.

Signed: …… Date: ……

In the Chair

Pippa Ecclestone	**Finance scorecard** Two items have been RAG rated 'Inadequate Is the "capital expenditure" item referred to, an EPUT or a 'System' issue?	SC confirmed that this was a system issue and EPUT are on track and in a good position.
Pippa Ecclestone	**The Quality Committee Report.** Refers to the unannounced CQC inspection of EPUT CAMHS units in May….following an SI which resulted in the death of a young person. Later on there is mention of intensive support groups being in place to complete actions in line with the issues raised. What we're the issues raised?	NH confirmed in short observation and engagement - adherence to policy time of observation not to be rounded up to the nearest 10 minutes as an example) Staffing – use of temporary staffing high to meet children acuity – skills and competencies questioned for CAMH's specialist training. Learning lessons re an incident on one unit not known by one member of staff on another. All of our key priorities – you will see under safety in Pauls CEO report is focusing across the organisation on the above

Signed: …… Date: ……

In the Chair

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 28 July 2021)

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

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

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 035/21	Refreshed Board Assurance Framework To be presented to the Board of Directors in July 2021 in line with refreshed Strategic Objectives.	PS	~~July 2021~~ ~~Sept 2021~~ Nov 2021	**Update 28.07.2021:** BAF refresh unable to take place until Board of Directors have approved strategic objectives. Timescale for strategic objectives is presentation to TB in July 2021. Therefore BAF refresh will aim for September TB. Work is underway on refresh using draft objectives and taking into account learning from Amberwing sessions. **Update 29.09.2021** Strategic Priorities to be approved at 29th September Board and to be reflected in new strategic BAF to be presented in November.	Open	
March 040/21	Engagement Strategy to be reset and presented to the next Board of Directors meeting.	SL	~~May 2021~~ ~~July 2021~~ November 2021	Part of the HR review which will be completed in June 2021. **Update 28.07.2021**: there is a lot of work being undertaken following the HR review and therefore this action is deferred to November 2021.	Open	
July 090/21	Disciplinary (Conduct) Policy and Procedure – approved in principle however further development and articulation of equalities piece and guidance for managers when it is believed an allegation to be malicious to be included.	SL	~~September 2021~~ November 2021	Deputy Director of HR is currently in the process of liaising with Non-Executive Director to gain further insight into the "further development and articulation of equalities' piece"	Open	

Agenda Item No: 5

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 September 2021

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Publication of CQC Report re EPUT Child and Adolescent Mental Health Inpatient Services
- Mid and South Essex Community Collaborative
- World Suicide Prevention Day / World Mental Health Day / World Patient Safety Day
- Staff Survey
- Service Visits
- National Data Collection Exercise
- Large Group Meetings – Future Plans

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

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
Accompanying Report

Lead
Professor Sheila Salmon **Chair of the Trust**

Agenda Item: 5
Board of Directors
29 September 2021

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Publication of CQC Report re EPUT Child and Adolescent Mental Health Inpatient Services

As you will be aware, the CQC has published their full report following their visit to EPUT Inpatient CAMHS services in May 2021. CAMHS services are under extreme pressure regionally and nationally. The CQC subsequently rated our CAMHS service as inadequate, raising significant concern, including staffing levels, robust observation and engagement processes and timely learning from patient safety incidents. We received early feedback from the CQC that until improvements had been made we should temporarily stop new admissions to Larkwood Ward, Longview Ward and Poplar Unit. The Trust took immediate actions to improve safety and considerable progress has already been achieved against the agreed action plan. Patient safety remains our highest priority and we continue to work closely with the CQC and our partners to further improve standards at these units.

2.2 Mid and South Essex Community Collaborative

Our Mid and South Essex Community Collaborative, where we are working together with NELFT and Provide to review and develop how we can best meet the needs of local communities, continues to make traction. To ensure our staff and service users are an integral part of this exciting journey, promoting co-production of services and how we work with colleagues, an Engagement Network has been established. All staff are invited to this network for updates on the key work-streams of this collaborative. Inter-connecting overarching proactive work is forging ahead in parallel with regard to patient and public engagement.

2.3 World Suicide Prevention Day / World Mental Health Day / World Patient Safety Day

This autumn we are hosting a series of online events focussing on suicide and mental health to mark three very important awareness days. This month long programme of events features training sessions, live presentations and discussions designed to get us all talking about suicide and taking action to prevent it. This is an important area of focus for everyone working at EPUT but we know that for some people it has particular personal significance. Our Here for You Service continues to be available for our staff members and colleagues across the health system.

2.4 Staff Survey

With the Staff Survey nearly upon us, the Trust are holding engagement workshops with staff to demonstrate how we have made changes based on feedback from the 2020 NHS Staff Survey and to encourage our staff to complete this year's survey. These sessions also share with staff information on how Quality Health (external survey provider) keep responses confidential and anonymous.

2.5 Service Visits

As reported in July, the NEDs and I have recommenced in person visits to services across the organisation. We have received a warm welcome from our staff and have

witnessed the dedication and commitment they have to caring for our vulnerable patients. Visits have taken place to Topaz Ward, St Aubyn Centre, Meadowview Ward, Gloucester Ward, The Lakes, West Essex Community Services at Latton Bush, Bernard and Tower Ward, 439 Ipswich Road, Thurrock Vaccination Centre and the newly refurbished Kelvedon Ward at Basildon MHU.

We are also currently looking at the recommencement of the Governor 15 Step Quality Visits to services and these will be reinstated soon, with safety as a key consideration.

2.6 National Data Collection Exercise

Our Community Nursing Service in South East Essex has been invited by NHS England and NHS Improvement to trial a new community nursing safer staffing measurement tool, looking at the workload, team staffing and service quality levels of community nursing teams. This is the first time such information has been collected at a national level and it is hoped that the findings will highlight the value and importance of community nursing. This piece of work comes as part of Chief Nursing Officer for England, Ruth May's commitment to collecting local evidence to information national transformation work.

2.7 Large Group Meetings – future plans

We are continuing to examine the safety and practicalities of resuming the conduct of large-scale meetings in public in person. There remains a significant level of Covid-19 virus in general circulation. We will therefore retain virtual meetings for the time being. This situation will be kept under close review going forward.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **Mental Capacity Act 2005, Deprivation of Liberty Safeguards – 2020-21**
  Please see the link below for a copy of the report published on 19 August 2021 that provides findings from the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) data collection for the period 1 April 2020 to 31 March 2021. **For Information: Link**

- **Untapped? Understanding The Mental Health Clinical Support Workforce**
  Please see the link below for a copy of the report published on 20 August 2021 that examines the profile of mental health clinical support staff and discusses how issues around recruitment retention can be improved. **For Information: Link**

- **Getting Ready For The COVID-19 Public Inquiry**
  Please see the link below that outlines how any organisation can be called upon to provide evidence for the inquiry that is due to begin in Spring 2022. **For information: Link**

- **A System Approach To The Demand Crunch**
  Please see the link below for a copy of the report published on 18 August 2021 that outlines what needs to be done to ensure the NHS does not become overwhelmed to include the surge in mental health and primary care. **For Information: Link**

- **Urgent Investment Needed For Children And Young People's Mental Health Services Under Severe Strain**
  Please see the link below for a copy of a report published on 25 August 2021 that outlines that further funding is required as 1.5 million children and young people may need new or additional mental health support because of the pandemic. **For Information:**

Link

- **SHARE: Consent, Confidentiality And Information Sharing In Mental Healthcare And Suicide Prevention**
  Please see the link below for a copy of the report dated 26 August 2021 designed to support health and social care staff in information sharing and suicide prevention. **For Information:**
  Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by
Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon
Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

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

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	x
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	x
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	x

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	x
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	x
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	x
CO4: 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	x

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

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			
MDP	Manager Development Programme	NHSEI	NHS England / Improvement
CAMHS	Child & Adolescent Mental Health Services	OoAPs	Out of Area Placements
PICU	Psychiatric Intensive Care Unit	DNA	Did Not Attend
EDI	Equality, Diversity & Inclusion	M4	Month 4
YTD	Year to Date	HCA	Health Care Assistant
EoE	East of England		

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Paul Scott Chief Executive Officer

Agenda Item: 6
Board of Directors Part 1
29 September 2021

CEO Report – September 2021

1.0 Introduction

I write this report at the end of summer with schools and universities returning; and other work places getting back to a "new normal". Many of my colleagues in EPUT will have taken a much needed, and well earned, break over the summer holidays. It is sometimes hard to spot the toll that the last 18 months has taken until we take a break. Colleagues in EPUT, and the wider health and care system, have worked tirelessly under very challenging conditions. I hope you got the break you deserve and have come back refreshed as we enter into the autumn and winter.

With the re-opening of society, health and care services across the country have seen a re-bound of demand in excess of that experienced before the pandemic. This is a result of a backlog of elective activity, presentations/referrals that were delayed because of the pandemic as well as a return to normal activity. Our community nursing teams are seeing unprecedented demand to support people leaving hospital as well increased requests for support from primary care – they continue to work under huge pressure and we continue to explore ways to support them more. Equally, our mental health teams continue to deal with increased demand both in terms of acuity and numbers. The Board is very conscious of this pressure and is actively listening to colleagues to ensure we understand what it is like to work in these circumstances to make sure our decision making is focussed on providing the best support we can. A number of initiatives are in place to increase permanent clinical staff, release time to care and to enhance the care we provide with cutting edge technology.

Whilst we are under pressure the appetite for continuous improvement, learning and reform in EPUT is tangible and I remain extremely optimistic that we will continue to be an organisation that is at the forefront of positive developments in clinical services. Whilst talking to colleagues across the Trust I am always struck that alongside the obvious pressure there are always examples of brilliance and people doing extra-ordinary things to support our service users and their families. It is always worth remembering that for every 1 complaint we have 9 compliments. Our services are regularly recognised for the quality of their services through awards and accreditation – the most recent being the services we provide to veterans and our dementia services who have both received accolades recently. Our vaccination services were also shortlisted for the HSJ patient's safety awards. Well done to everyone.

2.0 Key Issues

Safety

We continue to implement our safety strategy. Last month I identified our 4 priorities for this financial year which we are making progress on

- Staffing – undoubtedly this is our biggest challenge. We are investing heavily in recruitment. We have increased our permanent front line staffing budgets by £14m. We are making employment offers directly to students who will be qualifying. We will be undertaking an ambitious overseas recruitment campaign. We are also investing heavily in making EPUT a great place to be a clinician – we will be offering increasingly flexible rota's, making it less time consuming to record clinical activities, investing in training and development and developing a staffing resource that can respond flexibly to pressures as they arise in our services.

- Ward environment (including ligature risk) – our multi £m investment programme continues with newly refurbished wards being completed across our estate, we also have a clear and ambitious programme of ligature reduction to be completed this financial year.
- Culture of Learning – Our 'Schwartz rounds' initiative has been launched, with staff trained to facilitate learning panels based on compassionate care, feedback analysis was 92% recommending Schwartz rounds to colleagues, strong commitment was received to attend further sessions.
- Observation and engagement – this will be enhanced with the staffing improvements identified above and enabled by digital tools, better engagement with AHP's and improved oversight through the accountability framework.

Strategic Objectives and Accountability Framework

We are continuing with the modernisation and development of EPUT as an organisation. This means we will be better placed to face the challenges and opportunities of the future. I am pleased that Board will be receiving proposals to implement an accountability framework and our new strategic objectives in this Board meeting.

The new strategic objectives are a summation of what our colleagues, and health and care partners, have told us is important to them and I am excited to have a "true north" that will guide us over the coming months and years. By the time of my next Board report I hope that we will have implemented, subject to the correct processes, a new clinical management structure that further strengthens the clinical voice in decision making, as well as allowing increased focus on both our inpatient wards but also our place based partnerships. We will also be implementing reform to many of clinical support services so that they are best placed to support the continued improvement to EPUT's services.

The accountability framework supports the delivery of the strategic objectives. It will place clinicians at the heart of decision making and resource allocation. It helps promote collective responsibility whilst establishing clear accountability. It focuses on integrated service delivery, with greater alignment of patient, people and performance issues. It enables corporate teams to develop their business partnering approach, with a focus on data and informed discussion; it is in line with our clinically/operationally led and corporately enabled approach.

Vaccination Programme

As society returns to something akin to normal we can reflect on the success of the vaccination programme in enabling the delicate balance of restricting the spread of the virus and the re-opening society. We have learned how damaging lockdowns are to our children, our economy and our wellbeing. The vaccination teams in EPUT have now delivered well over ¾ million jabs to people in Mid and South Essex as well as Suffolk and North East Essex. Everyone involved in this should be proud of this incredible achievement. Vaccinations are still open for booking if you have not had the chance to get yours yet.

The Government has announced the extension of the vaccination programme to teenagers and the over 50's (and other cohorts of people) to receive a booster jab. I am delighted to say that we will be offering the school age vaccinations through our established School Immunisation Teams and we will be working in partnership with primary care and community pharmacies to deliver the booster jabs.

Children's and Adolescents Mental Health Tier 4 Inpatient Services (CAMHS) CQC report

The CQC recently published its report from its inspections of our CAMHS inpatient services in May. We fully accept and acknowledge the CQC's findings and we took immediate action

to re-inforce the improvements already underway. Improvements that are already in place include:

- Enhanced clinical and operational leadership
- Increased clinical workforce
- Enhanced training

We are hopeful that these improvements can lead to a safe re-opening of our service to new admissions in the near future.

The report acknowledges the context that the services were operating in and acknowledges the care that colleagues showed to their patients. I want to thank all colleagues who have been working in a very challenging environment and have been very involved in helping us make the changes needed to the service.

3.0 Performance and Operational Updates

Safety and Quality – Natalie Hammond, Executive Nurse

Safety and Quality

We continue to meet weekly with colleagues at NHSEI to review progress of our action plan to address the S.31 and their support offer. Meetings with each of the leads for our safety priorities continue to track progress. NHSEI have been supportive of the progress and are assisting with a number of system wide conversations and in addition, a plan to utilise industry standard software with training days to aid us with staffing solutions.

One of our key priorities in this period has been the planning for a phased reopening of our CAMHS wards. A task and finish group has produced a clinically led plan with the reopening predicated on a number of dependencies including transfer of patients requiring care in low secure settings, a dashboard of quality and safety metrics to indicate sustained improvement and estates reconfiguration to provide enhanced care areas. A clear escalation process involving a daily risk assessment indicating safety to progress the phased reopening will be based on staffing, patient acuity or safety measures. We are proposing Poplar ward, as the first unit to reopen. The task and finish group will continue to meet to review acuity, staffing and other metrics with the goal of full capacity safe care.

We continue to make further appointments to strengthen our CAMHS wards. These new roles include 10 nursing preceptors, which is a great achievement. Other new administrative roles will alleviate Ward Managers from a number of administrative duties including rostering and enable them to focus on patient care and colleague coaching/support.

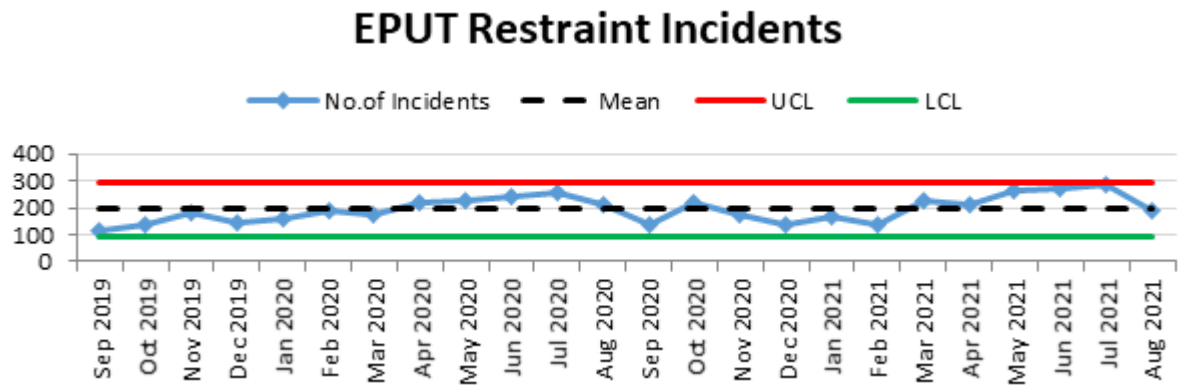
We continue to submit our bi-weekly observations audit to our CQC colleagues and we are collecting data via the audit tool Perfect Ward. Training video storyboards are developed and agreed with stakeholders and filming will be complete by the end of September.

The Culture of Learning project has now formally mobilised and has held its first Steering Group with the terms of reference and inputs/outputs defined and agreed. Software options will be option appraised to host lessons logs and currently we are looking at in-house availability and we are out to market for external options.

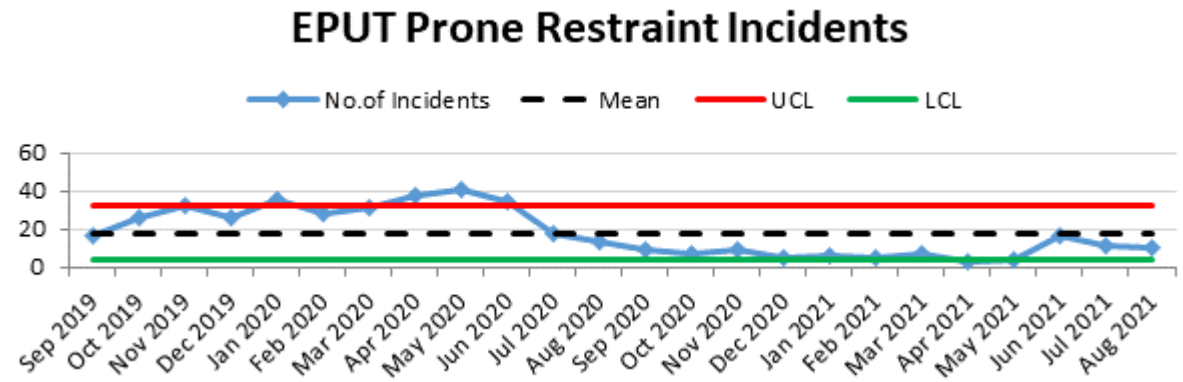
Successful outcomes for patients and staff evidenced following the piloting of staff body worn cameras, agreed is that continued rollout will commence. Body-worn camera technology promotes safety. It will reduce likelihood of violence, abuse and allegations. It will also assist and reduce the time and costs of associated investigations.

Physical Interventions

Incidents of physical interventions have remained within control limits for the last 24 months. A high proportion of restraint incidents over the last 24 months are attributable to 4 wards, The 4 wards accounted for 2433 (52.3%) of the total number of incidents for the period, with Longview Ward the highest, reporting 849 (15.6%). Significant patient acuity and complexity is recognised in the children and young people services and in intensive care units.

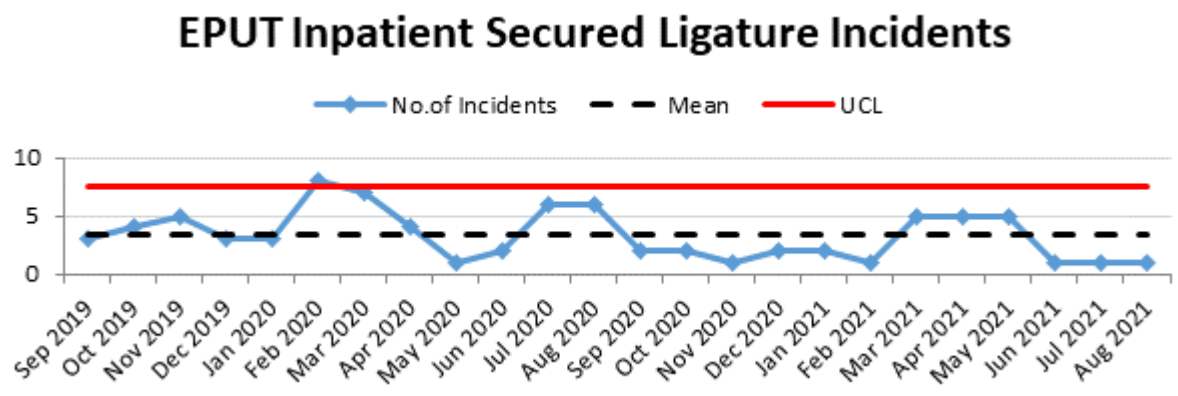


Incidents of prone restraint continue to show a significant decline since over the 24 month period in which all incidents have been subject to further scrutiny. Training regarding the administration of IM medication and the use of alternative injection site is in place and continues. A new position for restraint (Side) has been added to the Datix system due to the number of incidents reported which were recorded as prone for the administration of IM, when this was actually administered during repositioning whilst in supine. A high proportion of the prone restraint incidents relate to enabling staff to exit seclusion safely. The TASID team are working with the Christopher unit to pilot an alternative exit strategy.

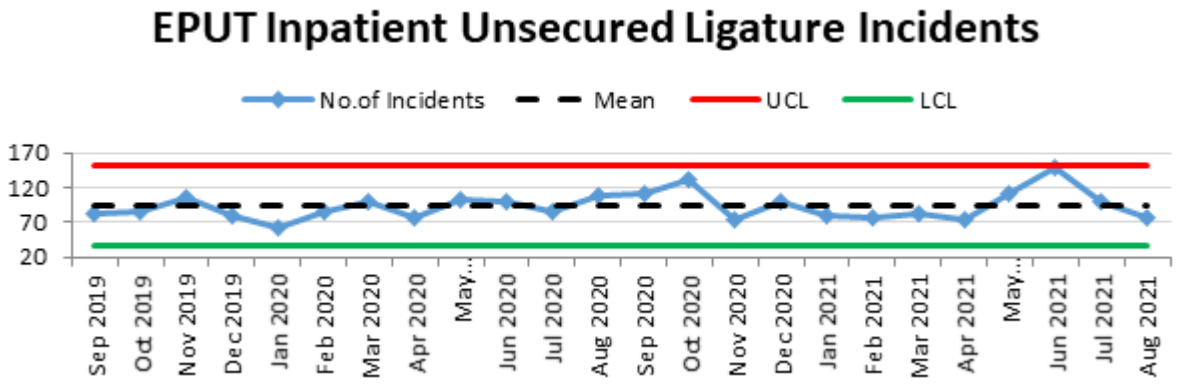


Inpatient Secured Ligature

During the 24 month period 80 incidents have been reported, over 9% incurred no harm to the patient. Ardleigh Ward are the highest reporting unit across the period, accounting for 14 incidents (17.5%). Work streams remain in place to support wards, review use of items used to ligature and environmental factors. A full cycle of investigation, learning and remedial estates action continues to manage new presenting risks in the environment.



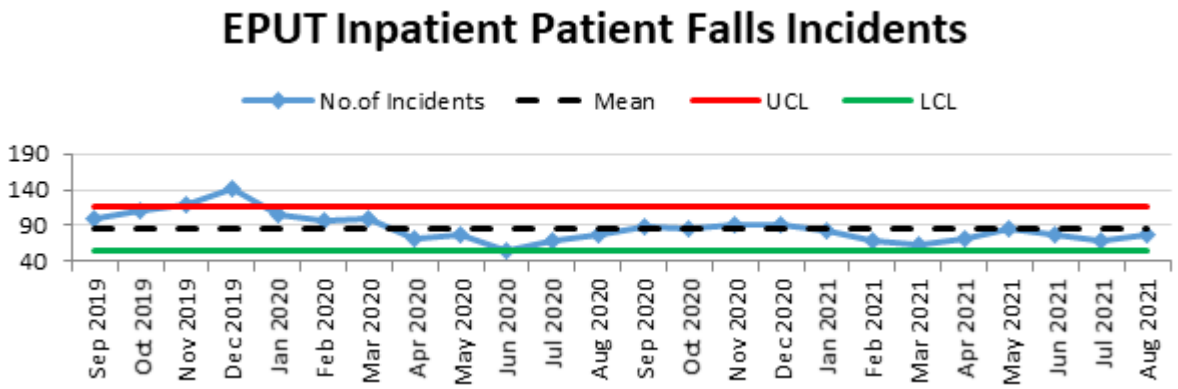
The Lower Control Limit for inpatient secured ligatures is below zero due to the low numbers of reported incidents and has therefore been removed from the above chart.



There were 2253 incidents where an unsecured ligature incident was (not fixed to a secure point) reported during the 24-month period. 87.8% of these resulted in no harm to the patient. The highest reporting unit was Longview Ward, 860 incidents (38.2% of all unsecured incidents).

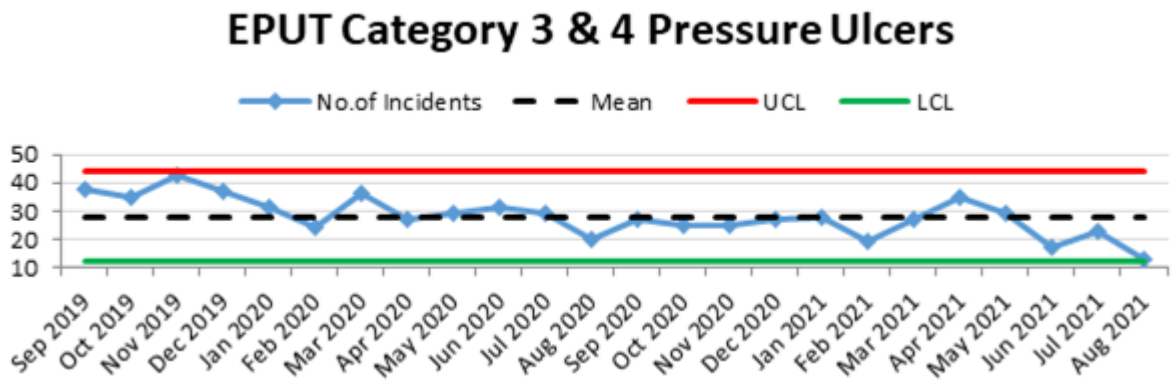
Falls

2078 falls have been recorded by inpatient areas across the 24 month period. 70.9% resulted in no harm, 25.8% in low harm. Clifton Lodge were the highest reporting unit across the 24 month period, accounting for 216 incidents (10.4%). A working group continues to meet and Falls Champions support all inpatient areas**.** Specific work programme for prevention is complete for Clifton Lodge with the support of the Falls co-ordinator.



Pressure Ulcers

The number of Category 3 & 4 pressure ulcers remains constant. Those with omissions in care continue to decrease. Meeting arrangements and support pathways continue to be in place. We have reported no omissions in care in our pressure ulcer reporting for the past year.



Operational Performance – Alex Green, Executive Chief Operations Officer

In August there were 30 performance and quality indicators within target, with 5 areas of inadequate performance. This was an improvement on July's position. Of the 5 inadequate areas, CPA performance improved for the third consecutive month, with each ICS area achieving the 95% target. All four indicators for clients seen within 12 months have sustained an improved position as a result of a clinically led task and finish group which has focused on positive change improvements.

I am pleased to report a further reduction in the number of patients placed in out of area placements (OoAPs) with 8 patients in OoAPs at the end of the month. It should be noted that beds commissioned from the Priory as part of our phase 3 recovery plan are now deemed as appropriate placements and performance data has been adjusted as a result. Inpatient adult mental health occupancy rates were within target having improved in August. However our average length of stay for both adult acute and PICU increased in month and continued to fall outside of national benchmarks.

There were 11 performance and quality indicators which require improvement and an improvement in the number of indicators at variance with local targets.

Community health services performance remained stable with majority of waiting times and DNA target rates met. Children's wheelchair waiting times (West Essex) were impacted by staff absence and manufacturer supply with 3 children waiting longer than 18 weeks; the position has since improved. The recovery of podiatry/podiatric surgery waiting times require further review following the pandemic related suspension/pause in service delivery.

Medical – Dr Milind Karale, Executive Medical Director

Dr Jennifer Wenborn has joined the Trust on 1st September 2021 as a Senior Clinical Research Advisor role; to encourage greater engagement of clinical staff in research.

Following International recruitment drive we have appointed the below Doctor's to the trust. These are fully trained psychiatrists holding senior positions in their countries and have GMC registration in UK.

- Dr Peethala, MD (Psychiatry) joined the trust this month and shall be supporting Dr Suresh within the Inpatient Older Adults West, Dr Peethala, joins us from Kamineni Academy of Medical Sciences and Research Hospital, Hyderabad, Telangana.

- Dr Meshreky, MD (Psychiatry), MSc also recently joined the trust and shall be working with Dr Sethi within the General Adult Community, West Leigh, Dr Meshreky's previous role was Specialist Psychiatrist and Teaching Assistant of Psychiatry, Faculty of Medicine at Cairo University.

- Dr Soliman, MD (Psychiatry), MSc Neurology, joined the trust this month and shall be working with Dr Thapa at the Brentwood Resource Centre, Dr Soliman joins us from Ain-Shams University in Cario, Egypt where he was working as Lecturer of Psychiatry.

The Medical Director is thankful to the medical staffing team who ensured that these doctors had smooth transition and had their IT equipment and access and relevant registrations ready before their arrival.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Income & Expenditure:

- YTD deficit is £0.1m consistent with M4 results.
- In month spend for temporary staffing was £5.9m (£6.2m in M4). During M5 bank budgets have been converted into substantive establishments.
- In month spend for COVID totalled £1.6m (£1.6m in M4) bringing the YTD spend to £7.6m, £0.8m above resource allocation.
- In month spend for Mass Vaccination totalled £1.4m (£2.0m in M4) with YTD spend to £10.3m. Expenditure levels are reducing as the programme to rationalise sites has commenced.
- In month spend for MHIS totals £1.0m (£0.8m in M4) and the YTD MHIS spend is £4.4m being £1.2m behind current plan.
- The Trust has delivered £1.6m of efficiency. During the period efficiency work stream meetings with all Directorates and Corporate functions occurred.

Capital:

- Annual plan £14.4m. YTD spend £3.1m; £0.6m behind plan. Further estate improvement and safety schemes have been approved as part of the existing capital programme.

H2 Planning:

H2 guidance and allocations are expected by 24th September. The current expectations is:

- A fixed efficiency target of 0.82% will be applied plus a discretionary target applied to the ICS based on Financial Improvement Targets (FIT).
- To expect a 5% reduction in COVID allocation.

National Cost Collection Submission:

- The Trust has submitted its National cost collection on 16th September. A detailed action plan was presented to Audit Committee on the 15 September 2021.

Major Projects – Nigel Leonard, Executive Director of Major Projects & Programmes

Essex Mental Health Independent Inquiry

Following a period of consultation and comments on the draft terms of reference, the Essex Mental Health Independent Inquiry published its terms of reference for the Inquiry. These are available on their website and on EPUT's website. The Trust is continuing to work with the Inquiry Secretariat to provide information requested, and co-operating fully to ensure learning is built into our safety practice.

Covid-19 Vaccination Programme

EPUT has continued to play a major role in the roll out of the COVID-19 vaccination programme across Essex and Suffolk, with the large-scale vaccination centres provided by EPUT now having delivered in excess of 780,000 vaccinations since commencement of the programme in January. My thanks continue to be extended to all the staff, volunteers and partner organisations who have been involved in such a tremendous achievement.

Over the last two months, we have continued to deliver 1st and 2nd doses to priority groups 1 – 12 and have continued to work hard to urge those eligible who have not yet been vaccinated to come forward to take up the evergreen offer of vaccination.

We began planning some time ago, together with partner organisations across Essex and Suffolk, the anticipated delivery of the Phase 3 booster programme against interim advice issued by the Joint Committee for Vaccination and Immunisation (JCVI) early in the summer. On 14th September, the JCVI issued its confirmed guidance for the Phase 3 booster programme. Delivery of Phase 3 will commence on 20th September and will again be via a range of delivery models including Local Vaccination Services (GP led), Community Pharmacies and the large scale vaccination centres operated by EPUT.

The JCVI advice indicates that, for the 2021 COVID-19 booster vaccine programme, individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1 to 9) should be offered a third dose COVID-19 booster vaccine. This includes:

- those living in residential care homes for older adults
- all adults aged 50 years or over
- frontline health and social care workers
- all those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19 (as set out in the green book) and adult carers
- adult household contacts of immunosuppressed individuals

The advice also indicates that the booster vaccine dose is offered no earlier than six months after completion of the primary vaccine course, and that the booster programme should be deployed in the same order as during Phase 1, with operational flexibility exercised where appropriate to maximise delivery.

The EPUT large-scale vaccination centres have commenced delivery of the booster programme in line with the guidance; and there is a national process in place for eligible individuals to be invited to book their booster via the National Booking System at the appropriate time.

The offer of a 1st and 2nd dose vaccine will also remain in place throughout Phase 3 for all those who have not yet taken up a vaccination.

The programme for COVID-19 vaccination of children aged 12 – 15 has also commenced and is being delivered by the Trust's School Aged Immunisation Services predominantly within the school environment.

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

Recruitment Highlights and Workforce Planning

There has been a high level of focus on the recruitment of staff for our CAMHS wards, further emphasised with the CQC report and rating. We have successfully recruited the below:

- Poplar – 7 posts; Matron, 2 x Staff Nurse, 3 x HCA, 1 x Psychology Assistant
- Larkwood – 4 posts; 2 x HCA, 2 x Staff Nurse
- Longview – 7 posts; 3 x Staff Nurse, 3 x HCA, 1x Ward Manager

We plan to carry forward actions taken into recruitment planning going forward to share lessons learned.

Nesta Williams has been appointed as a Strategic Culture Advisor & Transformation Lead and will play a crucial role in our planned staffing narrative review. Engagement has started with our NHSEI colleagues, in particular Paul Hopley, to understand best practices and learn from other trusts ahead of our review. The activity will lead to a clear view of staffing across our wards and thus address gaps in our establishment. We can then repeat successes we've had in relation to CAMHS recruitment and apply these trust wide to address gap remediation. In addition to this, knowledge and data gained will serve as a platform for the adoption of industry standard software, MHost. This software calculates clinical staffing requirements in mental health wards based on a variety of factors, including patients' needs (acuity and dependency) which, together with professional judgement, can guide ward based clinical staff with safe staffing decisions.

Recruitment and Retention Highlights

- **Vacancy rate** – Information not available as reported in the last performance report
- **Turnover rate** 9.7% against target of 12%. This is a 0.2% increase since last report
- **Starters and Leavers** There were 81 staff members (8 registered nurses, 21 Healthcare Assistants and 37 Admin/management) who joined the organisation in August this is a slight increase from June and July. . 45 staff left the Trust in August 2021 of which 10 were nurses and 13 healthcare assistants. The main reasons for leavings are retirement, not disclosed, undertake further education and work life balance.
- **Time to Hire –** KPIs from placing advert to sending unconditional offer for August is 57.8 days compared to 59.3 for July (equates to 8.25 weeks)
- **Recruitment Programmes**
    - **Student nurse Recruitment –** 78 student nurses of which 13 have commenced in post, 17 have agreed start dates and 35 awaiting pre-employment checks. The remainder are still going through recruitment process (e.g. awaiting form completion etc.)
    - **International Nurse Recruitment -** The first 9 Registered Nurses were offered positions in August 2021. Unfortunately, 3 withdrew due to poor press surrounding EPUT we are exploring this further. 6 have start dates of 21 September 2021. 6 further interviews scheduled for 16 September 2021. Finance confirmed EPUT have the £400k funding available but additional request has been sent to Trevor Smith to utilise the relocation expenses (£8k per nurse) to improve our welcome package and hopefully improve our supply problems re MH Nurses. NHSE/I and EoE confirmed that the deadline will hopefully increase from 31 Dec 2021 to 31 March 2021 to help support MH Trusts with supply issue.

Sickness Management

- Trust Sickness % are unavailable as per performance report. However, in reviewing weekly sickness absence monitoring in place the Trust is reporting increases in general sickness across the last 3 months. The top reason for sickness absence is anxiety, stress and depression (103 staff off sick as at 13th September 2021 – 67% of which is long term absence).
- Over the last two months there have been gradual increases in covid related sickness absence. As at 14th July the Trust has 27 staff reporting covid sickness absence, 11 staff isolating not working and 13 isolating but working.

Employee Relations Highlights

- 17 Formal disciplinary cases (7 is in relation to temporary worker)
- 9 Suspensions (5 temporary workers)
- 20 17 grievances (4 Temporary Workers)
- 2 Appeals
- 2 Temporary worker appeals (reconsideration)

- 4 Whistleblowing (Supported by HR)
- 2 Employment Tribunals

Employee Relations activities within disciplinary, suspensions, grievances and appeals have increased since previous reported however, we have seen decreases in whistleblowing cases supported by HR. The increases are primarily relating to concerns being reported in relation to our temporary workforce HR support has to been realigned to manage increasing concerns in these areas

Temporary Staffing

- **Current EPUT Temporary Staffing Establishments (as at 16 September 2021)**

Staff Group	Bank Only	Bank and Substantive
Add Prof Scientific and Technic	49	140
Additional Clinical Services	2007	1014
Administrative and Clerical	735	646
Allied Health Professionals	109	142
Estates and Ancillary	118	288
Healthcare Scientists	2	
Medical and Dental	57	4
Nursing and Midwifery Registered	862	1322
Grand Total	**3939**	**3556**

There has been a small decrease in Bank only staff and a small increase in Bank and substantive staff since last report

- **Bank and agency usage**

	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Timeframe	16-Aug-15	w/c 26 April 2021 to w/c 24 May 2021	w/c 31 May and w/c 28 June 2021	28 June - 31 July 2021	1 August - 31 August 2021
Agency Duties	3915	5752	6584	8224	7558
Bank Duties	22207	30021	31834	38896	31029
Total	**26122**	**30021**	**38418**	**47120**	**38587**

- **Highest Bank and Agency usage (Hours) – Top 10 teams**

Agency Usage	Unit	Hours	Duties	Bank usage	Unit	Hours	Duties
1st	300 Longview Ward	5069.25	442	1st	300 Larkwood Ward	8280.25	766
2nd	300 Christopher Unit	3591	314	2nd	300 Longview Ward	8070.15	741
3rd	364 EA504 Hadleigh Unit (Picu)	2866.5	250	3rd	364 EA520 Mh Assessment Unit	7580.25	677
4th	300 Topaz Ward	2841.5	249	4th	364 EA504 Hadleigh Unit (Picu)	6411	559
5th	364 EA505 SE Willow Ward Adult Inp	1924.49	171	5th	364 MSE - Pop Up Southend Civic Centre, Victoria Avenue, SS2 6ER - E1M83	4914	823
6th	300 Finchingfield Ward	1821.5	159	6th	364 EA505 SE Willow Ward Adult Inp	4861.17	444
7th	300 Tower Ward	1809.25	161	7th	364 EC490 Camhs I/P Poplar Ward	4595.33	426
8th	364 E5SWD Avocet Ward (Swch)	1767.33	160	8th	364 EA304 Beech Ward	4314.9	392
9th	300 Galleywood Ward	1744.5	152	9th	364 SNEE-Colchester Football Club CO4 5UP POD 1 AZ - E1M35	4282.85	728
10th	364 E5ACK Bridging Service	1597.5	138	10th	300 Christopher Unit	4165	362

Mandatory Training

- The overall mandatory course compliance for August was 91% which is a drop of 1% on the previous month. Bookings were lower last month so it is likely that the holiday season has had an impact.
- The overall compliance does mask some areas of concern, some individual courses are significantly lower and this tends to be the classroom courses: TASID 83%; Basic Life Support 84%. However, other high risk areas are also low: Information Governance 91%, Fire Inpatient 89%.
- Essential courses have a higher overall compliance level of 94% but there are also areas of concern and low compliance: Personal Safety 73%.
- The figures quoted above are calculated using the Covid emergency update frequencies where a year was added to most courses. Compliance under the normal update periods is significantly lower in some cases (e.g. TASID 44%, Basic Life Support 55%).
- Discussions have been taking place at Gold Command to decide whether we should commence a phased return to the normal update periods for all courses. In discussion with operational leads it was decided that staffing pressures are still above normal levels with high levels of vacancies and bank/agency usage. Taking this into consideration it has been decided to return e-learning programmes to normal update frequencies in a phased manner but to review the classroom courses later. This will be re-examined in two months' time.

Apprentices

Apprentice numbers are growing through expansion of the courses on offer as well as increasing our recruitment onto existing programmes. There are increasing numbers of courses for therapists (we have just recruited our first podiatrist apprentice) and all the support workers recruited as part of the recent initiative were offered an apprenticeship.

Currently we have 123 active apprentices in the Trust (this has enabled us to meet our public sector apprenticeship target of 2.3% of the substantive workforce).

We have:
19 Clinical Associate Psychologists
34 Level 3 Support Workers
15 Associate Practitioners (plus a cohort of 22 about to start as one cohort is about to complete)
26 Nursing Top-up
8 Occupational Therapy (with another 8 about to commence)

The balance is made up of business administration, pharmacy technicians, and leadership apprentices

Student Placements
This remains an area of concern with extreme pressure on placements across all clinical courses but especially acute in nursing. Work is continuing to look at innovative placements using on-line sessions, new placements (e.g. in vaccination centres) and new areas opening up in social care with supervision and support offered by 'legacy nurses' (bank nurses who will work supervising students in a variety of settings).

Our partner HEIs have been sent mapping documents that show our placement capacity so that they can work with us to match capacity to demand. We are working with staff to ensure that the quality of the clinical learning environment remains robust.

Staff Engagement & Well Being
The Staff Engagement and Wellbeing team have initiated our NHS National Staff Survey campaign, working closely with the communications team to ensure the narrative continues in the lead-up to survey launch on 21 September 2021. Focus groups were held to strengthen staff interaction with the survey, providing them with guidance and resources in preparation for the launch. In response to feedback centred on confidentiality, a session with our survey administrator, Quality Health, was arranged and they briefed staff on confidentiality, the anonymity of the survey, and answered staff questions. Guidance packs created and disseminated to staff as a supporting resource to enable managers and champions to brief their teams.

Other key activity:
- The new quarterly Pulse Survey was delayed and is now on track for release in January 22.
- Collaboration on staff engagement and surveys continues with other national NHS trusts and the Staff Engagement Team.
- Monthly Staff Engagement Champions Network Meetings with executive grill panel.
- Team Newsletter now developed to be shared with Champions.
- A review into strengthening the champion network, membership, purpose, roles, and responsibilities is underway.
- Continued Staff Engagement/Wellbeing attendance at local team meetings to strengthen staff support message. In response to the arrivals from Afghanistan and the impact on staff, a support guide was produced by our Here for You service and shared with staff.
- We continue to recognise the invaluable effort and commitment from our staff through our Staff Recognition Awards: 96 nominations have been put forward to the September 2021 judging window.

Equality and Inclusion
We are pleased to welcome Lorraine Hammond as our new Director of EDI Lorraine will be working on a system wide revised strategy to present to the board in December

Patient Experience
Current Period:
- Volunteers has moved into Patient Experience, with the teams now working hand in hand to increase involvement and placement opportunities
- A new Public involvement and engagement strategy has been approved by ET in September with a 6-month delivery plan drafted
- The plan starts in October 2021 with baselining our current position
- The team has been reconfigured to deliver the update strategy for involvement, with a new Head of Patient Experience joins the team from 27th Oct

- NHSEI ran a series of 6 x 2-hour workshops to benchmark our performance against the NHSEI Patient Experience Improvement Framework, for which a summary report will be shared in November
- People with lived experiences having a regular slot on the corporate induction to set the tone for all staff around compassion and learning from lived experience
- Recompense is now up and running, successfully, with lots of services utilising, allowing them to pay people with lived experience for their time
- We have a base build for the I want great care platform and are now working on the plan to properly embed the platform in the coming months

Next Period:

- Baselining our current position on public involvement
- Reviewing all policies, procedures, and associated docs, for volunteering, recompense, and public participation to improve and enhance our offering
- Establishing the working group for delivering update involvement strategy
- Kicking off a series of co-production projects with NHSEI to understand what works for us, providing evidence to formulate the EPUT Way To Coproduction
- We will be working on increasing our volunteers' database and creating more placement opportunities, to embed meaningful involvement

PALS and Complaints

Current Period:

- MDP slides have been updated for Complaints Training and the first session delivered.
- Team training session on Complaints Handling delivered to Mid & South Community team managers.
- Improved process for keeping complainants updated has been implemented. This is now done within the Complaint Team to ensure deadlines are closely monitored.
- Backlog of compliments that built up due to influx of Vaccination enquiries has now been cleared.
- Rapid Response Process is fully implemented and has helped to reduce formal complaints and resolve simple complaints more quickly.

Next Period:

- Development of Datix so that Compliments and Local Complaint Resolutions can be logged directly by all staff (like Incidents)
- Complaints Reports being consolidated and simplified.
- Complaints Policy to be updated.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

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

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

Purpose of the Report		
The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance "inadequate indicators". 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 2021). The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance in detail for August 2021.

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

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

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

- Out of Area Placements

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

The CQC completed an unannounced inspection of the CAMHS services in May/June 2021. The CAMHS service has been rated Inadequate.
The final CQC CAMHS report is expected mid-September, full details will be presented in the CQC Compliance report at the September Board meeting.

Within the Finance scorecard one item has been RAG rated inadequate for August.

- Efficiency Programmes

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

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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

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

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott **Chief Executive Officer**

NHS
Essex Partnership University
NHS Foundation Trust

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

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

Report Guide

Use of Hyperlinks

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

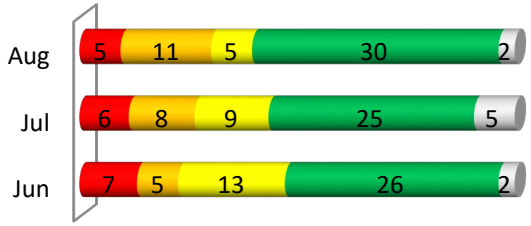
How is data presented?

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

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

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

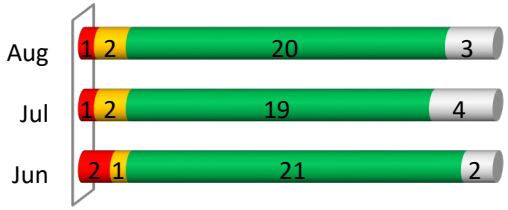


August Inadequate Performance

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

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

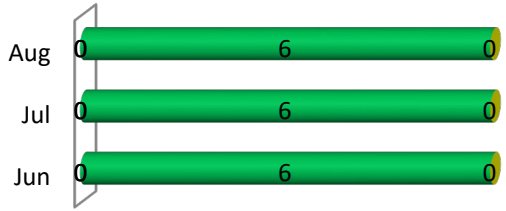
Summary of Oversight Framework Indicators



August Inadequate Performance

- Out of Area Placements

Summary of Safer Staffing Indicators

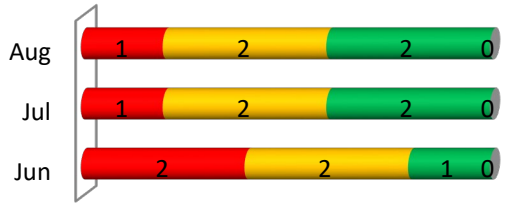


No risks identified within the Safer Staffing section.

Summary of CQC Indicators

The CQC completed an unannounced inspection of the CAMHS services in May/June 2021.
The CAMHS service has been rated Inadequate.
The final CQC CAMHS report is expected mid September, full details will be presented in the CQC Compliance report at the September Board meeting.

Finance Summary



August Inadequate Performance

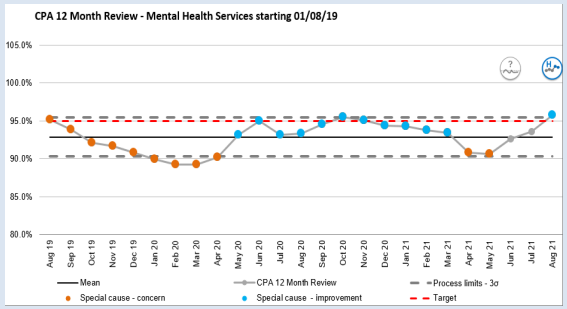
- Efficiency Programmes

SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

<table>
<tr><th colspan="7">Effective Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M4
Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">2.3 CPA Reviews

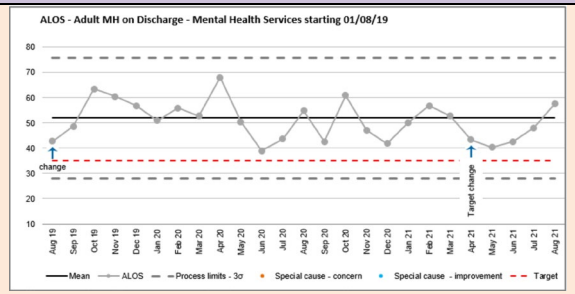
Committee: Quality
Indicator: National
Data Quality RAG: Amber</td><td colspan="6">Inadequate
In August, overall performance improved from 92.5% to 95.8% and is above target, however this indicator with remain as inadequate until performance has been maintained for three months.

The Productivity Team investigate all breaches. There are issues with reviews becoming overdue and then completed in the 13th month. The Productivity Team continue sending clinicians a report of Reviews that are becoming overdue in advance to enable the review to be booked and completed before they become overdue. As well as this, teams monitor their CPA review target on a weekly basis. The Director of service has also brought in a new member of staff to undertake a deep dive on the CPA review breaches.</td></tr>
<tr><td>People on CPA will have a formal CPA review within 12 months

Target 95%</td><td>95.8%</td><td></td><td>Above Target = Good
 
</td><td></td><td>There were ten Teams in the South, three Teams in Mid, two Teams in NE and three Teams in West below target</td><td></td></tr>
<tr><td rowspan="2">2.9 Inpatient Capacity Adult & PICU MH

Committee: Quality
Indicator: Local
Data Quality RAG: TBC</td><td colspan="6">Inadequate
The adult average length of stay on discharge continues to increase in August and is consistently failing to achieve stays that are in-line with or shorter than the NHS benchmark. The Adult rate is currently at 57.6 days against a target of 31.6 days. There were 121 discharges in August (32 of whom were long stays (60+ days)).
Occupancy rates have now improved and performance is within target for August.</td></tr>
<tr><td>2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark
Target: <35</td><td>57.6 days</td><td></td><td>Below Target = Good</td><td></td><td>Consistently failing target

121 discharges in August (32 of whom were long stays (60+ days)).</td><td>TBC</td></tr>
</table>

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M4**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	(Adult Acute Benchmark 2020 35)					Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	

<table>
<tr><th colspan="8">Responsive Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M4
Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>4.5 Out of Area Placements

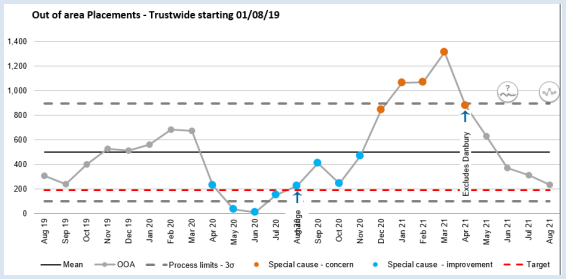
Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Amber</td><td colspan="7">Inadequate
A further positive reduction has occurred in out of area bed days; 235 (excluding Danbury) in August. Recent levels have been in part due to the requirement for social distancing on wards limiting occupancy levels. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and reinstatement of Topaz in March 21 to further offset any COVID surge demand.

It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract.

Eight new clients were placed OOA in August, and following the repatriation of nine, there were eight remaining OOA at the end of the month.

The Trust currently has a target to reduce OOA placements to 0 by the end of September 2021. There are comprehensive actions plans in place to accomplish this and we are currently on target to meet trajectory.

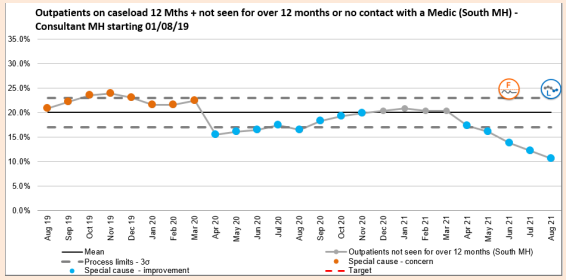
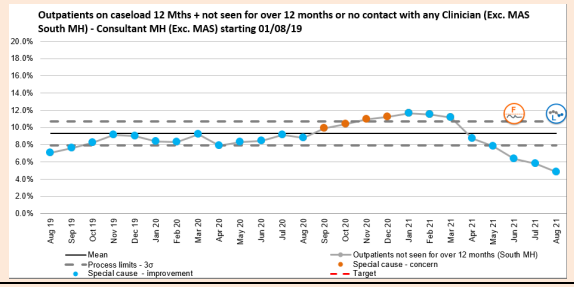
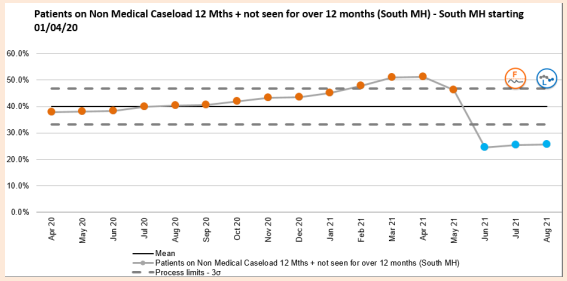
These assumptions are based on recovery from COVID 19 infection. Current numbers are raising concerns that there will be more OOA if wards are closed to admission due to COVID 19.</td></tr>
<tr><td></td><td>Reduction in Out of Area Placements

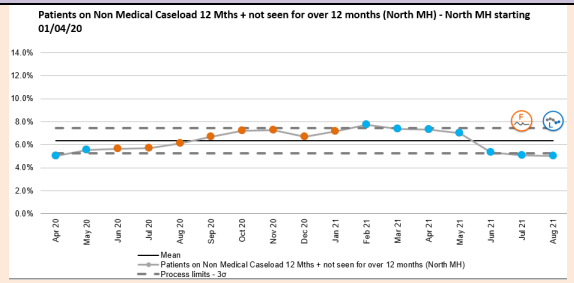
Target: Reduction to achieve 0 OOA</td><td>235 Days</td><td></td><td>Below Target = Good
 
</td><td></td><td>Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.
Data excludes patients placed on Danbury Ward.</td><td>TBC</td></tr>
<tr><td>4.9 Patients Not Seen / no contact for over 12 months

Committee: Quality
Indicator: Local</td><td colspan="7">Inadequate
Further meetings have been held with the clinical task and finish group. The long waiters T&F group has had the conversation now of bringing this group to a close, as the outstanding actions are reducing week on week. The group have met for the final time on the 17th August and one follow up meeting will take place in three months time, date to be agreed.

IMT & Outpatient Administrative staff concluded the below key outcomes/positions:

• Technical issues and bugs (slow forms, auto scheduling gaps) have been remediated.
• Significant progress made on the accuracy of the waiting list dashboard
• Dashboard needs to be expanded to include patients who have DNA'd, cancelled, etc. The breakdown of these figures will be included in next months report.</td></tr>
</table>

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M4 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
Data Quality RAG: **Blue**	The non-medical indicator constructs have also be revised to now include telephone contacts, contact by other clinicians, and current inpatients effective 1st June 2021. This amendment has improved performance further. This is expected to be the final piece of clean-up data activity for these indicators and we are now reporting the most accurate position available. All four indicators have witnessed significant improvements following these changes and performance has continued to improve since they were made.						
	4.9.1 Patients with no consultant review within 12 months **Target 0%**	10.7% (462 / 4,321 clients)	●	On Target = Good 	N/A	The construct of this indicator has been reviewed and now counts the number of clients who have been on a medic caseload for 12 months + and have not been seen or had contact with a medic for 12 months + as at the end of the reporting period. (inc. telephone contacts / inpatients and contacts with any consultant)	
	4.9.2 Patients on Consultant Caseload South Essex not seen / no contact by any clinician for over 12 months **Target 0%**	4.9% (201 / 4,144 clients)	●	On Target = Good 	N/A	As above but excludes MAS Medic Caseload and includes any contact with another HCP.	
	4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%**	25.7% (1,201 / 4,674 clients)	●	On Target = Good 	N/A	The constructs for non-medical caseloads have been updated to include telephone contacts (Mobius Only), contact by other clinician and current inpatients effective 1st June 2021. This is expected to be the final piece of clean-up data activity for these indicators and we are now reporting the most accurate position available.	
	4.9.4 Patients on any North East, West or Mid	5.0%	●	On Target = Good	N/A	Work continues to validate and improve these indicators with breach and	

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M4**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	caseload not seen / no contact by any clinician for over 12 months **Target 0%**	(205 / 4,954 clients)				monitoring reports being supplied to the Operational Productivity team. These indicators will also continue to be monitored as part of the Data Quality & Performance meeting group.	

4.10 Psychology  Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	As a result of demand significantly outweighing capacity, and services suffering a legacy burden of under-investment until 2020/2021, wait times across all MDTs in SEE to access second phase psychological interventions, following PAP and assessment, remain lengthy. However, please note that these waits are for second phase Psychological intervention, usually for specialised 1:1 interventions. The service prioritises a front end loading of engagement in the form of first provision through a Psychological Awareness Programme. This leads to an accessible formulation focused assessment that can support the development of a clinically informed treatment and safety plan. This results in people accepted initially being seen in a responsive timeframe (longest wait is 4 months, average is 3 months). This set-up also supports wider MDT engagement, a robust risk management response and ensures that people are sitting in a clinical pathway confirmed as being appropriate to meet their needs, and fast-tracks treatment in groups. It also prevents DNA's and provides service users with informed choice regarding treatment. It also assists in ensuring that service users are ready for active psychological intervention. It is also important to note that "longest wait" statistics include service users who have had treatment delayed due to illness (such as COVID), or have declined appointments offered. On average, waiting times for first offer of intervention is half that of the longest wait. Wait times are as follows (September 2021): • Basildon: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 84 waiting. Across all interventions, the longest waiter is 29 months and this is for specialist individual psychology. • Brentwood: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 28 waiting. Across all interventions, the longest waiter is 28 months and this is again for specialist individual psychology. • Thurrock: Individual psychology currently has the highest number of clients awaiting intervention with 25 waiting. Across all interventions, the longest waiter is 30 months and this is for specialist individual psychology. • Southend: Individual psychology currently has the highest number of clients awaiting intervention with 91 waiting. Across all interventions, the longest waiter is 31 months and this is for specialist individual therapy. • Castle Point: Individual psychology currently has the highest number of clients awaiting intervention with 16 waiting. Across all interventions, the longest waiter is 25 months and this is for DBT Skills group. • Rochford/Rayleigh: Individual psychology currently has the highest number of clients awaiting intervention with 33 waiting. Across all interventions, the longest waiter is 23 months and this is for PTSD Stabilisation. The management of demand and capacity for psychological interventions across South Essex remains a priority. The following priorities are being mobilised in efforts to mitigate and improve access and flow throughout our clinical pathway: 1. Recruitment to additional transformation posts. This consists of the already recruited Clinical Associate in Psychology (CAP) Apprenticeship posts who all commenced their roles in late May 2021. CAPs have picked up the delivery of the PAP pathway, as well as some assessments and running protocol based group interventions such as Trauma Stabilisation. Additional 8a posts have also been invested in, and are actively being recruited. 2. Implementation of 3 monthly clinical reviews, facilitated by our CAP apprentices. The service has developed a clinical and risk review protocol, to both keep in touch with people waiting for a planned intervention and to robustly review risks and reinforce safety plans over time. These reviews can also be used to guide people through self-help resources and engage them with goal setting and targeted skills development whilst they continue to wait.

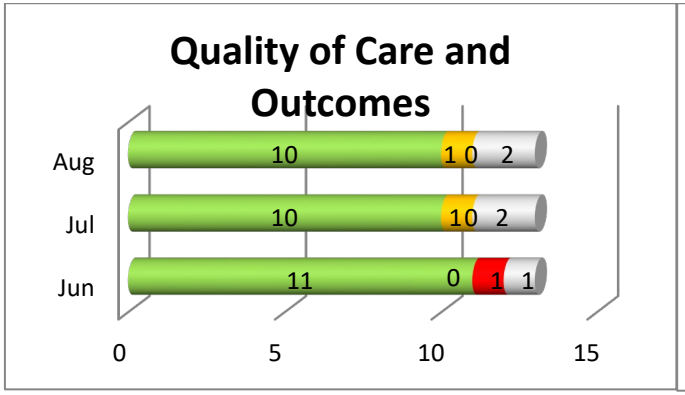
		3. Commissioner discussions on bridging gaps in service provision with a focus on primary care. Additional resources have been agreed in Thurrock, Basildon & Brentwood, South East Essex & CPR, and Mid Essex Adult Community Psychology Teams. With additional investment a redesigned interface enabling movement towards a primary care model of accessing psychological interventions, with bolted on expertise, supervision and training. This represents a viable option in terms of enhancing capacity, recruitment and seamless service provision. In Basildon & Brentwood, and Thurrock, new Step 4 IAPT services have been invested in, and integrated working protocols have been agreed with our partners. This should make a significant difference to the demand placed on our services in CMHTs. We envisage that this will substantially address waiting times issues over the next 6 – 9 months.

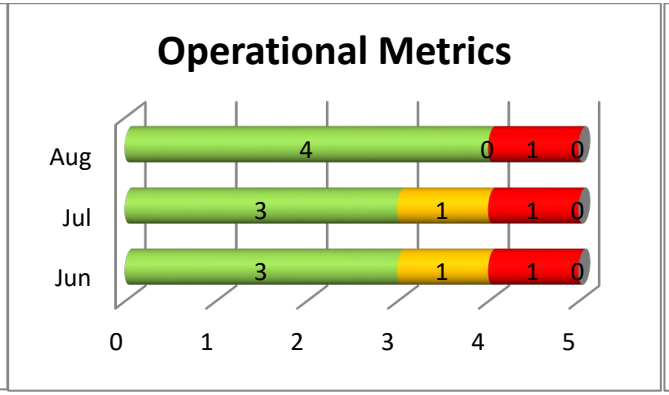
SECTION 3 – Oversight Framework

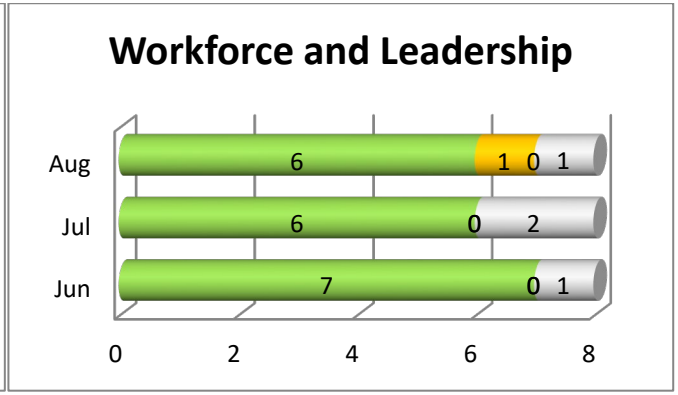
Click here to return to Summary

Summary

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





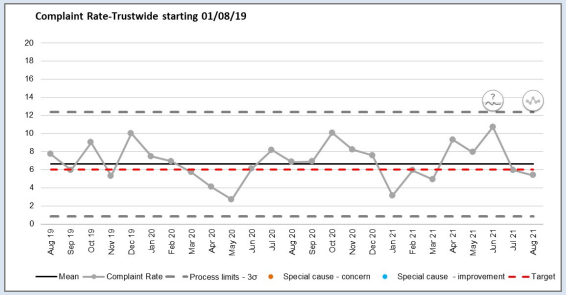


Inadequate

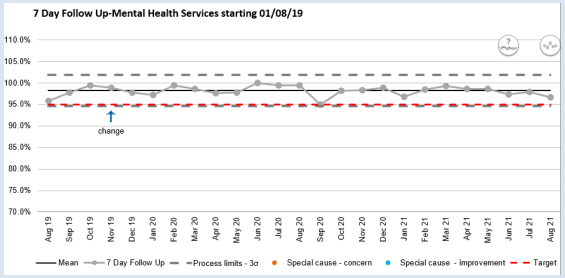
- Out of area placements

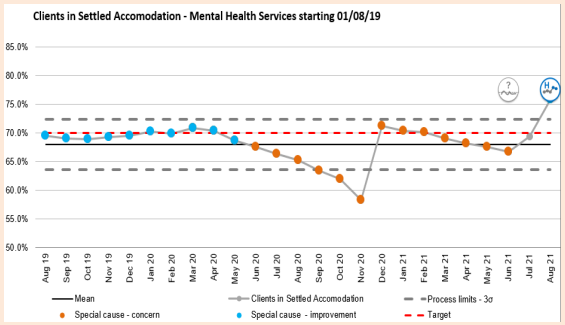
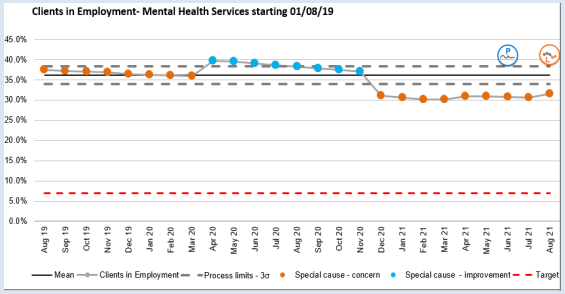
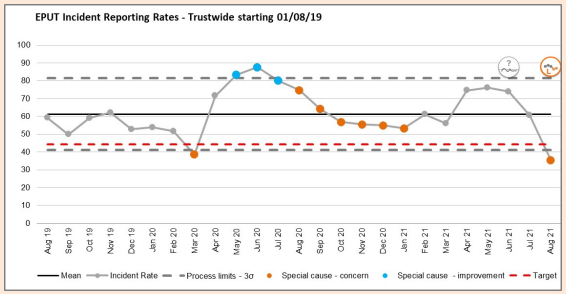
Requires Improvement

- Incident Reporting Rates
- Staff Sickness

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**	Achieve a rating of Good or better	Good	●	The Trust is fully registered with the CQC. A restriction has been imposed onto the registration for the CAMHS service.			
4.1 Complaint Rate Committee: FPC Data Quality RAG: **Green**	4.1.1 Complaint Rate **No OF Target** Locally defined target rate of 6 each month	5.4	●	Below Target = Good 	●		N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	5.6.1 Staff FFT recommend the Trust as place to work **Target 63%** 5.6.2 Staff FFT recommend the Trust as a place to receive treatment **Target 74%**		●		●	Indicator continues to be suspended nationally	
1.1 Never Event	0 Never Events 2019/20 Outturn 0	0	●	Year to Date 0	●		N/A

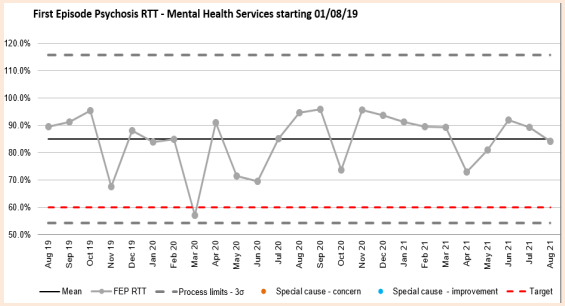
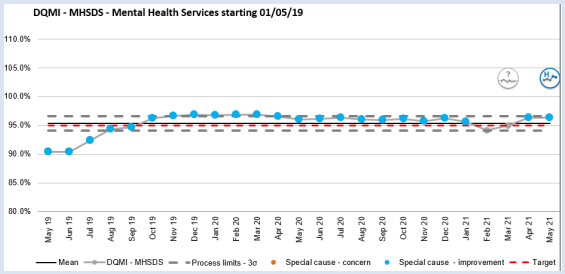
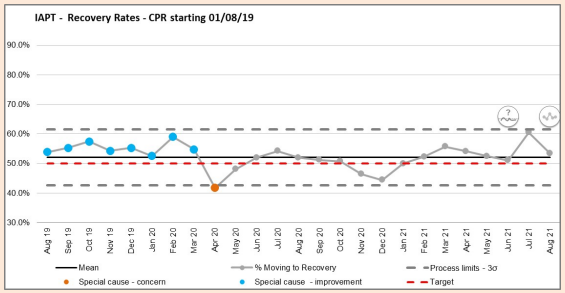
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality 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 Committee: Quality Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	EPUT achieved "about the same" in all 11 domains in the 2020 survey when compared with other Trusts					N/A
3.3.1 Patient FFT MH	3.3.1 Patient FFT MH response in line with benchmark Target = 88.3%	92%	●		●	54 total responses for MH 50 Very Good/Good Adult Acute 2020 benchmark EPUT result was 88%, against a National mean of 88%.	

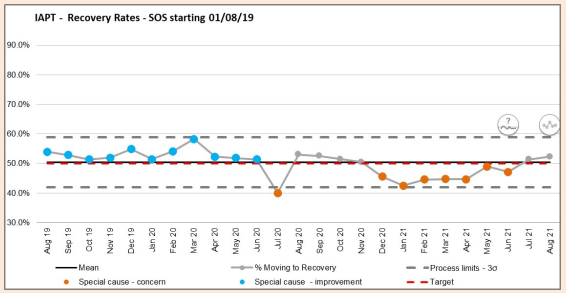
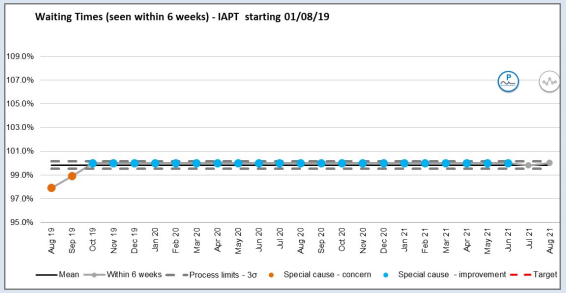
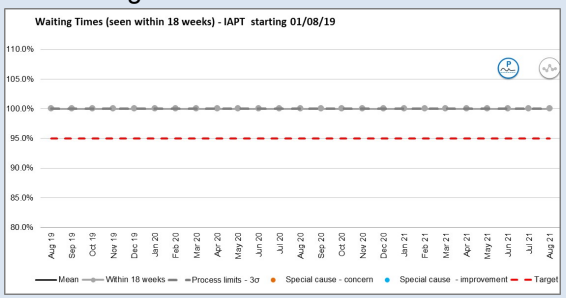
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**	(Adult Acute 2020 Benchmark 88%)						
3.3.2 Patient FFT CHS Committee: Quality Data Quality RAG: **Green**	Patient FFT CHS response in line with benchmark **Target = 96%**	100%	●		●	10 total responses for CHS 10 Very Good/Good	
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95%** (Adult Acute 2020 Benchmark 98%)	96.6%	●	Above Target = Good 	●	Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%.	

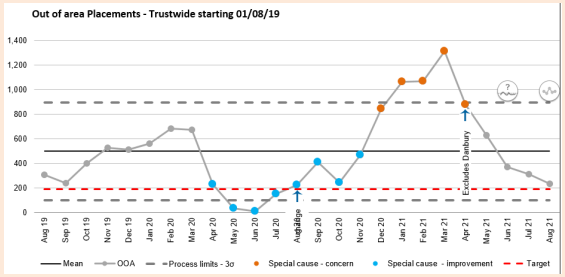
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	We will support patients to live in settled accommodation **No OF target** Target 70% (locally set)	75.8%	●	Trend above Target = Good 	●	August performance : Paris 74.7% Mobius 78.9% Additional operational work continues to help improve performance going forward.	N/A
2.5 Employment Committee: Quality Data Quality RAG: **Green**	We will support patients into employment **No OF target** Target 7% (locally set)	31.6%	●	Trend above Target = Good 	●	Assurance indicates consistently Passing target.	N/A
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** **MH Benchmark**	35.4	●	Above Target = Good 	●	Below target for August. Performance is refereshed each month and does improve. **Fewer incidents have been signed off by managers in time to be included in this report. This is due to the earlier production of performance reporting since November.**	
1.15 Under 16 Admissions	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in August One year to date.	N/A		N/A

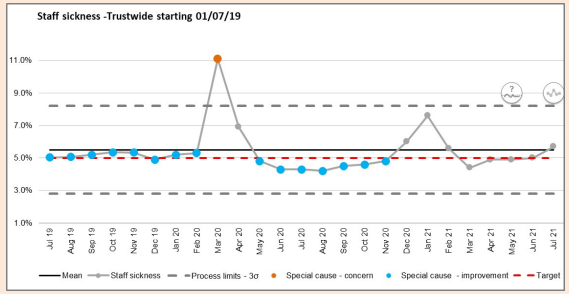
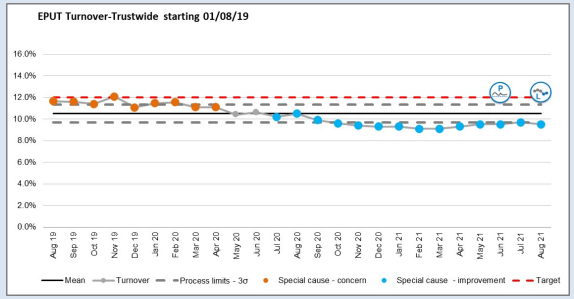
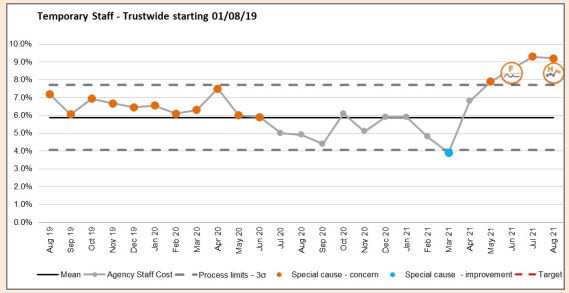
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
 Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**							

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**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	84.2%	●	Trend above Target = Good 	●	August performance represents: 16 / 19 patients.	N/A
2.2 DQMI Committee: FPC Data Quality RAG: **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	96.3%	●	Trend above target = good 	●	Latest published figures are for May 2021	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	CPR 53.5%	●	Trend above target = good 	●	Decrease from July but continues to meet the target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	52.3%	●	Above Target = Good 	●	Slight increase from the July position and is continuing to achieve target.	
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	NEE 51%	●	Above Target = Good Graphs will be produced once sufficient data is available.		The NEE service is on target this month.	
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	CPR & SOS 100%	●	Above Target = Good 	●	Consistently passing target	N/A
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	NEE 96.2%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Consistently above target.	
2.16.9/10 IAPT Waiting Times ● Committee: FPC	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	CPR & SOS 100%	●	Above Target = Good 		Consistently above target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	NEE 100%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Consistently above target.	
4.5 Out of Area Placements ● Committee: FPC Data Quality RAG: **Amber**	A further positive reduction has occurred in out of area bed days 235 (excluding Danbury) in August. Recent levels have been in part due to the requirement for social distancing on wards limiting occupancy levels. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and reinstatement of Topaz in March 21 to further offset any COVID surge demand. It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract. The Trust currently has a target to reduce OOA placements to 0 by the end of September 2021. There are comprehensive actions plans in place to accomplish this and we are currently on target to meet trajectory. These assumptions are based on recovery from COVID 19 infection. Current numbers are raising concerns that there will be more OOA if wards are closed to admission due to COVID 19						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	235 Days	●	Below Target = Good 	●	Eight new clients were placed OOA in August, and following the repatriation of nine, there were eight remaining OOA at the end of the month.	TBC

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	5.7%		Below Target = Good 		Just two directorates breaching the overall sickness <5% target: • Finance & Resources • Operations The sickness figures are reported in arrears to allow for all entries on Health Roster. Adult Acute 2020 benchmark EPUT result was 5%, against a National mean of 7%.	
5.2.2 Turnover Committee: FPC Data Quality RAG: Green	Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	9.5%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative. Adult Acute 2020 benchmark EPUT result was 9%, against a National mean of 12%.	N/A
5.7.3 Temporary Staff Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: Green	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	9.2%		Below Target = Good 	N/A		
5.5 Staff Survey	5.5.1 Outcome of CQC NHS staff survey						

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M5** **Perf** / **RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**	
Committee: FPC Data Quality RAG: **Green**	5.5.2 Support & Compassion, Team Work and Inclusion						on si

Information from the 2020 Staff Survey

The Staff Survey ran from September to November 2020.

The Trust was measured against 10 themes in the 2020 Survey. EPUT scored above average in one theme, in line themes.

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

Staff Survey 2020	EPUT	Average	Comments	
Safe Environment – Bullying & Harassment (high is better)	8.0%	8.3%	Below Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)	11.9%	10.5%	Above Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)	17.2%	15.5%	Above Average	●

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

Staff Survey 2020	EPUT	Average	Comments	
Q4h The Team I work in has a set of shared objectives	75.4%	74.6%	Better than average	●
Q4i The Team I work in often meets to discuss the team's effectiveness	68.5%	69.8%	Below Average	●

Trusts in lowest third across the sector will represent a concern

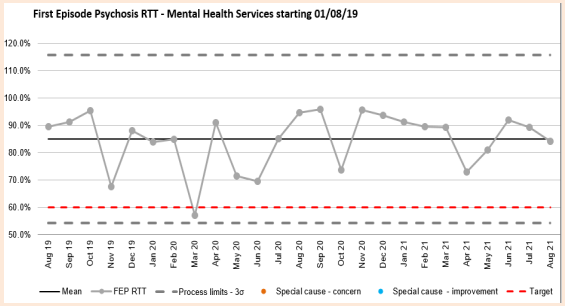
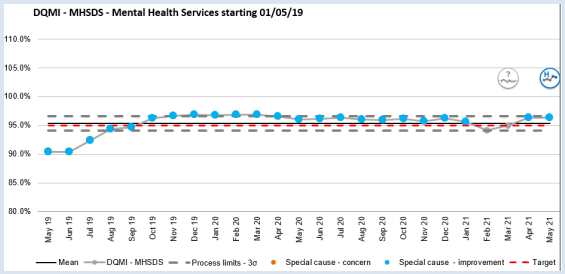
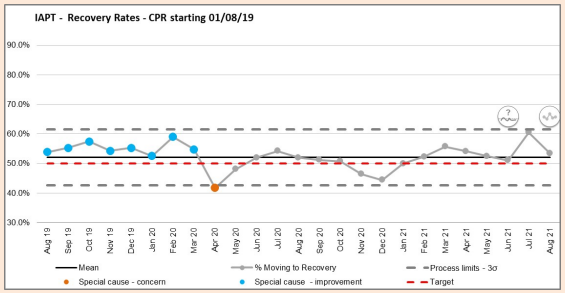
Inclusion (1) Average of

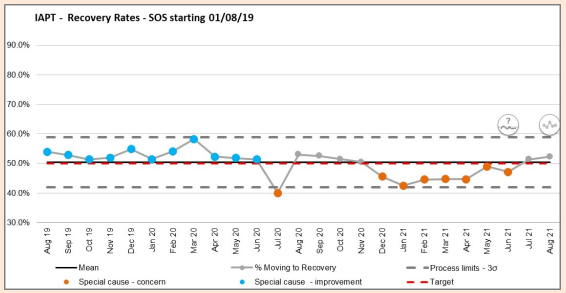
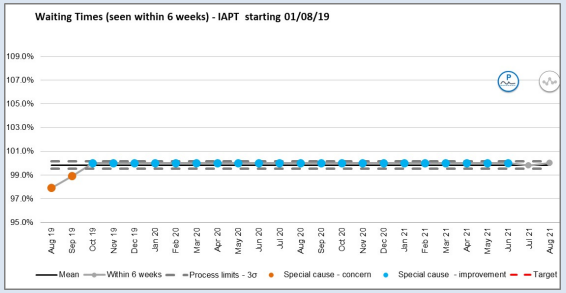
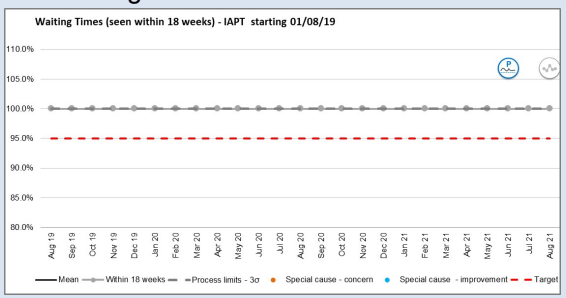
- % staff believing the trust provides equal opportunities for career progression or promotion
- % experiencing discrimination from their manager/team leaderor other colleagues in the last 12 months

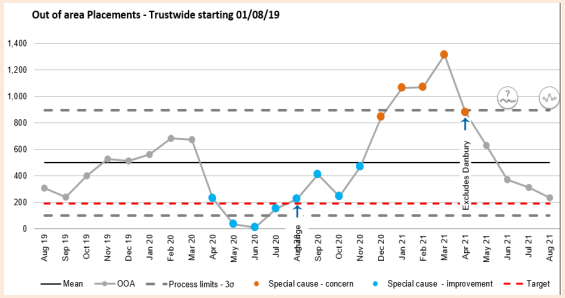
Staff Survey 2020	EPUT	Average	Comments	
Q14 Does your organisation act fairly with regard to career progression / promotion,	84.7%	86.6%	Below Average (Better than last year)	●

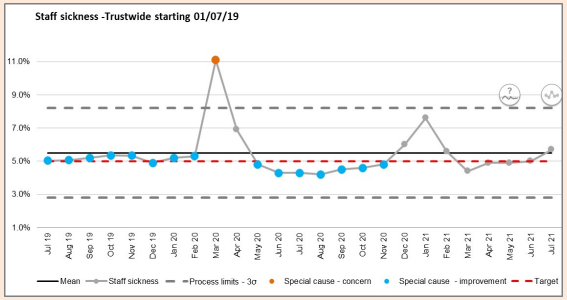
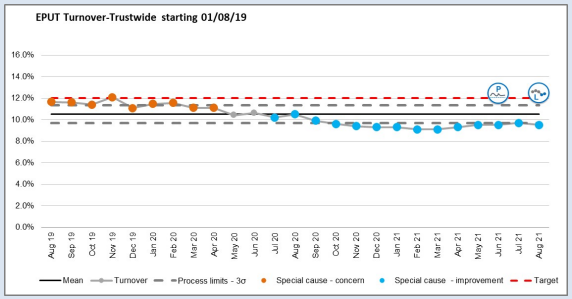
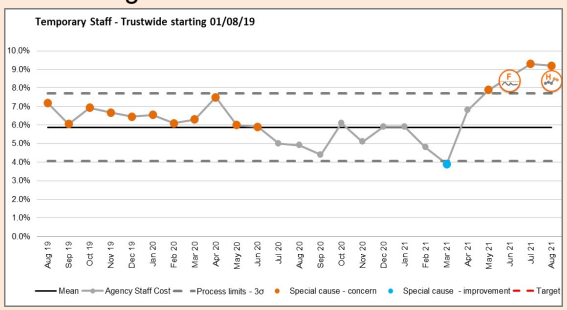
Workforce and Leadership									
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat**	**Narrative**			**Recovery Date**
		Perf	**RAG**		**RAG**				
		regardless of ethnic background, gender, religion, sexual orientation, disability or age							
		Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months	8.6%	7.1%		Above average	●		

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**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	84.2%	●	Trend above Target = Good 	●	August performance represents: 16 / 19 patients.	N/A
2.2 DQMI Committee: FPC Data Quality RAG: **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	96.3%	●	Trend above target = good 	●	Latest published figures are for May 2021	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	CPR 53.5%	●	Trend above target = good 	●	Decrease from July but continues to meet the target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	52.3%	●	Above Target = Good 	●	Slight increase from the July position and is continuing to achieve target.	
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	NEE 51%	●	Above Target = Good Graphs will be produced once sufficient data is available.		The NEE service is on target this month.	
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	CPR & SOS 100%	●	Above Target = Good 	●	Consistently passing target	N/A
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	NEE 96.2%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Consistently above target.	
2.16.9/10 IAPT Waiting Times ● Committee: FPC	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	CPR & SOS 100%	●	Above Target = Good 		Consistently above target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	NEE 100%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Consistently above target.	
4.5 Out of Area Placements Committee: FPC Data Quality RAG: **Amber**	A further positive reduction has occurred in out of area bed days 235 (excluding Danbury) in August. Recent levels have been in part due to the requirement for social distancing on wards limiting occupancy levels. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and reinstatement of Topaz in March 21 to further offset any COVID surge demand. It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract. The Trust currently has a target to reduce OOA placements to 0 by the end of September 2021. There are comprehensive actions plans in place to accomplish this and we are currently on target to meet trajectory. These assumptions are based on recovery from COVID 19 infection. Current numbers are raising concerns that there will be more OOA if wards are closed to admission due to COVID 19						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	235 Days	●	Below Target = Good 	●	Eight new clients were placed OOA in August, and following the repatriation of nine, there were eight remaining OOA at the end of the month.	TBC

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	5.7%		Below Target = Good 		An uptick in staff sickness due to Covid has been noted in Silver Command Meetings, with contingency planning discussions underway. The sickness figures are reported in arrears to allow for all entries on Health Roster. Adult Acute 2020 benchmark EPUT result was 5%, against a National mean of 7%.	
5.2.2 Turnover Committee: FPC Data Quality RAG: Green	Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC Target <12%**	9.5%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative. Adult Acute 2020 benchmark EPUT result was 9%, against a National mean of 12%.	N/A
5.7.3 Temporary Staff Committee: FPC Indicator: Oversight Framework Indicator	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	9.2%		Below Target = Good 	N/A		

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
Data Quality RAG: Green							

5.5 Staff Survey

Committee: FPC
Data Quality RAG: **Green**

5.5.1 Outcome of CQC NHS staff survey

5.5.2 Support & Compassion, Team Work and Inclusion

Information from the 2020 Staff Survey

The Staff Survey ran from September to November 2020.

The Trust was measured against 10 themes in the 2020 Survey. EPUT scored above average in one theme, in line

themes.

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

Staff Survey 2020	EPUT	Average	Comments	
Safe Environment – Bullying & Harassment (high is better)	8.0%	8.3%	Below Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)	11.9%	10.5%	Above Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)	17.2%	15.5%	Above Average	●

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

Staff Survey 2020	EPUT	Average	Comments	
Q4h The Team I work in has a set of shared objectives	75.4%	74.6%	Better than average	●
Q4i The Team I work in often meets to discuss the team's effectiveness	68.5%	69.8%	Below Average	●

Trusts in lowest third across the sector will represent a concern

Inclusion (1) Average of

- % staff believing the trust provides equal opportunities for career progression or promotion
- % experiencing discrimination from their manager/team leaderor other colleagues in the last 12 months

Staff Survey 2020	EPUT	Average	Comments	

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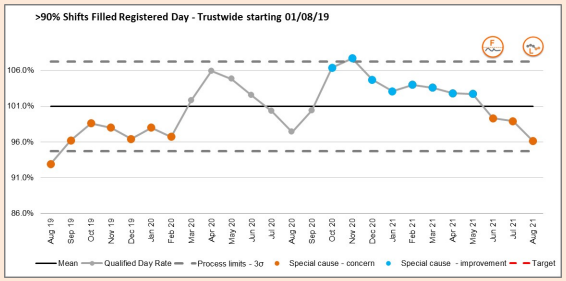
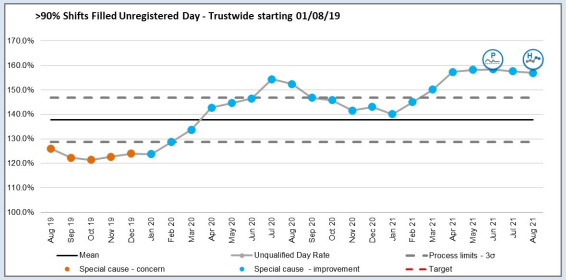
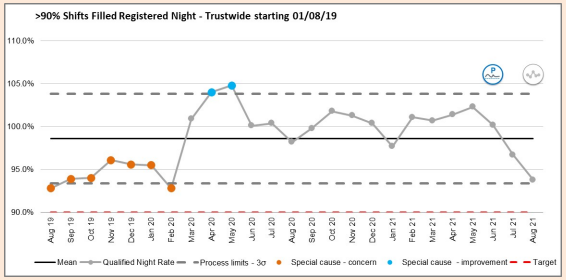
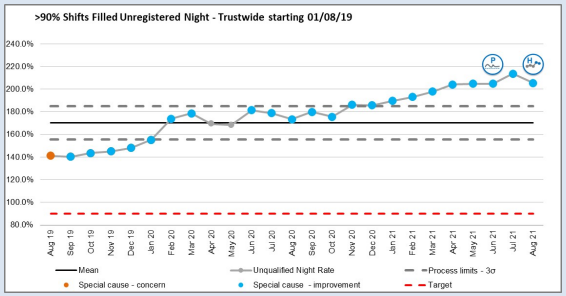
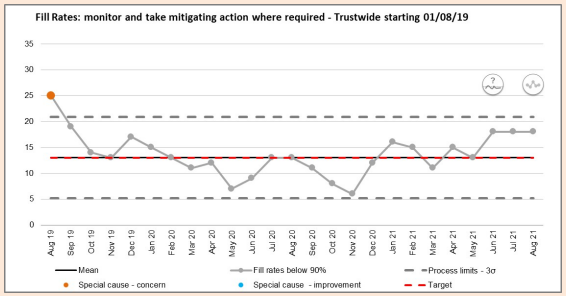
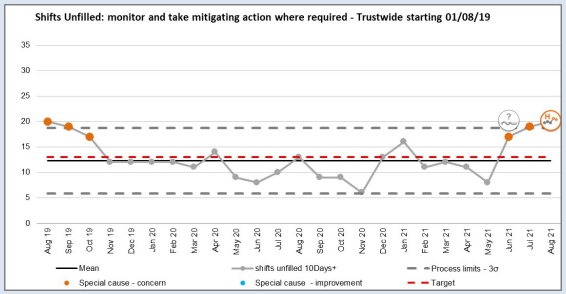
Workforce and Leadership										
RAG	**Ambition / Indicator**	**Position M5**		**Trend**		**Nat**	**Narrative**		**Recovery Date**	
		Perf	**RAG**			**RAG**				
		Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age		84.7%	86.6%		Below Average (Better than last year)	●		
		Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months		8.6%	7.1%		Above average	●		

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.	96.1%	●	Trend above target = good 	●	The following wards were below target in August: CAMHS: Poplar ward - Rochford Nursing Home: Clifton Lodge Specialist: Edward House & Fuji Adult: Ardleigh, , Basildon MHAU, Willow, Galleywood, Gosfield & Peter Bruff Older: Ruby PICU: Christopher Unit LD: Heath Close	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	156.9%	●	Trend above target = good 	●	The following wards were below target in August: Specialist: Causeway	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	93.8%	●	Trend above target = good 	●	The following wards were below target in August: Older Adult: Beech – Rochford, Kitwood & Henneage Nursing Homes: Rawreth Court Adult: Gosfield	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	205.5%		Trend above target = good 		There were no wards below target in August	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	18		Below Target = Good 		The following wards had fill rates of <90% in August: Adult: Ardleigh, Basildon, Willow, Galleywood, Gosfield & Peter Bruff Older Adult: Beech – Rochford, Henneage, Kitwood & Ruby Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Causeway, Edward House & Fuji CAMHS: Poplar ward – Rochford PICU: Christopher Unit LD: Heath Close	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	20		Below Target = Good 		The following wards had more than 10 days without shifts filled in August: Adult: Ardleigh, Willow, Finchingfield, Galleywood, Gosfield & Peter Bruff Older Adult: Beech – Rochford, Henneage, Kitwood, Ruby & Tower Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Causeway, Edward House, Fuji & Woodlea Clinic CAMHS: Larkwood PICU: Christopher Unit	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						CHS: Avocet	

SECTION 5 – CQC

Click here to return to summary page

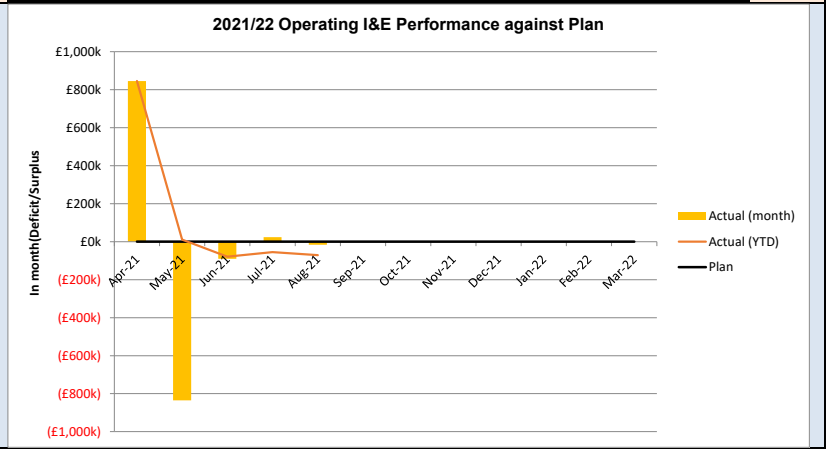
Unannounced CQC Inspection (CAMHS Service May/June 2021)

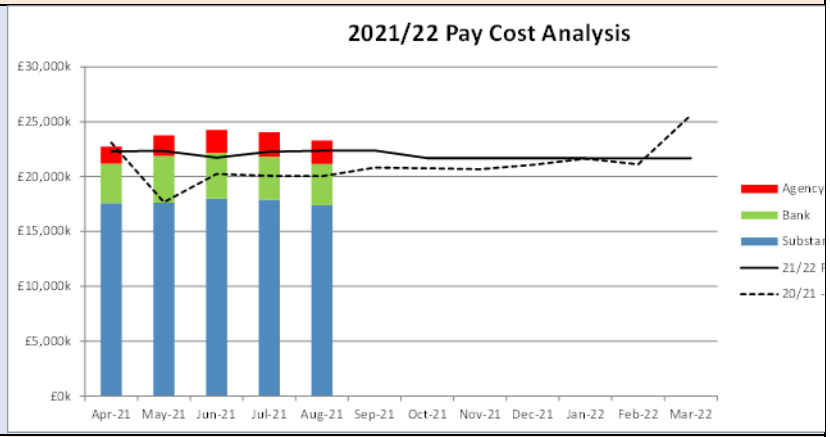
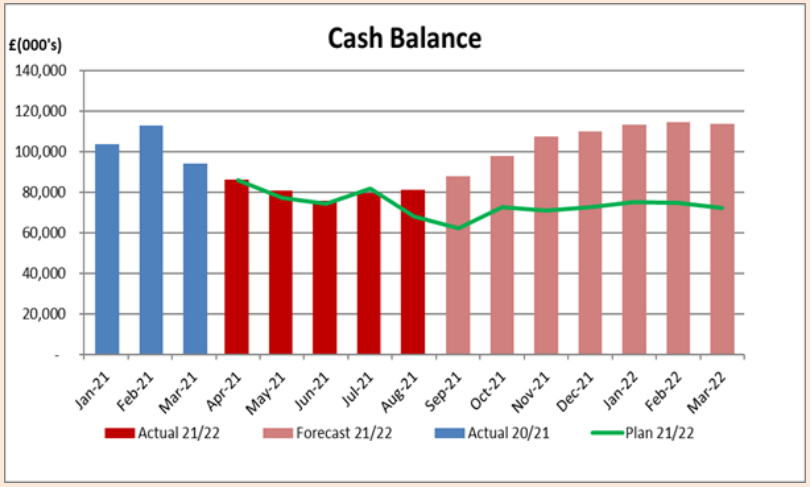
The CQC have completed an unannounced inspection of the CAMHS services in May/June 2021. The draft feedback report for the CQC Focused Inspection was received in July 2021 and factual accuracy checking was undertaken and the response was sent back to the CQC, meeting the deadline. The final CQC CAMHS report is expected mid September, full details will be presented in the CQC Compliance report at the September Board meeting. The CAMHS service has been rated Inadequate.

The CAMHS Clinical Intensive Support Group is meeting weekly to address the areas identified and ensure the restrictions imposed are adhered to.

SECTION 6 - Finance

Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr>
<td>Capital Expenditure</td>
<td>Maximising Capital Resources</td>
<td>The Trust's annual capital programme remains at £14.4m. YTD revised plan is £3.7m with actual spend at £3.1m i.e. £0.6m behind YTD plan. The Trust continues to invest in estates improvement and safety related schemes with further investments totalling c£1m being approved during the period</td>
<td>
Capital
<table>
<tr><th></th><th>Annual Plan £'000's</th><th colspan="3">Year to Date</th></tr>
<tr><th></th><th></th><th>Plan £'000's</th><th>Actual £'000's</th><th>Variance £'000's</th></tr>
<tr><td>ICT (including ePrescribing)</td><td>2,428</td><td>220</td><td>284</td><td>-65</td></tr>
<tr><td>MEMS / Other equipment</td><td>200</td><td>37</td><td>26</td><td>11</td></tr>
<tr><td>Safety & Ligature</td><td>1,942</td><td>127</td><td>397</td><td>-270</td></tr>
<tr><td>Backlog Maintenance</td><td>2,349</td><td>162</td><td>194</td><td>-32</td></tr>
<tr><td>Health & Safety</td><td>1,000</td><td>192</td><td>154</td><td>38</td></tr>
<tr><td><u>Strategic Schemes:</u></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dormitory Project</td><td>2,159</td><td>284</td><td>284</td><td>0</td></tr>
<tr><td>Other</td><td>1,085</td><td>498</td><td>344</td><td>154</td></tr>
<tr><td>Charge against Capital Allocation</td><td>11,163</td><td>1,520</td><td>1,683</td><td>-164</td></tr>
<tr><td>DHSC Dormitory Project</td><td>3,080</td><td>2,103</td><td>1,339</td><td>764</td></tr>
<tr><td>PFI Residual Interest</td><td>109</td><td>45</td><td>45</td><td>0</td></tr>
<tr><td>Net CDEL</td><td>14,352</td><td>3,668</td><td>3,068</td><td>601</td></tr>
</table>
</td>
</tr>
<tr>
<td>Trust I& Capital Expenditure E 2020/21</td>
<td>Operating Income and Expenditure</td>
<td>The Trust continues to operate within the adapted financial regime for H1. The year-to-date position is a £0.1m deficit. H2 planning guidance and financial allocations are expected by end September. Following updated allocations the Trust will reassess its financial plan for H2.</td>
<td> 
</td>
</tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Efficiency Programmes	Planned improvement in productivity and efficiency	The Trust's annual efficiency target for 21/22 is £10.1m. This target will be reassessed when H2 allocations are released. YTD performance is £1.6m being £0.5m behind plan. The Trust has undertaken a series of efficiency meetings with Directorates. The key focus is to identify recurrent efficiencies for 22/23.	
Temporary Staffing	Level of Temporary Staffing Costs	The Trust has converted relevant temporary staffing budgets to substantive positions to support substantive recruitment. Overall temporary staffing costs for the month of £5.9 (£6.2m M4). The reduction in spend is mainly associated with the consolidation of the Mass vaccination programme. A number of substantive recruitment initiatives are underway and the Trust is developing further plans to increase substantive staffing levels.	
Cash Balance	Positive Cash Balance	Cash balance as at end of August was £81.4m, which is above planned of £68m. The variance of £13.3m is mainly due to: • Higher NHS receipts due to Provider collaborative income not planned for. • Lower payments than planned in respect of pay and capital expenditure	

EPUT 21/22	Efficiencies / Waste Reduction Plan £m	YTD Plan £m	YTD Delivery £m	YTD Variance £m
H1 (M1-M6)	3.5	2.1	1.6	(0.5)
H2 (M7-M12)	6.6	0.0	0.0	0.0
EPUT Total	**10.1**	**2.1**	**1.6**	**(0.5)**

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Mental Health Act Annual Report – 2020/21**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Lynn Proctor, Mental Health Act Senior Support Manager, Debbie Radley Mental Health Act Senior Manager on behalf of Angela Butcher, Associate Director for Professional Development					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	N/A
Are you recommending a new risk for the EPUT BAF?	N/A
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors: • MHA activity during 2020/21	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

MHA ACTIVITY

- The use of Section 5(2) can fluctuate from month to month demonstrated as common variation. This may indicate a least restrictive option in that patients are coming into hospital informally.
- At the start of April 2020 the data demonstrated that Section 2s were below the normal range, however, towards the end of April 2020 there was a substantial increase in the number of detentions under Section 2 and this remained so until February 2021 which then saw a decrease.
- At the start of April 2020 the data demonstrated that Section 3s were at the normal range although there was a slight increase in September 2020, following this, the detentions under Section 3 have fallen month on month through to February 2021.
- As reported in last year's MHA Annual Report, March 2020 showed a significant increase in the number of AWOL's which was identified to be specifically in the CAMHS directorate. The identified issue for this increase has now been resolved. From April

2020 to March 2021 AWOLs have been significantly lower which may be due to the Government restrictions around COVID-19.
- The Trust has had four CQC Remote Reviews during 2020/21, these were to Meadowview, 14/07/2020 Tower Ward, 15/09/2020, Ardleigh Ward, 22/09/202 and Grangewaters Ward, 21/03/2021.

POSITIVE ASSURANCE
- East Suffolk and North Essex Foundation Trust signed a service level agreement from the 1st October 2020 to provide MHA administration support.
- In order to support Associate Hospital Managers (AHMS) to participate in AHM virtual hearings during the pandemic, a Standard Operational Procedure was developed to provide guidance and identified the functions that are carried out by AHMs on behalf of the Trust during the pandemic.
- To support regular audits of MHA paperwork the introduction of the Perfect Ward App has been innovative. The App has been designed to assist professionals to own patient safety and conduct quicker and more efficient audits especially around MHA compliance across the Trust.

HOTSPOTS
Previous hotspots:
Previous hotspots identified in the Mental Health Act Annual Report 2019/2020 have been addressed:
- **Mental Health Tribunal Room Specifications**: completed
- **Completion of CQC Monitoring reports by Ward Mangers:** this has been superseded by the introduction of Remote MHA CQC Reviews where a provider statement is no longer issued. This has been replaced with a letter. The Senior MHA Managers support the clinical team in completing a response
- **PARIS Clinical System: -** As previously reported, the Mental Health Act Administration Team were unable to renew Section 3's on the system. The issue had been identified and discussed with the PARIS Technical Team and as a planned update of PARIS was not due until November 2020, this issue was placed on the Risk Register. It is pleasing to report that this issue was resolved on the 20th October, 2020 jointly by the Civica (Supplier) and the PARIS Technical Team.

Outstanding hotspots:
- **Associate Hospital Manager Appraisals: -** Outstanding Associate Hospital Manager Appraisals, which will be completed using the current platform – Microsoft Teams. - Valuable work has continued to be undertaken during the last year by the AHM Chair and Vice-Chair in revising the current Appraisal Forms. It is expected that all AHM Appraisals will be completed during 2021 and in line with the timing of the review of AHM Agreements in April 2022.

New hotspots:
- **Mental Health Act Team Workload Pressures: -** Significant workload pressures have been experienced by members of the Mental Health Act Administration Team during 2020/2021 and continue to do so. Robust support has been provided to members of the team to enable them to function, whilst continuing to meet the requirements and compliance required for the administration of the Mental Health Act. Moving forward a review will be undertaken of the staffing requirements for the Mental Health Act Team to provide a more enhanced service.

FORWARD PLAN
- As in previous years, work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration.

- The Mental Health Act Senior Team members and the Mental Health Act Team meet at regular intervals to review each respective area of practice. This provides an opportunity to discuss any changes to the Mental Health Act Code of Practice and Case Law as well as devising and developing monitoring tools/training packages to redress themes identified from the virtual visits carried out by the Care Quality Commission during 2020/2021.

- Mental Health Act Managers, have during the pandemic faced challenges in the delivery of Mental Health Act Training across the Trust. It is acknowledged that the Trust has in place a robust 'e' learning module that provides training to all staff around the required compliance of the Mental Health Act. In addition, Mental Health Act Managers have offered any further support for bespoke training needs via Microsoft Teams. The Mental Health Act Team have a fully functioning Trust Intranet page which provides support to all staff in regards to the complexities of the Mental Health Act. The Mental Health Act Managers and their team continue to promote lawful practice, compliant with the Mental Health Act Code of Practice 2015.

- The Mental Health Act Team remains committed to meeting deadlines from actions plans set following visits from the Care Quality Commission. In addition the Mental Health Act Business Meeting which is attended by senior members of the Mental Health Act Administration Team along with senior Operational Managers will continue adopt a comprehensive approach to identifying operational needs in regards to Mental Health Act Compliance.

- Senior members of the Mental Health Act Team will continue to explore a comparable Service Level Agreement with Mid & South Essex NHS Foundation Trust covering services in Basildon General Hospital, Southend General Hospital and Broomfield Hospital in Chelmsford.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

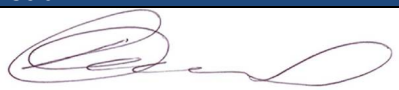
Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

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

Acronyms/Terms Used in the Report			
MHA	Mental Health Act 1983	CAMHS	Children and Adolescent Mental Health Services
AHM	Associate Hospital Manager		
CQC	Care Quality Commission		
AWOL	Absence Without Leave		

Supporting Documents and/or Further Reading
Mental Health Act Annual Report 2020/2021

Lead



Natalie Hammond
Executive Nurse

Essex Partnership University
NHS Foundation Trust

Mental Health Act Annual Report
1 April 2020 to 31 March 2021

Author: Lynn Proctor, Mental Health Act Senior Management Support
on behalf of Angela Butcher, Associate Director – Professional Development

Essex Partnership University
NHS Foundation Trust

Contents

FOREWORD

This year's 2020/21 Mental Health Act Administration Annual Report again confirms the Trust's commitment to ensuring the effective delivery of its statutory responsibilities across all service areas. This commitment remains at the heart of our core business.

As an organisation that provides high-quality mental health care, we come into contact daily with some of the most vulnerable adults and children in society. We take our responsibility to promote the safety of those in our care very seriously and in order to positively impact this we provide high-level consistent support, guidance and training to our frontline staff to equip them with the daily challenges they face in this area of their practice.

The COVID-19 pandemic has tested our response to lead this agenda. It is recognised that it has never been more important to demonstrate strong leadership and management, ensuring that throughout our services we demonstrate high levels of support, intervention and expert guidance. Partnership working with our colleagues from neighboring services including the police, Clinical Commissioning Groups and local authorities remains vital. Effective communication is the cornerstone to making sure that we deliver on our commitment to protect our vulnerable populations.

To meet our commitments the Trust has the following ambitions:

- To unify the clinical system to streamline Mental Health Act processes
- Embedding a robust succession planning system to provide stability
- Continue developments to achieve recognition as a centre of excellence

Natalie Hammond
Executive Nurse

EXECUTIVE SUMMARY

This is the fourth Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Committee operates, provides an overview of its activities in 2020/21 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2021/22.

The Board recognises that high standards of governance throughout the Trust are essential for the delivery of the identified strategic objectives, the safety of its services, the quality of service user and carer experience, and the long-term protection of stakeholder interests. Good governance emanates from the Board but pervades the entire organisation, being reflected in its operating practices, policies and procedures.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April, 2020 to 31st March, 2021. It will provide an overview of the work undertaken in the administration of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

DETENTIONS UNDER THE MENTAL HEALTH ACT – 2020/2021

Data Source

As there are currently two clinical systems being used for the administration of the Mental Health Act in the Trust - Mobius in the Basildon/Rochford/Thurrock Area and Paris in the Chelmsford/Colchester/Harlow Area, this report provides details for both systems, which are provided by the Trust's Information and Performance Team.

People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.

The main facts and figures in this report has been benchmarked against national government figures reported on 4th March, 2021.

National Data

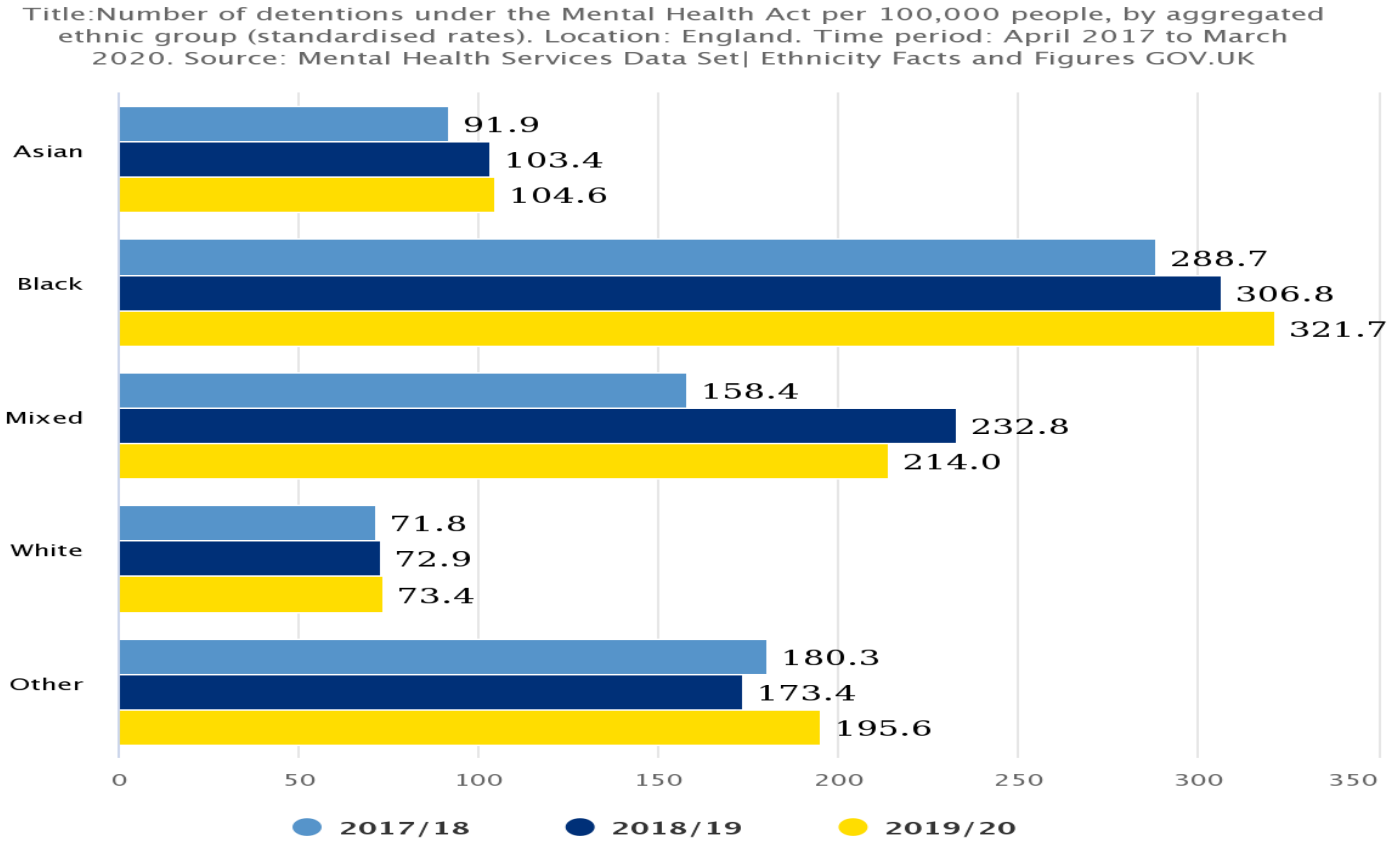
The most recent data available (DoH March 2020), Black people were more than 4 times as likely as White people to be detained under the Mental Health Act. 321.7 detentions per 100,000 people, compared with 73.4 per 100,000 people.

Black Caribbean people had the highest rate of detention out of all ethnic groups, (excluding groups labelled as 'Other').

The lowest detention rates were in the Chinese (54.1 per 100,000), White Irish (69.9 per 100,000), White British (70.5 per 100,000) and Indian (71.9 per 100,000) ethnic groups.

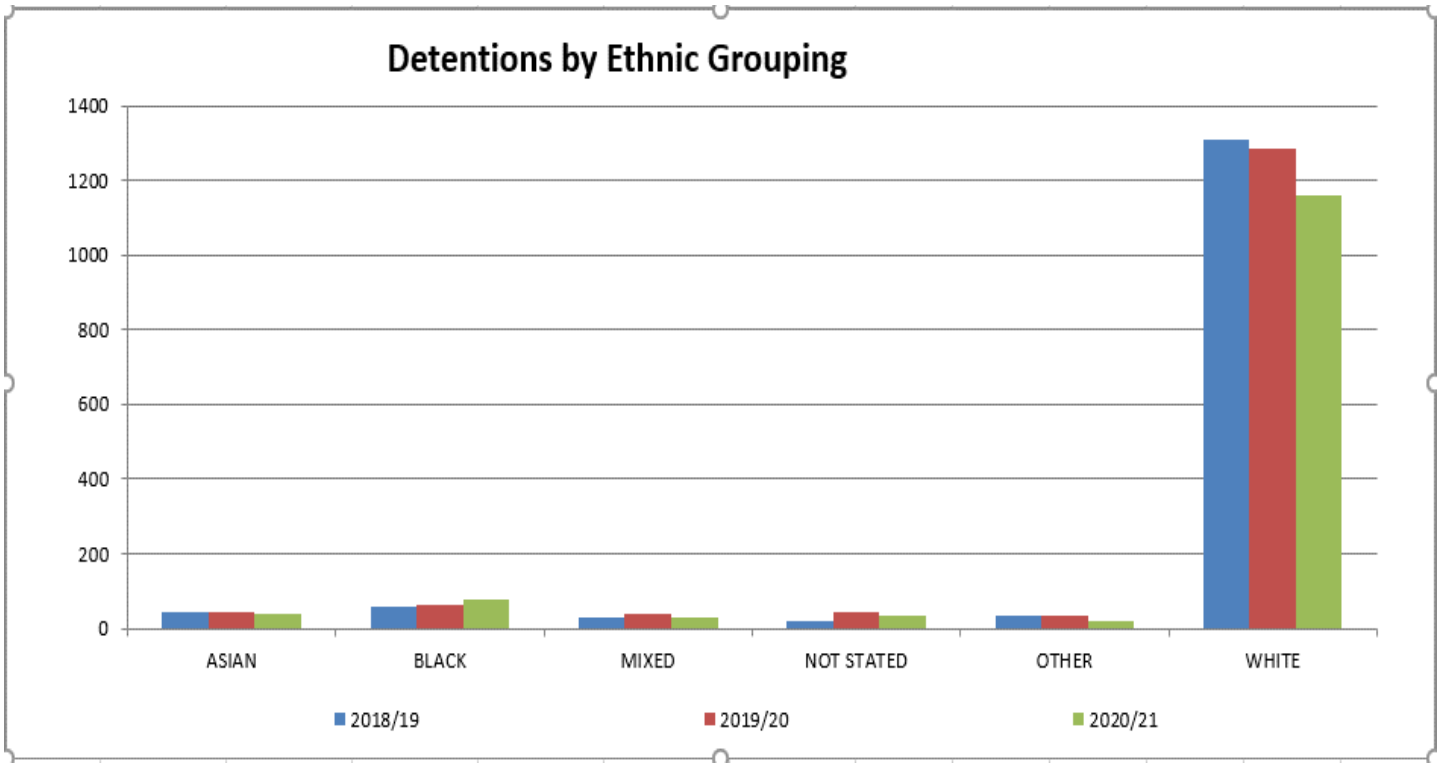
Overall it is estimated that detentions increased by 0.8% in the year to March 2020 – this is based on figures from service providers who submitted good quality data in each of the last 5 years, rather than all providers. The data does not include detentions under Section 136 of the Mental Health Act that have taken place in non-healthcare settings, for example, Police Cells.

National detentions under the Mental Health Act per 100,000 people, by specific ethnic group (standardised rates)



EPUT Data

The table below details the ethnic grouping of detained patients in receipt of care from EPUT. The ethnic profile appears to be stable, with a slight increase in detentions of Black individuals. Going forward the Mental Health Act Office will continue to monitor and analyse any fluctuating trends. Based on any emerging trends, they will review and adapt policy and procedure, as well as training to ensure cultural and ethnicity needs are reflected.

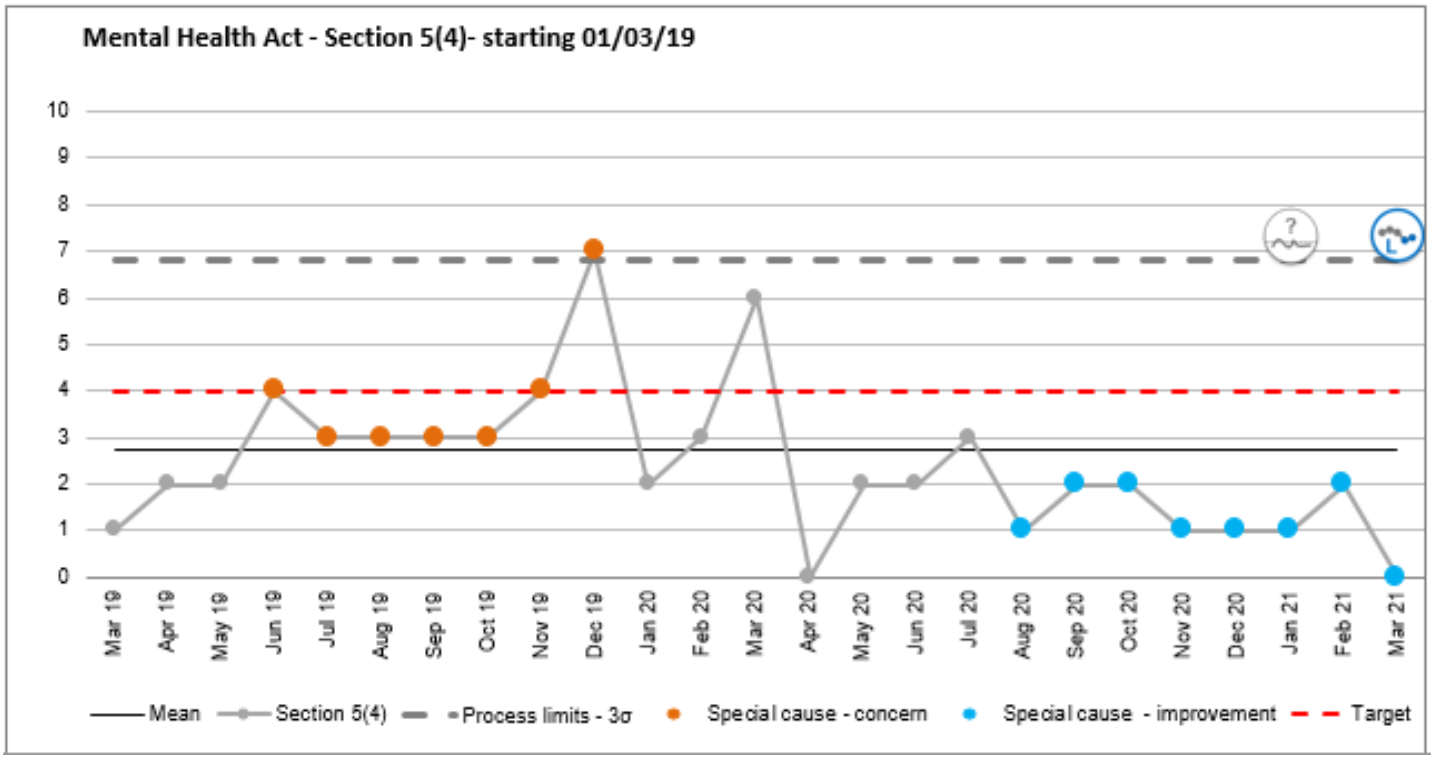


Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated 'drill down to understand the context and circumstances; and remedial action taken as appropriate.

The below SPC Charts provides an overview of Mental Health Act Activity. Whilst there is some fluctuation in the use of some of the detentions, they are all within the expected range. The fluctuations may be attributable to the effect of COVID-19 restrictions – e.g. lockdown.

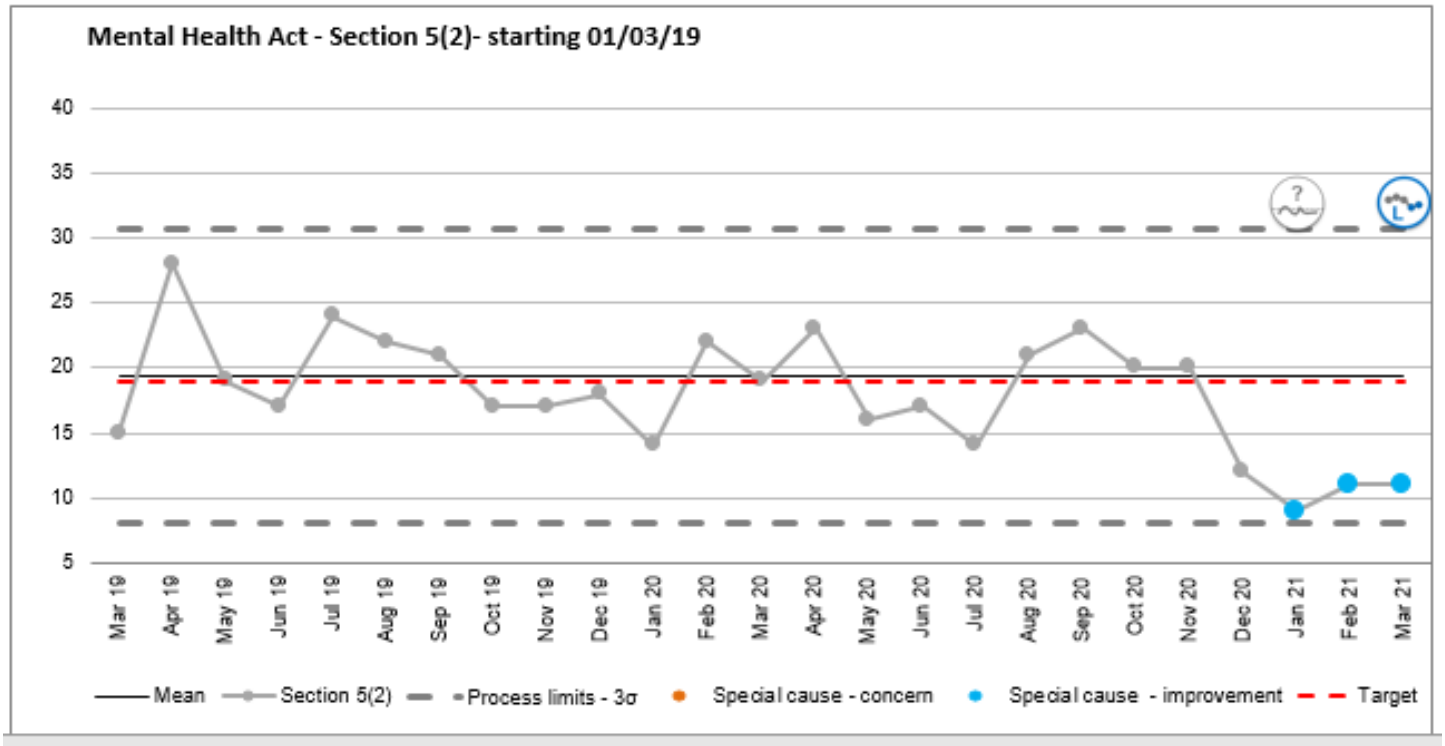
Section 5(4)

A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the register indicates that their field of practice is either mental health or learning disability. A Section 5(4) lasts for up to six hours or until the doctor attends to assess the patient



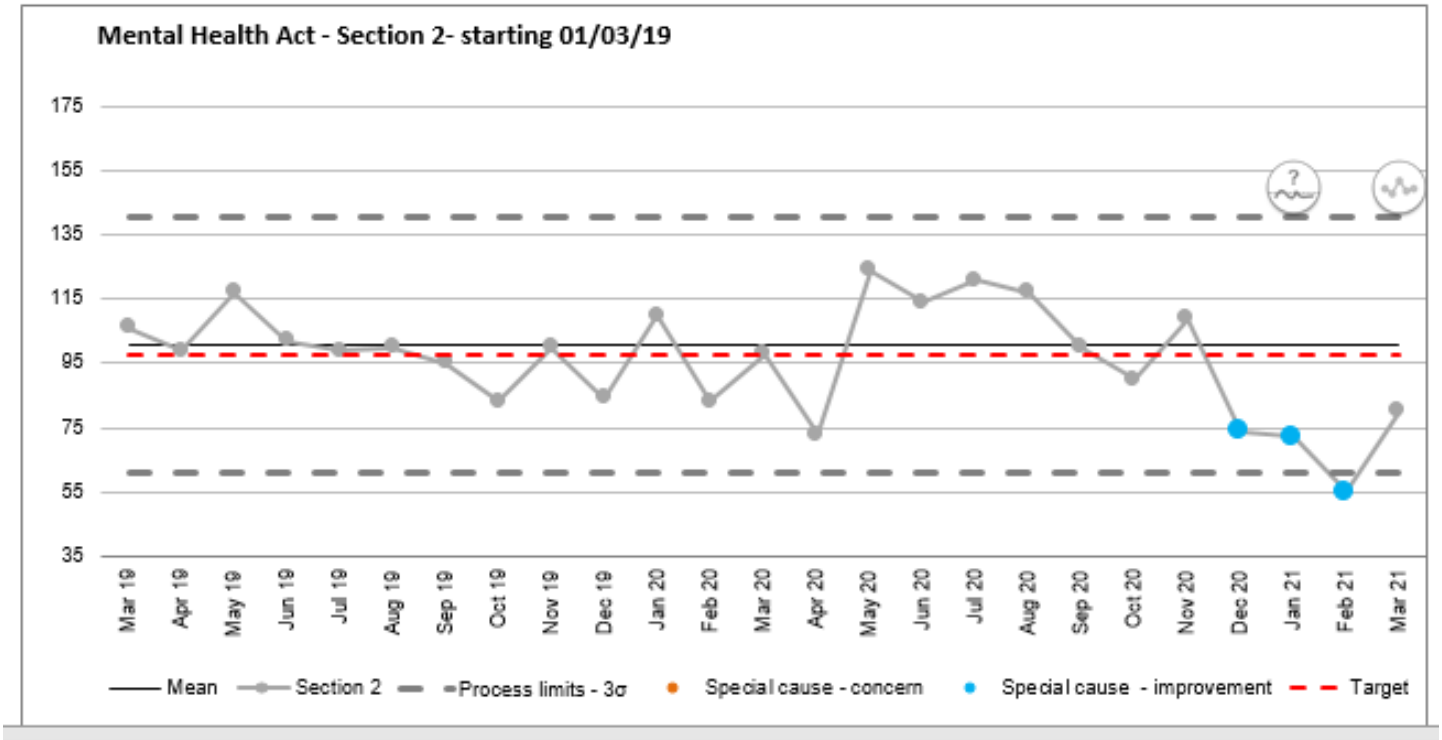
Section 5(2)

Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983. A Section 5(2) is only used where the patient has expressed the intention to discharge themselves and there is an assessed risk to themselves or others should they do so. The usage of a 5(2) can therefore fluctuate from month to month demonstrated as common variation.



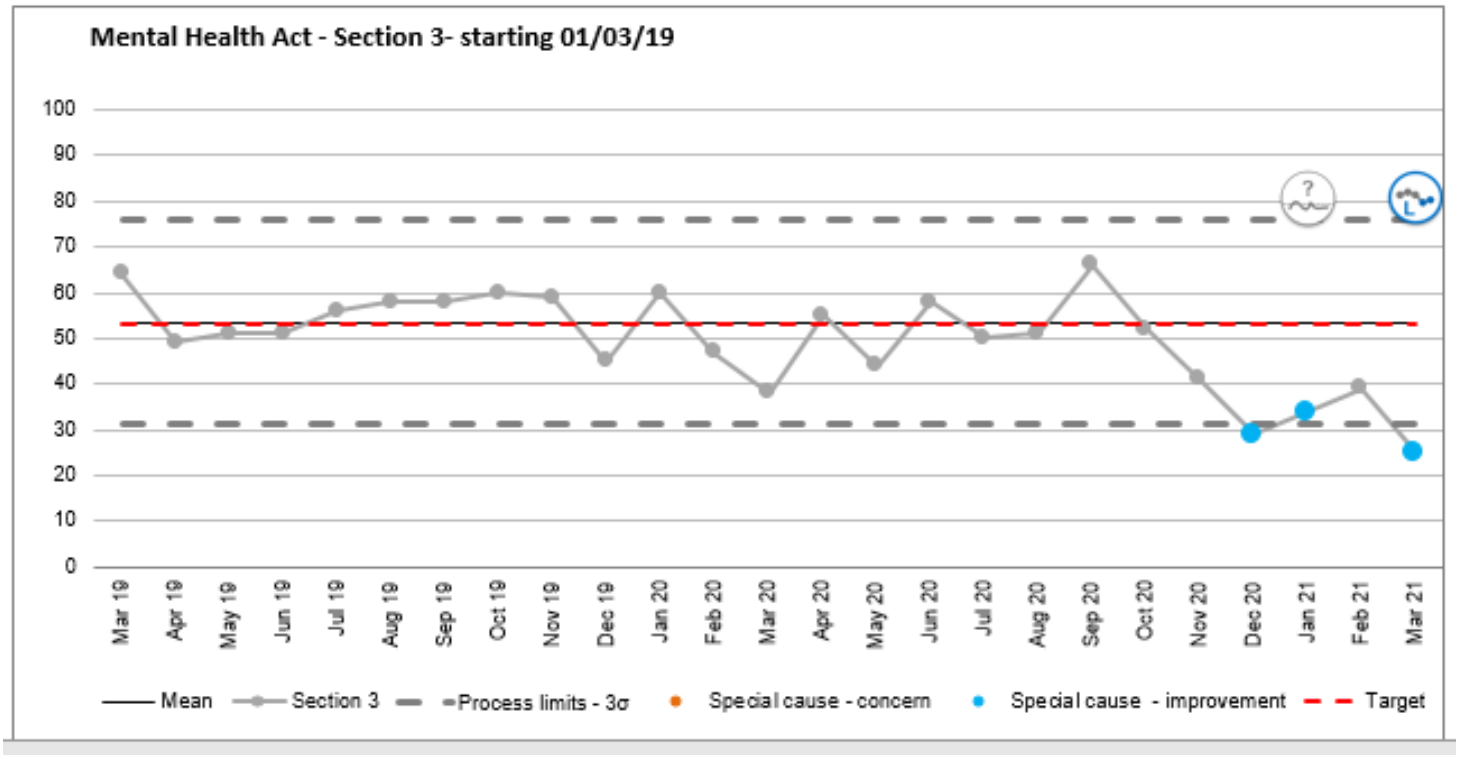
Section 2

A Section 2 is an assessment & treatment section for detention up to 28 days. Clinicians during the period of assessment will be looking for an improvement in the patient's mental state and would towards the end of the twenty eight day period be looking for the least restrictive option of the patient remaining in hosptial informally rather than being detained further under section 3. Section 3 is a longer term treatment section for up to six months, renewable at six months and then yearly. The charts highlight the reduction the movement towards least restrictive care options for patients that come under the care of the Trust.



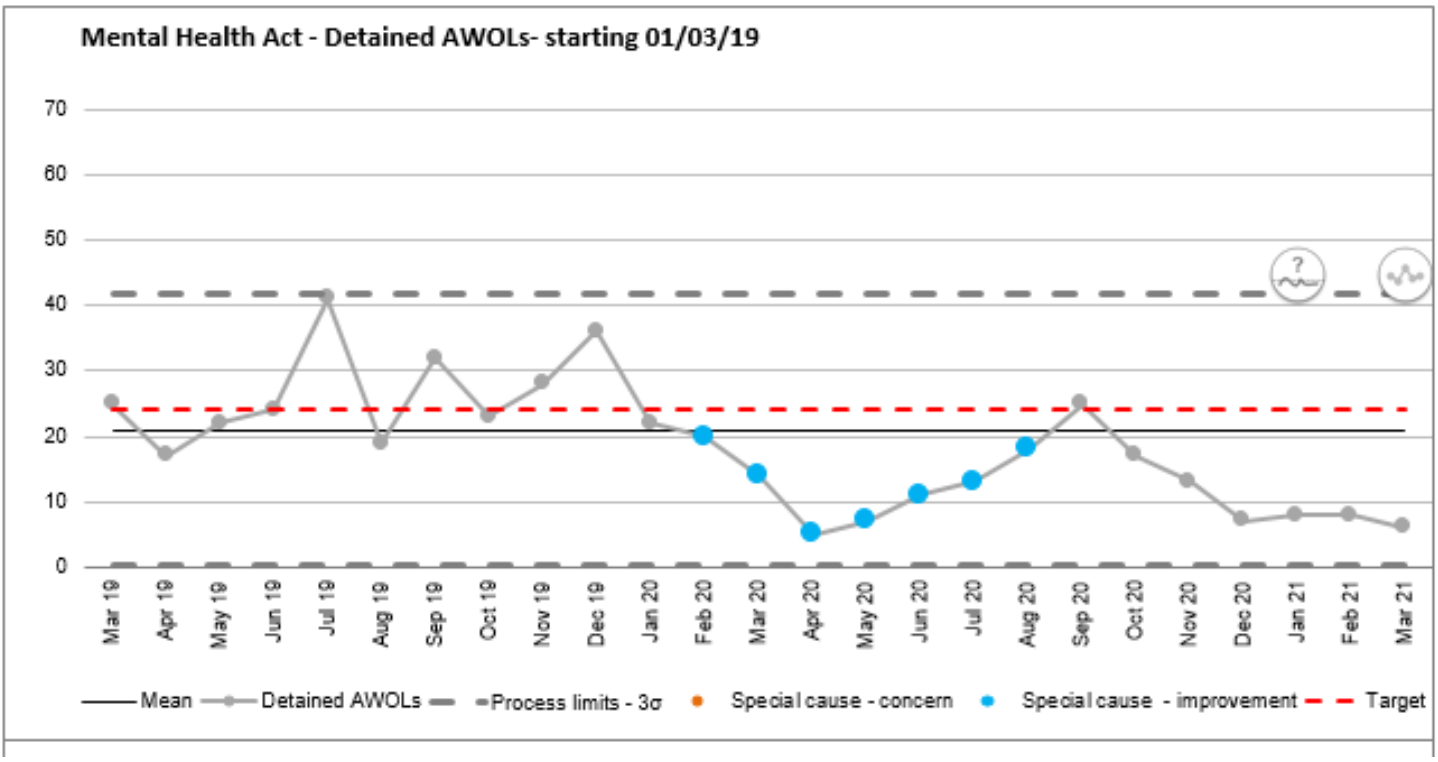
Section 3

Section 3 is a longer term treatment section for up to six months, renewable at six months and then yearly. The charts highlight the reduction the movement towards least restrictive care options for patients that come under the care of the Trust. The increase in October and February could be attributed to patients requiring longer term treatment, hence the requirement to be placed under a Section 3.



Absence Without Leave

Section (18) of the MHA sets out the definition and the powers available when a person is absent without leave**.** A high percentage AWOLs relate to a small number of patients in Child and Adolescence Mental Health Services. Measures are being put in place to secure the physical environment and manage the patient's leave to mitigate against them going AWOL, e.g. escorted as opposed to un-escorted leave.



SERVICE LEVEL AGREEMENT WITH OTHER HEALTH CARE PROVIDERS

As reported in the previous 2019/2020 Mental Health Act Annual Report, a Service Level Agreement with Princess Alexandra Hospital, Harlow continues to be in operation. It is pleasing to report that East Suffolk and North Essex NHS Foundation Trust responsible for services in Colchester General Hospital duly completed and signed a Service Level Agreement with the Trust to provide Mental Health Act Administration support on 1st October, 2020. As with Princess Alexandra Hospital, the Service Level Agreement included the provision of Mental Health Act Training.

Number of detentions at Princess Alexandra Hospital – 1st April, 2020 to 31st March, 2021

3 x Section 2
2 x Section 3

Number of detentions at Colchester General Hospital – 1st April, 2020 to 31st March, 2021

2 x Section 2
1 x Section 3

Looking forward, senior members of the Mental Health Act Team will continue to explore a comparable Service Level Agreement with Mid & South Essex NHS Foundation Trust covering services in Basildon General Hospital, Southend General Hospital and Broomfield Hospital in Chelmsford.

CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. They do this by looking across the whole patient pathway experience from admission to discharge.

Following the outbreak of Coronavirus pandemic the CQC introduced new remote monitoring methods. This included collecting data from a range of sources via phone, email or video calls. If the CQC believe that there were risks of harm, ill-treatment or human rights breaches for people detained in services they would, if required carry out site visits.

In light of the introduction of remote reviews, the Mental Health Act Office has introduced a supportive process for the wards to help co-ordinate the visit. This involves pre and post meetings with the ward manager, an audit of all Mental Health Act documentation prior to the visit and the support of a named Mental Health Act Manager or Officer on the day of the visit. The Mental Health Act Office also help compile any responses that may be required to the CQC, during or following their visit. To date this has proved a very successful process and is deemed valuable to all parties concerned.

CQC Mental Health Act Reviewers undertook the following:-

1. Identify services that require monitoring based on emerging concerns and their previous contacts with the service;
2. For some services, a desktop activity was carried out only. Where more information was needed, the MHA Reviewer would begin a two-week programme work, gathering as much information as they could remotely, but they would also offer contact with local advocacy services or other local stakeholders to understand issues impacting detain patients.
3. If the review identified concerns that indicate a site visit would be needed, this would be discussed with the inspection teams and escalated for a final decision from the CQC Chief Inspector of Hospitals or their Deputy.

The CQC no longer issue a formal provider action plan but provided a letter with the outcome of the visit indicating any points where they would expect action to be taken.

The Care Quality Commission made the following visits to the Trust from the 1st April, 2020 to the 31st March, 2021:-

- 14th July, 2020 – Meadowview
- 15th September, 2020 – Tower Ward
- 22nd September, 2020 – Ardleigh Ward
- 1st March, 2021 – Grangewaters.

Overall, the visits to these wards were positive and the common themes identified were:

- Wards response to COVID-19 e.g. testing on admission, the care and treatment received by patients needing to isolate and the staff commitment during COVID-19;
- Introduction of COVID-19 hospital passports (Meadowview). These included important information about the patient's medical history, pre-existing medical conditions, the patients preferred commination method, details of relative. This meant in the event of patient requiring transfer to an acute general hospital the information would easily transfer with the patient;
- The IMHA maintained contact with the patients;
- Patients had access to the garden or hospital grounds for fresh air.
- Staff spoke highly of the support they received from the Infection Control Team and other professionals who were available with support and information. These included the Psychologist, management and one of the local Hospices. In addition, regular supervisions and team catch-ups also provided additional support and staff positively commented on these meetings/ reviews being more focused on staff well-being.

- The MHA team developed systems to ensure detention paperwork could be received and checked. They developed systems to ensure paperwork was uploaded on the electronic patient records. First tier Tribunals and managers' hearings were held remotely. Systems were in place to facilitate these reviews.

As part of the CQC visits the following observations were made:

- For some patients, limited access to technology i.e. iPads, to facilitate contact with family and friends;
- Incorrect clinical data recorded on care plan;
- Access to fresh air (Grangewaters – this was due to refurbishment, alternative arrangements had been made);
- Reduction in family visits due to COVID-19 restrictions (Grangewaters);
- Apparent delay in patients receiving their rights in accordance with Section 132.

All the above were addressed directly with the wards and any remedial action necessary taken e.g. wards provided with additional iPads, reminders to ensure correct clinical data is entered. All remedial actions were confirmed to the CQC.

It was pleasing to note a number of positive comments from patients, relatives and carers provided to the CQC Reviewer (as part of the MHA review):

- *"Doesn't matter how many times I phone the ward, the staff always have the time for me, don't know what I will do when mum leaves the hospital, because they {staff} have been so good with her, I'm so grateful to all the staff. The staff are brilliant; they are marvellous with her, a very good team."* (Meadowview)
- *"A very pleasant experience, care is good no concerns, I'm kept informed and involved, I speak to staff every day."* (Tower)
- *"You don't feel stigmatised in here, I feel quite empowered, and they have really supported me."* (Ardleigh patient)
- *"The staff are great, on admission I was self-isolating in my room, we are waited upon here, if you are in isolation, food, drinks and everything we wanted is brought to our room."* (Ardleigh patient)
- *"The staff were "respectful and listened" and "the treatment is good"* (Grangewaters)

EPUT GOVERNANCE

Mental Health Act Training in EPUT

Mental Health Act training of staff within the organisation prior to the onset of COVID-19 was delivered by the Mental Health Act Managers. Training needs are usually highlighted through results from ongoing Mental Health Act Audits, Mental Health Act Care Quality Commission visits and requests from Ward Managers to address team or individual needs. However, in line with Government restrictions, visits to wards were suspended in order to minimise the spread of the virus.

Alternative ways of supporting training needs were identified by using Microsoft Teams and providing support by telephone discussions with the MHA Team Managers.

In addition to bespoke training provided by the Mental Health Act Office (currently over Microsoft Teams), Mental Health Act Training is mandatory to both registered and un-registered staff. This training is regularly reviewed and will be updated in light of any changes resulting from the White Paper.

Mandatory Mental Health Act Training is available via the Trust's on line training system. Completion of the training is automatically tracked via the online management system as well as the Trust's training tracker. The Trust's Target Compliance figure is 85%. The table below depicts the figures both registered and unregistered staff:

	Overall Competence		
	Total Target	Trained	
		No	%
Registered staff	1390	1327	**95%**
Unregistered staff	839	784	**93%**

Mental Health Act Team Development

As an organisation, EPUT supports development of its workforce and aims to ensure that staff are fully competent to undertake their role; unfortunately, due to restrictions in regards to COVID-19, this has been somewhat restricted. Despite these restrictions as previously reported in last year's report, two members of staff from the team completed qualifications, one with a Masters in Mental Health Law and the other with a Certificate in Mental Health Law and Practice. The conclusion of these qualifications was facilitated through distance learning and in line with Government restrictions at the time. These additional qualifications enhances the skills within the Mental Health Team enabling the team to provide expert advice where necessary to Operational Services.

In addition, members of the Mental Health Act Team have continued to enhance their knowledge of the Mental Health Act by receiving regular distributions regarding changes to the Mental Health Act through Mental Health Law Online, the Care Quality Commission, The London Mental Health Network and the Law Society.

Mental Health Act Team – Working From Home

Following the onset of COVID-19 and in line with Government guidelines, Mental Health Act staff were required to adopt a flexible approach to working both at home and in the office. In order to support this new way of working a Standard Operational Procedure for Mental Health Act staff working at home was devised. The purpose of the document was to provide guidance and identify

the functions that were to be carried out by those members of staff working at home in relation to admissions only.

Working from home has proved successful, both in terms of team members experience and in terms of productivity. Going forward it is intended to continue this flexible approach to working and to support the wellbeing of the team.

Mental Health Act Team - Staffing

In recognition of the need to 'grow our own' and develop a career pathway, work was undertaken in 2020/2021 by the Senior Managers in the MHA Team in regards to reconfiguration of the team to provide a structured career pathway with the introduction of a Band 3 Administrative Support post. This reconfiguration has provided a robust structure, which allows continued development of the team as well as individuals going forward.

ASSOCIATE HOSPITAL MANAGERS

Section 145 of the Mental Health Act advises upon the Managers of hospitals various powers and duties which should not be confused with tasks undertaken by individuals employed by organisations in managerial roles. The identity of the 'Hospital Managers' depends on the nature of the organisation concerned. In an NHS Trust or NHS Foundation Trust, the 'Hospital Managers' will be the Trust or Foundation Trust as a body. In practice many duties within the Act for which 'Hospital Managers' are responsible will be delegated. Delegation is authorised within the Mental Health Act Regulations and in the case of discharge powers, under Section 23 of the Act. Many of the functions will usually be delegated to Mental Health Act Administration. Organisations may delegate the Section 23 role to a group of people referred to as 'Associate Hospital Managers'. 'Hospital Managers' retain overall responsibility for any delegated duties.

The Trust currently has thirty-four Associate Hospital Managers.

One Associate Hospital Manager resigned during 2020/2021

Associate Hospital Manager Training

The training needs of the Associate Hospital Managers is regularly discussed and agreed by the Independent Associate Hospital Manager Chair and Vice Chair.

The Trust has facilitated the following training session for Associate Hospital Managers:-

AHM Training – 18th November, 2020 – Microsoft Teams Training – The need for this training was in line with the introduction remote reviews.

Associate Hospital Standard Operational Procedure for Virtual Hearings

In order to support Associate Hospital Managers to participate in AHM Virtual Hearings during the pandemic, a Standard Operational Procedure was developed, and approved by the Mental Health Act & Safeguarding Sub Committee. The procedure provided guidance and identified the functions that

are carried out by the Associate Hospital Managers (AHMs) on behalf of Essex Partnership University NHS Foundation Trust during the current COVID-19 pandemic.

The Standard Operational Procedure was developed to ensure compliance under the Mental Health Act and in the interests of patient rights. The procedure identified functions to enable Hospital Manager Review Hearings to be held virtually using Microsoft Teams. The process was in line with existing procedures as detailed in the AHM Operational Manual.

AUDITS

Associate Hospital Manager Audit

Two audits a year are undertaken of Associate Hospital Manager decision forms.

Decision Form Audit

The decision form audit took place during December 2020**.** The process involves scrutinising a number of decision forms (12 in total) to ensure that the forms give sufficient evidence to justify the decision to discharge or not, the patients' detention under the Mental Health Act.

The Independent Chair noted that there had been a visible improvement to the completion of the decision forms since the last audit in January 2020.
The themes identified from the audit were as follows:

- The use of acronyms should be discouraged, as they may not be familiar to non-clinicians
- Nine out of the twelve forms did not indicate who communicated the decision to the patient
- Ensuring that all the boxes are completed to demonstrate that the box/questions has not been overlooked

Full Panel Audit

The full panel audit took place on the 27th November, 2020. The Audit Team looked at the case of a patient that was detained on a Community Treatment Order.

A number of themes were identified in the reports reviewed including:

- Use of old report format;
- Lack of evidence supporting continued detention i.e. degree criteria;
- Replication of reports (Social Circumstances Report)
- Limited information provided within the care plan

The audit confirmed that although the AHMs made the correct decision based on the evidence put before them, a more in-depth explanation of the decision could have been given. The Audit Panel agreed that the correct decision was made based on the procedure of the hearing and the information available to them on the day.

A report identifying the themes was presented to the Mental Health Act & Safeguarding Sub-Committee. An action plan will be devised to address the themes identified by the audit.

Mental Health Tribunal Room Audit

A revised audit tool looking at the Mental Health Tribunal Room Specifications was circulated in light of the introduction of video conferencing following changes introduced by the Ministry of Justice during COVID-19 with positive returns received from all wards who have Mental Health Tribunal Room facilities. Currently there are no identified issues and Operational Services are encouraged to seek advice from the Mental Health Act Office when considering room changes to ensure that the Trust remains compliant with the Mental Health Tribunal Room Specification.

Perfect Ward App

To support regular audits of Mental Health Act paperwork the introduction of the Perfect Ward App has been innovative. The Perfect Ward App has been designed to assist health and care professionals to own patient safety and conduct quicker and more efficient quality audits, especially around Mental Health Act compliance across the Trust. Audits are undertaken on a monthly basis by ward staff, the results of which are produced and viewed through an Inspection Summary. The Inspection Summary is made up of various components containing previously agreed questions that are required to be asked of individual wards regarding compliance. The questions vary in regards to differing sections of the Mental Health and adherence to the MHA Code of Practice. The results of these monthly inspections are discussed as a standing agenda item at the MHA Bi-Monthly Meeting. Any areas of concerns are then escalated and any remedial action taken e.g. bespoke training to wards and staff.

INDEPENDENT MENTAL HEALTH ADVOCATES (IMHAs)

The presence of Independent Mental Health Advocates (IMHAs) on the wards has improved the access and quality of Tribunal applications, as patients are often supported placing applications for Appeal by the Independent Mental Health Advocate (IMHA). Previously Care Quality Commission Monitoring Reports confirm the presence and availability of IMHAs across the Trust.

GOVERNMENT WHITE PAPER

It is two years since Professor Sir Simon Wessely delivered his landmark Independent Review of the Mental Health Act. The White Paper sets out what needs to change in both law and practice in order to deliver a modern mental health service that respects the patient's voice and empowers individuals to shape their own care and treatment. It also made recommendations on how to address the disparities in how the Act affects people from Black, Asian and minority ethnic minority (BAME) backgrounds.

This briefing sets out the Government's proposed changes as laid out in the White Paper issued by the Department of Health and Social Care on 13th January, 2021. There was a consultation period of three months ending on 21st April, 2021.

The White Paper was split into three main parts. These were:

- **Part 1:** legislative reforms – the changes proposed to the Mental Health Act itself;
- **Part 2:** reforming policy and practice to improve patient experience – the government's plans to bring about an overall culture change within mental health services, so that people have a far better experience of care under the Act;
- **Part 3:** the UK government's response to the Independent Review of the Mental Health Act– the government's response to each of the review's recommendations.

A detailed summary of the proposed legislative changes was prepared by the Mental Health Act Team for presentation and information to the Trust Board.
A 'Staff Live Event' was publicised via Microsoft Teams inviting all EPUT staff to attend on 12th April, 2021 to give them an opportunity to make any comments in regards to the White Paper Reforms:-

'The Mental Health Act White Paper has been published, setting out the Governments proposed reforms to mental health legislation. The aim of these proposed reforms is to provide a modern mental health service that respects the patient's voice and empowers individuals to shape their own care and treatment. This live event is a chance for you to learn more and have your say on the proposed changes by contributing to our trust-wide response'.

Staff who attended the event made a number of comments and these were included in the Trust response to the consultation by the deadline of 21st April, 2021.

The Trust's Associate Hospital Managers met on the 3rd March, 2021 to discuss the proposals outlined in the White Paper and following collation of their comments, the AHM Chair submitted these independently to the Department of Health before the 21st April, 2021.

Following the end of the consultation period, it is understood that the intention of the Government will be to publish a draft Mental Health Bill in 2022. The proposals are potentially wide ranging and may have a significant impact on the way mental health services are delivered. However, the details of the proposed changes are not yet available and whether the resources for the necessary investment will be provided remains to be seen. Once any changes are published along with timescales, the Mental Health Act Office will finalise the draft Implementation Plan, which addresses both policy and training needs.

DEVONSHIRE JUDGEMENT

The Department of Health and Social Care issued guidance on the19/05/2020 that allowed for MHA Assessments to be undertaken remotely during the COVID-19 Pandemic. This guidance was challenged by Devon Partnership NHS Trust resulting in a High Court Judgement on the 22nd January 2021 that remote assessments were unlawful. The ruling applied to Part II of the MHA.

It applied to both new assessments for detention and section renewals including Community Treatment Orders. Individuals who were currently detained under the Act following a remote assessment were required to be reassessed in person to ascertain if ongoing detention was deemed necessary.

Instructions were issued by EPUT to cease forthwith using remote methods for any new or ongoing assessments for detention or section renewals under Part II of the Act. The MHA Office devised an action plan to identify patients who had had a remote assessment and were still currently detained, including those that had since been discharged from Section as well as CTO patients. All affected patients were informed in writing that their Section, Renewal or CTO Renewal was invalid.

INNOVATIONS

Despite the impact of COVID-19 and the restrictions, the MHA Office have been able to support the below innovations:

- **Electronic Statutory Forms** – The Mental Health Act Office prior to the introduction of Electronic Statutory Form devised a procedure to provide support and guidance to Clinical Staff, Approved Mental Health Professionals (AMHPs) and any other staff involved in Mental Health Act detentions. This procedure informed about the secure and effective service of Mental Health Act documentation via electronic transmission which was effective from 1st December, 2020. As directed by the Department of Health there was an agreed transition period until 31st January, 2021. This transitional provision allowed for the use of the old statutory forms, if served by non-electronic means until 1st February, 2021.

- **Electronic Signatures** - Following the introduction of the Electronic Statutory Forms on 1st December, 2020, electronic signatures on electronically submitted forms were permitted to be a:-
    - Typed name;
    - Initials;
    - Scan or photo of a wet ink signature;
    - An electronically drawn signature

COVID-19

The onset of COVID-19 and the administration of the Mental Health Act across the Trust was changed in order that both compliance and safety were adhered to in line with COVID-19 guidance as stipulated by the Government. New ways of working were introduced with daily sit rep calls with members of the MHA team via Microsoft Teams, these calls have now become custom and practice and form part of a twice-daily routine team process.

The Mental Health Tribunal issued Pilot Practice Directions that made changes to practice and procedure during COVID-19. The introduction by the Tribunal Service of video conferencing during the pandemic may influence and change the practice of how Tribunals will be held in the future. This practice adopted by the Mental Health Tribunal has continued through into 2021 and is expected to continue beyond 2022.

The Care Quality Commission introduced a new remote method of working, including the collection of data from a range of sources via telephone, ‘e’ mail and video conferencing. Changes were

introduced in regards to the Second Opinion Appointed Doctors (SOAD) provision. This remote method of work has continued through to 2021 and is expected to remain into 2022.

Amendments to the Mental Health Act 1983 were introduced by the Coronavirus Act 2020 and were only to take effect if, and when the Secretary of State made the relevant Commencement Order. The Government did not enact these amendments.

Following the guidance issued by the Government in response to COVID-19, Associate Hospital Manager Review Hearings were suspended due to Associate Hospital Manager colleagues being unable to attend hospitals. The Trust recognised the importance of these hearings and working together with the Mental Health Act Administration Team and IT developed an alternative solution to hold hearings remotely using the approved secure platform, Microsoft Teams. Twenty-seven Associate Hospital Managers are now able to participate in supporting remote hearings and AHM Hearings both contested and uncontested are scheduled in the normal day-to-day business of the MHA Office. The introduction of this new practice has continued through 2021. It is favorable to note that the Associate Hospital Managers have supported this process so that patient rights are maintained despite the challenges of the pandemic.

An independent view from AHMs on how hearings have been conducted in EPUT during the pandemic' was sought by the Trust with the following comments:-

'I have been a Mental Health Act manager more than 10 years, participating in many hearings in the capacity of the chair of the panel or, as a panel member.

I was concerned how the MHA hearings would continue during the COVID-19 pandemic. I was reassured and pleased to learn that they would continue virtually using Zoom or Microsoft Teams and generally work extremely well. Although, in every case this is not an ideal method: it can be difficult communicating with the patient particularly if they are sharing a screen, family members may join by phone. The patient's interaction during the hearing and with the panel as well as family input can be an important dynamic in decision-making. It is satisfying to know that patients are continuing to have the section reviewed, or if they wish, the opportunity to challenge their section with an independent panel of people.

What I am particularly passionate about is that the hearing process is carried out in such a professional manner with the patient at the centre. Not all MHA hearings result in a discharge of a section, however, the discussion gives a great deal of clarity to the patient for the pathway forward. I have witnessed that the information regarding their care and treatment shared with individuals not associated with the hospital has often been invaluable to the patient

I value the on-going training we receive, and I am very appreciative to be one of the team. I hope to be able to continue for many more years'.

It should be acknowledged, as with Mental Health Tribunals, the way the Trust has been conducting Associate Hospital Manager hearings during the pandemic has influenced practice during 2020/2021 and it is envisaged that this is set to continue for the ensuing year into 2022.

It is acknowledged that The Trust has provided significant support to its entire staff, including the MHA Office during the pandemic and will continue to do so for some time into the future.

HOTSPOTS

Previous hotspots

Previous hotspots identified in the Mental Health Act Annual Report 2019/2020 have been addressed:

- **Mental Health Tribunal Room Specifications**: completed
- **Completion of CQC Monitoring reports by Ward Mangers:** this has been superseded by the introduction of Remote MHA CQC Reviews where a provider statement is no longer issued. This has been replaced with a letter. The Senior MHA Managers support the clinical team in completing a response
- **PARIS Clinical System: -** As previously reported, the Mental Health Act Administration Team were unable to renew Section 3's on the system. The issue had been identified and discussed with the PARIS Technical Team and as a planned update of PARIS was not due until November 2020, this issue was placed on the Risk Register. It is pleasing to report that this issue was resolved on the 20th October, 2020 jointly by the Civica (Supplier) and the PARIS Technical Team.

Outstanding hotspots

- **Associate Hospital Manager Appraisals: -** Outstanding Associate Hospital Manager Appraisals, which will be completed using the current platform – Microsoft Teams. - Valuable work has continued to be undertaken during the last year by the AHM Chair and Vice-Chair in revising the current Appraisal Forms. It is expected that all AHM Appraisals will be completed during 2021 and in line with the timing of the review of AHM Agreements in April 2022.

New hotspots

- **Mental Health Act Team Workload Pressures: -** – Significant workload pressures have been experienced by members of the Mental Health Act Administration Team during 2020/2021 and continue to do so. Robust support has been provided to members of the team to enable them to function, whilst continuing to meet the requirements and compliance required for the administration of the Mental Health Act. Moving forward a review will be undertaken of the staffing requirements for the Mental Health Act Team to provide a more enhanced service.

FORWARD PLAN

As in previous years, work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration.

The 'Mental Health Act Team Core Competencies Booklet' for Mental Health Act Team staff and Nursing Staff is under development. This will aid staff in what is expected of them in regards to individual roles and responsibilities. Due to excessive workload demands, it is unfortunate that the Mental Health Act Team Core Competencies Booklet has yet to be devised. It remains the aim of the Mental Health Act Team to develop the booklet, however, in light of the recent White Paper Consultations and the proposed reforms to the Mental Health Act, it is expected that the development of the booklet will take place following any changes to the Mental Health Act.

The Mental Health Act Senior Team members and the Mental Health Act Team meet at regular intervals to review each respective area of practice. This provides an opportunity to discuss any changes to the Mental Health Act Code of Practice and Case Law as well as devising and developing monitoring tools/training packages to redress themes identified from the virtual visits carried out by the Care Quality Commission during 2020/2021.

Mental Health Act Managers, have during the pandemic faced challenges in the delivery of Mental Health Act Training across the Trust. It is acknowledged that the Trust has in place a robust 'e' learning module that provides training to all staff around the required compliance of the Mental Health Act. In addition, Mental Health Act Managers have offered any further support for bespoke training needs via Microsoft Teams. The Mental Health Act Team have a fully functioning Trust Intranet page which provides support to all staff in regards to the complexities of the Mental Health Act. The Mental Health Act Managers and their team continue to promote lawful practice, compliant with the Mental Health Act Code of Practice 2015.

The Mental Health Act Team remains committed to meeting deadlines from actions plans set following visits from the Care Quality Commission. In addition the Mental Health Act Business Meeting which is attended by senior members of the Mental Health Act Administration Team along with senior Operational Managers will continue adopt a comprehensive approach to identifying operational needs in regards to Mental Health Act Compliance.

Senior members of the Mental Health Act Team will continue to explore a comparable Service Level Agreement with Mid & South Essex NHS Foundation Trust covering services in Basildon General Hospital, Southend General Hospital and Broomfield Hospital in Chelmsford.

CONCLUSION

The MHA Administrators will continue to support the Associate Hospital Managers to perform their role/duties by providing robust training in relation to the Mental Health Act and Mental Health Act Code of Practice 2015.

As always, this report acknowledges the commitment of the Trust and in particular that of the Mental Health Act Senior Manager, Mental Health Act Managers, Mental Health Act Officers, Mental Health Act Administrators and Mental Health Act Assistant who work within the legal framework, which continues to challenge and change the way, that Mental Health Services are delivered.

ASSURANCE STATEMENT

This report provides assurance that the Trust has robust systems, comprehensive policies and robust training in place to work within the parameters of the Mental Health Act 1983 as amended by the Mental Health Act 2007. The Mental Health Act Team continues to experience difficulties and duplication in relation to the current usage of the two clinical information systems Mobius and Paris to aid Mental Health Act Administration compliance. Going forward, the Mental Health Act Team will be charged to continue to embrace continued changes in the way they work, promotion of equal workload, a standardised way of practice and enhancement of knowledge.

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Workforce Disability Equality Standard (WDES) Report 2021**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director – People and Culture					
Report Author(s):	Gary Brisco – Equality Advisor Chris Jennings - D&MH Equality Network Chair Lorraine Mitchell- D&MH Equality Network Vice Chair					
Report discussed previously at:	D&MH Staff Equality Network sessions					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	√

Risk Assessment of Report	
Summary of Risks highlighted in this report	There is a risk of inequality of experience and opportunities for disabled staff in comparison to their non-disabled counterparts in the Trust.
State which BAF risk(s) this report relates to	BAF61: Equality and Diversity
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	Implementation of the WDES Action Plan after Board approval.

Purpose of the Report		
This report provides the annual report for the Workforce Disability Equality Standard and sets out the experience of our Disabled Staff in comparison to their Non-Disabled counterparts across a range of metrics.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Approve the report for publication and wide promotion internally and externally
- Discuss the contents of the report and note the lack of progress across six of the metrics
- Approve the proposed Action Plan to address these gaps.

Summary of Key Issues

There was an improvement in seven of the ten Metrics; whilst this is encouraging, it still shows more that work is needed to improve the experience of our Disabled workforce. There will have to be close scrutiny and further support from Action Plan leads in order to ensure that these Metrics improve across 2021 – 22 as well as discussion on how to further support the Disability and Mental Health Network and Equality and Inclusion functions of the Trust.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	√
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	√
CO4: 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	

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

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

Acronyms/Terms Used in the Report			
WDES	Workforce Disability Equality Standards		

Supporting Documents and/or Further Reading
WDES Report 2021 & Appendices • Appendix A - WDES Breakdown and Metrics • Appendix B – WDES Action Plan

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

Agenda Item: 7c
Board of Directors Part 1
29 September 2021

NHS WORKFORCE DISABILITY EQUALITY STANDARD DATA ANALYSIS 2021 (EPUT YEAR 3)

1 Purpose of Report

The purpose of this report is to share the data from Workforce Disability Equality Standard (WDES) with Trust Board showing the experiences of our disabled workforce compared to our non-disabled workforce.

Following on from The WDES introduction in 2019, this report sets out our performance across each of the 10 metrics set by NHS England. The attached action plan sets out our agreed priorities for the first year (Appendix B).

The report has been developed in partnership with the Disability and Mental Health Staff Equality Network Chair and Vice Chair. Input from the Network membership was also requested before submission to the Equality and Inclusion Sub-Committee, Quality Committee and Trust Board of Directors for approval.

2 Executive Summary

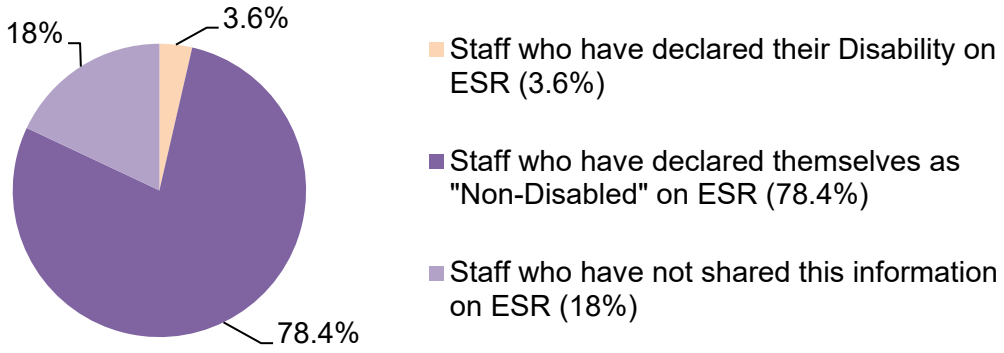
This is our third official WDES report for the Trust and a full summary of our findings can be found in Appendix A. Bank Staff are included in our figures because we believe they are an integral part of our workforce. Initial findings show:

- 3.6% of our workforce have identified that they have a disability on our Electronic Staff Record. This is a positive increase from the previous year.
- Whilst there was increased representation in many bands for both Clinical and Non-Clinical Staff, six out of thirteen bands are lower compared to 3.6% overall representation in the Trust. *(Appendix A Fig 1 and 2)*
- There has been a negative increase of the relative likelihood that disabled staff compared to non-disabled staff would enter formal capability procedures (Metric 3).
- There were improvements in Metric 4, with a reduction in disabled staff members experiencing harassment, bullying or abuse from managers and colleagues.
- Disabled staff feel more pressure to come to work despite not feeling well enough. *(This metric has shown decline since 2020)*
- Disabled staff are less likely to be appointed from shortlisting (*This metric has shown decline since 2020)*
- The % of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work has increased from 72% to 78%
- The staff engagement score for Disabled staff, compared to non-disabled staff has increased in 2021

We as a Trust should be mindful of the effects of both the COVID-19 Pandemic, as well as the awareness raised of disparities in society because of this. It was suggested by members of our D&MH Network that the events of 2020 – 21 would have had an impact on the wellbeing, morale and appraisals of the Trust by those providing feedback.

3 EPUT Declaration Rates as of July 2021

Currently 3.6% of our workforce are recorded as having a disability on EPUT's Electronic Staff Records (ESR).



It should be noted that based on the ESR Data as of July 2021, there is a visible reduction of staff members who have not shared their disability status. In 2020 this was 30% compared to 2021's 18%. This could suggest a more positive view from staff in declaring their Disability Status on ESR and may also explain the increase in staff declaring they have a Disability, which was 3% in 2020 and 3.6% in 2021.

This suggests a partial success in the effort to encourage staff to update their ESR status in 2020-21, and in providing a culture where these staff feel safe to do so.

4 Action Planning

An action plan is attached as Appendix B. This is not a full breakdown of the work taking place to support these groups. The work will be captured in the NHS People Plan EPUT response to belonging and equality; instead, it focusses on priorities for this year that we believe will result in progress for people with disabilities, mental health conditions and physical health conditions.

Quarterly updates on the action plan will be supplied to all relevant committees. Monthly meetings will be arranged to track progress, allow responsible leads to feed back on their work and review actions as appropriate. All discussions include the Disability and Mental Health Staff Network.

5 Use of Model Hospital Data for Benchmarking

In comparison to the NHS Model Hospital figures from 2020, EPUT performed better on five out of the ten metrics. It should be noted that National Average Data for 2020 was not yet available at the time of compiling this report, which have been previously used in assessing our progress in comparison to the NHS as a whole. National Medians have been used on the guidance of the WDES team, which were gathered from their Model Hospital online resource where available.

6 Conclusion

There was an improvement in seven of the ten Metrics; whilst this is encouraging, it still shows more that work is needed to improve the experience of our Disabled workforce. There will have to be close scrutiny and further support from Action Plan leads in order to ensure that these Metrics improve across 2021 – 22 as well as discussion on how to further support the Disability and Mental Health Network and Equality and Inclusion functions of the Trust.

We must now focus on not only improving the individual metrics, but look overall at how we are addressing the issues faced by our disabled workforce. The Trust needs to take action now to ensure that staff with disabilities do not feel pressured to come into work when they are feeling unwell and are not at more risk of entering formal capability processes and less likely to be approved from shortlisting as their non-disabled counterparts. 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 these inequalities, but rather those that are agreed to address these metrics.

7 Action Required

The Board of Directors is asked to:

- Approve the report for publication and wide promotion internally and externally
- Discuss the contents of the report and note the lack of progress across six of the metrics
- Approve the proposed Action Plan to address these gaps.Report prepared by

Name **Gary Brisco**
Job Title **Equality Advisor**
Date **September 2021**

Names **Chris Jennings and Lorraine Mitchell**
Job Title **Disability and Mental Health Staff Equality Network Chairs**
Date **September 2021**

On Behalf of:

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

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

Key	
Symbol	Meaning
▲ ▼	An Improvement from WDES 2020 Data
▼ ▲	A Decline from WDES 2020 Data
-	No Increase / Decrease from WDES 2020 Data

METRIC 1 – PERCENTAGE OF DISABLED STAFF IN EACH BAND COMPARED TO THE OVERALL WORKFORCE 2021.

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

Fig 1 – NON-CLINICAL POSTS

Cluster (Bandings)	Disabled	Non-Disabled	Unknown	Total	Same / Higher or Lower than overall Workforce 3.6%	Comparison to NHS (National Medians 2020)*
C1 (1-4)	(70) 3.5% ▼	(1513) 75.4%	(424) 21.1%	2007	Lower	**5.2%**
C2 (5-7)	(11) 3% ▲	(254) 68.8%	(104) 28.2%	369	Lower	**5.4%**
C3 (8a / 8b)	(3) 3.9% ▼	(58) 76.3%	(15) 19.7%	76	Higher	**4.5%**
C4 (8c +)	(2) 3.3% ▲	(42) 68.9%	(17) 27.9%	61	Lower	**3.4%**

Figure 1 shows that for non-clinical posts, C1, 2 and 4 have under-representation of disabled staff.

Fig 2 - CLINICAL POSTS

Cluster (Bandings)	Disabled	Non-Disabled	Unknown	Total	Same / Higher or Lower than overall Workforce 3.6%	Comparison to NHS (National Medians 2020)*
C1 (1-4)	(108) 3.3%▲	(2752) 84.2%	(409) 12.5%	3629	Lower	**4.7%**
C2 (5-7)	(124) 4.1% ▲	(2254) 75.3%	(617) 20.6%	2995	Higher	**5.4%**
C3 (8a / 8b)	(12) 2.7% ▼	(310) 68.9%	(128) 28.4%	450	Lower	**3.8%**
C4 (8c +)	(2) 4.8% ▲	(24) 57.1%	(16) 38.1%	42	Higher	**3.8%**
C5 (Consultants)	(1) 1% ▲	(68) 68%	(31) 31%	100	Lower	Not available
C6 (Career Grade)	0% -	(35) 79.5%	(9) 20.5%	44	Lower	Not available
C7 (Trainees)	(1) 1% ▲	(71) 85.5%	(11) 13.3%	83	Lower	Not available

Figure 2 shows that for clinical posts, despite improvements in the percentage of disabled staff across most bands, all clusters apart from C1 and C3 have under-representation of disabled staff.

METRICS 2 – 10 Fig 3 – Summary of WDES Metrics 2021

Met.	Type	Description	EPUT		Comparison to NHS (National Medians 2020)*
			2020	2021	
1	**Workforce Data**	Percentage of Disabled staff in the workforce	**3%**	**3.6% ▲**	**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)*♦	**0.95**	**1.17 ▲**	**1.08**
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)*	**1.41**	**2.61 ▲**	**Not Available***
4a I	**Staff Survey Results 2020**	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)*	**39%**	**39% -**	**33.2%**
4a II		Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers in last 12 months. *(Lower %'s are better)*	**20%**	**18% ▼**	**18.0 %**
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)*	**26%**	**22% ▼**	**26.1%**
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)*	**52%**	**52% -**	**50.2%**
5		Percentage of Disabled staff compared to non-disabled staff believing the Trust provides equal opportunities for career progression or promotion. *(Higher %'s are better)*	**75%**	**79% ▲**	**79.3%**
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)*	**30%**	**32% ▲**	**29.8%**
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)*	**38%**	**43% ▲**	**39.3%**
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)*	**72%**	**78% ▲**	**74.4%**
9		The staff engagement score for Disabled staff, compared to non-disabled staff. *(Higher scores are better)*	**6.5**	**6.8 ▲**	**6.7**
9b		Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	**See 2020 Report**	**See Below**	**N/A**
10	**Board Membership**	Difference between disabled Board membership and overall workforce (lower % = better) **	**-3%**	**8.9%▲**	**4.8%**

METRIC 9b HAS 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:-

- 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. Messaging of this Network has opened this out to Autistic Staff (as well as those with other forms of neuro-diversity) in 2021.
- Implementation of Reasonable Adjustments Policy into Trust Policy and Procedure, as well as promotion of this through Trust and guidance materials to facilitate manager and employee conversations.
- A Staff Engagement Equality Champion Scheme that includes staff with lived experience of mental or physical health conditions, involved in collecting feedback from and providing guidance to teams across the Trust as well as promoting inclusive behaviours and EPUT E&I projects.
- Lived experience videos and articles share staff lived experience and how colleagues can support these conditions (including Neurodiversity and Long Term 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. Online resources supporting those with disabilities who feel pressured to come into work.
- Regular articles encouraging staff to update their ESR status.
- Promotion and intranet articles for disability and mental health events across the year.
- Targeted work to engage with and support those with Disabilities during COVID-19 Pandemic through regular MS Team sessions, providing talking therapy services and guidance for reasonable adjustments and wellbeing.
- Sensory Champions training offered across Trust in collaboration with Essex Cares Ltd. Teaching staff how they can support those with sensory impairments in the workplace.
- Interview Panel Disability representative for senior interviews (8a and above).

****METRIC 10 - PERCENTAGE DIFFERENCE BETWEEN THE ORGANISATION'S BOARD MEMBERSHIP AND ITS OVERALL WORKFORCE. (Lower Figure / closer to zero is better)**

Executive Membership
Executive Membership includes members that sit on the BOD e.g. "Executive Medical Director"

EPUT's workforce that has declared a disability is 3.6% and no Executive Members have declared a disability. **This difference between the Executive Membership and its overall workforce is -3.6%**

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

EPUT's workforce that has declared a disability is 3.6% and 2 members (12.5%) of its 16 voting board members have declared a disability. **This difference between the Board Voting Membership and its overall workforce is 8.9%**

Regarding the progression from 2020 – 21
In 2020's WDES report, it was identified that there were no members of the Board declaring a Disability. As EPUT's workforce that had declared a disability at this point was 3%, this led to a difference of -3%.

In 2021, EPUT's Board had two members who had declared a disability (12.5%) with the difference between this and the workforce (3.6%) being 8.9%. Whilst this number is an increase in difference in comparison to the previous year, it is an improvement as there is a higher number of board members who have declared a disability, meaning better representation.

* **Comparison to NHS (National Medians 2020)**
Whilst in previous years, our scores were compared to NHS National averages from the previous year's WDES report (the value obtained by dividing the sum of all by the amount of scores) this report was not currently available at the time of developing this document or Appendix B. As a result we have been advised by the WDES Team to use the National Medians (denoting or relating to a value or quantity lying at the midpoint of a frequency distribution of observed values or quantities) available on NHS England's online "Model Hospital" System. It was also explained by the WDES Team that Metric 3 was not provided as part of this data due to the use of likelihood scoring but that this area also needed improvements on a national level.

- **Discrepancy between Metric 3 and Metric 1**
On the 24th August 2021, shortly after the submission of the Data Collection Framework to the WDES. The Trust was contacted with an enquiry. They asked why the Trust had appeared to grow in size by approximately 3000 members but had only had 759 staff members appointed from shortlisting. It was explained that this relates to substantive hires only; extra bank staff were employed to support COVID but employed as bank on 0 hours and this increased the headcount by 3,000 including the 759. This was accepted as a reasonable response by the DCF and our data updated to reflect this.

Essex Partnership University
NHS Foundation Trust

APPENDIX B: WORKFORCE DISABILITY EQUALITY STANDARD. ACTION PLAN - 2021 - 2022

This document supports the Workforce Disability Equality Standard Report 2021 - 22 which was approved at Trust Board on 29 Sept 2021

Slippage / Critical	Slippage likely / Not Critical	On Track, Good Progress	Delivered

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Progress
Metric 1 Percentage of staff in National NHS 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, 3.6% of Staff declare that they have a disability within the workforce) [Higher score is better] 2020: 3% 2021: 3.6%	**Improvement:** Higher rate of staff disclosing they have disabilities in the Trust on ESR. These percentages across the bands are lower than national medians. See Appendix A for further details.	[1.1] Compare staff declaring Disability status compared to last year by area and establish gaps and carry out a campaign to increase declaration status of staff.	Ensures we are accurately reporting the amount of Disabled Staff within the Trust. Identifying potential areas where staff may not be doing so already.	Director of Equality	31 March 2022	
		[1.2] Work closely with the KickStart Scheme and encourage more young people to join via apprenticeships	Kickstart programmes encourage young people with disabilities back to work and would help us to encourage disabled people to work in the Trust in future.	Director of Equality, Equality and Inclusion Sub-Committee members	31 March 2022	
Metric 2 Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. **[Lower score is better, with a score of 1 showing an equal likelihood]** 2020: 0.95 2021: 1.17	**Deterioration:** Higher than National Medians (+0.9), See Appendix A for further details	[2.1] Produce a drilldown of this Metric by Directorate to ascertain if there are hotspot areas that need to be addressed.	Assess performance against the existing Disability Confident scheme and identify gaps and improvements in process.	HR Business Partner for Resourcing Associate Director of Human Resources	31 March 2022	
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. **[Lower score is better, with a score of 1 showing an equal likelihood]** 2020: 1.41 2021: 2.61	**Deterioration:** This figure is taken as an average score over the past two years from the point of collection. Disabled Staff are more than 2.61 times more likely to enter formal capability procedure than non-disabled staff. *(It should be noted that the data set used for these were based on small sample sizes; see Appendix A)*	[3.1] HR Representative to report on a Quarterly Basis to D&MH Network with an anonymised list of examples of those entering the Formal Capability Procedure due to Disability and Mental Health.	Involvement of the D&MH Network in reviewing staff entry into the formal capability procedure will help identify key issues and help develop systems that take Disability and Mental Health into account.	Associate Director of Human Resources	Quarterly	

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Progress
Metric 4 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues **[Lower % is better]** 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. **[Higher % is better]** **2020 - 21** i) 39% - 39% ii) 20% - 18% iii) 26% - 22% b) 52% -52%	i) **No Change** ii) **Improvement** iii) **Improvement** b) **No Change** **Compared to National Medians** i) **Lower** ii) **Higher** iii) **Higher** b) **Lower**	[4.1] Monitor, Maintain and Continue to Improve. Ensure that HR and LSMS are represented at each D&MH Network to update on current progress.	Regular involvement in D&MH Network will allow our members with Lived Experience to advise and work alongside LSMS and HR Department.	Associate Director of Human Resources, Local Security Management Specialist	Bi-Monthly (in conjunction with D&MH Network Sessions)	
		[4.2] Review September 2021 Staff Survey Data, continuing to review this on a Quarterly Basis from January 2022 following introduction of quarterly Staff Survey updates.	Regularly reviewing Staff Survey Data will give the D&MH Network a clear picture of these factors across the year.	Head of Staff Engagement Equality Director	Quarterly	
		[4.3] Review Pulse Survey Data by Disabled Vs. Non-Disabled staff members and identify any patterns and trends. Share with the Disability Network and Executive Team as appropriate.	Regular monitoring of staff feedback allows us to effectively target negative trends and develop actions throughout the year to mitigate them.		Quarterly	
Metric 5 Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. **[Higher % is better]** 2020: 75% 2021: 79%	**Improvement** Lower than National Median (-.03%), See Appendix A for further details	[5.1] Monitor, Maintain and Continue to Improve by implementing new tools and processes related to Talent Management and Personal Development Plans within the Trust	Improvements observed after last year's WDES Actions, further plans by Workforce Development Team to improve the Talent Management within the Trust to ensure this is Merit-Based and ensure Equality in career opportunities and progression.	Associate Director of Learning and Development Head of Organisational Development.	30 September 2022	
		[5.2] Run additional cohorts of the Trust's Reverse Mentoring Programme for Disabled staff.	Reverse Mentoring allows staff to share learning with senior leads and develop new skills and opportunities within the Trust.		30 September 2022	

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Progress
Metric 6 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. **[Lower % is Better]** 2020: 30% 2021: 32%	**Deterioration:** In comparison, in 2019 this was 31%. Higher than National Medians (+2.2%) See Appendix A for further details.	[6.1] Review the current wellbeing offer to develop resources to encourage and guide managers in better supporting the wellbeing of those with Disabilities in their teams.	Creating new resources and providing guidance to managers on existing resources in the Trust (Appraisal process / Wellness Plans, Reasonable Adjustments Passports) allow managers to better support to those not feeling well enough to perform their duties.	Wellbeing Leads Head of Staff Engagement.	31 March 2022	
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. **[Higher % is Better]** 2020: 38% 2021: 43%	**Improvement** Higher than National Medians (+3.7%) See Appendix A for further details	[7.1] Continue to Monitor and Maintain evidence that we as a Trust are effectively showing recognition to the contributions of staff with Disabilities and championing the contributions of the D&MH Network (via outlets including CEO Brief, Wednesday Weekly, Staff Survey Summaries.)	Continue positive progress and build on raising this awareness with EPUT Staff.	Director of Comms Head of Staff Engagement.	30 September 2022	
Metric 8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. 2020: 72% 2021: 78%	**Improvement** Higher than National Medians (+3.4%) See Appendix A for further details	[8.1] Promote Reasonable Adjustments Passport (as part of the Sickness and Wellbeing Policy) to staff and ensure managers are able to use this in support of staff. Ensure this is implemented throughout Trust Practice. Promote “Good News Stories” where this has benefitted staff members.	Reasonable Adjustments Passport appears to have had a significant effect through Staff Training, Promotion and Resources, giving staff the tools to empower them to have these discussions with their supervisors.	Equality Advisor	30 September 2022	

Metric	Result	Action Required	Rationale / Intended outcome	Lead	Due Date	Progress
Metric 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff. **[Higher Score is Better]** 2020: 6.5 2021: 6.8	**Improvement** Higher than National Medians (+0.1) See Appendix A for further details	[9.1] Continue to Monitor and Maintain, regularly engaging with our Staff Engagement / Equality Champions Networks to promote our work on the work we do as a Trust to support disabled employees.	Sharing good practice and raising awareness of the positive steps we take to support EPUT Staff.	Head of Staff Engagement.	30 September 2022	
		[9.2] Assess disabled representation in Staff Engagement Champions and campaign accordingly including the Network.	Better representation of Disabled staff in Staff Engagement Champions Network.	Head of Staff Engagement	31 March 2022	
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 2020: -3% 2021: 8.9%	**Improvement** See WDES Report Appendix for a full breakdown and summary. Higher than National Medians (+4.1%) See Appendix A for further details	[10.1] Continue to Monitor and Maintain. Encourage Board to ensure their ESR is up to date to ensure accurate representation.	Positive result can be reinforced by ensuring all board are accurately declaring disability status, role-modelling this in the Trust.	Director of Equality, Head of Staff Engagement.	31 March 2022	

	Action Required	Rationale	Lead	Due Date	Progress
GENERAL WDES ACTIONS	Quarterly push for ESR: Encouraging Trust Board / All Staff to complete this on a quarterly basis.	An accurate baseline of the proportion of staff in the workforce who are disabled.	Equality Advisor	Quarterly	
	Submit proposals for funding across the year to support Disability, Mental Health and Long Term Condition awareness campaigns and events via Executive Team. Including training on specific areas for staff.	Funding needs to be provided to facilitate the work of the Disability and Mental Health Network and Equality functions of the Trust to allow them to better raise awareness and promote the Trust's support of these communities.	Director of Equality	31 March 2022	
	Apply as a Trust for Level 3 Disability Confident Employer Status.	Application will encourage the Trust to ensure they provide a higher level of support to disabled staff in the Trust.	Director of Equality	30 September 2022	
	Implement Protected Time for Chair and Administrative Support for the Disability and Mental Health Staff Network.	The Disability and Mental Health Network is a vital function of the Trust and will require investment to better support the Trust and Trust Projects.	Director of Equality	30 September 2022	

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**NHS Workforce Race Equality Standard (WRES) Report 2021**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director – People and Culture					
Report Author(s):	Gary Brisco, Equality Advisor					
Report discussed previously at:	BAME Staff Equality Network					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	√

Risk Assessment of Report	
Summary of Risks highlighted in this report	There is a risk of inequality of experience and opportunities from those of Black, Asian and Minority Ethnicity Groups in comparison to their white counterparts in the Trust.
State which BAF risk(s) this report relates to	BAF61: Equality and Diversity
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	Implementation of the WRES Action Plan after Board approval.

Purpose of the Report		
This report provides the annual report for the Workforce Race Equality Standard and sets out the experience of our Black, Asian and Minority Ethnicity (BAME) in comparison to their White counterparts across a range of metrics.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Issues

It is concerning to see a decline in six of the nine Metrics; and more work is needed to improve the experience of our BAME workforce.

We expect a steady progression over time on each metric and whilst this has happened on three of our Metrics, we need to address issues highlighted by the WRES including recruitment, formal disciplinary processes, bullying, harassment and discrimination.

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	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	√
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	√
CO4: 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	

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard	HRBP	Human Resources Business Partner
BAME	Black Asian and Minority Ethnicity	LSMS	Local Security Management Specialist
VSM	Very Senior Manager		
BOD	Board of Directors		

Supporting Documents and/or Further Reading
WRES Report 2021 & Appendices • Appendix A - WRES Breakdown and Metrics • Appendix B – WRES Action Plan • Appendix C – BAME Staff Appointment Trajectory Chart and Ambition Modelling

Lead
Sean Leahy Executive Director – People and Culture

Agenda Item: 7d
Board of Directors Part 1
29 September 2021

NHS WORKFORCE RACE EQUALITY STANDARD DATA ANALYSIS 2021 (EPUT YEAR 4)

1 Purpose of Report

The purpose of this report is to share the data from Workforce Race Equality Standard (WRES) with Trust Board, showing the experiences of our Black, Asian and Minority Ethnicity (BAME) workforce compared to our White workforce. This is year 4 of the Workforce Race Equality Standard for EPUT – Year 7 overall.

Following on from The WRES introduction in 2015, this report sets out our performance across each of the nine metrics set by NHS England. The attached action plan sets out our agreed priorities for the year (Appendix B). Appendix C shows our current progress based on NHSI/E's Model Employer initiative.

The report has been written with Input from the BAME Network membership before submission to the Equality and Inclusion Sub-Committee, Quality Committee and EPUT's Board of Directors for approval.

2 Executive Summary

This is the fourth official WRES report for the Trust and a full summary of our findings can be found in Appendix A. Bank Staff are included in our figures because we believe they are an integral part of our workforce. Initial findings show:

- Whilst there has been an increase in BAME staff across most bands in the Trust *(Appendix A, Fig 1 and 2),* there has been a decrease (-1.3%) in their overall percentage in the workforce. Our BAME staff percentage is still higher than the national average.
- White staff members are more likely to be appointed from shortlisting compared to BAME Staff. (Metric 2)
- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff has continued to increase from 2019 to present. (Metric 3)
- BAME Staff are more likely to access non-mandatory training / career progression and development (CPD) in comparison to 2020 (in comparison to their white counterparts; see Metric 4).
- The percentage of BAME Staff experiencing bullying and harassment from patients, carers and members of the public (based on FFT scores) has decreased. (Metric 6)
- The reported experiences of Bullying, Abuse, Harassment and Discrimination from colleagues and managers have increased. These are both worse than the national average. (Metrics 7 and 8)
- There has been a significant increase in representation of BAME staff on our Trust Board, and this is better than the national average. (Metric 9)

3 Action Planning

An action plan is attached as Appendix B. This is not a full breakdown of the work that will take place in this period to support these groups; this work will be captured in the NHS People Plan EPUT response to belonging and equality. The WRES action plan focusses on priorities for this year that we believe will result in progress for our equality and inclusion goals for Black, Asian and Minority Ethnicity Staff members.

Quarterly updates on the action plan will be discussed in all relevant committees, as well as monthly meetings to track progress and review the agreed actions. The action plan for 20/21 will be complete by the end of September 2021 and there are some key highlights as follows:

- Reverse Mentoring involving Black, Asian and Minority Ethnicity staff members as Mentors, a live celebration event was held to thank them and remunerate participation (via gift vouchers).
- Cultural Intelligence (CQ) Coaching for Board and Senior Leadership Team provided by Above Difference.
- BAME Network Chair has regularly met with HR Leads in 2020-21 to review monthly suspension and grievance reports alongside Trust Freedom to Speak up Guardian.
- Disciplinary Decision Making Tool developed and any cases involving a staff member from a Black, Asian or other Minority Ethnicity group include a discussion with the BAME Network Chair before proceeding to formal process.
- 1:1 Support & Appraisal Policy has been re-written with a view to improve Talent Management in the Trust and remove potential bias.
- Initial development of Race Allyship and Equality Coaching in collaboration with staff focus groups and BAME Network, set to be implemented in late 2021.
- BAME Network Chair involved in Staff Induction and EPUT Career Lounge sessions to discuss BAME Network and Race Equality.
- Investment in a Director of Equality in acknowledgement of the importance of Equality, Equitable Treatment and Inclusion in the organisation.

4 Conclusion

It is of concern that there has been a decline in six of the nine Metrics; more work is needed to improve the experience of our BAME workforce. There will have to be close scrutiny and further support from Action Plan leads in order to ensure that these Metrics improve across 2021 – 22 as well as discussion on how to further support the BAME Network and Equality and Inclusion functions of the Trust.

It cannot be the case that our BAME workforce are at a disadvantage in the workforce in comparison to their white counterparts.

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.

5 Action Required

Trust Board is asked to:

- Approve the report for publication and wide promotion internally and externally.
- Discuss the contents of the report and note the lack of progress across six of the metrics.
- Consider and agree the proposed Actions to address these gaps.
- Make general recommendations for improving the experience of Black Asian and Minority Ethnic Staff at EPUT.

Report prepared by

Name: Gary Brisco
Role: Equality Advisor
Date: September 2021

Name: Lorraine Hammond
Role: Director of Equality and Inclusion
Date: September 2021

Name: David Uzosike and Moriam Adekunle
Role: BAME Staff Network Contributors
Date: September 2021

On Behalf of:
Name **Sean Leahy**
Job Title **Executive Director - People and Culture**

Appendix A: Breakdown and Results of WRES Metrics

Key	
Symbol	Meaning
▲	An Improvement from WRES 2020 Data
▼	A Decline from WRES 2020 Data
-	No Change from WRES 2020 Data

Metric 1: Black and Minority Ethnicity (BAME) Staff Breakdown by Banding
(% rounded to 2dp)

1a) Non-Clinical Workforce					
	2020	**2020 %**	**2021**	**2021 %**	**BAME Staff**
Band 1	3	0.05%	**Band 1 Removed from Grading System**		
Band 2	72	1.11%	98	1.05%	▲
Band 3	56	0.87%	119	1.27%	▲
Band 4	30	0.46%	36	0.38%	▲
Band 5	15	0.23%	12	0.13%	▼
Band 6	11	0.17%	15	0.16%	▲
Band 7	5	0.08%	8	0.09%	▲
Band 8a	5	0.08%	8	0.09%	▲
Band 8b	4	0.06%	5	0.05%	▲
Band 8c	2	0.03%	3	0.03%	▲
Band 8d	1	0.02%	1	0.01%	-
Band 9	0	-	0	-	-
VSM	0	-	2	0.02%	▲

1b) Clinical Workforce (of which non-medical)					
	2020	**2020 %**	**2021**	**2021%**	**BAME Staff**
Band 1	0	-	0		
Band 2	416	6.43%	611	6.53%	▲
Band 3	242	3.74%	335	3.58%	▲
Band 4	28	0.43%	133	1.42%	▲
Band 5	263	4.07%	324	3.46%	▲
Band 6	234	3.62%	286	3.06%	▲
Band 7	97	1.50%	115	1.23%	▲
Band 8a	32	0.49%	33	0.35%	▲
Band 8b	14	0.22%	19	0.20%	▲
Band 8c	1	0.02%	5	0.05%	▲
Band 8d	0	-	0	-	-
Band 9	0	-	0	-	-
VSM	1	0.02%	1	0.01%	-
Clinical Workforce (of which Medical and Dental)					
Consultants	64	0.99%	63	0.67%	▼
Of which, Senior Medical Manager	0	-	1	0.01%	▲
Non Consultant, Career Grade	35	0.54%	33	0.35%	▼
Trainee Grades	50	0.77%	48	0.51%	▼
Other	0	-	1	0.01%	▲

Ind No	Type	Description	EPUT 2020 score	EPUT 2021 Score	EPUT Direction 2021	National 2020 Report	EPUT Comp to National
1	Workforce Data	Percentage of staff in each of the National NHS Pay bands (1-9 and VSM including Executive Board members) compared with the percentage of staff in the overall workforce. *Higher = Better*	26%	24.7%	▼	21%	Higher
2		Relative Likelihood of BAME staff being appointed from shortlisting compared to White staff across all posts *Lower = Better*	0.91	1.59	▲	1.61	Lower
3		Relative Likelihood of BAME staff entering formal disciplinary process compared to White staff. *Lower = Better*	2.73	3.40	▲	1.16	Higher
4		Relative Likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff *Lower = Better*	2.10	1.64	▼	1.14	Higher
5	Staff Survey Results 2020	Percentage of BAME staff experiencing harassment, bullying or abuse from patients relatives and public in last 12 months, in comparison to White staff. *Lower = Better*	39%	33%	▼	30%	Higher
6		Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months, in comparison to White staff. *Lower = Better*	25%	27%	▲	28%	Lower
7		Percentage of BAME staff believing the Trust provides equal opportunities for career progression & promotion, in comparison to White staff. *Higher = Better*	74%	67%	▼	71%	Lower
8		In last 12 months have you personally experienced discrimination at work from Manager or Team? (In comparison to White staff) *Lower = Better*	13%	18%	▲	15%	Higher
9	Board Membership	Difference between BAME Board membership & overall workforce *Lower = Better*	19.3%	0.3%	▼	7%	Lower

METRIC 9 - PERCENTAGE DIFFERENCE BETWEEN THE ORGANISATION'S BOARD MEMBERSHIP AND ITS OVERALL WORKFORCE (Lower Figure / closer to zero is better)

Executive Membership includes members that sit on the BOD e.g. Executive Medical Director or Executive Finance Director. EPUT's BAME staff account for 24.7% of the overall workforce and this current WRES report shows one member (14.3%) of the Executive Board as being from a BAME background.

Board membership includes all voting members of the board irrespective of whether they are executive or non-executive. EPUT's BAME staff account for 24.7% of the overall workforce and this this current WRES report shows four members (25%) of the Board as being from a BAME background. **The difference between these two scores is 0.3%**

APPENDIX B: WORKFORCE RACE EQUALITY STANDARD. ACTION PLAN - 2021 - 2022

This document supports the first Workforce Race Equality Standard Report which was approved at Trust Board on 29 Sept 2021

Slippage / Critical	Slippage likely / Not Critical	On Track, Good Progress	Delivered

Metric	Result	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
Metric 1 Percentage of BAME staff in each of the National NHS Pay Bands, Medical and Dental subgroups and very senior managers including executive board members, compared with the percentage of staff in the overall workforce **[Higher = Better]** 2020: 26% 2021: 24.7%	**Deterioration:** Whilst representation has increased across the majority of bandings in the Trust, the overall figure is lower than last year but still higher than the NHS National Average (21%)	[1.1] Targeted recruitment for Band 6 (and above) positions and Medical grade positions.	Targeted recruitment will address the lack of representation in these areas.	Associate Director of People Services HR Business Partner for Resourcing	31 March 2022	
		[1.2] Review the Talent Management Arrangements specifically for Ethnic Minority Staff alongside reviewing and collaborating with NHSEI Talent offer for BAME Staff. Include engagement with BAME staff in the review.	Identify any gaps and barriers faced by BAME staff.	Associate Director of Workforce Development and Learning	31 March 2022	
Metric 2 Relative likelihood of BAME staff being appointed from shortlisting across all posts in comparison to White staff. **[Lower = Better]** 2020: 0.91 2021: 1.59	**Deterioration:** Whilst there was an increase in this score, we are still achieving a better likelihood score in comparison to the national average by -0.02	[2.1] Conduct a deep dive into Professional Groups and Bandings. Localised actions to be developed accordingly in conjunction with the BAME Network.	Identify hotspots in selection processes and address with local managers.	HR Business Partner for Resourcing	31 March 2022	
		[2.2] Lower the Mandate of BAME representation on interview panels from 8a posts to Band 7 and above. Human Resources will work alongside the BAME Network to appoint representatives to interview panels for Band 7 and above	Monitor whether increasing BAME representation at lower levels impacts on overall % representation	HR Business Partner for Resourcing	31 March 2022	
		[2.3] Engage with recruiting managers through Race Equality and Allyship coaching sessions to address this.	Providing Race Equality and Allyship coaching sessions to recruiting managers will give them a better understanding of inequalities faced by BAME Staff and support them in making positive changes.	HR Business Partner for Resourcing	31 March 2022	

Metric	Result	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
		[2.4] Review our shortlisting, appointment process and paperwork for all EPUT Staff vacancies with representation from a member of staff from the BAME community where possible.	Sharing and discussing these processes with representatives to ensure that there are no barriers to these communities.	HR Business Partner for Resourcing	31 March 2022	
		[2.5] Create targeted recruitment adverts or materials that promote opportunities for BAME staff to our existing portfolio.	**Carried over from WRES 2020 – 21,** to increase representation in the Trust.	HR Business Partner for Resourcing	30 September 2022	
Metric 3 Relative likelihood of BAME staff entering the formal disciplinary process in comparison to White staff, as measured by entry into a formal disciplinary investigation **[Lower = Better]** 2020: 1.41 2021: 3.40	**Deterioration:** In comparison to their White Counterparts, staff from Black, Asian and Minority Ethnicity Groups are more than three times as likely to enter the formal disciplinary process. We have changed the way we manage staff who are alleged to have been sleeping on shifts, as a large majority of disciplinary cases for Ethnic Minority Staff fell under this category. This has been done alongside the BAME Network Chair. Higher than National Average (+2.24), see Appendix A for further details.	[3.1] Embed Just and Learning Culture and Implement new Conduct Policy and Procedure.	Immediate progress is required on this metric, as there has been an ongoing deterioration in this metric since 2019.	Associate Director of People Services	31 March 2022	
		[3.2] Update Management Development Programme Training content and materials regarding managing concerns of Bank Staff in line with Just and Learning Culture.				
		[3.3] Implement monthly reporting to enable trends to be identified quicker and addressed between HR and BAME Network Chair				
		[3.4] HR to implement effective use of the Behaviour Toolkit into existing processes, and are guided by the principles within before a BAME person is entered into formal disciplinary process.	Ensure ongoing use of tools developed from previous WRES.	Associate Director of People Services	31 March 2022	

Metric	Result	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
Metric 4 Relative likelihood of BAME staff accessing non-mandatory training and career progression and developlemt (CPD) in comparison to white staff. **[Lower = Better]** 2020: 2.10 2021: 1.64	**Improvement** Higher than National Average (+0.50), see Appendix A for further details.	[4.1] OD team to attend BAME Network and provide a Career Lounge discussion on Appraisal and 1:1 Support, discussing Talent Development and to review the development opportunities within EPUT.	Raise awareness of the development opportunities available.	Head of Organisational Development	31 March 2022	
Metric 5 Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last twelve months, in comparison to white staff. **[Lower = Better]** 2020: 39% 2021: 33%	**Improvement:** Higher than National Average (1.16), see Appendix A for further details.	[5.1] Local security management specialist (LSMS) To attend BAME Network sessions to gain feedback and also share current progress on Zero Tolerance work in the Trust.	Maintaining improvement and ensuring that LSMS is aware of and able to take actions on BAME Network Action Plan, as well as ensuring Network is regularly updated on how EPUT is mitigating this Metric.	Local Security Management Specialist (LSMS)	Network Attendance	
		[5.2] Develop Civility and Respect work as part of the Just and Compassionate Culture work in the Trust and the NHS People Plan. (Cross refer to the EPUT People Plan). Ensure this is communicated to all staff.	Promote early resolution and encourage strong behaviours. **[This action also ties into Addressing Metric 6]**	HR Business Partner for Bullying and Harassment	31 January 2022	
Metric 6 Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last twelve months, in comparison to white staff. **[Lower = Better]**	**Deterioration** Lower than National Average (-1%), see Appendix A for further details.	[6.1] Implement Behaviour Toolkit within the Trust.	Clarity around standards and examples of good and bad behaviour to give staff clarity.	Head of Organisational Development	31 October 2021	
		[6.2] Introduce “Civility, Respect and Resolution” Policy and Procedure.	Changing culture in how we manage concerns raised by individuals and supporting them better.	HR Business Partner for Bullying and Harassment	[Cross Refer to EPUT People Plan]	

Metric	Result	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
2020: 25% 2021: 27%		[6.3] HR staff who investigate these concerns should have an understanding of racial discrimination and utilise the BAME Network representatives within the investigation	Ensuring that Investigators have a clear understanding of racial discrimination, discriminatory behaviour and involve appropriate representation will help identify potential biases.	HR Business Partner for Bullying and Harassment BAME Network Chair	30 September 2022	
		[6.4] Ensure there is clear guidance and narrative on the sanctions against staff who engage in discriminatory behavior against other staff	All EPUT staff should be able to clearly understand that	HR Business Partner for Bullying and Harassment Local Security Management Specialist	31 March 2022	
Metric 7 Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion, in comparison to white staff. **[Higher = Better]** 2020: 74% 2021: 67%	**Deterioration** Lower than National Average (-4%), see Appendix A for further details.	[7.1] Develop and Implement Talent Database system within the Trust (alongside HR Team). Quarterly Updates provided to BAME Staff Network.	Implementation of Talent Database allows the Trust to identify high-performing staff based on Merit instead of relying on nominations, and helps to remove bias.	Associate Director of Workforce Development and Learning	31 March 2022	
		[7.2] As part of current HR Review, carry out a complete review of recruitment processes – including acting up / secondments. BAME Network to be involved by HR Team in focus groups across the trust with BAME staff.	As this has deteriorated this year and is lower than the national average, reassurance is required immediately to demonstrate this to staff.	HR Business Partner for Resourcing	30 September 2022	
		[7.3] Deliver two cohorts of Reverse Mentoring Programme, including BAME Staff representatives.	Positive feedback and learning for Reverse mentoring program should be replicated across 2021, and awareness raised to involve new mentors and mentees.	Associate Director of Workforce Development and Learning	30 September 2022	
		[7.4] Implement EPUT BAME Leadership Programme (“Rise”), with 60 BAME staff member. (Commencing Oct / Nov 2021)	A pilot session designed to develop confidence and raise awareness of employment opportunities for these staff.	Associate Director of Workforce Development and Learning	30 November 2021	

Metric	Result	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
Metric 8 "In the last twelve months have you personally experienced discrimination at work from Manager / team leader or other colleagues?" (responses from BAME staff in comparison to white staff.) **[Lower = Better]** 2020: 13% 2021: 18%	**Deterioration** Higher than National Average (+3%), see Appendix A for further details.	[8.1] Refer to Metric 5.2 and 6.1 regarding "Behaviour Toolkit" and "Civility, Respect and Resolution" Policy and Procedure.	Refer to Metric 5.2 and 6.1	Refer to Metric 5.2 and 6.1	Refer to Metric 5.2 and 6.1	
		[8.2] Increase the number of Race Allyship Coaching sessions and mandate through the mandatory training process that all L100 (Band 7) and above attend within the next year.	There needs to be a push to encourage senior leads to develop these skills and implement them in their work and their team culture.	Director of Equality and Inclusion BAME Network Chair Local Security Management Specialist	31 March 2022	
		[8.3] Communicate a clear process of action when a staff member reports bullying or harassment from their manager or senior manager with the support of a BAME appointed person.	Clarify what happens when a staff member is discriminated against by a manager or senior lead. This would encourage staff to report these incidents.	HR Business Partner for Bullying and Harassment	31 March 2022	
Metric 9 Percentage difference between the organisation's Board membership and its overall workforce for BAME staff: **[Lower = better]** 2020: 19.3% 2021: 0.3%	**Improvement:** The percentage of EPUT Board and Overall workforce only have a difference of 0.3% (See Appendix A for further data) Lower than National Average (-6.7%), see Appendix A for further details.	[9.1] Maintain Trust's current progress and review after six month period.	Positive results need to be monitored and will hopefully lead to more representative decision making in the Trust.	Director of Equality and Inclusion Trust Secretary	31 March 2022	

	Action Required	Rationale / Intended Outcome	Lead	Due Date	Progress
GENERAL WRES ACTIONS	**[G1]** Agree, mark and celebrate key dates in the BAME calendar, provide funding through proposals and Communications support. Dates include • Black History Month (October 2021) • Asian Heritage Month (18 July – 17 August 2022)	Strong messaging and awareness across the Trust around Race and Culture.	Equality Advisor BAME Network Chair	Monthly	
	[G2] Develop an E&I Strategy with a strong Race Element reflecting the WRES Priorities through a stakeholder engagement process	Set and agree a strategic direction for race and WRES to give impetus.	Director of Equality and Inclusion	31 May 2022	
	[G3] Work collaboratively on system-wide Race Priorities through our localiites.	System wide collaboration on race will impact on EPUT overall race equality.	Director of Equality and Inclusion	Immediate / Ongoing	
	[G4] Secure two WRES Expert positions within EPUT. Agree protected time for this role and open out for competition depending on number of spaces EPUT is allocated. (August 2021: We have applied for four places in this programme via NHS East of England).	WRES experts are connected nationally and trained in data analysis and solutions. EPUT has been without for 12 months.	Director of Equality and Inclusion	Dependent on NHSI	
	[G5] Report the 2022 Staff Survey results by ethnicity – reporting through the E and I committee for discussion.	Better Identify the overall experience of Ethnic Minority staff	Head of Staff Engagement	31 May 2022	
	[G6] Race Equality added as a specific Risk on the Board Assurance Framework (BAF) Risk Register.	Lack of progress over time requires a stronger focus on Race equality.	Director of Equality and Inclusion	31 October 21	
	[G7] Embed WRES (Equality) performance indicators within appraisal process for senior leaders, managers and team leads responsible for recruitment. These should be measureable and leads held accountable.	Senior Leaders, managers and team leaders responsible for recruitment are held accountable for their contributions to the WRES (as well as all E&I projects) and are encouraged to engage.	Head of Organisational Development Director of Equality and Inclusion	30 September 2022	
	[G8] Implement Protected Time and Administrative assistance for the BAME Staff Network	The Network plays a vital function in the Trust's goals, and should be supported to ensure it is able to continue doing this at a Trust standard independently.	Director of Equality and Inclusion	30 September 2022	

Appendix C: BAME Staff Appointment Trajectory Chart and Ambition Modelling

	Fig 1. Trajectory of Black, Asian and Minority Ethnicity Staff being appointed into Band 8a+ Roles									2028	
	2019			2020			2021			Ambition	Appt's required
	Ambition	Actual	Diff.	Ambition	Needed	Diff.	Ambition	Actual	Diff.		
Band 8a	36	29	**-7**	37	37	**0**	39	41	**+2**	51	+ 10
Band 8b	16	13	**-3**	16	18	**+2**	17	24	**+7**	21	0
Band 8c	6	5	**-1**	7	3	**-4**	7	8	**+1**	13	+ 5
Band 8d	2	2	**0**	2	1	**-1**	3	1	**-2**	4	+ 3
Band 9	0	0	**0**	0	0	**0**	0	0	**0**	1	0
VSM	1	1	**0**	1	1	**0**	1	3	**+2**	3	0

How do we calculate our WRES Ambition Modelling goals?

These Model Employer figures are based on the 2019 Trajectory Goals (attached at bottom of appendix) set by NHS Improvement. Our ambition goals are based on the 10 Year Plan proposed by NHS England to ensure that these bandings have equitable representation by 2028.

How are we performing?

The above table shows how far away we are from achieving the overall 2028 goals in the next 6 years and the figures are optimistic provided the Trust continues its programme of increasing the proportion of ethnic minority staff in the workforce overall and then uses strong career progression and recruitment processes to achieve representation at senior level.

WRES Aspirational Goals 2019 update fo

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	Board Assurance Framework 2021/22 September 2021					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	ET BAF Sub-Group August and September 2021 (single reports – note September papers circulated but meeting cancelled)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents the EPUT Board of Directors with an overview of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2021/22 as at 29 September 2021 covering the two month period August and September 2021	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note progress on the BAF refresh
2 Note progress on procurement of an electronic risk register
3 Note assurances to Executive Team and the Audit Committee
4 Review the risks identified in the BAF 2021/22 September summary (Appendix 1) and approve the risk scores including recommended changes outlined below taking account of actions by the BAF ET Sub-Group at its August meeting
5 Approve the BAF risk closures and amendments iterated in the key issues and main report
6 Note the September (Q2) Key Performance Indicators (Appendix 2)
7 Review the risks identified in the CRR 2021/22 July summary (Appendix 3) including actions taken by BAF ET Sub-Group at its August meeting
8 Approve the CRR risk closures and amendments iterated in key issues and main report
9 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

Introduction

- This report covers two months of reporting to the ET BAF Sub-Group and the September summary includes reference to any changes made by it in August 2021
- In view of the work progressing at Board/ Executive level around governance, structure and accountability, the BAF, CRR and Directorate Risk Registers (DRR) continue to roll over until Board approval of Strategic Objectives for 2021/22

Board Assurance Framework (Appendix 1)

- There are **16 risks** on the Board Assurance Framework. There are no recommendations for escalation or closure.
- The **summary sheet (Appendix 1)** iterates the current mitigating actions/ controls in place for risks on the BAF and any further actions required.
- **BAF action plans** are under regular review with Executives and their direct reports. All action plans receive review and scrutiny by the relevant Board Standing Committees on a quarterly basis. Approval and monitoring of action plans sits with the relevant sub-Committee or Group.

- **Actions and decisions made by ET Sub-Group at its August meeting**
  - Approved new risk BAF67 CAMHS Tier 4 service
  - Approved closure of BAF58 Clinical Activity/ Record Keeping
  - Approved new ID for BAF36 to BAF36a to reflect change from personality disorders to purposeful admissions
  - Noted two risks sitting at an extreme score of 5 x 4 = 20 BAF50 Skills, Resource and Capacity and BAF67 CAMHS Tier 4
  - Noted separate work to be undertaken to refocus the clinical activity risk(s) to replace BAF58
  - Noted the following summaries for August 2021 – BAF, CRR, Covid-19 and Mass Vaccinations
  - Noted August Key Performance Indicators
  - Agreed to remove the process for scoring Strategic and Corporate Objectives
  - Discussed and noted timescale and implementation/ roll out plan for BAF refresh and Electronic Risk Register

- **Actions taken following ET Sub-Group August 2021**
  - Assurance report submitted to and approved by Executive Team
  - Strategic and Corporate objective scores removed from spreadsheets and summaries
  - Strategic Risks session with Amberwing and Finance Directorate
  - Strategic Risks session with Amberwing and Chief Executive
  - Strategic Risks session with Amberwing and Operations Directorate
  - Strategic Risks session with Amberwing and Nursing/ Quality Directorate
  - Follow up Strategic Risk governance sessions with Amberwing
  - Shortlisting of Electronic Risk Register providers – refresh demonstrations and question/ answer sessions

- **Actions, decisions and recommendations from ET Sub-Group September 2021**
  - Papers circulated to Executive BAF Sub-Group but meeting cancelled
  - No actions taken or decisions made

- **There are no risks recommended for escalation or closure on the BAF**

- **The wording on BAF4 Fire Safety has a change from 'implement' to 'maintain' with reference to fire safety systems.**

- **In the table below there are two risks sitting at a score of 20 (extreme):**

ID	Risk	Comments/Action
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	Action plan drafted – with NJ/PS for discussion prior to approval at ESOG

BAF67	If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in possible closure of the service	Awaiting input from Specialist Services. Discussed in ESOG and summary updated accordingly.

Key Performance Indicators (Appendix 2)

As at the end of Q2 all KPI's are RAG rated green for the six months to date. There is fluctuation between red and green each month but there is improvement in cumulative year to date.

Corporate Risk Register (Appendix 3)

- There are **13 risks** on the Corporate Risk Register. Recommendations in this report take this to **14** following approval
- CRR40 remains at threshold; de-escalation not recommended, as Cyber Essentials Accreditation is due for renewal later this year.

- **There is one risk recommended for escalation to the CRR**

ID	Risk	Rationale and discussion points
CRR79	If EPUT's alternative approach to season flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations C4 x L4 = 16 Lead: Natalie Hammond	Plan to commence flu programme in September in conjunction with Covid boosters. Risk attached to meeting national programme of flu uptake expectations

- **No risks are recommended for increase, reduction in score or de-escalation**

Covid19 Risk Register Summary

The Covid19 Risk Register summary forms part of the Covid 19 update report to Board. There are currently 17 risks with 10 at threshold. CVG46 RIDDOR score reduced from 16 to 12.

Mass Vaccinations Risk Register

The EPUT Mass Vaccination risk register updates contain no significant changes.

EU Exit Trade Deal Risk Register

The EU Exit Trade Deal Risk Register is closed.

Directorate Risk Registers

Updates on Directorate Risk Registers continue on a regular basis with presentation to Service Management Teams

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

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
DRR	Directorate Risk Register	CQC	Care Quality Commission
IT	Information Technology	CVG	Covid19 Gold Risk
CVS	Covid19 Silver Risk	EU	European Union
RAG	Red Amber Green	ESOG	Executive Safety Oversight Group
KPI	Key Performance Indicators	IAPT	Access to Psychological Therapies
EOSC	Executive Operational Sub Committee	ECTAS	Electroconvulsive Therapy Accreditation Standards
PMO	Project Management Office	HSE	Health and Safety Executive
SEECHS	South East Essex Community Health Services	CAMHS	Child and Adolescent Mental Health Services
F&PC	Finance & Performance Committee	MHSS SMT	Mental Health and Specialist Services Service Management Team

Supporting Documents and/or Further Reading
Appendix 1 Summary of BAF as at 29 September 2021 Appendix 2 Key Performance Indicators as at 29 September 2021 Appendix 3 Summary of CRR as at 29 September 2021

Lead
Paul Scott **Chief Executive Officer**

Agenda item 8a
Board of Directors Part 1
29 September 2021

EPUT

BOARD ASSURANCE FRAMEWORK 2021/22 SEPTEMBER 2021

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2021/22 as at 29 September 2021 and incorporates Q2.

UPDATE AS AT SEPTEMBER 2021

1. Board Assurance Framework 2021/22

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 16 risks on the BAF. **Appendix 1** provides a summary of BAF risks as at September 2021 including a heat map of risks against the 5 x 5 scoring matrix and movement on scoring from October 2019 to September 2021.

The ET BAF Sub-Group meets monthly to discuss the BAF and CRR and a Task and Finish Group meets informally to undertake further work.

1.1 BAF Refresh

Work on a BAF 'refresh' remains underway in parallel with high-level governance, assurance and diagnostic work that will frame EPUT's strategic objectives for 2021/22.

A review of the Risk Management and Assurance Framework is underway and will be on the next Audit Committee agenda. This includes synthesis of a risk appetite statement. The Executive BAF Sub-Group will consider risk appetite levels, impact types and their alignment and plotting of risk appetite levels against new strategic objectives.

Wider engagement is in train on the direction of travel on risk registers and the procurement of the electronic risk register. This will feed into the final decision on awarding the contract.

Executive sessions have taken place with Amberwing to discuss strategic risks to align with draft strategic objectives

1.2 Electronic Risk Register

Shortlisting has taken place with follow up refresher demonstrations and question and answer sessions involving IT, IG and procurement stakeholders.

1.3 Assurance

- Assurance report submitted to and approved by Executive Team
- Verbal update to Audit Committee September 21 by Chair of Audit Committee

- Review and scrutiny of action plans by Standing Committees September 21 (Quality Committee and Finance and Performance Committee; note PIT cancelled)
- Full engagement with Executive Team on risk management

2. Recommendations for BAF escalation, closures and amendments

The key issues in the cover sheet above iterate:

- There are no risks recommended for escalation or closure on the BAF
- The wording on BAF4 Fire Safety has a change from 'implement' to 'maintain' with reference to fire safety systems.

- **In the table below there are two risks sitting at a score of 20 (extreme):**

ID	Risk	Comments/Action
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	Action plan drafted – with NJ/PS for discussion prior to approval at ESOG
BAF67	If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in possible closure of the service	Awaiting input from Specialist Services. Discussed in ESOG and summary updated accordingly.

3. BAF Action Plans

Potential risks on the BAF should have (in most cases) a detailed action plan to mitigate risks. BAF action plans are under regular review with Executives and their direct reports.

All action plans receive review and scrutiny by the relevant Board Standing Committees on a quarterly basis, most recently September 21.

Approval and monitoring of action plans sits with the relevant sub-Committee or Group.

4. Key Performance Indicators

Appendix 2 highlights Key Performance Indicators and progress against these for September 21.

The table below highlights an improvement to a full green RAG rating status on the cumulative year to date.

KPI	RAG
KPI 1 % risks with action plans completed by target completion date	⇔
KPI 2 % stagnant risks	↑
2a % increased risk/ scores	⇔
2b % decreased risk/ scores	↑
KPI 3 % current risks on BAF over 12 months	⇔
3a % current risks on BAF over 24 months	⇔
3b % current risks on BAF over 12 months (excluding known ongoing risks)	⇔

5. Corporate Risk Register

- There are **13 risks** on the Corporate Risk Register. Recommendations in this report take this to **14** following approval.
- CRR40 remains at threshold; de-escalation not recommended, as Cyber Essentials Accreditation is due for renewal later this year.
- **Appendix 3** provides a summary of CRR risks as at September 2021 including a heat map of risks against the 5 x 5 scoring matrix.

- **There is one risk recommended for escalation to the CRR:**

ID	Risk	Rationale and discussion points
CRR79	If EPUT's alternative approach to season flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations C4 x L4 = 16 Lead: Natalie Hammond	Plan to commence flu programme in September in conjunction with Covid boosters. Risk attached to meeting national programme of flu uptake expectations

6. Covid19 Risk Register

The Covid19 Risk Register summary forms part of the Covid 19 update report to Board. There are currently 17 risks with 10 at threshold. CVG46 RIDDOR score reduced from 16 to 12.

7. Mass Vaccinations Risk Register

The EPUT Mass Vaccination risk register updates contain no significant changes. This is available on request.

8. EU Exit Trade Deal Risk Register

The EU Exit Trade Deal Risk Register is closed.

9. Directorate Risk Registers

Updates on Directorate Risk Registers continue on a regular basis with presentation to Service Management Teams.

10. Recommendations

The Board of Directors is asked to:

1 Note progress on the BAF refresh
2 Note progress on procurement of an electronic risk register
3 Note assurances to Executive Team and the Audit Committee
4 Review the risks identified in the BAF 2021/22 September summary (Appendix 1) and approve the risk scores including recommended changes outlined below taking account of actions by the BAF ET Sub-Group at its August meeting
5 Approve the BAF risk closures and amendments iterated in the key issues and main report
6 Note the September (Q2) Key Performance Indicators (Appendix 2)
7 Review the risks identified in the CRR 2021/22 July summary (Appendix 3) including actions taken by BAF ET Sub-Group at its August meeting
8 Approve the CRR risk closures and amendments iterated in key issues and main report
9 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Report prepared by**:**

Susan Barry
Head of Assurance

On behalf of:

Paul Scott
Chief Executive

Table 1 – BAF 2020/21 Summary of Risks as at September 2021

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

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
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							
BAF63	If EPUT does not continuously learn and improve then serious incidents will occur resulting in a failure to achieve our safety strategy ambitions	NH supported by all Executive Leads	Quality	Action Plan to be developed - ESOG	• Approval of Safety First, Safety Always Strategy • Workstream in place for continuous learning as part of the Safety First, Safety Always Strategy Implementation Project • Task and Finish Group in place (NED led) to integrate quality improvement, research and innovation with governance arrangements • Key principles set • Newton Diagnostic work is the first partnership in relation to Quality Improvement • Executive Safety Oversight Group in place – will monitor action plan • Director of Patient Safety appointed • PSIRF implemented as the alternative SI approach to move to continuous learning • Continuing with stakeholder engagement • Deep dive into Datix system to understand lessons previously reported • Lessons learned log in CAMHS provided • Continuing to look at Patient Safety Champions	**Score agreed by Executive Team April 5 x 3 = 15** **Align target date with Safety First, Safety Always** **Target score 5 x 2 = 10**	• Newton action plan • As part of the Safety First, Safety Always Strategy ensure improvement journey is a continuing process by taking urgent actions to ensure safe care and developing a culture of continuous learning and improvement • Improve record keeping • Take urgent action on estate and security issues • Scope EPUT Trust wide infrastructure to integrate Executive portfolios into learning and forums at all levels – Individual, Team, Profession, Service and Directorate • Ensure Accountability Framework enables a management leadership culture with mechanisms and processes for robust governance, monitoring and assurance • Approval of implementation plan for Safety First, Safety Always Strategy • Develop standardised language for understanding and communicating continuous learning • Create dedicated learning time and mentorship • Safety strategy is 3 year strategy for organisational development

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
							• PID capturing workstreams for learning • Reference the themes – continuous improvement, enhancing environments, governance and Executive portfolios • Cover strategic, tactical and operational • Start with CAMHS as a pilot • Consider dedicated resource • Action plan in development for submission to ESOG for approval – chased 31/08 MA – agreed extension until end September. • Data analysis – limited resource available • Explore Cloud based updated to Datix • Understand resource requirements • Work with communications • First steering group to take place on 6 September 21 • Updated from ESOG notes
BAF4	If EPUT does not ~~implement~~ maintain fire safety systems and processes then serious injury or death may occur resulting in Fire Authority enforcement action and failure to meet our safety ambitions	TS	Finance and Performance	Action Plan monitoring by FSG	• Trust follows all relevant statutory fire safety legislation and adheres to articles of RRO, HTM Fire Code and Government standards/ guidance as best practice • Fire Safety Policy updated and approved at April 21 FSG • Fire Safety Group (Executive led) • Rolling Fire Strategy programme in place • Fire Risk Assessments in place with spot checks undertaken • Directorate Risk Registers have this risk mirrored particularly in relation to fire wardens and fire drills • BAF action plan 2020/21 signed off by FSG June 21	**Risk score unchanged 5 x 3 = 15** **Target date March 2022 4 x 3 = 12**	• Sustain compliance with fire training targets • Complete work on manual overrides and compartmentation by year end • Continue to improve situation on outstanding fire risk assessment remedials, in particular operational remedials • Continue to train Fire Wardens – Rawreth remains high risk as at August 21 • Link fire safety to accountability framework • As at August, the following sites still require fire drills: King's Wood Centre, The Lakes, Landermere (due for

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• BAF action plan 2021/22 approved by FSG June 21 and updated monthly • FRA programme now recovered and up-to-date following Mass vaccination work • Edward House compartmentalisation complete • Fire training compliance two months running for Category 1 sites and maintaining compliance on Category 2 sites. August Cat 1 slipped back to 89% just below target, Cat 2 remains at target. • Fixed term contract Fire Trainer in place attached to the Workforce Team and funded through Estates • £50k backlog maintenance funding for manual over-rides – following full evaluation the situation is more positive than originally thought. Progress is good including upgrades to existing systems and key allocation to staff for overrides. • All P1 sites evaluated and confirmed with possible market testing to take forward programme of works in progress • Good progress is being made on fire risk assessment remedial works, especially estates • Status on fire wardens is much improved with 167 trained across the Trust • Report completed by Estates Compliance Manager for ECFO. Sent to BDO internal audit for endorsement.		completion within a week), Poplar (Rochford). Drills must take place once all remedial works completed. TFO working with clinical leads. • Make decision on whether to de-escalate this risk from the BAF following endorsement by BDO of report to ECFO from Estates Compliance Manager. To be subsequently reported into Audit Committee (September 2021). • Evidence controls at operational level – driving up number of fire wardens and management of patients

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF10	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	TS supported by PS and all Executives	Quality	Action Plan monitoring by LRRG	• Robust governance through LRRG and policy and procedures • New corporate risk identified for all inpatient areas from increased ligature incidents involving towels and bedding supplied by new contractor – risk shared by operations, estates/ facilities, and compliance/ assurance • Working with Cambridge University on management of ligature risk • Clinical Lead for Compliance and Ligature in post • Increased awareness and ownership of ligature reduction work at all levels • Action plan in place from BDO internal audit recommendations • Tidal training in place • Estates Ligature/ Patient Safety Co-ordinator job share in post working closely with Compliance and EPRR Team • Appendix 9 approved May 21 • Independent review undertaken at EPUT by ELFT July 21 and high level feedback received • Independent review undertaken at ELFT 10 August • CAMHS audited against updated minimum (Larkwood and Poplar) standards and now planning to address gaps • Audit programme for acute wards established	**Risk score unchanged 5 x 3 = 15** **Target date March 22** **Threshold 4 x 3 = 12**	• Develop project plan on open actions and non-compliance, looking at actions more than three years old. ESOG to monitor governance process. Still cross-referencing 3i system with Datix to identify gaps • Mitigation statement work added to Clinical Lead for Compliance and Ligature work plan for further action when new post holder in place discuss in LRRG what the action is going forward • Increase awareness and ownership of ligature reduction work at all levels of the organisation – awareness recommendation paper to LRRG 8/09 • Develop the process of governance around ligature reduction work including a SOP for use of 3i system and a resource to input and monitor • Review policy by March 22 • Review LRRG TOR by Jan 22 • Review Anti-Ligature shop and the Design in MH Forum work • Re-establish local area ligature forum • Task and finish group meeting in July to revisit mitigation statements • Awaiting report from ELFT • Develop robust and systemic processes for disseminating learning related to ligature reduction – take to clinical support group

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
							• Review policy to reflect movement away from setting different standards for amber and red areas – review standards • Develop KPIs and dashboard to highlight progress on ligature reduction • Action plan from ligature site visits internal audit to take to LRRG • Strengthen mitigation statements for any actions where there is reliance on clinical monitoring • Review and embed process of updating heat maps with photos • Complete actions from BDO internal audit recommendations • Align with accountability framework • Develop robust and systemic processes for disseminating learning related to ligature reduction • Undertake formal policy review • Reflect movement away from setting different standards for amber/ red areas in policy • Develop KPIs and dashboard to highlight progress on ligature reduction • Review LRRG Terms of Reference • Review Anti-Ligature Shop and Design in MH Forum Work • Re-establish local area ligature forum to share information • Reinstate ligature audit process • Issue report from independent review by ELFT

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
							• Report on learning from independent review at ELFT • Overarching ligature Workstream PID to be drafted for ESOC by end August 21 • Audit and gap analysis for Longview to be completed • Ensure planned remedial work communicated to Estates • Estates to complete works • Reconciliation of historic action plans against completed and scheduled maintenance work to ensure no gaps
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	NL	Finance and Performance	Monitoring/ Covid19 Action Log - Command Structure	• Business Continuity Plans in place and undergoing constant review • Command structure in place • Sit rep daily monitoring • Covid intranet page and range of staff training in place • Covid dashboard issued weekly to monitor prevalence • Mirrored to Covid19 Risk Register • Action plan developed and approved by ESOG with Covid19 assurance report • Executive Lead for Emergency Planning confirmed as NL as well as single point of contact for Covid Inquiry • Non-Executive Lead for Emergency Planning in place • Paper on lessons learnt taken to Executive Team and disseminated more widely including next steps for new ways of working	**Risk score remains at threshold 5 x 2 = 10** **Target date – ongoing throughout pandemic**	• Prepare for Covid19 Statutory Inquiry • Promote awareness of various media methods that could be called as evidence including retrospective personal and team WhatsApp, MS Teams and Pando messages

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Demonstrating lessons learnt from Covid19 through bi-monthly Trust Board reports and EPRR quarterly report • Request for media awareness via communications 13/8		
BAF36a	If EPUT does not focus on and work collaboratively to achieve purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	AG supported by MK/NH/PS	Quality	Action Plan / Task and Finish Action Log	• Multi-disciplinary Steering Group in place with operational groups, action logs and BAF action plan • Operational group in place for purposeful admission, implementation and mobilisation plan, with action plan in place • Terms of reference agreed • Operational group in place and action log created for therapeutic offer/ model • Out of area placement at lowest for two years • Draft Inpatient Admission Process	**Risk score unchanged 5 x 3 = 15** **Target date March 22 Threshold 5 x 2 = 10**	• Get new model up and running for purposeful admission with robust mechanisms for flow and length of stay, and allow 12 months to embed before closing risk • Take immediate action around current long-stay patients by taking to Executive panel • SMT to record approval of the BAF action plan • BAF action plan circulated to Steering Group following discussion – all to identify leads and target completion times then meeting arranged SB/LW 7/09 to update before next Steering Group • Responses received from Dr Lynn Prendergast and Dr Sophie Bellringer
BAF45	If EPUT does not learn from focused inspections, patient safety incidents and meeting CQC fundamental standards then further regulatory action may take place resulting in a failure to maintain or improve on our Good rating	S supported by all Executives	Quality	Action Plan monitored by ESOG	• PHSO/ HSE action plan testing completed and ongoing (quarterly) • CQC 2019 Well Led inspection action plan testing completed • CQC 2020 Adult Acute Inspection action plan testing completed • Testing tools in place • Internal support visits to all wards completed • Action plans from internal support visits completed	**Risk Score unchanged 4 x 3 = 12** **Target date July 2021 Threshold 4 x 2 = 8**	• Pull together themes from PHSO/ HSE action plan testing • Key Committees to address gaps in testing from CQC 2019 well-led inspection • Pull together themes from CQC 2020 testing for presentation to ESOG and ISG • Develop process for single learning framework covering all action plans • Implement and validate action plans from internal support visits

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Schedule in place for internal support visits to community teams • Process in place for nursing team to undertake safety walk rounds and compliance team to undertake internal support visits • Conduit between compliance team and matrons for co-ordination • Reporting to ESOG for monitoring and Quality Committee for overview and scrutiny and other Committees as necessary • Dedicated communications team in place, meeting regularly and discussing any communications required • Intensive Support Group in place with action plan • All CQC evidence requests completed • Factual accuracy completed for CQC May 2021 draft report • Draft action plan developed from initial findings of above • Fortnightly audit reporting to CQC on actions resulting from inspection • Report on training, staffing and temporary workers in relation to CAMHS submitted to CQC • Undertaking internal support visits to community teams • Internal insights complete and first version August 21 circulated for comments		• Consider any reporting requirements to relevant operational meetings as part of the accountability framework • Communications strategy • Develop final action plan from CQC May 2021 CAMHS inspection • Implement action plan • Share learning • Undertake action plan testing • Develop clear document on staffing needs for number of beds utilising Newton and progressive road map (nursing team in conjunction with operational teams) • Develop longer term plan with clear engagement with partners to meet CQC requirements • Produce a clear list of clinical information on patients unsuitable for St Aubyn Centre • Review intensive support process

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF54	If EPUT is not open, transparent or demonstrates learning from the Essex Mental Health Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	NL/All Executives	Quality	Monitoring	• Executive Lead identified • Establishing governance arrangements • Updated stakeholders including NHSE/I • Principles developed on EPUT approach • Job matching and posts advertised on secondment or permanent basis • Core team in place with appropriate skills, and resources required to support EPUT internally • Met with Inquiry Team and first phase now underway • Independent Director and Independent Medical Advisor appointed • Inquiry Terms of Reference now issued	**Risk score unchanged 5 x 3 = 15** **Target date April 23 (or length of Inquiry)** **Threshold 5 x 2 = 10**	• Pick up the historical elements of the HSE investigation through a dedicated estates work stream under ESOG • If/ when asked demonstrate how we are supporting staff through the impact of the HSE investigation • If/ when asked demonstrate how we are improving partner approaches to EPUT through the impact of the HSE investigation • If/ when asked demonstrate actions on fixed ligatures and safety strategy • Meeting with the Secretariat to the Independent Inquiry awaited • Awaiting methodology on how the independent inquiry will be delivered
BAF50	If EPUT does not have the skills, resource and capacity to deliver on high quality care and other wide ranging priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	PS and all Executives	PIT	Action Plan to be developed for 2021/22	• Participation in system calls • Command structure in place for Covid19 • Project Board in place for mass vaccination programme • Creating resilient teams • Continuous improvement work stream as part of Safety First, Safety Always Strategy • Collective leadership – identifying senior talent, succession planning and Quality Champions • Leadership handbooks • Robust and forward thinking Executive Leadership Team • Programme Management Office related to Safety First, Safety Always Strategy • Preparation for Independent Inquiry	**Risk score unchanged 5 x 4 = 20** **Ongoing for duration of pandemic** **Threshold 5 x 2 = 10**	• Develop new strategic and corporate objectives for 2021/22 and articulate risks to achieving those • Newton diagnostics to ensure systems and processes are effective • Bolstering staffing and project support as required • Redefining Executive portfolios to best manage services and resources • Develop a new action plan for 2021/22 • Transfer Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 1000 under consideration • Prioritise areas as new staff are appointed • Scope high risk areas with staffing difficulties for impact on incidents

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Transferring Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 30 transferred as at August • PID in place • Mirrored on Mass Vaccs risk register		• Consider dedicated permanent resource to meet changing ward needs • Develop a plan that illustrates BAU vs project work underway • MHOST review • Action plan drafted – with NJ/PS for discussion prior to approval at ESOG
BAF67	If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in remaining closed to admissions	AG	Quality	ESOG	• Emailed Specialist Services leads 12 August for input to this new risk • Staff recruitment continues • Young person placements continues • Seclusion room work at design phase	Risk score 5 x 4 = 20 Target March 22 Target score 5 x 2 = 10	• Focus on lifting the restrictions to admissions • Develop a plan for the next six months to look at resettling the service – session planned with key leads, Executive Team and Consultants to agree an approach – plan in progress • System risk – in A&E support for young people from Adult MH services. No support available from NELFT CAMHS Community Services • Add thresholds for decision making and roadmap for opening beds and stopping inappropriate placements • Undertake trend analysis • Group to look at future mix of patients • Develop inclusion and exclusion criteria – in progress • Seclusion room estates work required
BAF68	If EPUT does not manage observation and engagement then patients may not receive the prescribed levels resulting in undermining	AG	Quality	ESOG	• Weekly ward huddles and discussing perfect ward reports • ADs undertaking 15 leadership steps each week • New videos being implemented in CAMHS • National discussion ongoing	**Risk score 4 x 4 = 16** **Target Mar 22** **4 x 2 = 8**	• Clinical audit planned • Review of policy and procedure planned • Structured task and finish group to be held end September 21 • Review the use of arm bands • Continue with training videos • Link to purposeful admissions work

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
	our Safety First, Safety Always Strategy				• Electronic tool trial • Collation of learning • Ongoing task and finish group		
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: Paul Scott supported by all other Executive Directors							
BAF61	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	SL supported by all Executives	PIT	Action plan to be developed and monitoring by EIG	• Risk was escalated from Corporate Risk Register to the BAF in March 2021 • Range of Equality and Diversity Networks • Equality and Inclusion Hub on InPut • Staff Network pages and virtual networks • Equality Champions • Equality and Inclusion Sub-Committee • The NHS People Plan • Equality Advisor and Network Chairs • Executive Lead • Collaborative working with ICS, CCG and Mid and South Essex Trusts • Collaborative working on the WRES/WDES • EDS2 2020/21 scored positively by stakeholders, EDS2 2021/22 approved by stakeholder focus group and E&ISC • Development of sensory champions, LGBTQ+ awareness and race equality and Allyship in conjunction with staff network focus groups	**Risk score unchanged 4 x 4 = 16** **Target March 2022 or aligned with action plan when complete Threshold 3 x 2 = 6**	• People and Culture Team will be undertaking an Equality and Diversity root and branch review • Engagement of a senior Equality, Diversity and Inclusion lead • Will have a Director of Equality, Diversity and Inclusion in post by 1 September • Consider merging new role with People Experience Director role • Deep dive into current WRES data that shows lack of progress across nine metrics • Action plan drafted – submit to E&ISC for approval
BAF62	If EPUT does not support staff effectively then staff recovery from the HSE prosecution and the Covid19 pandemic is compromised resulting in	SL supported by all	PIT	Action Plan to be developed	• Diagnostic work being undertaken by Newton around Health Rosters, reliance on temporary staff and establishment budgets • Proposal presented to EOSC regarding staffing establishment issues and the larger piece of work that needs to take	**Risk score unchanged 5 x 3 = 15** **Target Nov 21 5 x 2 = 10**	• Develop action plan from Newton diagnostic work • Transfer Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 1000 under consideration - ongoing

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
	a failure to meet our People Plan ambitions				place in reviewing staffing numbers and skills mix to mitigate this risk • Recruitment successes • Continue high visibility of Executive and Non-Executive Directors • Transferring Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 30 transferred as at August • Further movement of Band 2 and 3 from Bank to permanent • Safer Staffing Policy and Procedure in draft stage • Moving forward with MHOST • Staffing escalation process in draft stage • Establishment budgets in health roster		• Establishment review as part of project initiation document • Allocate software diagnostic around rostering software • Demonstrate how we are supporting staff through the impact of the HSE investigation • Manage the level of exhausted staff including burn out • When permitted and safe to do so Executive and Non-Executive Directors physical visits will happen • Draft fostering options paper • Development pathway for Band 5-6 planned • First working group meeting with ward representatives planned 2 September 21 • Updated from ESOG notes. No further updates received.
BAF65	If EPUT does not plan and manage its resources effectively then recovery of services following the HSE prosecution and the Covid19 pandemic is challenged resulting in a failure to meet our organisational ambitions	AG	F&PC	Monitoring is in place via various action plans and groups	• Daily management of resources in place • Recovery support in place •	**Risk score 5 x 3 = 15** **Target Nov 21 5 x 2 = 10**	• Review of systems and processes • Action plans and monitoring is in place, for example, sit reps, oversight meeting for adult Mental Health and various monitoring of service delivery in each of the areas. There is also daily operational planning. Covers Mental Health and Community. Further discussions ongoing • No update – meeting AG 9/8
BAF66	If recurrent efficiencies for 2021/22 are not identified then delivery of the programme is compromised resulting in	TS	F&PC	As above	• EPUT is working with the MSE ICS regarding the efficiencies for 2021/22. The Efficiency Plan target for 2021/22 is £10.1m. H1 target £3.5m and H2 target	**New risk Score 4 x 4 = 16**	• Deliver the key activities and workstreams with a focus on delivery plans, quantification and implementation

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
	a challenge to the sustainability of EPUT going forward				£6.6m with a recurrent requirement of at least £4.1m. • The key activities and workstreams have been communicated to the Finance and Performance Committee with a focus on delivery plans, quantification and implementation • Active participation in Regional, ICS and service efficiency groups	**Target April 2022** **Threshold 4 x 2 = 8**	• Efficiency Workstream meetings with Operational and Corporate Teams being established and commencing • Awaiting update 31/8
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	TS	F&PC	Monitoring through finance meetings	• The Trust's 21/22 financial plan has been set to deliver a breakeven position. The plan includes £8.1m of Covid allocation for H1. • Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board will continue. • Continue to monitor financial situation, Covid19 and Mass Vaccination costs to ensure recovery. • Efficiency requirements are included in the financial plan and schemes under development. Some internal schemes developed and others in development alongside combined work with ICS and NHSI/E. • The ICS has also undertaken a financial sustainability exercise. Year to date M12 Covid19 costs of £16.2m with M7-M12 recovery anticipated from M&SE and H&CP • Planning for anticipated reduction in system monies of 3.5%	**Risk score unchanged 4 x 3 = 12** **Target March 22 Threshold 4 x 2 = 8**	• The financial settlement for H2 are not finalised and will be informed by future National Guidance • Awaiting update 31/8

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Mirrored on Covid19 risk register		
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							
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SNEE	NL	Quality	Monitoring by Project Management Group	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Programme Board in place • Working in partnership, with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Clinical oversight and governance in place at all vaccination centres • All costs passing through NHSE and laptop costs supported by skill mix work • Robust communication in place with vaccination centres • Good coverage in both MSE and SNEE with robust joint working (rationale for reducing consequence to 4) • Moving towards phase 3 preparation for mainstreaming the vaccination programme to become business as usual • 'Big weekender' event 4,500 people were contacted inviting them for earlier appointments and second doses brought forward where feasible • Licences being extended as part of phase 3 awaiting NHSE approvals • Pre-assessment model developed by EPUT now approved by Region	**Risk score unchanged 4 x 3 = 12** **Target date is ongoing for the duration of the mass vaccination programme** **Target 4 x 2 = 8**	• Implement phase 3 from early September to late February 22 in line with national guidance • Maintain watching brief on variable vaccine supply and impact on programme • Assessment of recently published national security guidance to draw out any actions • Close attention nationally to 16 year olds in terms of uptake • 12-15 year old programme about to commence by school aged immunisation teams

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses • Maintaining workforce at vaccination centres (and other delivery centres) with forward planning to identify workforce challenges • Maintaining vigilance and awareness on security and potential criminal activity at vaccine sites • Mirrored on Covid19 and Mass Vaccs risk register • 12-15 age group programme planned for early September start • 12-15 age group School Immunisation Teams now part of the project as a separate work stream		

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2					38↔
	3				42↔ 45↔ 51↔	4↔ 10↔ 36a↔ 54↔ 63↔ 62↔ 65↔
	4				61↔ 66↔ 66↔	50↔ 67
	5					

Table 3: Movement on scoring – period from October 2019 to September 2021 *Notes: Risks closed for over two years removed from table*

Risk ID	Initial Score	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Risk ID
BAF4	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF4
BAF6	12	12↔	12↔	12↔																						BAF6
BAF9	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	8↔	8↔	8↔	close							BAF9
BAF10	12	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓																	BAF13
BAF15	15	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	Close											BAF15
BAF18	15	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔																	BAF18
BAF20	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close										BAF20
BAF21	15																									BAF21
BAF22	16																									BAF22
BAF23	15	20↔										Esc	20	20↔	16↓	16↔	12↓	12↔	12↔	12↔	12↔	12↔	Close			BAF23
BAF30	12																									BAF30
BAF31	16	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close											BAF31
BAF32	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	close						BAF32
BAF33	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓																	BAF33
BAF34	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	8↓											BAF34
BAF35	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	close							BAF35
BAF36	15		New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Closed					BAF36
BAF36a	15																					15	15↔	15↔	15↔	BAF36a
BAF37	15				New	15	15↔																			BAF37
BAF38	15					New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	BAF38
BAF39	20					New	16																			BAF39
BAF40	12							New	12	16↑	16↔	16↔	12↓	12↔	Close											BAF40
BAF41	16							New	16	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	9↓	Close				BAF41
BAF42	12							New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20							New	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	close					BAF43
BAF44	12								New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	close							BAF44
BAF45	12								New	12	12↔	12↔	12↔	12↔	12↔	16↑	20↑	20↔	20↔	20↔	12↓	12↔	12↔	12↔	12↔	BAF45
BAF46	16									New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	close							BAF46
BAF47	16										New	16	16↔	16↔	16↔	16↔	16↔	16↔	close							BAF47
BAF48	16										New	16	16↔	16↔	Close											BAF48
BAF49	15										New	15	15↔	15↔	8↓											BAF49
BAF50	20													New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	BAF50
BAF51	20													New	20	20↔	20↔	15↓	15↔	12↓	12↔	12↔	12↔	12↔	12↔	BAF51
BAF52	20													New	20	20↔	20↔	Close								BAF52
BAF53	20													New	20	20↔	20↔	20↔	close							BAF53
BAF54	20														New	20	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	BAF54
BAF55	20														New	20	15↓	15↔	close							BAF55
BAF56	20														New	20	Merge	Close								BAF56
BAF57	20														New	20	20↔	20↔	20↔	20↔	20↔	close				BAF57
BAF58	20														New	20	20↔	20↔	20↔	20↔	16↓	16↔	16↔	Close/ replace		BAF58
BAF59	20													Esc	from	CRR	20	Close								BAF59
BAF61	20																		20	20↔	16↓	16↔	16↔	16↔	16↔	BAF61
BAF62	20																		20	20↔	15↓	15↔	15↔	15↔	15↔	BAF62
BAF63	15																		New	15	15↔	15↔	15↔	15↔	15↔	BAF63
BAF64	20																		New	16	20↑	20↔	Close			BAF64
BAF65	15																				New	15	15↔	15↔	15↔	BAF65
BAF66	16																				New	16	16↔	16↔	16↔	BAF66
BAF67	20																							20	20↔	BAF67
BAF68	16																							16	16↔	BAF68

Table 4: Milestones

Risk ID	Initial Score	Length of time on BAF	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 22	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Risk ID
BAF4	15	> 2 years																									BAF4
BAF9	16	> 2 years								12↓						8↓				Closed							BAF9
BAF10	12	> 2 years			20↑					15↓																	BAF10
BAF20	12	> 2 years															Closed										BAF20
BAF23*	15	> 2 years													20↔	16↓		12↓						Closed			*BAF23
BAF32	16	> 2 years														12					Closed						BAF32
BAF35	16	> 1 year	16																	Closed							BAF35
BAF36	15	> 1 year		New	15																	Closed					BAF36
BAF36a		<6 months																									BAF36a
BAF38	15	> 1 year					New	15																			BAF38
BAF41	16	> 6 months							New	16					20↑	12↓						9↓	Closed				BAF41
BAF42	12	> 1 year							New	12					16↑	12↓											BAF42
BAF43	20	> 6 months							New	15	20↑											Closed					BAF43
BAF44	12	> 6 months								New	12									Closed							BAF44
BAF45	12	> 1 year								New	12						16	20↑				12↓					BAF45
BAF46	16	> 6 months									New	16								Closed							BAF46
BAF47	16	>6 months											16							Closed							BAF47
BAF48	16	<6 months											16			Closed											BAF48
BAF49	15	<6 months											15			Closed											BAF49
BAF50	20	>6 months													New	20											BAF50
BAF51	20	>6 months													New	20			15↓		12↓						BAF51
BAF52	20	>6 months													New	20			Closed								BAF52
BAF53	20	>6 months													New	20				Closed							BAF53
BAF54	20	>6 months														New	20					15↓					BAF54
BAF55	20	<6 months														New	20	15↓		Closed							BAF55
BAF56	20	<6 months														New	20	Merge	Closed								BAF56
BAF57	20	>6 months														New	20						Closed				BAF57
BAF58	20	>6 months														New	20					12↓			Close / replace		BAF58
BAF59	20	<6 months																20	Closed								BAF59
BAF61	20	>6 months																		20		16↓					BAF61
BAF62	20	>6 months																		20		15↓					BAF62
BAF63	20	<6 months																			15						BAF63
BAF64	20	<6 months																			16↓	20↑		Closed			BAF64
BAF65	15	<6 months																					15				BAF65
BAF66	16	<6 months																					16				BAF66
BAF67	20	<6 months																						New	20		BAF67
BAF68	16	<6 months																						New	16		BAF68

Appendix 2 - Key Performance Indicators for Board Assurance Framework August 21

KPI Ref	Key performance indicator (KPI)	Target	Q3 YTD	Jan 21	Feb 21	Mar 21	Q4 YTD	Apr 21	May 21	Jun 21	Q1 YTD	Jul 21	Aug 21	Sep 21	Q2 YTD
Total number of risks on BAF			**24 (19)**	**25**	**22**	**24 (20)**	**24 (20)**	**19 (17)**	**18 (17)**	**18(17)**	**18(17)**	**17(15)**	**15(15)**	**16(16)**	**16**
KPI 1	% risks with action plans completed by target completion date	90%	Q3 100% (1)	0	0	100% (2)	100% (2)	100% (5)	0	0	100% (5)	0	0	0	0
KPI 1a	Number of risks open with action plans fully completed	Information only	0	0	0	2 (0)	2 (0)	5 (action plans replaced with new)	1	0	0	0	0	0	0
KPI 1b	Number of risks with open action plans	Information only	12(11)	9	10	10 (8)	10 (8)	4	4	4	4	5	10	10	10
KPI 1c	Number of risks with no action plan	Information only	14(13)	15	12	14 (12)	14 (12)	14 (13)	14	14 (7 to develop)	14	12 (10) (5 to develop)	5	6	6
KPI 1d	Number of risks closed/de-escalated in month (YTD)	Information only	Q3 7(6) YTD 11(10)	0	3	4 (0)	7 YTD 18(14)	1 (1)	1 (2)	2 (4)	4	2	1	0	7
KPI 1e	Number of new/ escalated risks in month (YTD)	Information only	Q3 9(4) YTD 19(14)	0	0	2 (0)	2 (0) YTD 21(19)	2 (0)	0	3 (0)	5	0	1	0	1
KPI 2	% stagnant risks (no movement)	Less than 30%	57.8%	56%	45%	55%	55%	88%↑	55.5%↓	88%↑ (15)	41%↓ (7)	88%↑ (15)	93%↑ (14)	100% ↑ (16)	24% (6 out of 24 in qtr)

KPI Ref	Key performance indicator (KPI)	Target	Q3 YTD	Jan 21	Feb 21	Mar 21	Q4 YTD	Apr 21	May 21	Jun 21	Q1 YTD	Jul 21	Aug 21	Sep 21	Q2 YTD
KPI 2a	% of increased risks	Less than 10%	26%	0%	9%	10%	10%	0%↓	0%↔	0%	0%	0%	0%	0%	0%
KPI 2b	% of decreased risks	60%	26%	8%	4.5%	10%	10%	11.7%↑	38.8%↑	11.7%	58% (10)	11.76%↑ (2)	6%↑ (1)	100% (0)	54% (13 out of 24)
KPI 3	% of current risks on BAF over 12 months	Less than 40%	21%	8%	9%	15%	15%	11.7%↓	11.7%↓	23.5%↑	23.5%↑	29%↑ (5)	26%↔ (4)	31% (5)	31% (5)
KPI 3a	% of current risks on BAF over 24 months	Less than 30%	15.7%	20%	22.7%	25%	25%	0%↓	16.6%↑	11.7%↓	11.7%↓	11.76%↑ (2)	13%↓ (2)	12.5% (2)	12.5% (2)
KPI 3b	% of current risks on BAF over 12 months (excluding known ongoing risks)#	0%	6%	0%	0%	0%	0%	0%↔	0%↔	0%↔	0%↔	23.5%↑ (4)	0%	0%	0%

Notes:
#known ongoing risks – BAF4 Fire Safety BAF10 Ligature Reduction BAF38 Emergency Planning BAF45 CQC
Any action plans of risks carried forward into a new financial year are reviewed and updated

Table 1 – CRR 20/21 Summary of Risks as at September 21

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

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors						
CRR11	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 supports by MK	Quality Committee and Sub-Committees	• Implementation of 2018-20 Suicide Prevention Strategy • Local reflective sessions • Links to ligature reduction • Medical lead in place • Draft Suicide Prevention Strategy 2021-23 approved at Mortality Sub-Committee May 21 & ESOG June 21 • Agreed implementation plan in place with STPs and ICS • Detailed work plan in place • Events linked to the strategy taking place for four weeks from 10 September to World Mental Health Day on 10 October	**Risk score unchanged** **4 x 3 = 12** **(ET BAF Aug 21)** **Target March 2022** **4 x 2 = 8**	• Implementation of revised Strategy • Align with Safety First, Safety Always Strategy • Project support requested • Evidence that Suicide Prevention Strategy is working
CRR48	If EPUT is unable to suitably fill consultant vacancies across clinical services on a substantive or locum basis then the Trust may not be able to deliver safe and effective services, resulting in poor patient flow and possible patient harm	MK	Medical Staffing Committee	• Cover maintained by locum and agency staff • GMC approval to allow overseas doctors to work in the UK • National Fellowship Scheme in place – three arrived in UK with a fourth later in September with a view to obtaining specialist registration • Staffing deployment is a key risk for 2021/22 • Running advertise in BMJ, NHS Jobs and Trac throughout September • New branding for adverts imminent	**Risk score unchanged** **4 x 4 = 16** **Target September 2021** **4 x 2 = 8** **Above threshold**	• Continue to recruit to vacancies - there are 20 Consultant vacancies, of which Locum posts cover 16. Locums remain hard to source. • New trainees will in time help mitigate recruitment problems • Interviews from advertising campaign planned for October/ November – national recruitment remains poor • National Fellowship Scheme likely to take two years to home-grow Consultant applicants

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
				• Situation improved with regard to availability of agency doctors (locums dictating market rates)		• Interview further fellows in October to fill vacant speciality doctor posts thus reducing agency spend
CRR68	If EPUT does not complete annual General Workplace Risk Assessments or they are of poor quality then its statutory requirement is not met resulting in non-compliance with CQC well led standards	PS supported by all Execs	HSSC	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate reviewed and simplified risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Legal advice received on proposed documentation • Discussion through HSSC • Two options being piloted	**Risk score unchanged** **4 x 4 = 16** **Target ~~June~~ July 2021** **4 x 2 = 8** **Above threshold**	• Evaluate pilot • Formal launch of new GWPRA documentation • Past deadline date • No update available
CRR74	If EPUT inpatient areas do have robust airlocks in place for access/egress then patients detained under the MHA may abscond resulting in potential serious harm to patients, staff or the public	TS	Executive Safety Oversight Group	• Recent incident on Finchingfield resulted in the death of a patient, injury to a member of staff and a focused inspection by the CQC – all action taken as required by the CQC inspection report • Linden Centre work completed • Rochford work completed • The Lakes work completed	**Risk score unchanged** **5 x 3 = 15** **Target Mar 22** **5 x 2 = 10** **Above threshold**	• HSSC action log requested a one page report confirming the scope of the airlock work – phase 1 perimeter phase 2 interior • Peter Bruff, Crystal Centre and Gloucester – all three areas included in 2021/22 funding and a timescale is in development • Awaiting update 31/08
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	TS	ESOG/LRRG	• Contractor has visited site to review quality of towels and agreed to add new towels to the system • Manufacturer confirmed towels are for high risk areas • Observation and engagement • Datix analysis undertaken • Safety Alert issued reminding staff to return any sub-standard towels and bedding	**Risk score unchanged** **5 x 3 = 15** **Target June 21** **5 x 2 = 10** **Above threshold**	• Ensure patient privacy and dignity is not compromised • Enhanced observation and engagement • Look at alternative options for towels as they continue to be an issue • Deep dive into how towels are being torn • Consult Mental Health Forum

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
				• Additional quality checks before linen arrives on ward • Daily increased inspections on quality of linen carried out • Alternative linen now being brought in for clinical and operational staff to view and comment upon		• Visit to manufacturers by Trust team to look at strengthened linen • Past deadline date • Awaiting update 31/08
CRR77	If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use resulting in a failure to achieve our safety first, safety always strategy	NH	Medical Devices Group/Physical Health Sub-Committee	• Robust procurement process in place • Executive Nurse is Executive for Medical Devices • Nominated person for CAS alerts is Datix Manager • Chair of Physical Health Sub-Committee is Director of Nursing and five priorities agreed for 2021/22. Medical Devices Group is the Governance group.	**Risk score unchanged 4 x 4 = 16** **Target date Sept 21** **4 x 2 = 8** **Above threshold**	• Analysis of MD inventory • MD lead communicate with teams • Streamline inventory • Establish financial impact of contracts for missing devices • Review Medical Devices policy to include definitions and robust governance • Identify resource for MD • Assisted technology to align with priorities and clinical rationale/ pathways, training processes • AW meeting with MA to pull together high level proposal in terms of resourcing the senior nursing team during September – this will include the medical devices resource
CRR40	~~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~~	TS	ESOG PST	• Windows 10 upgrade licences now purchased • Cyber Essentials Accreditation • Cyber Team in place • Robust updates and patching • Software asset risk log in place	**Risk score unchanged and at threshold 4 x 2 = 8**	• End of life software in EPUT has been identified and placed on the cyber risk log - mitigation options to be presented to IGSSC • Cyber Essentials Accreditation will be coming up for renewal in the autumn • Awaiting update 31/08

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
	Suggested rewording: If EPUT experiences a cyber-attack then access to systems may cease resulting in compromised safety ambitions and patient experience					
CRR53	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.	TS	Estates Capital Group	• Phases 1 and 2 completed • Tender specification document issued to contractors end Jan 21 • Phase 3: Cherrydown and Kelvedon – redundant pipe work complete. Infrastructure on Cherrydown installed – cabling, new heating pipework, potable water and domestic water services. • Phase 4 moving Cherrydown Ward to Langdon Unit and Sankey House and relocate Kelvedon Ward to Willow Ward completed • Phase 8 alterations to the Assessment Unit to reduce bed numbers to 18 and create better male and female segregation • Cherrydown Ward opening date 18 August – core service female adult inpatient acute MH • Kelvedon Ward opening date 8 September – core service male adult inpatient acute MH	**Risk score unchanged 4 x 3 = 12** **Target date March 2022** **Target score 4 x 2 = 8** **Above threshold**	• Phase 4 Grangewaters Ward/ Thorpe Ward – affected by delays to Cherrydown/ Kelvedon; works include refurbishing the ward to 16 single en-suite bedrooms. Work planned 21/22. Thorpe Ward will become a staff rest and change area with some offices, touchdown, meeting, conference and training rooms • Awaiting update 31/08
CRR34	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal	NH supported	Suicide Prevention	• Training is now virtual • Suicide prevention month provided a range of events and opportunities for learning for all staff	**Risk score to increase 5 x 3 = 15 (ET BAF August 21)**	• Exploring Connecting for People training virtual delivery • Improvement trajectory and reporting on suicide prevention training.

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
	patients resulting in self-harm or death and a failure to achieve our safety first, safety always strategy			• 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 • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT • Transparent monitoring through contracting • MH/LD network members discussion on Suicide Prevention Training • ET has approved a paper on moving to STORM training • Business case approved for training • Level 1 training in place for all staff (Zero Suicide Alliance Training) • Level 2 launching September as stop-gap to STORM trainers – being delivered by Psychology Services two workshops per month • Recruitment for STORM trainers at expression of interest stage – 1.5 WTE • Added to P&C Workforce DRR	**Target March 2022** **3 x 2 = 6** **Above threshold**	• Raise frequency of training and adherence to targets with workforce as budget/resource holder – continue dialogue • Cover required for appointed suicide prevention trainer for 12 months commencing late 2021 • Explore whether role can be moved to Nursing Directorate to provide closer support/management and oversight • Workforce to provide ET with further finance information on STORM training • Recruit 1.5 WTE trainers and service based trainers once finance agreed • Gain assurance that ongoing national OLM issue does not negatively affect training numbers – training tracker figures incorrect • Develop a quality improvement project to address the barriers on completing the suicide prevention training • NH - How to we make the transition to STORM training and what are the timelines? Increase score whilst the forecast projection is unknown. AW/AB/AH to work on a structured plan. NZ chairs the SPG but there is a need to look at the

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
						detail, what are the numbers, compliance and action. • STORM trainers being trained Nov-Dec 21 with a launch date Jan 22
CRR72	If EPUT does not have a suitable IT/communication systems in place for its STaRS and dual diagnosis services then patients may not receive appropriate care, treatment or medication, partners may not be able to access clinical records in a timely manner, and data integrity may be compromised, resulting in potential serious harm to patients, staff vulnerability and poor system working	AG	SSMG	• Auditing and monthly data cleansing exercises in place • Dual Diagnosis working group restarted and reviewing Policy and Procedure • Pilot in West using Pando for Consultants at Derwent Centre to ping each other drug and alcohol cases to check with STaRS • Continue to reinforce importance of Datix recording to map incidents and build evidence of problems • STaRS tender published	**Risk score unchanged 4 x 3 = 12** **Target March 23** **4 x 2 = 8** **Above threshold** **This is likely to be a stagnant risk for two years**	• Theseus does not constitute an official medical record as content may be deleted – numerous difficulties experienced with Theseus including non-connection to HIE and no access to prescribing activity - ECC advise Theseus 2.0 in development • Open Road not checking if patient known to MH and vice versa – poor system working and communication • Plan to move to SystmOne for prescribing • EPUT ITT working towards a resolution • Obtain implementation date from ECC for Theseus 2 • Publication of STaRS tender presents an opportunity for EPUT to mitigate this risk through the bidding process – bid under initial review • Awaiting IT update 31/08
CRR78	If EPUT does not manage the supply and use of blood collection tubes then requests for blood tests may not be fulfilled resulting in disruption to urgent care	TS supported by Executive Operational Leads	ESOG	• Recommended actions to optimise resources for pathology laboratory work circulated to Silver/Gold • Order levels to be maintained at normal levels with no stockpiling • Rotation of stock to avoid wastage	**Risk score 3 x 3 = 9** **Target Sept 21** **3 x 2 = 6**	• Encouraging add-on testing to reduce the need for blood tube usage • Follow guidelines on retest intervals • Optimise inpatient and assessment unit sampling

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
				• Orders managed through NHS Supply Chain for UK wide management • Training involving use of tubes to be delayed • Double tube practices to be halted • The products in stock are; KFK042, KFK112, KFK114, KFK117, KFK119, KFK171, and KFK233	**Above threshold**	• Reduce non-essential testing • National level work between DHSC, NHS Supply Chain and BD • NHSE/I instruction issued to reduce demand by a minimum of 25% for three week period up to 17 September 21 however this would be more applicable to acute hospitals • Nicole Rich designated as clinical lead for oversight
CRR79	If EPUT's alternative approach to season flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations	Natalie Hammond	Command Structure	• Project management in place • Clinical oversight in place • Plan in place to commence flu programme in September in conjunction with Covid boosters • Weekly task and finish group in place	**New risk Score 4 x 4 = 16** **Target March 22 Score 4 x 2 = 8** **Above threshold**	• Awaiting national and regional communications about approach • Ensure local measures as ready prior to programme starting • Encourage uptake of flu vaccinations in conjunction with offer of Covid boosters
Corporate Objective 3: Deliver our people agenda for 20/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors						
CRR14	If EPUT does not continue to work on staff morale then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	WTG	• Thank you vouchers sent to staff • Staff are saying they are tired and fatigued as opposed to having low morale • EPUT hero badges sent to all staff • Continue with Executive Team Live events	**Risk score unchanged 4 x 3 = 12** **Target March 2022 4 x 2 = 8** **Above threshold**	• Reviewing and refreshing communication strategies • Review retention strategies • Review promotion pathways • No update available
CRR 45	If EPUT does not achieve mandatory training policy requirements then patient and	SL supp.	Traini ng and	• Local trajectory in place for safety focused and IG mandatory training as a priority	**Risk score unchanged 4 x 4 = 16**	• Plan to return to recommended update training intervals

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
	staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements			• Monthly reporting to ET • National OLM issue resolved	**Target March 2022** **4 x 2 = 8** **Above threshold**	• All staff to ensure that mandatory training is up-to-date as soon as possible, including Information Governance and fire training for all staff and Grab Bag and TASI training for frontline colleagues • Managers are reminded to check training trackers and prompt staff whose training is overdue • Risk materialised on meeting the Information Governance Toolkit requirements – further work to be done in 2021/22

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				40	
	3			78 11	14 53 72	74 76
	4			34	45 48 68 77 79	
	5					

Agenda Item No: 8b(i)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 September 2021

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	BAF41 – Efficiencies (CIP's) BAF42 – Financial Plan & Covid
Does this report mitigate the BAF risk(s)?	Yes/ ~~No~~
Are you recommending a new risk for the EPUT BAF?	~~Yes/~~ No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To Request any further information or action.

Summary of Key Issues

- Matters Arising
- Local Counter Fraud Service
- External Audit
- EPUT Culture of Learning
- Fire Safety Audit Report
- National Cost Collection
- Draft Charitable Fund Accounts 2020/21
- Waiver of Standing Orders
- Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs
- Scheme of Reservation and Delegation (SORD)
- Standing Orders for the Board

- Audit Committee Chair's Annual Report
- Finance Policies and Procedures
- Losses and Special Payments
- Review of Standing Committees to the Board
- Provider Collaborative

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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

Acronyms/Terms Used in the Report			
SoRD	Scheme of Reservation and Delegation		
SFIs	Standing Financial Instructions		

Supporting Documents and/or Further Reading
Appendix 1 – Audit Committee Chair's Annual Report

Lead

Janet Wood
Chair of Audit Committee

Agenda Item: 8b(i)
Board of Directors Part 1
29 September 2021

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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 15 September 2021

The Audit Committee met on the 15 September 2021 and approved the minutes of the meeting held on 14 July 2021. These minutes are available to Board members on request.

At the meeting held on 15 September 2021 the following matters were discussed:

Matters Arising:

Risk Management Assurance Framework 2020/23
An extension to the above framework was approved by the Committee.

Governance Review & Accountability Framework
The above was discussed and noted.

1. **Internal Audit**
   Internal Audit Progress Report 2020/21
   The following reports have been finalised and are waiting for Executive sign off:
   - Complaints
   - Clinical Audit

   The following report has been issued in draft:
   - Inpatient Deaths

   Local Counter Fraud Service Progress Report

   Referrals
   The Committee received an update on the current investigations/referrals.

2. **External Audit**

   Appointment of External Auditors
   The Council of Governors approved the reappointment of the external auditors for the 5th and final year of their contract.

3. **EPUT Culture of Learning**
   The above was discussed and noted.

4. **Fire Safety Audit Report**

It was agreed that an update would be presented to the Committee in March 2022.

The above was discussed and noted.

5. National Cost Collection

The outcome of the National Cost Collection (NCC) for 2019/20 was noted, and the costing assurance action plan was discussed. The NCC for 2020/21 is due to be submitted on the 16 September 2021, this submission, with the indicative high level metrics were reviewed.

6. Draft Charitable Fund Accounts 2020/21

The Committee approved the submission for the above accounts to the external auditors.

7. Waiver of Standing Orders

During the period from 1 July 2021 to 31 August 2021, standing orders for competitive quotations were waived on three occasions to the value of £110,794.09 (including VAT). It was noted that one of these related to the mass vaccination to the value of £83,027.26. For the same period, standing orders for competitive tenders were waived on one occasion to the value of £2.6 million.

8. Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs

The Executive Chief Finance Officer has approved the write off of £1,997.16. This is in relation to historical balances in the Statement of Financial Position and un-reconcilable balances.

9. Scheme of Reservation and Delegation (SORD)

The Committee approved the changes to the above and agreed to recommend the SoRD as presented to the Board. This excluded Section 8A from the Joint Venture Agreement.

10. Standing Orders for the BoD

The Committee approved the minor changes to the above and agreed to recommend the Standing Orders to the Board for approval apart from Section 4.5.4.

11. Annual Review of SFI's 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

12. Audit Committee Chair's Annual Report

The above report was discussed and noted. The report is attached at Appendix 1.

13. Finance Policies and Procedures

The following Finance Policy and Finance Procedures were approved:

- FP09/03a Charitable Funds Policy
- FP09/03b Charitable Funds Procedure
- FP02/03 Cash Income Procedure
- FP04/01 Raising Invoices Procedure
- FP09/11 Credit Control Procedure

14. Losses and Special Payments

The report highlighted that as at the end of Month 5 the Trust is reporting losses and special payments of £2,147

15. Review of Standing Committees to the Board

It was agreed that the above would be discussed at an Extraordinary Audit Committee Meeting in November 2021.

16. Provider Collaborative

The above report was included for information. This may be included for discussion at the Extraordinary Audit Committee meeting in November 2021.

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 15 September 2021.
2. Confirm acceptance of assurance given in respect of risk.
3. Request further action/information as required.

Janet Wood
Non-Executive Director
Chair of Audit Committee

Appendix 1

Agenda Item No: 15

SUMMARY REPORT	AUDIT COMMITTEE PART 1	15 September 2021

Report Title:	**Audit Committee Chair's Annual Report for the Accounting Period April 2020 to March 2021**					
Executive/Non-Executive Lead:	Janet Wood, Chair of the Audit Committee					
Report Author(s):	Janet Wood, Chair of the Audit Committee					
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. Note 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 2020/21 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:

- Internal audit programme to support Safety First, Safety Always
- HSE Prosecution and independent inquiry
- COVID-19 and vaccination programme

Internal audit programme to support Safety First, Safety Always

The 2020/21 Internal Audit programme has been flexed significantly to ensure that it supports the Safety First, Safety Always strategy. This year there were audits of the design and effectiveness of fire safety, ligature risk management, Mental Health Act compliance, patient experience, safety alerts and safeguarding. There were no areas of limited assurance. A total of 16 recommendations were made and these are being implemented and monitored. The 2021/22 programme will continue to support the strategy.

HSE Prosecution and independent inquiry

The Audit Committee were regularly updated on the HSE prosecution and the impact of this in the 2020/21 Annual Accounts and financial targets. Following the announcement of the Essex Mental Health Independent Inquiry the Audit Committee has taken on a governance oversight role with regular updates.

COVID-19 and vaccination programme

The costs associated with COVID-19 have been subject to internal audit to assess that approval and reporting of COVID expenditure has been robust and compliant with national guidance. The Audit Committee has also reviewed the waivers to standing orders that have been necessary to deliver the vaccine programme. No matters of concern have been identified.

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 results report issued by the Trust's external auditors
- monitoring of recommendations from both internal audit and external audit reports
- review of the Standing Financial Instructions and related documents
- reviewing bad debt write offs and waivers to standing orders and standing financial instructions
- the receipt and debate of regular assurance reports
- receipt and debate of counter fraud reports from the counter fraud specialist
- receipt and debate of local security management services reports
- Clinical Governance, Clinical Audit, whistleblowing and Freedom to Speak Up reports presented to the Committee as appropriate
- approval of financial policies and procedures
- regular review of the Audit Committee's terms of reference
- regular update on the Audit Committee Chair's activities
- review the use of management consultants, legal advisors, losses and compensations and Directors expenses

The Audit Committee Chair continues to meet with the Trust's Accountable Officer regularly to discuss any issues arising from Audit Committee meetings. The Audit Committee Chair also meets with the appropriate Directors to review matters associated with assurance in relation to patient safety, quality, risk and assurance and governance. The Audit Committee Chair also meets regularly with both sets of Auditors for private discussions.

Relationship to Trust Strategic Priorities	
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**

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		Agenda Item No: 8b(ii)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

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

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

Purpose of the Report		
This report provides the Board of Directors: • Assurance to the Board that the duties of the Charitable Funds Committee have been appropriately complied with and adhered to.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. To confirm acceptance of assurance given in respect of risks and actions identified
3. Request any further information or action.

Summary of Key Issues

- Minutes of the meeting held on the 21 October 2020
- Report of the Financial Trustee
- Administration Charge
- Investment Policy
- NHS Charities Together Grants
- Annual General Bidding Round 2021/22
- Communications Plan

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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
Accompanying Report

Lead
Amanda Sherlock Non-Executive Director **Chair of Charitable Funds Committee**

Agenda Item: 8b (ii)

Agenda Item: 8b(ii)
Board of Directors Part 1
29 September 2021

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 9 September 2021 and approved the minutes of the meeting held on the 21 October 2020. These are available to Board members via Content Locker.

At the meeting held on 9 September 2021 the following matters were discussed

Report of the Financial Trustee
As at the end of July 2021, the overall charitable fund had a value of £1,122,937. The previous report presented to the Committee included the financial position as at the end of September 2020, which was £1,022,200, this increased to £1,038,358 as at the end of March 2021.

As at the end of the first four months of the 2021/22 financial year, the value of the fund has increased to £1,122,937.

Funds continue to be held in a mix of long term investments and short term deposits, with outstanding creditors of £8,809. This creditor includes the audit fee for previous and current financial years.

Administration Charge
The Council of Governors had previously requested a review of the administration charge, made by the Trust to the Charity, for the 2020/21 financial year which resulted in a small saving. The committee approved the administration fee of £26,788 for 2021/22.

Investment Policy
The investment of the charitable funds is supported by an Investment Policy which forms part of the Trusts Charitable Fund Policy (FP09/03). It was agreed by the Committee that Section 3, first bullet point, of the Investment Policy relating to “sufficient funds” should be made more explicit and amended accordingly.

The Charitable Fund Policy is due to be reviewed by the Audit Committee at their meeting on the 15 September 2021.

NHS Charities Together Grants
Stage 1 - The Charity has received £172.1k of NHS Charities Together funding. To date £168.3k has been committed. There are uncommitted funds of £3.8k held as a potential means of funding any suitable bids that may be submitted as part of the general bidding process.

Stage 2 - NHS Charities Together have also allocated £30 million to Stage 2 Community Partnership grants. Member charities are able to bid against these funds until the end of December 2021, with funds needing to be spent within two years of the award of the grant if successful.

A member of the Council of Governors and founder of the Mental Health Specialist for the Heads2Minds charity is in the process of preparing a bid for their charity work.

Stage 3 - The Trust has also successfully secured £42,000 of Stage 3 Recovery Funding from NHS Charities Together to support the extension of the Open Arts project, and is continuing to work with colleagues in staff engagement to enhance and resubmit a bid in respect of physical health improvements.

Annual General Bidding Round 2021/22
The Committee reviewed the available general funds and agreed to commence the annual general bidding round with a closing date for bids to be received on mid-October 2021.

Communications Plan
It was agreed to continue to focus on raising funds for the general fund and to promote staff raising money for the Trust's Charitable Funds via communications.

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 summary of the meeting held on the 9 September 2021
2. Confirm acceptance of assurance given in respect of risks and actions identified
3. Request any further information or action.

Amanda Sherlock
Non-Executive Director
Chair of Charitable Funds Committee

		Agenda Item No:8b(iii)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis, Chair of the Finance and Performance Committee					
Report Author(s):	Amy Tucker Senior Performance Manager					
Report discussed previously at:	Finance & Performance Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with details that: • 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. Assurance to the Board of Directors that the Finance and	**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

Inpatient & Community MH Benchmarking ONS Resident Population

The Executive Director of Operations & the Director of ITT discussed the results of the benchmarking report.

The Director of ITT brought to the attention of the Committee that of the 22 benchmarking standards, 15 were achieved, leaving seven requiring an action plan on how the services are going to address the standards not achieved. A focus group is being established to work on the findings of this report.

The Committee thanked the Executive Director of Operations and asked that an updated position is brought to the next meeting for further discussion understanding that this piece of work will need at least three months for completion.

Performance Report

The Executive Director of Operations updated the Committee on each of the inadequate performance areas, and gave the Committee assurance that each of the areas identified had an improvement plan and significant progress has been made in many of the areas identified. Many of the requiring improvement indicators were also discussed, and challenges faced by these areas are known and being addressed.

Performance and Quality

In August 2021 there were 5 areas of **inadequate performance** (6 in July):

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

Members of the Committee thanked The Executive Director of Operations and praised the excellent work that has been undertaken to achieve target on the CPA reviews KPI. Performance has witnessed a trend of improvement and all areas have met the target.

Financial Update – Month 5 Results

The Director of Operational Finance updated the committee on the month 5 results.

M5 Results

- £0.1m YTD deficit consistent with M4 results.
- Continued underspend on MHIS standards (£1.2m YTD). CCGs supporting wider investment in recruitment initiatives.
- Efficiency meetings have commenced with all Directorates. Trust is aligning efficiency reporting with ICS. Review of Governance and QIA process underway. Key focus is to identify recurrent efficiency plans prior to 22/23.

The Committee gave praise to the great work being undertaken on the Trusts finances and advised that recent work was well received by Region.

Facilities & Estates Plan

The Transformation Director for Estates & Facilities presented the key items to the Committee.
Members were pleased to hear the Estates & Facilities transformation work remains ongoing with focus being on driving up standards, quality, and improving services.

BAF Action Plan

The Interim Director of Risk & Compliance, provided an update to the Committee that three risks have been closed.

The Finance and Performance Committee agreed it now has responsibility for overview and scrutiny of five core risks.

Mandatory Training Report

The Executive Director of People & Culture and the Associate Director of Workforce Development presented four topics for the Committee to consider and review:

- OLM – problems with the use of OLM have now been resolved.
- Training Curriculum – comparison with neighbouring Trusts shows that we are very similar. The Committee agreed to make no changes to the EPUT curriculum.
- Training Tracker – the Committee has reviewed and agreed that the tracker will remain in use, and a move to ESR will not occur at present.
- Training update periods – A focus group is being established to review how we can improve accessibility to training courses and to look at investment that could be made to enable staff to complete their training in different ways and times. The Committee agreed to monitor and review the outcomes of the focus group.

Capital Update

The Director of Operational Finance updated the committee on the current system Capital.

ICS Capital

- ICS YTD capital spend is £18m, £0.4m overspent on plan (£1m overspend in Mid Essex and £0.6m underspend in EPUT). Organisations forecasting to spend £72m allocation.

EPUT Capital

- £1m of the Trusts annual Capital programme (£14m) remains available.
- Priority 1 Estates and Safety schemes have been identified. These schemes total £0.9m in 22/23 with a £1.1m impact in 22/23. The Schemes have been shared with the Capital Group, L30 and Exec's and have received support. See appendix 1.
- A request to progress these investments was supported with agreement to inform the Trust Board as part of the F&P Assurance update.
- It was noted that if additional capital becomes available either by new capital allocation or changes to existing schemes then addition/substitution priority requests may be required in the future.

The Committee noted the update given by the Director of Operational Finance.

Policy Extension Request

The Committee approved the extension of the policies & procedures listed below:

- Spiritual & Pastoral Care Policy
- ITT Purchasing Policy
- Virtual Private Network (VPN) Policy
- Purchasing Policy
- Travel & Business Costs Policy

Any Risks or Issues

There were no risks or issues identified.

Any Other Business

There was no other business.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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			
ITT	Information Technology & Telecommunications	CPA	Care Program Approach
MH	Mental Health	PICU	Psychiatric Intensive Care Unit
BAF	Board Assurance Framework	ESR	Electronic Staff Record
ICS	Integrated Care System	YTD	Year to Date

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Manny Lewis **Non-Executive Director** **Chair of the Finance & Performance Committee**

Agenda Item 8b(iii)
Board of Directors Meeting Part 1
29 September 2021

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

The Executive Director of Operations & the Director of ITT discussed the results of the benchmarking report.

The purpose of this report is to look at the benchmarking for 2019/2020 with a view to amend the Trusts existing targets in line with the national standards reported in the February 2021 Inpatient and Community Mental Health benchmarking report. The new targets pertaining to indicators within the Trust performance report have now been updated to reflect the new National benchmarks.

The Director of ITT brought to the attention of the Committee that of the 22 benchmarking standards, 15 were achieved, leaving seven requiring an action plan on how the services are going to address the standards not achieved.

It is pleasing to report that the number of standards identified as not achieved are already part of the Trust existing program for improvement.

The Executive Director of Operations informed the group that a focus group is being established to work on the findings of this report.

The Committee thanked the Executive Director of Operations and asked that an updated position is brought to the next meeting for further discussion understanding that this piece of work will need at least three months for completion.

2.0 Quality and Performance Report

This report covers the position for month 4 and month 5.

The report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using inadequate, requires improvement and Good as the principles for the prioritisation of focus. This report covers the position for months 4 and month 5.

Performance and Quality

In August 2021 there were 5 areas of **inadequate performance** (6 in July):

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

In August 2021 there were 11 areas **requiring improvement** (8 in July):

- Patient Harm Incidents
- Incident Reporting Rates
- MH Restrictive Practice

- Ligature Incidents (Adult & Older Adult)
- Cardio Metabolic Assessments / SMI
- Inpatient Capacity Older Adults
- IAPT – Access Rates
- Essex STaRS
- Perinatal
- Sickness Absence
- Temporary Staffing (Agency & Bank)

The Executive Director of Operations updated the Committee on each of the inadequate performance areas, and gave the Committee assurance that each of the areas identified had an improvement plan and significant progress has been made in many of the areas identified. Many of the requiring improvement indicators were also discussed, and challenges faced by these areas are known and being addressed.

The Executive Director of Operations also shared with the Committee that the activity contacts KPI has now been removed from the inadequate list. Discussions have taken place with the commissioners who are in discussions about what it can be replaced with.

Members of the Committee praised the excellent work that has been undertaken to achieve target on the CPA reviews KPI. Performance has witnessed a trend of improvement and all areas have met the target.

3.0 Financial Position – Month 5

The Director of Operational Finance, updated the Committee on the current financial position at Month 5:

M5 Results

- £0.1m YTD deficit consistent with M4 results.
- Continued underspend on MHIS standards (£1.2m YTD). CCGs supporting wider investment in recruitment initiatives.
- Efficiency meetings have commenced with all Directorates. Trust is aligning efficiency reporting with ICS. Review of Governance and QIA process underway. Key focus is to identify recurrent efficiency plans prior to 22/23.

H2 Planning

- H2 Guidance and allocations due 24 September.
- Current Regional and National expectations are the levels of efficiency targets and COVID reductions be lower than originally forecast (original 3%-3.5% efficiency and 5% reduction in COVID) respectively). Efficiency target will be set with a fixed 0.82% component and a discretionary target linked to original Financial Improvement Trajectories within ICS.
- On receipt of allocations the original Board approved plans will be compared to new H2 allocations including a reassessed efficiency requirement.
- Trust will produce a full mid year financial review to include impact of H2 allocations, risk and opportunities.

The Committee gave praise to the great work being undertaken on the Trusts finances and advised that recent work was well received by Region.

4.0 Facilities & Estates Plan

The Transformation Director for Estates & Facilities presented the key items to the Committee.

August has seen a reduction of reported tasks that were completed within the required timeframe. The impact of holidays and supply chain issues has doubled the number of "Overdue" tasks from July's reported data. Work is being undertaken to address this and ensure stability with these factors moving forward.

All PLACE audits have now been completed and the results will be uploaded once the portal is live. A planned Board report will highlight any issues that need attention as part of the departments continuous improvement ethos.

Members were pleased to hear the Estates & Facilities transformation work remains ongoing with focus being on driving up standards, quality, and improving services.

5.0 BAF Action Plan

Nicola Jones, Interim Director of Risk & Compliance, provided the following update to the Committee:

Since the last report to Finance and Performance Committee, the following risks are closed:

- BAF23 EU Exit Transition – no longer a risk and removed from command structure sitrep.
- BAF41 CIPS 2020/21 – replaced by BAF66 Efficiencies
- BAF57 HSE (financial risk) – new risks articulated around staff support and service recovery

The Finance and Performance Committee agreed it now has responsibility for overview and scrutiny of five core risks.

The new Strategic Objectives should be agreed and signed at the next Board meeting. A new format of the BAF report will then be published in November.

6.0 Mandatory Training Report

The Executive Director of People & Culture, and Anthea Hockly, Associate Director of Workforce Development, presented a number of topics for review by the Committee.

The mandatory training curriculum and its delivery is under regular review. All OLM issues have now been resolved. The Director of ITT, Business Analysis & Reporting confirmed this.

A comparison of the EPUT curriculum with those of neighbouring trusts shows that they are very similar. Some trusts do only report on a mandatory sub-section of their training but all of the curriculum is monitored internally. After discussion the Committee supported the decision that the Trust curriculum should remain as it is.

The Director of ITT, Business Analysis & Reporting and the Executive Director of People and Culture are working on a project to maximise the potential of ESR.

The Committee discussed the development of the Trusts existing ESR system and supported this approach. The Committee also agreed that the Training Tracker would continue to be used and reassessed at a later date alongside the use of the self service tools on ESR.

Discussions around returning to business as usual took place and the impact on staff. As a result the change to training update periods to those of pre-covid timelines has been postponed. A focus group is being established to review how we can improve accessibility to training courses and to look at investment that could be made to enable staff to complete their training in different ways and times.

The Committee agreed to monitor and review the outcomes of the focus group.

7.0 Capital Update

The Director of Operational Finance updated the committee on the current system Capital.

ICS Capital

- ICS YTD capital spend is £18m, £0.4m overspent on plan (£1m overspend in Mid Essex and £0.6m underspend in EPUT). Organisations forecasting to spend £72m allocation.

EPUT Capital

- £1m of the Trusts annual Capital programme (£14m) remains available.
- Priority 1 Estates and Safety schemes have been identified. These schemes total £0.9m in 22/23 with a £1.1m impact in 22/23. The Schemes have been shared with the Capital Group, L30 and Exec's and have received support. (see appendix 1)
- A request to progress these investments was supported with agreement to inform the Trust Board as part of the F&P Assurance update.
- It was noted that if additional capital becomes available either by new capital allocation or changes to existing schemes then addition/substitution priority requests may be required in the future.

The Committee noted the update given by the Director of Operational Finance.

8.0 Policy Extension Request

The Committee approved the extension of the policies & procedures listed below:

- Spiritual & Pastoral Care Policy
- ITT Purchasing Policy
- Virtual Private Network (VPN) Policy
- Purchasing Policy
- Travel & Business Costs Policy

9.0 Any Risks or Issues

There were no risks or issues identified

10.0 Any other Business

There was no other business.

Report prepared by:

Amy Tucker
Senior Performance Manager

On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No:8b(iv)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Quality Committee Assurance Report**					
Executive/Non-Executive Lead:	Rufus Helm, Non-Executive Director					
Report Author(s):	Gill Mordain, Strategic Advisor on behalf of Natalie Hammond, Executive Nurse					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report provides an update on assurance overseen by the Quality Committee against EPUTs performance related to patient safety and quality metrics. It incorporates a review of a number of risks that appear on the Board Assurance Framework and feedback from all Sub-Committees. The Committee found no new risks for escalation to appropriate structures.
State which BAF risk(s) this report relates to	BAF38 C19 Emergency Planning BAF 54 Learning Approach BAF 55 Independent Enquiry BAF45 CQC BAF63 Learning BAF10 Ligature Reduction
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	Yes
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
This report provides the Board of Directors with assurance on actions being taken by Sub-Committees to drive improvements in patient safety and progress key aspects of the quality agenda. It outlines risk and mitigation identified by the Quality Committee in relation to delivery against the Trust's primary Strategy, '*safety first, safety always'.*	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: • Note the content of this report • Confirm acceptance of assurance given in respect of actions identified to mitigate risks • Request any further information and or action.

Summary of Key Issues
The Quality Committee has reviewed the work of all Sub-Committees accountable to the Quality Committee. This report is provided to give assurance of the review, monitor and challenge initiated. Overall the Quality Committee has been given assurance that all work streams are in place and actions are being taken to mitigate risk. In addition, the Committee commended a number of areas for their best practice particularly in relation to Safeguarding and End of Life Care: • All Sub-Committee formal meeting arrangements continue to take place virtually as a result of COVID-19 • Assurance is provided that all Sub-Committees are delivering against agreed action plans and schedules of business • Positive progress continues against core areas of delivery • Corporate teams are focusing their efforts on supporting operational teams with both frontline delivery and putting arrangements in place to reduce risk • Against each Sub-Committee agenda, risks have been identified and where possible actions to mitigate have been taken • Due to the rapidly changing landscape, the scope of work is reviewed against each Sub-Committee and actions taken to mitigate risk on an ongoing basis • Resourcing was highlighted as an ongoing risk but it was noted that a large scale piece of work was being undertaken to improve recruitment and retention across services The Committee received a number of annual reports and commended the Trust's partnership working to keep populations safe, and noted that the Trust had been asked to present good areas of practice at a national level

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓

Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
EPUT	Essex Partnership University NHS FT	PD	Personality Disorder
PICU	Clinical Commissioning Group	SMI	Severe Mental Illness
ALOS	Average length of stay	CQC	Care Quality Commission
OPEL	Operational Pressure Escalation Level	BAF	Board Assurance Framework

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Rufus Helm **Non-Executive Director**

Agenda Item: 8b(iv)
Board of Directors Part 1
29 September 2021

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 8 July were agreed as a correct record.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting on 9 September 2021.

2.2.1 Combined Sub-Committee Assurance Report: The Committee received the report that gave assurance that all sub-committees were taking appropriate actions to mitigate risks. A number of elements of the report in relation to escalation of risk were challenged for increased assurance which were given by members of the Committee.

2.2.2 Quality Academy Update Report The Committee received an update on the Trust's journey in relation to Quality Improvement. It was noted that all Directorates have a quality improvement hub in place that were energizing the workforce to be involved in improvement work. Due to pressure of resources activity was currently being focused around patient safety priorities but all staff were being encouraged to continuously seek opportunities for improvement in relation to quality and safety. The Committee were advised that the Trust was building connections across other QI networks and were participating in a number of collaboratives and contributing to the development of system wide training programmes. The Committee were informed that with the exception of induction, face to face training appeared to have higher value and it was agreed, when circumstances allowed, face to face training would recommence.

2.2.3 End of Life Annual Report: The Committee received the annual report that sought to provide assurance that end of life care sought to enhance the quality of life in the face of death by addressing the physical, psychological, social and spiritual needs of patients with advanced diseases and their families. It was noted that delivery was continuing against the following six ambitions:

- Each person is seen as an individual
- Each person gets fair access to care

- Maximising comfort and well being
- Care is coordinated
- All staff prepared to care
- Each community is prepared to help.

The Committee were informed that Tower Ward had achieved the Gold Standards Framework confirming they were delivering a good practice model of end of life care. The hard work of the teams was recognised by the Committee noting that only three mental health Trusts had achieved this status. The feedback stories were noted positively, with recognition being given to the team for innovative work practices. Also Tracy Reed has been describing the outstanding work undertaken in the Trust nationally.

The Committee agreed that it would be helpful to have a presentation at the Trust Board in the near future.

2.2.4 EPPR Quarterly Assurance Report: The Committee received an assurance report providing an update on progress with all aspects of EPPR plans and processes across the Trust. It was noted that a command structure remains in place to manage the response to the pandemic with a control structure in place 7 days a week. The EU Exit Task & Finish Group had been meeting by exception although the requirement for highlighting any areas of concern on the Daily Sit Rep had ended in line with national guidance. BAF 23 had now been closed but for assurance purposes regular reporting will be managed through EPRR

The Committee were also given assurance in relation to training, receipt of NHSE Core Standards on 27 July 2021 and confirmation that the current compliance level for business continuity plans was at 84%.

2.2.5 CQC Assurance Report: The Committee received an update and assurance on the key CQC related activities that are being undertaken within the Trust. The Committee noted that all immediate actions required as a result of the unannounced inspection of CAMHS services in May/June 2021 were now complete although the Compliance Team continue to test action plans.

It was noted that a new compliance framework is under development with the aim to utilise available information to identify potential areas of non-compliance providing focus when undertaking site visits which will work alongside a new safety walk around process.

In addition, the Compliance Team have been focusing on the following areas:

- CAMHS support visits and auditing
- Intensive Clinical Support Group (CAMHS)
- Inpatient Support Group (Adult Acute, Secure Service and Older Adults)
- Action Plan Testing
- Ward Heat Maps/Internal Insight Indicator development
- Quarterly PHSO action plan testing
- Nursing Home deep dive review visit.

2.2.6 Mental Health Act Annual Report: The Mental Health Act Annual Report confirmed the Trust's commitment to ensuring the effective delivery of its statutory responsibilities across all service areas. The Committee acknowledged that the COVID-19 pandemic had tested the Trust's response to this agenda and commended the team on work undertaken in response to the Devonshire Judgement that decided that virtual mental health assessments could not be used when detaining patients

using the Mental Health Act. It was noted that moving forward the Trust has the following ambitions:

- To unify the clinical system to streamline Mental Health Act processes
- Embed a robust succession planning system to provide stability
- Continue developments to achieve recognition as a centre of excellence.

2.2.7 Safeguarding Annual Report: The report gave assurance that safeguarding of children, young people and adults is considered to be core business and is a shared responsibility with the needs for effective joint working between partner agencies and professionals.

The Committee acknowledged the challenges associated with the agenda and the ongoing increase in referrals primarily as a result of the pandemic. It was noted that the team had restructured, strengthening and improving arrangements in place. A number of key partners had commented on the work and support being provided by the team and the Committee acknowledged this as positive actions.

The report was accepted by the Committee and credit was given to the team for work undertaken and the partnership arrangements in place to protect local populations.

2.2.8 Ligature Update Report: The Committee received a report that gave an overview of the action that is currently underway and planned to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in-patient estate. It was noted that the Trust's internal independent auditors (BDO) had completed an audit in May 2021 and following receipt of the report actions to be taken have been agreed. The report had provided substantial assurance over the design of the controls and moderate assurance on the effectiveness of the controls. This provided the same assurance provided from the ligature risks audit undertaken in 2020/21.

Proactively the Trust invited East London Foundation Trust (ELFT) to undertake a peer review of ligature processes. Following completion of the audit a draft report has been received that is being reviewed by the Ligature Risk Reduction Group**.**

It was noted that the Ligature Policy and Procedure is being reviewed in line with new guidance and learning.

Of the 11 secured ligature incidents from 1 April 2021 – 30 June 2021 10 were rated low/minor harm. All involved a door being used to secure the ligature. In mitigation the Trust is ensuring door top alarms are in place and have successfully driven the roll-out of Oxehealth.

Embedding a culture of learning was a priority and it was noted that the Trust continues to provide bespoke TIDAL ligature risk assessment training delivered over 2 full days. To date 60 staff have completed the training programme.

2.2.9 BAF Action Plan Report: The Committee received an update on the Board Assurance Framework. Risks and action plans were reviewed along with current risk scores and status of target completion dates as at the end of August 2021. It was noted that since the Committee received the last report in March the following risks have been closed:

- BAF58 Record Keeping – new risk(s) in scoping process
- BAF64 CAMHS – new risk articulated.

A comprehensive update was given of all eight Board Assurance Frameworks

managed by the Quality Committee. The Committee were assured that a comprehensive approach to the management of risks was being undertaken but requested that a strong focus was taken in relation to outstanding risks.

2.2.10 IPC Board Assurance Framework: An update was provided of the previous report submitted to the Committee giving assurance on the position regarding infection, prevention and control during Covid-19 Pandemic. It was noted that the framework is a live and dynamic collection of evidence, risks, gaps and mitigation. The Committee noted that there was one gap in assurance relating to FFP3 provision as previously issued FFP3 stock expired at the end of March 2021; therefore, a programme of refit and replace is underway for those staff fitted to the expiring stock. Mitigating actions were confirmed inclusive of the recruitment of a fit test assessor.

The Lateral Flow Device programme for asymptomatic patient facing staff testing was confirmed to be ongoing. This will continue to be led by the DIPC and IPC team.

2.2.11 NHS Workforce Race Equality Standard (WRES) Annual Report: The Committee received the report that gave a comprehensive assessment of the risk of experience and opportunities from those of Black, Asian and Minority Ethnicity Groups in comparison to their white counterparts in the Trust.

It was concerning to note that there had been a decline in six of the nine metrics embedded within the standard but the Committee was assured that they could expect a steady progression over time on each metric. Actions required are in association with recruitment, formal disciplinary processes, bullying, harassment and discrimination.

The Committee were advised that it was imperative that action was required with immediate effect to reverse the negative experience of key members of the workforce.

2.2.12 WDES Annual Report: The Workforce Disability Equality Standard (WDES) provides feedback against a set of ten specific measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The Committee noted that there had been an improvement in seven of the ten metrics. Assurance was given that action plans are in place to ensure delivery against all standards. It was note that the Trust has in place Disability and Mental Health Network and Equality and Inclusion functions of the Trust.

2.2.13 Patient Experience Annual Report: The Director of Patient Engagement gave a verbal update in relation to driving engagement and involvement of individuals with lived experience with the development and delivery of services within the Trust. The Committee were advised that active engagement was taking place in relation to transformation and patient safety. The strategy and associated policies were being reviewed and the Committee would receive an update within a short timeframe.

2.2.14 Annual Senior Information Officer (SIRO) Annual Report: The Committee received a report outlining a summary of the activities and achievements of the Information Governance Team during the period April 2020 – September 2021. It was noted that the Information Governance team have built on previous successes and successfully implemented changes in legislation as a result of the Coronavirus Pandemic. The Committee were assured that information governance remains a priority within the Trust and appropriate actions are being taken.

2.2.15 Patient Story: The Committee were advised that due to redeployment of corporate resource to frontline teams a patient story had not been developed. It was

proposed that a story would be taken to the next Committee meeting regarding the transfer of an individual to Chelmer Ward**.**

2.3. Policies and Procedures

The Committee approved the following policies and procedures:

:

- CP43 Responding to External Visits
- CP72 Pseudonymisation Policy
- Lone Working Policy (RM17)
- Combined IGSSC Policies

Policy extensions were agreed for the following that had received approval from the Executive Team on 31 August due to an expiry date in September 2021:

- CLP56 NICE Implementation Guidelines
- CP34 Copying Letters to Patients Policy
- CP41 Dress Code (For Clinical and Non-Clinical Staff) and Uniform Policy
- SMS Text Messaging to Service Users Procedures
- ICPG1 (Infection Prevention & Control) Section 7 – Prevention and Management of TB
- ICPG1 Section 8 – Infestations
- Section 10 – Pets and Pests
- Section 11 – Decontamination of Mattresses
- MCP2 Mental Capacity Act & Deprivation of Liberty Standards (DoLS) Policy
- Assured Safe Catering Policy

2.4. Risks/Hotspots:

The Committee identified:

- No risks to be escalated to the corporate risk register
- No risks or issues to be raised with other outstanding committees
- Acknowledged pressure on the safeguarding team.

The Committee identified the following areas of good practice:

- Innovation and national engagement from the End of Life Team and principally Tracy Reed
- Good examples of commissioned audits and partnership working.

Report prepared by:
Gill Mordain, Strategic Advisor

On behalf of:
Rufus Helm, Non-Executive Directors/Chair of the Quality Committee

		Agenda Item No: 9(i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	29 September 2021

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Jane Cheeseman, Head of Compliance and Emergency Planning					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report outlines current response to Covid 19 national pandemic
State which BAF risk(s) this report relates to	• BAF38 Emergency Planning • BAF50 Skills Resource and Capacity • BAF42 Financial Plan • BAF43 Surge Planning • BAF44 Learning from C19
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors 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 are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1)
4. Request any further information and or action

Summary of Key Issues

Background

- The country has now been dealing with the corona virus outbreak for 18 months. The Trust's arrangements continue to be in place and are working effectively.
- A further decrease of prevalence across the country continues as we also see a complete reduction in the need for Covid beds within the trust.
- Nationally we remain at a level 3 incident response
- Covid rules were lifted for the general public on 19th July 2021 removing all legal limits on social contact with the exception of self-isolation following positive test or contact. The NHS remains with Covid-19 restrictions in place
- We remain aware that the virus is still in general circulation
- We continue to monitor prevalence amongst our patients and staff

Command Structure

- The Gold, Silver and Bronze Command meetings have been stepped up to twice weekly joint and an additional Gold command once per week.
- The (virtual) Incident Control room operational times continue to run 8am until 6pm 7 days a week
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.
- 14 individuals now hold the full Strategic Command training certificate. In addition a further 10 staff have been scheduled to attend the training in 2021 which will provide the Trust with 24 'Gold Command' trained individuals.

Impact to Date

- There have been 2 reported outbreaks in the period within the trust both of which have since been closed
- There have been no further reported patient or staff deaths as a result of Covid-19 since last reporting
- At time of writing we have a total of 39 staff off sick due to Covid-19 and there are 3 Covid-19 confirmed patients
- The Trust Committee and Governance Structures have now fully resumed through the utilisation of Microsoft Teams.

Trustwide Response

- From the 23rd August 2021 staff are to source a personal supply of Lateral Flow Tests (LFT) from the Gov.uk website and results are to be reported onto the Government portal, staff are to continue with the twice weekly testing.
- Staff can now evidence their vaccination status via the launch of the NHS App.
- There has been updates to the Covid-19 testing, 'stay at home and return to work' guidance for staff who are double vaccinated to facilitate a potential reduction in requirement to isolate and thereby supporting the staffing pressures.
- The quarantine and isolation following travel abroad has led to a change in the trust travel guidance covering what is required when arriving in England from abroad and reminding staff of the need to consider the annual leave requirement to cover isolation time if required
- There has been a national supply disruption to blood collection tubes from Becton Dickenson with a requirement to identify a clinical leader and single point of contact for this incident. EPUT identified the Acting Director for Health and Care Delivery, West Essex. The impact on EPUT is currently minimal
- Preparation continues for the Covid-19 Statutory Inquiry commencing next spring 2022 and actions have been build into BAF 38 Emergency Planning document. A requirement of the statutory inquiry was to identify a single point of contact which has been confirmed as the Executive Director of Special Projects who is also the Accountable Emergency Officer (AEO).
- The government has issued an open consultation on the mandatory vaccination of all staff which closes on 22nd October 2021. Staff have been advised of the consultation and are encouraged to respond directly.

Communication

- Decisions made by the Command meetings and any changes in guidance continue to be communicated to all staff through the regular production of the Live briefings and the Wednesday Weekly publication

Risks

- There is 1 extreme risk open on the Covid 19 Risk Register (Skills, Resource and Capacity) with controls in place.

Learning

Learning continues to be a key part of the Trust response to Covid-19 and a number of activities are continuing to take place, alongside some new initiatives to support our staff such as:

- The launch of a new website offering free and immediate access to support from our mental

health specialists in response to the COVID-19 pandemic. The website, www.covidwellbeingsupport.com features a series of self-help videos put together by psychologists and therapists from our Therapy for you (IAPT) and Clinical Health Psychology teams.

- In partnership with online mental health platform Omnitherapy, we have also launched the videos share tools and techniques to help people better struggling with the impact of COVID-19 and the challenges they may be facing.
- Continual reminder of IPC process' to ensure staff do not become complacent and maintain low level of Covid positive cases.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.			✓
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading
Covid Assurance Report Gold Command Covid Risk Register Summary (Appendix 1)

Lead
Paul Scott **Chief Executive Officer**

Agenda Item 9(i)
Board of Directors Part 1
29 September 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

Purpose of Report

The purpose of this report is to provide an update on how the Trust continues to respond to the Covid-19 pandemic, and assurance that the actions being taken are mitigating the risks identified.

Background

The country has been dealing with the corona virus outbreak for over 18 months and the Trust's arrangements continue to be in place and working effectively. Nationally we remain at a level 3 incident response and regional prevalence has seen a decrease in trend of Covid numbers and Covid sickness along with a decrease seen in the R and Growth rate for East of England.

The Government lifted Covid rules for the general population on 19th July 2021 removing all legal limits on social contact with the exception of self-isolation following positive test or contact. Yet, the NHS remains with Covid-19 restrictions in place and we remain vigilant to the fact that the virus is still very much in general circulation. As such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

Command Structure

In line with a slight increase in activity since last reporting the command structures have increased with a joint Silver and Gold command meeting now twice weekly on a Monday and Thursday. Bronze command meetings continue to mirror these. In addition, there is now a stepped up Gold Command held on a Tuesday to ensure decisions made and information received continues to cascade through the organisation, and that we are responsive to changes required.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre. This is mainly covered by the Compliance and Assurance Directorate with the additional help of other corporate staff on a rota at the weekends buddied by the EPRR leads for support and on call should there be any areas for escalation or Covid-19 Patient Notification System (CPNS) death reporting required.

The regular sit rep submissions required by the Centre continue, namely the National Covid daily sit rep, Community discharge daily sit rep, the regular Lateral Flow Testing numbers, monthly community sit rep and more recently Long Covid activity.

The incident control inbox continues to receive the national and regional information/guidance alongside a wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through we are able to remain responsive. Any national/ regional guidance, information and/or requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response.

The equalities network leads continue to have a presence at the command meetings to ensure that issues are captured and a reflection on risks and impact is undertaken to safeguard that no staff group is adversely affected by decisions made.

The Strategic Command training offered for all staff that have a command role has been booked for 2021 for those staff who require either a full or refresher course. To date EPUT currently have 14

individuals that hold an in date 'Gold Command' training certificate. In addition a further 10 staff have been scheduled to attend the training in 2021 which will provide the Trust with 24 'Gold Command' trained individuals.

Impact to Date

Since last reporting in July 2021 there has been a slight increase in our reporting of Covid-19 positive cases for staff. At time of writing, we currently have 3 Covid-19 confirmed patients within our services and a total of 39 staff off sick due to Covid-19 related illness which is an increase from 19 at last report.

Since early March 2021 we have not had any further patient deaths to report onto the Covid-19 Patient Notification System (CPNS).

Since last reporting, we have had 2 outbreaks declared to Public Health England both of which have since passed the 28 day period and therefore have now been closed from outbreak status. To note an outbreak is classified by PHE when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred. All processes for an outbreak are followed as advised through joint meetings with NHSE, CCG's and PHE.

The regular lateral flow testing of both our patients and asymptomatic staff continues across the trust and the Trust Committee and Governance Structures have all resumed through the continued utilisation of Microsoft Teams on a virtual basis.

Trustwide Response

There has been a number of Trust wide changes in line with guidance received such as;

From the 23rd August 2021 staff are now responsible for sourcing a personal supply of Lateral Flow Tests (LFT) from the Gov.uk website. The Infection Prevention and Control team (IPC) are no longer distributing the LFT's with the last supplies used and only a small supply of tests held for emergency use. Staff are to continue with the twice weekly testing and the results are now to be reported onto the Government portal.

The launch of the NHS App means that staff can now evidence their vaccination status via the app. This is important in light of the recent guidance for all care home staff to be vaccinated along with the implementation of the double vaccination requirements. The Human Resources team are running a project to analyse if there is a staffing impact.

There has been an update to the Covid-19 testing, 'stay at home and return to work' guidance for staff who are double vaccinated to facilitate a potential reduction in requirement to isolate and thereby supporting the staffing pressures.

The quarantine and isolation following travel abroad has led to a change in the trust travel guidance developed for staff covering what is required when arriving in England from abroad and reminding staff of the need to consider the annual leave requirement to cover isolation time if required when returning from travelling abroad.

There has been notification of a supply disruption in relation to Becton Dickinson (BD) Blood Specimen Collection Portfolio along with an alert issued by NHSE advising of significant supply issues with blood collection tubes. As a result the system call for partners was stood up in order to brief on the current position agree any further actions or mitigations that are required to support the local system and identify any escalations or asks of Region. There was an ask to confirm a clinical leader and single point of contact for this incident. EPUT identified the Acting Director for Health and Care Delivery, West Essex.

A review of products ordered by EPUT has been undertaken to identify any order not fulfilled or are

out of stock. There has only been 3 products affected none of which were high volume lines and are now reported to be back in stock, therefore the impact on EPUT is currently minimal. We continue to provide any data requests from the system where applicable to EPUT and continue to attend the system partner meetings and monitoring of the incident cascading information through our incident control centre and command meetings.

As previously reported it has been announced that there will be a Covid-19 Statutory Inquiry commencing next spring 2022. This is part of an entire Government response, UK wide and has been built into our BAF 38 Emergency Planning document. A requirement of the statutory inquiry was to identify a single point of contact which has been confirmed as the Executive Director of Projects who is also the Accountable Emergency Officer (AEO). Preparation for the Statutory Inquiry is underway and we are currently promoting awareness of various media methods that could be called as evidence including retrospective personal and team WhatsApp, MS Teams and Pando messages.

The government has issued an open consultation on the mandatory vaccination of all staff in the health and wider social care sector. The consultation closes on 22nd October 2021 and proposes that, if introduced, requirements would apply to staff with face-to face contact with patients though the delivery of services as part of a CQC regulated activity. Staff have been advised of the consultation and are encouraged to respond directly.

Communication

Decisions made by the Command meetings and any changes in guidance continue to be communicated to all staff through the regular production of the Live briefings and the Wednesday Weekly publication.

The success of the weekly Live events and time hosted by the Chief Executive Officer with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives. In addition to this there has also been the implementation of frequent virtual events made available to support staff and their wellbeing.

Risks

The Trust Covid risk register has remained a live document with the risks constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. There are currently 1 Extreme Risk, 11 High Risks and 9 Medium Risks open.

The major risk currently facing the Trust continues to be in regards to Skills, Resource and Capacity; the following mitigating action/controls have been noted:

- Participation in system calls
- Command structure in place for Covid19
- Project Board in place for mass vaccination programme
- Creating resilient teams
- Continuous improvement work stream as part of Safety First, Safety Always Strategy
- Collective leadership – identifying senior talent, succession planning and Quality Champions
- Leadership handbooks
- Robust and forward thinking Executive Leadership Team
- Programme Management Office related to Safety First, Safety Always Strategy
- Preparation for Independent Inquiry
- Transferring Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 30 transferred as at August
- PID in place

Learning

Learning continues to be a key part of the Trust response to Covid 19 and a number of activities as reported previously are continuing to take place, alongside some new initiatives to support our staff such as:

- The launch of a new website offering free and immediate access to support from our mental health specialists in response to the COVID-19 pandemic. The website, www.covidwellbeingsupport.com features a series of self-help videos put together by psychologists and therapists from our Therapy for you (IAPT) and Clinical Health Psychology teams.

- In partnership with online mental health platform Omnitherapy, we have also launched the videos share tools and techniques to help people better struggling with the impact of COVID-19 and the challenges they may be facing.

- Continual reminder of IPC process' to ensure staff do not become complacent and maintain low level of Covid positive cases.

Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1)
4. Request any further information and or action

Report compiled by:
Jane Cheeseman,
Head of Compliance and Emergency Planning

On Behalf of

Paul Scott
Chief Executive Officer

Table 1 – COVID RISK REGISTER 2021/22 Summary of Risks as at August 2021

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

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	NL	Finance and Performance	Monitoring/ Covid19 Action Log - Command Structure	• Business Continuity Plans in place and undergoing constant review • Command structure in place • Sit rep daily monitoring • Covid intranet page and range of staff training in place • Covid dashboard issued weekly to monitor prevalence • Action plan developed and approved by ESOG with Covid19 assurance report • Executive Lead for Emergency Planning confirmed as NL as well as single point of contact for Covid Inquiry • Non-Executive Lead for Emergency Planning in place • Paper on lessons learnt taken to Executive Team and disseminated more widely including next steps for new ways of working • Promoted awareness of rules around use of new medial methods which can be called as evidence for inquiry	**Risk score remains at threshold 5 x 2 = 10** **Target date – ongoing throughout pandemic**	• Prepare for Covid19 Statutory Inquiry

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF50	If EPUT does not have the skills, resource and capacity to deliver on high quality care and other wide ranging priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	PS and all Executives	PIT	Action Plan to be developed for 2021/22	• Participation in system calls • Command structure in place for Covid19 • Project Board in place for mass vaccination programme • Creating resilient teams • Continuous improvement work stream as part of Safety First, Safety Always Strategy • Collective leadership – identifying senior talent, succession planning and Quality Champions • Leadership handbooks • Robust and forward thinking Executive Leadership Team • Programme Management Office related to Safety First, Safety Always Strategy • Preparation for Independent Inquiry • Transferring Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 30 transferred as at August • PID in place for staffing project	**Risk score unchanged 5 x 4 = 20** **Ongoing for duration of pandemic** **Threshold 5 x 2 = 10**	• Develop new strategic and corporate objectives for 2021/22 and articulate risks to achieving those • Newton diagnostics to ensure systems and processes are effective • Bolstering staffing and project support as required • Redefining Executive portfolios to best manage services and resources • Develop a new action plan for 2021/22 • Transfer Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels – 1000 under consideration • Prioritise areas as new staff are appointed • Scope high risk areas with staffing difficulties for impact on incidents • Consider dedicated permanent resource to meet changing ward needs • Develop a plan that illustrates BAU vs project work underway • MHOST review

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
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	TS	F&PC	Monitoring through finance meetings	• The Trust's 21/22 financial plan has been set to deliver a breakeven position. The plan includes £8.1m of Covid allocation for H1. • Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board will continue. • Continue to monitor financial situation, Covid19 and Mass Vaccination costs to ensure recovery. • Efficiency requirements are included in the financial plan and schemes under development. Some internal schemes developed and others in development alongside combined work with ICS and NHSI/E. • The ICS has also undertaken a financial sustainability exercise. Year to date M12 Covid19 costs of £16.2m with M7-M12 recovery anticipated from M&SE and H&CP • Planning for anticipated reduction in system monies of 3.5%	**Risk score unchanged 4 x 3 = 12** **Target April 2021 Threshold 4 x 2 = 8**	• The financial settlement for H2 are not finalised and will be informed by future National Guidance

BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SNEE	NL	Quality	Monitoring by Project Management Group	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Programme Board in place • Working in partnership, with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Clinical oversight and governance in place at all vaccination centres • All costs passing through NHSE and laptop costs supported by skill mix work • Robust communication in place with vaccination centres • Good coverage in both MSE and SNEE with robust joint working (rationale for reducing consequence to 4) • Moving towards phase 3 preparation for mainstreaming the vaccination programme to become business as usual • 'Big weekender' event 4,500 people were contacted inviting them for earlier appointments and second doses brought forward where feasible • No licences being extended as part of phase 3 • Pre-assessment model developed by EPUT now approved by Region • Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses • Maintaining workforce at vaccination centres (and other delivery centres) with forward planning to identify workforce challenges • Maintaining vigilance and awareness on security and potential criminal activity at vaccine sites	**Risk score unchanged 4 x 3 = 12** **Target date is ongoing for the duration of the mass vaccination programme** **Target 4 x 2 = 8**	• Implement phase 3 from early September to late February 22 in line with national guidance • Maintain watching brief on variable vaccine supply and impact on programme • Assessment of recently published national security guidance to draw out any actions

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG19	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	NH	Quality	Monitoring by Command Structure	• Assurance visits being undertaken and clinically held action plans • IPC Board Assurance Framework (national document) updated bi-monthly • New guidance reviewed and implemented through Command structure as received • National recommendations derived from other organisations during C19 are reviewed against EPUT measures • C19 secure procedures are in line with IPC guidance • IPC Dashboard developed to monitor potential risk areas	**Risk score at threshold 4 x 2 = 8** **Ongoing**	• None identified
CVG33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	Quality	Monitoring by Command Structure	• Plan in place for the ongoing requirement for fit testing • Appointed to fixed term role so Fit Testing programme has a sustained resource	**Risk score 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• Review of plan
CVG51	If EPUT staff do not follow the rules and guidance issued around PPE then there will be breaches resulting in the potential for outbreaks and related staffing issues and harm to patients	NH	Quality	Command Structure	• Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc. • Training including PPE Self-Assessment • Policies and procedures • Appropriate access to PPE with no incidents • Responded to alerts • Command continually updated on PPE use and stock levels	**Risk Score to reduce 5 x 2 = 10** **Ongoing** **Target 5 x 2 = 10**	• Continue with vaccination programme for patients and staff • Continue reminders around PPE

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG37	If EPUT does not maintain Covid-19 secure risk assessments then premises may not conform to guidance resulting in a possible spread of infection	PS	Quality	Command structure	• Covid19 Secure risk assessments completed locally and reviewed by a member of risk team before approval • Datix is monitored in order to pick up any risks	**Risk score 4 x 3 = 12** **December 21** **Target 4 x 2 = 8**	• Identification of buildings where assessments not yet complete • Develop process for managing the out of date secure risk assessments
CVG10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	TS	F&PC	Command structure	• Capital projects continuously under review • Building contractors have returned to BAU • No delay identified and no significant risk to future programme • Situation continues to be managed	**Risk score 3 x 3 = 9** **Ongoing** **Target 3 x 2 = 6**	• Contractors working within social distancing guidelines still an issue
CVG45	If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff	TS	F&PC	Command structure	• Procurement put in place alternative storage arrangements whilst there was an issue with the contractor • Contact maintained with contractor • Environment agency are aware of any issues and understand the necessity to store waste on site in locked cages • Team of clinicians, risk management, infection control and estates set up to market test the service	**Risk score at threshold 4 x 2 = 8** **Target March 22** **Ongoing**	• Facilities continue to monitor the situation around issues with collection of clinical waste during the second wave • Specification for total waste contract (following extension to April 2022) will be reviewed along with Risk and Infection Control to take the service out to the market as a combined service or separately • Carry out market testing using multi-disciplinary team

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG48	If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing	NH	Quality	Command structure	• Staffing risk assessment completed with identified mitigating actions • NHS Lateral Flow Testing Webinar attended • Range of learning from other Trusts produced regionally • Weekly Task and Finish Group and Project Team to ensure project continues with phase 3 roll out • Dashboard monitoring • Nationally moved to staff sourcing own LFT from Government and recording onto Government Website	**Risk score 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• Some gaps in staff reporting their LFT • Continue to monitor
CVG52	If EPUT does not have sufficient resource/ finance to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme	NH	Quality	Command structure	• EPUT distributes Covid19 swab testing kits for asymptomatic patient facing staff • Page dedicated to asymptomatic testing on InPut including video guides, manager action lists, FAQs and self-testing guide • Live event held on asymptomatic testing including the video • Daily submission using form on InPut to report on LFT for the previous day, 7/7. • Delivering phase 3	**Reduce risk score to threshold 4 x 2 = 8** **Ongoing** **Target 4 x 2 = 8**	• Gain clarity on continuation of funding for asymptomatic testing • Assess what business as usual will look like – asymptomatic testing may be commissioned with EPUT to fund
CVG55	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/ virtual support and potential harm to patients	AG	Quality	Command structure	• Mitigation in place for swabbing, lateral flow testing on wards • ICP Dashboard developed to help identify wards at potential risk • Daily sit reps provide information on any Covid positive patients/Staff • Outbreak management process in place • Extend completion date in line with national lockdown easing	**Reduce Risk score 5 x 2 = 10 at threshold** **June 21** **Target 5 x 2 = 10**	• Continue to revisit this risk following lifting of restrictions

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH	Quality	Command structure	• Competency skills assessment carried out in wave 1 reviewed • IPC competency self-assessments • Covid care pathway document in place and updated with any new guidance	**Reduce risk score to threshold** **5 x 2 = 10 at Threshold** **Ongoing** **Target** **5 x 2 = 10**	• Continue to review training in line with national guidance
CVG46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes (following NHS mail national update) then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns	TS	F&PC	Command structure	• ITT working with NHS Digital to resolve this issue for EPUT • Staff have been reminded to check their junk email boxes for any important missed information • Changes to the NHS Mail junk filtering configuration made to minimise the likelihood of legitimate emails being marked as spam/ junk	**Risk score reduced** **4 x 2 = 8** **June 21** **Target** **4 x 1 = 4**	• Maintain watching brief • Changes to the NHS mail junk filtering configuration has demonstrated to have significantly reduced the volume of legitimate emails going into junk – continue to monitor
CVG57	If EPUT continues to experience delays in staff Covid investigations then RIDDOR submissions may be may more than 12 months late resulting in failure to comply with regulations and manage staff safety	NH	Quality	Command structure	• In May IPC took over responsibility for staff Covid sickness investigations to confirm if RIDDOR reportable • Regular RIDDOR outcome meetings in place to agree submissions • Additional resource in place to support investigation • Draft letter to HSE • Presented paper to Executive Team with actions to resolve the issues	**Risk score** **4 x 4 = 16** **Ongoing during C19 crisis** **Target** **4 x 2 = 8**	• Volume of outstanding investigations to be addressed • Regular reporting to Silver Command • Communications to staff and HSE being discussed with legal team • Met with legal adviser and agreed that any staff member involved in an outbreak and contracted Covid-19 will have RIDDOR process instigated • Update SOP in accordance with legal advice

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVS3	If EPUT does not respond appropriately to Government guidance on clinically extremely vulnerable people then those with underlying health conditions may be missed resulting in the potential for serious illness	NH MK AG	Quality	Command structure	• National guidance on clinically extremely vulnerable people ceased on 1 April 21 • Staff risk assessments updated • New guidance published on 20th September 2021 ends shielding for clinical vulnerable people	**Risk score at threshold 3 x 2 = 6** **Ongoing**	• Close Risk
CVS27	If EPUT is unable to maintain management oversight for the backlog of incidents on Datix then some more serious incidents may slip through the net resulting in no investigation taking place or action being taken	PS	Quality	Command	• Business as usual management oversight reinstated on 1 October 20 • Routine monitoring in place • Monitored via HSSC and will be part of new Accountability framework and ward heat maps. No longer a Covid management risk.	**Risk score 3 x 3 = 9** **Target passed Target score 3 x 2 = 6**	• Close Risk
CVS29	If EPUT staff do not comply with Covid-19 requirements and Covid Secure arrangements then the safety of patients and colleagues are put at risk resulting in a dip in staff morale, the potential for increased cases and the CQC requesting significant improvements	AG	Quality	Command structure	• Number of outbreaks has reduced to zero • Reduction in breaches of Covid secure • Local guidance in place • Ensuring continuous rigour of PPE and IPC is reinforced through Bronze command	**Reduce risk score to threshold 4 x 2 = 8** **Ongoing**	

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVS30	If EPUT does not manage the levels of fatigue within the organisation then sickness levels may rise resulting in a failure to deliver services in a safe way	SL	PIT	Command structure	• Wobble rooms where practicable • Take a break initiative promoted • Annual leave guidance updated • Wellbeing events and mindfulness • Wellbeing Festival Summer 21 • Rest nest sessions • PULSE survey to be reinitiated August 21 • Discussions at Senior Leadership Team • Refocus on the environmental factors that are affecting staff stress levels e.g. excessive workloads and demands	**Reduce score to 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• Continue to encourage staff to take up offers of online support • Senior and local leaders to address environmental factors affecting staff morale and wellbeing through discussion focus • Commitment to transfer bank and agency staff to permanent posts • Full establishment review
CVS25	If EPUT is unable to meet the rehabilitation needs of Covid-19 patients in recovery then their recovery from Covid-19 may be delayed, resulting in possible adverse health and socioeconomic outcomes for the patient and associated impacts on their families & carers.	AG	Quality	Command structure	• National and local guidance in place on Covid rehabilitation • Piloting 'Living with Covid' Recovery App from AHSN for the West Essex Long Covid assessment service – has evidenced outcomes in supporting access and flow in Covid assessment services • AHP led Fatigue management training delivered in EPUT and on behalf of partners • Other Long Covid services led via respective ICS systems in Essex all governed by a regional approach with second funding imminent to support all systems	**Reduce score to threshold 4 x 2 = 8** **Ongoing** **Target 4 x 2 = 8**	• Continue engagement with ICS/ STP workstreams regarding Covid recovery • Continue collaborative work to address gaps in knowledge and skills • Work with partner agencies across Essex to devise treatment plans • Staff issues re Long Covid covered by support groups and continuous monitoring of data

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			CVS3	CVG19 CVG45 CVG46↓ CVG52 CVS25	BAF38 CVG24 CVG51↓ CVG55↓
	3			CVG10 CVS27	BAF42 BAF51 CVG33 CVG37 CVG48 CVS30	
	4				CVG57 CVS29	BAF50
	5					

		Agenda Item No: 9(ii)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Ligature Risk Management Q1**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Jane Cheeseman, Head of Compliance and Emergency Planning					
Report discussed previously at:	Health Safety and Security Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report	
Summary of Risks highlighted in this report	See below BAF10
State which BAF risk(s) this report relates to	BAF10 - If EPUT does not reduce ligature risks then serious incidents will occur resulting in a failure to deliver our Safety First, Safety Always ambitions
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors 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 Board of Directors is asked to:

- Discuss the contents of this report
- Identify any further actions required.

Summary of Key Issues

Independent Assurance

The Trust's internal independent auditors (BDO) completed an audit in May 2021 that focussed on implementation of the Ligature Risk Assessment and Management policy and procedure. BDO were able to provide the Trust with substantial assurance over the design of the controls and moderate assurance on the effectiveness of the controls. An action plan has been developed overseen by the Ligature Risk Reduction Group. This reflects the same assurance provided from their Ligature Risks audit undertaken remotely in 2020/21.

The CQC are currently updating the previous 2020 briefing guide for inspection teams, once the revised guidance is available, a review against the criteria will be undertaken to provide assurance of the trust position against meeting the new or updated criteria.

The Trust has invited East London Foundation Trust (ELFT) to undertake a peer review of Ligature processes. This review has been completed and a draft report received. There are a

number of recommendations for consideration that are being considered in detail by the Ligature Risk Reduction Group.

Governance
The Ligature Risk Reduction Group (LRRG) continues to be held each month; chaired by the Executive Chief Operating Officer. Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

The Ligature Policy and Procedure has continued to be reviewed as new guidance and learning is published.

Ligature Environmental Risk Assessments of all MH and LD wards continues undertaken by a team of professionals from H&S, Estates and the Ward. A review of the assessment tool has been undertaken to ensure this considered all national safety alerts when received and the new electronic assessment tool has been approved and implemented. Actions identified are shared with the Ligature Risk Reduction Group who monitor until completion.

Ligature risk remains on the BAF 10 and the full action plan continues to be reviewed and monitored regularly.

Continuous Learning - Ligature Incidents
The Ligature Risk Reduction Group continues to receive incident analysis to identify learning and review national and local safety alerts.

Enhancing Environment
The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. The trust has also instigated a project team looking at the trust standards and how these can be applied universally across the inpatient estate.

Culture - Staff Training
The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards. The uptake of the training is monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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	LRRG	Ligature Risk Reduction Group
CQC	Care Quality Commission	ELFT	East London Foundation Trust

Supporting Documents and/or Further Reading
Ligature Report Q1

Lead
Paul Scott **Chief Executive Officer**

EPUT

LIGATURE RISK MANAGEMENT

1.0 Introduction

This report provides the 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. Reports on the action that has been taken are provided regularly to the Board of Directors. This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning. It also has to be recognised that the Trust's inpatient environments (consistent with many providers of mental health services) will rarely be entirely free of fixed ligature points because most were not designed to mitigate the potential risks being identified currently and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 Independent Assurance

Internal Audit

The Trust's internal independent auditors (BDO) carried out an audit between the 10th and 20th May 2021 that focussed on the operational ward and staff compliance with Ligature Risk Assessment and Management policy and procedure. The audit incorporated visits to 16 of the trusts inpatient mental health wards. A final report has been produced advising that overall, BDO were able to provide the Trust with substantial assurance over the design of the controls and moderate assurance on the effectiveness of the controls. This reflects the same assurance provided from their remote (due to Covid19) Ligature Risks audit undertaken in 2020/21.

Good practices were acknowledged and a number of recommendations made to consider for both the inspection team and operationally at ward level. These are being taken forward by the Ligature Risk Reduction Group with an implementation date of December 2021.

CQC New Inspection Criteria

The CQC are currently updating the previously reported 2020 briefing guide for inspection teams. As soon as the revised guidance is available, a review against the criteria will be undertaken to provide assurance of the trust position against meeting the new or updated criteria.

ELFT Review

EPUT has been working with East London Foundation Trust (ELFT) to undertake peer reviews.

The purpose of the ELFT review is to identify improvements that could be made to EPUT ligature processes through shared learning with ELFT. The review was undertaken at the end of March 2021 with onsite ward visits to assess the environments and to compare processes followed in the two organisations.

A draft report has been received from ELFT giving the opportunity for factual accuracy checking which has been completed with no material changes identified. The report has been considered in detail by the Ligature Risk Reduction Group, Executive Safety Operational Committee and the Quality Committee. The report highlights good practice and provides some recommendations for EPUT to consider.

3.0 Governance

The Ligature Risk Reduction Group (LRRG) continues to be held each month; chaired by the Executive Chief Operating Officer. Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

The Ligature Policy and Procedure has continued to be reviewed as new guidance and learning is published.

Ligature Environmental Risk Assessments of all MH and LD wards continues undertaken by a team of professionals from H&S, Estates and the Ward. A review of the assessment tool has been undertaken to ensure this considered all national safety alerts when received and the new electronic assessment tool has been approved and implemented. Actions identified are shared with the Ligature Risk Reduction Group who monitor until completion.

As previously reported a protocol is in place to safely include a person with lived experience (PWLE) as part of the assessment team. Unfortunately since the full on-site inspections have recommenced (previously paused due to the pandemic) there has been limited progress with this initiative as no further inspections have as yet been undertaken with the inclusion of a PWLE. This is due to be reviewed with the Patient Experience team to ensure involvement going forward and that mutually agreed dates are secured to join the assessments.

The Ligature BAF risk is reviewed on a monthly basis and has been fully reviewed and updated for 2021/22. The BAF is included in the Quality Committee papers and details the ongoing ligature risk reduction actions, progress and controls.

4.0 Continuous Learning

The Ligature Risk Reduction Group continues to receive incident analysis to identify learning and review national and local safety alerts.

5.0 Enhancing Environments

The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. The environmental standards have been updated to take into account all known safety alerts and ligature learning. The trust has instigated a project team looking at the trust standards and how these can be applied universally across the inpatient estate.

6.0 Culture – Staff Training

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package (launched in March 2018 and reviewed December 2019) "Preventing Suicide by Ligature" on an annual basis. The training package details:

Overall trust compliance with training as of the end of June 2021 was 89%, broken down as follows:

- Bedford 95%
- South Essex 90%
- North Essex 87%

The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards. The training is delivered over 2 full days by TIDAL training; attendees include clinical staff Band 6 and above, members of the risk team and estates staff who undertake ligature risk assessments. To date 60 staff have been trained as follows:

- 38 Ward Staff B6 and above
- 14 Estates staff
- 7 Corporate/Risk Staff

The uptake of the training is monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training. It has been agreed that TIDAL training will be paused over the summer months to account for a potential increase in annual leave being taken and will recommence in September 2021.

7.0 Conclusion

The summary of information provided in this report is by its nature only potentially a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

It is intended that the information provides sufficient assurance that the Trust continues to take mitigating the risk of ligature seriously.

8.0 Action Required

The Board of Directors is asked to:

- Discuss the contents of this report
- Identify any further actions required.

Report Prepared By:
Jane Cheeseman
Head of Compliance and Emergency Planning

On behalf of:
Paul Scott
Chief Executive Officer

		Agenda Item No: 9(iii)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	29 September 2021

Report Title:	EPUT Winter Planning 2021-22					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director – Executive Director of Major Projects and Programmes					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	If EPUT does not manage winter pressures and Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements and affect the ability to deliver high quality business as usual services and the wide range of priorities and pressures.
State which BAF risk(s) this report relates to	BAF38, BAF50
Does this report mitigate the BAF risk(s)?	In part
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors with an overview of how EPUT will respond to seasonal demand in addition to managing the Covid-19 pandemic.	**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

The Winter Plan is the Health and Social Care response to unscheduled care over the winter to supplement existing year round plans. This report presents the Trust Board of Directors with EPUTs Winter and Resilience Plan, which is a working document that is continuing to be developed. There will be some variances in each area and some changes to this initial plan as the system responds to changing pressures

Winter resilience planning is undertaken in partnership with the various Integrated Care Systems EPUT is in collaboration with. Each system has their own resilience plan and central returns which EPUT is part of.

EPUT continues to work collectively with local partners to effectively manage and safely respond to the ongoing challenges of COVID-19. We have moved into the next phase of our re-mobilisation and recovery planning to bring services back to pre-covid running, as safely as possible; ensuring we have the capacity that is necessary to deal with the continuing presence of COVID-19; and preparing the health and care services for the winter season. We are also continuing to learn positively from the new and innovative ways of working that were employed to respond to the demands on services by the COVID-19 pandemic.

The overall aim of the plan is to provide an overview of how EPUT will respond to seasonal demand in addition to managing the Covid-19 pandemic.

The strategic objectives of the plan are:

- To ensure robust governance and escalation processes are in places to manage system surge, capacity and risk. Proactively managing system in line with statutory responsibilities
- Enhance system capacity through winter pressure in order to:
  1. Meet additional winter demands on front services
  2. Focus on supporting vulnerable groups to enable as many people to remain living as independently as possible in the community, with access to high quality, timely placements for those who need them
  3. Ensuring sufficient resource to manage Covid-19
- Managing system pressures – Inpatient Service
- Managing system pressures – Community Services
- Maintaining service delivery and protecting the most vulnerable
- To prevent and control the spread of infection including delivering an enhanced flu Vaccination programme
- To provide oversight of the national and local winter communication campaigns that actively engage with the public to ensure the right services are used at the right times.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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			
EPUT	Essex Partnership University NHS Foundation Trust	ICS	Integrated Care Systems
IPC	Infection Prevention Control	DCO	Directors of Commissioning Operations
SMART	Surge Management and Resilience Toolset	MaST	Management and Supervision Tool
BCP	Business Continuity Plan	A&E	Accident & Emergency
CHS	Community Health Services	OPEL	Operational Pressures Escalation Levels
SEE	South East Essex	WE	West Essex
MDT	Multi-Disciplinary Team		

Supporting Documents and/or Further Reading
Winter and Resilience Plan and appendices

Lead
Nigel Leonard Executive Director of Major Projects and Programmes

EPUT Winter Planning 2021-22

1.0 Introduction

The Winter Plan is the Health and Social Care response to unscheduled care over the winter to supplement existing year round plans.

EPUT continues to work collectively with local partners to effectively manage and safely respond to the ongoing challenges of COVID-19. We have moved into the next phase of our re-mobilisation and recovery planning to bring services back to pre-covid running, as safely as possible; ensuring we have the capacity that is necessary to deal with the continuing presence of COVID-19; and preparing the health and care services for the winter season. We are also continuing to learn positively from the new and innovative ways of working that were employed to respond to the demands on services by the COVID-19 pandemic.

The overall aim of the plan is to provide an overview of how EPUT will respond to seasonal demand in addition to managing the Covid-19 pandemic.

The strategic objectives of this plan are:

- To ensure robust governance and escalation processes are in places to manage system surge, capacity and risk. Proactively managing system in line with statutory responsibilities

- Enhance system capacity through winter pressure in order to:
    1. Meet additional winter demands on front services
    2. Focus on supporting vulnerable groups to enable as many people to remain living as independently as possible in the community, with access to high quality, timely placements for those who need them
    3. Ensuring sufficient resource to manage Covid-19

- Managing system pressures – Inpatient Service

- Managing system pressures – Community Services

- Maintaining service delivery and protecting the most vulnerable

- To prevent and control the spread of infection including delivering an enhanced flu Vaccination programme

- To provide oversight of the national and local winter communication campaigns that actively engage with the public to ensure the right services are used at the right times.

2.0 Risk Assessment

To understand the key actions needed to ensure resilience over the winter period all operational services have undertaken a risk assessment focusing on 4 key areas:

1. Workforce and Leadership
2. Capacity and Demand
3. Seasonal demand
4. COVID

Key risks identified through this exercise include sufficient acute capacity to meet need whilst also maintaining safe IPC processes due to physical space restrictions, maintaining the workforce across all providers in response to a potential outbreak and self-isolating policy implications and maintaining community capacity to support an increase in housebound and vulnerable patients.

The overarching risks and mitigations are included in the EPUT Winter Plan Risk assessment and will be monitored throughout the period. Please see appendix 1.

3.0 Governance for Operational Management

3.1 Mental Health Services Escalation (Inpatient & Community MH)

EPUT MH services utilise the Operational Pressures Escalation Levels (OPEL**)** Framework to describe daily sit rep position. This provides a standardized approach to grading and responding to current pressures that can be reacted to by the whole system. The aim of the OPEL framework is to provide consistent approach in times of pressure, specifically by:

- Enabling local systems to maintain quality and patient safety
- Providing a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards to align with their existing escalation processes
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level (providers, commissioners and local authorities), by Directors of Commissioning Operations (DCO) and NHS Improvement sub-regional team level, regional level and national level
- Setting consistent terminology

To manage system pressures we will

- ✓ Continue with the 24/7 Trust Director on call programme
- ✓ Be part of local resilience plans with partners (see appendix 2)
- ✓ WE MH daily RAG rating added to system SHREWD dashboard
- ✓ WE MH escalation system calls stand up process
- ✓ 3 x daily sit-reps
- ✓ Local system escalation calls with acutes
- ✓ Surge Management and Resilience Toolset (SMART) Mental Health Capacity Management System operational.
- ✓ Weekly Senior Inpatient Oversight Huddle.
- ✓ MH Community (North) piloting Management and Supervision Tool (MaST)
- ✓ Build upon learning from previous winter plans and Covid 19 response
- ✓ Service BCP's in place
- ✓ Ongoing communication with Primary care to avoid A&E attendance where appropriate: GP dedicated line, crisis café (where commissioned), neighbourhood integrated community pathway developments.
- ✓ Teamed with 3rd sector partners supporting home treatment teams

3.2 Community Health Services Escalation (Inpatient & Community CHS)

EPUT CHS SEE utilise the Daily MSE Community Provider Collaborative sitrep to describe the daily sit rep position. This provides a system partnership response when concerns are raised. EPUT CHS WE feed into the system OPEL status. This provides a system partnership response when concerns are raised.

To manage system pressures we will

- ✓ Continue with the 24/7 Trust Director on call programme

- ✓ Be part of local resilience plans with partners (SEE in development) (see appendix 2)
- ✓ Build upon learning from previous winter plans and Covid 19 response
- ✓ Provide a single community SEE sit rep with is explicit about the expectations of key community services
- ✓ Aim to improve seven day services to support good patient flow
- ✓ Ensure that seasonal demand will not compromise patient care, experience and service standards
- ✓ Identify potential risks and options to mitigate
- ✓ Single voice and key reference point for community service processes and contacts throughout the winter period.
- ✓ Daily sit-reps for the collaborative in addition to escalation calls
- ✓ Service BCP's in place

Community Winter Plans have three areas of focus:

1. The provision of Community Health Beds for Intermediate Care and Stroke (Step UP and Step Down)
2. Provision of services supporting Discharge and Flow (inc. Community Service Actions to deliver National Policy and Operating Model – Hospital Discharge and Community Support)
3. Provision of Services providing Admission Avoidance including Urgent Community Response Teams alongside community nursing and specialist teams such as palliative care & REACT

3.3 Specialist Services Escalation

EPUT Specialist Services utilise calls with case managers and commissioners within the Provider Collaborative and other commissioning bodies. This provides immediate and direct routes for communication.

To manage system pressures we will

- ✓ Continue with the 24/7 Trust Director on call programme
- ✓ Service BCPs in place (see appendix 2)
- ✓ Direct communication routes with the Exec Lead of the PC on any system concerns to draw attention to these
- ✓ T&F groups looking at flow and capacity and week/ monthly forums for escalation of concerns.
- ✓ Daily and weekly bed management returns are submitted that are visible to the whole system which show current capacity. New bed management systems are currently being explored and embedded by PC's
- ✓ Contract meetings with commissioners are in place which look at flow and capacity
- ✓ Collaborate with other providers within PC's to share and manage local and regional requirements
- ✓ Examine the potential for innovation and adapt service delivery to urgent and long term change requirements
- ✓ Develop and support workforce issues such as long term recruitment and retention, training and development

4.0 Maintaining service delivery and protecting the most vulnerable

This year, the Health and Social Care System are focusing strongly on vulnerable patients including those at high risk of Covid-19 by ensuring;

- ✓ Service BCP's in place
- ✓ Vulnerable lists remain in place from Covid planning including Risk Assessments

- ✓ Re-prioritise to enable maximum capacity
- ✓ Adopt learning from Covid
- ✓ Good system working

5.0 Covid 19 Management

To ensure ongoing robust Covid pandemic management we will

1. Continue with Covid Command Structure while risk remains
2. Continue to implement Covid 19 guidance
3. Provision of PPE will continue to be provided through the Trust's procurement processes and escalations and assurance monitored through the command structure
4. The Trust will continue to provide a dedicated Covid track and trace phone line accessible 24/7 with working hours exert IPC management
5. The trust will continue to promote staff undertaking twice weekly asymptomatic lateral flow testing in accordance with NHS guidance. In-Patients will continue to be asymptomatically swabbed on admission, day 3 and 7 and then every 14 days thereafter. All patients will be swabbed with symptoms clinically suggestive of Covid-19 and care and management supported by latest trust guidance. Covid outbreak management protocols will continue if 2 or more linked positive cased are detected.

6.0 Alignment of winter communications and robust patient engagement in planning winter services.

Please see appendix 2

7.0 Organisation Assurance Plans

7.1 Workforce and Leadership

It is recognised that the delivery of safe and effective Health and Social Care services is dependent on the skills, dedication and availability of our staff.

- The Trust has a long established understanding of staffing level requirements during the winter periods, and winter plans have been submitted for supplementary staff.
- Executive Cover is provided at all times 24/7 either on site or via the Trust's On Call system.
- Additional workforce arrangements
- Contingency plans are in place to manage short term sickness absence in all services.
- Staffing needs are managed through the Trusts Bank Staffing system.
- Community staff absence is covered through rationalisation of case work utilising risk stratification or through Bank and Agency staffing arrangement.
- The Trust has proof of system efficacy from providing staff cover during the COVID-19 response.
- The Trust has an established Bank Staffing office and is ensuring national policy around staff isolation is appropriately interpreted to deliver safe and timely care.
- Possible re-deployment of staff in non-essential services to provide support in essential service

7.2 Capacity and Demand

- Utilisation of bank and agency workforce
- Safer Staffing - OPEL

- MAST
- Daily Staff and capacity Sit-reps
- Community beds part of MSE community bed provision
- Flow and capacity within community
- Recruiting to new MH Primary Care Teams – Help support early intervention with aim to ease pressure of more specialist services
- West CHS - 19 Intermediate care beds accessed via MDT approach with a broad criteria supporting patients that no longer need to be in an acute setting and medical needs that can be met by primary care.
- Essex Priory and Essex Private PICU contracts in place to support winter pressures

7.3 Seasonal Demand

The Trust has developed Severe Weather / Business Continuity plans which will be initiated as required.

Every year delivering a wide spread flu vaccination programme is one of the key preventative measures. This year, more than ever the flu vaccination programme is essential to prevent the spread of flu and reduce flu related illnesses.

The Trust has established a Flu Vaccination Task & Finish group who are taking forward the vaccination programme for 2021. This is being overseen by the IPC and Executive Team.

The Trust has a full Flu vaccine programme in place which was launched on the 22nd September. Staff uptake of the Flu vaccine is monitored.

7.4 Covid-19 Planning

See section 5.0 above

8.0 Cold Weather Plan Self-Assessment

Please see below EPUT Self-Assessment against level 1 cold weather months plan (initiated 1st November – 31st March), assurance is to be provided by services on prior to 1st November to ensure services are prepared:

Action Required		EPUT Assurance
1.1	Circulate Cold Weather guidance to staff	Cold weather guidance will be available on the Intranet which is accessible to all staff
1.2	Identify individuals who are at particular risk from cold snaps, especially those living on their own, in poor housing and those aged 75+	BCPs in place Operations have clear process for identification of individuals at risk
1.3	Increase awareness and information to all staff of winter warmth benefits	To be included as part of Communications Plan
1.4	Undertake regular reviews of care plans and actions taken where necessary.	This is BAU therefore services to continue
1.5	Review EPUT and Team Service Continuity Plans (including surge/capacity plan and staff shortage plans) to reduce pressure on system	Winter Plans in place for operational services
1.6	Check resilience of estate and equipment, especially medical and IT	Estates and IT BCP Ongoing testing

	systems, to ensure they can be maintained	
1.7	Provide people with information about how people can keep their homes warm in winter, how money can be saved and things to do in order to stay warm and well.	Guidance will be available on the Intranet which is accessible to all staff in addition to being contained in the Cold Weather Policy
1.8	Provide staff and care settings with information on driving in ice, snow, wet and windy conditions, winter resilience and risk assessments for their sites.	Guidance will be available on the Intranet which is accessible to all staff in addition to being contained in the Cold Weather Policy

The following self-assessment actions are to be implemented in response to weather forecasts as required, with assurance needed from the services:

Level 2: Cold/Snow Forecast: Alert and Readiness - Severe winter weather is forecast – Alert and readiness: *Mean temperature of 2°C and/or widespread ice and heavy snow is predicted within 48 hours, with 60% confidence*		**Level 3: Period of Freezing Conditions / Snow: Cold Weather Plan -** Response to severe winter weather – Severe weather action: *Mean temperature of 2°C or less and/or widespread ice and heavy snow*, Triggered by Met Office forecast and local situation.	
2.1	Stay informed of forecasts and 'Cold Watch' messages and alerts	3.1	Issue information, including media statements about "keep well, keep warm"
2.2	Consider forecasts when planning forthcoming activity	3.2	Identify particularly vulnerable patients/service users
2.3	Communicate key messages to staff through Wednesday Weekly and ensure advice about reducing the effects of cold weather are distributed and implemented, i.e. keep well, keep warm	3.3	Ensure the health status of the vulnerable patients/service users are checked regularly
2.4	Identify through review of care plans those patients/service users at high-risk.	3.4	Services to visit/phone high-risk people
2.5	Undertake appropriate home checks i.e. room temperature, medications & Where necessary, visitor/phone call arrangements to be put in place if normal services are disrupted	3.5	Staff to look out for neighbours
2.6	Alert and readiness in inpatient and day services (review: capacity, discharge/admission, staff, surge, supplies and travel plans)	3.6	Reduce unnecessary travel and give longer time for journeys
2.7	Monitor indoor temperatures	3.7	Ensure staff aware of risks and protective actions to be taken
2.8	Ensure sufficient staffing	3.8	Avoid unnecessary exposure to cold weather
2.9	Identify high-risk people	3.9	Implement Service Continuity plans
2.10	Ensure sufficient heating, clothes and food are available	3.10	Communicate "keep well keep warm" and safety advice to all staff and ensure advice about reducing

			the effects of cold weather are distributed and implemented.
		3.11	Ensure that services are in a state of readiness in case of increased service demand
		3.12	Ensure discharge planning takes into account the temperature of accommodation and level of daily care required
		3.13	Liaise with partner agencies

Level 4: Prolonged Period of Freezing Conditions / Snow: Major Incident - Indicates that significant parts of the country are experiencing exceptionally cold winter weather. Such weather conditions are likely to have significant impacts not only on health, but also on other sectors and critical infrastructure. A cross-governmental response may be required. A Major Incident could be declared locally or nationally **Action Required**	
4.1	Consider the setup of Major Incident Response Team (MIRT)
4.2	Liaise with partner agencies
4.3	Identify key services that must be maintained and the impact of maintaining these services
4.4	Identify patients/service users most vulnerable to periods of prolonged cold weather and ensure safety measures are taken
5.6	Ensure estates and buildings provide adequate clearing of snow and gritting of key access/egress route to ensure safe emergency access/egress

9.0 Version Control

V1	22 September 2021	Shared with TB 29.09.21

Appendix 1

EPUT Winter Plan risk Assessment

	Assumption	Potential Risk (If .. Then .. Resulting in)	Lead	Controls
Workforce and Leadership	There will be staffing challenges across the system	If there are staffing shortages across the system (due to range of reasons including seasonal sickness, Covid isolation, carer responsibilities) Then services will not be able to achieve minimum safer staffing levels Resulting in significant risk in the safe running of key services and ability to deliver provision in a timely way	Operational Directors	Opel Escalation Recruitment initiatives including Kickstart and Apprenticeships Ongoing staffing review to ensure capacity is sufficient to meet demand. Daily inpatient safer staffing oversight.
Capacity and Demand	There will be insufficient inpatient capacity to meet the expected demand levels	If there is a shortage of available beds across the system (due to a range of reasons including physical space constraints, workforce challenges, onward destinations not being available, increase in demand) Then services will not be able to support all required admissions Resulting in significant pressure on community services and emergency services	Operational Directors	Sub-contracted beds at Priority – continue until December – appropriate OOA beds Moving 2 dormitory wards to single room wards – Remove social distancing constraints in dormitory increasing bed capacity
Capacity and Demand	There will be insufficient community services to manage demand	If there is a shortage of community capacity across the system (due to a range of reasons including physical space constraints, workforce challenges, increase in demand) Then services will not be able to support all required community care Resulting in significant pressure on inpatient and Primary Care services and the most	Operational Directors	Prioritise – use workload accordingly Sit-rep & RAG rating help mitigate OPEL status Use of mutual aid as part of the collaborative

	Assumption	Potential Risk (If .. Then .. Resulting in)	Lead	Controls
		vulnerable patients being unable to be cared for in the community		
Seasonal Demand	Patients and Staff don't receive flu vaccinations in a timely manner	If staff and patients do not receive the flu vaccination in a timely manner Then services will have additional workforce pressures Results in staffing shortages	Director IPC / Executive Director Special Projects	Deliver Flu vaccination programme aligned to Covid booster programme Assurance through Flu project meeting and escalation to ET
Covid	Infection control Covid 19 measures may not be followed	If staff are unable to meet Covid 19 measures (due to range of reasons including non-adherence to trust/national guidelines, Covid Swabbing delays or omissions for Admitted patients, increase in demand for beds) Then there is an increased risk for hospital acquired Covid Results in Covid outbreaks	Director IPC/ Operational Directors	Command meetings Inpatient Covid assurance dashboard IPC leadership and guidance implementation and expert support

Appendix 2

System Winter and Resilience Plans

NB. The embedded documents are for illustrative purposes and cannot be opened on a PDF document. The documents are available on request.

Mental Health

EPUT Winter Plan 21-22v0.1.potx

Community Health

Winter Plan - Community Collabor

WE Sytem Winter Plan 2021.22 V2 late

Specialist (not part of local Resilience Plans BCPs provided below)

BCP1 - Brockfield House - All wards - I

BCP1 - Byron Court LD Inpatients and C

BCP1 - Robin Pinto Unit & Woodlea Clir

BCP1 - Larkwood.doc

BCP1 - Longview.doc

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29th September 2021**

Report Title:	Mid & South Essex Community Collaborative - Transition to Decision-Making Form					
Executive/Non-Executive Lead:	Paul Scott, CEO, James Wilson, Transformation Director					
Report Author(s):	Lauren MacIntyre; Director of Corporate Affairs, NELFT, James Day, Interim Trust Secretary EPUT, James Wilson, Transformation Director					
Report discussed previously at:	Executive Team					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	The principal risk of a failure of approval would be a weakness of strategic direction to the Community Collaborative to ensure high quality patient care is delivered for in-scope community services
State which BAF risk(s) this report relates to	BAF 36 Working Collaboratively, BAF 50 Skills, resource and capacity to deliver high quality business as usual care and services and manage the wide range of priorities and pressures
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the EPUT Board of Directors with the opportunity to review and approve the terms of reference and emerging governance arrangements for the Mid and South Essex Community Collaborative, and thereby enable the Mid and South Essex Community Collaborative Board to immediately transition into a decision-making forum.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to review and approve, subject to any requested amendments:

1. The contents of the report
2. The transition of the community collaborative board to decision-making status
3. Approve the Terms of Reference for the Community Collaborative Board in decision-making form (Appendix One)
4. Request any further information or action.

Summary of Key Issues

In June 2021, the Mid and South Essex Community Collaborative Joint Operational Group and the Community Collaborative Board (previously named Partnership Board) considered the transition to a decision-making partnership. It was noted that there were two ways in which a Foundation Trust Board of Directors could delegate its functions:

1. To a committee only if the voting members of the committee comprised the directors of the FT (paragraph 15 of Schedule 7 of the NHS Act 2006)
2. To an officer of the Trust (through delegation to the Chief Executive)

(NB: These delegation restrictions do not apply for a Community Interest Company).

In order for the Community Collaborative Board to transition to a decision-making forum, the above two options were considered: a 'committees in common' model or delegation through Executive Directors. The latter was approved as the preferred approach.

To put this into practice, it was agreed that each party would delegate decision-making authority to one of its Executive Directors sitting on the Community Collaborative Board. Each organisation within the partnership would have one vote and unanimity across all parties would be required for a decision to be made and implemented. Individual organisations would be expected to discuss proposals and preferences ahead of the Community Collaborative Board meeting and then delegate the decision to their Executive Director representative to present at the meeting. If a decision was not unanimous, and a resolution could not be found, the parties would be able to commence the dispute resolution process outlined in Schedule 4 of the Contractual Joint Venture Agreement.

In order to enact the above, and to transition to a decision-making partnership, the following steps were agreed:

- A review of the constitutional documents of each party including scheme of delegations, standing financial instructions and articles of association (complete)
- A review of the Community Collaborative Board and Joint Operational Group Terms of Reference, including membership (complete)
- Implementation of a Community Collaborative Performance Committee and Community Collaborative Quality Committee. (Proposals for this are under review and do not form part of this consideration by the EPUT Board)
- Sovereign Board approval of changes to constitutional documentation as required. In EPUT this has been to confirm EPUT engagement with collaboratives generally. (These changes have already been approved by the EPUT Audit Committee on 15th September 2021 and are a separate agenda item)
- Approval of the Community Collaborative Board Terms of Reference, (attached for consideration and approval as Appendix One), which will allow completion of a contract variation for the CJVA.

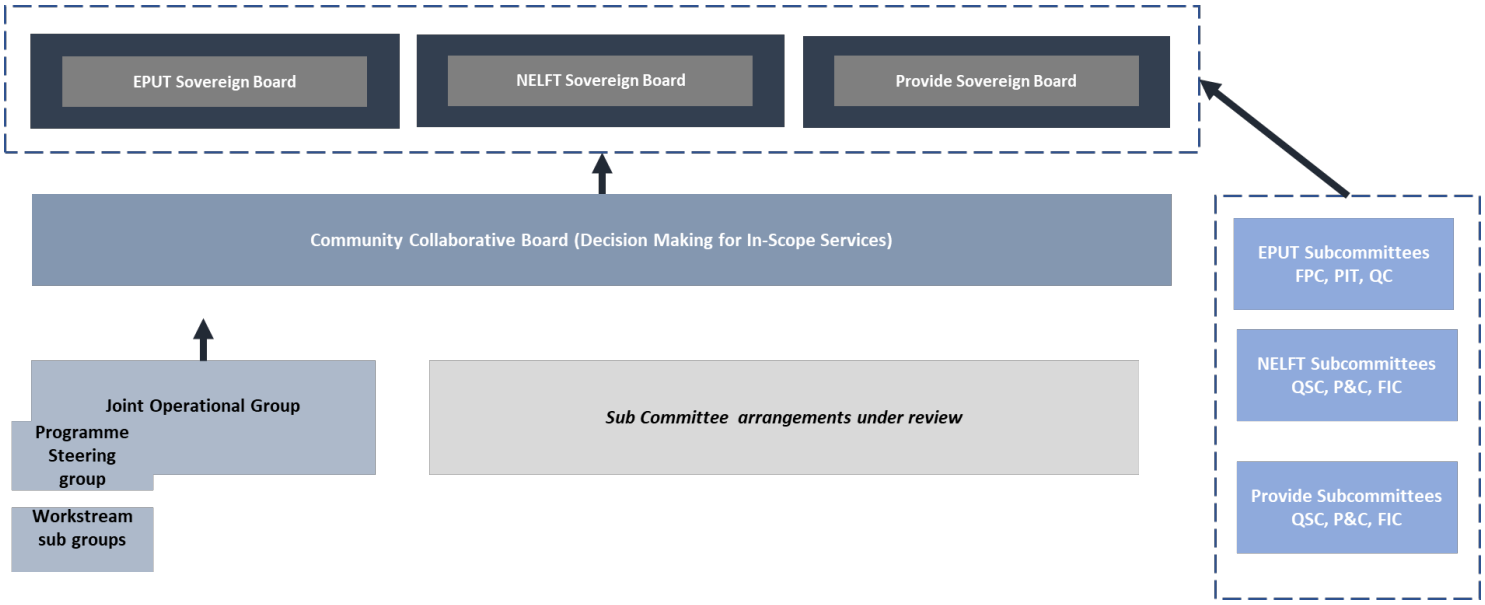
Bevan Brittan Solicitors and the governance workstream have reviewed all relevant constitutional documents from the three provider organisations and the suggestions for EPUT were also reviewed by the EPUT Executive team and Audit Committee. In EPUT, the amendments required to confirm the delegation of authority to Executive Directors on the Community Collaborative Board were small, given the authority to act in the way proposed was pre-existing. However, opportunity was taken to reconfirm such authority shall be exercised only within the limits of existing and not extended financial delegations.

The proposed amendments are amongst a tranche of changes approved by the EPUT Audit Committee on 15th September 2021 and are separately before the 29th September EPUT Board for Board approval.

The Governance Workstream has reviewed, revised and signed off the Terms of Reference for the Community Collaborative Board in its decision-making form. These Terms of Reference can be found as Appendix One and approval is sought to enable the Board to now transition to a decision making forum.

The Governance Workstream has also reviewed proposals for sub-committee arrangements. This is still under consideration and will be subject to a future proposal.

ADDITIONAL INFORMATION / ANALYSIS
GOVERNANCE STRUCTURE

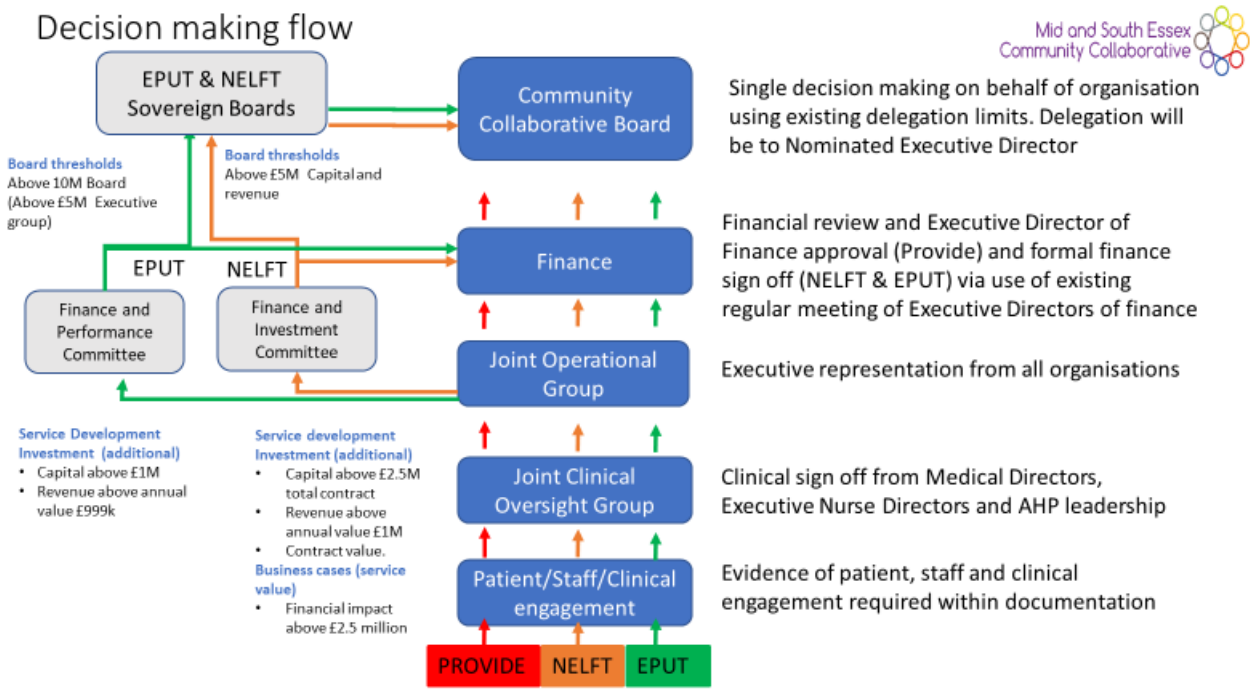


The purpose of the Community Collaborative Board is to provide strategic direction to the Community Collaborative to ensure high quality patient care is delivered for in-scope community services. The Community Collaborative Board will be accountable for the Contractual Joint Venture Agreement, ensuring that arrangements and practice are in line with the Partnership Principles and that the strategic objectives are delivered.

The purpose of the Joint Operational Group is to oversee and monitor the delivery of the day-to-day operations and activities of the Community Collaborative and to oversee the collaborative working around specific workstreams and service model developments, in accordance with the Partnership Principles set out in the Contractual Joint Venture Agreement. The Joint Operational Group will be accountable to the Community Collaborative Board to ensure the delivery of an integrated community healthcare offering.

To ensure effective governance and oversight across the partnership, subcommittee arrangements are being considered and will be subject to a future formal proposal to the Board.

Due to the fast-changing landscape, and to ensure the proposed governance continues to be fit for purpose for the future ambition of the collaborative, these arrangements will be formally reviewed after 6 months.



NB: For NELFT and EPUT dual sign off by the Executive Director with delegated authority and Finance Director will take place up to the finance committee thresholds.

Provide has uncapped thresholds for Community Collaborative decision-making.

Representation on the MSE Community Collaborative Board

As well as having the NED Chairs and nominated executive directors with decision-making powers on the Community Collaborative Board representing individual organisations, there will be director representation from the workstream leadership areas (Operations, Clinical, Quality, Finance, People, Governance) representing subject matter expertise on behalf of all three organisations. This will ensure good decision-making and cross speciality input, whilst avoiding an unwieldy membership.

Role	Organisation	Who
Chair x3	Provide, EPUT and NELFT	Derrick Louis, Sheila Salmon, Joe Fielder
Chief Executive x3	Provide, EPUT and NELFT	Mark Heasman, Paul Scott, Oliver Shanley
Finance	Provide	Philip Richards
Quality (Nursing)	Provide	Stephanie Dawe
People/HR	EPUT	Sean Lehey
Medical /Clinical	EPUT	Milind Karale
Transformation	Provide, EPUT and NELFT	James Wilson
Operations	NELFT, EPUT & Provide	Selina Douglas, Alex Green, Stephanie Dawe
Governance (and board secretariate)	NELFT	Lauren Macintyre
Local Authority	ECC, SBC, TC	Representation TBC

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives Sovereign organisations are still accountable by statute and regulated on an individual basis			✓
Data quality issues			none
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required There is an engagement workstream in the collaborative to ensure that sufficient co-production and engagement is undertaken.			✓
Service impact/health improvement gains			
Financial implications: Financial matters will be considered by the finance workstream		**Capital £** **Revenue £** **Non Recurrent £**	✓
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity All organisations will have an equal vote in decision-making.			✓
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
MSE	Mid and South Essex	CJVA	Contractual Joint Venture Agreement

Supporting Documents and/or Further Reading
Appendix 1 - Community Collaborative Board – Terms of Reference (Incorporated below)

Lead
James Day, Interim Trust Secretary

Appendix 1 - Community Collaborative Board – Terms of Reference

COMMUNITY COLLABORATIVE BOARD TERMS OF REFERENCE

1 PURPOSE

1.1 The purpose of the Community Collaborative Board is to provide strategic direction to the Parties' Mid and South Essex Community Collaborative to ensure high quality patient care is delivered for in-scope community services. The Community Collaborative Board will be accountable for the Contractual Joint Venture Agreement, ensuring that arrangements and practice is in line with the Partnership Principles and that the strategic objectives are delivered.

1.2 The Parties are Essex Partnership University NHS Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company. The Services, defined in the Contractual Joint Venture Agreement, are the Community Healthcare services for Mid and South Essex. The Community Collaborative Board will oversee priorities and risks, receiving assurance from the Integrated Performance Committee and holding the Joint Operational Group to account for the delivery of an integrated Community Healthcare offering. As the Mid and South Essex Community Collaborative evolves, additional members may be added to the Community Collaborative Board.

2 AUTHORITY AND ACCOUNTABILITY

2.1 The Community Collaborative Board is established by the Parties, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Parties in line with the Partnership Principles, including the provision of the Services.

2.2 The Community Collaborative Board is not a separate legal entity to any Party, and as such is unable to take decisions separately from the Parties, or to bind any of them (subject to paragraph 2.3).

2.3 The Community Collaborative Board was initially established as an advisory forum with no authority to take decisions for or on behalf of the Parties. The Parties have now taken steps to provide their respective representatives with the delegated authority to take certain decisions on their behalf through the Community Collaborative Board subject always to the principle that no one Party can 'overrule' the other on any matter (although the Parties will be obliged to comply with the terms of the Contractual Joint Venture Agreement).

2.4 The Community Collaborative Board will function through engagement and discussion between its members so that each of the Parties makes a decision in respect of, and expresses its views about, each matter considered by the Community Collaborative Board. The decisions of the Community Collaborative Board will, therefore, be the decisions of the individual Parties, the mechanism for which shall be authority delegated by the individual Parties to their representatives on the Community Collaborative Board.

2.5 The Parties have delegated to their executive representatives on the Community Collaborative Board such authority as is agreed to be necessary in order for the Community Collaborative Board to function effectively in discharging its responsibilities in these Terms of Reference.

2.6 The Parties confirm that their representatives have equivalent delegated authority, which is in writing, agreed between the Parties and recognised to the extent necessary in the Parties' respective schemes of delegation (or similar). The Parties will ensure that the Community Collaborative Board members understand the status of the Community Collaborative Board and the limits of the authority delegated to them.

2.7 The Community Collaborative Board may only pass a resolution by consensus of the Parties. Each Party shall have one vote (establishing a "one party one vote" mechanism, regardless of how many of its representatives have participated in the relevant meeting (subject to the requirements on quorum set out above at paragraph 5 having been met)).

2.8 Further to paragraph 2.3 above, the Community Collaborative Board shall in their discretion make recommendations to the Parties' sovereign Boards for any variations to the Contractual Joint Venture Agreement where appropriate

2.9 In line with the principle that the Community Collaborative Board is not a separate legal entity to the Parties, the individual members of the Community Collaborative Board are accountable to their respective organisations.

2.10 The Community Collaborative Board is accountable to the Parties' Contractual Joint Venture Agreement. All accountability to regulatory requirements remains within the sovereignty of each Party, where relevant.

3 ROLE OF THE COMMUNITY COLLABORATIVE BOARD

3.1 The Community Collaborative Board members are responsible for providing strategic direction to the Parties' collaborative to ensure high quality patient care is delivered for in-scope community services.

3.2 The Community Collaborative Board will also be responsible for developing the Parties' collaborative approach across the Mid and South Essex geography and will:

3.2.1 *ensure alignment of the organisations to the Partnership Principles;*

3.2.2 *promote and encourage commitment to the Partnership Principles;*

3.2.3 *formulate, agree and ensure the implementation of strategies for achieving the Strategic Objectives and the Business Plan;*

3.2.4 *discuss strategic issues and resolve challenges such that the Strategic Objectives can be achieved;*

3.2.5 *respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Parties to the extent that they affect the Services;*

3.2.6 *agree policy as required;*

3.2.7 *agree performance outcomes/targets for the integrated Community Healthcare offering such that it achieves the Strategic Objectives;*

3.2.8 *review the performance of the Business Plan, receiving assurance from the Integrated Performance Committee and holding the Joint Operational Group to account, and determine strategies to improve performance or rectify poor performance;*

3.2.9 *identify and manage the risks associated with the development of an integrated Community Healthcare offering and integrating where necessary with each Party's own risk management arrangements;*

3.2.10 *generally ensure the continued effectiveness of the Parties working in partnership, including by managing relationships between the Parties and its stakeholders;*

3.2.11 *oversee the implementation of, and ensure the Parties' compliance with, the* Contractual Joint Venture Agreement *and the Contracts;*

3.2.12 *review internal matters and decisions proposed by the Parties which impact the integrated Community Healthcare offering and services to the population of Mid and South Essex, where relevant;*

3.2.13 *review the governance arrangements for the Community Collaborative at least annually;*

3.2.14 *be open, transparent and accountable in its actions and recommendations;*

3.2.15 *oversee and support the resolution of disputes between the Parties; and*

3.2.16 *establish subcommittees as it agrees is necessary to carry out its functions, including the Integrated Performance Committee.*

4 MEMBERSHIP AND ATTENDANCE

4.1 The voting membership of the Community Collaborative Board will be an individual from each party with delegated authority.

4.2 Those in attendance at the Community Collaborative Board shall be:

- Trust Chairs x 3 (Chairmanship of the Community Collaborative Board will rotate between the Trust Chairs on a six-monthly basis)
- Chief Executives x 3
- Director of Finance Provide
- Quality/ Nursing Director Provide
- Director of People EPUT

- Medical Director EPUT
- Transformation Director
- Director of Operations EPUT and NELFT
- Director of Corporate Affairs NELFT
- Local Authority

4.3 It is important that members or their deputies commit to attending Community Collaborative Board meetings. Where a member cannot attend a meeting, the member can nominate a named deputy to attend.

4.4 At the invitation of the Community Collaborative Board, the following individuals will be in attendance as and when required:

- Director of Adult Social Services, Essex County Council
- Director of Adult Social Services, Southend-on-Sea Borough Council
- Director of Adult Social Services, Thurrock Council

4.5 The Community Collaborative Board may invite others to attend meetings of the Community Collaborative Board as observers or to provide such clinical or other professional advice and contribution as required.

5 QUORUM

5.1 The Community Collaborative Board will be quorate if an Executive Director with delegated authority from each Party is present.

6 CONDUCT OF BUSINESS

6.1 Only members of the Community Collaborative Board have the right to attend Community Collaborative Board meetings.

6.2 Meetings of the Community Collaborative Board will be held a minimum of six times a year or such other frequency as may be agreed between the Parties. Initially it is intended to meet monthly Extraordinary meetings may be called to discuss additional items.

6.3 Meetings may be held by telephone or video conference.

6.4 The agenda will be developed in consultation with the Chair and formal minutes will be taken.

6.5 After meetings, an exception update will be provided to the sovereign Boards.

6.6 At the discretion of the Chair, a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting

but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

6.7 The Community Collaborative Board will aim to achieve consensus for all decisions of the members.

6.8 To promote efficient decision making at meetings of the Community Collaborative Board it shall develop and approve detailed arrangements through which proposals on any matter will be developed and considered by the members with the aim of reaching a consensus. These arrangements shall address circumstances in which one or more Parties decides not to adopt a decision reached by the members.

6.9 The Parties will be free to determine their reserved matters, but will aim to achieve consensus and alignment.

6.10 Decisions relating to a particular service delivered by one of the Parties which does not affect the Services; will be determined by the relevant Party to the exclusion of the other Parties.

7 CONFLICTS OF INTEREST

7.1 The members of the Community Collaborative Board must refrain from actions that are likely to create any actual or perceived conflicts of interests.

7.2 Community Collaborative Board members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

7.3 If there is any conflict between these Terms of Reference and the Contractual Joint Venture Agreement, the latter will prevail.

7.4 The Community Collaborative Board shall develop and approve a protocol for addressing actual or potential conflicts of interests among its members. The protocol shall:

7.4.1 require conflicts of interest to be a standing item on the agenda for each meeting of the Joint Operational Group;

7.4.2 at least include arrangements in respect of declaration of interests and the means by which they will be addressed; and

7.4.3 be consistent with the Parties' own arrangements in respect of conflicts of interests, and any relevant statutory duties;

8 CONFIDENTIALITY

8.1 Information obtained during the business of the Community Collaborative Board must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial activity and performance data associated with services and any institutions, including for the avoidance of doubt, the Parties. The main purpose of sharing such information will be to inform new integrated service delivery models and such information should not be used for

other purposes (e.g. performance management, securing competitive advantage in procurement).

8.2 Members of the Community Collaborative Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Community Collaborative. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

9 REVIEW

The Terms of Reference shall be reviewed by the Community Collaborative Board and sovereign Boards at least annually and initially on a six-monthly basis.

Date approved by Community Collaborative Board:

Date approved by sovereign Boards:

Date of review:

		Agenda Item No: 10b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**New Strategic Objectives & Accountability Framework**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Graeme Jones, Director /Trevor Smith, Executive Chief Finance and Resources Officer					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report asks the Board of Directors to: • Adopt the new strategic objectives set out in the paper along with the vision and purpose. • Note the new Accountability Framework approved by the Trust Executive which will support the delivery and oversight of the new strategic objectives.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the process to develop the new strategic objectives
2 Adopt the new strategic objectives
3 Note the Accountability Framework as a new system of Executive management and oversight.

Summary of Key Issues

The paper sets out the process followed to arrive at a new vision, purpose, strategic objectives and values.

The paper also sets out the process to develop and the key features of the new Accountability Framework.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: 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	✓

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

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
Accompanying Report EPUT Accountability Framework

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 10b
Board of Directors Part 1
29 September 2021

EPUT

NEW VISION, PURPOSE, STRATEGIC OBJECTIVES AND VALUES

1. INTRODUCTION

This paper sets out the process to develop a new vision, values and strategic objectives. This includes a broad and inclusive engagement programme with external partners, a review of national and stakeholder strategies, work with internal groups, our Governors and Non-Executive Directors.

The paper asks the EPUT Board to agree the new vision, purpose, set of strategic objectives and values.

2. DRIVERS OF THE REFRESH

The Trust's strategic objectives had become out of date with the context for the Trust changing significantly since the previous strategic objectives were set. Key changes to the context in which the Trust operates include:

- The development of Integrated Care Systems
- A focus on collaboration rather than competition
- A greater focus on Place based delivery
- The Covid-19 pandemic
- National Community Mental Health Framework
- Investment in and focus on earlier intervention and prevention

EPUT also has a new leadership team, refreshed relationships with local partners and a new Quality and Safety strategy.

3. STAKEHOLDER PROCESS

The Trust Board agreed to a process to refresh the strategic objectives that involved a series of stakeholder interviews together with a review of national strategies and the strategic objectives and plans of partners. A series of interviews took place with partners including:

- Essex County Council
- Essex police
- Health and Well-being Boards
- Essex based CCGs
- Three Essex based ICS leaders
- Other Essex based NHS providers
- Anglia Ruskin University
- University of Essex
- UCL Partners

The key themes from the interviews with partners and the review of their strategic plans included:

- Integrating physical and mental health services
- Integrating health and social care services
- Focus on place based provision
- Clinically led innovation
- Prevention and earlier intervention
- Investment in Primary Care
- Left shift of services to community based settings ahead of bed based provision
- Provider collaboration
- New roles, gateway roles and in-role development of staff
- Anchor institutions impacting upon the wider determinants of health
- Greater use of technology and digital services

Partners are looking for a refreshed relationship with EPUT and shared ideas to feed into a new strategic plan.

4. INTERNAL PROCESS

Following consideration of the feedback from stakeholders and the review of relevant national and local strategies, the process to develop a new set of strategic objectives engaged with:

- Council of Governors
- Leadership (L30) group
- Trust Executive
- Trust Board
- People Investment Transformation Board committee
- Staff engagement champions
- Other internal groups

A series of iterations of potential strategic objectives, a new vision and purpose have been shared with internal groups for comment, informing those presented to the Board for adoption.

5. VISION, PURPOSE, STRATEGIC OBJECTIVES AND VALUES

The following vision, purpose and strategic objectives are presented to the Board for agreement.

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

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

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

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

These values are underpinned by openness and transparency which are key pillars of our new Accountability Framework.

6. ACCOUNTABILTY FRAMEWORK

The Trust Executive has agreed a new Accountability Framework as an Executive management system to oversee performance improvement and gain Executive assurance in an integrated, consistent and transparent way.

The Accountability Framework was developed following a series of interviews with members of the Trust Executive and responds to the themes of the feedback that noted EPUT could oversee performance and delivery in a more integrated way with representatives of the Trust Executive meeting with the multi-disciplinary leadership teams of the new operational and clinical divisions on a regular basis to review key issues, risks and successes.

It will help to promote collective responsibility whilst establishing clear accountability. It will focus on integrated service delivery, with greater alignment of patient, people and performance issues.

It enables corporate teams to develop their business partnering approach, with a focus on data prompted informed discussions; it is in line with our clinically/operationally led and corporately enabled approach. Monthly meetings will be held with:

1. Community – Mid and South
2. Community – North
3. Community – West
4. Inpatient Services
5. Psychology
6. Specialist Services

The monthly Accountability Framework meetings will cover:

1. Quality and safety
2. Operational performance
3. Workforce and culture
4. Finance
5. External relations

The first round of Accountability Framework meetings Commenced in September focusing on introducing the Framework and agreeing expected behaviours. The second round of meetings in October will begin the integrated discussions on issues, risks, successes and plans for improvement.

Work has begun on new data packs to inform the discussions. The meetings will enable a change of focus in the Board performance report to highlight progress in resolving issues and in delivering improvement plans.

7. RECOMMENDATION

The Board of Directors is asked to:

1. Agree to adopt the new vision, purpose, strategic objectives and values.
2. To note the new Accountability Framework that will support deliver of the new strategic objectives.

Report prepared by Trevor Smith, Executive Chief Finance Officer and Graeme Jones, Director.

On behalf of

Paul Scott
Chief Executive Officer

Essex Partnership University NHS Foundation Trust

Accountability Framework

Version 11

23 September 2021

1. Introduction-

1.1 Purpose

The purpose of this Accountability Framework is to outline the mechanisms which will be used to hold to account service and corporate directorates to support the achievement of the Trust's strategic objectives and key performance indicators. The framework sets out how oversight will take place in a consistent way in EPUT, the KPIs that will be used, and the approach to regular directorate level accountability review meetings within the Trust. The framework also sets out expected behaviours which are consistent with the Trust values.

This Accountability Framework is based on the premise that decisions need to be made as locally as possible. The Framework sets out how autonomy and local decision-making will be encouraged; how additional autonomy can be earned and the routes for escalation of significant and persistent issues.

1.2 Scope

This Accountability Framework covers the six operational service directorates and corporate directorates. The Accountability Framework is the primary oversight and performance management process for the Trust. In 2021/22, the Framework will be applied to the operational service directorates. Corporate and other directorates will be incorporated as part of the business planning cycle for 2022/23.

1.3 Principles and approach

The purpose of the Accountability Framework is to ensure the Trust delivers its strategic objectives and key performance indicators. The approach is based on principles of transparency, consistency, being constructive, integration and appropriate ownership of issues. These are detailed below.

1.3.1 Transparency - The Accountability Framework seeks to promote transparency within the Trust. The Accountability Framework seeks to ensure that the information used in reviewing delivery is consistent with that used to report performance to the Trust Executive and Trust Board.

Service directorates will receive an Accountability Framework report which will be used in the Accountability Framework review meetings and in reporting and discussing delivery with the Executive, Board, commissioners and regulators. Directorates will receive copies of papers and reports that relate to their delivery and improvement plans. Directorates will receive timely feedback from Executive, Board and external meetings.

1.3.2 Consistency - The framework introduces a more consistent approach to the management and reporting of progress and delivery against strategic objectives and key performance indicators. There will be a consistent approaches to RAG ratings, earned autonomy and rules-based escalation.

The Accountability Framework seeks to introduce one consistent model to be applied across the Trust. The Accountability Framework will be applied to both service and corporate directorates. The first phase, in 2021/22, will be to apply the Framework to the service directorates. Phase two of roll out will be to apply the Framework to corporate and other services in 2022/23 as part of the business planning process.

1.3.3 Constructive – The interactions set out in this Accountability Framework need to be constructive to be of value. Challenging poor performance, a lack of clarity on plans to recover delivery issues or a lack of grip is appropriate but must be constructive and support the resolution of issues.

The Accountability Framework review meetings need to be clear and transparent. They are an opportunity to discuss issues, provide assurance and to ask for support. They are not established to provide a platform for aggressive performance management or for issues to be downplayed, hidden, externalised or inappropriately escalated.

1.3.4 Integrated – The Accountability Framework brings together the oversight of various areas of delivery that have previously been managed separately. The Framework will oversee quality and safety; operational performance; workforce and culture; and finance and external relationships in one place. Delivery or issues in any one of these areas will impact on others and as such, will now be reviewed in an integrated way.

1.3.5 Appropriate ownership of issues – The Trust Executive representatives should encourage and expect directorate leadership teams to bring plans and proposals to resolve issues. The Trust Executive representatives should be supportive and constructive but should reject inappropriate escalation. The Trust Executive representatives should refuse to tolerate debates about data in the review meetings. Directorate leadership teams must own the data they submit to Trust systems.

2. Trust values and strategic objectives

The Accountability Framework will be implemented in line with the Trust values and support the delivery of the strategic objectives.

Trust values

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

Draft strategic objectives

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

3. Measuring performance

3.1 Domains

The measurement of directorate performance will be derived from headline ratings under five domains:

1. Quality and safety
2. Operational performance
3. Workforce and culture
4. Finance
5. External relations

Each area will be rated red, amber or green on a monthly basis. The rating will be agreed at the Accountability Framework review meetings and be derived from hard data linked to agreed KPIs and soft intelligence from the review meeting discussions and beyond.

3.2 Key Performance Indicators

A set of Trust Key Performance Indicators have been agreed by the Trust Executive and are appended to this Framework. The list of KPIs will be reviewed and adjusted as part of the annual planning cycle. By exception, new KPIs or the removal of a KPI, will be approved by the Trust Executive.

The Trust has a wider set of KPIs, for example, contractual and system level KPIs. These are important and should continue to be monitored and delivered by the relevant service directorate. Issues that require escalation in relation to the much wider set of KPIs can be raised by exception in the monthly Accountability Framework review meetings.

3.3 RAG rating

A simple approach will be taken to RAG rating the Key Performance Indicators. If an indicator is being delivered it will be rated green. If an indicator is not being delivered but there is a recovery/improvement plan in place that is on track, then the indicator will be rated amber. For an indicator that is not being delivered, that does not have a recovery/improvement plan, and/or is not on track with a restorative plan, it will be rated red.

- Red – a KPI that is not being delivered
- Amber – a KPI that is not being delivered but has an agreed recovery plan with a trajectory that is being met
- Green – a KPI that is being delivered

4. Performance monitoring

4.1 Service directorates

At the core of the Accountability Framework are directorate level performance reports and monthly review meetings between the Trust Executive representatives and directorate leadership teams. Monthly Accountability Framework review meetings will take place with the following directorates:

- Inpatient Services
- Specialist Services
- Community – North
- Community – West
- Community – Mid and South
- Psychology

4.2 Trust and Directorate level reports

Each month, a directorate level report will be made available to the leadership team of each directorate. The aggregation of the Key Performance Indicators in each directorate should equal the Trust position on any indicator.

The Trust performance report will focus on the Key Performance Indicators agreed by the Trust Executive. The performance report will include a narrative on progress to resolve issues and the overall headline ratings for each directorate.

The directorate level report should be reviewed by the directorate leadership team ahead of the monthly Accountability Framework monthly review meetings. The directorate level KPI report will be used as the basis of the discussion at the monthly review meetings.

Alternative data should not be introduced at the monthly meetings. Service directorates must take ownership of the data submitted to Trust systems and used to monitor performance.

4.3 Monthly Accountability Framework review meetings

Each service directorate will participate in monthly review meetings with the Trust Executive representatives. The introduction of these meetings should enable a considerable number of single topic review and assurance meetings to end. The review of internal governance meetings is being undertaken in the context of the introduction of this framework.

The monthly review meetings should be a single integrated forum to have joined up discussions on:

1. Quality and safety
2. Operational performance
3. Workforce and culture
4. Finance
5. External relations

The meetings should be a two-way discussion on the key challenges and successes of each directorate, a check and challenge of the plans to recover areas of non-delivery and the progress of those plans. The Trust Executive representatives should encourage and expect service directorates to bring plans and proposals to resolve issues.

The meetings can also be used to realise plans to devolve accountability, to agree any necessary corporate support or escalation, and to gather learning and best practice to share elsewhere in the Trust.

The meetings will cover planning, data and business growth, where and when appropriate.

4.4 Attendance

These meetings should be prioritised by the leadership team of each directorate and the Trust Executive representatives.

The monthly review meetings will be led by the Trust Executive representative team which will include:

- Dr Milind Karale, Executive Medical Director
- Natalie Hammond, Executive Nurse
- Sean Leahy, Executive Director of People and Culture
- Trevor Smith, Executive Chief Finance and Resources Officer
- Alex Green, Interim Executive Chief Operating Officer

The directorate leadership team should all attend the monthly review meetings and come prepared to discuss their key issues and progress. For the service directorates the expected attendance would be:

- Clinical lead
- Quality lead
- Operational director
- Workforce partner
- Finance partner
- Patient representation

A representative of each directorate leadership team should become part of an extended Executive Team meeting on a monthly basis that considers key issues and takes key decisions.

4.5 Preparation

At least one week in advance of the Accountability Framework monthly review meetings all attendees should receive:

- Agenda
- Directorate KPI pack
- Notes of the previous meeting

A template agenda is attached at appendix two.

The directorate KPI pack should include trend information against the Trust Executive agreed key performance indicators.

All attendees should have reviewed the directorate pack ahead of the meeting. The directorate leadership team should be prepared to discuss the progress made with previously agreed actions, the development of recovery/improvement plans,

implementation of recovery/improvement actions and areas of progress to share with other directorates.

Each directorate should hold a monthly review of delivery as part of the rhythm of management meetings. This may be through a focus in one of the regular senior management team meetings or via a bespoke meeting.

These meetings should take place ahead of the Accountability Framework review meetings set out above so that information can be fed into the discussions rather than an upcoming directorate meeting being used as a mechanism to defer discussion with the Trust Executive.

The directorate leadership team should attend the Accountability Framework review meeting fully aware of the factors causing an adverse performance against the expected standard of measure for the priority KPIs; what actions have been taken to date and the impact these actions have had; and what actions are yet to be taken and the expected outcome linked to timeframes.

Action notes will be captured and circulated within a week of the review meetings. The actions should be followed up between meetings, to the timeframes agreed. The delivery of previously agreed actions should be reviewed at each monthly meeting.

4.6 Outcomes from the monthly review meetings

The monthly review meetings will be used to gain integrated assurance across the broad range of topic areas. Specific outcomes of the monthly meetings will include:

- Agreed actions to address areas of concern – owner and timings agreed
- Agreed changes to the directorate risk register, to the Trust risk register and the BAF
- Agreed narrative for the Trust performance report
- Informing the provision of assurance to the Trust Executive and through them to the Board committees
- Examples of good practice to share within the Trust

4.7 Reporting

The Trust performance report will be considered by the Trust Executive on a monthly basis. The narrative element of the report should focus on whether recovery plans are in place to resolve key issues and whether they are on track to deliver recovery. The Trust performance report should contain the scorecards for each directorate.

5. Earned autonomy and escalation

For extended periods of strong delivery the Accountability Framework review meetings could be used to agree less frequent reviews, a change to the focus of the standard agenda, some showcasing of successes, opportunities to buddy with other teams or other agreed freedoms or rewards.

The meetings for all directorates should be used to promote local decision-making on most issues by the local leadership team.

In terms of escalation, more frequent or specific meetings could be set up to focus more closely on a long-standing challenge. Escalation to a CEO led meeting might also be agreed. Buddy arrangements with another team that has successfully resolved an issue could be applied.

6. Review of the Accountability Framework

The EPUT Accountability Framework will be reviewed in Q4 of 2021/22, alongside the planning and KPI setting processes for 2022/23.

Appendix one

Key performance indicators and data to be shared ahead of the meetings

The measurement of directorate performance will be derived from headline ratings under five domains:

1. Quality and safety
2. Operational performance
3. Workforce and culture
4. Finance
5. External relations

<u>Quality and safety</u>

1. An upward trend in the number of patients and families that say they feel safe in EPUT's care
2. An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation
3. 100% of patients have safety plans
4. 100% of inpatients have been involved in completing their safety plans
5. Suicide awareness training targets achieved
6. Number of Never Events
7. Patient safety incidents not signed off
8. Ligature incidents – fixed and non-fixed
9. Incidents of self-harm
10. Incidents of violence and aggression
11. Incidents of seclusion
12. Incidents of restraint
13. Incidents of prone restraint
14. Absence without leave
15. Falls
16. Admission of under 16s to adult facilities
17. Pressure ulcers

18. Safety alerts not signed off
19. MHA detentions
20. MHA admissions
21. Complaints received
22. Complaints resolved within agreed timeframes
23. Medication incidents

Operational performance

Access

1. IAPT access
2. IAPT recovery
3. IAPT waiting
4. EIP – 2-week standard
5. 6-week diagnostic standard
6. 18 weeks referral to treatment
7. CAMHS Eating Disorders – 1 week and 4-week standards
8. Adult CMHT Access – 5 day and 6-week standards
9. 52 week waits – initial and internal waits
10. Drug and alcohol services

Patient flow

11. Occupancy
12. Length of stay
13. DTOC
14. Gatekeeping
15. CPA 72-hour follow up
16. Readmission rates
17. Out of area placements

Employment, accommodation and data

18. MH patients in employment
19. MH patients in settled accommodation
20. Data quality maturity index

Workforce and culture

1. Safe staffing – fill rates
2. Incidents of bullying and harassment
3. Turnover rate
4. Vacancy rate
5. Sickness rate
6. Cost of sickness absence
7. Agency costs
8. Bank utilisation
9. Mandatory training
10. Annual appraisals
11. Equality and diversity
12. Flu vaccination
13. Clinical supervision
14. Patient engagement

Finance

1. Income v budget YTD
2. Expenditure v budget YTD
3. Expected year end position v budget
4. Better Payment Practice Code - % not paid in 30 days
5. Efficiency Delivery
6. Capital – Actual vs Plan YTD
7. FPM Performance

8. Waiving of competitive tendering / quotations (where outside of agreed exemptions in SO's)

External relations

Judgement based on links to the VCS, PCNs, Place, local authorities and other partners.

Appendix two

Standard agenda – Accountability Framework review meetings

1. Welcome, introductions and apologies
2. Actions from the previous meeting
3. Quality and safety
4. Operational performance
5. Workforce and culture
6. Finance
7. External relations
8. Other issues requiring escalation
9. Agreeing changes to the directorate or Trust risk register
10. Summary of agreed actions
11. Directorate Accountability Framework ratings
12. Any other business

Appendix three

Directorate scorecard

Directorate	Quality and safety	Operational performance	Workforce and culture	Finance	External relations
Inpatient services					
Specialist services					
Community North					
Community West					
Community Mid and South					
Psychology					

END

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Review of SFI's and Standing Orders**					
Non-Executive Lead:	Paul Scott Chief Executive Officer					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Audit Committee Council of Governors					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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 Orders For The Council Of Governors
4 Approve the Standing Financial Instructions
5 Approve the Scheme of Reservation and Delegation
6 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 Orders For The Practice and Procedure of The Council of Governors, 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 1-5. Any formatting issues caused by the track changes will be rectified in the final version of the document. 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

- **(Page 21) Section 4.6 Delegation to Committee and Officers:** Section 4.6.4 has been added to note the Board can delegate authority to an Executive Director to make decisions on behalf of the Board for any community collaborative board, in line with limitations set-out in the SoRD and DSoD. The Executive Team considered this addition and agreed although Section 4.6 provides this authority in general; it was good to include collaborative boards specifically to provide clarity.
- **(Page 29 & 31) Section 9.4 Formal Competitive Tendering & Section 9.6 Where tendering or competitive quotation is not required:** This section has been reviewed and amended by the Head of Procurement.

The Standing Orders were circulated to the Council of Governors for virtual consultation (as previously agreed by the Council to reduce formal paperwork). Some minor amendments were suggested and incorporated into the document. One Governor raised the issue of using the "he" pronoun in the document and suggested changes to be made. However, there are a number of governance documents with this same issue; therefore, it is proposed a review is undertaken over the next few months of all governance documents, to ensure the "he" pronoun is changed, without altering the meaning of any statements.

Appendix 2: Standing Orders For The Council Of Governors

- **Section 3.5.3:** Additional statement to encourage Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly to confirm if any alternative action can be taken. However, this does not prevent any Governor from directly contacting Monitor (NHSE/I) should they wish to do so.
- **Section 3.7.3:** Additional statement added to confirm action if a Governor vacancy cannot be filled.
- **Section 14.7.3:** Additional statement added to clarify when a meeting takes place entirely virtually, the meeting will be recorded as having taken place via the specific virtual platform. The current statement refers more to meetings that take place virtually across two locations (such as video conferencing).

Appendix 3 Standing Financial Instructions

- **(Page 5) Section 1.1.7:** A new section has been included in respect of the Trusts membership of the East of England Provider Collaborative and Mid and South Essex Community Collaborative. This confirms that these will be supported by legally binding contracts and that unless explicitly stated, the Trusts governance documents must be followed.
- **(Page 6) Section 1.2.1e:** Confirmation that the role of Budget Manager can include responsibility for income and capital budgets, as well as expenditure.
- **(Page 7) Section 1.2.1m:** Amendment to the definition of Director to confirm these are posts that are 'as appointed by an Executive Director'. The definition previously included all staff who report into an Executive Director, which could potentially assign signatory rights to staff who are not an appointed Director of the Trust.
- **(Page 7) Section 1.2.1q:** Confirmation that legal advisor could include a professional legal firm in addition to an officer of the Trust
- **(Page 10) Section 2.1.6:** Confirmation of Governor involvement in the selection process for external audit.
- **(Page 13) Section 2.3.10:** Updating of external auditors responsibilities for securing economy, efficiency and effectiveness in the use of resources and the new requirements of the Code of Audit Practice 2020. In addition, the wording has been amended to clarify that the auditors are required to assess if they are satisfied.
- **(Page 17) Section 3.1.3a:** To include reference to the Trusts income, revenue and capital plans needing to align to the wider system financial plans.
- **(Page 31) Section 9.1.2:** To delegate approval for the establishment of new or amending of existing signatories to the relevant Assistant Director, Director or Executive Director. Any such requests would be in line with the limits stated in the Detailed

Scheme of Delegation. Previously the approval of such requests also required the approval of the CFO or DoF.

- **(Page 37) Section 11.1.4:** Updated to include new capital allocation included in the annual plan for health and safety.

Appendix 4 Scheme of Reservation and Delegation

- **(Page 4) Section 2.6:** This section has been amended to provide for the new process agreed by the BoD Remuneration & Nomination Committee to allow the CEO to identify an Executive Director to act as Deputy CEO in their absence. The statement has also been amended to provide for formal acting-up status to an Executive Director should it be required for the CEO / CFO to approve income or expenditure and the CFO is acting as the CEO.
- **(Page 4) Section 2.8:** Section added to provide a general statement to allow the Board to delegate authority to Executive Directors to make decisions on behalf of the Board for any community collaborative board to ensure it functions effectively. Clarity has been made that this must be in-line with any limitations provided by the DSoD.

Appendix 5 Detailed Scheme of Delegation

- **(Page 3) Section 1.1:** Confirmation that this section covers pay, non pay and income.
- **(Page 3) Section 1.1e:** Delegation of approval of authorised signatory form to Assistant Director, Director or Executive Director as per 9.1.2 of the SFI's. This was previously undertaken by the CFO or DoF.
- **(Page 3 – 4) Section 2.1a (i-viii):** There are two proposed changes around the delegated financial limits assigned to staff. This includes confirming that only authorised staff are able to sign up to £4,999 and that Executive Directors can now sign up to £99,999 without the need for secondary approval by the Director of Finance. Current and proposed limits are as follows,

	CURRENT	**PROPOSED**
Up to £4,999	Other Staff	Other *Authorised* Staff
Up to £9,999	Budget Manager	Budget Manager
Up to £24,999	Assistant Director	Assistant Director
Up to £49,999	Director / ED	Director / ED
Up to £99,999	DoF and ED	*Executive Director*
Up to £249,999	ECFO or CEO	ECFO or CEO
Up to £999,999	ECFO and CEO	ECFO and CEO
Over £1m	Board	Board

- **(Page 4) Section 2.1a (viii):** Approval of expenditure in excess of £1m has remained unchanged and requires Board approval. However, two agreed exemptions have been included. This includes authority to transact payroll related expenditure (tax, national insurance, pensions etc) arising from our payroll provider or direct engagement supplier which has been delegated to Band 8c finance staff and above for expediency and control. The second relates to the approval of NHS and independent sector transactions relating to the East of England provider collaborative which has been delegated to CFO and CEO.
- **(Page 5): Section 3a & 3b:** Currently the ECFO or CEO have a delegated approval limit of up to £999,999 for the release of capital funds to individual capital schemes from a pre-Board approved allocation. A new lower approval limit of up to £100,000 has now been included for the CPPG, with all approvals by CPPG and the ECFO / CEO requiring noting to the Finance & Performance Committee. Following agreement that PIT would become more focussed on the people agenda, approval to release funds to individual capital schemes in excess of £1m is amended to the Finance & Performance Committee rather than the PIT. This also applies to the approval of new capital allocations not in the plan or in excess of plan (3b).

- **(Page 6) Section 4:** Clarification that 'where possible' each competitive tender process should include one contractor that has not bid for the preceeding 12 months to ensure that the unavailability or lack of response from a potential contractor, does not invalidate the process.
- **(Page 7) Section 4d:** The ability to approve tender submissions has been amended so that EOC can approve up to £10m and Board thereafter. This had previously been based on up to 2.5% of income (circa £9m) to ECFO and CEO, up to 5% of income (circa £18m) to PIT and Board thereafter.
- **(Page 8): Section 6c & d:** Clarification of types of agency staff that can be approved by Directors and Executive Directors.
- **(Page 15): Section 17f (v):** Confirmation that the approval of annual leave in excess of 10 days due to maternity or long term sickness is an automatic approval by the line manager as a requirement of the Disability Act.
- **(Page 15): Section 17f (vi):** Confirmation that the line manager can also approve compassionate leave in line with the relevant HR procedure.
- **(Page 16): Section 17g (ii):** Confirmation that the agreement for a member of staff to return to work part time on full pay to assist recovering is a requirement of the Disability Act.

Directors will be aware that there are a number of workstreams in progress which may require a mid-year review of the Trusts governance documents. This includes the roll out of the accountability framework, arrangements to support the collaboratives and the development of guidance and processes around business cases (for both expenditure and income opportunities).

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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			
CEO	Chief Executive Officer	CFO	Chief Finance Officer
DoF	Director of Finance	SFI	Standing Financial Instructions
SoRD	Scheme of Reservation & Delegation	DSoD	Detailed Scheme of Delegation
SOs	Standing Orders		

Supporting Documents and/or Further Reading
Appendix 1: Standing Orders for the Board of Directors
Appendix 2: Standing Orders for the Council of Governors
Appendix 3: Standing Financial Instructions (SFI's)
Appendix 4: Scheme of Reservation & Delegation (SoRD)
Appendix 5: Detailed Scheme of Delegation (DSoD)

Lead
Paul Scott **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:	004
KEY CHANGES FROM PREVIOUS VERSION	~~Minor amendments~~ Addition of section to provide delegated authority to Executive Directors as part of a collaborative board (4.6.4) Amendments to formal competitive tendering and where competitive tendering is not required. (9.4, 9.6)
AUTHOR:	Trust Secretary
CONSULTATION GROUPS:	Board of Directors Audit Committee Executive Team Council of Governors ~~CoG Governance Committee~~
IMPLEMENTATION DATE:	01 April 2017
AMENDMENT DATE(S):	08 November 2017 (Chair's action) August/September 2018 September 2019, September 2020, September 2021
LAST REVIEW DATE:	September 2021~~0~~
NEXT REVIEW DATE:	September 2022~~1~~
APPROVAL BY BOARD OF DIRECTORS	September 2022~~0~~
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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	✓	

The Chief Executive is responsible for monitoring and reviewing this policy

INDEX

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

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 The Board may delegate executive powers to an Executive Director to make decisions on behalf of the Board of Directors as part of a Collaborative Board. However, this must be in line with limitations set by the DSoD and SoRD.

4.6.54 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

4.6.65 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 2013)* 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 (h) 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 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) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

(d) Where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender

(e) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source

(f) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor for the new task would be inappropriate

(g) There is clear benefit to be gained from maintaining continuity with an earlier project. (The benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering)

(h) Sole/single source supplier; or

(i) 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 and other NHS Frameworks 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) Part order of locally tendered contract.

(b) NHS/National Framework Agreement – if the supply of goods or services is on a national framework agreement, and the price is certain (i.e. quoted)

A waiver form does not need to be completed if either 9.6.1 (a), or 9.6.1 (b) applies.

In all other circumstances where three competitive quotations cannot be obtained, then a formal waiving of competitive quotations needs to occur and section C of the waiver form needs to be completed and authorised by either the Executive Chief Finance Officer or the Chief Executive. This decision then needs to be reported to the next available meeting of the Audit Committee

Reasons for waivers may include;

(c) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

(d) Where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender

(e) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source only

(f) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor for the new task would be inappropriate

(g) There is clear benefit to be gained from maintaining continuity with an earlier project. (The benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering)

(h) Sole/single source supplier

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 2018 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. **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.

3.0 IMPLEMENTING THE GUIDING PRINCIPLES ABOVE:

Gifts

3.1 With the exception of items of little value (less than £50) 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.

STANDARDS FOR MEMBERS OF NHS BOARDS AND CLINICAL COMMISSIONING GROUP GOVERNING BODIES IN ENGLAND

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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

STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE COUNCIL OF GOVERNORS

POLICY REFERENCE NUMBER:	TB02
VERSION NUMBER:	0054
KEY CHANGES FROM PREVIOUS VERSION	~~Updated to include references to digital working and virtual meetings.~~ ~~Updated sections relating to Conflict of Interest to reflect national guidance.~~ Section 3.5.3: Amended to provide Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly. Section 3.7.3: Amended to provide action to be taken if a Governor vacancy cannot be filled. Section 14.7.3: Amended to clarify the formal location of a meeting when held completely virtually.
AUTHOR:	Trust Secretary
CONSULTATION GROUPS:	Board of Directors Council of Governors CoG Governance Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	September 2018, September 2019, November 2019, September 2020, September 2021
LAST REVIEW DATE	September 2021~~0~~
NEXT REVIEW DATE	September 2022~~1~~
APPROVAL BY COUNCIL OF GOVERNORS	~~23 September 2020~~01 September 2021
RATIFIED BY	Not applicable
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POLICY SUMMARY
The purpose of the Standing Orders for the Council of Governors is to set out the practice and procedures of the Council in order to maintain good standards of governance.
The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the Standing Orders for the Council of Governors will be undertaken by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this policy is the Chief Executive Officer

CONTENTS

INTRODUCTION

Regulatory Framework

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1st April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act), by Monitor - 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.

The principal place of business of the Trust is The Lodge, Lodge Approach, Wickford, Essex SS11 7XX.

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary)

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 or regulations made under it shall have the same meaning in these standing orders and in addition:

1.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)

1.2.2 **2012 Act** means the Health & Social Care Act 2012

1.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

1.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**

1.2.5 **Chair of the Board** or **Chair of the Trust** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from a meeting or is otherwise unavailable or such other Non Executive Director as may be appointed as acting Chair in accordance with these SO

1.2.6 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution

1.2.7 **Committee** means a committee appointed by the Council of Governors

1.2.8 **Committee members** means persons formally appointed by the Council of Governors to sit on or to chair specific committees

1.2.9 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act

1.2.10 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution

1.2.11 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.2.12 **Executive Director** means a member of the Board of Directors, including the Chief Executive, appointed under paragraph 31 of the constitution

1.2.13 **Lead Governor** is the person appointed by the Council of Governors in accordance with (Monitor's) *NHS Foundation Trust Code of Governance* (July 2014)

1.2.14 **Licence** means the Trust's provider licence (no: 120163) issued by Monitor on 1st April 2017

1.2.15 **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

1.2.16 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting

1.2.17 **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

1.2.18 **SOs** mean these Standing Orders (for the Council of Governors)

1.2.19 **Trust** means Essex Partnership University NHS Foundation Trust

1.2.20 **Trust Secretary** means a person appointed by the Chair and Chief Executive as the Trust Secretary

1.2.21 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution

1.2.22 **Working days** a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday

1.3 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

1.4 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

2. COUNCIL OF GOVERNORS ROLES AND RESPONSIBILITIES

2.1 The purpose of these SOs is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations

2.2 The roles and responsibilities of the Council which are to be carried out in accordance with the Trust's constitution, licence and (Monitor's) *NHS Foundation Trust Code of Governance* (July 2014) (and any subsequent versions) are:

General Duties

2.2.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

2.2.2 To represent the interests of the members of the Trust and the interests of the public

Chair and Non-Executive Directors

2.2.3 To approve the policies and procedures for the appointment and removal of the Chair and/or Non-Executive Directors in accordance with any guidance issued by Monitor (NHSE/I) and on the recommendation of the Council's Nominations Committee

2.2.4 To appoint and remove the Chair and other Non-Executive Directors. The Council should only exercise its power to remove the Chair or any other Non-Executive Directors after exhausting all means of engagement with the Board

2.2.5 To approve the policies and procedures for the appraisal of the Chair and Non-Executive Directors on the recommendation of the Council's Remuneration Committee. The performance of Non-Executive Directors should be subject to regular appraisal and review. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council should ensure planned and progressive refreshing of the Non-Executive Directors

2.2.6 To decide the remuneration, allowances and other terms of office for the Chair and Non-Executive Directors having regard to the recommendations of the Council's Remuneration Committee. Professional advisers should be consulted to market test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when there is a material change to the remuneration of the Chair or another Non-Executive Director.

Chief Executive

2.2.7 To approve the appointment of the Chief Executive of the Trust.

Auditors

2.2.8 To approve the criteria for the appointment, removal and re-appointment of the auditor

2.2.9 To appoint, remove and reappoint the auditor having regard to the recommendation of the Trust's Audit Committee.

Strategy Planning

2.2.10 To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate

2.2.11 To collaborate with the Board in the development of the Trust's forward plan

2.2.12 Where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purpose of the NHS in England, to determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and notify its determination to the Board

2.2.13 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the NHS in England, approve such a proposal

2.2.14 To approve entering into any significant transactions (as defined under paragraph 49 and Annex 9 of the constitution) in accordance with the 2006 Act and the constitution

2.2.15 When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

2.2.16 To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council.

Representing Members and the Public

2.2.17 To prepare and from time to time review the Trust's membership engagement strategy and policy

2.2.18 To notify Monitor (NHSE/I), via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level

2.2.19 To report to the members annually on the performance of the Council

2.2.20 To promote membership of the Trust and contribute to opportunities to recruit and engage members in accordance with the membership strategy

2.2.21 To seek the views of stakeholders and feedback to the Board

2.3 All business shall be conducted in the name of the Trust

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council

The composition of the Council shall be in accordance with paragraph 14 of the constitution

3.2 Appointment of the Chair

The Chair is appointed by the Council as set out in paragraph 28 of the constitution

3.3 Terms of Office of the Chair

The provisions governing the period of tenure of office of the Chair are set out in Board of Directors SO 2.8

3.4 Role of the Chair

3.4.1 The Chair is not a member of the Council. However, under the regulatory framework, he presides at meetings of the Council and has a second or casting vote

3.4.2 Where the Chair has died or has ceased to hold office, or where he is unable to perform his duties as Chair owing to illness or any other cause, and there will be an absence of a Chair for less than 3 months the Vice-Chair of the Board shall act as Chair until a new Chair is appointed or the existing Chair resumes his duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform his duties, be taken to include references to the Vice-Chair

3.4.3 Where an absence of the Chair has or will exceed a period of 3 months the Council at a general meeting shall appoint one of the Non-Executive Directors as the acting Chair. Before a resolution for such an appointment is passed,

the Board shall be entitled to advise the Council of the Non-Executive Director (who may be the Vice-Chair) who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision. The Vice Chair shall act as Chair until an appointment of an acting Chair is made by the Council.

3.5 Role of the Lead Governor

3.5.1 The Lead Governor shall be appointed by the Council

3.5.2 The Lead Governor will facilitate communication between Monitor (NHSE/I) and the Council where Governors have concerns about the leadership provided to the Trust by the Board or in circumstances where it would be inappropriate for the Chair to contact Monitor (NHSE/I), or vice versa (for example, regarding concerns about the appointment or removal of the Chair)

3.5.3 Having a Lead Governor does not prevent any other Governor from making contact with Monitor (NHSE/I) directly if they feel this is necessary. However, any Governor should consider contacting he Lead Governor prior to contact with Monitor (NHSE/I) For the avoidance of doubt, a person holding the role of Lead Governor shall not assume greater power or responsibility than other Governors. Where the Trust chooses to broaden the Lead Governor's role, the Chair and the Council should agree what powers should be included.

3.6 Termination of Office and Removal of Governors

Paragraphs 16, 17 and Annex 6 paragraph 5 of the constitution sets out the period of tenure of office of Governors and provisions relating to the termination or suspension of office of Governors.

3.7 Vacancies Amongst Governors

3.7.1 Where a vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement

3.7.2 Where a vacancy arises amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacant office for the unexpired balance of the retiring member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled

3.7.3 Where the vacancy cannot be filled, consideration will be given for holding a by-election, based on cost of the election and the proximity of any by-election to other elections to the Council of Governors.

3.8 Appointment and Powers of Vice-Chair

3.8.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in his place

3.8.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision

3.8.3 Subject to SO 3.4.2 and SO 3.4.4 in the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust

3.8.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 3.8

4. MEETINGS OF THE COUNCIL

4.1 Subject to SOs 4.2.1 and 4.2.2 below and any other provisions of these SOs, the Council may only exercise any powers and make decisions when in formal session. The Council may be advised by committees appointed by the Council but may not devolve any decision making powers to these committees, which, for the avoidance of doubt, shall operate as working groups of the Council.

4.2 Admission of the Public and the Press

4.2.1 The meetings of the Council shall be open to members of the public and the press

4.2.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Council will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 13(2) of Schedule 7 of the 2006 Act, the Council of Governors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed."

4.2.3 The Chair may exclude any person from a meeting of the Council if that person is interfering with or preventing the proper conduct of the meeting

4.2.4 Nothing in these SOs shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council

4.2.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Council and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting

4.2.6 All decisions taken in good faith at a meeting of the Council or of any committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

4.3 Calling Meetings

4.3.1 Ordinary meetings of the Council shall be held at such times and places or via digital platforms as the Council may determine

4.3.2 There shall be not less than four meetings in any year except in exceptional circumstances

4.3.3 Meetings of the Council may be called by the Trust Secretary, or by the Chair. Not less than one-third of the Governors in office can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary stating the business to be considered at the meeting.

4.4 Notice of Ordinary Meetings

4.4.1 The Trust Secretary shall give to all Governors at least 10 (ten) working days written notice of the date and place of every ordinary meeting of the Council

4.4.2 Agendas will be sent to Governors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent business under a meeting called under paragraph 4.5.1

4.4.3 A notice or other document(s) to be served upon a Governor under these SOs shall be delivered by hand or sent by post to the Governor at the place of residence which he shall have last notified to the Trust, or where sent by email, to the address which he shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means

4.4.4 A notice or other document(s) where delivered by hand or sent by post shall be presumed to have been served on the next working day following the day it was sent and where it was sent by email at the time at which the email is sent

4.4.5 Failure to serve notice and supporting papers on any Governor shall not affect the validity of an ordinary meeting

4.4.6 Save in the case of urgent meetings, for each meeting of the Council a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office and on the Trust's internet site for general access at least three working days before the meeting.

4.5 Notice of Urgent/Extraordinary Meetings

4.5.1 At the request of the Chair or not less than one-third of Governors, the Trust Secretary shall send written notice of a meeting to all Governors as soon as possible after receipt of such a request. The Trust Secretary shall give Governors as much notice of the meeting as is practicable in light of the urgency of the request

4.5.2 If the Trust Secretary does not call a meeting of the Council of Governors within ten (10) working days of receiving a requisition from Governors pursuant to SO 4.3.3, the Governors who made the requisition may convene the meeting themselves by giving written notice to all Governors; this notice must be signed by all of the Governors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition

4.5.3 In the case of a meeting called under SO 4.4.2, 4.4.3 or 4.5.1, the notice shall be signed by the Chair or by at least one-third of Governors in office

4.5.4 No business at a meeting called under SO 4.4.2, 4.4.3 or 4.5.1 shall be transacted at that meeting other than that specified in the notice. Agendas will be sent to Council members three (3) working days before the meeting and supporting papers, shall accompany the agenda, save in the case of urgent meetings

4.5.5 In the case of a meeting called under SOs 4.4.2, 4.4.3 and 4.5.1 failure to serve such a notice on more than three (3) Governors will invalidate the meeting

4.6 Setting the Agenda

4.6.1 The Council may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted

4.6.2 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chair at least seven (7) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) working days before a meeting may be included on the agenda at the discretion of the Chair

4.7 Motions

4.7.1 **Notices of motion:** A Governor desiring to move or amend a motion shall send a written notice thereof at least seven (7) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda

4.7.2 **Withdrawal of motion or amendment:** A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair

4.7.3 **Motion to Rescind a Resolution:** Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. Such notice shall be sent to the Chair at least 10 (ten) working days before the meeting, who shall insert it in the agenda for the meeting. When any such motion has been disposed of by the Council, no Governor may propose a motion to the same effect within six months. However, the Chair may do so if he considers it appropriate

4.7.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto

4.7.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Governor to move one of the following motions:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*
(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate

4.7.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8 Petitions

Where a petition has been received by the Trust not less than 10 (ten) working days before a meeting of the Council, the Chair of the Council shall include the petition as an item for the agenda of the next meeting of the Council.

4.9 Chair of Meeting

4.9.1 At any meeting of the Council the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or another Non-Executive Director, if there is one present, shall preside

4.9.2 If the Chair, Vice-Chair and all Non-Executive Directors are absent, the Lead Governor, if present, shall preside. If the Lead Governor is not present, such Governor to be appointed from amongst the Council present shall preside

4.10 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11 Record of Attendance

4.11.1 The names of the Chair and Governors present at a meeting shall be recorded in the minutes. Board Directors who attend a meeting will be recorded in the minutes as 'in attendance'

4.11.2 Governors who are unable to attend a Council meeting should advise the Trust Secretary in advance of the meeting so that their apologies may be submitted

4.11.3 A meeting of the Council refers to officers being physically present or officers being present via the use of technology, as defined in SO 4.12.6.

4.12 Quorum

4.12.1 The quorum for every meeting of the Council shall be one-third of the total number of Governors in office on the date of the meeting, a majority of whom must be Public Governors

4.12.2 If at the time of the meeting no quorum is present:

(a) The Chair shall announce a 30 minute delay
(b) If after the delay a quorum is present, the meeting shall proceed
(c) If a quorum is not present after the delay, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such a time and place as the Chair shall determine and a notice of the adjourned meeting shall be circulated to Council members. When the meeting reconvenes, if a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum

4.12.3 Where during a meeting of Council a quorum is no longer present:

(a) The Chair shall announce a five (5) minute delay

(b) If after the delay there remains no quorum, the Council meeting shall be adjourned

4.12.4 Where the Council is adjourned under SO 4.12.3(b), the Trust Secretary shall list the uncompleted business from the meeting as the first items for consideration at the next following meeting of Council

4.12.5 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business

4.12.6 Governors may participate (and vote) in its meetings by telephone, teleconference, video or computer link in accordance with SO 4.19 below. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.13 Voting and Decisions

4.13.1 At the end of a discussion on business not subject to a decision, the Chair may summarise the view of the Council for recording in the minutes

4.13.2 On any matter requiring a decision, Council shall determine its position by voting

4.13.3 Subject to statutory or constitutional requirements, a decision of the Council is reached by a majority of Governors present and voting. Votes in abstention shall not be counted in determining a majority. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors present and voting

4.13.4 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote

4.13.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands

4.13.6 On the request of the one-third of the Governors present, a recorded vote shall be taken:

(a) The Trust Secretary will call the names of all Governors
(b) Each Governor shall declare their vote as 'In Favour', 'Against' or 'Abstain'
(c) The vote of each Governor shall be recorded in the minutes accordingly

4.13.7 On the request of the majority of Governors present at the meeting, a vote may be taken by secret ballot:

(a) Each Governor shall be issued with a ballot paper allowing a vote of 'In Favour', 'Against' or 'Abstain'
(b) Each Governor shall have the opportunity to vote in secret
(c) The Trust Secretary shall count the ballots, and record the number of votes cast for each option on the minutes

(d) Governors may not record their vote in the minutes if a secret ballot is taken.

4.14 Voting by Paper Ballot

4.14.1 If the Chair of the Trust calls an extraordinary meeting of the Council under SOs 4.4.2, 4.4.3 and 4.5.1 he may, subject to SO 4.16.2 below, determine that any Governor may cast his vote on the matter(s) to be dealt with at the meeting by paper ballot in accordance with the process set out at SOs 4.16.3 - 4.16.5 (inclusive) below

4.14.2 The Chair may only determine that Governors may cast their vote by paper ballot on any matter where this is compatible with the 2006 Act

4.14.3 Where the Chair makes a determination pursuant to SO 4.14.1 in respect of any extraordinary meeting of the Council, the Trust Secretary shall circulate a ballot paper to all of the Governors together with the papers for the meeting

4.14.4 Any Governor may cast his vote at the meeting or by:

(a) marking the ballot paper, in accordance with the instructions on the ballot paper, to show how he wishes to vote
(b) subject to SO 4.14.6, signing the ballot paper
(c) returning the ballot paper to the Trust Secretary so that it arrives before the date and time stipulated on the ballot paper

4.14.5 Governors must return the ballot paper by hand, by email or by post. Any ballot paper received on or after the date and time stipulated shall be rejected

4.14.6 If a Governor returns a ballot paper to the Trust Secretary by email, the ballot paper does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.14.7 Any votes duly cast by paper ballot shall be added to the votes cast by Governors voting in person at the meeting. Unless otherwise provided by the Trust's constitution or by law, every matter shall be determined by a majority of votes cast and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors voting, whether at the meeting or by paper ballot

4.14.8 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all ballot papers for at least twelve (12) months from the date of the meeting in respect of which the votes were cast. The votes (whether in person or by ballot) shall recorded in the minutes in accordance with SO 4.13.

4.15 Prevention of Disorder at a Meeting

If there is disorder in the public gallery (including members of the public attending in a virtual capacity) at a meeting of the Council:

4.15.1 The Chair may direct those causing the disorder to leave the meeting, and they shall thereupon leave and not return to the meeting

4.15.2 The Chair may suspend the meeting to a stated time (not longer than 30 minutes from the time of the suspension) to allow order to be restored

4.15.3 If those causing disorder refuse to comply with the Chair's direction, the Chair may move *that the public gallery be cleared to allow the Council to proceed in proper order*

4.15.4 A motion under SO 4.15.3 shall be voted on immediately and without debate

4.15.5 If Council agrees to a motion under SO 4.15.3, the Chair shall suspend proceedings until the public gallery is cleared; the gallery shall remain cleared for the remainder of the meeting, unless the Council shall otherwise decide.

4.16 Written Resolution Process

4.16.1 Subject to SO 4.16.2, the Council may use the process for adopting a written resolution set out in this SO 4.16 to enable it to transact business between meetings of the Council. The process for adopting a written resolution shall not be used to replace meetings of the Council

4.16.2 The Council may only use a written resolution for transacting business where this is compatible with the 2006 Act.

Proposing written resolutions

4.16.3 At the Chair's request, the Trust Secretary shall propose a written resolution to the Governors

4.16.4 A written resolution is proposed by giving notice of the proposed resolution to the Governors. Such notice shall stipulate:

(a) the proposed resolution; and
(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the Trust Secretary
(c) Notice of a proposed written resolution must be given in writing to each Governor. Notice by email or post is permitted.

Adopting written resolutions

4.16.5 Unless otherwise provided by the Trust's constitution or by law and subject to SO 4.16.7 below, a proposed written resolution shall be adopted when it has been signed and returned to the Trust Secretary by hand, by email or by post by a majority of the Governors

4.16.6 If a Governor returns a written resolution to the Trust Secretary by email, the written resolution does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.16.7 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been returned by the requisite number of Governors pursuant to SO 4.16.6 above, by the longstop date

4.16.8 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Council of Governors' meeting in accordance with these SOs

4.16.9 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

4.17 Meetings: Electronic Communication

4.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof

4.17.2 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council or of a committee of the Council shall be regarded for all purposes as being present and personally attending such a meeting provided that, and only for so long as, at such a meeting 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

4.17.3 A meeting at which one or more of the Governors attends by way of electronic communication shall be deemed to be held at such place at which the Chair is physically present. If the meeting takes places by way of electronic communication entirely, the meeting shall deemed to have been held via the electronic communication platform and will be recorded in the minutes as such.

4.17.4 Meetings held in accordance with this SO are subject to SO 4.12. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting

4.17.5 The minutes of a meeting held in this way must state that it was held (whether wholly or partly) by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

4.18 Minutes

4.18.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the person presiding at it, including electronically.

4.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting

4.18.3 Minutes shall be retained in the Trust Secretary's office

4.18.4 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

4.19 Additional Powers

4.19.1 The Council may require one or more of the Directors to attend a Council meeting to obtain information about the Trust's performance of its functions or the directors' performance of their duties, and to help the Council to decide whether to propose a vote on the Trust's or Directors' performance

4.19.2 The Trust may choose to involve Governors in hospital/service visits or volunteering. However, Governors acknowledge that they do not have a right to inspect Trust property or services and they are not under a duty to meet patients and conduct quality reviews

4.19.3 Governors may refer a question concerning whether the Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006

Act to the Panel for Advising Governors appointed by Monitor (NHSE/I) under the 2006 Act.

4.20 Variation and Amendment of Standing Orders

4.20.1 Any variation of these SOs shall not constitute a variation of the constitution. These SOs shall be amended only if:

(a) unless proposed by the Chair, a notice of motion under SO 4.7 has been given; and
(b) not fewer than half of the Trust's Governors vote in favour of amendment; and
(c) at least half of the Governors are present at the meeting at which the amendment is considered; and
(d) the variation proposed does not contravene a statutory provision or requirement, condition or notice issued by Monitor (NHSE/I); and
(e) the amendment is approved by the Council.

5. ARRANGEMENTS FOR THE EXERCISE OF COUNCIL FUNCTIONS

5.1 The Council may not delegate its functions to any committee of the Council. Subject to the constitution and any requirements of Monitor (NHSE/I), the Council may appoint committees to assist the Council in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly of the Chair and members of the Council.

5.2 A committee appointed under this SO 5 may, subject to such requirements, conditions or notices as may be given by Monitor (NHSE/I) or such directions as may be issued by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The SOs of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the chair of the committee as the context permits, and the terms "member of the Council" or "Governor" is to be read as a reference to a member of the committee also as the context permits.

5.4 There is no requirement to hold meetings of committees established by the Council in public.

5.5 Each such committee shall have such terms of reference and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the regulatory framework and any requirement, condition, notice or guidance issued by Monitor (NHSE/I). Such terms of reference shall have effect as if incorporated into the SOs.

5.6 The Council shall approve the terms of reference and appointments to each of the committees which it has formally constituted.

5.7 The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.8 A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable) until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.

5.9 A Governor or a non-Governor in attendance at a committee or of a meeting of the Council shall not disclose any matter dealt with by the committee or the Council, notwithstanding that the matter has been reported or concluded, if the Council or committee resolves that it is confidential.

5.10 The Trust Secretary or his deputy or assistant will attend all meetings of the committees in support of them.

5.11 Notwithstanding anything in these SOs, the Chair and Governors may meet informally or as a committee of the Council at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation. For the avoidance of doubt, no business shall be conducted at such meetings.

6. PREVENTION OF CONFLICTS OF INTEREST

6.1 Declaration of Interests

6.1.1 The Trust recognises that, as volunteers, Governors may have private interests that could conflict with those of the Trust. It is the responsibility of Governors to ensure that any potential conflicts of interest are registered and declared at meetings in accordance with this SO and paragraph 22 of the constitution.

6.1.2 The Trust policy for Conflicts of Interest, Gifts and Hospitality (CP80) defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold"

6.1.3 A conflict of interest may be

- **Actual:** There is a material conflict between one or more interests.
- **Potential:** There is the possibility of a material conflict between one or more interests in the future.

6.1.4 Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see if different and perceived conflicts of interests can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

6.1.5. Interests fall into the following categories:

(a) Financial interests: Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

(b) Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

(c) Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

[1] This may be a financial gain, or avoidance of a loss.

(d) Indirect interests: Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6.1.6 Governors must declare interests which are relevant and material to the Council. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment

6.1.7 At the time Governor's interests are declared they should be recorded in the Council register of interests and in the minutes of the relevant meeting at which the declaration is made. Any changes in interests should be declared at the next meeting following the change occurring

6.1.8 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports

6.1.9 During the course of a meeting of the Council, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision

6.1.10 There are a number of common situations which can give rise to risk of conflicts of interest, as follows:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership issues
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

6.1.11 The interests of Governors' spouses or partners if living together, in contracts are to be declared. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 Register of Interests

6.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors. In particular the register will include details of all directorships and other actual and potential interests which have been declared by Governors, as defined in paragraphs 22 of the constitution and SO 6.1.3

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

6.2.2 The Trust Secretary shall keep these details up to date by means of an annual review of the register, for which Governors will be required to complete a further declaration via an Annual Declaration of Interest Form. It is the responsibility of each Governor to provide an update to the Trust Secretary of their register entry if their interests change. The form will also require Governors to provide consent to process and publish this information as per GDPR requirements.

6.2.3 The register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it

6.2.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by the NHSE/I.

6.3 Interests of Relatives, Spouses and Partners

6.3.1 A Governor is required to declare, as if it was their own interest, interests owned or otherwise held by:

6.3.1.1 Their spouse or civil partner
6.3.1.2 Any person with whom they have a long-term relationship as a couple on a domestic basis
6.3.1.3 Their children, step-children or other minors living in the same household as them
6.3.1.4 Any parent, grandparent, uncle or aunt living in the same household as them

6.3.2 Where a declaration is made under SO 6.3, the Governor shall declare and the Trust Secretary shall note on the Register:

6.3.2.1 The name of the individual having the interest
6.3.2.2 Their relationship to the Governor making the declaration.

6.4 Interest of Governors in Contracts

6.4.1 If it comes to the knowledge of a Governor that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner

6.4.2 A Governor should also declare to the Trust Secretary any other employment or business or other relationship of his, or of a cohabiting spouse, civil partner or person living together with them as partner, that conflicts or might reasonably be predicted could conflict with the interests of the Trust. Interests, employment or relationships declared, are to be entered in a register of Governor's interests.

6.5 Further details are included in the Conflict of Interest, Gifts and Hospitality policy & procedure.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Standards of Conduct

7.1.1 The Council shall agree, from time to time, codes of conduct for the proper execution of the office of Governor

7.1.2 Governors must comply with the Council's *Code of Conduct,* the requirements of the regulatory framework, the constitution and any guidance, requirement condition or notice issued by Monitor (NHSE/I).

7.2 Canvassing of, and Recommendations by, Members of the Council of Governors in Relation to Appointments

7.2.1 Except in relation to the appointment of a person as a member of the Trust, a Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust

7.2.2 This SO does not prevent a Governor from contributing to the appointment of a Non-Executive Director to the Trust or the Chief Executive in accordance with the statutory requirements

7.2.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8. MISCELLANEOUS

8.1 Standing Orders to be given to all Governors

It is the duty of the Trust Secretary to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these SOs.

8.2 Review of Standing Orders

The SOs shall be reviewed annually by the Council. The requirement for review extends to all documents having the effect as if incorporated in the SO.

8.3 Potential Inconsistency

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in these SOs, the legislation shall prevail. In the event of any conflict or inconsistency between these SOs and the licence and/or the constitution, the licence and/or the constitution shall prevail.

9. DISPUTE RESOLUTION

9.1 Where there is a dispute between the Council of Governors and the Board of Directors, Governors shall follow the procedure set out in the current *Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance.*

9.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

9.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

9.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

10. RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

10.1 Governors should discuss and agree with the Board how they will undertake their statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice.

10.2 Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts (including any report of the auditor on them) and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

10.3 The annual report should state how performance evaluation of the Board, its committees, and its Directors, including the Chairman is conducted and the reason why the Trust adopted a particular method of performance evaluation.

10.4 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the appointed Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and Directors and it should be made available to members on request.

10.5 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Trust's Audit Committee, which provides information to the Governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

10.6 If the Council does not accept the Audit Committee's recommendations, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.

10.7 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors.

END

Essex Partnership University
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

POLICY REFERENCE NUMBER	FP10
VERSION NUMBER	4
KEY CHANGES FROM PREVIOUS VERSION	Annual review which includes provider collaborative impact, and clarity around role of Director
AUTHOR	Head of Financial Accounts
CONSULTATION GROUPS	Audit Committee Executive Operational Committee Senior Finance Staff
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 18 (GDPR), September 2018, September 2019, September 2020, September 2021
LAST REVIEW DATE	September 2021
NEXT REVIEW DATE	September 2022
APPROVAL BY	Audit Committee
RATIFIED BY	Not applicable
COPYRIGHT	

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, SCHEDULE OF RESERVATION AND DELEGATION, DETAILED 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 Reservation and Delegation ~~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 2021

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 Reservation and Delegation ~~Decisions Reserved for the Board~~ and the Detailed 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 all associated documents. ~~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, Schedule of Reservation and Delegation and Detailed Scheme of Delegation will take precedence.

1.1.7 The Trust has entered into collaborative arrangements in respect of the provision of core services. The specific arrangements will be defined in legally binding contracts between all parties and where these contracts do not cover a specific matter, the Trusts Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation, and Detailed 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 (including income, expenditure and capital where relevant) 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 (as appointed by an Executive 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 or legal firm 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 Care 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 Schedule of Reservation and Delegation ~~of Powers to the Board document~~.

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Schedule of Reservation and Delegation ~~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, Audit Committee and Trust Governor 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 assess if they are ~~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 assess if they are ~~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 assess if they are ~~be~~ satisfied that proper practices have been observed in compiling the accounts
4. to assess if they are ~~be~~ satisfied the quality report has been prepared in accordance with the detailed guidance issued by NHSI
5. to assess if they are ~~be~~ satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources and to provide commentary in line with the reporting criteria stated in the Code of Audit Practice 2020
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) align with the wider system financial plan..~~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);~~
(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 including cash, debtors and creditors 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.

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; and
(c) the committed working capital facility (where relevant) 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 (by exception) 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;

(b) the maximum approval value for each manager and the system for authorisation above that level; and

(c) delegate approval for establishing new or amending existing authorised signatories (via associated processes / forms) to the relevant Assistant Director, Director or Executive Director.

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 Detailed 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 Detailed 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 detailed 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, Patient Safety, Health and 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 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 detailed 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 Schedule of Reservation and Delegation ~~reserved powers of the Board of Directors~~ and the Detailed 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 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 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.

SCHEME OF RESERVATION & DELEGATION (SoRD)

POLICY REFERENCE NUMBER	FP12
VERSION NUMBER	005
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.~~ **Section 2.6:** This section has been amended to provide for the new process agreed by the BoD Remuneration & Nomination Committee to allow the CEO to identify an Executive Director to act as Deputy CEO in their absence. The statement has also been amended to provide for formal acting-up status to an Executive Director should it be required for the CEO / CFO to approve income or expenditure and the CFO is acting as the CEO. **Section 2.8:** Section added to provide a general statement to allow the Board to delegate authority to Executive Directors to make decisions on behalf of the Board for any community collaborative board to ensure it functions effectively. Clarity has been made that this must be in-line with any limitations provided by the DSoD.
AUTHOR	Trust Secretary
CONSULTATION GROUPS	Executive Team Audit Committee Board of Directors
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 2018, September 2019, September 2020, September 2021
LAST REVIEW DATE	September 2021~~0~~
NEXT REVIEW DATE	September 2022
APPROVAL BY	September 2021
RATIFICATION BY BOARD OF DIRECTORS	September 2021
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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.~~

If the CEO is absent, powers delegated to him/her may be exercised 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.

Where the CFO is appointed to act up as the CEO, a further executive shall be named to act up with the CFO for the purposes of approving expenditure and income up to an amount delegated by the DSoD a responsibility normally conferred to the CEO and CFO. Formal acting-up status shall be confirmed in writing by either the Chair, CEO, or the CFO.

If the ECFO is absent powers delegated to him/her may be exercised by a Director of Finance.

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

2.8 The Board has delegated to any Executive Director who is a member of a collaborative board, such authority as agreed to be necessary in order for the collaborative board to function effectively in discharging its responsibilities as set out in any agreement. For the avoidance of doubt, this cannot exceed financial limits set-out in the Trust Detailed Scheme of Delegation (DSoD)

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 involved with the matter under consideration

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			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 economy as well as the quality of its healthcare delivery (including

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				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.
			3.4.3	Approve and monitor the Trust's programme of risk management

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			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 special payments previously approved by the Board

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			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 Resolution risk pooling schemes. 3.4.18 Approve proposals for ensuring equality and diversity in both employment and the delivery of services
Constitution Audit Committee	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) 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 areas of performance

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			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	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	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	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 and Removal of	Chair Non-Executive Directors	5,9	5.9.1	The NEDs shall appoint or remove the CEO. The appointment shall require the approval of a majority of the COG present at a

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
CEO				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) 34.1. Board of Directors 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
34.2. Board of Directors Meetings	Trust Secretary	5.12	5.12.1 5.12.2	Send a copy of the agenda to the Council prior to holding a Board meeting 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
41, Documents	Trust Secretary	5.15	5.15.1	The Trust shall make the following documents available for

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
Available for Public Inspection				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 5.22.2	Retention and public inspection of election documents (para 57.1) – these will be destroyed after one year unless otherwise directed by the Board 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)

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 disposed of without the consent of NHSE/I
	CEO		6.5.12 ensure that conflicts of interest are avoided, whether in the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
			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 in the Government Internal Audit Standards
12 – 15: Advice to	CEO ECFO	6.6	6.6.1 Ensure that appropriate advice is tendered to the Board and the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
the Board				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 wider responsibilities for economy, efficiency and effectiveness, it is the Accounting Officer's duty to draw the relevant factors to the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				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 an Accounting Officer	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 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

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				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

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	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 SOs
2.9 Vice-Chair appointment	Board of Directors	7.3	7.3.1	Recommend the appointment of the Vice-Chair / Acting Chair to

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				the Council
2.9.5. Acting Chair appointment			7.3.2	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	7.10	7.10.1	Responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems
	ECFO CEO		7.10.2	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
			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

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				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 / 3.4.2 / 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
			7.14.2	Issue notice of meetings
			7.14.3	Issue notice of and calling of extraordinary meetings and urgent

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				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
	Chair		7.19.6	Has a second or casting vote in the event of equality of votes
3.12 / 3.15Minutes	Trust Secretary	7.20	7.20.1	Ensure meetings are minuted and submitted for agreement at the

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				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
3.16 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, the CEO has consulted with and gained the agreement of the Chair
4.7 Non-compliance	All Executive Directors	7.25	7.25.1	Disclosure of full details of any non-compliance with SOs shall be

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
with Standing Orders				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
	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 12 months will be incorporated
6.3 Register of gifts	Trust Secretary	7.28	7.28.1	Maintain a register of gifts and hospitality for Board members and staff

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
and hospitality			7.28.2	Publish on Trust's website in line with regulatory requirements
7 Conflict of interest and pecuniary interest	Directors 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 *NHSE/I Standards of Business Conduct policy* (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 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 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

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				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 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 Panel		7.33.11	Make a recommendation to the Executive Operational Sub-

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				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
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

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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 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 2.3.12	ECFO	8.21	8.21.1	Provide Internal Auditors and External Auditors with information
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) NHSE/I
2.3.13	ECFO	8.24	8.24.1	Forward to (Monitor) NHSE/I within 30 days any public Interest

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
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 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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				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
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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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	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 8.52.3	Submit time records in line with timetable Complete time records and other notifications in required form 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 8.54.2	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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				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
			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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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. 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. The technical audit of these contracts shall be the responsibility of the relevant Director.
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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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 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 ECFO	8.69	8.69.1 Issue procedures for management of contracts involving stage payments 8.69.2 Assess the requirement for the operation of the construction industry taxation deduction scheme

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			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 ~~People, Innovation & Transformation Committee~~ Finance & Performance Committee Capital Projects Program Group (CPPG)	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 11.3	ECFO	8.72	8.72.1	If required, demonstrate that the use of private finance/Procure 22 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				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 & IT	6.96	8.96.1	Responsible for accuracy and security of computerised data
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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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 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	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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
	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 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

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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

DETAILED SCHEME OF DELEGATION

POLICY NUMBER:	FP11
VERSION NUMBER:	5
KEY CHANGES FROM THE PREVIOUS VERSION:	Annual review which includes review of Executive Director delegated authority.
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, September 2020, September 2021
NEXT REVIEW DATE:	September 2022
APPROVAL BY AUDIT COMMITTEE:	September 2021
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
DoF	Director of Finance
~~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
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
1.1	**MANAGEMENT OF BUDGETS (PAY, NON PAY AND INCOME)**		
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.	DoF / HoFM / HoFA / DHoFA	
e	Approval of authorised signatory forms (revenue or capital)	AD / Director / ED	
f	Approving expenditure (revenue or capital) up to an increase of 10% on the tender price or £20k whichever is the lower.	~~DoF /~~ Director ~~/ ED~~	
g	Approving expenditure as above, but up to a maximum of £100k.	~~CE~~ ED	
h	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 Authorised Staff	SFI Section 9 / FP01-03 Requisitioning of Goods and Services
	ii) Requisitions / invoices up to £9,999	Budget Manager	

	iii) Requisitions / invoices up to £24,999 or up to individuals authorisation limit (whichever is lowest)	Assistant Director	
	iv) All requisitions / invoices from £25,000 to £49,999	Director / ED ~~DCFO and ED~~ Executive Director	
	v) All requisitions / invoices from £50,000 to £99,999		
	vi) All requisitions / invoices from £100,000 to £249,999	CFO or CE	
	vii) All requisitions / invoices from £250,000 to £999,999	CFO and CE	
	viii) All requisitions / invoices over £1 million with exception of agreed exemptions:	Reserved for Board and verification against Register of Interest	
	• All payroll related transactions including HMRC, pensions and deductions via payroll provider / direct engagement supplier	DoF / HoFA / HoFM / DHoFA	
	• All NHS and independent sector transactions relating to the East of England provider collaborative arrangements	CFO and CE	
	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 / DoF / 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**		

	i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	SFI Section 3 / FP03-01 Budgetary Control
	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 and non-pay lines	Dir or ED	
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 £100,000	CPPG (with noting to FPC) CE or ECFO (with noting to FPC)	
	i) Up to £999,999		
	ii) Over £1,000,000	~~PIT~~ FPC	
	b Approval of any new capital allocations not included in Operational Plan, and any requests which exceed total capital allocated in Operational Plan	~~PIT~~ FPC	
	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 / DoF	

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, where possible, 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 £10m ~~2.5% of Trust annual income~~.	EOC ~~CE and ECFO~~	
	ii) Annual Tender price above £10m ~~between 2.5% and 5% of Trust annual income~~	BoD ~~PIT~~	
	iii) Annual Tender price on Sole Supplier cumulatively on a number of different projects above £10m ~~5% of Trust annual income~~.	BoD	
	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 (including psychologists) and other clinical agency staff	ED Operations / Operational Directors	
	d Booking of all other agency staff	Corporate ED's / Directors ~~ECFO / DoF~~	
	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	DoF (& 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	DoF (& 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, DoF 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 / DoF	
	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)	Director (in writing) & Declaration Form	

	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		
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	CPL19
g	Sponsored posts	HR Department	
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)**		
		All staff & Declaration	CP8 / CPG8

		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.		
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)	DoF	SFI Section 5
	b	Investment of Charitable Funds	Charitable Funds Committee	SFI Section 16 / FP09/03a (appendix 1)
17		**PERSONNEL AND PAY**		SFI Section 8
	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~~ Line Manager in accordance with Disability Act	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)	Line Manager / 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~~ Line Manager in accordance with Disability Act	
	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 Panel	Whitley Council / NHS T&Cs (AFC) & CE / Study Leave 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**		HR57 / HRPG57

		Authorisation of payment of relocation expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		
	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 Mobile Phone Users**		
	i)	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 with Recruitment & Retention Policy (HR57)	HR57 / HRPG57
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 Work experience students	Director 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	DoF / HoFA / HoFM / DHoFA	
	c	Payment of invoices and signing of contracts	DoF / HoFA / HoFM / DHoFA	
47	**LEGAL SERVICES**			
	Authority to engage any of the Trust's panel law firms		Persons authorised in legal protocol	

		Agenda Item No: 11b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	29 September 2021

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	Executive Safety Oversight Group Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Non-compliance with internal CQC Action Plan timeframes July-August 2019 Action plan testing identified gaps of non-compliance CQC rating CAMHS service as 'inadequate'
State which BAF risk(s) this report relates to	BAF45 - CQC Inspections and Learning BAF67 - If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in remaining closed to admissions
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Identify any further action that is required to be taken

Summary of Key Issues

Meeting Registration Requirements

EPUT is fully registered with the CQC and currently has restrictions imposed on registration with regards to CAMHS.

CQC Inspections

Following an unannounced inspection in May by the CQC at the three children and young people's mental health services (CAMHS) T4 inpatient wards in Essex (EPUT), the CQC served a Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008.

The CQC imposed conditions, taking the decision to suspend admissions to all three of the CAMHS T4 wards (Larkwood, Longview and Poplar) with immediate effect in June 2021. The service had been rated by the CQC as 'Outstanding' following a previous inspection in 2019.

The final report was published by the CQC on 15th September 2021 and the CQC has re-rated our CAMHS service as 'inadequate'. The report has identified 22 areas for improvement (13 Must Do, 9 Should Do). The Trust is currently in the process of developing an enhanced action plan to address the concerns raised; this will require submission to the CQC.

We take the CQC's findings very seriously. We took immediate action to make improvements to our CAMHS services.

We have made fundamental immediate improvements ensuring safer staffing of wards, observation and engagement is in line with policy, and that there is timely learning from patient safety incidents.

The CQC acknowledges the capacity pressures at a regional and national level on CAMHS services. We recognise this has been exacerbated by the COVID-19 pandemic and are working hard to provide the assurance required that our services have improved to ensure every patient has access to the best and safest care possible.

We are working together with the CQC and our system partners to plan and implement further improvements needed to enable a phased reopening of the wards.

Internal Compliance Programme
A new compliance framework is under development with the aim to utilise available information to identify potential areas at risk of non-compliance and provide focus for the Trust Compliance Team in undertaking site visits. This will work alongside a new safety walkaround process.

In addition the Compliance Team has been focusing work on the following areas:

- CAMHS Support Visits and auditing
- Intensive Clinical Support Group (CAMHS)
- Inpatient Support Group (Adult Acute, Secure Services and Older Adults)
- Action Plan Testing
- Ward Heat Maps / Internal Insight Indicator development
- Quarterly PHSO action plan testing
- Nursing Home deep dive review visit
- CICC deep dive

CQC Guidance / Updates
The CQC have published "Responding to our consultation: Changes for more flexible and responsive regulation".

CQC and PHSO Action Plan Testing
As previously reported the Compliance Team are continuing to test action plans completed to ensure actions have been embedded. Where gaps are found these are escalated to the appropriate Trust Committee to agree and take forward the actions required to ensure changes have been embedded.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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	LRRG	Ligature Risk Reduction Group
T4	Tier 4	CAMHS	Child & Adolescent Mental Health Services
NoD	Notice of Decision	PHSO	Parliamentary Health Service Ombudsman
CICC	Cumberlege Intermediate Care Centre		

Supporting Documents and/or Further Reading
Accompanying Report – CQC Compliance Appendix 1: CAMHS CQC Summary Report

Lead
Paul Scott **Chief Executive Officer**

Agenda Item 11b
Board of Directors Part
1 29 September 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1. Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

2. Meeting Registration Requirements

EPUT is fully registered with the CQC. No changes were required in this reporting period.

Restrictions were imposed onto the registration for the CAMHS service and is detailed in Section 3.

3. CQC Inspections

3.1. Unannounced CQC Inspection (CAMHS May 2021)

Following an unannounced inspection in May by the CQC at the three children and young people's mental health services (CAMHS) T4 inpatient wards in Essex (EPUT), the CQC served a Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008.

The CQC imposed conditions, taking the decision to suspend admissions to all three of the CAMHS T4 wards (Larkwood, Longview and Poplar) with immediate effect in June 2021. The service had been rated by the CQC as 'Outstanding' following a previous inspection in 2019.

The final report was published by the CQC on 15th September 2021 and the CQC has re-rated our CAMHS service as 'inadequate'. The report has identified 22 areas for improvement (13 Must Do, 9 Should Do). The Trust is currently in the process of developing an enhanced action plan to address the concerns raised; this will require submission to the CQC.

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Insufficient evidence to rate
Are services caring?	Inadequate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

We take the CQC's findings very seriously. We took immediate action to make improvements to our CAMHS services.

We have made fundamental immediate improvements ensuring safer staffing of wards, observation and engagement is in line with policy, and that there is timely learning from patient safety incidents.

The CQC acknowledges the capacity pressures at a regional and national level on CAMHS services. We recognise this has been exacerbated by the COVID-19 pandemic and are working hard to provide the assurance required that our services have improved to ensure every patient has access to the best and safest care possible.

The CQC shared positive findings in their final report:

- Ward areas were clean, well maintained and well furnished. Staff knew about any potential ligature anchor points and mitigated the risks. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff reviewed risk assessments and positive behaviour support plans; where patients had them, regularly. Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment. Staff involved patients in decisions about the service, when appropriate
- Patients had access to areas such as de-escalation and chill out rooms.

The CQC issues the following recommendations:

Must Do Actions:

- The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. (Regulation 12(1)).
- The trust must ensure that staffing establishments are regularly reviewed in order to meet patient needs. (Regulation 12(1)).
- The trust must be assured as to the skills and experience of agency staff who work on the wards. (Regulation 17(1)).
- The trust must ensure that the wards are staffed with regular and familiar staff so as to not impact on the quality of patient care. (Regulation 12(1)).
- The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)).
- The trust must ensure that patients are able to return from leave at their request and there are staff in place to accommodate this. (Regulation 12(1)).
- The trust must ensure that staff follow policy and procedures on the use of enhanced support when observing patients assessed as being higher risk of harm to themselves or others minimising the opportunity for patients to self-harm, This includes, but not limited to, observing patients at their prescribed times, and at irregular intervals. (Regulation 12(1)).
- The trust must ensure staff have access to enough and multiple sizes of tear proof clothing items to meet patient needs (Regulation 10(1)).
- The trust must ensure that lessons learned are shared effectively across all wards and the wider service where appropriate. (Regulation 17(1)).
- The trust must ensure that are responsive to patient needs (Regulation 10(1)).
- The trust must ensure that all staff understand the needs of the patients they are caring for. (Regulation 10(1)).
- The trust must ensure that staff recognise incidents and report them appropriately, clearly and in line with trust policy. (Regulation 12(1)).
- The trust must ensure that managers are proactive in responding to risk and that risks and issues are dealt with appropriately and quickly. (Regulation (12(1)).

Should Do Actions:

- The trust should ensure that ward managers know what guidance the ward follows.
- The trust should ensure that patients have access to nurse call bells.

- The trust should ensure that staff inform and involve families and carers.
- The trust should ensure that all staff have access to the patient records.
- The trust should ensure that patients who require positive behaviour support plan have one.
- The trust should ensure that all staff have regular appraisals.
- The trust should ensure that all leaders have the skills, knowledge and experience to perform their roles.
- The trust should ensure that leaders have a good understanding of the services they manage.
- The trust should ensure that leaders are aware of the risks, issues and challenges in the service to patients and staff.

The Trust is currently in the process of developing an enhanced action plan to address the concerns raised; this will require submission to the CQC. The full summary report of the inspection is attached as Appendix 1.

It should be noted that work has already commenced in regards to the concerns raised and as such in the last few months, we have:

- Strengthened clinical and operational leadership across all three CAMHS wards
  - Established leadership development and coaching support for our colleagues
  - Initiated our new culture of learning approach – our CAMHS wards are pioneering this to ensure learning is shared between them and across the Trust
  - Enhanced leadership and governance led by Executive team reporting to the Board Safety Oversight Group (BSOG) to ensure the active delivery of the CQC action plan
- Improved staffing levels, including increasing the number of permanent staff on these wards
  - CAMHS temporary staff secured as dedicated resource, helping build stronger relationships with patients and maintain consistency across staffing
- Provided additional training to improve adherence to observation and engagement policy
  - Developed a new task and finish group that meets regularly to ensure patient observations on the wards follow Trust policy.
  - We have implemented a new engagement and observation plan, including weekly auditing and daily checking.

The Trust continues to work closely with the CQC to improve standards and make sure that every patient has access to the best and safest care possible.

Due to improvements made as detailed above a CAMHS re-opening Task and Finish Group has been established to clearly identify the safe process for seeking to reopen the CAMHS wards to admissions.

4. Internal Compliance Programme

New Compliance Framework

A new compliance framework is under development with the aim to utilise available information to identify potential areas at risk of non-compliance and provide focus for the Trust Compliance Team in undertaking sit visits. This will work alongside a new safety walkaround process and ward heatmap indicators currently under development.

CQC Visit Preparation

The Compliance Team continue in conjunction with the Corporate Nursing team in supporting the wards to prepare for inspections. All inpatient areas have now had a support visit undertaken and all inpatient areas have completed their self-assessments.

Self-assessment tools have been circulated to the Community Services (both MHS and CHS) to support services with their CQC preparation. Support visits will be arranged to a random selection of Community Service ensuring all geographical areas are covered

Learning

Following a review of all the information received via the Support visits and Self-assessments, all Core Service action plans have been populated and distributed. These will be monitored through the relevant Quality & Safety Groups.

Staff Engagement

Staff engagement is underway with a number of reflective sessions held and future sessions planned. Attendance at sessions has been patchy and work is underway to join existing meetings to undertake engagement sessions. MDP CQC sessions have recommenced the first undertaken 9th July and bimonthly going forward.

Clinical Support Groups/Deep Dives

CAMHS Intensive Clinical Support Group
The Compliance Team continue to facilitate the established CAMHS Intensive Clinical Support Group with weekly meetings and continuous checking and monitoring of the Support plan which was developed following the Serious Incident on Longview prior to the CQC unannounced Inspection. The actions required as part of the CQC visit have been incorporated into the Support Plan.

Upon receipt of the CQC Inspection final report any additional identified actions will be monitored through the Group.

The Compliance Team are providing intensive support to the CAMHS wards following the CQC inspection

Inpatient Clinical Support Group
The Adult Intensive Clinical Support Group ended following completion of their CQC action plan and action plan testing. However it was felt that this forum had continued benefits for shared learning and it has been agreed that an Inpatient Clinical Support Group will continue (this includes representatives from all inpatient areas). TOR are being developed for the group.

CICC Deep Dive
A deep dive has been initiated at CICC following a serious fall. A deep dive project group has been established who have taken forward a review of the service. Findings have been discussed with the unit staff and an action plan agreed.

Rawreth Court Deep Dive
A deep dive has been initiated at Rawreth Court following an anonymous whistleblowing to the CQC raising concerns. A deep dive project group has been established who have taken forward a review of the service. So far no evidence has been found to substantiate the concerns. Next steps include review of internal insight information and considering recommendations and actions.

Ward Heat Maps

A new process is being developed utilising data available in the organisation to give a picture of the wards against a range of key indicators. These indicators will provide an internal insight framework and will be used to celebrate wards who are performing well and put support packages in place for those where improvement is needed.

5. CQC Guidance / Updates

5.1. Responding to our consultation: Changes for more flexible and responsive regulation

The CQC identified it wanted to make changes to how it assessed and rated services to enable a more flexible approach in order for the ratings to be more accessible, responsive and proportionate.

The Trust responded to proposed changes during the consultation phase. The CQC welcomed the high level of response to this consultation, particularly at a time of great pressure for health and care services.

Following the consultation the CQC have identified the outcome and next steps:

The CQC proposed to assess quality and rate services by using a wider range of regulatory approaches – not just on-site or comprehensive inspections.

The CQC are encouraged by the level of support for this proposal and will therefore take this forward. The CQC want to build on the flexible and proportionate approach it adopted at the start of the pandemic.

- The CQC will continue to focus its on-site activity where it is needed most. Site visits will remain an important part of its regulation, but the CQC will also draw on a wider range of regulatory approaches to assess quality without always needing to visit. The CQC will do this when, for example:
    - The CQC have gathered evidence without a site visit and used this to take enforcement action – the CQC will be able to use this evidence to update a rating
    - a provider can show the CQC full evidence that they have made improvements following an inspection – the CQC will be able to update that rating without another site visit
    - inspecting homecare providers using remote technologies, building on their evaluation of the pilot phase
- The CQC will introduce some further flexibility so that it can use more focused activity to update ratings in a broader range of circumstances. This includes:
    - allowing more flexibility and professional judgement in how the CQC aggregate service level ratings for NHS trusts
- The CQC will continue to develop its regulatory approach in line with the proposals in its new strategy, ensuring that its regulation is targeted and dynamic, and that data and information about quality and ratings are up to date.

Rather than following a fixed schedule of inspections, the CQC proposed to move to a more flexible, risk-based approach for how often it assess and rate services.

The CQC are encouraged by the level of support for this proposal and will therefore take this forward. The CQC want to build on the flexible and proportionate approach it adopted at the start of the pandemic. Building more flexibility into its regulatory approach includes:

- Moving away from its published inspection frequencies based solely on overall ratings. For 2021, the CQC will continue to respond to risk and inspect and re-rate services where this is appropriate, as the CQC explained in its update on CQC's regulatory approach published in March 2021. The CQC will then provide further information on its website about how often it will update ratings as it implements the approach to Smarter Regulation.
- Developing the process to update ratings and assess quality more frequently and dynamically and update ratings when the CQC have evidence that shows a change in quality.

The CQC will start to work in this way in July 2021. Their website will explain clearly how the CQC are regulating and rating services as it develops their approach, and the CQC will carry out targeted engagement on its detailed proposals as it develops them.

The CQC proposed to remove aggregation for NHS trust-level ratings and develop its current approach to assessing the well-led key question for a trust.

The level of support for this proposal is endorsement for the CQC to take it forward. The CQC will implement these changes in Spring 2022. In developing the approach, the CQC will:

- work with providers, partners and key stakeholders to develop its assessment approach for NHS trusts
- work with NHS England and NHS Improvement to align its approach and ensure links with the System Oversight Framework
- review and develop its framework and approach to rating and reporting in line with wider changes to its regulatory approach.

The full response can be found at: https://www.cqc.org.uk/about-us/our-strategy-plans/responding-our-consultation-changes-more-flexible-responsive-regulation

6. CQC Action Plan Testing

The compliance team is now involved in a range of action plan testing including following CQC visits and PHSO action plan testing. Work is currently underway to look at developing one central learning plan which will focus on the testing findings and assurance of action embedding.

Compliance CQC action plan testing found some gaps in embedded actions following the completion of CQC Action Plans. These have been previously reported to Executive Safety Oversight Group where it was agreed that the gaps found should be allocated to the appropriate Trust Committees to agree and take forward appropriate actions to ensure changes have been embedded.

7. Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Senior Emergency Planning and Compliance Officer

On behalf of:

Paul Scott
Chief Executive Officer

Essex Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

Trust Head Office, The Lodge
Lodge Approach
Wickford
SS11 7XX
Tel: 03001230808
www.eput.nhs.uk

Date of inspection visit: 11 May 2021, 12 May 2021, 19 May 2021, 25 May 2021, 27 May 2021 and 07 June 2021
Date of publication: 15/09/2021

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Insufficient evidence to rate**
Are services caring?	**Inadequate**
Are services responsive to people's needs?	**Insufficient evidence to rate**
Are services well-led?	**Inadequate**

Our findings

Child and adolescent mental health wards

Inadequate 

We carried out this unannounced focused inspection following the notification of a serious incident on one of the wards and we received information of concern about the safety and quality of the services.

We inspected all three wards of the children and adolescent mental health service; Larkwood ward, Longview ward and Poplar unit.

Due to the serious nature of the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act 2008 to take urgent enforcement action and imposed conditions on the provider's registration. This included a condition to restrict the provider from admitting any new patients without the prior written agreement of the Care Quality Commission and a condition to staff all three wards with the required numbers of suitably skilled staff to meet the patient's needs and to undertake patient observations as prescribed.

We did not rate all key questions of this core service, however, our ratings of safe, caring and well-led went down because:

- The service did not have enough nursing and support staff to keep patients safe. Staffing establishments were not regularly reviewed in response to current patient need. Managers did not accurately calculate and review the number and grade of nurses and healthcare assistants for each shift. The service did not have enough staff on each shift to carry out any physical interventions (for example, restraint) safely and complete patient observations.
- Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff. The lack of regular and familiar staff impacted on the quality of patient care. Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for.
- Staff missed opportunities to prevent or minimise harm and did not always act to prevent or reduce risks. Staff did not always follow the trust policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others.
- Staff did not always have the correct items of clothing to respond to risks posed by patients on Larkwood ward and Longview ward.
- Staff were not always responsive to patient needs. There was a lack of suitable tear proof clothing on both Larkwood ward and Longview ward.
- Staff did not always report incidents clearly and in line with trust policy. Lessons learned were not always completed in incident forms or shared effectively across wards.
- Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. Governance processes did not operate effectively at team level and that risks were not always managed well. Managers were reactive in responding to risk.

However:

Our findings

- Ward areas were clean, well maintained and well furnished. Staff knew about any potential ligature anchor points and mitigated the risks. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff reviewed risk assessments and positive behaviour support plans; where patients had them, regularly. Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment. Staff involved patients in decisions about the service, when appropriate
- Patients had access to areas such as de-escalation and chill out rooms.

We undertook a focused inspection of this service. For this inspection, we reviewed all of the safe, caring and well led key questions and parts of the effective and responsive key questions.

Essex Partnership University NHS Foundation Trust provide community health, mental health and learning disability services for a population of approximately 1.3 million people across Bedfordshire, Essex, Suffolk and Luton.

Essex Partnership University NHS Foundation Trust provides child and adolescent mental health in patient services to young people and their families living across the country where a community setting would not be a safe or appropriate place for the young person's treatment. The child and adolescent mental health inpatient service consists of three wards located across two sites at the St Aubyn Centre, Colchester and Rochford Hospital.

The St Aubyn Centre accommodates Larkwood ward and Longview ward. Larkwood ward is a ten bedded, mixed sex, locked psychiatric intensive care unit. It provides acute and intensive psychiatric care and treatment for young people between the ages of 13 and 18, who are experiencing acute, complex and / or severe mental health problems.

At the time of inspection there were seven patients on the ward, all the patients were detained under the Mental Health Act.

Longview ward is a 15 bedded, general psychiatric mixed sex ward, providing inpatient assessment and treatment for young people aged 13 to 18 years. At the time of our inspection there were 13 patients on the ward, seven of whom were detained under the Mental Health Act.

Rochford Hospital accommodates Poplar ward, a 13 bedded general psychiatric, mixed sex ward providing inpatient assessment and treatment for young people aged 11 to 18 years. At the time of our inspection there were 12 patients. All three wards had education facilities on site, providing education and vocational opportunities in line with the national curriculum.

CQC have registered this service for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

The inspection team visited all three wards between 11 May and 19 May 2021 and completed further off-site inspection activity until 07 June 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environment

Our findings

- Spoke with four patients that were using the service
- Interviewed 21 staff and managers
- Spoke with five carers
- Observed two multidisciplinary meetings, one care programme approach meeting and two community meetings
- Reviewed 14 patient care records relating to physical health
- Reviewed 21 prescription charts
- Reviewed policies and procedures relevant to the running of the service.

What people who use the service say

All patients we spoke with told us they felt uncomfortable with unfamiliar staff and it made it hard to build therapeutic relationships.

A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing.

Patients told us there was not enough activities after school. Patients told us they would ask staff for items such as the television or computer remote control, but staff would tell them to wait and then staff forget.

Carers told us that incidents often happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks and whilst the patient was being observed on enhanced observations. Carers told us staff do not always understand the patients complex needs.

Carers told us that their relative had had their activities and escorted leave cancelled due to staffing issues.

Not all carers felt staff kept them informed of their relatives care. However, carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

However, all carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

Carers told us their relative had a positive behaviour support plan that staff should follow when their relative was in crisis.

Patients, relatives and carers knew how to complain or raise concerns. All carers we spoke with said that they had not had to make a formal complaint. Two carers said that they had made informal complaints to nursing staff and that these were dealt with appropriately.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Our findings

Safe and clean care environments

Not all wards were safe and fit for purpose. However, all wards were clean, well equipped, well-furnished and well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards.

Ward managers were not clear on what guidance they were following about how to manage a mixed sex ward. However, the ward complied with guidance and there were no mixed sex accommodation breaches.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Where there were potential ligature anchor points, staff mitigated the risks by always being with patients in those areas.

Patients did not have access to nurse call systems. We observed a community meeting on one ward and two patients complained about not having call bells and asked staff what they would do in an emergency to gain staff attention. Patients were told nurse call bells would be fitted in their bedrooms within the next few weeks. Staff had easy access to alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished.

Staff followed infection control policy, including handwashing.

Seclusion room

Only one of the wards we visited had a seclusion room. The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The trust told us staff have online access to the medicines reference book. Providers are required to ensure staff have up to date information on medicines they are giving to patients.

Staff checked, maintained, and cleaned equipment

Safe staffing

The service did not have enough nursing staff, who knew the patients. Permanent staff received training to keep people safe from avoidable harm.

Our findings

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. Wards were not staffed safely and regularly under the numbers planned to keep patients safe. Between 1 November 2020 and 30 April 2021 129 shifts were not filled across all wards. Staff recorded 34 incidents of staffing difficulties. Staff told us that being short staffed was a regular occurrence. Managers did not accurately calculate and review the number and grade of nurses and healthcare assistants for each shift. Staffing establishments were not regularly reviewed in response to current patient need; Larkwood ward had recently had its establishment increased to seven, despite consistently requiring 21 staff to meet the needs of patients for the six weeks pre-dating our inspection visit.

The Care Quality Commission also recognises that over the time period we reviewed, there was a national pandemic which caused staffing shortages across all NHS services. The Care Quality Commission recognises at the time of the inspection there were national challenges for wards for children and adolescents relating to patient acuity and bed availability.

The lack of regular and familiar staff impacted on the quality of patient care. We reviewed incidents where patient safety and care was impacted by lack of familiar staff. This included examples of unfamiliar staff not knowing patient risks. All patients we spoke with told us they felt uncomfortable with unfamiliar staff and it made it hard to build therapeutic relationships. Two carers stated that quite often incidents happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks. Staff told us the wards used a lot of unfamiliar agency staff. Staff told us this impacted on patient care and their workloads.

Patients did not have regular one to one sessions with their named nurse.

Patients had their escorted leave, or activities cancelled, when the service was short staffed. Three carers told us that their relative had had their activities and escorted leave cancelled due to staffing issues. One carer said that their relative has had to have a medical appointment rearranged as there were not enough staff to escort them.

A patient was unable to return from leave when the ward was short staffed. On the first day of our inspection, a patient was unable to return to the ward from extended leave at the time they made their request as no staff were available. The patient expressed a need for increased support. The patient was told they would need to wait until the evening (request made in the afternoon) and if their mental health became unmanageable, they should attend Accident and Emergency.

Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff. From November 2020 to May 2021, Larkwood ward used bank and agency for 4970 shifts, Longview for 2671 shifts and Poplar for 1796 shifts. Not all staff on shift were able to carry out any physical interventions (for example, restraint) safely. Agency staff were not always trained in the same physical intervention training approved by the trust. We reviewed four agency staff records; none of the staff were trained in TASI (The trust approved physical intervention technique). The Trust reviewed the standard of physical intervention training provided to agency staff and were satisfied it met national occupational standards, care certificate standards and NICE guidance. The trust reported that untrained staff had worked 76 shifts on Poplar ward and 128 shifts on Longview ward from November 2020 to the time of the inspection. However, bank staff receive the same training as substantive staff in the trust's physical intervention techniques.

Managers supported staff who needed time off for ill health.

Staff shared key information to keep patients safe when handing over their care to others.

Our findings

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not manage risks to patients and themselves well. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. However, risks were not managed well in practice on the wards.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff missed opportunities to prevent or minimise harm and did not always act to prevent or reduce risks. Following a serious incident where a patient was harmed, staff identified learning relating to observations. Despite this, issues remained with observations. Staff did not always follow the trust policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We reviewed 12 patient observation records. Staff had not carried out patient observations at the intervals prescribed in eight out of 12 observation records we reviewed. Staff did not always sign patient observation records. As a result of staff poor observation practice patients had been harmed, this included incidents of patients tying ligatures and self harming whilst on enhanced observations.

Permanent staff knew about any risks to each patient, not all agency staff did.

Staff did not always have the correct items of clothing to respond to risks posed by patients on Larkwood ward and Longview ward. Staff on these wards did not have access to adequate tear proof clothing items. Patients wore tear proof clothing if they were at risk of ripping and using their normal clothing to self-ligature. The multidisciplinary team decided when the use of tear proof clothing was appropriate.

Staff did not always identify and respond to changing risks to, or posed by, patients. However, staff reviewed risk assessments and positive behaviour support plans; where patients had them, regularly. Patients had access to areas such as de-escalation and chill out rooms.

Not all patients who required a positive behaviour support plan had one. Senior staff told us this was because patients did not want to contribute in writing their plans. However, three carers told us their relative had a positive support plan that staff should follow when their relative was in crisis.

Our findings

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Permanent staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

The only access to the seclusion room was via the long-term segregation suite. We saw, and staff told us that if someone required seclusion at the same time as another patient requiring long-term segregation, the long-term segregation care would take place in the patient's bedroom space. However, when a patient was placed in seclusion, staff kept clear records.

Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. The rationale for continued long-term segregation was not always clearly evidenced and not all records justified the continued use of long-term segregation. According to the Mental Health Act Code of Practice, "Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis". Not all records we viewed evidenced that there was a sustained risk of harm posed by the patient or that the patient's risk was a constant feature of their presentation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There was a family room adjoined to each ward where visits could be held so young children did not have to go onto the ward.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Permanent staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Not all staff were aware of how to access patient records if they did not have a permanent log in to the trust's electronic recording system. The service used a lot of bank and agency staff. Agency staff did not always have access to the providers electronic recording systems and were therefore unable to access patient notes. However, patient notes were comprehensive and all permanent staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes when safely administering and recording medicines. We reviewed 21 prescription charts and found two patients had not had one of their medications signed for on two separate days, one patient had not had three of their medicines signed on one day and one patient's medicines chart was not complete with the correct reason for omission across three days. However, staff followed systems and processes when safely prescribing and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

Our findings

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents and but did not share lessons learned with the whole team and the wider service. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always know what incidents to report and how to report them. Staff were not recording all incidents relating to staffing issues. This meant that the senior leadership team may not always be aware of the staffing issues on the wards.

Staff raised concerns and reported most incidents and near misses in line with trust policy.

Staff did not always report incidents clearly and in line with trust policy. We reviewed nine incident forms and lessons learnt was not complete in any of them. This section was blank in five of the incident forms and 'no' was written in this section on the other four incident forms. Where restraint was used staff completed this section in six out of seven incident forms we reviewed.

Managers did not always sign off incident forms in line with the trust policy. Two out of nine incident forms were not signed off by managers. Three of the incidents happened in May 2021, the month of our inspection, but one incident happened in April 2021.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff and patients after any serious incident. We saw evidence of robust and regular support for staff with psychological input for both patients and staff.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service.

Lessons learned were not always shared effectively across wards. Staff on Longview ward were not aware of environmental issues that contributed to a safety incident on Larkwood ward, despite their ward having the same features. Patients will or may be exposed to the risk of harm if learning from specific incidents, or general learning is not disseminated across the wards to prevent recurrences of incidents.

Is the service effective?

Insufficient evidence to rate

We did not rate this key question.

Our findings

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers gave each new member of staff a full induction to the service before they started work.

Not all managers supported staff through regular appraisals of their work. The trust's target rate for appraisal compliance is 90%. At the time of our inspection the average staff appraisal rate for child and adolescent mental health wards from November 2020 to March 2021 was 75.7%. The trust told us that during the global pandemic an extension to appraisals was granted by the trust executive team to all staff to help address the staffing pressures that operational staff were facing at the time.

Managers supported staff through regular clinical supervision of their work.

Is the service caring?

Inadequate 🔴 ↓↓↓

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always respect patients' privacy and dignity. Not all staff understood the individual needs of patients. However, staff treated patients with compassion and kindness. Staff supported patients to understand and manage their care, treatment or condition.

Staff were not always responsive to patient needs which impacted on patients' privacy and dignity. There was a lack of suitable tear proof clothing on both Larkwood and Longview wards. A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing. However, staff were discreet and respectful when caring for patients. Patients told us there was not enough activities after school. Patients told us they would ask staff for items such as the television or computer remote control, but staff would tell them to wait and then staff forget.

Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for. One carer stated their relative had complex needs which staff did not understand. They told us that staff did not always know how to deal with challenging behaviour and their relative had been told "do not shout you are disturbing other patients". One carer told us that sometimes staff use the wrong pronouns or question their relative's identity. They told us one staff member had said "but she still looked like a boy". However, permanent staff understood and respected the individual needs of each patient.

Our findings

Access to the seclusion room was not dignified or safe for patients. Both Larkwood ward and Longview wards are situated in the same building. Larkwood ward had a seclusion room. If Longview ward needed to put patients in seclusion at any time the patients would only be able to access this via the corridor between the two wards which was visible from the reception area, or via the courtyard which other patients could be in which could compromise the patient's emotional safety, wellbeing, dignity and privacy.

We could not always be assured that patients' needs and preferences were being taken into consideration. On day two of our inspection Care Quality Commission staff witnessed a staff member respond to a patient request for access to regular staff as, 'We will not have young people dictating to us who does what observations.'

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the trust policy to keep patient information confidential.

Involvement in Care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates and to child helplines.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each ward had an admission pack which was sent to the patient prior to their admission if possible or given to each patient on admission which orientated them to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. We saw that patients had been involved in their care plans when we looked at care records. We observed ward rounds where patients were part of these. We observed a community meeting where patients asked for an updated copy of their care plans and straight after the meeting the ward manager printed these off for the patients.

Staff made sure patients understood their care and treatment. All patient records were suitable for the patient group to encourage involvement.

Staff involved patients in decisions about the service, when appropriate. Patients had been involved in designing the new sensory room on Poplar Unit and patients had painted the walls to make the ward look inviting.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed patients doing this in community meetings and feedback was written in community meeting minutes.

Staff supported patients to make decisions on their care.

Our findings

Staff made sure patients could access advocacy services. Advocacy regularly attended the wards and staff made referrals to advocacy if the patient was not able to advocate for themselves.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always inform and involve families or carers. Two carers stated that they did not think the staff always kept them informed that they don't always explain things such as medication changes. One carer told us they are informed of any incidents their relative had been involved in but not as timely as they would like. Two carers stated that they are not always invited to their relatives review meetings and that information following these meetings is not always shared with them. However, all carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

Staff helped families to give feedback on the service.

Is the service responsive?

Insufficient evidence to rate

We did not rate this key question.

Access and discharge

Staff managed beds well. Patients were not moved between wards unless this was for their benefit. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

There is a national shortage of child and adolescent mental health service beds. We reviewed a total of 335 referrals across the wards from 1 January 2021 to 21 May 2021. The wards were only able to accept 27 (8%) of their referrals for admission. The wards were unable to accept most of the referrals made to them due to not having any beds available, referred patients being out of area or referred patients not being suitable for the wards.

Discharge and transfers of care

The service had a low number of delayed discharges. The trust told us there were currently four patients awaiting discharge, which were delayed, across the child and adolescent mental health wards. There were three delayed discharges on Larkwood ward, one on Longview ward and none on Poplar Unit.

The Care Quality Commission recognises at the time of the inspection there were national challenges for wards for children and adolescents relating to patient acuity and bed availability.

Facilities that promote comfort, dignity and privacy

Our findings

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

The service had an outside space that patients could access easily.

Listening to and learning from complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. All carers we spoke with said that they had not had to make a formal complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Two carers said that they had made informal complaints to nursing staff and that these were dealt with appropriately.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Our findings

Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. However, local leaders were visible in the service and approachable for patients and staff.

Governance and leadership were inconsistent across the wards. Not all leaders had the necessary experience, knowledge, capability or integrity to lead effectively.

Leaders were not always aware of the risks, issues and challenges in the service to patients or staff.

Leaders were visible in the service and approachable for patients and staff. Leaders had an open-door policy for both staff and patients. Staff knew who the local leaders were.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Culture

Wards were short staffed, and staff felt overworked and stretched.

Staff told us because they were short staffed, they felt overworked and stretched. One staff member told us the staff team were 'struggling and broken'. Another staff member told us they were 'burned out'. Most staff felt supported by their colleagues. However, one staff member told us the team felt criticised rather than supported.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff stated that they felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff were also provided ongoing support for their wellbeing, including access to flexible working.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that risks were not always managed well.

Managers were reactive in responding to risk. Larkwood ward was short by seven members of staff on day two of our inspection. Managers were already aware of this, but this had not been escalated. Care Quality Commission staff escalated this to the senior leadership team. Both Larkwood ward and Longview ward did not have enough tear proof clothing for patients who were currently using it. Managers were aware of this, but this had not been escalated or additional tear proof clothing sought. Care Quality Commission staff escalated this to the senior leadership team. The following day a request for tear proof clothing was made by local managers to Poplar Unit to request additional tear proof clothing where there were adequate amounts stored.

Staff reported a low staff morale.

The quality of care planning was consistently of a high standard and were always written from the patient's perspective.

Our findings

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care however this information was not used to good effect.

Risks and issues are not always dealt with appropriately or quickly enough. The approach to service delivery and improvement is reactive and focussed on short term issues.

We were not assured that care and treatment was being delivered in a safe way for patients. The trust had not taken every step available to do all that is reasonably practicable to assess and mitigate risk. Neither have the trust ensured that all staff have the competence, skills and experience to care for patients safely.

Information management

Staff engaged actively in local and national quality improvement activities.

Our findings

Areas for improvement

Children and adolescent mental health wards

- The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. (Regulation 12(1)).
- The trust must ensure that staffing establishments are regularly reviewed in order to meet patient need. (Regulation 12(1)).
- The trust must be assured as to the skills and experience of agency staff who work on the wards. (Regulation 17(1)).
- The trust must ensure that the wards are staffed with regular and familiar staff so as to not impact on the quality of patient care. (Regulation 12(1)).
- The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)).
- The trust must ensure that patients are able to return from leave at their request and there are staff in place to accommodate this. (Regulation 12(1)).
- The trust must ensure that staff follow policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others minimising the opportunity for patients to self-harm. This includes, but not limited to, observing patients at their prescribed times, and at irregular intervals. (Regulation 12(1)).
- The trust must ensure that staff have access to enough and multiple sizes of tear proof clothing items to meet patient needs. (Regulation 10(1)).
- The trust must ensure that lessons learned are shared effectively across all wards and the wider service where appropriate. (Regulation 17(1)).
- The trust must ensure that staff are responsive to patient needs. (Regulation 10(1)).
- The trust must ensure that all staff understand the needs of the patients they are caring for. (Regulation 10(1)).
- The trust must ensure that staff recognise incidents and report them appropriately, clearly and in line with trust policy. (Regulation 12(1)).
- The trust must ensure that managers are proactive in responding to risk and that risks and issues are dealt with appropriately and quickly. (Regulation 12(1)).

SHOULDS

Children and adolescent mental health wards

- The trust should ensure that ward managers know what guidance the ward follows.
- The trust should ensure that patients have access to nurse call bells.
- The trust should ensure that staff inform and involve families or carers.
- The trust should ensure that all staff have access to the patient records.

Our findings

- The trust should ensure that patients who require a positive behaviour support plan have one.
- The trust should ensure that all staff have regular appraisals.
- The trust should ensure that all leaders have the skills, knowledge and experience to perform their roles.
- The trust should ensure that leaders have a good understanding of the services they manage.
- The trust should ensure that leaders are aware of the risks, issues and challenges in the service to patients and staff.

Our inspection team

The team that inspected the service comprised a Care Quality Commission lead inspector, two other Care Quality Commission inspectors, an assistant inspector and a Care Quality Commission inspection manager. The inspection team was overseen by a Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

		Agenda Item No: 11c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2021					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Major Projects & Programmes (EPRR AEO)					
Report Author(s):	Amanda Webb Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	Executive Committee and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Partial Compliance with Deep Dive
State which BAF risk(s) this report relates to	BAF38 - C19 Emergency Planning
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2021-22.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Note the information contained within this report
- Note Emergency Preparedness, Resilience and Response national core standards self assessment 2021-22 for EPUT

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 27th July 2021, the Trust received a communication from the regional EPRR team at NHSE/I (East) informing the Trust of the newly published national EPRR core standards and the process for the national annual assurance process (which requires organisational submissions to ultimately be approved by Boards of Directors).

The Standards are split into two sections, the main EPRR Core Standards and Oxygen Management Standards. All organisations were required to submit completed self-assessments by 10th September 2021. EPUT completed the self-assessment and submitted within deadline. Self-Assessment is attached as appendix 1.

The Trust reported full compliance against all EPRR Core Standards and part compliance against Oxygen Management. The Oxygen Management Standards only apply to wards with piped oxygen, for EPUT this is only the wards at St Margaret's Hospital and are dependent on the facilities available at St Margaret's Hospital. Members of the medical gas working group have assisted with the Oxygen self-assessment and will take forward a review of the gaps found.

As part of the national process, the next step following submission of the Core Standards is for the Trust to attend a "confirm and challenge" meeting with the Regional EPRR team. This is scheduled to take place on the 30th September 2021. At this meeting, the Trust will be required to present the evidence available to demonstrate compliance with standards and to agree the final overall rating as a result. If NHSE/I do not agree with the Trust self-assessment an action plan will be required to be put in place and submitted to NHSE/I and the Board of Directors.

The NHS England Core Standards inform the Trusts annual EPRR work programme which is held in the Security Framework Plan and overseen by the Health Safety and Security Committee.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
AEO	Accountable Emergency Officer		

Supporting Documents and/or Recommended Further Reading
2021 Core Standards amended (FINAL)_

Lead

Nigel Leonard,
Executive Director of Major Projects & Programmes (EPRR AEO)

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England and NHS Improvement Region	NHS England and NHS Improvement National	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	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
Domain 1 - Governance																							
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Name and role of appointed individual		Fully compliant				AEO = Nigel Leonard, Executive Director of Projects NED = Janet Wood
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	Y	Y	Y	Y	Y	Y	Y	Y	Y			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.	E1. RM14 - Major Incident Plan - June 2021 E3. RM22 - Emergency Preparedness, Resilience and Response Policy - June 2021 E4. RMPG14d - EPUT Heatwave Plan - June 2021 E5. RMPG14e - EPUT Cold Weather Plan - June 2021 E6. RMPG14a - Business Continuity Management Procedure - June 2021 E17. RMPG14b - EPUT Flood Plan - June 2021 E18. RMPG14c - EPUT Fuel Shortage Plan - June 2021 E19. RMPG14f - EPUT Pandemic Flu Plan - June 2021	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021)
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	E2. EPRR Annual Report 2020 - 21 E8. #0 Part 1 BoD Agenda July FINAL	Fully compliant				EPRR Annual Report 2020/2021 approved at HSSC & Quality Committee (standing committee of the Board of Directors) June 2021 and to Board July 2021
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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	E3. RM22 - Emergency Preparedness, Resilience and Response Policy - June 2021	Fully compliant				EPRR team incudes SRO , Deputy SRO, EPRR Lead and EPRR Support. During COVID pandemic EPRR team has been suppported by the command structure and an separate ICC team.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Major Incident Plan details debriefing and post-incident learning arrangements.
Domain 2 - Duty to risk assess																							
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	E7. Risk Management & Assurance Framework 2020-23	Fully compliant				Risk management framework in place. Evidence that Major Incident Plan takes account of risks identified in local community risk registers. Involvement in LHRP (and thus LRFs). Organisational risk register risk framework reflects EPRR risk.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	E7. Risk Management & Assurance Framework 2020-23	Fully compliant				Risk management framework in place and risk management processes referenced in EPRR Policy and Major Incident Plan.
Domain 3 - Duty to maintain plans																							
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Major Incident Plan reviewed, approved by HSSC June 2021 and ratified by Quality Committee in July 2021 (this Committee has delegated authority from the Board to approve) which contains listed elements.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				As above.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E4. RMPG14d - EPUT Heatwave Plan - June 2021	Fully compliant				Heatwave Plan in place - reviewed and approved by HSSC June 2021. Available on intranet and prompting emails advising action required also sent out to distribution list when alert levels change. MET Office weather warning circulated as appropriate alongside Heatwave Level Prep
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E5. RMPG14e - EPUT Cold Weather Plan - June 2021	Fully compliant				Cold Weather Plan in place - reviewed and approved by HSSC June 2021. Available on intranet and prompting emails advising action required also sent out to distribution list when plan activated. MET Office weather warning circulated as appropriate.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Major Incident Plan includes reference to and framework to be followed should it be necessary to increase capacity in community / mental health services to facilitate acute hospitals in their ability to meet mass casualty surge demand. Trust has engaged and assisted in mass casuality plans for Mid and West Essex.
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y												Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required						

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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Internal arrangements in place to set up an internal rest centre dependent on size and scale of incident. Larger rest centres would be established in partnership with local authorities and health support provided as appropriate.
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	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E10. HSSC Schedule of Business E11. EPRR Quarterly Assurance Report - Summary Main Report - February 2021 E12. EPRR Quarterly Assurance Report - Summary Main Report - May 2021	Fully compliant				Schedule of lockdown plans across the Trust are up to date/planned. Reviewed and tested every 2 years. Lockdown Policy being reviewed September 2021 Lockdown update provided to committee Bi-monthly
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	Y	Y	Y			Y					Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	E20. CPG43b - VIP Visits Procedure E1. RM14 - Major Incident Plan - June 2021	Fully compliant				CPG43b - VIP Visits Procedure in place to manage high profile visitors to the Trust and arrangements included and cross-referenced in Major Incident Plan.
Domain 4 - Command and control																							
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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.	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				24/7 senior manager and director on-call systems in place across organisation which would address any EPRR issues. Arrangements detailed in Major Incident Plan. Tested regularly through daily use for all operational matters. During COVID on call rota increased to provide resilience.
Domain 5 - Training and exercising																							
Domain 6 - Response																							
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Incident Co-ordination Centre arrangements in place. Fall-back location identified (Hawthorn Cente, Rochford). Comms tested frequently as it is a location in use constantly. Documented scheduled testing to be implemented to provide audit trail. Fall back would be mobile communications. On-call directors and key responders to a major incident are on priority mobile network. Major Incident Boxes in place in both locations. During COVID ICC command has been held virtually via Microsoft Teams.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans	E6. RMPG14a - Business Continuity Management Procedure - June 2021	Fully compliant				Business continuity plan arrangements in place - procedural guidance updated and approved by HSSC in June 2021 and ratified by Quality Committee in July 2021. Corporate and Services BCPs in place.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, signing off and submitting SitReps	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Established internal processes in place for sitrep reporting which would be utilised in the event of a major incident. Sitrep reporting processes to regional office included in Major Incident Plan.
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y													• Guidance is available to appropriate staff either electronically or hard copies						
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y																			
Domain 7 - Warning and informing																							
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Communications processes detailed in Major Incident Plan including multi-agency involvement / leadership. Social Media Policy CP58 in place and referenced in Major Incident Plan. Information unit to support Major Incident Response Team would be established if deemed appropriate.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Communications processes detailed in Major Incident Plan including multi-agency involvement / leadership. During COVID regular contact has been made with patients via co-ordinators, via a number of means and EPUT website is regularly providing up to date information.
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 media spokespeople able to represent the organisation to the media at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Details of communications included in Major Incident Plan - in line with regional arrangements for communication co-ordination etc. Media Strategy / Policy in place and trained media spokepersons.
Domain 8 - Cooperation																							
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	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	E1. RM14 - Major Incident Plan - June 2021	Fully compliant				Mutual Aid Arrangements in place and appended to Major Incident Plan. EPUT have provided mutal aid during recent COVID pandemic with IPC training, FFP3 fit testing and staff .
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y				Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs						
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					• Detailed documentation on the process for managing the national health aspects of an emergency						
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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'.	E1. RM14 - Major Incident Plan - June 2021 E16. ISA Summary Log	Fully compliant				Section on information sharing and principles included in Major Incident Plan. No formal information sharing agreements in place specifically relating to major incidents but a number of general information sharing arrangements in place with key partner organisations which could be used in a major incident. Full list of Information Sharing Agreements collated and copy in Major Incident Boxes.
Domain 9 - Business Continuity																							

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 commitment to a Business Continuiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	E6. RMPG14a - Business Continuity Management Procedure - June 2021	Fully compliant				Detailed in Business Continuity Planning Procedure (RMPG14) - reviewed and approved by HSSC June 2021 and ratified by Quality Committee July 2021 Procedure written in line with ISO23001
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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	E6. RMPG14a - Business Continuity Management Procedure - June 2021	Fully compliant				As above
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Statement of compliance	E13. Quality Committee IG Sub-Committe Assurance Report July 2021	Fully compliant				Trust Information Governance Toolkit return made and achieved 'Standards exceeded'
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	E6. RMPG14a - Business Continuity Management Procedure - June 2021 E9. Appendix 1 - BCP Template 2021	Fully compliant				Corporate and key service BCPs in place. All service BCP's in place and being reviewed yearly. New template being implement 2021/22 Q3
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports		Fully compliant				Process in place to set internal audit schedule which is based on organisational risk. BCMP not considered high risk and thus not included per se on internal audit schedule. Organisation satisfied with current position.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	E3. RM22 - Emergency Preparedness, Resilience and Response Policy - June 2021 E10. HSSC Schedule of Business E11. EPRR Quarterly Assurance Report - Summary Main Report - February 2021 E12. EPRR Quarterly Assurance Report - Summary Main Report - May 2021	Fully compliant				BCP Procedure sets out requirement to review templates 2 yearly - pro - forma reviewed based on experience (eg local comms cascade in event of loss of communication). BCPs updated following EU Exit planning and COVID pandemic.
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	Y	Y	Y	Y	Y	Y	n	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	E6. RMPG14a - Business Continuity Management Procedure - June 2021	Fully compliant				3rd party suppliers required to demonstrate to contracts team that they have business continuity plans in place to continue services to the Trust. A number of suppliers BCP's are held by the EPRR team.
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	E1. RM14 - Major Incident Plan - June 2021 Appendix 6	Fully compliant				Role card for CBRN incident included in Major Incident Plan and national guidance available on internet for staff - includes national telephone help line numbers on page 22/23. Reception staff also have hard copy to hand.
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	E1. RM14 - Major Incident Plan - June 2021 Appendix 6	Fully compliant				Initial role card in place, national guidance on internet and incidents referenced in Major Incident Response Plan and to be managed via Major Incident Plan framework
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities	E7. Risk Management & Assurance Framework 2020-23	Fully compliant				Trust Risk Framework in place, encompassing all EPRR risks.
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													• Rotas of appropriately trained staff availability 24 /7						
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							• Completed equipment inventories; including completion date		Fully compliant				Specialist equipment not required for mental health and community health provider. Trust will communicate with multi agencies if required for support
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks.	Y													• Record of equipment checks, including date completed and by whom. • Report of any missing equipment						
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													• Completed PPM, including date completed, and by whom						

64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y												• Organisational policy					
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y												• Maintenance of CPD records					
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y												• Maintenance of CPD records					
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y						• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	E1. RM14 - Major Incident Plan - June 2021	Fully compliant			Role card in Major Incident Plan details this requirement.
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y							E14. When_to_use_face_mask_or_FFP3 poster E15. PPE Ordering Guidance	Fully compliant			FFP3 face masks would currently be sourced from NHS Supplies. During COVID a large number of staff have been Fit tested trained and EPUT have a supply of FFP3 for use when required.

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non 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
HART Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						

H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						

H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						

H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						

Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						

M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						

M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
CBRN Domain: Capability										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						

B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										

B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles **Domain: Administration**										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties Concept of Operations										

V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* .	Y						
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control Domain: General										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						

C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						

C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						

C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						

C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP Domain: Embedding doctrine										
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						

J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	**JESIP**	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	**JESIP**	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	**JESIP**	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	**JESIP**	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	**JESIP**	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						

J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						
J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	**Self assessment RAG** **Red (not compliant) =** Not compliant with the core standard. The organisation's 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 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 - Oxygen Supply **Domain: Oxygen Suuply**										
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board		Partially compliant				No formal Trust medical gas committee. We have a medical gas working group which is working on aligning the Trust to the recent HTM. The plan once we have an agreed governance structure in place is that this working group will transition into the medical gas committee and develop the SOPs/ channels of communication. The current issue is that the PFI are challenging the point of being accountable for providing an Authorised Engineer who would appoint an Authorised Person to liaise with the two Trust officers on matters relating to the safe and secure use of medical gas systems in the Trust. This has become a legal dispute. NHS PS are working with the PFI on the formulation of structure with NHS PS formulating stepping in rights and commissioning its own A/E going forwards. This process could take 3 months to complete therefore the Trust may have to revert to bottled oxygen as no assurance of the piped system would be provided. In this case EPUT will need to begin contingency measures on taking this forwards including discussion of additional provision with BOC, discussion on training clinical colleagues and Porters of using bottled until the above has been concluded.
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases		Partially compliant				No formal BCP or disaster recovery plan. NHS PS instructed an Authorised Engineer who completed an independent audit of the system at the beginning of August; no concerns were raised however we are waiting for the formal inspection report.
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process						Section N/A The Trust does not make use of a cryogenic liquid supply system.
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.		Partially compliant				See section above regarding the PFI.
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO		Partially compliant				N/a N/a This has not been reviewed/ reflected on.
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report		Partially compliant				See section above regarding the PFI.
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)		Partially compliant				See section above regarding the PFI.

		Agenda Item No: 11(d)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29th September 2021**

Report Title:	**CP15 – Code of Conduct for Members of the Board of Directors – for Approval**					
Executive/Non-Executive Lead:	James Day, Interim Trust Secretary					
Report Author(s):	James Day Interim Trust Secretary					
Report discussed previously at:	Virtual consideration by Chair and CEO Finance & Performance Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	If the Trust does not encourage the most effective Board meetings and use of Non-Executive and Executive skills and time, there is the potential for poor decision making and reputational shortfalls.
State which BAF risk(s) this report relates to	BAF32 Quality Improvement
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/a
Describe what measures will you use to monitor mitigation of the risk	Yearly review of the implementation of the Code.

Purpose of the Report		
This report provides the Board with details of the Trust's minimally updated and amended Board Code of Conduct for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Approve the Trust's updated and amended Board Code of Conduct.

Summary of Key Issues

The Trust Board has operated subject to a Code of Conduct for many years, the most recent having been considered and codified in late 2017. No issues of concern have arisen since that time, reflecting the co-operative and positive focus of the Board.

The three-yearly review of the approved 2017 Code has provided an opportunity for the minimal correction of typographical errors and for improved cross referencing, but essentially little change is suggested or required for the updated Code now presented, given the constructive way the Board continues to function.

However, an opportunity has been taken in Appendix 1; Paragraphs 9, 10, and 11 to add the guidance provided by the Good Governance Institute on the conduct expectations of Directors. This guidance was developed from work with other NHS Trusts.

In additional recognition of the increased use of remote meetings, the expectation to sign–in in a timely manner has been added.

Whilst the Strategic objectives currently referenced in Paragraph 1.3 are in the process of approval, the fundamentals of Board conduct will remain the same and uncontroversial.

Key paragraphs to cross check on the essential elements are 4.7, 5.4 and Appendix 1, Paragraphs 9, 10, and 11 mentioned above.

The Finance and Performance Committee approved this in update in August 2021 and the Board of Directors is asked to consider the Code of Conduct and approve the same.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
CP15 Code of Conduct for the Board of Directors

Lead
James Day **Interim Trust Secretary**

Essex Partnership University
NHS Foundation Trust

CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS

PROCEDURE REFERENCE NUMBER:	CP15
VERSION NUMBER:	2
KEY CHANGES FROM PREVIOUS VERSION	Additions to Appendix 1
AUTHOR:	Interim Trust Secretary
CONSULTATION GROUPS:	2017 - Chair, Non-Executive Directors, Executive Operational Sub-Committee, HR, Finance & Performance Committee 2021 – Chair, CEO, Finance & Performance Committee
IMPLEMENTATION DATE:	October 2017
AMENDMENT DATE(S):	April 2021
LAST REVIEW DATE:	September 2021
NEXT REVIEW DATE:	September 2021
APPROVAL BY FINANCE & PERFORMANCE COMMITTEE:	August 2021
RATIFICATION BY BOARD OF DIRECTORS:	September 2021
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PROCEDURE SUMMARY
This document sets out in broad terms the role and responsibilities of members of the Board of Directors of Essex Partnership University NHS Foundation Trust (EPUT) and the standards of conduct expected of them.
The Trust monitors the implementation of and compliance with this procedure in the following ways:
The implementation and compliance with the Code will be monitored on an annual basis by the Trust Secretary. Reviews will take place on a three-yearly basis and will be included in the Trust's internal governance review.

Services	**Applicable**	**Comments**
Board of Directors	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this procedure is Chief Executive Officer / Trust Secretary

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS

CONTENTS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS

Assurance Statement

All members of NHS Boards should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. High standards of corporate and personal conduct are an essential component of public service. As individuals, they must understand both the extent and limitations of their personal responsibilities.

Adherence to the Code of Conduct ensures they maintain the three crucial public services values of accountability, probity and openness.

This procedural document provides guidance on the standards of conduct and behaviour expected of members of the Board of Directors.

1.0 INTRODUCTION

1.1 The Trust is governed by the 2006 National Health Service Act, the 2012 Health and Social Care Act and its constitution (i.e. regulatory framework). Members of the Board of Directors are required to act at all times in accordance with the regulatory framework and this Code

1.2 High standards of corporate and personal conduct are an essential component of public service. The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of Directors

1.3 The Code of Conduct is built on and demonstrates the Trust's corporate values and behaviours of being:

- Open
- Compassionate
- Empowering.

Demonstrating these behaviours and values will support the achievement of the Trust's strategic priorities to:

- To continuously improve service user experience and outcomes through the delivery of high quality, safe, and innovative services.
- To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts.
- To be a valued system leader focused on integrated solutions that are shaped by the communities we serve.

2.0 SCOPE

2.1 The Code of Conduct applies to all members of the Board of Directors

2.2 It applies at all times when members of the Board are carrying out the business of the Trust or representing the Trust

2.3 The Code of Conduct for the Board of Directors together with the Code of Conduct for the Council of Governors and the constitution forms part of the governance framework designed to promote the highest possible standards of personal conduct and behaviour and high standards of business integrity at all times within the Trust

2.4 The constitution details the way in which the Trust operates. It outlines the qualification and disqualification criteria for Directors together with detailing their statutory roles and responsibilities. The constitution also includes the Standing Orders for the Board of Directors. Directors should familiarise themselves with the content of both the constitution and Standing Orders

2.5 This Code should be read in conjunction with, but not limited to, the Trust's Provider Licence, Standing Orders, Standing Financial Instructions, and Scheme of Reservation & Delegation as well as NHSI's NHS Foundation Trust Code of Governance

2.6 This Code should also be considered alongside other organisational policies as listed under section 15 below.

3.0 INTERPRETATION AND DEFINITIONS

3.1 Unless otherwise stated, words and expressions contained in this Code of Conduct shall bear the same meaning as in the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the Trust's constitution

3.2 **2006 Act** means the National Health Service Act 2006

3.3 **2012 Act** means the Health and Social Care Act 2012

3.4 **Board/Board of Directors** means the Board of Directors as constituted in accordance with the Trust's constitution

3.5 **Code/Code of Conduct** means this Code of Conduct for the Board of Directors and any associated appendices

3.6 A **conflict of interest** is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. A **conflict of interest** may be:

- Actual: there is a material conflict between one or more interests
- Potential: there is the possibility of a material conflict between one or more interests in the future

3.7 **Council/Council of Governors** is the Council of Governors of the Trust as constituted in accordance with the Trust's constitution

3.8 **Director(s)** means the member(s) of the Board of Directors including the Chair, Chief Executive, Executive Directors and Non-Executive Directors

3.9 **NHS FT** means NHS Foundation Trust

3.10 **Governor** means a member of the Council of Governors

3.11 **NHSI/NHS Improvement** formerly known as Monitor, regulator for NHS Trusts and NHS Foundation Trusts

3.12 **Nolan Principles** means the seven principles of public life published by the Committee on Standards in Public Life

3.13 **SFIs** means the Standing Financial Instructions of the Trust

3.14 **SoRD** means the Scheme of Reservation & Delegation of the Board of Directors

3.15 **SOs** means the Standing Orders of the Board of Directors

3.16 The **Trust** means Essex Partnership University NHS Foundation Trust (EPUT)

4.0 GENERAL PRINCIPLES AND OBLIGATIONS

4.1 The Board of Directors of an FT has a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct

4.2 As described in the Trust's constitution, 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 wider public

4.3 The Board undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. It will lead in ensuring that the provisions of the Trust's constitution, the NHS Constitution, SOs, SFIs and SoRD conform to best practice and serve to enhance standards of conduct

4.4 Directors are required to act with discretion and care in the performance of their role and to maintain confidentiality at all times with regard to any information gained via their involvement in the Trust

4.5 Ideally any penalties for non-compliance would never need to be applied. However, the Trust reserves the right to impose such penalties and regards non-compliance with the Code as a serious matter. This Code is considered an essential guide for Directors

4.6 The principles underpinning the Code are drawn from the Seven Principles of Public Life[1] (adapted from the Nolan Report). All members of the Board are expected to abide by them:

- **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 benefits for themselves, their family or their friends
- **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
- **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
- **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
- **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands:
- **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
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

[1] HMSO 2013 Committee on Standards in Public Life 14th Report – *Standards Matter: a review of best practice in promoting good behaviour in public life*

4.7 All Directors are expected to demonstrate the Trust's values and behaviours:

- **Open:** Colleagues are expected to:
  - Be honest, accessible and responsive
  - Work collaboratively with colleagues and all stakeholders, and be open to new perspectives and ways of working
  - Actively listen and have confidence to speak up to improve services
  - Professionally challenge and take ownership to improve safety and change things for the better
- **Compassionate:** Colleagues are expected to:
  - Understand different perspectives and take responsibility to respond to patients, carers and colleagues
  - Be friendly and courteous and show a caring and empathetic approach in transactions with others
  - Value inclusiveness and respect individual and team differences
  - Strive to provide the highest possible standards of care and support
- **Empowering:** Colleagues are expected to:
  - Go the extra mile and help others achieve their goals
  - Encourage and embrace change and be proud to share ideas
  - Embrace continuous learning and self-development
  - Celebrate successes and have the courage to learn from mistakes.

5.0 EXPECTED STANDARDS OF BEHAVIOUR

5.1 The Code will inform and govern the decisions and conduct for all Directors

5.2 Directors have a responsibility to be honest and act with integrity and probity at all times. Directors will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to Directors' own duties or the functions of the Trust

5.3 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute

5.4 Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code
- Respect others and treat them with dignity and fairness
- Seek to ensure that no one is unlawfully or otherwise discriminated against and promote equal opportunities and social inclusion
- Be honest and act with integrity and probity
- Recognise that the Board is collectively responsible for the exercise of its powers and the performance of the Trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors
- Make every effort to attend Board meetings, and those committees, sub-committees and joint working groups of which they are members
- Adhere to the good practice requirements in respect of the conduct of meetings as set out in appendix 1 to this Code and the Board's SOs
- Take and consider advice on issues where appropriate and respect the views of others
- Acknowledge the responsibility of the Council to hold the Non-Executive Directors individually and collectively to account for the performance of the Board, and represent the interests of the Trust's members, public and partner organisations in the governance and performance of the Trust, and to have regard to the views of the Council
- Not use their position for personal advantage or seek to gain preferential treatment, nor seek improperly to confer an advantage or disadvantage on any other person
- Accept responsibility for their performance, learning and development.
- Training and development are essential for Directors in respect of effect performance in their current role. Directors will therefore attend any training/development session as is reasonably required by the Trust in order to assist their role and functions.

6.0 FIT & PROPER PERSON REQUIREMENT AND DUTY OF CANDOUR

6.1 Directors will need to be aware of the statutory duties imposed on the Trust under the 2012 Act in respect of NHS bodies meeting the 'fit and proper person' requirement for Directors and the duty of candour. The Trust acting through the Board will be legally responsible for compliance with its duties under the regulations. It is also a condition of the Trust's Provider Licence that every Director serving on the Board is a 'fit and proper person' as defined in the Licence

6.2 As detailed in the Trust's Fit & Proper Person Policy, Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person or it comes to light that a Director is not a fit and proper person, they will be suspended from being a Director with immediate effect pending confirmation and any appeal. Where it is confirmed that a Director is no longer a fit and proper person their Board membership is terminated

6.3 Directors must conduct themselves in a manner which ensures the Trust's compliance with the requirements set out in the Regulations in respect of the duty of candour and comply with the Trust's Policy on Being Open & Duty of Candour. The Directors must make sure that all staff are aware of the legal obligations that may apply in respect of the duty of candour when patients are harmed after a safety incident.

7.0 RAISING MATTERS OF CONCERN OR 'WHISTLEBLOWING'

7.1 The Board acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature The Trust has a Raising Concerns (Whistleblowing) Policy on raising matters of concern which will be followed at all times by Directors and staff.

8.0 REGISTER OF INTEREST

8.1 Directors are required to register all relevant interests in the Trust's register of interests in accordance with the provisions of the constitution. This will be undertaken on appointment and through an annual review

8.2 It is the responsibility of each Director to update their register entry if their interests change. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

9.0 CONFLICTS OF INTEREST

9.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust**.** Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity

9.2 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement

9.3 The Chair will advise Directors in respect of any conflicts of interest that arise during Board meetings, including whether the interest is such that the Director should withdraw from the meeting for the period of the discussion

9.4 In the event of disagreement it is for the Board to decide whether a Director must withdraw from the meeting. Conflict of Interest shall be dealt with in accordance with the Trust's constitution and SOs.

10.0 GIFTS AND HOSPITALITY

10.1 The Board will set an example in the use of public funds and the need for good value when incurring public expenditure. The use of Trust funds for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered**.** All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector

10.2 The Board is conscious that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community

10.3 All offers of hospitality and gifts whether accepted or not and provided to outside organisations, shall be recorded in a local register. These local registers must include all details including approximate value. All such registers will be reviewed at least annually by the Board

10.4 The Trust has a Conflicts of Interest, Gifts & Hospitality Policy which will be followed at all times by Directors and Trust staff. Directors must not accept gifts or hospitality other than in compliance with this policy which also requires adherence to the Bribery Act 2010.

11.0 CONFIDENTIALITY AND ACCESS TO INFORMATION

11.1 The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with current General Data Protection Regulation, the Freedom of Information Act 2000 and other relevant legislation which will be followed at all times by the Board. Directors must comply with the Trust's Confidentiality Policy. Directors must not disclose any confidential information, except in specified lawful circumstances

11.2 Information on decisions made by the Board and information supporting those decisions should be made available in a way that is understandable

11.3 Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled

12.0 ATTENDANCE AT COURSES AND CONFERENCES INCLUDING OVERSEAS TRAVEL

12.1 The Trust encourages the attendance of Directors at conferences and on courses. However, it is important to establish that there is a value to the Trust as well as the individual. In particular, there must be no basis whatsoever for any criticism that the attendance of an individual at such an event is not in the public interest. Attendance at courses and conferences should always be as set out in Trust Study Leave Policy and linked with appraisals / performance evaluations for Directors.

13.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

13.1 The Directors will satisfy themselves that the actions of the Board (and its committees) in conducting business fully reflects the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon

13.2 All Directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code. In addition Directors are required to sign up, on an annual basis, to the Code

13.3 An alleged breach of the Code by a Director shall be promptly considered. Directors will be held to account for their performance

13.4 The implementation and compliance with the Code will be monitored on an annual basis by the Trust Secretary

13.5 Reviews will take place on a three-yearly basis and will be included in the Trust's internal governance review.

14.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION

- Bribery Act 2010
- Code of Conduct for the Council of Governors
- Constitution
- Fraud Act 2006
- Freedom of Information Act 2000
- NHS Constitution (see appendix 2)
- NHS Improvement (formerly Monitor) Code of Governance for NHS FTs
- Scheme of Reservation & Delegation
- Standards of Business Conduct for NHS Staff
- Standing Financial Instructions
- Standing Orders for the Board of Directors

15.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

This policy should be read in conjunction with other policies in place that may be relevant. These include;

- Being Open & Duty of Candour Policy CP36
- Dignity and Respect at Work (Bullying & Harassment and Discrimination) Procedure HRPG2b
- Conduct and Capability Policy HR27
- Counter Fraud Policy CP11
- Conflicts of Interests, Gifts & Hospitality Policy CP80
- DPA & Confidentiality Policy CP59
- Equality & Human Rights Policy CP24
- Fit & Proper Persons Policy CP70
- Freedom of Information Policy CP25
- Hospitality and Sponsorship Provided by the Pharmaceutical Industry and Related Supply Companies and Contact with Company Representatives Policy CLP51
- Information Sharing & Consent Policy CP60
- Maintaining High Professional Standards Conduct and Capability Policy for Medical and Dental Staff HR32
- Raising Concerns (Whistleblowing) Policy CP53
- Study Leave HR18

END

Appendix 1: Etiquette for Board and Committee Meetings

All members of the Board of Directors shall comply with the requirements set out below when attending or preparing for Board meetings or meetings of the Committees of the Board.

1 The number of decisions required at Board meetings will be limited and the business will be conducted in a timely and focused manner

2 Meeting papers will be succinct and avoid too much detail, and written to an appropriate standard clearly detailing the purpose of the report, issues, risks and recommendations/actions to be taken

3 Every Director will have access to key information prior, at or after the meeting. This will include items discussed outside of Board/Committee meetings

4 The Chair will work to a timed agenda and all questions will go through the Chair

5 Clarity on feedback requirements and timescales will be agreed for all items requiring further action at the meeting

6 Messages to staff from Board/Committee meetings will be agreed at the end of each meeting

7 If any item on the agenda requires a vote to be taken, the most simple and effective process for implementing this will be adopted in line with the Standing Orders

8 In exceptional circumstances, the Chair will invoke Standing Orders

9 Directors will be expected to:

- Read all papers prior to attending the meeting to maximise effectiveness and clarify points of detail with the author beforehand
- Demonstrate mutual trust, courtesy, respect, honesty and openness
- Arrive or sign-in to meetings on time
- Contribute effectively and wholeheartedly to discussions at the meeting
- Be honest, open and constructive
- Show determination, tolerance and sensitivity
- Be rigorous, informed, challenging and constructive, employing questioning tempered by respect
- Be demanding and persistent but not attacking, crushing or dismissive
- Focus on material issues
- Be tolerant and understanding of diverse points of view, treating all ideas with respect and be ready to apologise
- Avoid giving or taking offence and stay open to discussion
- Show group support and loyalty to each other and the organization
- Be sensitive to the needs of colleagues when challenging or being challenged and ensure no-one becomes isolated when expressing their view
- Maintain confidentiality

- Act in a positive manner, expressing own point of view without being aggressive or overbearing and listen to what others say, respecting their viewpoint
- Challenge the issues not the individuals and raise issues concerns or conflicts appropriately
- Highlight or raise their issues or concerns if they experience conflict or disagreement during an agenda item discussion at that meeting and not revisit the issue once agreement has been reached
- Encourage and enable contribution from their peers
- Support the Chair of the meeting in maintaining focus on the relevant issues by stopping or refocusing discussions if this is lacking or not addressing the original issue including supporting colleagues and guests in making the best use of time and to maximise the scope and variety of viewpoints shared ; Individual points should be relevant and made succinctly

10 Directors will not entertain irrelevant interruptions and will not read/respond to emails or otherwise use their communication devices during meetings.

11 At the end of each meeting, review performance against the above standards and to ask:

- Did we use our resources well?
- Who else should have been there, (or not)?
- What helped it go as well as it did?
- What could be done in future to help it run better?

Appendix 2: The NHS Constitution for England

The *NHS Constitution for England* sets out a whole range of principles, values, rights, pledges and responsibilities for NHS organisations and employees as well as for patients and the public. The Trust is committed to abiding by these requirements in guiding its own actions and expects that directors, managers and staff will abide by these principles, values, rights, pledges and responsibilities when undertaking their own duties.

The NHS values which guide the NHS are:

- respect and dignity
- commitment to the quality of care
- compassion
- improving lives
- working together for patients
- everyone counting.

Under the *NHS Constitution* all Directors, managers and staff have the following duties:

- to accept professional accountability and maintain standards of professional practice
- to take reasonable care of health and safety at work for you, your team and others, and to co-operate with the organisation to ensure compliance with health and safety requirements
- to act in accordance with the express and implied terms of your contract of employment
- not to discriminate against patients and staff and to adhere to equal opportunities and equality and human rights legislation
- to protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of harm
- to be honest and truthful in applying for a job and in carrying out that job.

In accordance with the *NHS Constitution*, the Trust expects that its Directors, managers and staff should aim to:

- maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team, the organisation and the NHS as a whole
- take up training and development opportunities provided over and above those legally required for your post
- play your part in sustainably improving services by working in partnership with patients, the public and communities
- raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest opportunity
- be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in the spirit of co-operation. You should contribute to a climate where the trust can be heard and the reporting of, and learning from, errors is encouraged
- view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.

		Agenda Item No:11e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 September 2021**

Report Title:	**Chair and Chief Executive Officer: Division of Responsibilities**					
Non-Executive Lead:	Professor Sheila Salmon, Chair of the Trust					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report outlines the division of responsibilities between the Trust's Chair and Chief Executive Officer	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report.
2 Request further action/information as required.
3 Re-approve the attached document

Summary of Key Issues

The Foundation Trust Code of Governance (the Code) July 2014 provides under section A.2.1 that "The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors".

In accordance with best practice, a document was approved in April 2018 setting-out the respective roles of the Chair and CEO. The Code of Governance review completed in April 2020 suggested the document be reviewed and re-presented to the Board of Directors for approval following a new CEO being appointed that year.

The review of the document was delayed during the pandemic and the action carried forward as part of the Code of Governance review completed in April 2021. Therefore, the attached document has been reviewed and no changes have been made or are suggested to the content, as it is still relevant. The Board of Directors is asked to re-approve the attached document for the division of responsibilities between the Chair and CEO.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: 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	

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

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			
CEO	Chief Executive Officer		

Supporting Documents and/or Further Reading
Appendix 1 – Respective Roles: Chair of the Trust and Chief Executive Officer

Lead
Professor Sheila Salmon **Chair of the Trust**

RESPECTIVE ROLES: CHAIR OF THE TRUST AND CHIEF EXECUTIVE OFFICER

Board: **Board of Directors** **Council:** **Council of Governors**

Chair	Chief Executive
• Reports to the Board and is accountable to the Council for the performance of the Board	• Reports to the Chair and to the Board
• Other than the Chief Executive, no Executive reports to the Chair	• All members of the management structure report either directly or indirectly to the Chief Executive
• Ensures effective operation of the Board and Council	• Runs the Trust's operation and day-to-day business
• Ensures that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives,	• Responsible for proposing and developing the Trust's strategy and overall objectives
• The guardian of the Board's decision making processes	• Implements the decisions of the Board and its Committees
• Leads the Board and the Council	• Ensures the provision of information and support to the Board and Council
• Ensures the Board and Council work effectively together	• Facilitates and supports effective joint working between the Board and Council
• Oversees the operation of the Board and sets its agenda	• Provides input into the Board's agenda on behalf of the Executive Team
• Sets clear expectations concerning the Trust's culture, values and behaviours, including setting the style and tone of discussions at Board meetings	• Communicates the expectations of the Board concerning culture, values and behaviours to all employees
• Ensures the Board's and Council's take full account of the important issues facing the Trust	• Ensures the Chair is aware of the important issues facing the Trust and proposes agenda items accordingly
• Ensures the Board and Council receive accurate, timely and clear information	• Ensures the provision of reports to the Board and Council contain accurate, timely and clear information
• Ensures compliance with the Board's approved procedures	• Ensures the compliance of the Executive Team with the Board's approved procedures
• Arranges informal meetings of the Directors to ensure that sufficient time is given to complex, contentious or sensitive issues	• Ensures that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust
• Proposes a Schedule of Matters Reserved to the Board; proposes terms of reference for each Board Standing Committee and proposes other Board policies and procedures	• Provides input as appropriate on changes to the Schedule of Matters Reserved to the Board and Committees' terms of reference
• Facilitates the effective contribution and the provision of effective challenge by all members of the Board	• Supports the Chair in facilitating effective contributions by Executive Directors including effective challenge
• Facilitates constructive relationships between Executive and Non-Executive Directors	• Supports the Chair in sustaining constructive relations between Executive and Non-Executive Directors
• Ensures that constructive relations exist between elected and appointed Governors	• Supports the Chair in ensuring constructive relations between elected and appointed

Chair	Chief Executive
	Governors
• Ensures constructive and productive relations between the Board and the Council	• Supports the Chair in ensuring constructive and productive relations between the Board and the Council
• Ensures that Non-Executive Directors are able to lead in being accountable to the Council for the Board	• Ensures the presence and support of Executive Directors to the Non-Executive Directors in order to facilitate the accountability relationship
• Leads the Council in holding the Non-Executive Directors to account, ensuring the accountability process works effectively	• Supports the Chair in delivering an effective accountability process
• Chairs the Board's Nominations Committee	• If appointed, to serve on any Board Committee
• Initiates succession planning measures at Board level with the Nominations Committee to ensure appropriate Board composition and refreshment	• Provides information and advice on succession planning to the Chair and relevant Board Committees, particularly in respect of Executive Directors
• Proposes the membership and chairs of Board Committees	
• Ensures effective communication on the part of the Trust with patients, service users, carers, members, clients, staff and other stakeholders	• Leads the communication programme with members and stakeholders
• Leads the provision of a properly constructed induction programme for new Directors	• Contributes to induction programmes for new Directors and ensures that appropriate management time is made available for the process
• Leads in updating the skills and knowledge and in meeting the development needs of individual Directors and of the Board as a whole	• Ensures that the development needs of the Executive Directors and other senior management staff are identified and met
• Ensures that members of the Council have the skills, knowledge and familiarity with the Trust to fulfil their role	• Ensures the provision of appropriate development, training and information for the Council
• Ensures that the performance of the Board and Council as a whole, their Committees, and individual members are both periodically assessed. This will include an externally led assessment at least once in every three years	• Provides input to the wider Board's and Council's evaluation process
• Sets Non-Executive Director objectives and reviews individual and collective performance at least annually, and provides outcome report(s) to the Council's Remuneration Committee	• Sets Executive Directors objectives and reviews individual and collective performance at least annually, and provides outcome report(s) to the Board's Remuneration Committee
• Promotes the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at Board of Directors level	• Conducts the affairs of the Trust in compliance with the highest standards of integrity, probity and corporate governance • Promotes continuing compliance across the Trust
• Ensures a good flow of information each way between the Board, Board	• Provides effective information and communication systems

Chair	Chief Executive
Committees, the Council, senior management and Non-Executive Directors	