NHS
Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors

Wednesday 31 May 2023

EPUT

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Wednesday 31 May 2023 at 10:00

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

PART ONE: MEETING HELD IN PUBLIC AT ANGLIA RUSKIN UNIVERSITY, BISHOP HALL LANE, CHELMSFORD, CM1 1SQ, MICHAEL ASHCROFT BUILDING (MAB) ROOM 404a/b

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION The Self-Harm Reduction Pilot Diana Luckie, Head Occupational Therapist (Adult Inpatient Services)			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 29 March 2023	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Committee Chairs Report	Chairs	Attached	Noting
(c)	Board Safety Oversight Group Assurance Report	SS	Attached	Noting
(d)	Staff Survey and Bank Only Survey 2022	SL	Attached	Noting
(e)	Safe Working of Junior Doctors Annual Report	MK	Attached	Noting
(f)	CQC Compliance Update	DG	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2022/23	DG	Attached	Approval
(b)	End of Year Governance Reviews	DG	Attached	Approval
(c)	Complaints & Compliments Annual Report 2022/23	ZT	Attached	Approval
(d)	Patient Experience Annual Report 2023/24	ZT	Attached	Noting

9	**STRATEGIC INITIATIVES**			
(a)	Operational Plan 2023/24	TS	Attached	Approval
10	**REGULATION AND COMPLIANCE**			
(a)	Duty of Candour Annual Review	NH	Attached	Noting
(b)	Trust Constitution	SS	Attached	Approval
11	**OTHER**			
(a)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(b)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(c)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 26 July 2023, Anglia Ruskin University, Chelmsford, Essex			
15	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 27 September 2023 Wednesday 29 November 2023			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 29 March 2023
Held at Anglia Ruskin University Chelmsford, Essex

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Alex Green (AG)	Executive Chief Operating Officer
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Natalie Hammond (NH)	Executive Nurse
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Director of Finance and Resources
Dr Milind Karale (MK)	Executive Medical Director
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Marcus Riddell (MR)	Acting Executive Director of People and Culture
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Stephen Heppell (SH)	Non-Executive Director
Elena Lokteva (EL)	Associate Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Coordinator
John Jones	Lead Governor
Stuart Scrivener	Governor
David Bamber	Governor
Pippa Ecclestone	Governor
Prof Nigel Harrison	Dean of Faculty ARU
Vanessa Wakefield	Deputy Director of Care Coordination

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

Professor Nigel Harrison, Dean of Faculty for ARU was delighted to welcome the EPUT Board of Directors to the University, cementing the collaborative working partnership and was looking forward to the joint EPUT / ARU safety conference on 15 June to share good practice across both organisations.

The meeting commenced at 10:02

023/23 APOLOGIES FOR ABSENCE

Apologies were received from Sean Leahy who is currently seconded to the Mid and South Essex ICB and Jill Ainscough.

024/23 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

Signed: …… Date: ……

In the Chair

LL advised that there were two potential interests mentioned previously that were yet to be logged formally on the public register as they were not formally concluded. One was regarding the MHA working in private sector and the second working with a women's health company. Neither of these interests will affect LL working with EPUT but will put on the public register in due course.

025/23 PRESENTATION

SS welcomed Vanessa Wakefield, Deputy Director of Care Coordination to present regarding the West Essex Virtual Ward.

VW advised that as Deputy Director of Care Coordination and Lead for the Care Coordination in Essex, she was delighted to present to the Board the exciting work happening in West Essex around the Virtual Hospital and related transformation plans.

In December 2021 and January 2022 NHSE published guidance and a mandate that each ICS nationally was required to stand up a virtual ward, a safe efficient alternative to NHS bedded care. Virtual wards provide acute care, support and treatment to people who would otherwise be in an acute hospital bed and are often enabled by digital technologies. This support is provided as an alternative to admission and can also help support early discharge.

There are two models of virtual ward:

1. Technology enabled virtual wards
2. Hospital at home which includes frailty virtual wards.

The ambition for a fully integrated community led virtual hospital, looking at the needs of the individual was considered, resulting in a fully integrated virtual hospital with community wrap around services and health and social care. The virtual hospital is clinically led with a workforce to enable provision of acute level care in patient's homes.

The West Essex Virtual Hospital was launched on 05 December in EPUT in line with NHSE guidance and is operational 7 days per week 8am – 8pm.

The team is aligned into the care coordination centre which is consultant led, providing medical oversight. The team includes pharmacists, advanced clinical practitioners, senior clinical practitioners and clinical practitioners. Referrals received from primary care, acute setting and community services. The West Essex Virtual Hospital is partnered with Doccla who provide remote monitoring solutions, which is also in line with Hertfordshire services. Information is entered by a patient or carer and is monitored by the care team.

Positive feedback from patients has been received with some being nervous about using new technology, but with support from the team were able to use the equipment and managed to avoid admission to hospital. Stakeholder feedback has also indicated positive experience with referrals in to the virtual hospital. This is a new service which continues to develop and evolve but has been positively received thus far.

AG thanked VW for the presentation which showed a service that was full of possibility. The service was underpinned by holistic assessment and AG welcomed the wellbeing score to see how people are feeling. AG queried what possibilities for the future may be and thoughts on how we can capitalise on this model. VW responded that the service was well placed in West Essex with the care coordination centre which was also going through transformation. The ethos will be to use the Care Coordination Centre MDT to pull in and look at what services patients are known to and who needs to be involved in the discussions.

NH reflected on a recent visit to the virtual ward and care coordination centre, with the service being very well received by the regional director of nursing and quality. There is a phenomenal skill set and competency within the team. NH extended thanks to the team for hosting the recent visit and stated that this was a fantastic service with many exciting opportunities for the future.

LL expressed a desire to visit the Care Coordination Centre and this will be picked up as part of the NED service visit schedule. LL sought VW's thoughts on how to benchmark patient experience and communicate back in to the system that this is working as a better care model. VW acknowledged that this can be a challenge and that this was a whole cultural shift in terms of delivering health care. The team continue to work with NHSE and regional ICB, collecting data around person centred outcomes and looking at what outcomes are for individuals and their health status. The impact on reduced length of stay for acute will also be reviewed. VW reiterated that this was a new programme nationally, and EPUT are working with other areas to look at what they are delivering and their outcomes. There are also a number of KPIs to work to.

RH was impressed with service and was pleased to see the level of innovation taking place. RH queried whether in terms of flows in and out of service, whether there were plans for proactive case finding, and also what the average length of stay would be in the virtual hospital?

VW responded that the virtual hospital was a short term intervention of approximately 7 – 10 days. The referral in process will continue to be looked at proactively and work in integration with other services. Access to PAH systems to actively pull patients from acute trust was also currently being explored.

MK commented that with the health service there is significant reference to physical and mental integration and believed that this was a positive step closer to that. VW agreed that we are on a journey to have true integration with the care coordination centre being an integral part of that.

SS stated that this was an exciting journey and reflected that there was similar work happening within EPUT in other areas, such as the Mid and South Essex Community Collaborative pilot and there would be opportunities for shared learning. VW agreed that there was lots to learn from each other.

026/23 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 25 January 2023 were agreed as an accurate reflection of discussions held.

027/23 ACTION LOG AND MATTERS ARISING

The action log was reviewed and noted that there were no other matters arising that were not on the action log or agenda.

The Board discussed and approved the Action Log.

028/23 CHAIRS REPORT

SS presented the report and noted COG activity in terms of membership and engagement events. SS formally welcomed Elena Lokteva in the role of Associate NED, noting that this position would transition into a full NED role later in the year when JW finishes her term of office.

The Board received and noted the Chair's Report.

029/23 CEO REPORT

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

PS highlighted the following:

- The Safety Strategy sets out ambition and need to continue to improve safety for patients.
- PS extended thanks to MK and team in making the MH Emergency Care Department a reality. The service had received positive initial feedback.
- Investment continues with EPMA and electronic patient record. This will be a change in clinical practice to how we support patients.
- Thanks to everyone who supported the provision of safe services whilst junior doctors took industrial action. Further industrial action is planned after Easter and planning is currently taking place to ensure services continue to run safely and smoothly.

EL sought clarity in the Trust's approach to flexibility in accommodating fasting and praying needs of Muslim staff and service users during Eid. PS confirmed that as a Trust, EPUT aims to be flexible and respect the needs of religious observations. Guidance was sent out to all colleagues so that colleagues knew what behaviours were expected during Eid. MR added that the Trust strives to be as accommodating as possible be and have regular engagement with the faith network, feedback has been positive so far but there is always scope to improve and any feedback is welcomed.

Operational Update – Alex Green
AG noted that the Trust was beginning to see improvement in areas of key challenges. Acute adult length of stay had seen a third month of improved performance. This continues to remain outside of the national benchmark but is moving in the right direction. PICU indicators remain within the national benchmark, and the Trust had seen positive movement in Out of Area Placements.

AG highlighted some processes and clinical practice work taking place to drive improvement:

- Consultant meetings with a focus on length of stay had been stood up.
- Weekly MADE discharge events were taking place.
- The Trust had called its first system escalation call regarding mental health and saw the system come together around us.
- The Trust continues to work with Getting It Right First Time (GIRFT) and have a second GIRFT conference in May.
- Psychological services are stable.
- The Trust remains inadequate for IAPT in both areas, but are beginning to see green shoots of improvement and expect to see real improvement by June.
- Automation of referrals from SystmOne into IAPT services for those with mild to moderate anxiety.
- The Trust took on the Lighthouse Service in SEE in March 2022 and are now beginning to see improvements in waiting times. There are some data quality / validation issues that are being worked on with regional colleagues.
- Framework breaches have been driven by workforce challenges.

Finance – Trevor Smith
Operational performance and our financial results and plans are considered in depth at the Finance and Performance Committee. The recent F&P meeting considered the performance at month 11 and reported that we remain on target to deliver the forecast position of breakeven. The Trust has also been able to secure circa £1.2m of further capital funding from system colleagues and therefore the total capital spend will be circa £14m this year.

HR / Staffing – Marcus Riddell
Temporary staffing remains high, although progress is being made to reduce the vacancy rate which overall is expected to be around 10%, which is below national average and demonstrates the progress being made. Workforce planning for next year continues. MR provided a factual correction to the report, advising that there have been four bullying and harassment incidents reported in the past month.

MK advised that since opening, the Mental Health Urgent Care Department had seen 40 patients, 90% of which had been discharged which demonstrates how senior input and a calming atmosphere can have for our patients. Positive feedback has been received from patients, and it is anticipated that once the service expands to cover Southend and Mid Essex will have an impact on the bed pressures. SS queried whether the service was having a positive effect on waiting times in the main A&E at Basildon Hospital? MK confirmed that whilst a new service, early indicators showed a positive impact with no patients breached the 24 hour stay, and all seen on arrival.

With reference to IAPT, MJ noted the long waiting time, and queried how we manage the risk for those that are mild to moderate to progress to more severe? AG responded that there were two elements – patients were seen quickly for a first appointment but there is a challenge around second appointments. The improvement trajectory is monitored on a monthly basis and patients have contact with the team while they are waiting for their second appointment.

MR advised that with regards to temporary staffing, the Trust had seen over 200 bank members take on substantive contracts. The HR team were also in discussion with bank and agency partners about regularity of shifts to give a sense of continuity and safety for patients. MR confirmed that there are a number of ideas in the pipeline for consideration on how to transform temporary staffing.

JW reflected on the financial forecast, commenting that to achieve break even with all the operational pressures throughout the year shows real financial grip from the team and shows that EPUT understand finance as an organisation.

The Board received and noted the CEO's Report.

030/23 QUALITY AND PERFORMANCE SCORECARD

Discussed as above.

The Board of Directors received and noted the report.

031/23 COMMITTEE CHAIR'S REPORT

SS advised that going forward Board Sub Committee Assurance Reports would be presented in one new combined report. Board members indicated their approval of this format.

Audit – JW
JW advised that two issues were highlighted within the Governance Update however neither issue was cause for concern.

F&P – LL
LL advised that there were no issues to highlight in addition to the report.

PECC – ML
ML advised that feedback had been provided to DG with some thoughts regarding format of the report which could reflect a bit more on the added value the committees have made. The PECC

undertook a deep dive into pharmacy staffing, and were very impressed with Dr Hilary Scott in terms of how she is managing in very challenging recruitment difficulties and high vacancy rate. The recruitment team have now been given dedicated support to focus on new recruitment strategies. The PECC acknowledged how diligent some of our leaders are and Hilary Scott driving that service forward was very impressive.

Quality Committee – RH
RH emphasised the continued impact the patient safety strategy is having. RH also referred to the learning from deaths review, commenting that the team had taken a dry document and created more emphasis about the learning we can get from it.

The Board of Directors:

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

032/23 SAFETY FIRST, SAFETY ALWAYS STRATEGY (VIDEO)

SS reflected on exciting work that had taken place over the past two years as part of the Safety First Safety Always Strategy and reaffirmed key priorities going forward.

NH highlighted to colleagues, the video would begin with one of the new patient safety partners and should be symbolic that everything we do starts with a patient.

033/23 SAFETY FIRST, SAFETY ALWAYS STRATEGY ANNUAL REPORT

NH stated that the video said so much around the strategy and where we are with the ambition to be driven by the patient voice and be a real part of the community. The two year progress report shows the sheer volume of what we have tried to do as a Trust around safety.

NH continued that we must be humble regarding what more needs to be done. Healthcare is a high risk industry that is faced with safety challenges every day and realistically it is unlikely to reach a position to never face risk or safety challenges.

There are five key objectives / ambitions as part of the strategy:

- Patients and families feeling confident in our care.
- Stakeholders are confident in us as a provider and have confidence we are safe
- No preventable deaths
- A reduction in self-harm
- A reduction in patient safety incidents

The report shows progress over the past two years and what we want to do next and recognised the contribution of all that had contributed to the strategy. NH stated that it was important to acknowledge the context of what we deliver in:

- The strategy was launched during the pandemic in a period of immense uncertainty.
- Demand for MH services had been rising across the NHS with a 21% increase in demand.
- We also are likely to see demand, complexity and acuity that will present to us being impacted by the cost of living crisis and pandemic.
- During the pandemic, EPUT have worked as an anchor organisation by delivering over 1.5m Covid vaccines.
- There are national challenges around staffing in the NHS and challenges with industrial action that is taking place.
- The Essex Mental Health Independent Inquiry continues and we must keep open to the learning and outcomes of this inquiry.

It is recognised that there is lots to do but also we must recognise what has been achieved.

- NH was pleased to say that EPUT have been award winners in CAMHS service.
- We have a target operating model (TOM) that has restructured how we lead in the organisation and investment in clinical leadership is beginning to show.
- We have an accountability framework to ensure the organisation is behind those that face challenge.
- Coproduction is key and patient safety partners are key exemplar of how we hear the patient voice.
- We speak well as an organisation on innovation, we use technology to our advantage and aid safety.
- 94% of staff members stated they can identify incidents they might not have been able to before through use of technology.
- The self-harm reduction pilot had huge benefit to those we care for through activity therapy and engagement.
- Continuous learning and culture of learning continues to be embedded, accelerating and systemising learning.
- The Trust are an early adopter of PSIRF which puts us on a platform to be ahead of the curve around learning.
- NH acknowledged work around prone restraints, and the improved position to 95% reduction in prone restraints.
- The EDI agenda is building and broadening.
- Enhancing environments have been award winning and patient and staff feedback has been positive.
- Ligature reduction work has resulted in a 30% reduction in incidents.

NH concluded that we are seeing the impact of the strategy and improvements being made. NH extended huge thanks to the work around the digital strategy which has resulted in more intelligent data to work from and be informed from.

LL noted the very impressive achievements, however commented that with achieving so much what was next and what is seen as the next level of performance we need to be aiming for? NH acknowledged that safety was an ongoing journey, some work had been transformative and took time to see how this had fully landed and embedded, for example, being an early adopter of PSIRF. EPUT are one of the first in the country to take this approach to patient safety. We now must maintain momentum of energy and outcomes that will keep us moving forward in the safety space. The patient voice is at the heart of all we do and it is important to grow a greater depth of wealth and knowledge. There is still work to do around culture of safety and workforce, data has to keep developing and keep ahead of the curve in data and technology developments.

ML queried how we continue to assess risk of safety standards that we are not happy with or risk of breach of our safety standards. It is known that there are often factors that trigger risk of issues, and we know we have challenges, how do we give assurance about that in terms of heat maps where there are ongoing risks. NH acknowledged that this was something to develop further, to look at key data metrics. There is a need to get views regularly from staff and service users to give us triangulation. There is a lot to be probed and questioned around how we get true assurance and this is a question being tackled by the national inpatient quality review and is a national conundrum regarding how to address quality and safety, NH believed that the EPUT safety strategy could be informative to the national review.

JW reflected on the question of what does safety look like, stating that there was a need to show what safety looks like for the patient, for our staff, for the system and regulators and it is hoped that this also gives a regular tempo to fully benchmark and compare going forward.

TS stated that the accountability framework was a key enabler to make the link between ward to board, but equally important is the data that informs those sessions.

NL commented that this was a very comprehensive report and the breadth of the report was pleasing in how tied together all initiatives across the Trust.

AG agreed that the accountability framework and target operating model have completely refreshed leadership with an emphasis on clinical leadership. The TOM was developed last year and teams are now fully recruited and can see insights they share through the accountability process.

PS agreed that it was very impressive how everything had been pulled together and celebrated what we have achieved as well as setting the bar for the next year. The strategy was driven by learning lessons from the past and we have focussed over the last year on learning lessons from the HSE prosecution. This demonstrates that as a Trust we can learn lessons and make a difference to the patient experience. There is a question as we come to the third and final year of the strategy as to whether we have got enough from this work or is more time needed to demonstrate the broader work that we are doing. NH commented that it was clear in the report, safety never stops and as we go into the final year of the strategy, there will be continuous improvement and ambition. As a Trust it is imperative we need to be committed to a continuous improvement journey.

EL stated that the report demonstrated a high level of assurance and queried how this linked in to the risk management system. EL was not able to find the patient and families confidence as the possible assurance over our controls. NH responded that it is noted on the BAF the rating of risk was high around safety and there is continuous review we need to do. NH did not think that some ambitions were quantifiable enough and this is work for the coming year and was an area where there is more to be done.

ZT highlighted and supported some of the areas of focus:

- Lived experience was an important area of focus and was central to the strategic plan; since January that Trust have increased the number of safety ambassadors and continue to build on that fantastic pool of people who support our journey.
- Peer support roles have been piloted in the Linden Centre
- I Want Great Care (IWGC) was a key tool to capture systematic feedback from our service users.

ZT welcomed the continued focus and area of emphasis going forward adding that in regards to data informed focus, the Trust's commitment to an electronic prescribing system, and working to implement new systems to reduce risks around safety with medicines administration.

In terms of governance, it is highlighted in the report the role of the Board Safety Oversight Group and Executive Safety Oversight Group and speaks to the comments made that this is an initiative led across the whole leadership team and have seen collective responsibility from the board.

NH added that the Trust are working with partners and ICBs to approach our future focus to ensure the patient voice is heard by our system partners and are also working on an independent mental health advocacy opt in policy. There is also a quality together meeting with system partners and a focussed programme of visits.

Looking to the third year of the strategy, all agreed that the nature of the focus was right and this would continue to be a dynamic journey.

Board approved.

The Board of Directors:

Signed: …… Date: ……

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

034/23	LEARNING FROM DEATHS QUARTERLY OVERVIEW OF LEARNING AND DATA (QUARTER 3 2022/23)

NH presented the Learning from Deaths Quarterly Overview of Learning and Data, highlighting the change in format of the report following a piece of work to align both the patient safety and learning from deaths agendas. Combining these two agendas ultimately had been able to create a new fresh approach to the report, harnessing lessons identified and learning drawn up. NH welcomed colleague's comments on this approach to the new reporting method.

NH advised that there were no issues of concern to note from Q3 data which is in line with previous Q3 reporting periods.

ML welcomed the new format which allowed readers to really understand and digest information within. ML queried how aligned our data is with inquiry data. ML also noted that the slide within the report which references looking backwards, includes a statement identifying that the significant majority of deaths were not caused by anything untoward. NH responded that the mortality review process expects all trusts to look at deaths as an "occurrence" and reflect on learning on treatment and care provided. The majority of deaths were expected but the report does not leave out those categories where there could still be learning and that makes reference to the significant number. In terms of Inquiry data, NH confirmed that colleagues within the mortality review team were heavily aligned with the internal inquiry team and data was shared.

NL suggested that there were three pieces of work ongoing with significant liaison and overlap. The scope of the mortality review team is a much wider review of deaths. A report to be presented to the next BSOG meeting outlines work undertaken on historic deaths specifically looking at SI recommendations and a safety analysis of those recommendations. There is also close working with the culture of learning team to ensure we are mapping themes from the past to our current workload moving forward including how to map in the governance structures. These three work streams each look at the data from a different angle but through the strategy we all have the same goal.

EL referred to the data on historic incidents, and queried what are our peer's upper controls? NH responded that there was significant complexity within mortality data with no natural comparison with peers, and as such is based on internal data. ZT added that the upper and lower control are not an absolute standard, they merely describe statistically what would look unusual. It is not a judgement on what is acceptable it is just a statistical measure.

PS reflected on the question around benchmarking, noting that MK and NH have access to national groups and considered whether there was a conversation needed about how to move to a standardised mortality data set for mental health? SS agreed that it may be good to make representation for that and feed in and emphasise the benefit of guidance and national benchmarking.

ACTION:

1. **MK / NH to feed into national groups to emphasise benefits of guidance and national guidance around a standardised mortality set for mental health.**

The Board of Directors:

1. **Received and noted the content of the report.**

035/23	EQUALITY, DIVERSITY AND INCLUSION (EDI) ANNUAL BOARD REPORT 2023

PS advised that MR would present the three EDI reports together.

MR advised the following:

- EDI Annual Board report was the annual summary of activity over the past year, the challenges and moving forward.
- Public Sector Equality Duty Report was a factual summary of our equality data and will be published on the trust website
- Equality Delivery System (EDS) report is also a factual summary but includes feedback from patients.

Each of these reports have a slightly different purpose but all overlap.

Highlights of the reports were as follows:

- Significant activity on the EDI agenda had taken place, EPUT were particularly active with system partners and it had been a complement to have been asked to lead of EDI for MSE ICB and Herts and West Essex ICB.
- EPUT have a nationally regarded RISE programme
- Significant work has taken place locally with Essex Police on abuse, particularly around race.
- As is evident from the data within the reports, there are still some challenges remaining, particularly around bullying and harassment.
- There are challenges around how to elevate some of our messaging and communication
- Work is ongoing to improve recruitment and retention

LL emphasised the need for a clear executive summary, stating that some of the reports had some key information sometimes buried in the detail and suggested this could be reviewed prior to publishing. MR commented that there were limitations due to the mandated template but would review.

MK thanked the team for pulling together these reports stating that as executive sponsor for the faith and spirituality network, there were huge aspirations for the network and believed this would tie in to the ongoing work around equality, diversity and inclusion across the Trust.

ML commended the Executive Team for their leadership in setting up Trust networks adding that this was an excellent standard for the trust. The report identified that the Trust had performed well in terms of gender pay gap, and had 26% BAME work force, but was not sure representation levels and each grade or band were clear. ML emphasised the importance of the Board Sub Committees which give opportunity for further drill down into this data.

AG commented that there were clear areas of focus for the coming year and also welcomed executive sponsorship of networks. AG suggested there was further opportunity to use leadership structures to continue to change culture and how we can further enhance support.

ZT agreed that these were three helpful reports, as an organisation we have much further to go recognising that different staff groups don't always have a good experience and we must have continued focus . ZT noted that it was set out in the strategic plan the people and culture strategy will be working on giving further focus to this agenda and will give further clarity on the actions we are taking.

ACTION:

1. **MR to review and consider content of executive summary for EDI reports.**

The Board of Directors:

1. **Received and noted the content of the report.**

036/23 PUBLIC SECTOR EQUALITY DUTY REPORT 2022 - 23

As discussed above.

The Board of Directors:

1. **Approved the Public Sector Equality Duty (PSED) 2022-23 report so it can be published on the Trust website for public viewing.**
2. **Reviewed the data, key themes and trends discussed.**
3. **Approved EDI next steps based on this feedback.**

037/23 EQUALITY DELIVERY SYSTEM (EDS) REPORTING TEMPLATE 2023

As discussed above.

The Board of Directors:

1. **Noted the contents of the reporting template.**
2. **Approved this for public display on the EUPT website as part of our Public Sector Equality Duty.**

038/23 BOARD ASSURANCE FRAMEWORK

DG presented the Board Assurance Framework advising that reporting of the BAF and Corporate Risk Register (CRR) continue to be finessed and was a developing process. Each risk has been discussed and had an update on progress since the last report.

There have been two movements in risk score:

- SR8 use of resources, ET agreed to increase in risk exposure.
- CRR95 with the conclusion of the vaccination programme a reduction in risk exposure was agreed. DG confirmed that although this had been closed from the CRR it would remain on the Directorate Risk Register.

RH referred to the target risks set to be achieved at end of financial year, commenting that these had not been achieved and what could be done to improve that. DG responded that there is work to do to reflect movement in risk activities that drove the risk score in the beginning. In terms of the risk around finance risk, the risk had been managed well and the score had reduced, however coming in to the New Year new challenges had resulted in an increasing risk.

TS commented that during the course of the year, a review of efficiency programmes, cost pressures etc. had been undertaken to mitigate the financial risks. This resulted in some component parts moving but the overall risk scoring not being impacted; this could be drawn out and articulated more in future.

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

039/23 APPROVAL FOR POLICIES UNDER MATTERS RESERVED FOR THE BOARD OF DIRECTORS

DG advised that a policy oversight group had been established to remove the burden of policy and procedure approval from Board sub committees. DG presented the following policies under 'matters reserved for the Board for final ratification':

- Being Open Policy

- Corporate Health and Safety Policy
- Major Incident Plan
- Emergency Preparedness, Resilience and Response (EPRR) Policy

DG confirmed that all had been through relevant expert matter groups and had been circulated well in advance for review.

SS commented that it may helpful for discussion at some point as to whether new process is working and has streamlined board sub committees.

The Board of Directors:

1. **Received the report noting the documents had been previously circulated.**
2. **Noted the governance process followed for each document.**
3. **Agreed the Policy Oversight and Ratification Group recommendation for the detailed policies be approved by the Board in line with matters reserved for the Board.**

040/23 CODE OF CONDUCT FOR THE COUNCIL OF GOVERNORS

DG presented the Code of Conduct for the Council of Governors advising that Governors had been engaged and have approved in terms of taking forward for their meetings.

The Board of Directors:

1. **Received the report.**
2. **Approved the Code of Conduct for Governors.**

041/23 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.

042/23 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

JW stated that conversations had reflected ambitions with respect to safety and passion for access to services. EDI matters reports demonstrate how seriously as an organisation we take these matters progress and our commitment to continued improvement. Exec sponsorship of networks reinforces this commitment.

043/23 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:

044/23 ANY OTHER BUSINESS

There was no other business.

045/23 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

Signed: …… Date: ……

The next meeting of the Board of Directors is to be held on Wednesday 31 May 2023.

046/23 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 13:03.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 046/23)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	On page 46 of 318, at 2.9.4 Adult MH Bed Occupancy is shown as 88.4% (target 93.4%) and marked green. Given that there are currently some beds which temporarily cannot be occupied, what will be the effect on this figure when these become available?	To calculate bed occupancy we have to use a static bed base (contracted beds), as bed closure numbers change day to day and this cannot be factored in manually or recorded through Paris/Mobius. Therefore due to closures our bed occupancy can look lower, once those beds open and are filled, occupancy rates would rise.
John Jones	On page 70 of 318 re: Fill Rates, at Robin Pinto Unit the night unregistered fill rate is consistently over 200%. Why is this?	The calculation for fill rates is based on planned/established shift vs actual. In cases where the rate is over 100%, this is where the number of staff working in that shift is over the planned/establishment. Continued rates in a particular ward that has over 100% could suggest that their establishment/planned shifts may be set too low. I expect these will change quite a bit once Angela Wade has set new establishments with MHOST, and the changes Time to Care will push through in the new model.
John Jones	On page 97 of 318 in the Safety First, Safety Always 2 year Report, the Headline 5 key outcomes include "No Preventable Deaths". I cannot find in the Report any reference to whether or not there were any preventable deaths during the period and if there were what lessons were learned	NH some greater ambitions are not quantifiable at the moment. Some of the historic review of the past 20 years is being built into programme of work. New PSIRF process will do more around prevention of same themes and events.
Pippa Ecclestone	It is really great for governors to have the benefit from a face to face Boar meeting and is so effective for finding out information and would like to continue and benefit governors.	
Stuart Scrivener	Noting the challenges regarding recruitment within the Pharmacy team and good work around recruitment taking place across the Trust, it was surprising that at a recent recruitment fayre pharmacy were not present.	MR will take that back and follow through.

Signed: …… Date: ……

In the Chair

David Bamber	Welcome the conversation on safety. Glad that safety has become paramount. Healthcare is a safety critical industry. How can we strive to make the NHS and EPUT safer as they concern the safety and welfare of people and build in safety focus.	SS commented we must always strive to make ever safer for people who use and come in to contact with services, the Trust are also working with the Civil Aviation Authority to share learning and improve safety. NH James Reason who brought about safety thinking in high risk industries stated that working in health care is the most challenged as it relies on people, communication and use of technology. EPUT are bringing partnership in to our safety thinking, also using the Ministry of Defence and how they have approached learning lessons and systemised learning. Also bringing in partners with a different lens on what we can do, having open conversations with partners and population. Will have patient safety planning conversations with patients and carers and is a real shift. Working with the Civil Aviation Authority has opened up opportunity for partnership and have offered joint a workshop in June to share knowledge on safety which is a very exciting opportunity to present innovation and learn from a global leader on safety and security to help us with our safety strategy.

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 29 March 2023

Lead	Initials	Lead	Initials	Lead	Initials
Milind Karale	MK	Natalie Hammond	NH	Marcus Riddell	MR

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

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
034/23 March 2023	MK / NH to feed into national groups to emphasise the benefits of guidance around a standardised mortality set for mental health.	MK / NH	May-23	MK / NH to continue feeding this into national meetings.	Closed	
035/23 March 2023	MR to review and consider content of executive summary for EDI reports.	MR	May-23	This will be included in future EDI reports.	Closed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Non-Executive Director
- EPUT Executive Nurse
- Recommencement of Face to Face Meetings
- International Nurses Day
- Celebrating the King's Coronation
- Service Visits
- Herts and West Essex ICP/ICB inaugural conference

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

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

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

Acronyms/Terms Used in the Report			
CAMHS	Children and Adolescent Mental Health Services	NED	Non-Executive Director
CQC	Care Quality Commission	EMHII	Essex Mental Health Independent Inquiry

Supporting Reports/ Appendices /or further reading
Main report.

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors Part 1
31 May 2023

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Non-Executive Director

I would like to formally welcome Elena Lokteva to the Board of Directors as a Non-Executive Director. Elena was initially appointed as an Associate Non-Executive Director, however due to Jill Ainscough stepping down from her role as NED, with agreement from the Council of Governors and endorsed by the Board of Directors, Elena has now taken on the full NED role as of May 2023. Thank you to Jill for her contribution to the EPUT Board and welcome to Elena.

2.2 EPUT Executive Nurse

Our Executive Nurse, Natalie Hammond will be leaving EPUT to take up a new role as Executive Director of Nursing and Quality at Hertfordshire and West Essex Integrated Care Board (ICB). Natalie has been Director of Nursing for EPUT (and previously NEP) for the past 8 years and leaves a legacy where she has created a culture of learning and a relentless focus on patient safety. Although Natalie will be greatly missed here at EPUT, we extend our heartfelt thanks and wish her every success in her new role. The process for finding a new Executive Nurse has commenced ahead of Natalie's departure at the end of July. If necessary, as a stop-gap, interim executive arrangements will be confirmed by the Chief Executive in due course.

2.3 Recommencement of Face to Face Meetings

Following the long absence of face to face meetings due to the Covid-19 pandemic and social distancing restrictions, it was a pleasure to hold our March Board of Directors meeting in public at Anglia Ruskin University. The meeting was well attended by governors, members of the public and many student nurses from ARU. I was also pleased to be able to meet with Board members and the Council of Governors in person at our joint seminar in April. While not underestimating the flexibility the virtual meeting space can give us, it is good to be able to meet once again in person whilst not losing the overall flexibility that meetings in the virtual space can deliver, particularly when working across such a wide geographical footprint.

2.4 International Nurses Day

May 12 marked the annual International Nurses Day, a day to celebrate the amazing contribution nurses make here at EPUT and across the world. A celebratory event was held for staff via MS Teams led by Natalie Hammond, Executive Nurse and Angela Wade, Director of Nursing, to recognise our many nursing colleagues across the Trust and all that they do.

2.5 Celebrating the King's Coronation

As you will be aware the nation came together to celebrate the coronation of our new king, King Charles III. Staff and patients across the Trust joined in celebrations and our Estates and Facilities Team delivered cupcakes to patients receiving care in our inpatient wards as part of the celebrations.

2.6 Service Visits

The NEDs and I are pleased to be able to continue our schedule of visits to services across the Trust. Since the last Board meeting numerous visits have taken place to Adult Inpatient Wards at St Margaret's Hospital, Derwent Centre, Cumberledge Intermediate Care Centre (CICC), Clifton Lodge, Transformation Team, West Essex Frailty Services, West Essex Inpatient mental health

wards, West Essex Community inpatient services and outreach teams, North Essex Community MH Teams, The Lakes, Substance misuse team with Open Road (partner organisation). The value of these visits cannot be underestimated and provide a real insight into challenges faced by our staff at the coal face, but also are an opportunity for the Board members to see first-hand the excellent care provided by our dedicated staff.

2.7 Herts and West Essex ICP/B inaugural Conference

In company with several of our NEDs and our Executive Nurse Natalie Hammond, I was delighted to participate in the well-attended inaugural conference held at the Latton Bush Business Centre in Harlow on 24th May. Keynote speakers included the Right Honourable Patricia Hewitt, who shared the key findings from the Hewitt Review. EPUT led the second keynote presentation on the successful virtual hospital project, including patient and service user feedback. It was also very welcome to see lead members of the Essex and Hertfordshire County Councils sharing the platform.

3.0 LEGAL AND POLICY UPDATE

Not An April Fools – Procurement Law Changes: Reminder!

As of the 1 April 2023 Contracting Authorities must consider, and implement where relevant, the following PPNs within their procurement activity:

Please see the first link below for a copy of PPN/02/23: Tackling Modern Slavery in Government Supply chains. The second link is a copy of PPN 03/23 – A New Standard Selection Questionnaire and the third link is a copy of Carbon Reduction Plan Requirements.

For Information: Link; Link; Link

Items of interest identified for information:

Liberty Protection Safeguards delayed "beyond the life of this Parliament"

The Government announced on 5 April 2023 that there would be a delay in implementing the Liberty Protection Safeguards beyond the life of this parliament. Please see the link below for a copy of Next Steps to Put People at the Heart of Care.

For Information: Link

What Was The Court Of Appeal's Decision In The Worcestershire Case

Please see the link below for a copy of a report published on 19 April 2023 that outlines a decision made by the Court of Appeal in December 2021 has changed how local authorities determine responsibility for Section 117 aftercare.

For Information: Link

5.0 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**	**31 May 2023**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Summary of Key Issues
The report attached provides information on behalf of the CEO and Executive Team in respect of performance, strategic developments and operational initiatives, specifically: -

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

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

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

Acronyms/Terms Used in the Report

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Paul Scott **Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Essex Mental Health Independent Inquiry

Last week the Inquiry published an open letter sent to the Secretary of State for Health prior to their meeting last month to discuss the status of the Inquiry. We will update Governors with any developments as we are made aware of them. However, at this time, the Trust has received no confirmation of any change to the status of the Inquiry.

We understand the delay and uncertainty may be unsettling for staff. We continue to provide a range of mechanisms to support colleagues including both legal advice and psychological support via the British Red Cross and our Here for You programme. Nigel Leonard and Gill Brice are also visiting Trust sites to speak directly with and answer any questions staff may have.

Safety is and has always been our top priority and is at the forefront of everything we do at EPUT. From the outset, the Trust put in place arrangements to ensure we were in the best position to serve the inquiry and considered the provision of information in an open and transparent way to be paramount. We fully understand that there is a need to meet the commitment to families, carers and service users who rightly expect answers and we will continue to proactively encourage engagement with the Inquiry.

1.2 End of Financial Year Update

The Trust has submitted draft Accounts ahead of deadline with performance results including an income and expenditure surplus of £96k (against breakeven plan) and capital investments of £14.3m delivering performance consistent with capital allocations agreed with System partners. External Audit is currently underway and is due to complete by 16 June with final accounts to be submitted by 30 June.

1.3 Internal Inquiry Update

Following the Dispatches programme, aired in October 2022, I immediately commissioned an internal inquiry into the issues raised. The inquiry was tasked with identifying any concerns around patient safety, culture, practice or behaviours within Willow and Galleywood ward and any subsequent actions which may be required. Following the publication of the inquiry findings, the Trust mapped the recommended actions to both existing Trust work streams (e.g. Time to Care) and to the actions being taken to address the CQC's concerns following their unannounced visits to the wards in October 2022. The Trust also established a task and finish group, led by Nigel Leonard, the Executive Director of Major Projects and Programmes, to ensure all recommendations arising had been implemented and embedded. All 56 actions identified are on track with the exception of two: the installation of a whiteboard, which now forms part of a wider communication project, and the regularity of staff on the wards. Nevertheless, we have taken decisive action to ensure staffing is safe, increasing the proportion of staff with experience of working in the Trust on the wards, and we have seen an increase in regular staff from 43% to 66% and 40% to 70% in Galleywood and Willow Wards respectively from the beginning of this year. Both Galleywood and Willow wards have also seen a reduction in their nurse vacancy rates, mirrored in our wards across the Trust where staffing has improved substantially over recent months with a reduction in nurse vacancies from 158 to 117, and forecast to fall by a further 50% by the end of the year. The further fall will come from our domestic, student and international recruitment channels. It is worth

highlighting that we have a total of 59 registered nurses in our domestic pipeline and have a target to place 148 student nurses which we are on course for.

1.4 Safety Strategy Update

The Safety First, Safety Always strategy was agreed by Trust Board in February 2021, following widespread engagement with Trust staff, Non-Executive Directors, Governors and partners. The strategy sets out our ambition to be an organisation that consistently places patient safety at the heart of everything it does.

Since the creation of the strategy, considerable improvement to the safety of our wards has been seen, such as an approximate 30% reduction in fixed point ligatures. We have focused heavily on our staffing model, both in terms of reducing vacancy rates, and through the introduction of new roles. For example, our recent self-harm reduction pilot project which assessed the introduction of activity coordinators, saw 80% of patients who had previously self-harmed, said their urge to do so reduced as a result. We continue to embrace technology such as Oxevision, which 94% of staff tell us enables them to identify incidents they may not otherwise have known about. And underpinning all of this, is our continued focus on improving the collection and use of data in driving decision making, moving towards dynamic rather than static data collection and getting the data into the right hands, evidenced through the introduction of the new safety dashboard.

We know there is always more we can do, but we have made huge strides in terms of improving safety across the organisation. In order to showcase these, we are currently finalising arrangements for EPUT's Safety Conference to be held on 15 June. Hosted within Anglia Ruskin's Chelmsford Campus, the event will include presentations from some of our key partners, and will be attended by senior leadership, Trust staff and over 200 Anglia Ruskin medical students.

1.5 Mental Health Urgent Care Department

I am delighted to confirm that our Mental Health Urgent Care Department, based at Basildon Hospital, is now open to people living in Chelmsford. This means the department is now open to people aged 18 and over living in all areas of mid and south Essex. I would like to extend my thanks and appreciation for all the hard work from all involved in designing and launching this new department which will have a positive impact on the urgent care pathway in place across Essex, particularly for patients in mental health crisis who need urgent support.

1.6 New Mental Health Joint Response Car

A new Mental Health Joint Response Car has been launched in mid and south Essex to provide better access to urgent mental health care in the community. The scheme, supported by the Mid and South Essex Integrated Care Board, is the first of its kind in the area and brings mental health care and support to the patient, and in most cases, the patients' own homes. The vehicle and emergency clinicians provided by the East of England Ambulance Service NHS Trust, will work alongside EPUT's specialist mental health nurses to provide immediate crisis care in the community and ensure the most appropriate ongoing care is put in place to meet patient needs. The service, now covering mid and south Essex, is ready for callouts everyday between 1pm and 1am and can assist with mental health presentations in the community; concerns regarding risk to the patient and public; and issues involving the legal framework.

Within the first week of launch, the Mental Health Joint Response Car kept 95% of patients it had contact with out of the emergency department, whilst meeting their required needs.

We know that hospital emergency departments are not always the right environment for people experiencing mental health difficulties. This is an exciting and innovative development in being able to deliver mental health support in a timely manner within patients' familiar surroundings. The scheme has the potential to reduce any escalation of crisis, avoiding the need for inpatient admissions, whilst enabling better integrated care in the right place at the right time. I am delighted to be working with our partners to launch such a vital service.

1.7 NHS Pay Award

NHS Employers has confirmed details of the NHS pay deal 2023/2024. All staff on agenda for change terms and conditions will receive a non-consolidated pay award in the form of a one-off payment as well as a permanent salary uplift. Staff can expect to receive both of the 2022/23 non-consolidated payments and the 2023/2024 pay uplifts in June pay run.

The pay award does not apply to staff on local terms and conditions and bank workers – arrangements for these workers are currently being considered.

1.8 Professor Natalie Hammond

After eight years at both EPUT and predecessor organisation, Professor Natalie Hammond, our Executive Nurse, will be taking up a new role as Executive Director of Nursing and Quality at Herts and West Essex Integrated Care Board.

Natalie will leave a legacy at EPUT where she has created a culture of learning, a relentless focus on patient safety and on the delivery of compassionate patient care, and a commitment to drive the highest professional standards across the Trust.

I would like to take this opportunity to thank Natalie for her hard work, for being a fantastic colleague and for her passionate dedication to all who use our services. Although myself and colleagues will be sad to see her move on, I am however delighted that Natalie will remain a key colleague in the local health care system and we can look forward to working with her in her new role where, I have no doubt, she will carry on her inspiring work.

We have started the process for finding a new Executive Director of Nursing and will keep Governors updated on this process and when an appointment is confirmed.

1.9 Visit from Dr Tim Ferris, National Director of Transformation, NHS England

On 28 April we were delighted to host Dr Tim Ferris, National Director of Transformation at NHS England, for a morning of discussion and exploration into the opportunity of a single electronic patient record system across EPUT and MSEFT. The session was positively received by all and it was exciting to hear how encouraged Tim was by our plans, offering his support to help promote the opportunity nationally.

During the session, Tim visited some of our wards and was equally encouraged by the use of digital innovations such as Oxehealth to drive transformation and promote a safer workplace.

1.10 Dementia Action Week

Last week marked Dementia Action Week, which this year was dedicated to encouraging people to seek a timely diagnosis to enable access to vital support. The Alzheimer's Society, which organises the awareness campaign, says research shows that the biggest barrier stopping people seeking a diagnosis was thinking memory loss is a normal sign of ageing. Yet, nine in ten people living with dementia said they had benefited from getting a diagnosis.

We offer a number of services to support people with dementia. Our Memory Assessment Service, run by the North East Essex Dementia Service, was formally accredited last month for the third time by the Memory Services National Accreditation Programme (MSNAP) which awards accreditation to services that demonstrate good quality care and a commitment to continually improving the service they offer. The service cares for people living with dementia and early on-set dementia. As well as memory assessments and intervention, the team has specialist nurses who work in care homes and give intensive treatment to help people with complex needs continue living at home and maintain as much independence as possible.

EPUT offers a high level of care to help support people living with dementia, and I want to extend my congratulations to all the team who worked extremely hard in achieving accreditation and demonstrating the high standard of care they deliver to those people referred into the North East Dementia Service.

1.11 Mental Health Awareness Week

Last week marked Mental Health Awareness Week, an annual campaign encouraging us all to focus on our mental health, supporting ourselves and others. The campaign was an opportunity for us all – not just as healthcare professionals, but as colleagues, friends, family members and carers – to reflect, connect and take collective action to promote good mental health.

The week was an opportunity to showcase some of the incredible work going on at EPUT in promoting good mental health and wellbeing, sharing staff stories, and shining a spotlight on some of the outstanding examples of innovation in our services. The Suffolk and North East Essex ICB Health and Wellbeing Team also invited all EPUT staff to join them for a series of online events, each focussing on a different topic related to mental health, featuring a range of speakers from the NHS, charities and local community projects.

The week was a successful way to visibly show our commitment to supporting good mental health, sparking conversations and encouraging meaningful connection.

1.12 International Nurses Day

International Nurses Day, held on 12 May, was a chance for us to celebrate the amazing contribution nurses across the world make to healthcare. We have welcomed more than 200 nurses from countries including Nigeria, Ghana, Botswana, Zimbabwe and India as part of our international recruitment programme, bringing talent, experience and expertise from across the globe to our services. To mark the occasion, a number of our new colleagues shared some of their favourite recipes, creating a book of traditional recipes from their native countries.

All our nurses and health care assistants (HCAs) provide vital care every day and make a real difference to the lives of people we care for, and for that I would like to say thank you. So many nursing colleagues across the Trust go above and beyond to provide the best care, and International Nurses Day is about recognising all that they do.

2. PERFORMANCE AND OPERATIONAL ISSUES

2.1. Operations – Alex Green, Executive Chief Operating Officer

There have been no increases in the number of KPI's escalated as inadequate. Inpatient Mental Health Capacity, Access rates for NHS Talking Therapies (IAPT), Out of Area Placements, waiting times for Psychological Services, waiting times for the Lighthouse Childrens Centre, and Temporary Staffing continue to be areas of focus through the Accountability Framework.

We have refreshed our approach to adult mental health inpatient flow and capacity, underpinned by a better understanding of co-dependencies and which mitigations can implemented at pace and sustained.

Contractually the Trust is performing well with no Contractual Performance Notices (CPN's), and 6 of 17 contracts are highlighted with areas of inadequate performance.

Despite increases in activity levels within some community health services, performance has remained consistent with teams working to prioritise urgent cases and create plans to address capacity.

We have recently launched our first interactive dashboard to monitor performance. Teams can now monitor their performance in real time, allowing early intervention and escalation where appropriate.

2.2. Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Following National, Regional and ICS discussions the Trust has submitted a balanced/breakeven revenue plan for 23/24. The plan requires delivery of £22.9m (4.4%) efficiencies. The Trusts opening 23/24 capital programme is £20.4m inclusive of indicative funding associated with the EPR OBC.

M1 revenue results are a £1m actual deficit, £0.5m adverse to plan. Main drivers of overspend include shortfalls against the efficiency programme, pay overspends in inpatient areas and non-pay expenditure above budget provisions relating to out of area placements.

The Trust submitted its draft 22/23 Accounts ahead of National deadlines and reported a £96k revenue surplus and delivery of all planned capital investments totalling £14.3m. The Accounts are now subject to external audit which has commenced and this process is due to complete on 16 June with Final Accounts submission required by 30 June.

2.3. Nursing – Natalie Hammond, Executive Nurse

Safety First, Safety Always Review

The Safety First, Safety Always strategy was agreed by Trust Board in February 2021, following widespread engagement with Trust staff, Non-Executive Directors,

Governors and partners. The strategy sets out our ambition to be an organisation that consistently places patient safety at the heart of everything it does.

Since the creation of the strategy, considerable improvement to the safety of our wards has been seen, such as an approximate 30% reduction in fixed point ligatures. We have focused heavily on our staffing model, both in terms of reducing vacancy rates, and through the introduction of new roles. For example, our recent self-harm reduction pilot project which assessed the introduction of activity coordinators, saw 80% of patients who had previously self-harmed, said their urge to do so reduced as a result. We continue to embrace technology such as Oxevision, which 94% of staff tell us enables them to identify incidents they may not otherwise have known about. And underpinning all of this, is our continued focus on improving the collection and use of data in driving decision making, moving towards dynamic rather than static data collection and getting the data into the right hands, evidenced through the introduction of the new safety dashboard.

We know there is always more we can do, but we have made huge strides in terms of improving safety across the organisation. In order to showcase these, we are currently finalising arrangements for EPUT's Safety Conference to be held on 15 June. Hosted within Anglia Ruskin's Chelmsford Campus, the event will include presentations from some of our key partners, and will be attended by senior leadership, Trust staff, over 200 Anglia Ruskin medical, AHP and nursing students, the Civil Aviation Authority and National Patient Safety team.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

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

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

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the reports.

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 1 (April 2023).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for April 2023)

Six inadequate indicators (variance against target/ambition) have been identified at the end of April 2023 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Inpatient MH Capacity Adult & PICU
- IAPT Access Numbers
- Out of Area Placements
- Psychology
- Lighthouse Childrens Centre
- Temporary Staffing

There are two inadequate indicators which are Oversight Framework indicators for April 2023.

- Out of Area Placements
- Temporary Staffing

There is one inadequate indicator in the EPUT Safer Staffing Dashboard for April 2023.

- No. wards with more than 10 days of unfilled shifts

The CQC have published the report for Adult Acute Services & PICU, following the CQC inspection at Willow Ward & Galleywood Ward in October 2022. The CQC have re-rated this service as inadequate and issued 8 must do and 2 should do actions. An action plan has been created to capture improvements identified within the CQC report. There are no actions past timescale.

Within the Finance scorecard there are no items RAG rated inadequate for April 2023.

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

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

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

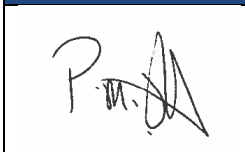
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓

Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead



Paul Scott
Chief Executive Officer

Essex Partnership University NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
April 2023

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.

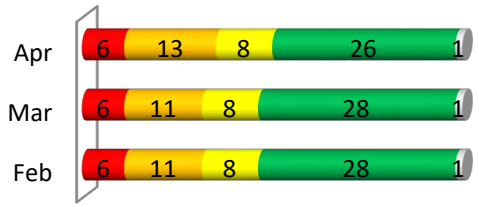
How is data presented?

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

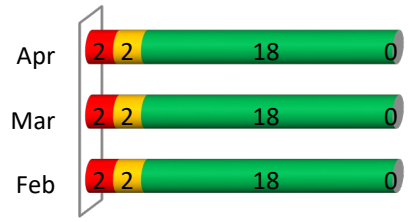
Summary of Quality and Performance Indicators



April Inadequate Performance

- Inpatient MH Capacity Adult & PICU
- IAPT Access Numbers
- Out of Area Placements
- Psychology
- Lighthouse Childrens Centre
- Temporary Staffing

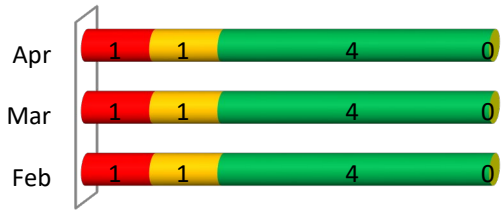
Summary of Oversight Framework Indicators



April Inadequate Performance

- Out of Area Placements
- Temporary Staffing (Agency)

Summary of Safer Staffing Indicators



One inadequate item identified within the Safer Staffing section for:

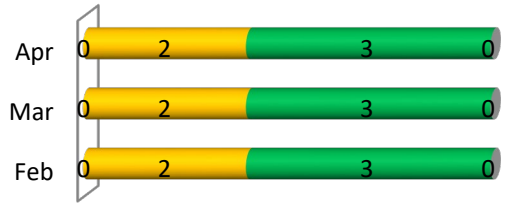
- No. wards with more than 10 days of unfilled shifts

This data is collected from SafeCare.

Summary of CQC Indicators

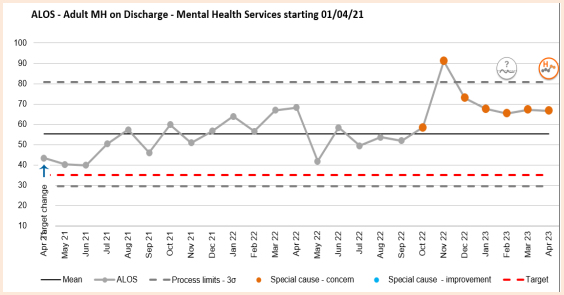
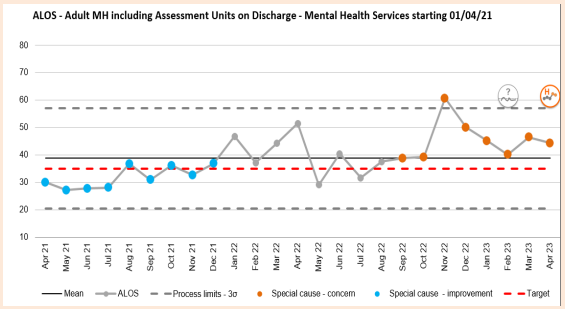
The CQC have published the report for Adult Acute Services & PICU, following the CQC inspection at Willow Ward & Galleywood Ward in October 2022. The CQC have re-rated this service as inadequate and issued 8 must do and 2 should do actions. An action plan has been created to capture improvements identified within the CQC report, the action plan has received Executive Operational Team approval and following this was submitted to the CQC. There are no actions past timescale.
The Trust is awaiting CQC reports for the inspection of 6 core services in November and December 2022, and the EPUT Well Led inspection in January 2023.

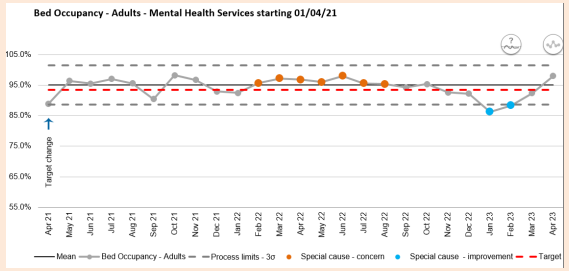
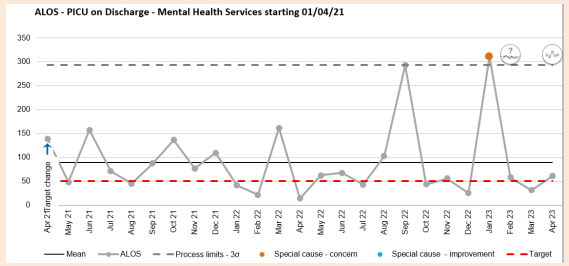
Finance Summary

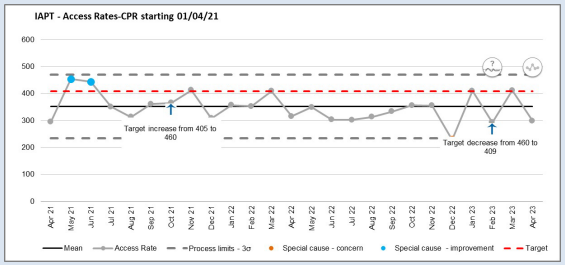
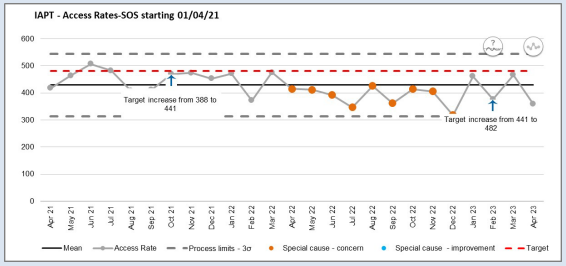
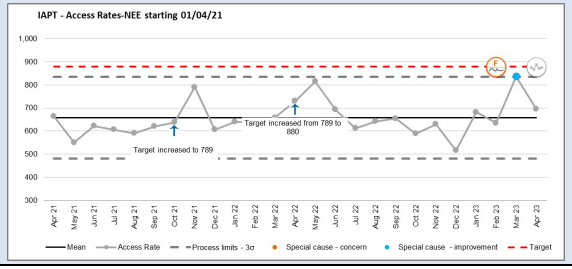


April Inadequate Performance
There are no Finance Indicators noted as inadequate.

SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** Adult average length of stay remained consistent in April and maintains performance outside the benchmark of <35 with performance at 66.7 (67.2 in March). There were 75 discharges, 22 of whom were long stays (60+ days). There have been less discharges and equal number of long stays in April. Length of stay data including the Assessment Units results in an April position of 44.4, which continues to be outside the <35 target. Adult occupancy rates increased for the third consecutive month to 98.0% in April, compared with 92.3% in March. This performance has now surpassed the benchmark of <93.4% for the first time since October 2022. PICU average length of stay increased outside target in April at 61 days, this performance is now outside the benchmark of less than 50 days. PICU bed occupancy continues to perform within target at 57.2%, against a benchmark of <88%. Please note that bed occupancy figures do not account for closed beds due to covid or other reasons.						
	2.9.2a Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	66.7 days	●	Below Target = Good 	●	Consistently failing target 75 discharges in April (22 of whom were long stays (60+ days)).	TBC
	2.9.2b Adult Mental Health including Assessment Unit ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	44.4 days	●	Below Target = Good 	N/A	126 discharges in April (22 of whom were long stays (60+ days)).	

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	98.0%	●	Below Target = Good 	●		N/A
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: <50** (PICU 2020 Benchmark 50)	61.0 days	●	Below Target = Good 	●	Seven discharged in April (four of whom were long stays (60+ days), Discharge from Hadleigh 93 days).	

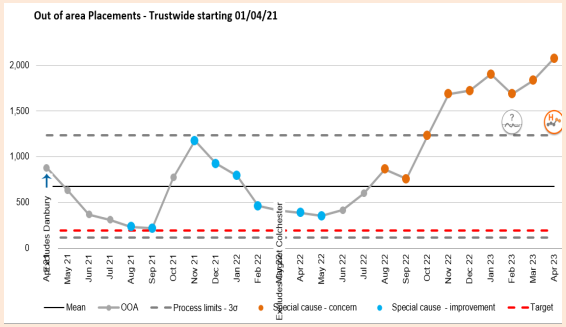
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.16 NHS Talking Therapies (IAPT) Committee: FPC Indicator: National Data Quality RAG: **Green**	**Inadequate** Access numbers across all three areas has been highlighted as inadequate due to sustained non-compliance with targets. Castle Point and Rochford is currently performing at 299 accessing services in April, against a target of 409; dropping again after improvement last month. Southend is reporting 359 in April, against a target of 482; again dropping after improving in March to just 15 under the target. North East Essex reports 695 accessing services in April, against a target of 880; dropping again after improvement in March.						
	2.16.1 IAPT Access Rate CPR CCG **Target – 409**	299	●	Above Target = Good 	●	Access rate targets have now been changed to a number rather than a percentage following an update to the STP trajectories nationally.	
	2.16.2 IAPT Access Rate SOS **Target – 482**	359	●	Above Target = Good 	●		
	2.16.3 IAPT Access Rate NEE **Target – 880**	695	●	Above Target = Good 	●		

<table>
<tr><th colspan="7">Responsive Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M1
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">4.5 Out of Area Placements

Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Amber</td><td colspan="6">Requires Improvement
April has seen a further increase in out of area bed days from 1,836 to 2,077 (excluding Danbury & Cygnet).

There were 35 new clients placed OOA (31 Adult & four PICU) in April, and following the repatriation of 26 (23 Adult, one Older Adult & two PICU), there were 73 remaining (65 Adult & eight PICU) OOA at the end of the month. This continues to be higher than previous years.

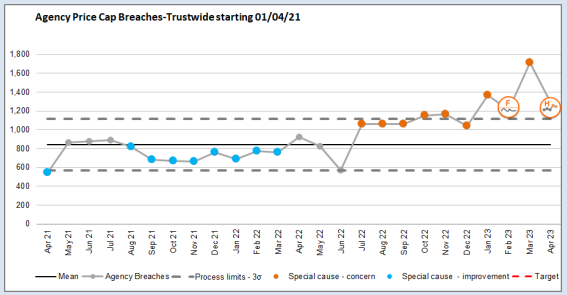
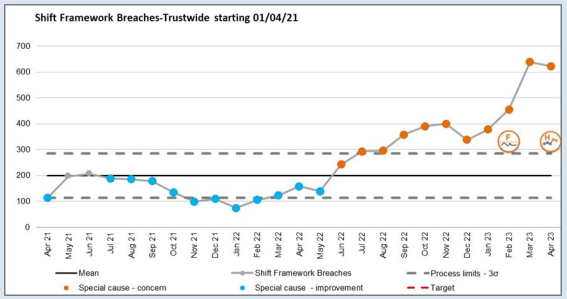
The Trust continues to place clients within contracted beds with the Priory (Danbury ward) and Cygnet Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. In addition, the Trust is working towards an expansion of appropriate OOA beds, and delegated authority agreements with local ICB's.</td></tr>
<tr><td>Reduction in Out of Area Placements

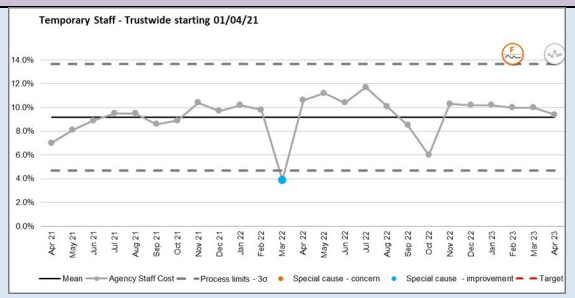
Target: Reduction to achieve 0 OOA by end of March 2023</td><td>2,077 Days</td><td></td><td>Below Target = Good
 
</td><td></td><td>Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.

Data excludes patients placed on Danbury Ward & Cygnet Colchester.</td><td></td></tr>
</table>

Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M1**
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	The number of people waiting for Psychology awareness Programme/Assessment (PAP) for Adult Community Psychology within South East has reduced due to another PAP running and assessments being offered as part of all qualified clinicians jobs plans. Increased screening capacity from CAPS and both OT and Psychological Services staff continues to keep the number of people waiting for DBT/STEPPS screening low. The latest 20 week STEPPS programme began in April 2023, reducing the number of people currently waiting. Four DBT skills groups continue to run across South East Essex, with new people joining at the intake of new modules (every 8 weeks). All people waiting continue to receive a scheduled call from the service to review wellbeing and risk every 8-12 weeks. Where there are identified risks and somebody isn't also monitored by a care co-ordinator wellbeing calls are further increased. Within South West the schema wait list is being reviewed to ensure that service users are able to access an equally evidence based therapy in a more timely manner. Two staff members began schema therapy training in May 2023 and longer term this is expected to reduce wait times. The latest STEPPS group is scheduled to start in June 2023, thereby reducing built up waits for this type of therapy. Vacancies continue to have a significant impact on the wait times. To mitigate as much as possible, staff from other areas in South West are supporting with psychological interventions and utilising bank Assistant Psychologists to facilitate the PAP group to free qualified staff to complete assessments and other psychological interventions. Waiting times, referrals, and staffing performance is monitored regularly through the Psychology Accountability Frameworks meetings.

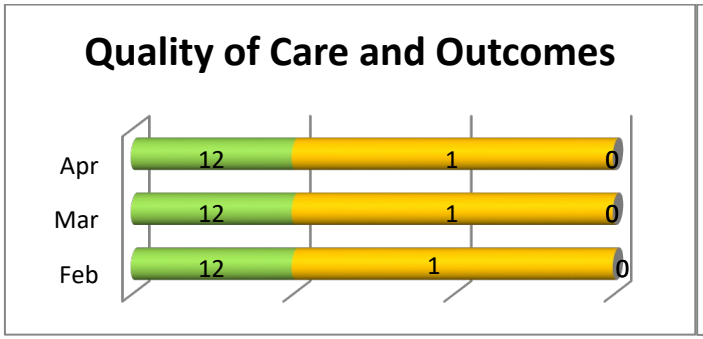
Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M1**
4.11 Lighthouse Childrens Centre Committee: FPC Indicator: National	4.11 Clients waiting on a Lighthouse Centre waiting list	In April we reported that the Trust had four patients waiting longer than 78 weeks for the Lighthouse Children's service. In May (as at 15th May) we are currently reporting three patients waiting longer than 78 weeks. One has an appointment booked for the 16th May, one has been referred to Provide, and one is being reviewed to confirm if a follow up or review is required. Lighthouse Paediatrics continues to have a focus on data quality, the service and information team have been meeting with the NHSE Improvement Support Team over the last month with sessions on RTT reporting and recording as well the policy documentation. In the last month two more tranches of patient data were sent over from MSEFT, these have all been validated and added where appropriate, this month they have advised of another PTL which will have patients for our service included within it, we are waiting for MSEFT to send the patient details across, the NHSE team are aware of the late transfer of this patient data.

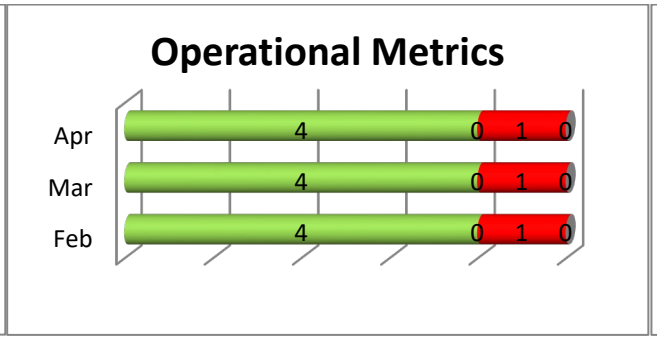
Well Led Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: Green	**Inadequate** There were 1,292 agency cap breaches and 623 shift framework breaches in April. There were also 376 cases that breached both framework and price cap. The proportion of agency staff within the Trust reduced to 9.4% in April. Recruitment are holding a medical recruitment fair on the 16th June which aims to attract new doctors and target medical students to choose psychiatry as one of their options for foundation training. All non-medical agency cap and shift framework breaches have Service Director approval. All medical breaches have been signed off by the Chief Medical Officer and the Chief Executive Officer.						
	5.7.1 Agency Cap Breaches Shift Price Cap **Target = 0**	1,292		Below Target = Good 	N/A	572 of these breaches were pertaining to the Medical & Dental and 667 Nursing Registered staffing groups.	
	5.7.2 Shift Frame-work **Target = 0**	623		Below Target = Good 	N/A	376 relate to Framework and Price Breaches. This figure includes 362 Nursing & Midwifery; the remainder are Medical Staffing.	

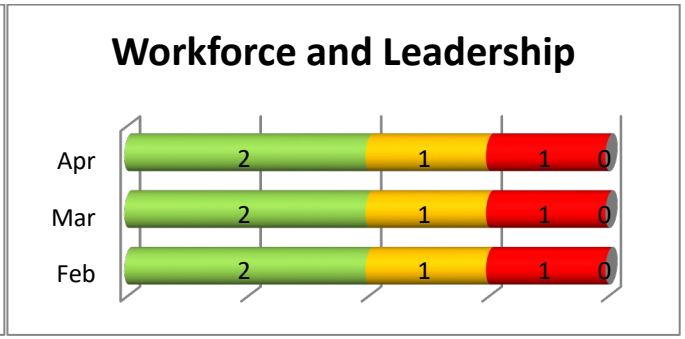
Well Led Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	9.4%	●		N/A	Medical and Operations are the directorates with the highest proportion of temporary staff.	

SECTION 4 - OVERSIGHT FRAMEWORK

Click here to return to summary page





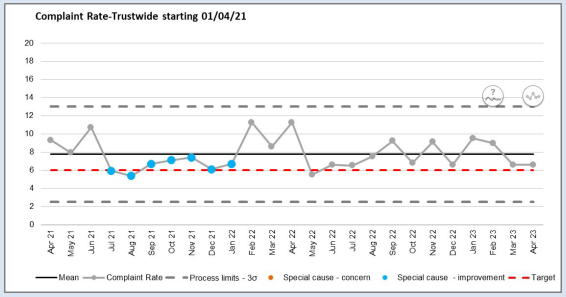


Inadequate

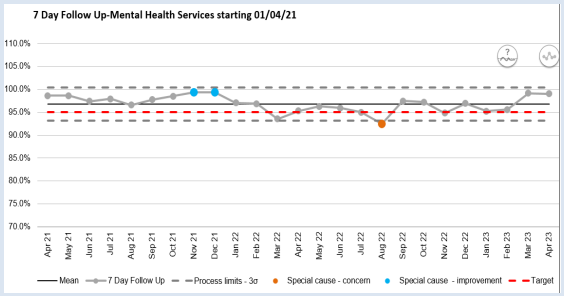
- Temporary Staffing (Agency)
- Out of Area Placements

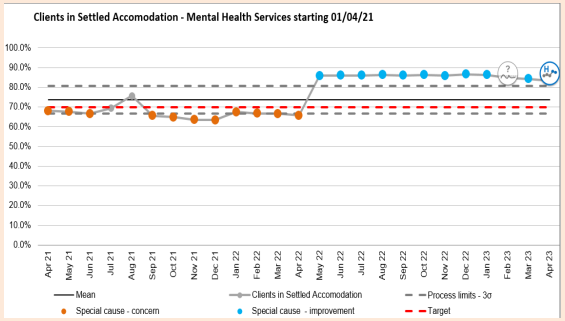
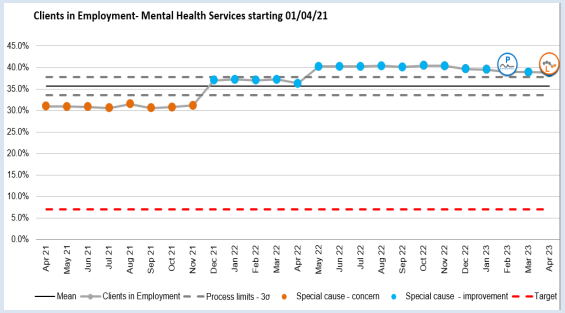
Requires Improvement

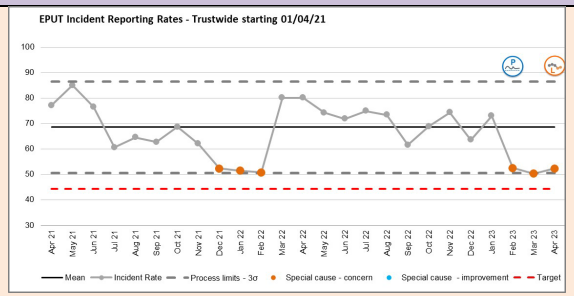
- Complaint Rate
- Staff Sickness

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good		The Trust is fully registered with the CQC. A restriction has been imposed onto the registration for the Adult Acute service.			
	No significant lapses in Compliance Progress against action plans			The CQC have published the report for Adult Acute Services & PICU, following the CQC inspection at Willow Ward & Galleywood Ward, in October 2022.The CQC have rerated this service as inadequate and issued 8 must do and 2 should do actions. An action plan has been created, to capture improvements identified within the CQC report, the action plan has received Executive Operational Team approval and following this was submitted to the CQC. There are no actions past timescale. The Trust is awaiting CQC reports for the inspection of 6 core services in November and December 2022 and the EPUT Well Led inspection in January 2023. Once received, the reports will undergo factual accuracy checks prior to publication on the CQC website. An initial action plan continues to be taken forward, based on feedback received by the CQC via a Letter of Intent. This action plan is being reviewed weekly by the Inpatient Clinical Support Group.			
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	6.60		Below Target = Good 			N/A
5.6 Staff FFT	National Quarterly Pulse Survey Results	The Staff FFT has been replaced with the National Quarterly Pulse Survey. In the most recent publication released in January, 559 responses were received in total. Response rates have seen a positive increase with 110 more respondents than the previous publication. In Q4, the percentage of staff who scored favourably (strongly agree/agree) increased in all nine NQPS Questions vs previous					

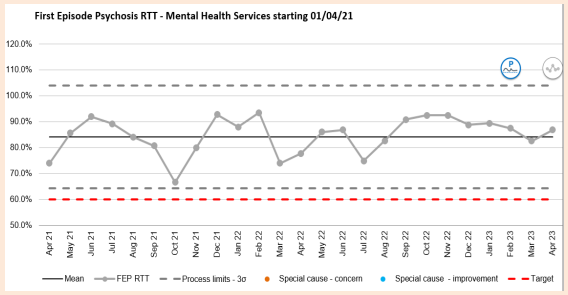
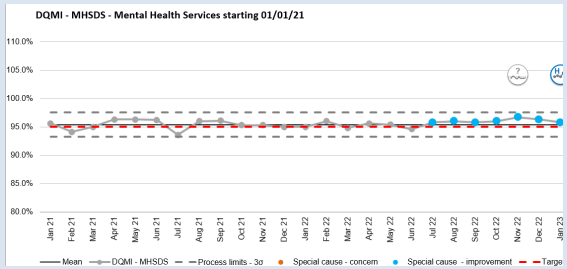
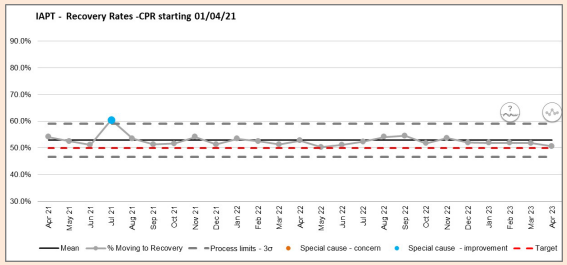
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
 Committee: FPC Data Quality RAG: **Green**		publication. A robust communications campaign has supported this and we also encouraged staff to fill in the survey at meetings, inductions, and training. This supports our drive to embed feedback and the NQPS as BAU and work will continue to develop the campaign after the National NHS Staff Survey has taken place. We received 366 unique comments. Key themes of comments: 30 relating to Psychological support, 35 relating to Support from management, other themes included Support for Staff, Working from home, Rest area/place to take a break, Staffing and Pay, Workload, Training, and Staffing and Training.					
1.1 Never Event  Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2021/22 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety Alerts  Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	There have been no CAS safety alerts incomplete by deadline.	●		N/A

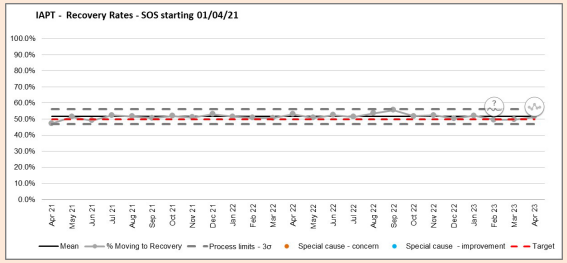
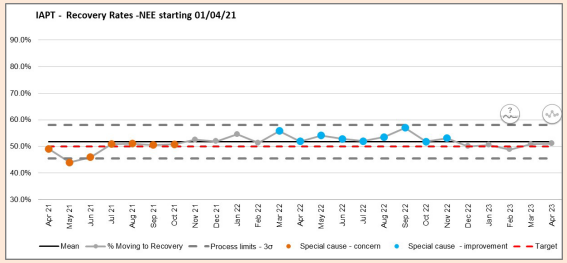
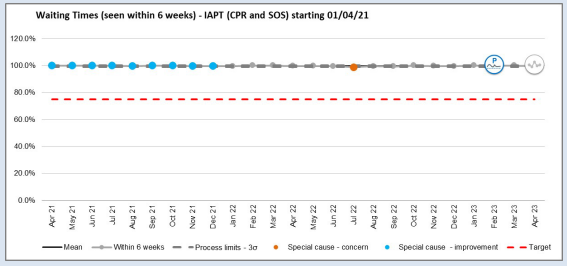
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.1 MH Patient Survey Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	The 2022 survey results have now been published. 1,250 EPUT clients were invited to take part, and 238 responded. This is a response rate of 20%, in line with the 21% response rate for all Trusts. EPUT achieved "about the same" for 21 questions in the 2022 survey when compared with other Trusts. Two questions scored "somewhat worse than expected". Seven scored "worse than expected"; these pertained to Support & Wellbeing.					
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)	94%	●		●	From April 2023 these figures are now reportable by MH and CHS.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%	93%	●		●		
2.8.1 Mental Health Discharge Follow up Committee: Quality	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	99.1%	●	Above Target = Good 	●	106 / 107 discharges followed up within 7 days in April Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	

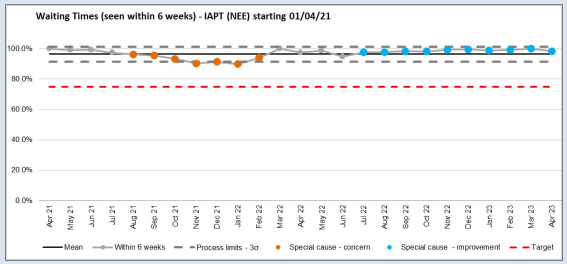
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Blue**							
2.4 MH Patients in Settled Accommodation Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	83.3%	●	Above Target = Good 	●		N/A
2.5 MH Patients in Employment Committee: Quality Indicator: OF Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	38.8%	●	Above Target = Good 	●		N/A
1.8 Incident Rates Committee: Quality	Incident Rates will be in line with national benchmark **>44.33** Benchmark	52.3	●	Above Target = Good	●		

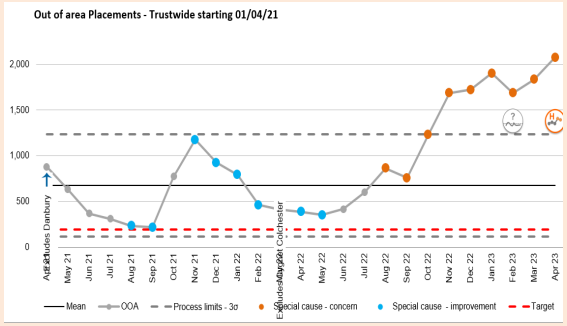
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Amber**							
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in April	N/A		N/A

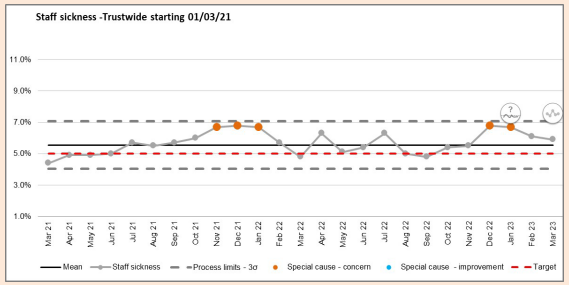
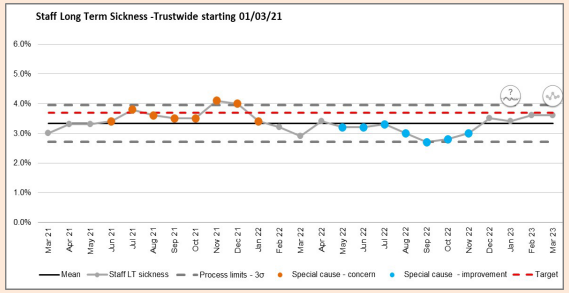
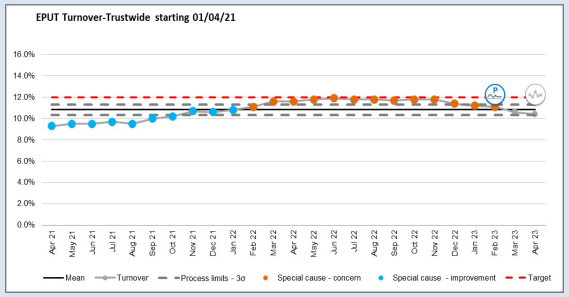
Click here to return to Summary

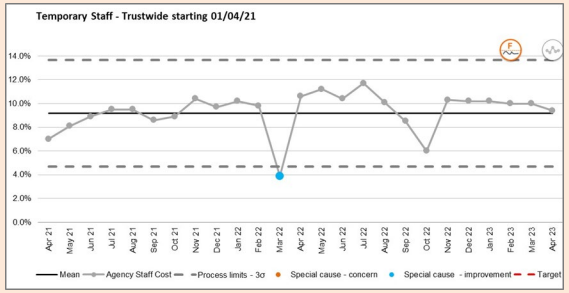
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	87.0%	●	Above Target = Good 	●	April performance represents: 20 / 23 patients. Castlepoint & Rochford CCG 0.0% (0 / 1) below target.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	95.8%	●	Above Target = Good 	●	Latest published figures are for January 2023. A Data Quality Improvement Plan for Mental Health has been produced to identify the areas of the MHSDS that we can improve upon.	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	50.6%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	51.4%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	99.7%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	98.3%	●	Above Target = Good 	●		
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	●	Above Target = Good	●		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	●	Above Target = Good	●		
4.5 Out of Area Placements ●	April has seen a further increase in out of area bed days from 1,836 to 2,077 (excluding Danbury & Cygnet). There were 35 new clients placed OOA (31 Adult & four PICU) in April, and following the repatriation of 26 (23 Adult, one Older Adult & two PICU), there were 73 remaining (65 Adult & eight PICU) OOA at the end of the month. This continues to be higher than previous years. The Trust continues to place clients within contracted beds with the Priory (Danbury ward) and Cygnet Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. In addition, the Trust is working towards an expansion of appropriate OOA beds, and delegated authority agreements with local ICB's.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	2,077 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**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%**	5.9%		Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. National data December 2022: The overall sickness absence rate for England was 6.3%. This is higher than November 2022 (5.4%) and is slightly higher than December 2021 (6.2%). EPUT reported lower than the England average for this period at 5.9%. Cold Cough Flu - Influenza was the most reported reason for sickness, accounting for over 580,600 full time equivalent days lost and 22.0% of all sickness absence in December 2022. This has increased since November 2022 (12.7%).	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.6%		Below Target = Good 	N/A		
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	10.4%		Below Target = Good 		Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7.3 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: **Green**	The proportion of agency staff within the Trust reduced to 9.4% in April. Recruitment are holding a medical recruitment fair on the 16th June which aims to attract new doctors and target medical students to choose psychiatry as one of their options for foundation training. This forms part of long term planning to reduce the Trust's reliance on temporary staff.						
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	9.4%	●		N/A	Medical and Operations are the directorates with the highest proportion of temporary staff.	
5.5 Staff Survey Committee: FPC	5.5 Outcome of CQC NHS staff survey	Results from the 2022 Staff Survey were released on 9th March 2023 and have been shared across the organisation through all-staff comms, Input, All-Staff Live Events and the Engagement Champions Network. Focus Groups are scheduled to take place between 26th April - 2nd May, which will aim to create meaningful dialogue and ensure that action planning has had meaningful staff input. **Information from the 2022 Staff Survey** EPUT is benchmarked against similar NHS organisations - 'Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts'. All eligible staff outlined in the national guidance were surveyed. 2547 surveys were returned giving a response rate of 42%. Whilst this is a 5% drop in response rate, the number of						

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
Indicator: Oversight Framework Data Quality RAG: **Green**		completed surveys is in line with 2021, indicating more staff were eligible for the survey this year. The survey window was open between September and November 2022. **Actions Taken** • Results shared across the organisation through all-staff comms, Input, All-Staff Live Events • Engagement Champions Network session has been held, with plans for an Engagement Champions Event with a special-event 'The Grill', involving Executive Team Members • Focus Group planning is underway, scheduled to take place between 26th April - 2nd May. These will aim to create meaningful dialogue and ensure that action planning has had meaningful staff input. • Throughout 2023, a clear and focussed on 'you asked, we delivered' campaign will take place, which was well received in 2022. • A trust wide action plan will be developed, informed by the Focus Group sessions **Areas of Focus for 2023** • The Experiences of staff with a Disability or Long-Term Condition (LTC) • We are Safe and Healthy sub-score: Burnout • Staff perceptions of standards of care and treatment (Q23d) have worsened in 2022. • The experience of BME Staff in relation to bullying, harassment and abuse, as well as opportunities for career progression • There will be a focus on the perception of staff around support received when raising concerns. **<u>Highlights from each Theme</u>** **Theme: We are Compassionate and Inclusive** — **Score** In 2022, there has been a 2.5% improvement in the number of staff who feel the organisation respects individual differences, with 75% of staff either 'agreeing' or 'strongly agreeing'. This represents the organisation's focus on celebrating our individual differences and efforts toward improving levels of equality. — Average **Theme: We are Recognised and Rewarded** — **Score** There has been an increased number of staff who feel their immediate manager values their work, with 78.8% staff agreeing or strongly agreeing. There has been a focus on supporting line managers and improving line management across the Trust through the Management — Below Average		

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

Development Programme; this measure along with others relating to line management perception have demonstrated positive improvements in comparison to 2021 results.

Theme: We each have a voice that counts	**Score**
Whilst there have been some areas of focus within this People Promise, EPUT scores highly within our benchmark group for Q3b,with 91.% of staff agreeing or strongly agreeing that they are trusted to do their job.	Below Average

Theme: We are Safe and healthy	**Score**
Fewer respondents in the staff survey reported experiencing physical violence from patients/service users, as well as fewer incidents of bullying, harassment, and abuse from patients/service users over the past 12 months (q13a, q14a). Staff safety is a priority for the Trust and it is encouraging to see improvements in these measures.	Average

Theme: We are always Learning	**Score**
The We are always learning Theme saw slight increases in almost all questions, notably q22b which saw a 3.5% improvement (58.0%) in the number of staff who agreed or strongly agreed that they felt there are opportunities to develop their career in the organisation. It is encouraging to see improvements across this People Promise, which is our lowest scoring People Promise.	Average

Theme: We work flexibly	**Score**
We have seen some improvements in perceptions around flexible working, with 2.4% more staff feeling the organisation is committed to helping achieve work-life balance (q6b, 57.4% agree or strongly agree), and 65.1% staff feeling satisfied or very satisfied with the opportunity for flexible working patterns.	Above Average

Theme: We are a team	**Score**
76.6% staff report the team they work in has a shared set of objectives, which is above the benchmark average for our group and an 1.1% improvement on 2021 Staff Survey results.	Average

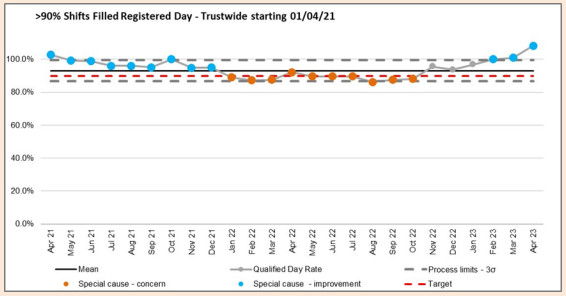
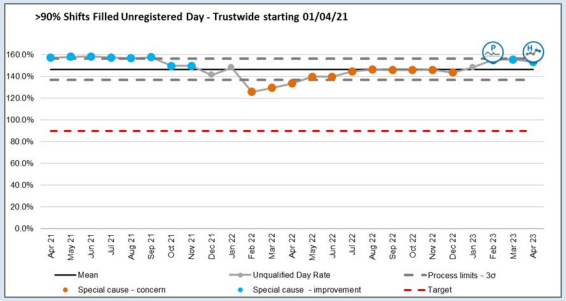
Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

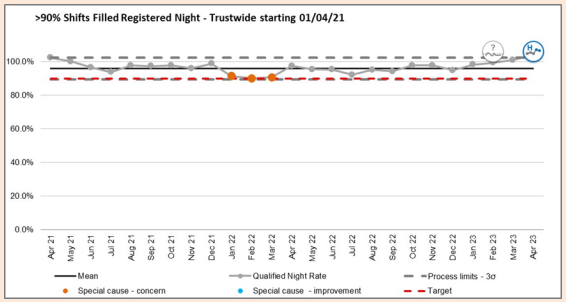
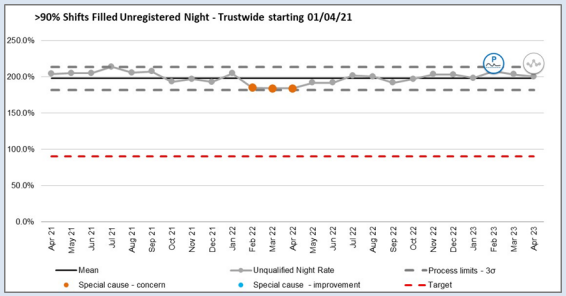
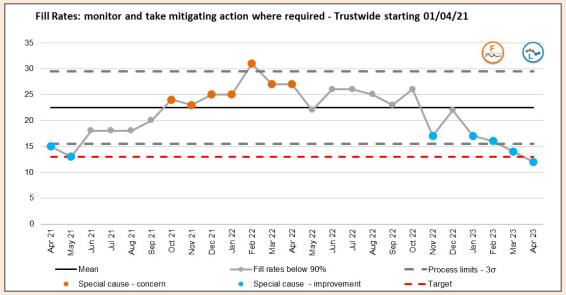
Theme: Staff Engagement	**Score**
2022 has been a challenging year for the Staff Engagement Theme, and work is being planned to improve engagement across 2023 and beyond. One notable improvement is an increased proportion of staff who feel the care of patients/service users is the organisation's top priority (77.6% respondents agree or strongly agree)	Average

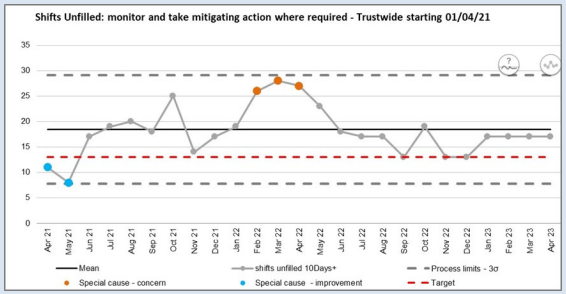
Theme: Morale	**Score**
There has been a fourth consecutive annual rise in the percentage of staff who feel their manager encourages them at work. It is encouraging to see small but consecutive improvements in this measure, ranging from 74.1% in 2019 to 78.3% in the most recent 2022 results. This demonstrates the organisation's continued focus on supporting managers and reinforcing the importance of good management practice.	Above Average

SECTION 5 - SAFER STAFFING SUMMARY

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	108.2%		Trend below target 		The following wards were below target in April: Adult: Ardleigh, Finchingfield, Adult Assessment: Peter Bruff CHS: Cumberlege Centre, Beech	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	153.5%		Trend above target = good 		The following wards were below target in April: Adult: Finchingfield, Galleywood CHS: Cumberlege, Poplar SMH Specialist: Rainbow	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	104.0%		Trend above target = good 		The following wards were below target in April: Adult: Ardleigh CHS: Cumberlege Nursing Home: Clifton Lodge, Rawreth Court Specialist: Rainbow, Causeway Older: Beech	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	200.1%		Trend above target = good 		The following wards were below target in April: CHS: Cumberledge, Beech Specialist: Rainbow	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	12		Below Target = Good 	N/A	The following wards had fill rates of <90% in April: Adult: Ardleigh, Finchingfield, Galleywood Adult Ass: Peter Bruff Nursing Homes: Clifton Lodge, Rawreth Specialist: Rainbow, Causeway CHS: Cumberledge, Poplar, Beech Older: Beech	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	17		Below Target = Good 	N/A	The following 17 wards had more than 10 days without shifts filled in April: Adult: Ardleigh, Willow, Chelmer, Finchingfield, Gosfield, Cherrydown Adult Assessment: Peter Bruff CAMHS: Longview, Larkwood, Poplar(Rochford) Older: Henneage, Ruby, Tower PICU: Hadleigh Unit Specialist: Alpine, Edward House CHS: Avocet	N/A

FILL RATES

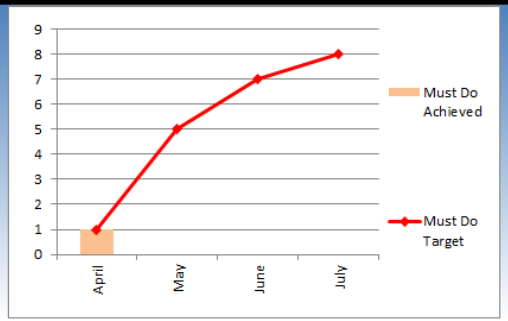
	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Feb-23				Mar-23				Apr-23			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
MH ADULT ACUTE												
ARDLEIGH WARD	53.4%	115.9%	82.2%	108.2%	45.9%	123.6%	86.0%	105.0%	57.6%	121.4%	75.8%	107.2%
CEDAR	137.0%	216.7%	111.7%	261.0%	132.8%	237.0%	116.7%	286.7%	142.6%	227.7%	131.6%	245.5%
WILLOW	115.9%	217.3%	108.0%	217.2%	120.9%	290.3%	114.7%	290.4%	129.9%	279.3%	120.6%	292.8%
CHELMER WARD	83.9%	491.3%	93.8%	911.9%	90.5%	399.8%	97.4%	682.5%	98.2%	399.3%	96.9%	686.7%
FINCHINGFIELD WARD	40.1%	86.0%	192.0%	186.8%	48.9%	79.3%	196.7%	217.3%	48.6%	75.6%	200.6%	203.0%
GALLEYWOOD WARD	59.4%	71.5%	99.9%	130.7%	69.9%	76.7%	99.8%	117.1%	93.7%	84.2%	110.0%	126.1%
GOSFIELD WARD	85.4%	264.8%	125.5%	474.9%	101.4%	254.9%	108.1%	467.3%	113.4%	216.2%	117.6%	419.6%
KELVEDON	169.3%	244.3%	136.4%	359.1%	142.7%	292.3%	84.1%	387.7%	159.5%	238.0%	126.7%	282.2%
STORT WARD	107.9%	187.5%	94.9%	318.0%	110.5%	192.7%	98.7%	312.5%	115.6%	206.5%	102.9%	319.8%
TOPAZ WARD	167.6%	151.1%	102.4%	483.5%	152.3%	173.7%	103.3%	587.0%	164.5%	184.1%	100.1%	595.0%
CHERRYDOWN	116.0%	353.3%	101.6%	473.2%	113.8%	443.0%	100.2%	586.3%	149.0%	394.8%	101.7%	523.3%
MH ASSESSMENT UNIT												
BASILDON MHAU	133.3%	478.4%	117.5%	544.8%	152.1%	415.4%	99.0%	448.3%	138.4%	323.6%	97.5%	373.3%
PETER BRUFF UNIT	73.1%	154.1%	118.9%	154.7%	77.4%	167.1%	125.5%	168.7%	87.4%	182.6%	130.8%	178.0%
MH OLDER ADULT												
BEECH (ROCHFORD)	93.8%	164.2%	73.3%	349.7%	96.4%	169.4%	90.6%	322.4%	105.1%	180.7%	84.9%	385.7%
GLOUCESTER	112.3%	149.8%	107.1%	215.8%	110.8%	155.4%	113.0%	209.2%	110.0%	188.5%	112.2%	318.5%
HENNEAGE WARD	136.4%	322.9%	99.4%	606.4%	147.1%	309.6%	93.5%	579.9%	127.0%	267.4%	102.2%	486.1%
KITWOOD WARD	96.2%	206.2%	142.1%	200.0%	118.2%	171.0%	151.6%	159.5%	115.7%	183.3%	153.0%	152.3%
MEADOWVIEW	115.8%	215.5%	98.2%	356.0%	109.9%	218.1%	109.7%	322.0%	108.8%	159.0%	109.3%	196.1%
RODING WARD	100.5%	156.3%	150.0%	128.8%	110.8%	170.4%	141.9%	161.3%	108.0%	164.3%	140.0%	158.1%
RUBY WARD	109.7%	456.4%	200.5%	473.4%	99.2%	452.4%	196.4%	472.4%	119.4%	490.2%	193.4%	490.9%
TOWER	104.1%	172.8%	92.9%	174.8%	120.4%	193.6%	80.3%	215.7%	113.3%	191.1%	93.5%	193.6%
MH ADULT PICU												
CHRISTOPHER UNIT	153.2%	126.3%	99.9%	183.2%	161.3%	129.8%	101.4%	198.8%	183.9%	129.1%	101.7%	197.7%
HADLEIGH PICU	153.2%	126.3%	105.2%	491.0%	114.3%	260.5%	97.1%	103.2%	115.1%	316.5%	111.4%	561.3%
MH ADULT REHAB												
IPSWICH ROAD	119.7%	100.0%	100.6%	196.4%	110.6%	92.7%	112.5%	196.8%	108.6%	100.6%	122.9%	200.0%
CAMHS SERVICES												
LARKWOOD	86.9%	208.7%	58.3%	115.5%	88.8%	132.8%	71.0%	95.9%	115.8%	141.4%	106.8%	122.8%
LONGVIEW	65.7%	219.7%	71.2%	349.8%	74.3%	213.8%	77.5%	335.8%	93.8%	234.7%	99.0%	313.3%
POPLAR	103.7%	77.0%	102.8%	190.5%	101.0%	185.4%	98.4%	117.3%	103.0%	125.2%	95.1%	227.2%

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Feb-23				Mar-23				Apr-23			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
SPECIALIST SERVICES												
EDWARD HOUSE	100.0%	143.1%	103.8%	140.6%	88.0%	128.6%	100.0%	118.8%	95.1%	143.3%	116.6%	112.5%
ALPINE	88.6%	101.7%	96.6%	103.8%	93.4%	101.0%	94.9%	96.2%	94.4%	114.6%	91.7%	107.8%
AURORA	101.9%	99.7%	96.4%	114.3%	103.0%	100.4%	100.8%	100.3%	100.7%	91.2%	100.2%	110.1%
CAUSEWAY	161.0%	134.0%	96.1%	126.6%	142.2%	128.9%	100.6%	109.7%	123.9%	117.1%	88.5%	107.8%
DUNE	98.2%	115.1%	100.1%	101.6%	94.5%	111.2%	98.8%	99.2%	102.3%	120.4%	110.3%	112.6%
FOREST	117.3%	125.2%	96.8%	112.1%	129.1%	140.9%	96.8%	110.3%	143.4%	136.0%	95.0%	100.0%
FUJI	96.6%	214.6%	96.4%	211.8%	91.3%	212.6%	98.7%	179.7%	100.2%	182.7%	93.5%	153.6%
LAGOON	96.8%	130.2%	94.3%	145.5%	95.1%	100.2%	95.4%	100.9%	103.0%	101.5%	95.7%	102.1%
ROBIN PINTO UNIT	136.5%	154.5%	112.5%	273.6%	166.2%	155.9%	146.9%	209.7%	115.3%	158.6%	106.7%	292.1%
WOODLEA CLINIC	112.0%	133.6%	200.0%	100.0%	122.5%	115.4%	221.4%	100.0%	136.0%	172.8%	218.5%	100.0%
RAINBOW UNIT	101.2%	88.4%	49.9%	112.8%	105.4%	70.6%	50.4%	85.7%	93.8%	53.6%	50.0%	66.6%
LEARNING DISABILITY SERVICES												
HEATH CLOSE	102.4%	116.7%	101.4%	112.7%	95.6%	110.5%	97.1%	103.2%	98.3%	110.2%	95.1%	106.7%
NURSING HOMES												
CLIFTON LODGE	120.1%	129.4%	89.3%	241.9%	118.7%	139.8%	87.1%	249.2%	162.1%	146.6%	87.9%	278.9%
RAWRETH	117.4%	118.1%	53.8%	110.5%	99.9%	131.3%	100.1%	108.0%	121.6%	131.2%	63.8%	107.5%
COMMUNITY HEALTH SERVICES												
CUMBERLEGE ICC	67.2%	52.9%	65.5%	79.9%	76.7%	51.9%	65.8%	79.9%	84.9%	56.6%	66.7%	79.2%
AVOCET	98.4%	120.5%	95.2%	160.3%	98.4%	122.3%	96.9%	140.3%	121.0%	126.4%	101.8%	154.6%
BEECH WARD	94.3%	92.7%	99.6%	88.1%	79.2%	93.1%	98.4%	88.1%	80.0%	96.8%	98.6%	86.7%
PLANE	101.0%	106.7%	100.0%	99.7%	98.8%	109.5%	100.0%	100.0%	100.4%	115.3%	100.4%	102.2%
POPLAR UNIT	103.7%	77.0%	98.5%	115.4%	79.5%	79.9%	98.4%	117.3%	96.4%	80.7%	100.0%	122.1%

SECTION 5 – CQC

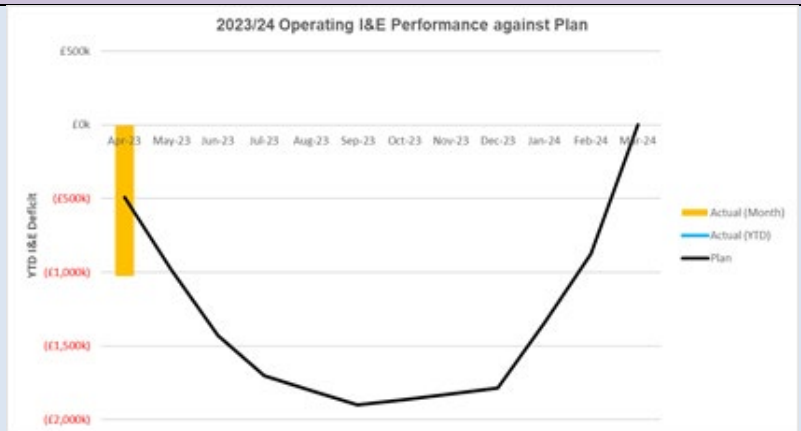
Click here to return to summary page

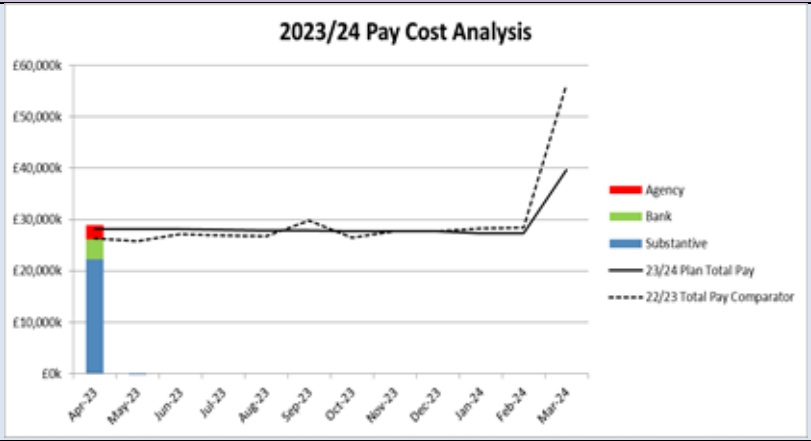
The CQC have published the report for Adult Acute Services & PICU, following the CQC inspection at Willow Ward & Galleywood Ward, in October 2022.The CQC have rerated this service as inadequate and issued 8 must do and 2 should do actions. An action plan has been created, to capture improvements identified within the CQC report, the action plan has received Executive Operational Team approval and following this was submitted to the CQC. There are no actions past timescale.

HOTSPOTS	AMBITION	POSITION	TREND	TREND PERFORMANCE KEY	NARRATIVE
Must- Do CQC Actions	There will be 0 CQC Must Do actions past timescale	At the end of April 0 actions were past timescale		Achieve target = good performance	0 CQC Must Do action are past timescale at the end of April 2023

SECTION 6 - Finance

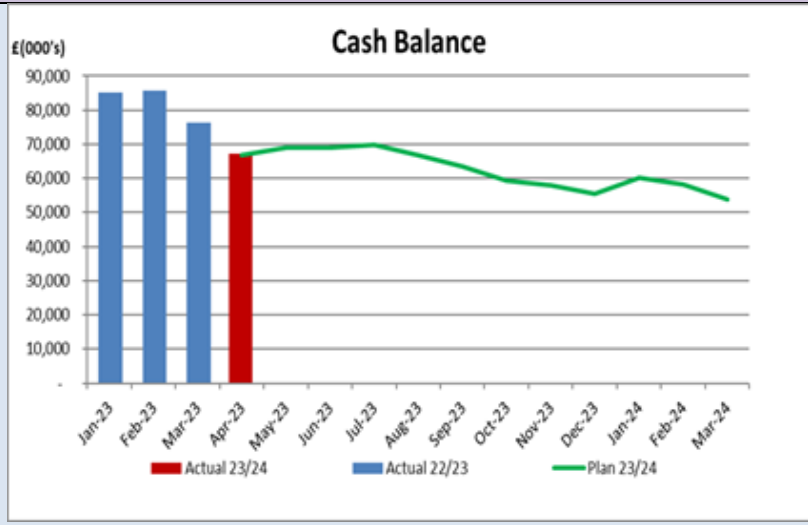
Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Income and Expenditure</td><td>Income and Expenditure</td><td>The 23/24 approved revenue budget is to deliver a break-even plan. The plan requires an efficiency target of £22.9m to be met. M1 results are a deficit of £1m, being £0.5m adverse variance to plan. The adverse variance includes pay overspends in Inpatient areas being partially offset by vacancies across the Trust, shortfalls against the M1 efficiency target and spend are greater than budgetary provision on Out of Area placements.</td><td> 
</td></tr>
<tr><td>Efficiency Programmes</td><td>Efficiency programme</td><td>In order to deliver the 23/24 financial plan, the Trust has to deliver £22.9m of efficiencies equivalent to 4.4% of operating spend. The M1 position is a delivery of £1.3m against the plan of £1.6m, £0.3m behind plan.</td><td>
<table>
<tr><th></th><th>Efficiencies £000</th><th>YTD Plan £000</th><th>YTD Delivery £000</th><th>YTD Variance £000</th></tr>
<tr><td></td><td>£000s</td><td>£000s</td><td>£000s</td><td>£000s</td></tr>
<tr><td>Identified</td><td>19,044</td><td>1,252</td><td>1,285</td><td>(32)</td></tr>
<tr><td>Unidentified</td><td>3,848</td><td>321</td><td>0</td><td>321</td></tr>
<tr><td>Total</td><td>22,892</td><td>1,573</td><td>1,285</td><td>288</td></tr>
</table>
</td></tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Temporary Staffing Costs	Total temporary staffing spend in the month was £6.6m; bank spend £3.9m and agency spend £2.7m. For 23/24, the increased deployment of International Recruitment nurses to operational areas will support the reduction in temporary staffing costs.	
Maximising Capital Resources	Maximising Capital Resources	The Trust has incurred capital expenditure of £89k at M1 which is on plan. Annual planned capital is £20.4m. This plan includes indicative allocations associated with the EPR project although these will be subject to change as the business case develops. The Trust also expects access to further in year discretionary capital allocations with any allocations subject to System Investment Group approval.	**Capital**

	Annual Plan £000	YTD Original Plan Plan £000	YTD Original Plan Actual £000	YTD Original Plan Variance £000
C'fwd Schemes	2,914	30	63	(33)
ICT	2,263	25	11	14
Medical / Other Equipment	100	0	0	0
Safety & Ligature	500	0	0	0
Health & Safety	500	0	0	0
Backlog Maintenance	500	0	0	0
Strategic	4,736	6	6	(0)
Charge against Allocation*	**11,513**	**61**	**80**	**(19)**
EPR	6,000	0	0	0
MH UEC (SNEE)	169	0	0	0
Leases	2,625	0	0	0
PFI Residual Interest	117	9	9	0
CDEL	**20,424**	**70**	**89**	**(19)**
Variance (%)				-27%

** Excludes discretionary capex of £1,387k held for system*

RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	The cash balance as at the end of M1 is £67.1m, ahead of plan by £0.4m. During M1, the Trust had £5m invested with the National Loans Fund and generated interest of £0.2m, the target for 23/24 is £1.2m.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the report and assurance provided
2 Provide feedback for any identified issues for escalation

Summary of Key Issues

The Board of Directors regularly delegates authority to the Standing Committees in line with Trust Governance documents (SoRD, SFI's etc.). Standing Committees are expected to provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve identified issues.

This report is the first Committee Chair's Report and aims to streamline the reporting process and ensure consistency across all Standing Committees of the Board of Directors.

Each Board meeting, Chairs of Standing Committees will provide details of meetings held and:

- Any key assurance to be provided to the Board
- Any issues identified for noting where the Standing Committee is taking action (Alerts)
- Any issues / hotspots for escalation to the Board for further action (Escalation)
- Any issues previously identified which have now been resolved, including the identification of lessons learnt.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main report.

Lead
Janet Wood, Chair of Audit Committee Loy Lobo, Chair of Finance & Performance Committee Manny Lewis, Chair of People, Equality & Culture Committee Dr. Rufus Helm, Chair of Quality Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Agenda Item: 7b
Board of Directors Part 1
31 May 2023

COMMITTEE CHAIR'S REPORT
MAY 2023

1.0 INTRODUCTION AND PURPOSE OF THE REPORT

The Board of Directors regularly delegates authority to the Standing Committees in line with Trust Governance arrangements (SoRD, SFI's etc.). Standing Committees provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve identified issues.

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

- Any key assurances to be provided to the Board (assurance)
- Any issues / hotspots for escalation to the Board (alert)
- Any issues identified for noting where the Standing Committee is taking action (action)
- Any issues previously identified which have now been resolved, including the identification of lessons learnt (information)

2.0 AUDIT COMMITTEE

Chair of the Committee:	Committee meetings held:
Janet Wood, Non-Executive Director	19 May 2023

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Agenda Item	Key Assurance Items	Alert/ Assurance/ Action/ Information

Internal Audit Progress Report	• Audits finalised
	  ○ Operational Performance – substantial/moderate
	  ○ Risk Maturity – Presented for information only
		Assurance

Local Counter Fraud Services (LCFS)	• Outstanding cases have been referred to TIAA, the Trust's newly appointed internal auditors	Information
Draft Internal Audit Plan 2023/24	• The draft internal audit plan for 2023/24 was approved.	Information
Anti-Crime and Anti-Crime Work Plan 2023/24	• An updated was provided on referral cases. • The Anti-Crime Work Plan for 2023/24 was approved.	Information
External Audit	• External audit are currently reviewing the draft 2023/24 annual accounts and annual report.	Information
Conflict of Interest	• A report on the Conflict of Interest process for EPUT was received and noted.	Information
Procurement	• An updated was provided highlighting how the procurement team are supporting operational and corporate colleagues, promoting good governance, advice and support.	Information
Cyber Security & Information Governance Assurance Report	• The Committee received a comprehensive update on cyber security and information governance	Assurance
Risk Management & Assurance Framework – Annual Report	• The Committee received and noted the Risk Management and Assurance Framework annual report for 2022/23.	Assurance
Losses and Special Payments	• As at the end of Month 12, the Trust is reporting losses and special payments of £128k.	Information
Director Expenses as at Month 12	• Director expenses for the 2022/23 financial year total £7,497.	Information

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

3.0 FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee:	**Committee meetings held:**
Loy Lobo, Non-Executive Director	20 April 2023 25 May 2023

Agenda Item	**Key Assurance Items**	**Alert/ Assurance/ Action/ Information**
MHED Unit (Apr)	• The Executive Medical Director attended the April committee to provide an update on the opening and success of the Mental Health Emergency Department. This update informed the committee that A&E attendance had reduced by 67% at the time of reporting. The unit has received positive feedback from patients and families. Members remarked on the big step forward this represents in being clinically led, and corporately enabled.	Assurance
Quality & Performance Report (May)	• Members were pleased to note the launch of the Trusts first interactive dashboard to monitor performance. This marks a big step in the Trusts Digital and Data strategies and will be pivotal in the flow of performance from Accountability Frameworks all the way through to Board. From June 2023 the traditional word document reports will be retired and the Finance & Performance Committee will instead use the Power BI dashboard to guide performance discussions.	Assurance
2023/24 Financial Plan (May)	• The final 23/24 Revenue and Capital Financial plans were submitted on the 4th May 2023, the financial plan to target to deliver a breakeven • The updated submission follows Regional and National discussions and includes additional funding agreements with Commissioners and an updated efficiency plan. • The Trust's initial capital plan is £20.4m with access to additional discretionary capital expected to be secured during the year.	Information
Transformation (May)	• The committee were presented with an update on the contribution and progress over previous 12 months of the Transformation Team. The report outlined the large scale of changes made across the Trust and how that shapes benefits for patients, staff, and families. Assurance was provided that these updates will continue to report through Finance & Performance committee as well as Board.	Assurance
Code of Governance for Foundation Trusts Review (May)	• Approval was sought and granted for the progression of EPUT's Code of Governance declaration to Board. EPUT is declaring full compliance under this year's review.	Assurance

NHS England Self-Assessment Report (May)	• EPUT has conducted the annual assessment and is declaring full compliance. Committee members were assured this has undergone scrutiny by the Executive Team and subsequently granted approval for its progression to Board.	Assurance

4.0 PEOPLE, EQUALITY & CULTURE COMMITTEE (PECC)

Chair of the Committee:	**Committee meetings held:**
Manny Lewis, Non-Executive Director	20 April 2023

Agenda Item	**Key Assurance Items**	**Alert/ Assurance/ Action/ Information**
Time to Care Update	The Committee welcomed received an update on Time to Care Business Case. The presentation covered: • Staffing model proposals and other initiatives within the Time to Care Programme. • Focus on initiatives to achieve stabilisation of the in-patients ward based staff and to assist with reducing the vacancy factor. • Outline of key dates for business case progress. • 16 high priority initiatives to be delivered in year one.	Information The Board will receive the Business Case in June 2023.
Emergent and Topical Issues	• **Industrial Action:** The Committee received feedback on the Junior Doctors strike action, covering business contingency plans which were put in place to ensure inpatient wards, urgent care and on-calls were covered as priority. Recovery plans for patient cancellations had commenced. • Details were also provided of upcoming strikes. There was no mandate for RCN industrial action in EPUT, but there be may be requests for mutual aid from system partners. • Lessons Learnt meetings were taking place in anticipation of future industrial action. • The Committee commended the work undertaken around industrial action. • **International Recruitment:** Received an update noting there were only 13 nurses that have not been allocated to a ward and that 87% of nurses have been allocated to wards with feedback that	Assurance / Information

	they were being well received. There are further nurses due to arrive in Q4, 14 of which had already been allocated wards. • **Recruitment:** nursing vacancy rate18%, and the vacancy rate overall is just under 10%.	
Student Placements	The Committee received an update in relation to Student Placements, noting the importance of students having an excellent experience whilst training at EPUT as they are the investment in the future. Overall mental health capacity is 282 students and noting that there was an action plan for managing placement capacity shared with HEI partners, including: • Ward placement audits • Student Supernumerary Status to be re-emphasised • Weekly ward visits by Student Education Facilitators – agreement from ARU for joint appointment/investment for SEF • Review of Higher Education Institutes link teams to ensure visibility – regular meetings and support from practice team • HEE/ARU Learner Escalation process to all services for display – know who to escalate concerns • Student forums to speak about experiences The Committee requested information on the number of students versus the number of students that work for EPUT permanently post qualification.	Assurance
Apprenticeship Update	The Committee received a verbal update on apprenticeships, including the numbers, systems in place, the RoTAP submission and the excellent Ofsted inspection since the last time of reporting.	Assurance
Mandatory Training	The Committee received an update on Mandatory Training, noting: • The planned recovery back to pre-COVID training schedules, noting the risk to the Trust being a TASI trainer if not achieved. On trajectory by the October 2023.	Information Alert
Appraisal Update	The Committee received an update regarding appraisals, noting:	Assurance

	• Appraisal window will take place between 1 May and 31 July
	• Supported by a communications plan with FAQs
	• Benefits
	  ○ annually report on appraisals
	  ○ focus activity on training/refresher courses
	  ○ trust objectives and team objectives can be shared
	  ○ The latest compliance rate for Appraisal within EPUT was 77.3%. The Pen Plan ratings would give a better understanding of the spread of talent within the organisation. Looked at the in-patient data which is important for succession planning.	

Leadership Development Programmes	Received an overview of the leadership programmes on offer within EPUT, noting that everyone delivering training had undertaken the PETALS teaching programme. • A new 'Ward Manager Development Programme' is currently in the pilot stage and was receiving positive feedback • A digital talent warehouse is in development for mentors and coaches • Developing a clinical B5 leadership programme • Board development sessions commenced in April 2023 • Developing a module on the RISE programme which will be offered out to ward managers This was linked with equality data in terms of access.	Information
Staff Survey – Action Plan Update	The Committee received a report regarding the staff survey, noting that it would receive updates throughout the year against the actions being taken,	Assurance A full report is to be presented to the Board.

5.0 QUALITY COMMITTEE

Chair of the Committee	Committee meetings held:
Dr. Rufus Helm	13 April 2023 11 May 2023

Agenda Item	Key Assurance Items	Alert/ Assurance/ Action/ Information
Quality & Performance Scorecard (Apr)	• The Committee noted the mitigating actions in place to improve flow and capacity performance and reduce the patient experience impact where possible. These include weekly Multi-Agency Discharge Events (MADE), Getting it Right First Time (GIRFT), MH discharge challenge events. • The Committee noted that performance for cardio metabolic measurement was also not performing at standard. Mitigation was offered that this is a data quality issue, which will be improved with the implementation of the new patient record system. The Committee requested a deep dive into patient harm and cardio metabolic performance.	Alert / Action
	• For Psychology, waiting times for all groups, are expected to reduce considerably due to the commencement of new client groups, which started throughout January and February. In addition, the Committee was assured risk assessments of patients on the waiting list are repeated every 12 weeks with additional calls to those identified as more vulnerable.	Information
Reducing Restrictive Practice Framework (Apr)	• The Committee noted and commended the Reducing Restrictive Practice Framework. Reducing restrictive interventions is one of the Trust's quality priorities embedded within the Patient Safety Strategy. The framework sets out the steps required over three years to make Trust services safer for those receiving care and working in the organisation. • The Committee requested progress be monitored through future reports to the Committee. The importance of making a clear linkage to the CQC and recent recommendations and findings is also crucial in order to demonstrate the impact of the framework on safety and experience.	Information
Power BI Progress Update (Apr)	• The Committee received, discussed and noted the Power BI verbal report. The Committee noted and emphasised that as the safety dashboard is live it is critical that governance on access and sharing is robust.	

CQC Assurance Report (Apr / May)	• The Committee received, discussed and approved the CQC Exception Report. A new rating had been issued on the 3 April 2023 for Acute Wards for Adults of Working Age and Psychiatric Intensive Care following an CQC unannounced visit to Willow and Galleywood Wards in October 2022. The CQC update to the Board includes detail of the MUST do and SHOULD do actions requested from the report. • The CQC are launching a "share your experience portal" on their website and have asked providers to place a link to this portal on their external websites, which the Trust has done. • The Trust is awaiting the CQC report following inspection of 6 core services in November and December 2022 and the Well Led inspection January 2023. • The Committee acknowledged that as the CQC inspection took place 6 months ago, the Trust has already worked on many of the issues raised. Further assurance on the impact of actions taken follows the ICB visit to Willow Ward, which resulted in positive feedback.	Assurance
Research Programme and Governance Framework (Apr)	• The Committee received, noted and discussed the framework. A key line of enquiry previously noted by the Committee is the impact pharmacy workforce is having on the ability of the Trust to engage in clinical trials. The Committee was informed that this issue continues to be a challenge, however through the Medicines Management Group support is being provided where possible, with the potential to increase this over the summer.	Information
Patient Safety Incident Response Framework (PSIRF) Progress Report (Apr)	• The Committee received, noted and discussed the report. The report is comprehensive and offers assurance on how PSIRF is being implemented within the Trust. • The report will help the wider Integrated Care Board (ICB) understand safety issues affecting the system. It is noteworthy that none of the Trust priorities have manifested as topics for thematic review, which adds confidence that previous learning and embedding of actions has resulted in positive changes to practice and safety.	Information
Sub-Committees Combined Assurance Report (May)	• The report was presented, noted and discussed by the Committee. The report identified some issues with the capacity of staff to actively participate in the Safeguarding and Mental Health Act Business Meetings and the progress in replacement of fire doors at Brockfield House. • Assurance was provided that the fire door issue is being satisfactory mitigated and resolved through the Board Safety Oversight Group, with completion date set for September. T	Assurance

	• The Committee focused on the uptake of I Want Great Care (IWGC) surveys, which is below expectation. The IWGC is a priority for the Trust, with the expectation that everyone should be a champion for the programme. The Committee recommended that a scoping exercise be carried out to ensure the organisation is making it as easy as possible for service users to participate. • The Associate Directors of Nursing and Quality will be asked to nominate named individuals to attend future MHA business meetings.	
1st Draft Quality Account (May)	• The Committee received and noted the first draft of the Quality Account. The Quality Account continues to be an opportunity to celebrate achievements by the Trust. Within this year's account is a thread of patient safety in the form of the PSIRF. • In recognition of the matrix way that the Trust works with partners, the ICBs will be combining their responses into one commentary for inclusion in the final report.	Information
Collaborating for Care Strategy Annual Review (May)	• The strategy was presented, noted and discussed by the Committee. There are three main elements to the strategy, patient centered, multidisciplinary and recruitment and retention. • With the Deputy Directors of Quality and Safety in place progress can begin in delivering the strategies main objectives. Making every contact count and ensuring physical and mental health needs receive equal recognition and response, will support early recognition of patient deterioration and reduce incidents of harm. The development of advanced clinical practice career pathways will also support retention of staff in clinical positions. • The strategy has links to the work underway with MSE on the System Partnership and Engagement Project offering further benefits from collaboration with MSE Hospital Group partners. • The Committee was assured that the strategy will also allow closer working with medical colleagues in terms of safety initiatives.	Assurance
System Partnership and Engagement Project (May)	• The Committe noted and discussed the latest update from the System Partnership and Engagement Project. The Project has the aim of supporting new norms in partnership working, for the benefit of the health and experience of people living with a mental illness using MSE and EPUT services. Trust staff from both MSE Hospitals Group and EPUT are encouraged and enabled to work collegiately with colleagues in the mental health and physical health space, in inpatient and community settings.	

	• The report highlighted achievements in MHA training within the MSE Group, staff shadowing opportunities and joint learning from patient safety incidents. • The Committee noted the project is a positive move towards a cultural shift in attitudes to mental illness. The QC requested that the positive developments in colocation MH and community services in West Essex be included with the work plan as these are delivering benefits to patients.	
Mental Health Activity Deep Dive (May)	• The Committee received and noted a comprehensive report. Broad themes that emerge from the report are access to fresh air and the existence of blanket rules, rather than those tailored to patient individual needs and risks. A lack of discharge planning is also seen as problematic. • The Committee raised a query regarding tribunal hearings and the 22 cases that were subsequently discharged. While it is acknowledged that this number is low considering the number of detentions that take place annually, the Committee sought assurance that thematic reviews will take place to ensure continuous learning and improvements in decision making. • The Committee also noted that there is a lot of process driven activity associated with the MHA and that this is an area where technology may be able to assist the process and the practitioner. The example offered was ChatGPT. Assurance was given that work on the new electronic patient record would help to address issues were additional technology can assist accurate adherence to MHA processes.	Assurance / Alert
Emergency Preparedness Resilience and Response (EPRR) Report (May)	• A major review of the EPRR plan was presented to and noted by the Committee. The report provides assurance that the Trust is compliant with all requirements within the Civil Contingencies Act and that systems and processes are in place to deal with major incidents. • The Committee reflected on the number and range of incidents the Trust has responded to in recent years and would welcome greater feedback on the learning coming from these incidents.	Assurance
Infection Prevention and Control Assurance Framework (May)	• The Committee received noted and discussed the report, which is now restructured to include a summary page with a focus on evidence. Noteworthy is the business as usual response to COVID-19.	Information
Community Mental Health Survey	• The Committee received, noted and reviewed the report.	Information

Action Plan 23/24 (May)		
Patient Experience Annual Report (May)	• The Committee recognised the report as an excellent and comprehensive piece of work. It was recommended that consideration should be given to looking at patient stories from the perspective of diversity, to add another layer of richness to the information gained from this approach. In addition the Committee suggested the engagement of patients and carers in the development of the report should be more explicit.	Assurance Full report for Board
Complaints and Compliments Annual Report (May)	• The Committee received, noted and approved the Complaints and Compliments Annual Report. The comprehensive report outlines how the co-designed process and additional resourcing has led to a reduction in delays by 35%. While a similar number of complaints were received to the previous year, it is notable that MP complaints decreased and there was an increase in the local resolution of complaints. Compliments were up by 13%. • The main areas of concern are complaints about treatment, communication, behavior and attitude of staff. • The Committee recommended that the report and its findings on the key areas concerning patients must be fed back comprehensively through the Trust to ensure everyone is aware of the issues.	Alert Full report for Board.

6.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

- Note the report and assurance provided
- Provide feedback for any identified issues for escalation.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	Board Safety Oversight Group Assurance Report					
Executive/ Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Alison Ives, Deputy Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with an update on the progress of projects, programmes and activities linked to the safety priorities within the safety strategy.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The 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 attached report provides details of the following:

- Ligature Risk Reduction
- EPUT Culture of Learning
- Embedding Gold Standard SOPs
- ePMA

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓

SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Professor Sheila Salmon Chair of the Trust

Agenda Item: 7c
Board of Directors Part 1
22 May 2023

BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

This report is provided as assurance to the Trust Board on the progress of projects, programmes and activities linked to the safety priorities within the Safety Strategy.

In this period the key areas of focus for the Executive Safety Oversight Group (ESOG) and Board Safety Oversight Group (BSOG) has been spotlight reports for Ligature Risk Reduction, EPUT Culture of Learning and Embedding Gold Standard Operating Procedures (SOPs). We have also been updating on progress of ePMA post approval at Trust Board in March.

Ligature Risk Reduction

Work continues on the ligature risk reduction programme with the focus on the environment of our in-patient estate, mobilisation of the ligature related training programme, and producing policies on a page relating to ligature risk reduction:

Environment

Our Estates colleagues have now completed the installation of a Kingsway Sentry door (three-sided alarm not just door top) to Aurora Ward at Brockfield House and will now use any learning from this installation to support a full programme roll out.

They have also installed 150 soft bins at Rochford and Basildon and the remaining 445 bins will be installed throughout the Trust by the end of May 23.

The garden project has also commenced at the Lakes and colleagues anticipate this will be completed by the end of June. Once finished at The Lakes the team will move on to commence the garden project at Gosfield ward.

A detailed list of the completed environmental works on our wards relating to ligature risk reduction, is included in Part 2 of this report.

Training

Following approval of the in-house ligature risk training programme the team have been completing the implementation plan for a pilot of this which is being trialled during June on Topaz Ward.

Policy

The Ligature Risk Assessment and Management ‘Policy at a Glance’ was approved by LRRG and has been trialled on the CAMHS wards. The team will now undertake facilitated feedback session before rolling out trust wide.

EPUT Culture of Learning (ECOL)

EPUT and MASS have now both signed a contract to deliver the Safety & Lessons Management Systems (ESLMS). Digital colleagues are now working through any data protection concerns before further development will take place.

An interim solution has been put in place in order to access historical workforce data to support backend development of the Safety Dashboard. The system vendor (Allocate) has provided assurance that a permanent fix will be implemented in the 25/05 upgrade.

The lessons handbook was circulated to key stakeholders and shared with the inpatient SMT with a request for feedback. Once this feedback has been reviewed and any necessary updates completed an on-line version of the handbook will be created.

Embedding of Gold Standard SOPs

Work continues alongside Carradale futures to develop the 10 key SOPs, with a number of these now moving into approval stage.

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The 10 key SOPs are:

- Local Induction
- Transfers
- Clinical Risk Assessment
- Admission
- Post Discharge Follow-up
- Record Keeping
- Disengagement
- Management of Deterioration
- Management of Falls
- RAG rating for Care Coordinators

For the digitisation of these SOPs, comprehensive governance has been put in place in order to ensure the digital app is fit for purpose. Part of this governance is the introduction of a Digital Standard Operating Procedure Project Board to work alongside key stakeholders. Their primary focus will be the Power Apps development and ensuring the sustainability of EPUTs Power Platform ahead of application User Acceptance Testing.

ePMA

EPUT and EMIS had an initial meeting post business case approval to discuss the interface and configuration work required and will meet again during May to plan the project initiation. An ePMA steering group is now meeting monthly and it has been agreed that from June 23 progress will be reported monthly to ESOG and BSOG via a spotlight report. A key dependency of the programme is the Ascribe pharmacy upgrade which we have now successfully completed.

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**Staff Survey and Bank Only Survey - 2022**					
Executive/ Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Lorraine Hammond, Director of Employee Experience Stuart Hastings, Head of Employee Experience					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

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

Purpose of the Report		
This report provides the Board of Directors with a summary of the results from the NHS Staff Survey 2022, Bank Only Staff Survey 2022 and associated Action Plan.	**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

National Staff Survey 2022

The results of the National Staff Survey (NSS) indicates **2547** surveys were returned giving a response rate of **42%**. This is a decrease in response rate in comparison to 2021, where 2602 surveys were returned giving a response rate of 47%. In 2020, 2305 were returned giving a 47% response rate.

Bank Only NHS Staff Survey

In 2022, EPUT was one of 115 Trusts in England whose results contributed towards results of the first Bank Only NHS Staff Survey. The Trust received 388 responses from Bank Staff, a return rate of **23.1%**. Whilst significantly below the response rate of the NHS Staff Survey (**42%**), EPUT's response rate was **5.1%** higher than the average of Trusts participating in the survey in 2022.

The attached documentation provides the results of both surveys and the associated action plan.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications:		**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			
NSS Bank	National Staff Survey - Bank only workers		
BME	Black and Minority Ethnic		
Bank only workers	Bank staff without a substantive contract		

Supporting Reports/Appendices/or further reading

Main Report

- National Staff Survey Benchmark Report
- National Staff Survey Breakdown Report (directorates)
- Directorates Comparison Tables
- Bank Only Staff Survey Results – National (Aggregated) Results
- EPUT Bank Only Staff Survey Results - IQVIA Local Report
- Bank Only Staff Survey - Table Breakdown of Responses in comparison to National Averages
- Staff Survey Action Plan

Lead

Sean Leahy
Executive Director of People and Culture

Agenda Item: 7d
Board of Directors Part 1
31 May 2023

STAFF SURVEY AND BANK ONLY SURVEY 2022

1 PURPOSE OF REPORT

1.1 The purpose of this report is to provide an overall and detailed summary of results from the NHS Staff Survey 2022 and Bank Only Staff Survey (NSS Bank), as well as our plans moving forward.

2 EXECUTIVE SUMMARY

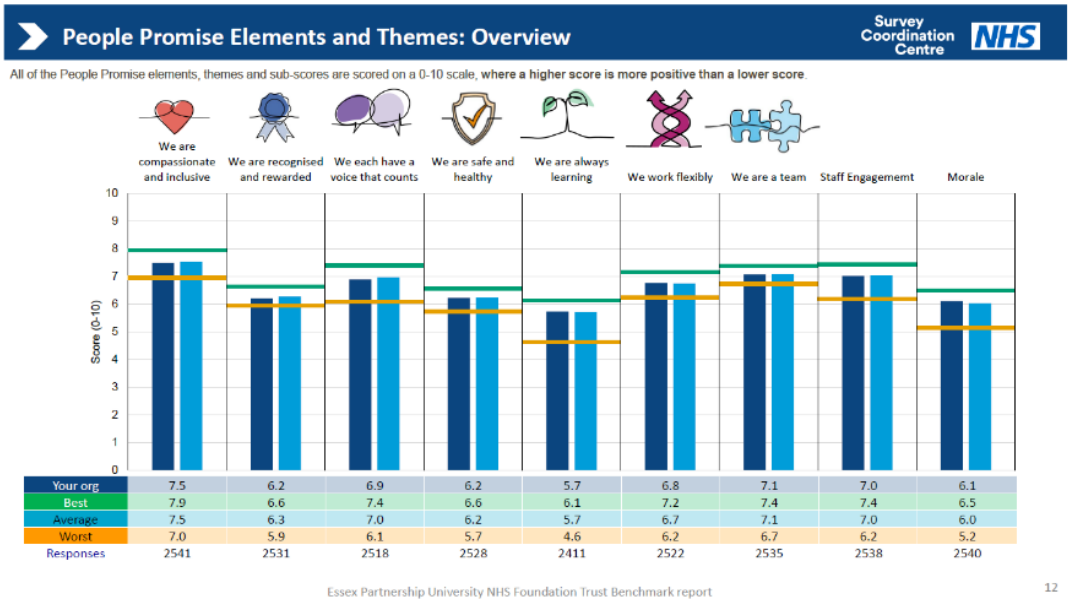
2.1 All NHS Trusts in England are required to take part in the National Staff Survey every year. Each Trust is required to commission an independent external survey provider (IQVIA/Quality Health for EPUT) to administer the survey and coordinate its results with the National Staff Survey Coordination Centre (SSCC)

2.2 To support inclusion and the People Promise commitment that "we each have a voice that counts", in 2022 NHS England extended eligibility to NHS staff who do not have a substantive contract but work for the NHS via an in-house bank. EPUT was one of **115** Trusts whose results contributed towards this survey, being run as a pilot. There is a high likelihood it will be a requirement for Trusts to participate in future years.

2.3 The NHS Staff Survey and Aggregated NSS Bank results have been aligned to the NHS People Promise elements (7 People Promises and Themes of Staff Engagement and Morale). Theming by People Promise elements was not included in the local report for the NSS Bank provided by IQVIA.

2.4 The NHS Staff Survey benchmarks the experience of substantive staff against 51 similar NHS Trusts in the 'Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts' group. All eligible staff outlined in the national guidance were surveyed.

2.5 See below for EPUT's 2022 results from the NHS Staff Survey which compares the 9 People Promise elements against the average of our benchmarked group:



2.6 Below are ranked People Promise scores for EPUT in 2022

Rank	People Promise	Score
1	We are compassionate and inclusive	7.5

2	We are a team	7.1
3	We each have a voice that counts	6.9
4	We work flexibly	6.8
5	We are safe and healthy	6.2
6	We are recognised and rewarded	6.2
7	We are always learning	5.7

2.7 Variations in scores for each People Promise elements and their sub-scores are not significant when compared benchmarked averages. Results in comparison to our benchmarking group can be seen below, with green indicating improvements and red indicating a worsening in score/placing:

People Promise	2021	2022	Score change
We are compassionate and inclusive	Average	Average	-no change-
We are recognised and rewarded	Below Average	Below Average	-no change-
We each have a voice that counts	Below Average	Below Average	-no change-
We are safe and healthy	Above Average	Average	-0.1
We are always learning	Average	Average	+0.1
We work flexibly	Average	Above Average	+0.1
We are a team'	Below Average	Average	+0.1
Staff Engagement	Above Average	Average	-0.1
Morale	Above Average	Above Average	-no change-

NB – Indicators relate to average results of Trusts our benchmarking group. The full breakdown report attached provides detail on the questions which make up each of the elements/themes and their individual scores.

2.8 **Key Highlights – NHS Staff Survey**

- On what grounds 'have you experienced discrimination? (Age) - EPUT is in line with the best performing Trusts in our benchmarking group (Q16c.6)
- A 7.3% decrease in staff who reported that they had experienced discrimination based on grounds of Gender (Q16c.2) - performing 4.3% better than average
- Staff are more likely to feel there are opportunities to access the right learning and development opportunities when they need to
- More likely to feel there are opportunities to develop their career within the Trust
- There have been improvements in perceptions amongst staff around EPUT being committed to helping achieve balance between work and home life.

2.9 **Key Highlights – NSS Bank**

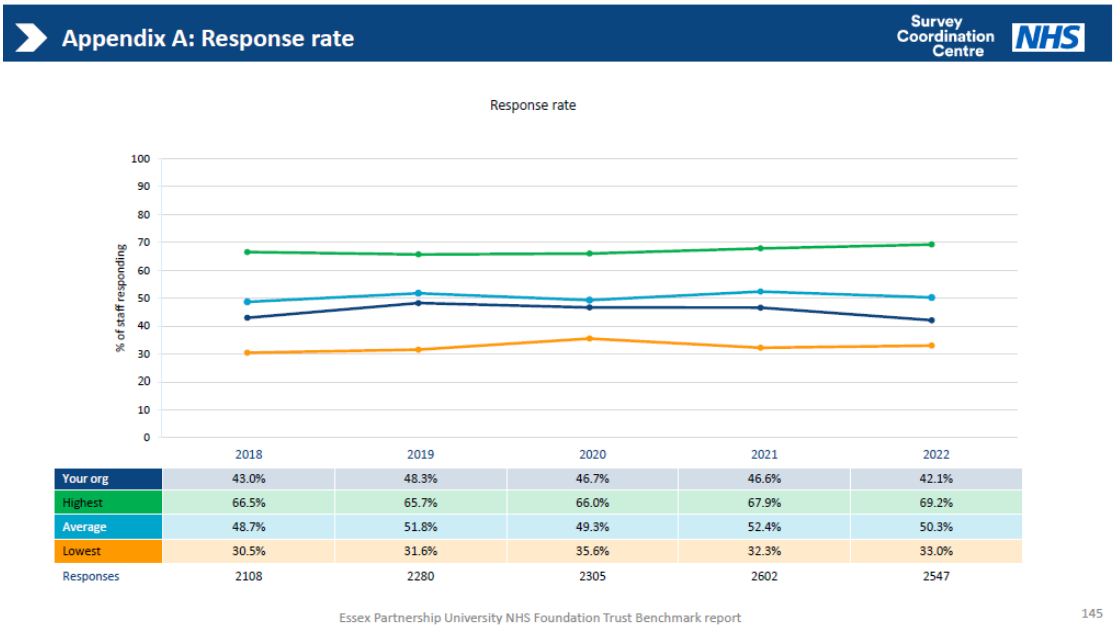
Whilst comparisons should be taken with caution, **highlights in results for Bank only workers include**:

- Responses to the 'we are safe and healthy' People Promise. (Bank only Workers are **less likely** to report feeling burnt out from work than national average and the experiences of substantive staff. They are also l**ess likely** to feel worn out at the end of a shift)
- Responses to the 'morale' theme (**74%** of bank only workers would like to continue working on bank within the Trust)
- Scores relating to incident reporting and perceptions around organization response
- **Responses to the support provided by the Bank Team** were positive, notably:
    - **62%** of respondents reported it being easy to get hold of the Bank Team if they had a query, compared with a national average of 57.9%
    - **59.8%** of respondents said that when contacting the bank team, they quickly received answers they needed. This is 5.6% higher than the national average of 54.2%

2.10 Further detail on Areas of Focus can be found in section 4

3 RESPONSE RATE, METHODOLOGIES AND DEMOGRAPHICS

3.1 The NHS Staff Survey saw **2547** surveys completed, giving a response rate of **42%**. This is a decrease of 5% compared to 2021 (47%) Contributing factors include the Dispatches documentary aired within the survey window, and CQC inspections. See below:



3.2 The NSS Bank received **388** responses, a return rate of **23.1%**. EPUT's response rate was **5.1%** higher than the average of Trusts participating in the pilot survey.

3.3 From a methodology perspective, substantive staff has the opportunity to complete the NHS Staff Survey via paper or electronic format. Bank only workers were only able to complete the pilot survey online, accessible either through email with a link or QR code. Bank staff without an email were sent a paper invitation with a link/QR code to complete the survey online survey.

3.4 The NHS Staff Survey and NSS Bank included many similar questions, however the NSS Bank included additional bank-specific questions. A full details of the differences between the surveys can be found in the Appendix of the Aggregated Results.

3.5 **Direct comparisons** between responses from **Bank only workers** and **substantive staff** should be **made with caution** for the following reasons:

- **Differences in the mix of staff responding**. For example, 23.5% of respondents to the NSS Bank were Nursing or Healthcare Assistants, compared with 7.8% in the NHS Staff Survey
- **Context effect** of questions being ordered differently, and some questions being added/removed when compared with the NHS Staff Survey. This can impact responses
- **Response volume** is much lower in the NSS Bank, when compared with the NHS Staff Survey. This means results are more likely to be subject to outlier results impacting overall scores.
- **Immediate managers and team questions.** It is widely recognised that Bank only workers may not be able to as easily identify an immediate line manager or team they feel part of, due to the flexible nature of their employment. Scores will therefore likely be impacted.

3.6 A demographic breakdown of the respondents to the NSS Bank has been included in the NSS Bank Comparison Table (page 1). Points of note include:

- A **higher proportion** of Bank only workers identified as having a **Black, Asian or Minority Ethnic Background (BME)** in comparison to the national average of Bank only workers (**41.8%** vs. 28.0%)

- A **higher proportion** of Bank only workers identifies as having a BME Background in comparison to EPUT substantive staff (**41.8%** vs. 18.7%)
- **Fewer** respondents **reported having a disability or long term illness** compared against the national average of bank only workers (**13.1%** vs. 20.3% national average)
- When compared with the responses of substantive workers, **4.6%** more respondents identified as **Male** in the NSS Bank compared with the EPUT substantive staff

3.7 The majority of Bank only workers responding to the survey have worked for EPUT for >2 years. Tenure is not significantly different when compared with national averages. The most notable difference in tenure between Bank only workers and substantive staff is in those working 15 years or more, with more than 20% substantive staff having 15 years' tenure compared to 5.2% Bank only workers.

4 AREAS OF FOCUS

4.1 **NHS Staff Survey Areas of Focus**

There are some concerning results within the NHS Staff Survey which will be the focus of further engagement and investigation. These include:

The Experiences of staff with a Disability or Long-Term Condition (LTC) has seen deteriorations in scores amongst staff who have a disability or LTC. These include a 5.4% decrease in staff who are satisfied with the extent to which their organisation values their work, increases in staff with a disability or LTC experienced harassment, bullying or abuse from other colleagues and a fall in the percentage of staff saying they reported their last experience of harassment, bullying or abuse at work

We are Safe and Healthy sub-score: Burnout will be an area of focus in the coming year, with 56.1% of staff reported working despite not feeling well enough in the past three months. There has also been a 2.2% increase in staff who report feeling exhausted at the thought of another day/shift at work, and 28.7% of staff reported feeling burnt out because of work. We perform below average in this sub-score compared to the benchmark group.

Staff perceptions of standards of care and treatment (Q23d) have worsened in 2022. 4.6% fewer staff would feel happy with the standard of care if a friend or relative needed treatment provided by the Trust. 2022 rates are 11.1% lower than 2020.

The Experience of BME Staff will continue to be a focus in 2022. Whilst there have been improvements in rates of bullying, harassment and abuse experienced by BME staff, rates remain lower amongst white staff at 21.6%, compared to BME staff 26%. Work will also continue to improve career progression and opportunities, to continue improvements seen in this area.

There will be a focus on the perception of staff around support received when raising concerns. This links to the 'We have a voice that counts' People Promise element and action planning will focus on empowering and supporting staff support staff to speak up.

4.2 **NSS Bank Areas of Focus**

There are a number of areas within the NSS Bank which highlight areas of concern when compared with both the experience of Bank only workers in other Trusts, and the experiences of EPUT substantive staff:

Line Management

Whilst the experience of Bank only workers in comparison to the average experience of Bank only workers in other Trusts, there are some notable variances when compared with the experience of EPUT substantive staff.

- Bank only workers are **less likely** to respond favourably to working with their manager to understand problems (56.5% vs 75.3% EPUT substantive staff)
- Bank only workers and are **less likely** to agree that their manager takes a positive interest in their health and wellbeing (58.5% vs 77.6% EPUT substantive staff)

We each have a voice that counts. EPUT Bank only workers scored poorly in responses within this People Promise, including:

- **32.6%** of Bank only workers reported feeling they have a choice in deciding how to do their work, compared with 43.5% nationally and 62.6% amongst EPUT substantive staff
- Bank only workers were **21.3%** less likely to feel involved in decisions around changes which affect their work area/team/department (31.6% agree/strongly agree, compared with 52.9% EPUT substantive staff)

Appraisals and Annual Reviews. 76.1% of Bank only workers who responded to the survey said they had **not had an appraisal or annual review** in the last 12 month. This compared to 65.1% nationally, and 17% amongst EPUT substantive staff.

Bank workers considering moving to a permanent contract. Whilst is it positive that 74% of Bank only workers intended on staying on the Bank register, **only 16.2% said they were considering moving to a permanent contract**. This is against a 24.3% national average.

Discrimination based on Ethnicity. Of Bank only workers who reported experiencing discrimination in the past 12 months, 61.3% report this being on the grounds of Ethnicity. This is **8% higher than EPUT substantive staff** and **2.5% higher than the national average.**

5 CONCLUSION AND NEXT STEPS

5.1 Despite challenges the organisation and a decrease in our response rates, results are positive in several areas including improvements in learning, perceptions amongst staff around flexible working support, and discrimination based on age and gender.

5.2 Participation in the NSS Bank has been positive, and provides useful insight for the Trust on the experience of Bank only workers in comparison to the experience in other Trusts, and substantive staff members within EPUT. These insights can be used to take proactive steps to improving the experience of Bank staff.

5.3 Work is taking place with the Temporary Staffing Manager, HR and other stakeholders across the organisation to improve the experience of Bank workers. As with the NHS Staff Survey results, sessions will be held for Bank only workers to attend to discuss what practical steps can be taken to improve the experience of staff.

5.4 We will continue to work with staff and directorates to establish what factors contribute towards improving engagement and forming plans to promote consistently good experiences for staff across the Trust

5.5 **Next Steps include:**

- Sessions with Bank only workers via group supervision sessions with clinical leads
- Ongoing engagement with the Temporary Staffing Team so that actions included in the Staff Survey Action Plan and other work is considered through the lens of Bank only workers and their experience
- Delivery of the Staff Survey Action Plan (attached)
- Continued dialogue with Staff Networks, Engagement Champions Network and stakeholders
- You Asked, We Delivered campaign in late June
- Monitoring and Iteration of Action Plan via People Equality & Culture Committee (PECC) through 2023

Lorraine Hammond, Director of Employee Experience
Stuart Hastings, Head of Employee Experience
On behalf of
Sean Leahy
Executive Director of People and Culture

Survey Coordination Centre

NHS

[TRUST NAME]

NHS Staff Survey Benchmark report 2022

Contents

Survey Coordination Centre

NHS

Introduction

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this Report

Survey Coordination Centre

About this report

This benchmark report for Essex Partnership University NHS Foundation Trust contains results for the 2022 NHS Staff Survey, and historical results back to 2018 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate*. Data in this report are weighted** to allow for fair comparisons between organisations.

Please note: Results for Q1, Q10a, Q24d, Q25a-c, Q26a-c, Q27, Q28, Q29, Q30a, Q31a-b, Q32a-b and Q33 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from our results website.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and subscores are related and mapped to individual survey questions.

*The data included in this report are weighted to the national benchmarking groups. The figures in this report may be different to the figures produced by your contractor.
**Please see Appendix C for a note on the revision to 2019 historical benchmarking for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trust benchmarking groups.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q23a, Q23b, Q23c, Q23d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q20
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q19a, Q19b, Q23e, Q23f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development	Q22a, Q22b, Q22c, Q22d, Q22e
	Appraisals	Q21a*, Q21b, Q21c, Q21d *Q21a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q23a, Q23c, Q23d
Morale	Thinking about leaving	Q24a, Q24b, Q24c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q15, Q16c, Q17, Q18a, Q18b, Q18c, Q18d, Q24d, Q30b

Report structure

Survey Coordination Centre NHS

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, themes and sub-scores, as well as features of the graphs used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise Elements, Themes and Sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise Elements, Themes and Sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These graphs are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

The Covid-19 pandemic

This section contains results for the People Promise elements and themes split by staff experience related to the Covid-19 pandemic.

Questions not linked to People Promise

Results for the questions that do not contribute to the result for any People Promise element or theme are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and Theme results for 2021 vs 2022.
- Data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Please note, where there are less than 11 responses for a question this data is not shown to protect the confidentiality of staff and reliability of results.

Using the report

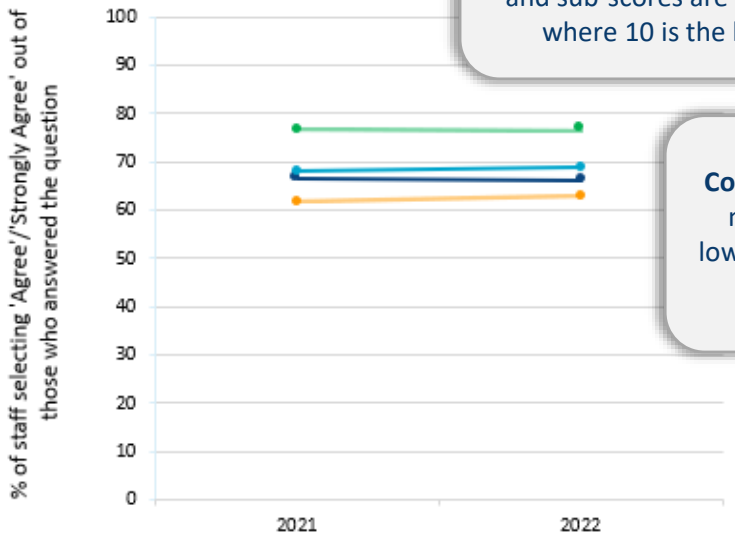
Please note this is example data

Key features

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

Question number and text (for summary measure) specified at the top of each slide.

The home icon on each slide is **hyperlinked** and takes you back to the contents page (which is also hyperlinked to each section).

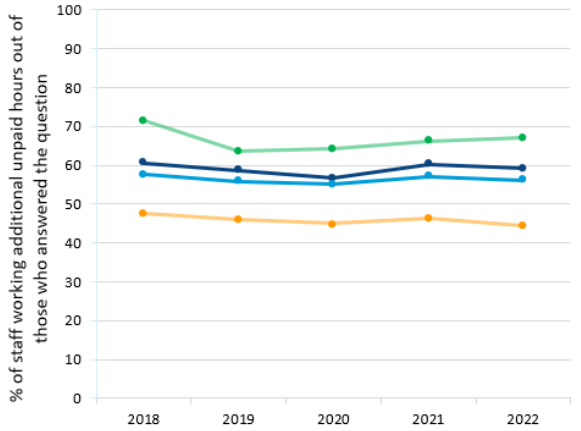


Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table.

	2021	2022
Your org	66.5%	66.3%
Best	76.8%	76.8%
Average	68.0%	68.7%
Worst	61.9%	62.8%

Number of responses for the organisation for the given question.

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	60.5%	58.7%	56.8%	60.2%	59.2%
Best	71.4%	63.6%	64.2%	66.1%	67.3%
Average	57.7%	55.9%	55.1%	57.0%	56.3%
Worst	47.7%	46.0%	45.0%	46.5%	44.6%

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results.**

Tips on how to read, interpret and use the data are included in the Appendices

Please note: charts will only display data for the years where an organisation has data. For example, an organisation with two years of trend data will see charts such as q10c with data only in the 2021 and 2022 portions of the chart and table.

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Organisation details

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre NHS

Essex Partnership University NHS Foundation Trust

2022 NHS Staff Survey

Organisation details

Completed questionnaires	2547
2022 response rate	42%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

2022 benchmarking group details

Organisations in group: 51

Median response rate: 50%

No. of completed questionnaires: 115361

For more information on benchmarking group definitions please see the Technical document.

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NHS

People Promise Elements, Themes and sub-score results

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

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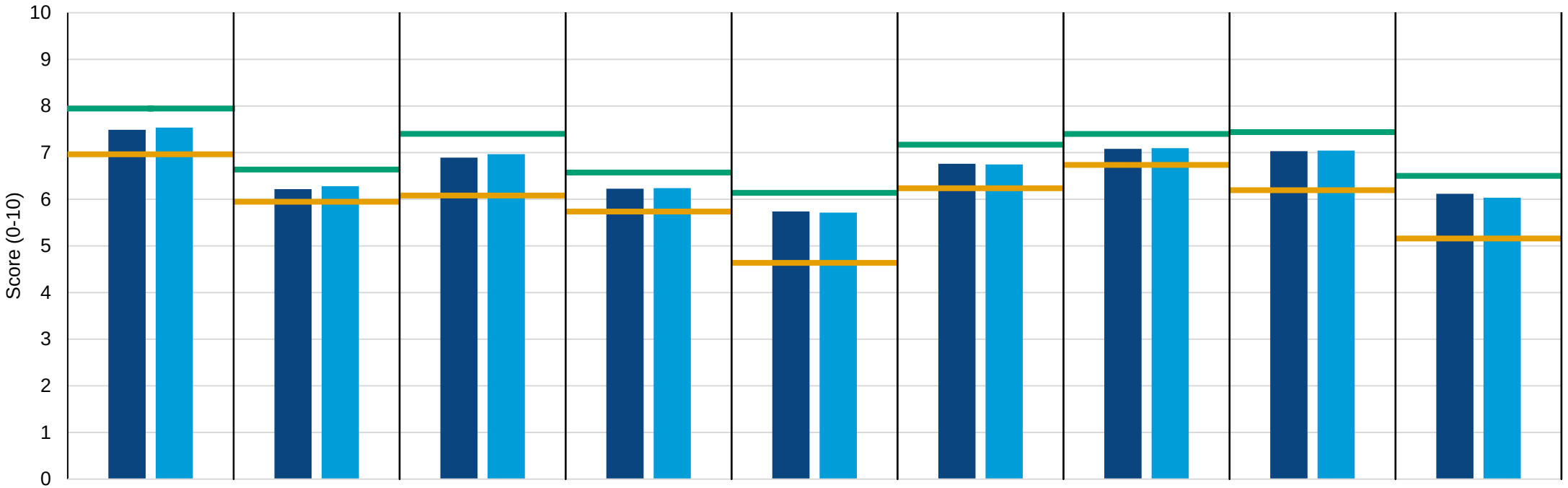
People Promise Elements, Themes and Sub-scores: Overview

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



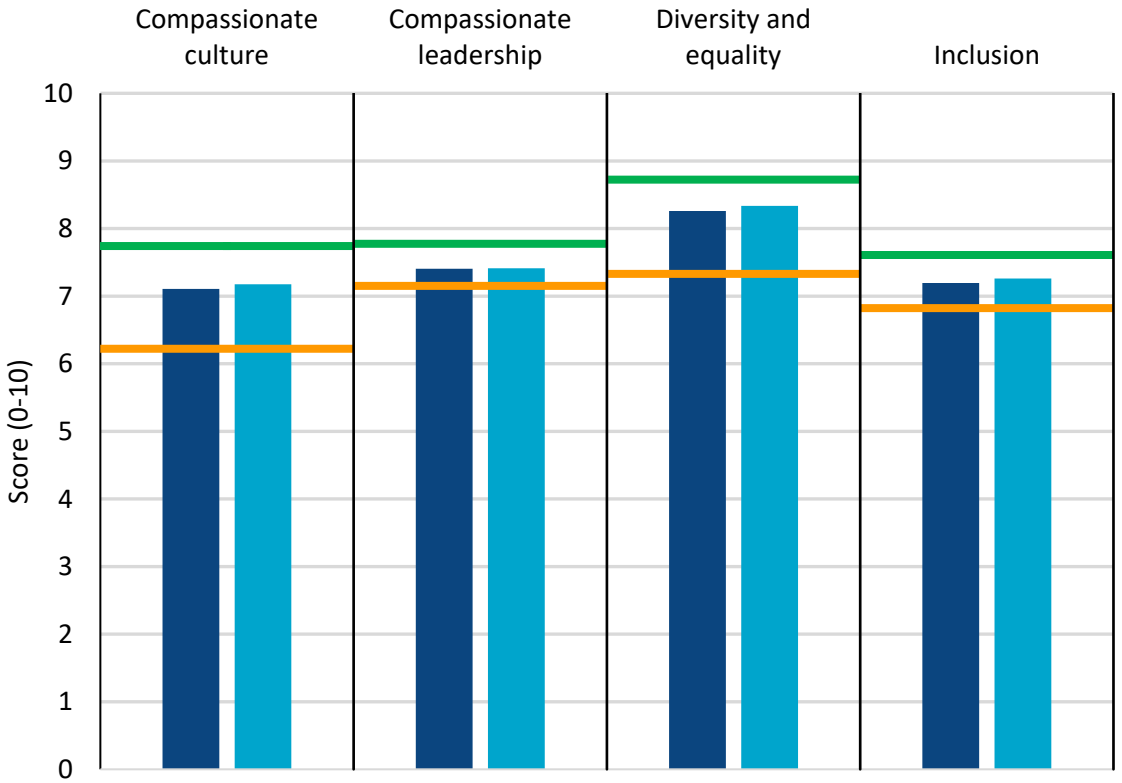
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2
Responses	2541	2531	2518	2528	2411	2522	2535	2538	2540

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre

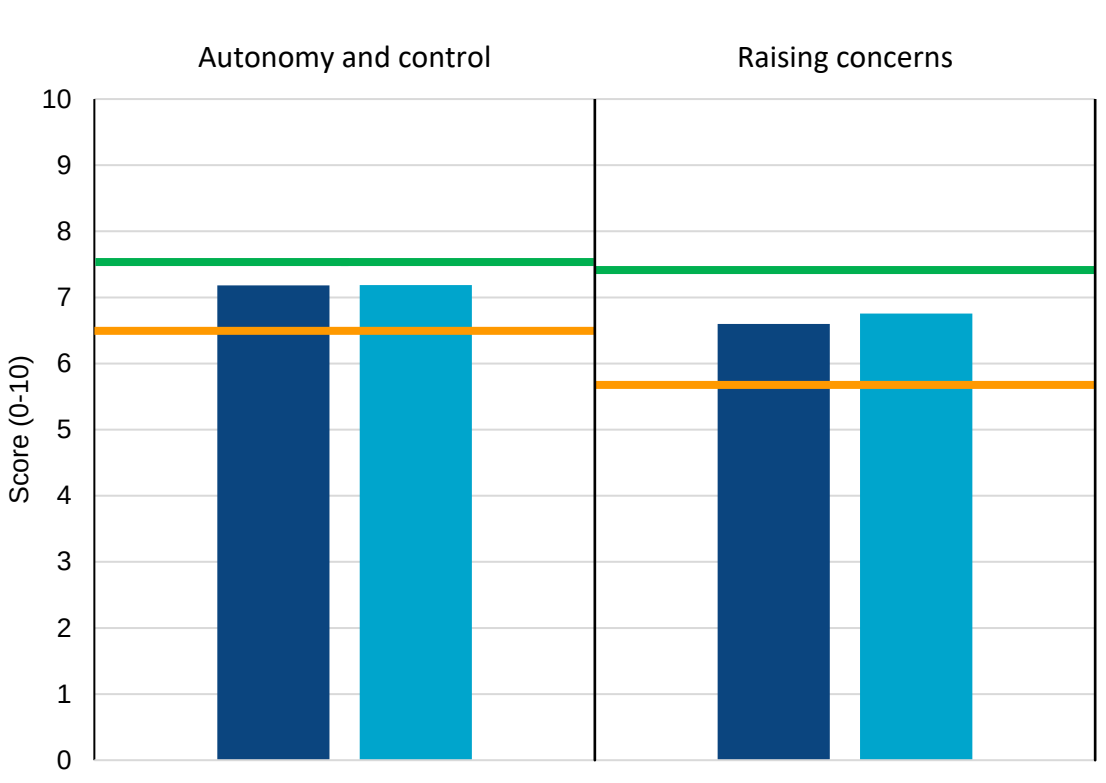
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.1	7.4	8.3	7.2
Best	7.7	7.8	8.7	7.6
Average	7.2	7.4	8.3	7.3
Worst	6.2	7.2	7.3	6.8
Responses	2535	2539	2535	2528

Promise element 3: We each have a voice that counts



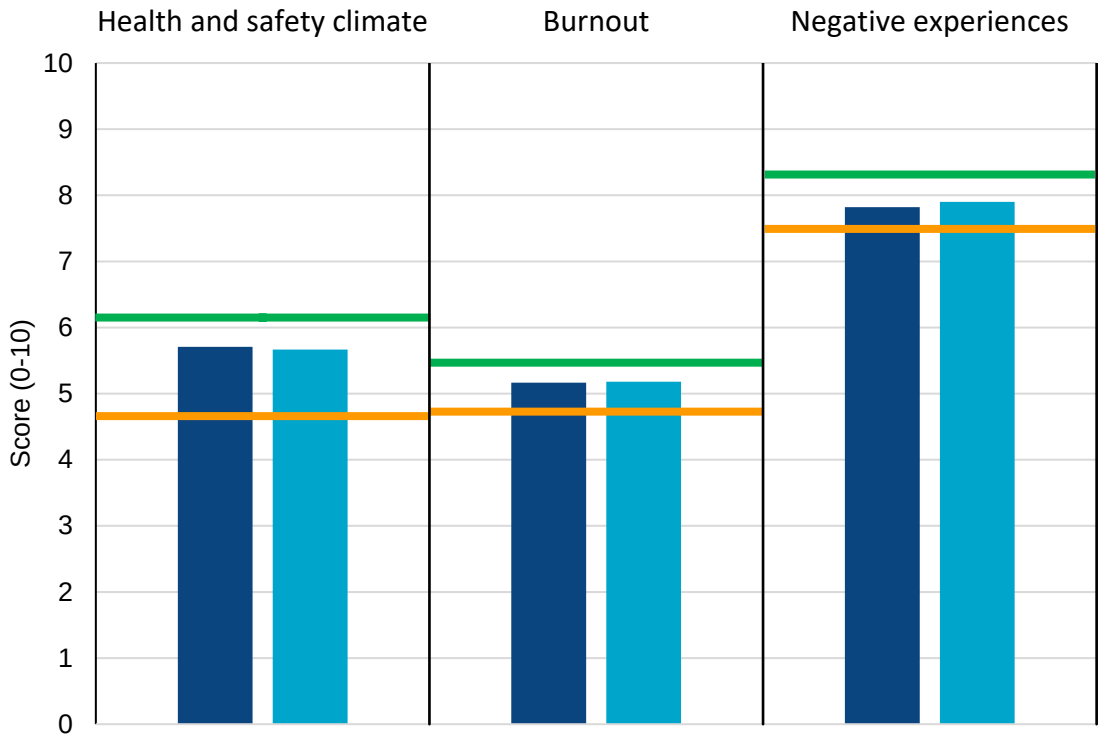
	Autonomy and control	Raising concerns
Your org	7.2	6.6
Best	7.5	7.4
Average	7.2	6.8
Worst	6.5	5.7
Responses	2538	2526

N.B. People Promise Element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 20.

People Promise Elements, Themes and Sub-scores: Sub-score Overview

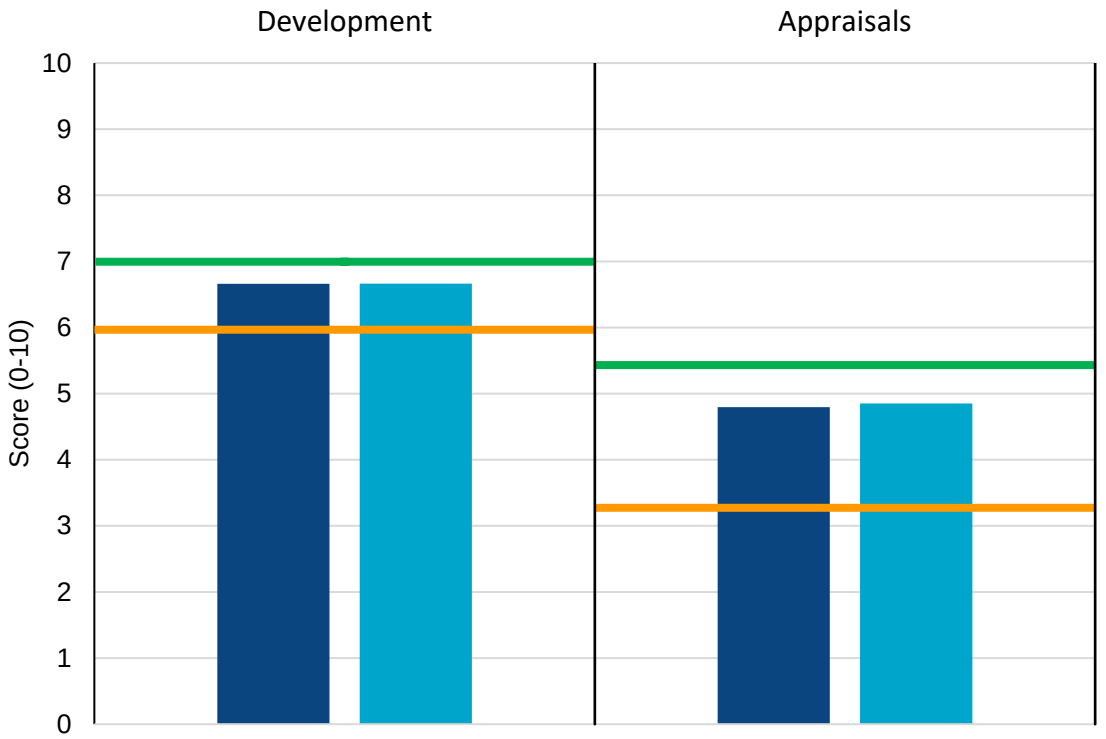
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.7	5.2	7.8
Best	6.2	5.5	8.3
Average	5.7	5.2	7.9
Worst	4.7	4.7	7.5
Responses	2538	2542	2537

Promise element 5: We are always learning



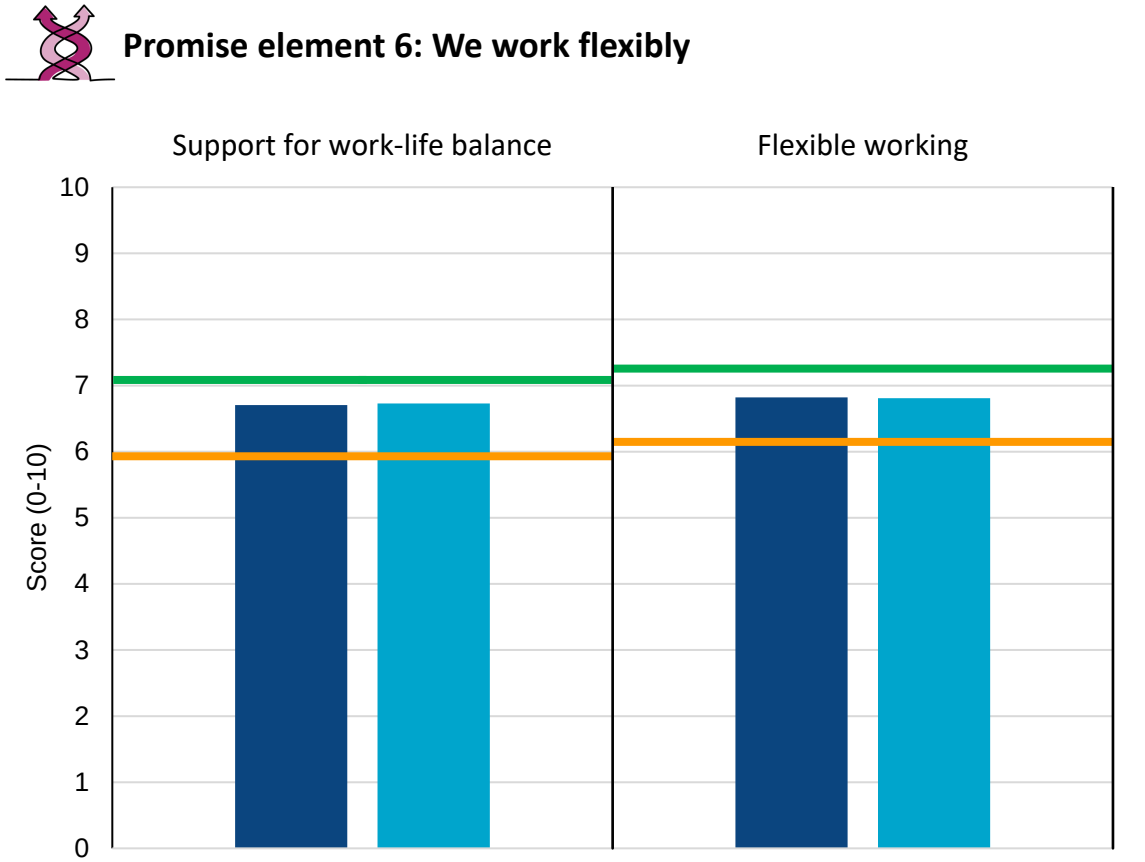
	Development	Appraisals
Your org	6.7	4.8
Best	7.0	5.4
Average	6.7	4.9
Worst	6.0	3.3
Responses	2537	2416

People Promise Elements, Themes and Sub-scores: Sub-score Overview

Survey Coordination Centre

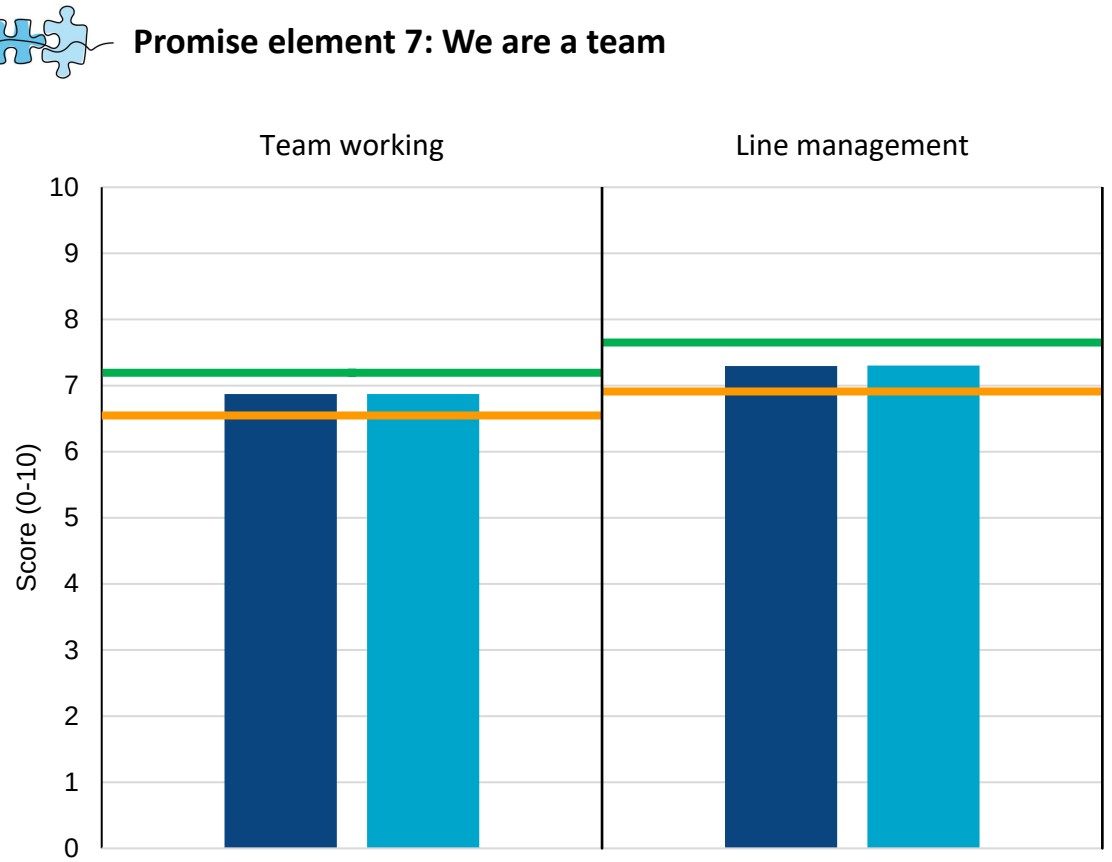
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.7	6.8
Best	7.1	7.3
Average	6.7	6.8
Worst	5.9	6.1
Responses	2541	2524

Promise element 7: We are a team

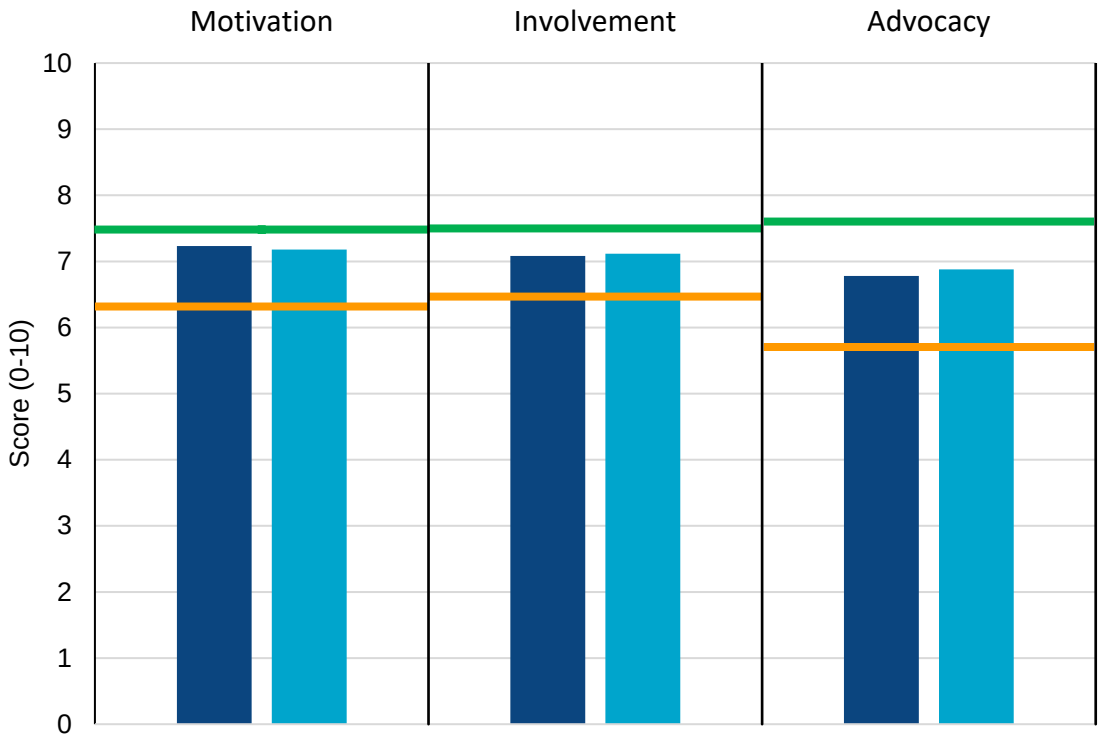


	Team working	Line management
Your org	6.9	7.3
Best	7.2	7.7
Average	6.9	7.3
Worst	6.5	6.9
Responses	2539	2540

People Promise Elements, Themes and Sub-scores: Sub-score Overview

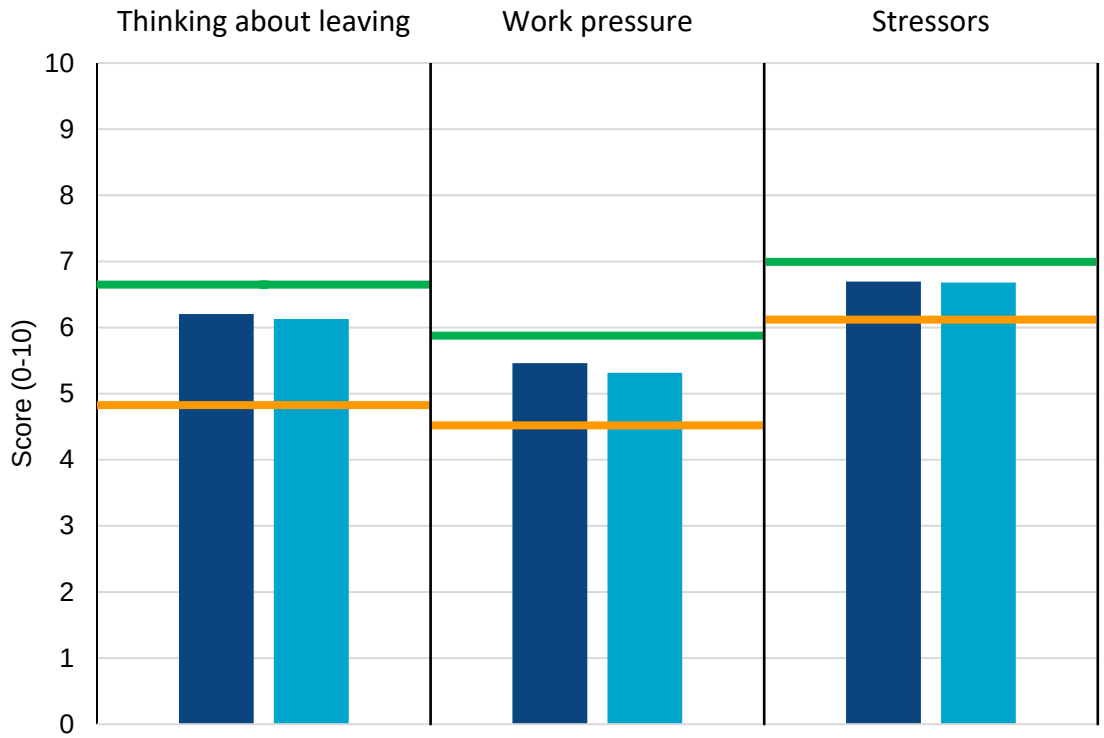
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.2	7.1	6.8
Best	7.5	7.5	7.6
Average	7.2	7.1	6.9
Worst	6.3	6.5	5.7
Responses	2491	2537	2533

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.2	5.5	6.7
Best	6.6	5.9	7.0
Average	6.1	5.3	6.7
Worst	4.8	4.5	6.1
Responses	2539	2537	2537

Survey Coordination Centre

NHS

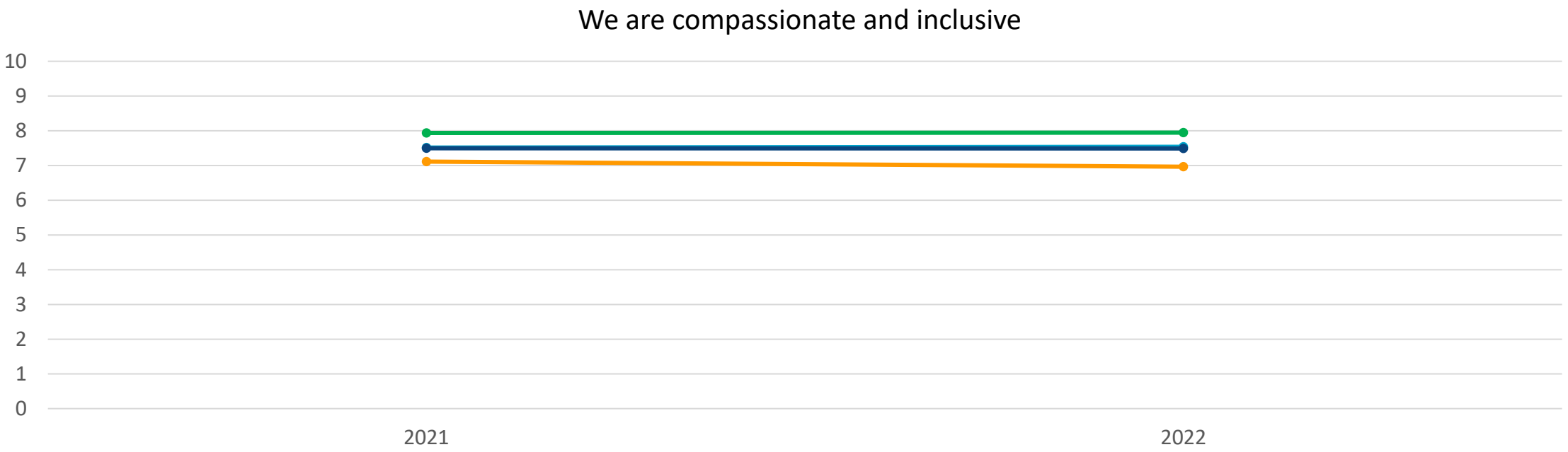
People Promise Elements, Themes and Sub-scores: Trends

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022
Your org	7.5	7.5
Best	7.9	7.9
Average	7.5	7.5
Worst	7.1	7.0
Responses	2594	2541

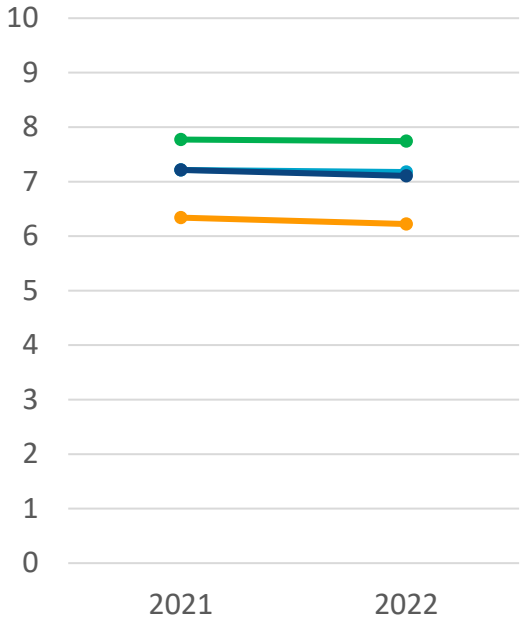
People Promise Elements, Themes and Sub-scores: Sub-score trends

Survey Coordination Centre

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

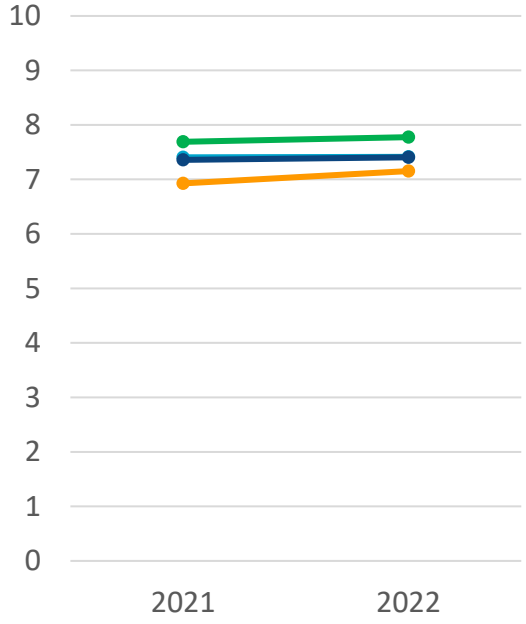
Promise element 1: We are compassionate and inclusive

Compassionate culture



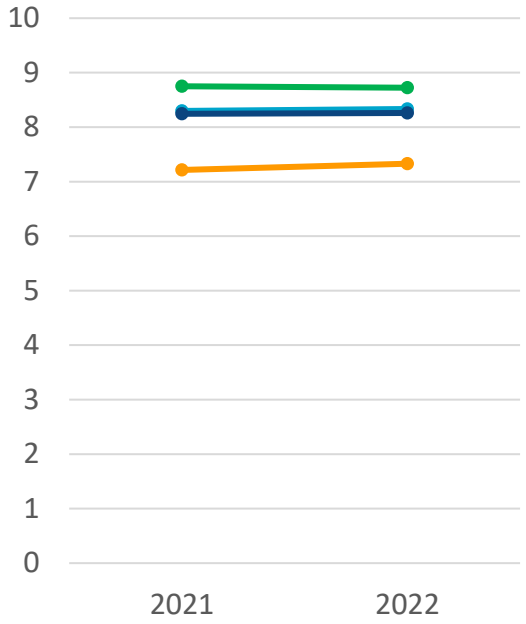
	2021	2022
Your org	7.2	7.1
Best	7.8	7.7
Average	7.2	7.2
Worst	6.3	6.2
Responses	2584	2535

Compassionate leadership



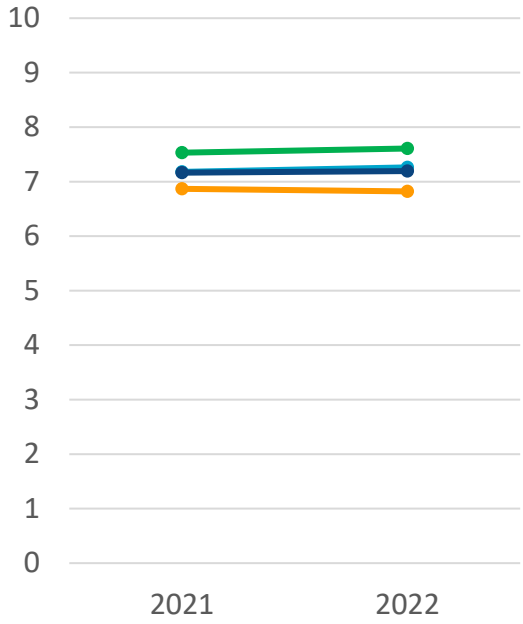
	2021	2022
Your org	7.4	7.4
Best	7.7	7.8
Average	7.4	7.4
Worst	6.9	7.2
Responses	2595	2539

Diversity and equality



	2021	2022
Your org	8.2	8.3
Best	8.7	8.7
Average	8.3	8.3
Worst	7.2	7.3
Responses	2585	2535

Inclusion



	2021	2022
Your org	7.2	7.2
Best	7.5	7.6
Average	7.2	7.3
Worst	6.9	6.8
Responses	2556	2528

People Promise Elements and Themes: Trends

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

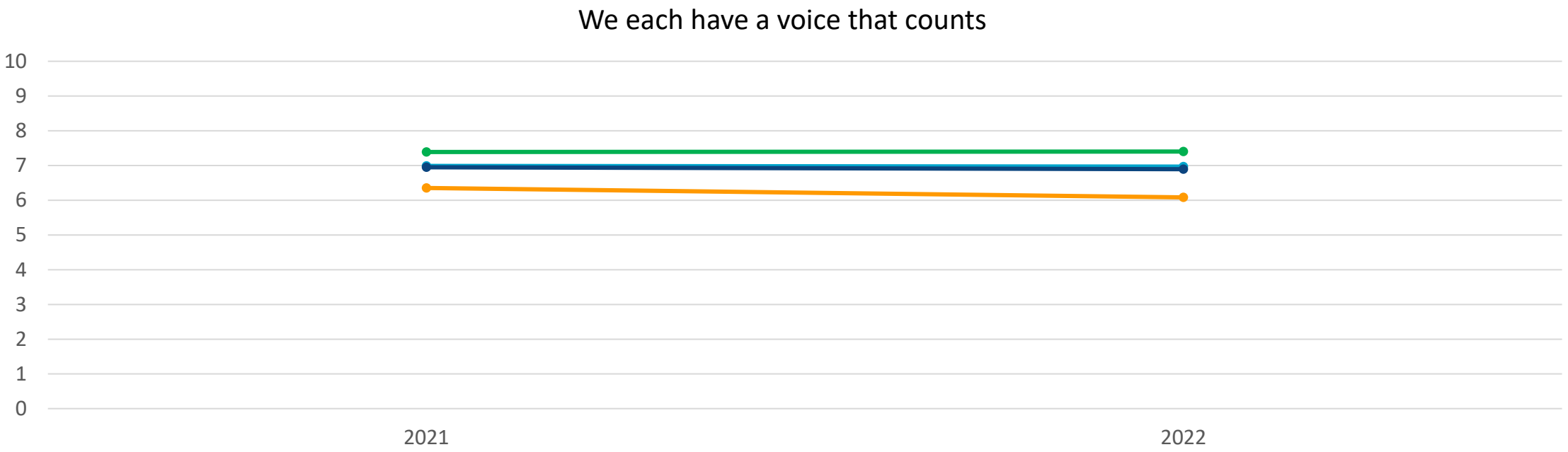
Promise element 2: We are recognised and rewarded

	2021	2022
Your org	6.3	6.2
Best	6.8	6.6
Average	6.3	6.3
Worst	5.9	5.9
Responses	2582	2531

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts

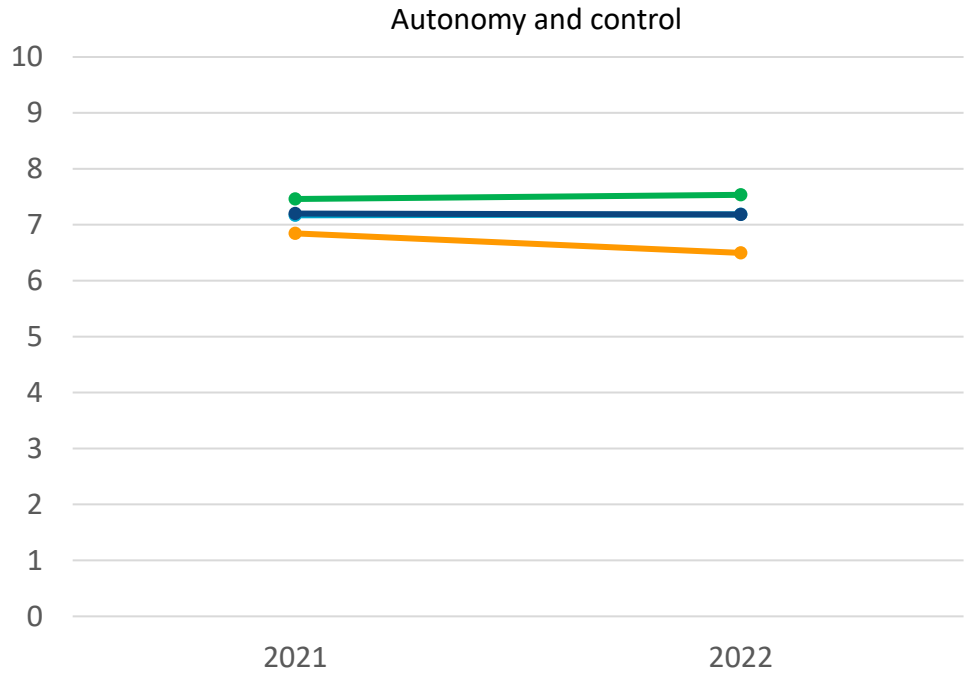


	2021	2022
Your org	6.9	6.9
Best	7.4	7.4
Average	7.0	7.0
Worst	6.4	6.1
Responses	2565	2518

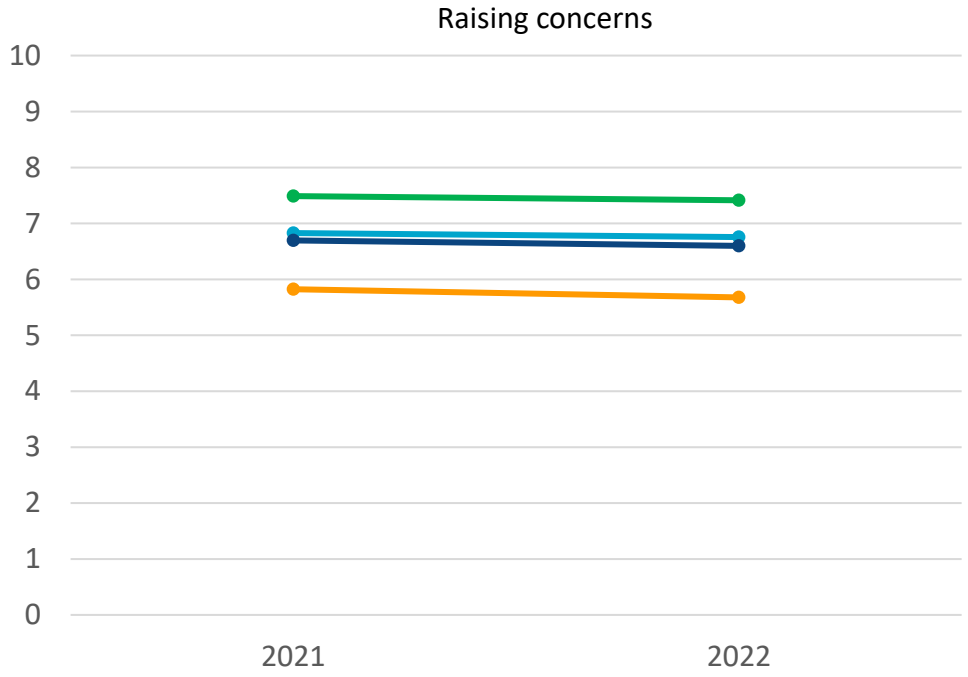
People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022
Your org	7.2	7.2
Best	7.5	7.5
Average	7.2	7.2
Worst	6.8	6.5
Responses	2594	2538

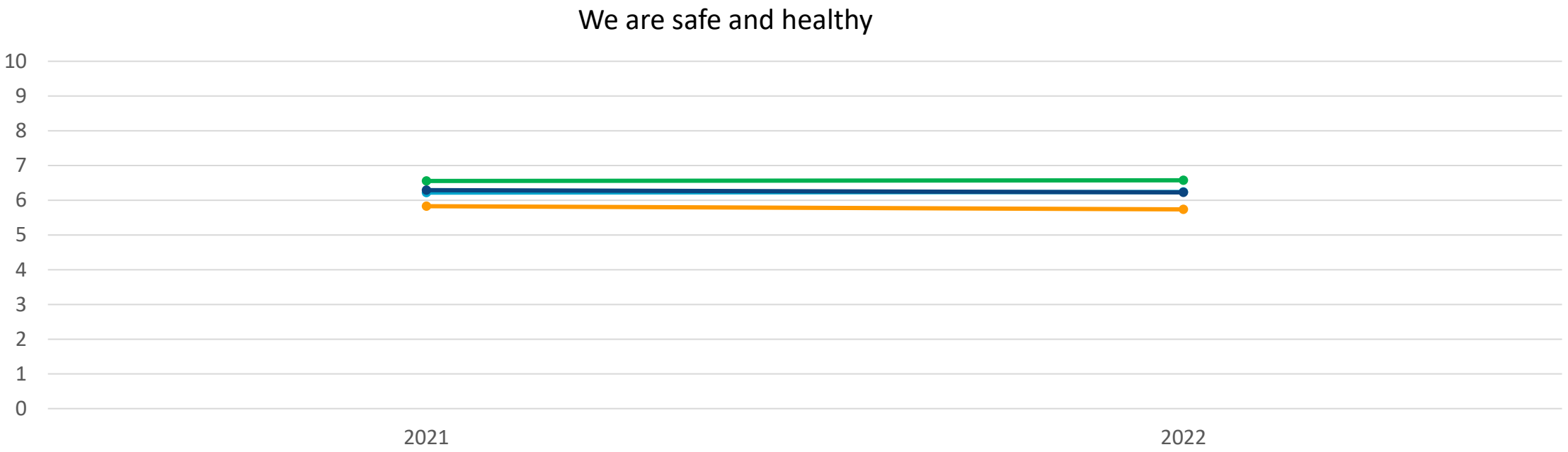


	2021	2022
Your org	6.7	6.6
Best	7.5	7.4
Average	6.8	6.8
Worst	5.8	5.7
Responses	2571	2526

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



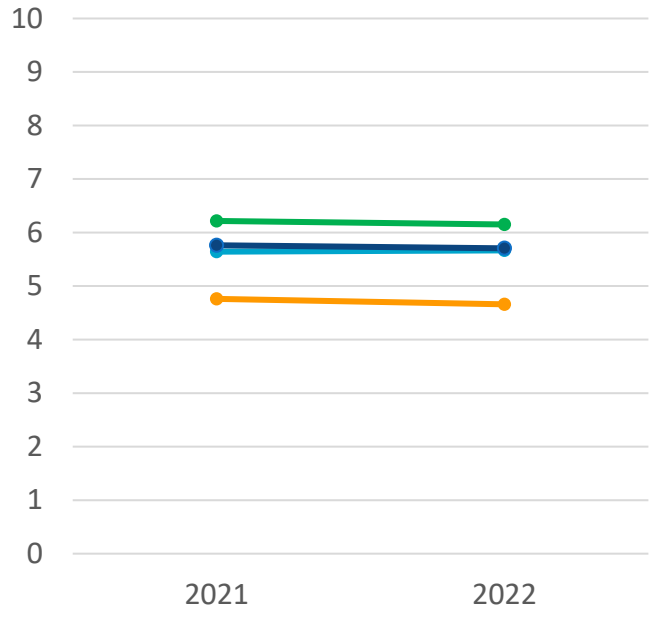
	2021	2022
Your org	6.3	6.2
Best	6.6	6.6
Average	6.2	6.2
Worst	5.8	5.7
Responses	2576	2528

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

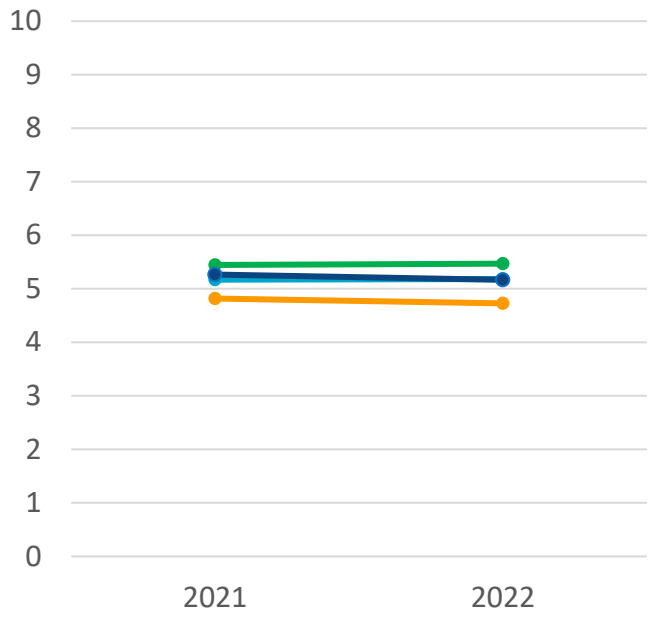
Promise element 4: We are safe and healthy

Health and safety climate



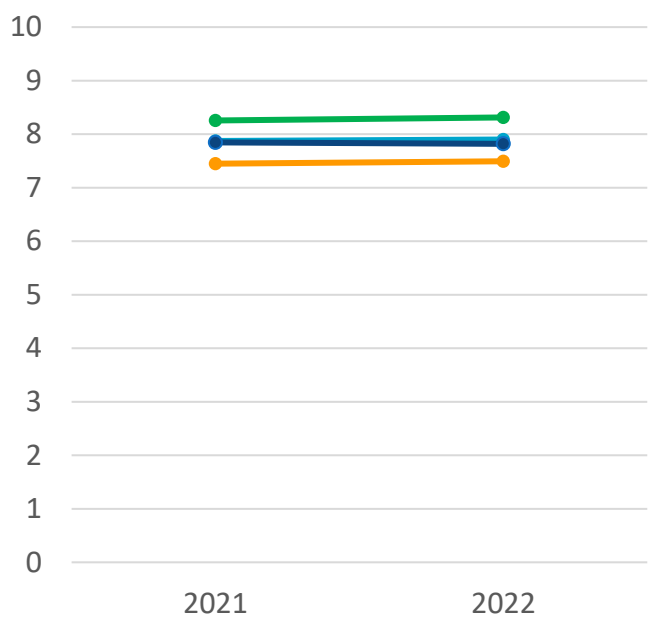
	2021	2022
Your org	5.8	5.7
Best	6.2	6.2
Average	5.6	5.7
Worst	4.8	4.7
Responses	2595	2538

Burnout



	2021	2022
Your org	5.3	5.2
Best	5.4	5.5
Average	5.2	5.2
Worst	4.8	4.7
Responses	2596	2542

Negative experiences

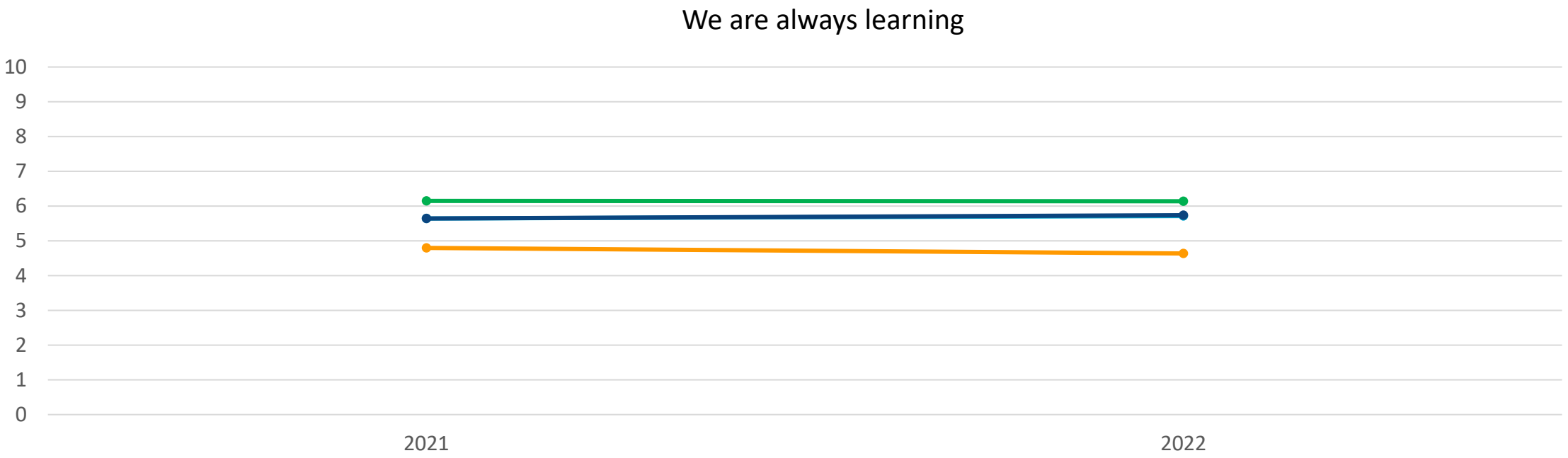


	2021	2022
Your org	7.8	7.8
Best	8.3	8.3
Average	7.9	7.9
Worst	7.4	7.5
Responses	2584	2537

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning



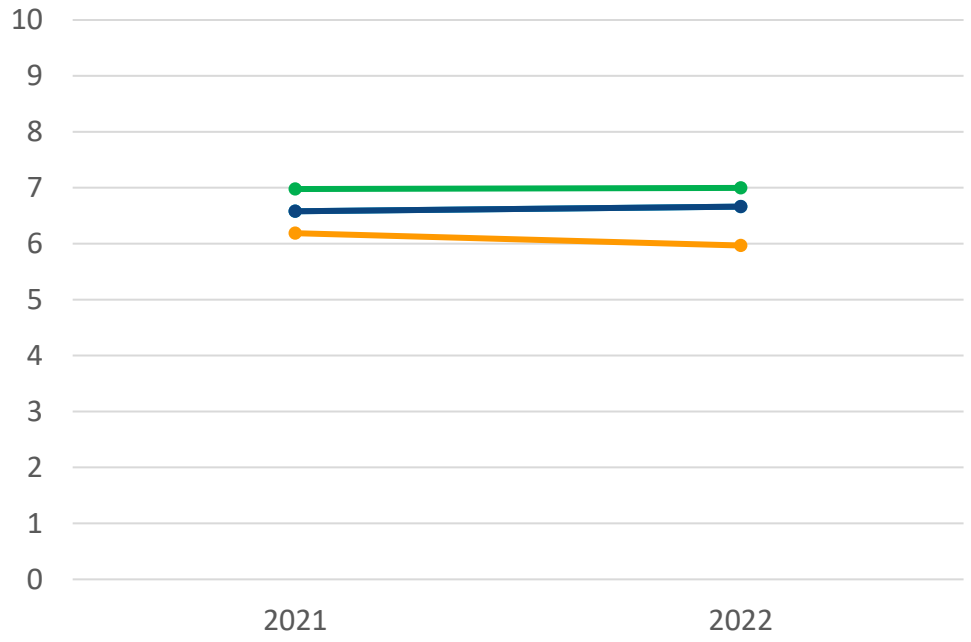
	2021	2022
Your org	5.6	5.7
Best	6.1	6.1
Average	5.6	5.7
Worst	4.8	4.6
Responses	2433	2411

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

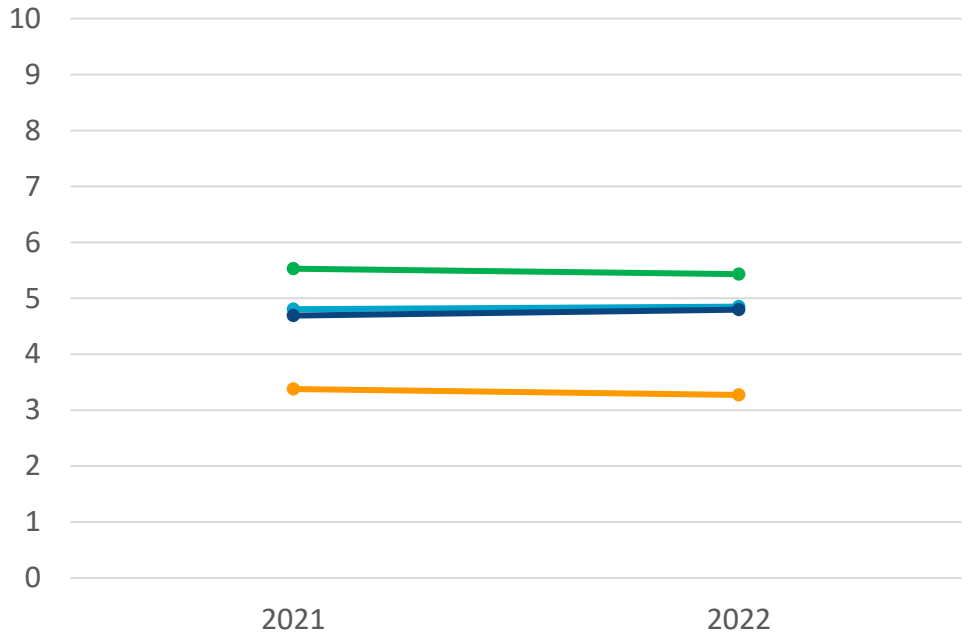
Promise element 5: We are always learning

Development



	2021	2022
Your org	6.6	6.7
Best	7.0	7.0
Average	6.6	6.7
Worst	6.2	6.0
Responses	2583	2537

Appraisals

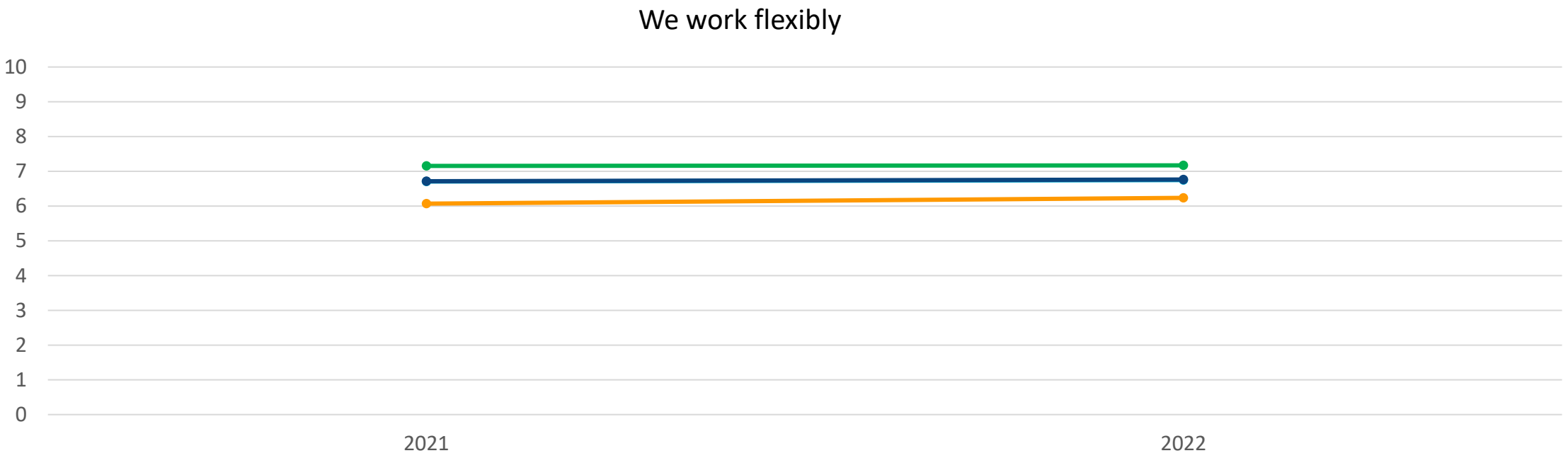


	2021	2022
Your org	4.7	4.8
Best	5.5	5.4
Average	4.8	4.9
Worst	3.4	3.3
Responses	2438	2416

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



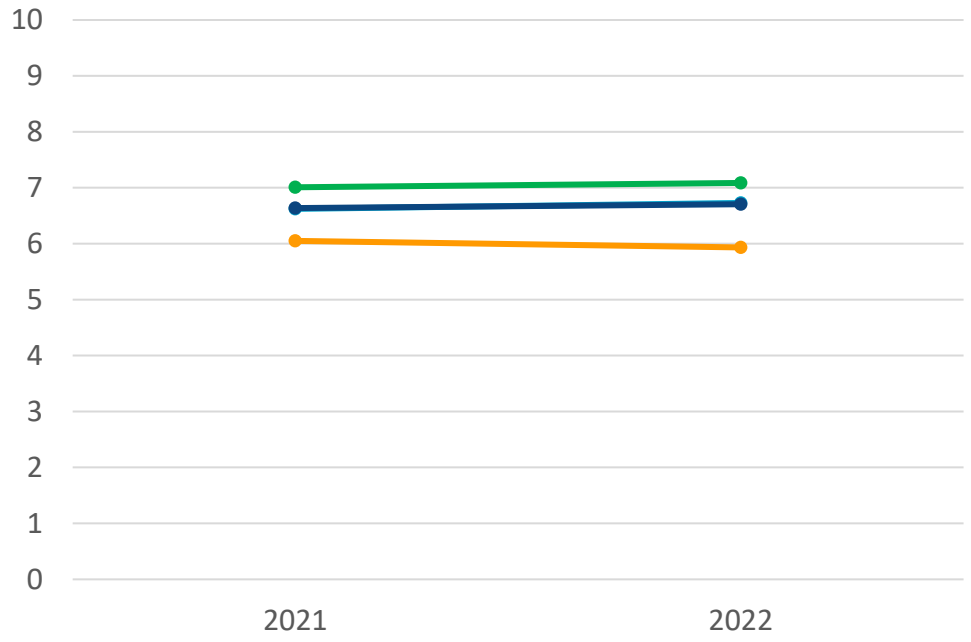
	2021	2022
Your org	6.7	6.8
Best	7.2	7.2
Average	6.7	6.7
Worst	6.1	6.2
Responses	2568	2522

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

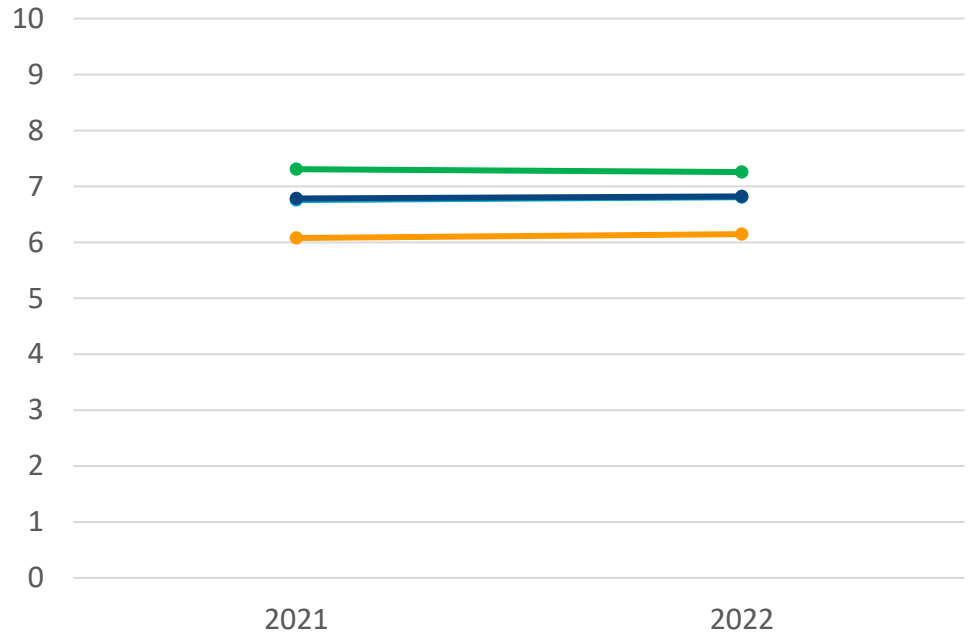
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022
Your org	6.6	6.7
Best	7.0	7.1
Average	6.6	6.7
Worst	6.0	5.9
Responses	2592	2541

Flexible working

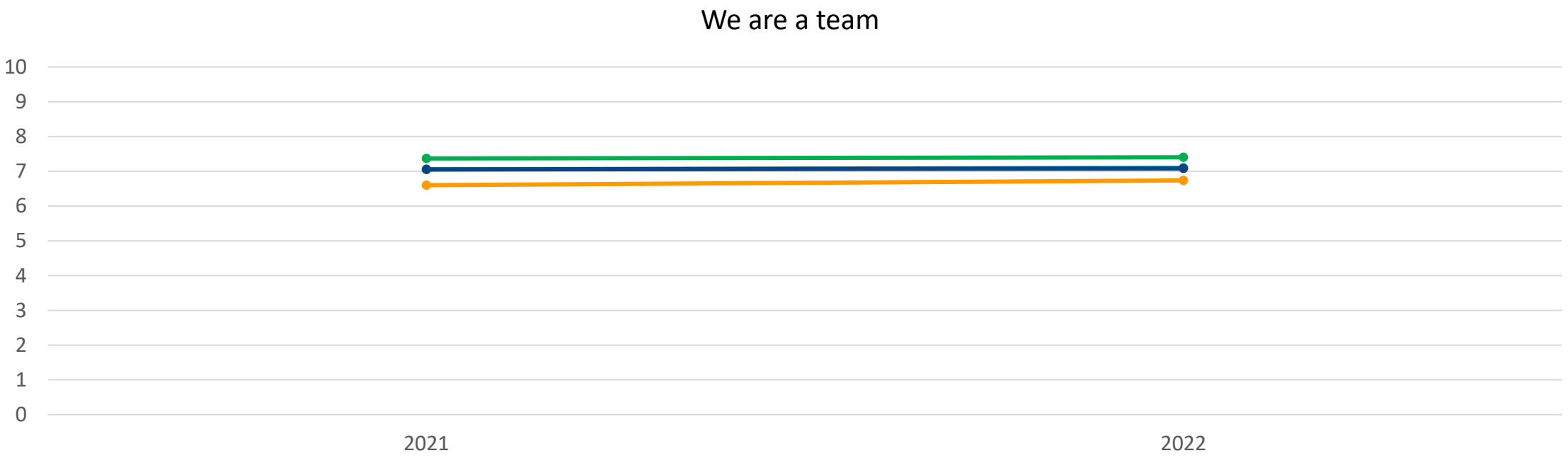


	2021	2022
Your org	6.8	6.8
Best	7.3	7.3
Average	6.8	6.8
Worst	6.1	6.1
Responses	2573	2524

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



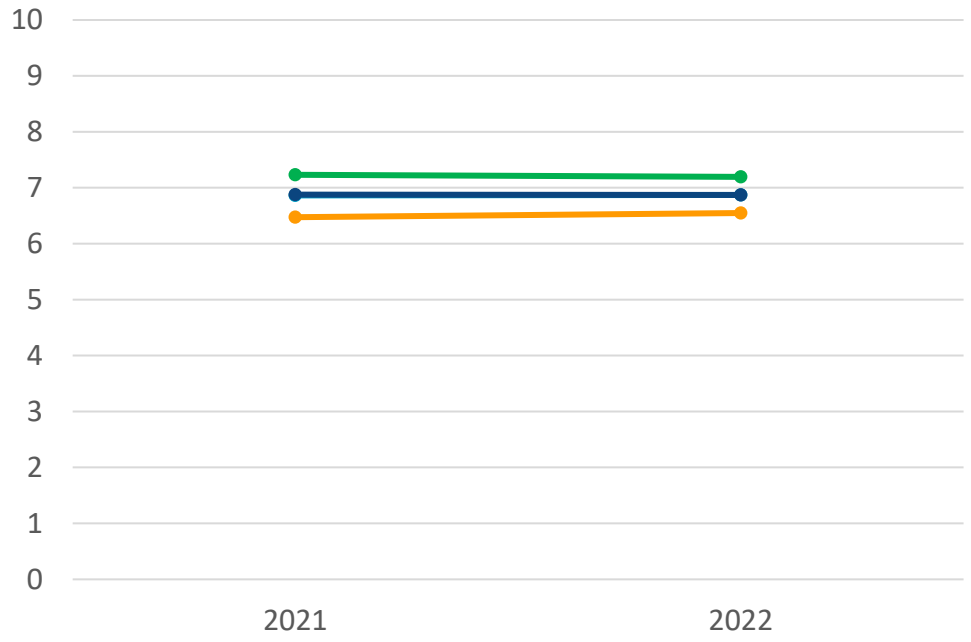
	2021	2022
Your org	7.1	7.1
Best	7.4	7.4
Average	7.1	7.1
Worst	6.6	6.7
Responses	2575	2535

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

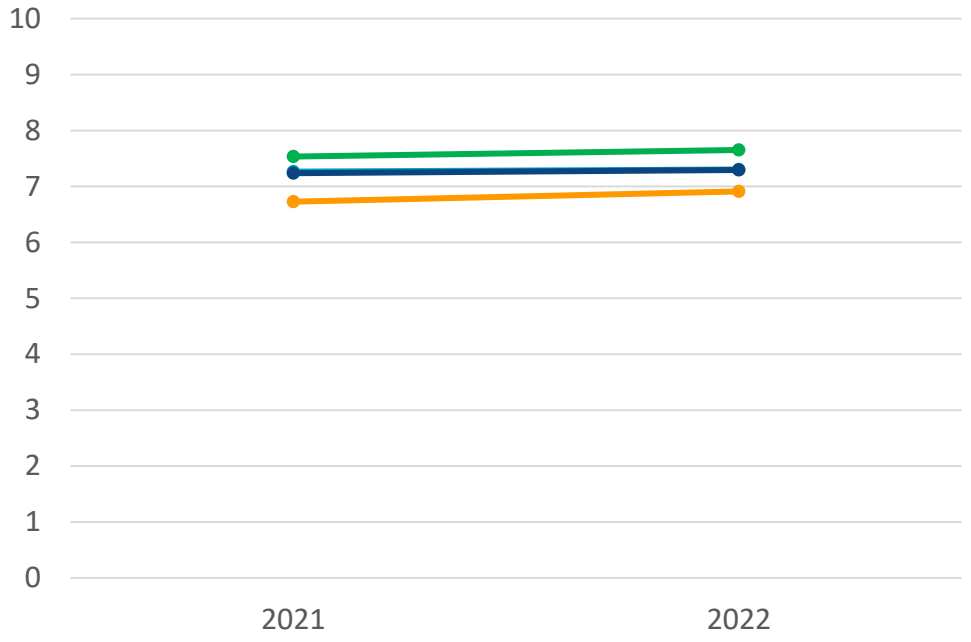
Promise element 7: We are a team

Team working



	2021	2022
Your org	6.9	6.9
Best	7.2	7.2
Average	6.9	6.9
Worst	6.5	6.5
Responses	2579	2539

Line management

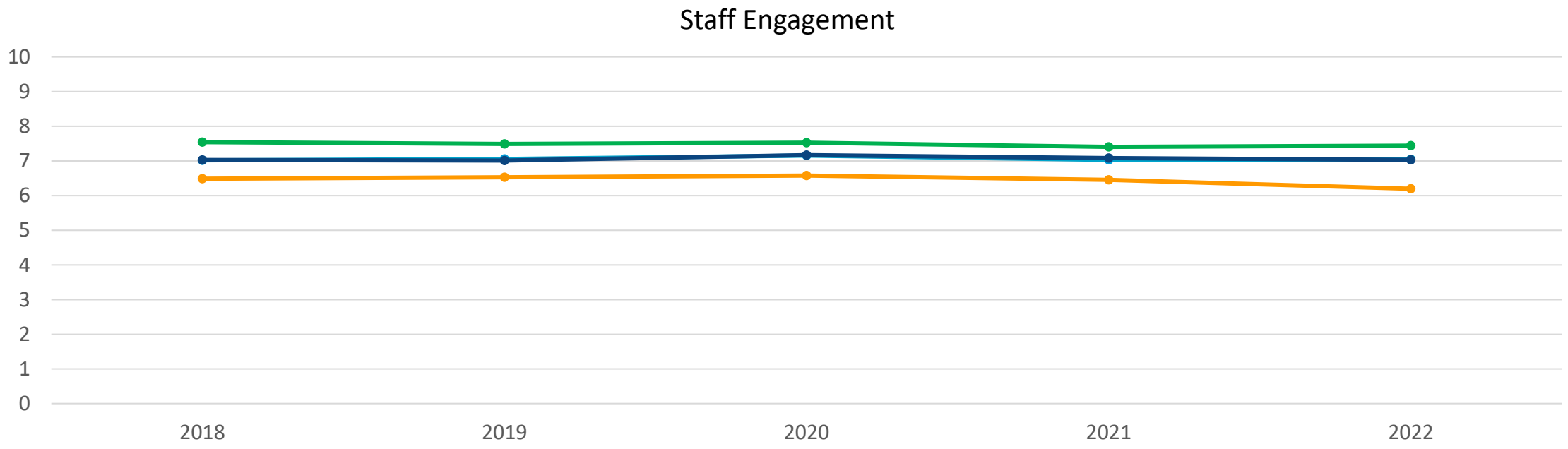


	2021	2022
Your org	7.2	7.3
Best	7.5	7.7
Average	7.3	7.3
Worst	6.7	6.9
Responses	2593	2540

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



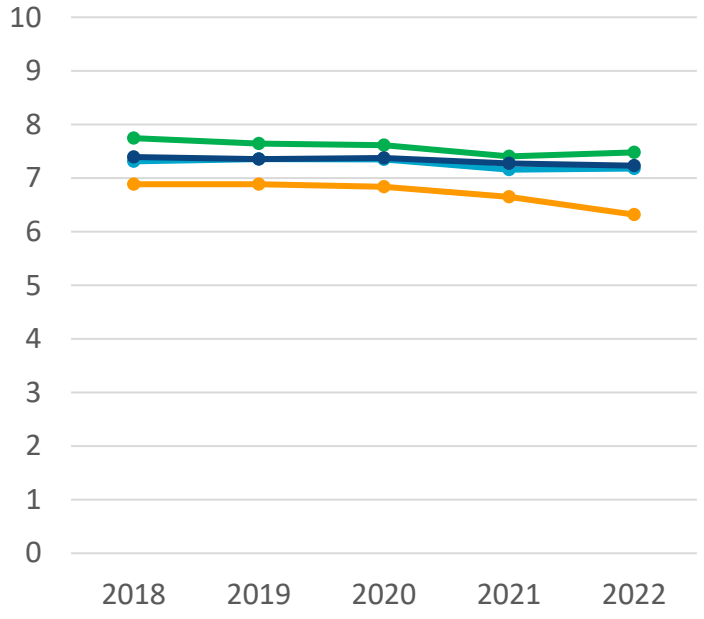
	2018	2019	2020	2021	2022
Your org	7.0	7.0	7.2	7.1	7.0
Best	7.5	7.5	7.5	7.4	7.4
Average	7.0	7.1	7.2	7.0	7.0
Worst	6.5	6.5	6.6	6.5	6.2
Responses	2106	2273	2303	2594	2538

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

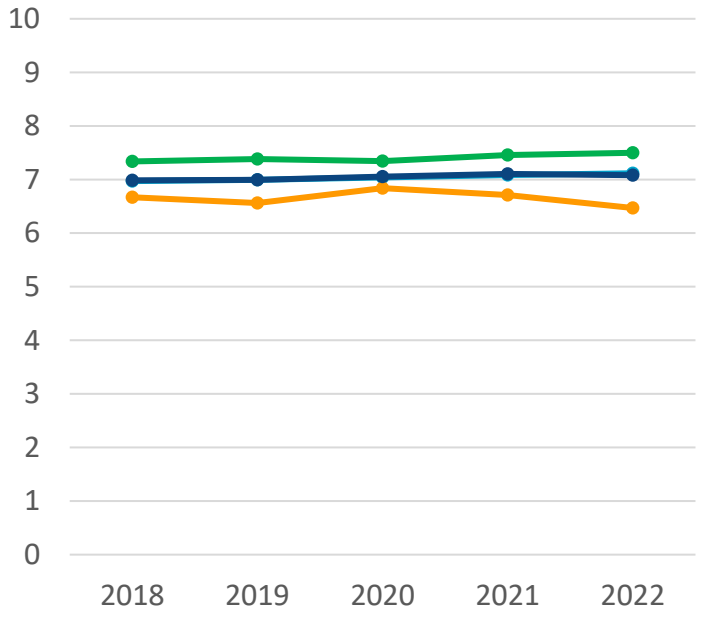
Theme: Staff Engagement

Motivation



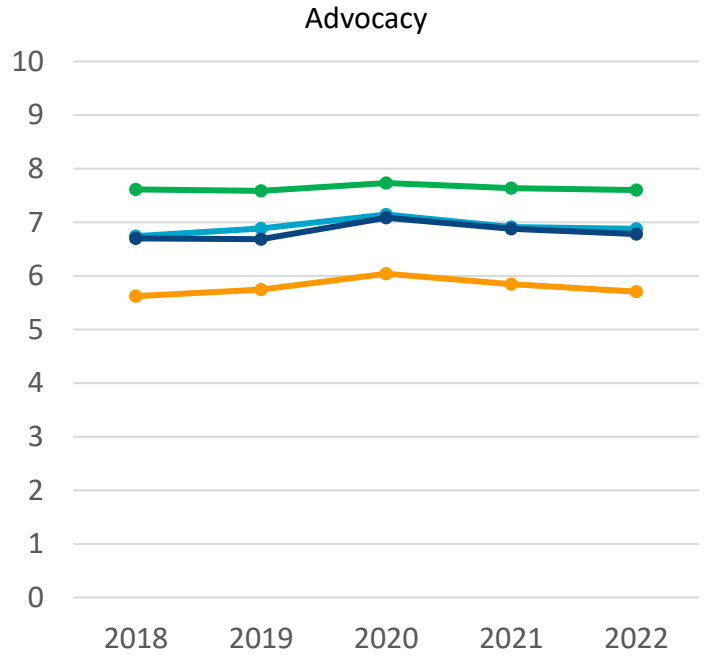
	2018	2019	2020	2021	2022
Your org	7.4	7.4	7.4	7.3	7.2
Best	7.7	7.6	7.6	7.4	7.5
Average	7.3	7.4	7.3	7.2	7.2
Worst	6.9	6.9	6.8	6.6	6.3
Responses	2095	2244	2283	2555	2491

Involvement



	2018	2019	2020	2021	2022
Your org	7.0	7.0	7.1	7.1	7.1
Best	7.3	7.4	7.3	7.5	7.5
Average	7.0	7.0	7.0	7.1	7.1
Worst	6.7	6.6	6.8	6.7	6.5
Responses	2104	2274	2301	2594	2537

Advocacy

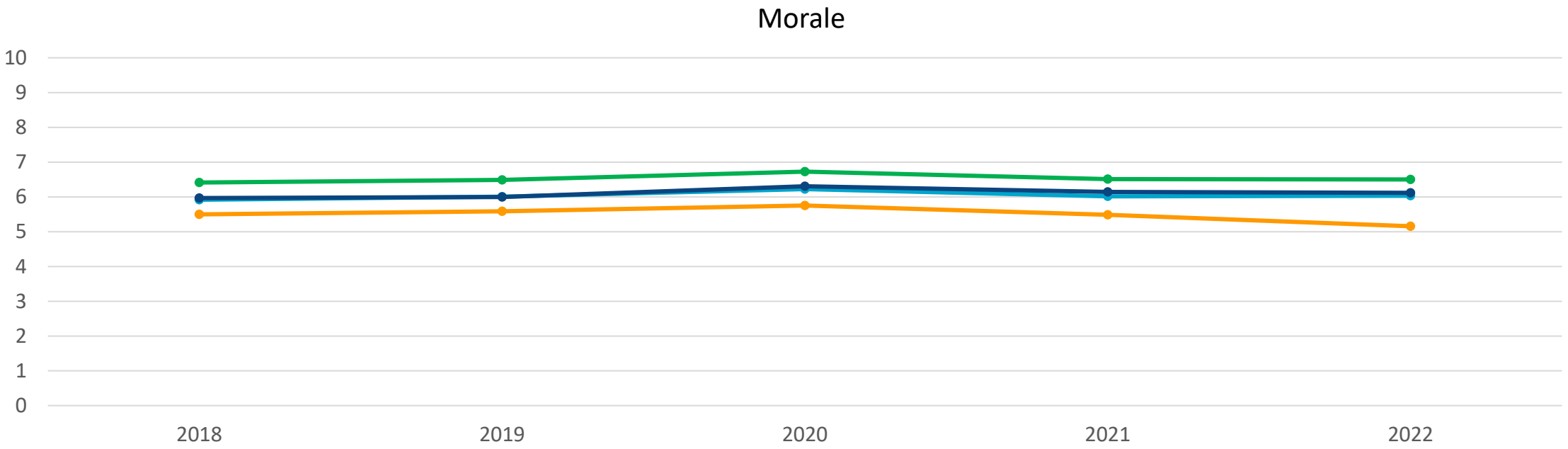


	2018	2019	2020	2021	2022
Your org	6.7	6.7	7.1	6.9	6.8
Best	7.6	7.6	7.7	7.6	7.6
Average	6.7	6.9	7.1	6.9	6.9
Worst	5.6	5.7	6.0	5.8	5.7
Responses	2069	2234	2291	2583	2533

People Promise Elements and Themes: Trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



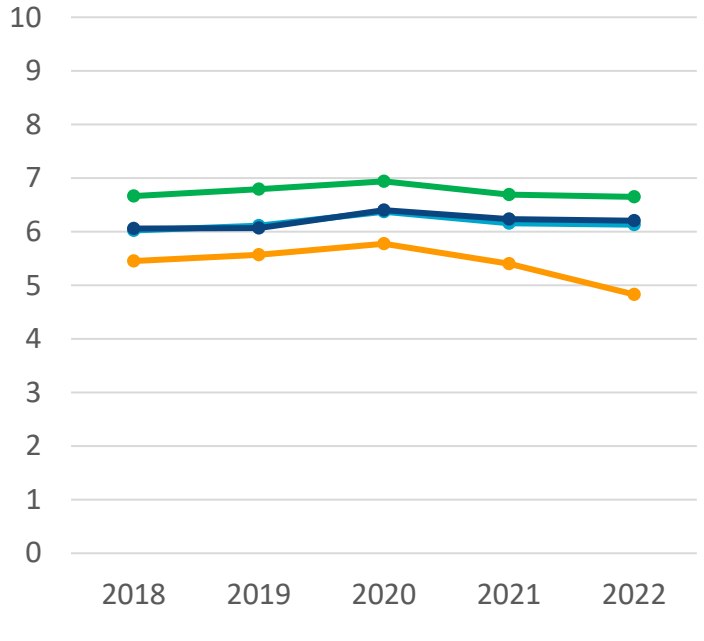
	2018	2019	2020	2021	2022
Your org	6.0	6.0	6.3	6.1	6.1
Best	6.4	6.5	6.7	6.5	6.5
Average	5.9	6.0	6.2	6.0	6.0
Worst	5.5	5.6	5.8	5.5	5.2
Responses	2103	2274	2303	2597	2540

People Promise Elements, Themes and Sub-scores: Sub-score trends

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

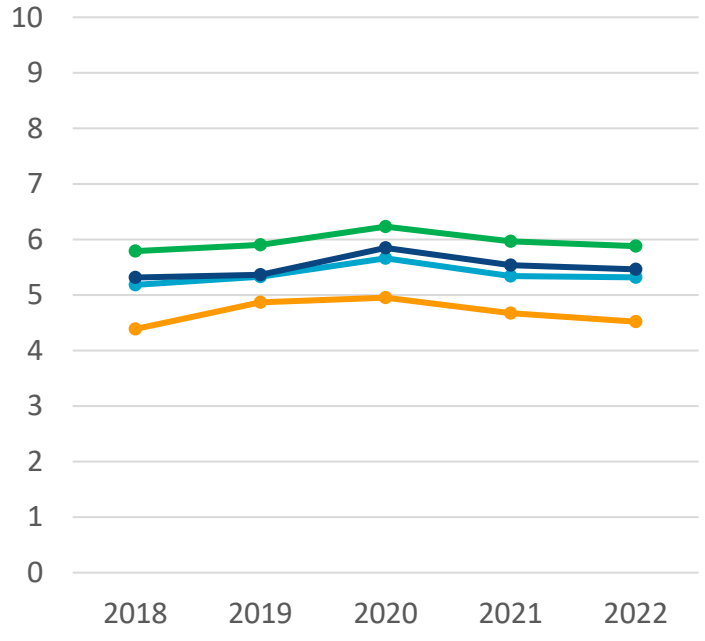
Theme: Morale

Thinking about leaving



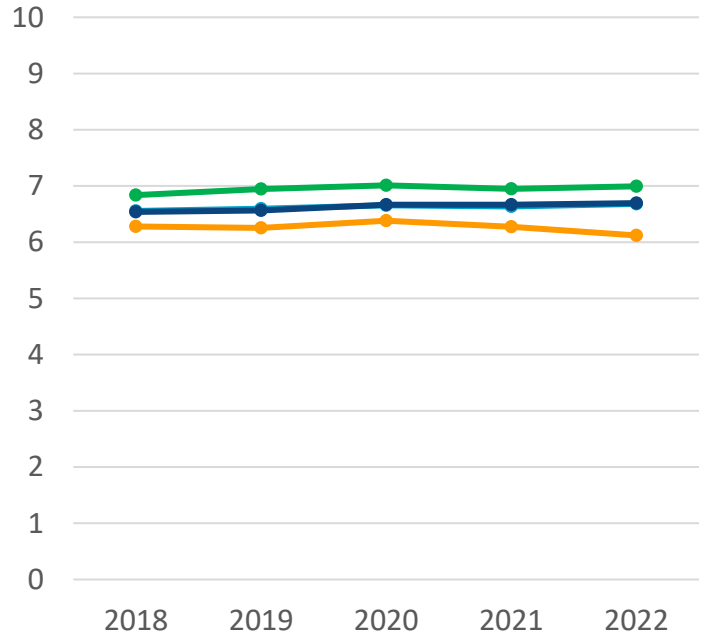
	2018	2019	2020	2021	2022
Your org	6.1	6.1	6.4	6.2	6.2
Best	6.7	6.8	6.9	6.7	6.6
Average	6.0	6.1	6.4	6.2	6.1
Worst	5.5	5.6	5.8	5.4	4.8
Responses	2069	2238	2296	2585	2539

Work pressure



	2018	2019	2020	2021	2022
Your org	5.3	5.4	5.8	5.5	5.5
Best	5.8	5.9	6.2	6.0	5.9
Average	5.2	5.3	5.7	5.3	5.3
Worst	4.4	4.9	5.0	4.7	4.5
Responses	2104	2272	2299	2593	2537

Stressors



	2018	2019	2020	2021	2022
Your org	6.5	6.6	6.7	6.7	6.7
Best	6.8	6.9	7.0	6.9	7.0
Average	6.6	6.6	6.7	6.6	6.7
Worst	6.3	6.3	6.4	6.3	6.1
Responses	2071	2246	2275	2594	2537

Survey Coordination Centre

NHS

Covid-19 Classification breakdowns

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Covid-19 classification breakdowns

Survey Coordination Centre NHS

Covid-19 questions

In the 2022 survey, staff were asked three classification questions relating to their experience during the Covid-19 pandemic:

a. In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?	1 ☐ Yes	2 ☐ No
b. In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?	1 ☐ Yes	2 ☐ No
c. In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?	1 ☐ Yes	2 ☐ No

The charts on the following pages show the breakdown of People Promise elements scores for staff answering 'yes' to each of these questions, compared with the results for all staff at your organisation. Results are presented in the context of highest, average and lowest scores for similar organisations.

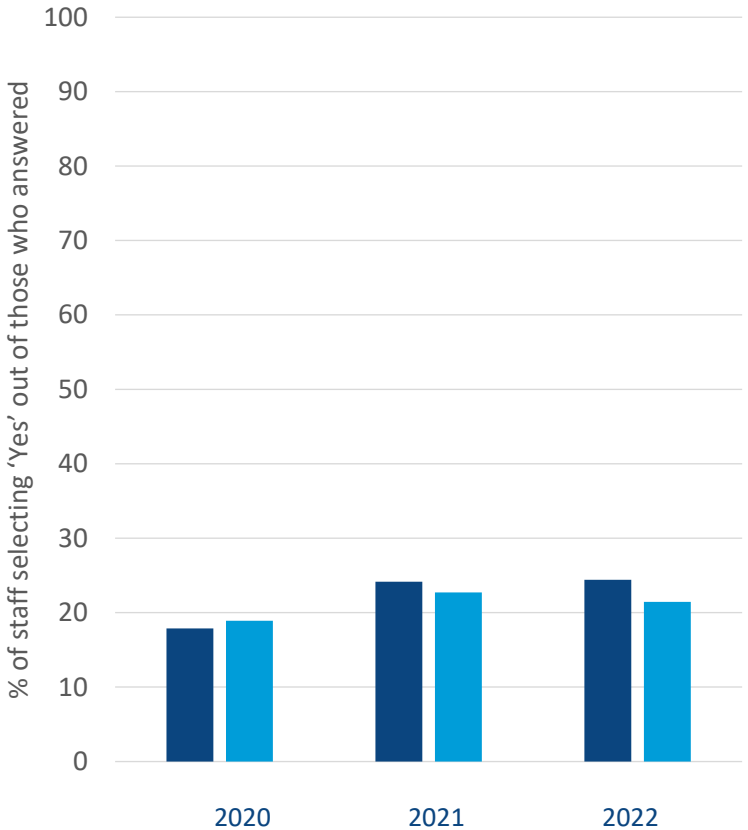
Comparing your data

To improve overall comparability, the data have been weighted to match the occupation group profile of staff at your organisation to that of the benchmarking group, as in previous charts. However, there may be differences in the occupation group profiles of the individual COVID-19 subgroups. For example, the mix of occupational groups across redeployed staff at your organisation may differ from similar organisations. This difference would not be accounted for by the weighting and therefore may affect the comparability of trend results. As such, a degree of caution is advised when interpreting your results.

Further information

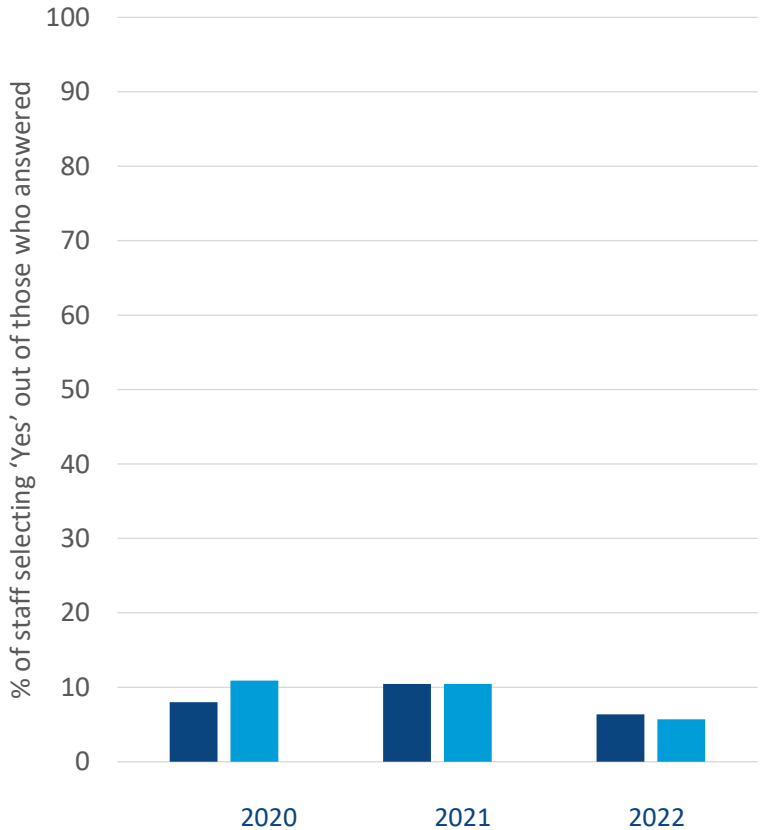
Results for these groups of staff, including data for individual questions, are also available via the online dashboards. Please note that results presented in these dashboards have not been weighted where no benchmarking takes place and so may vary slightly from those shown in this report.

Q25a In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?



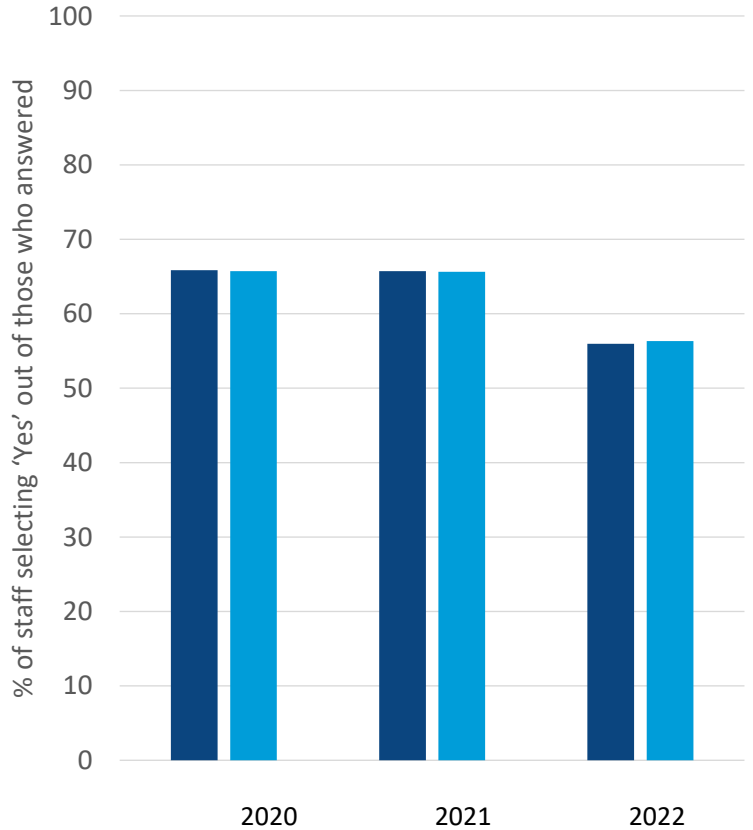
	2020	2021	2022
Your org	17.9%	24.2%	24.4%
Average	18.9%	22.7%	21.4%
Responses	2298	2579	2536

Q25b In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?



	2020	2021	2022
Your org	8.0%	10.4%	6.4%
Average	10.9%	10.4%	5.7%
Responses	2274	2559	2530

Q25c In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?

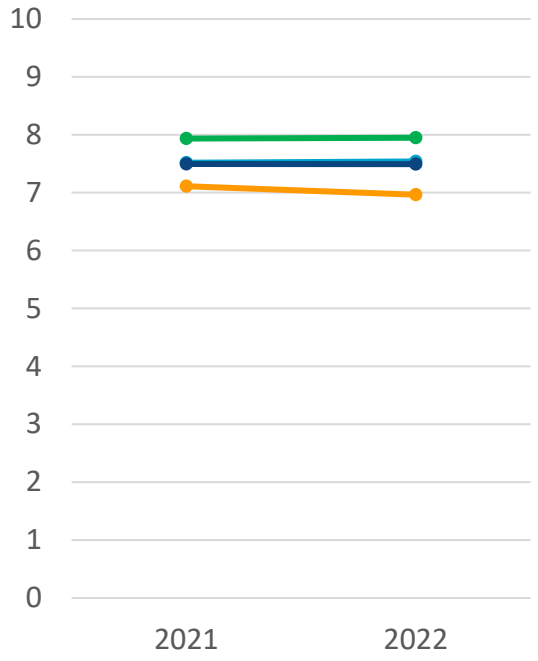


	2020	2021	2022
Your org	65.9%	65.7%	56.0%
Average	65.7%	65.6%	56.3%
Responses	2282	2576	2530

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

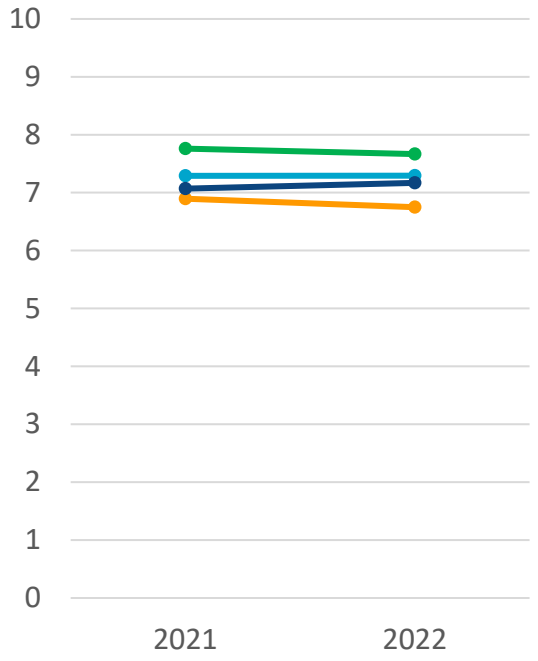
Promise element 1: We are compassionate and inclusive

All staff



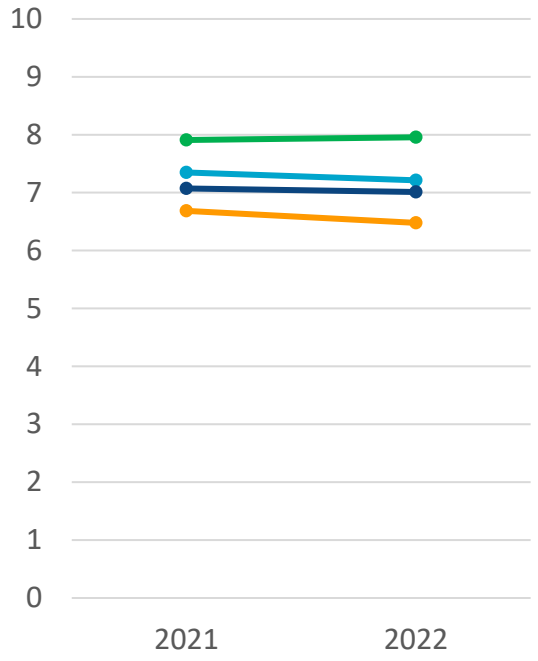
	2021	2022
Your org	7.5	7.5
Highest	7.9	7.9
Average	7.5	7.5
Lowest	7.1	7.0
Responses	2594	2541

Worked on a Covid-19 ward or specific area



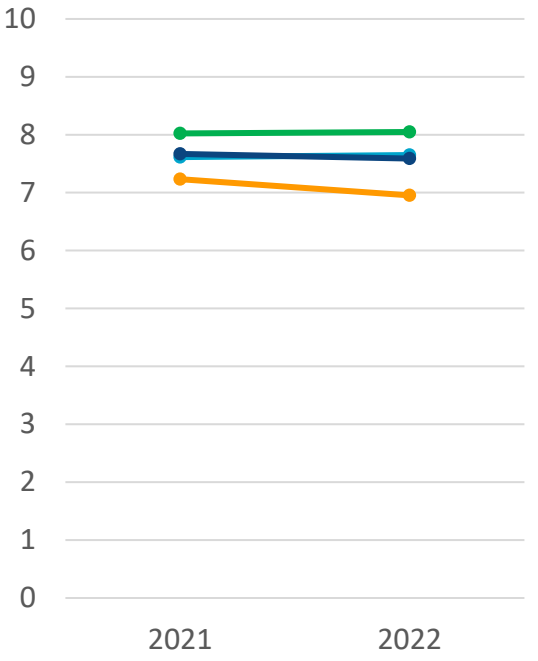
	2021	2022
Your org	7.1	7.2
Highest	7.8	7.7
Average	7.3	7.3
Lowest	6.9	6.7
Responses	622	616

Redeployed



	2021	2022
Your org	7.1	7.0
Highest	7.9	8.0
Average	7.3	7.2
Lowest	6.7	6.5
Responses	267	161

Required to work remotely / from home

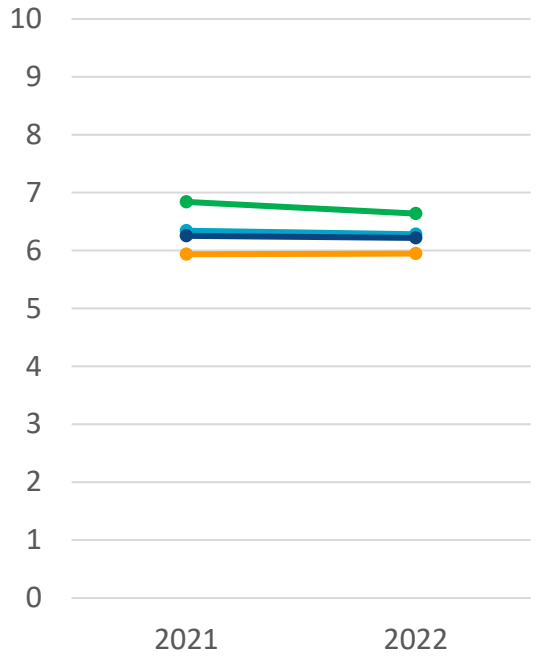


	2021	2022
Your org	7.7	7.6
Highest	8.0	8.0
Average	7.6	7.6
Lowest	7.2	7.0
Responses	1693	1415

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

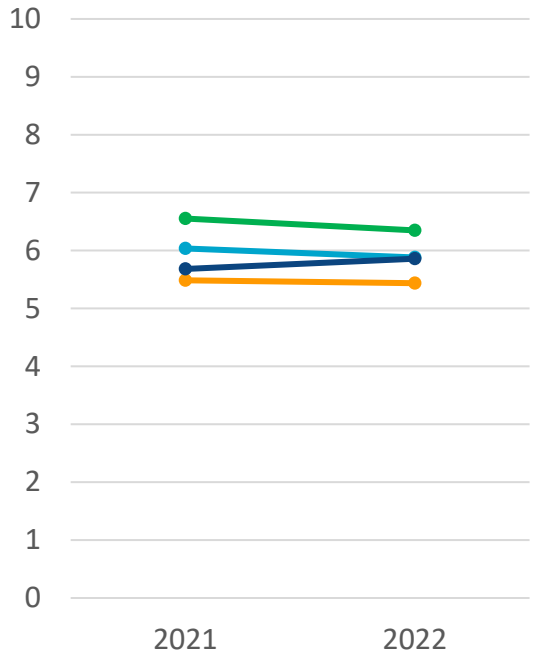
Promise element 2: We are recognised and rewarded

All staff



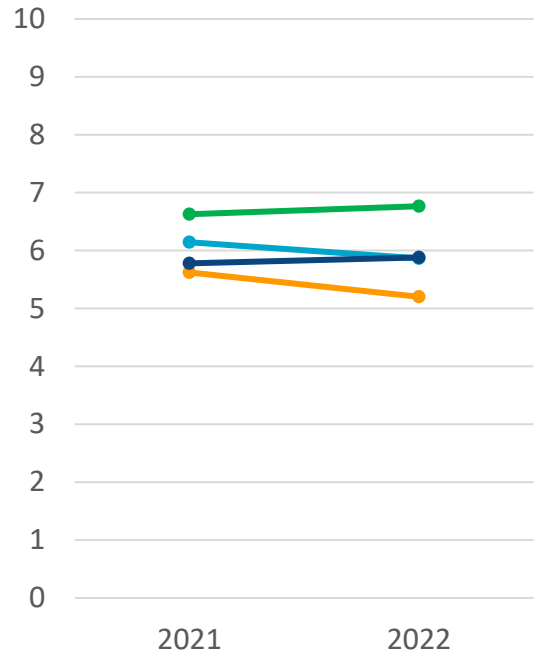
	2021	2022
Your org	6.3	6.2
Highest	6.8	6.6
Average	6.3	6.3
Lowest	5.9	5.9
Responses	2582	2531

Worked on a Covid-19 ward or specific area



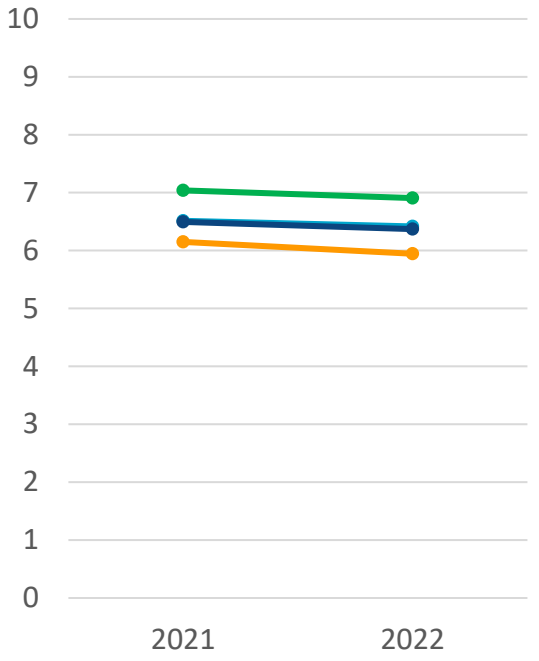
	2021	2022
Your org	5.7	5.9
Highest	6.6	6.3
Average	6.0	5.9
Lowest	5.5	5.4
Responses	617	610

Redeployed



	2021	2022
Your org	5.8	5.9
Highest	6.6	6.8
Average	6.1	5.9
Lowest	5.6	5.2
Responses	266	161

Required to work remotely / from home

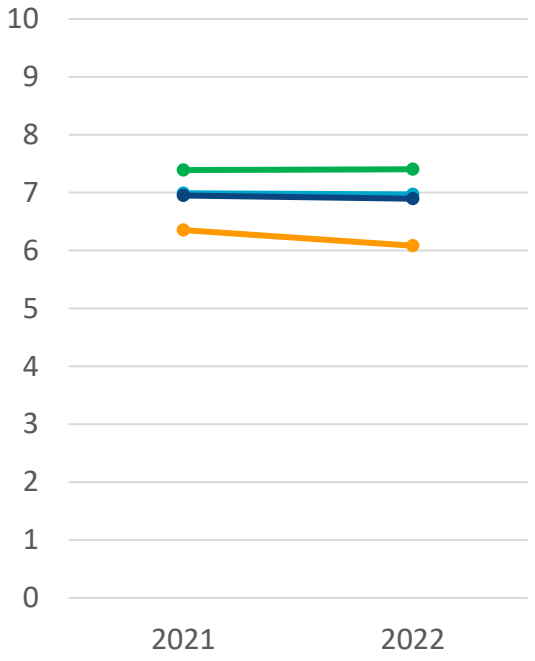


	2021	2022
Your org	6.5	6.4
Highest	7.0	6.9
Average	6.5	6.4
Lowest	6.1	5.9
Responses	1680	1408

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

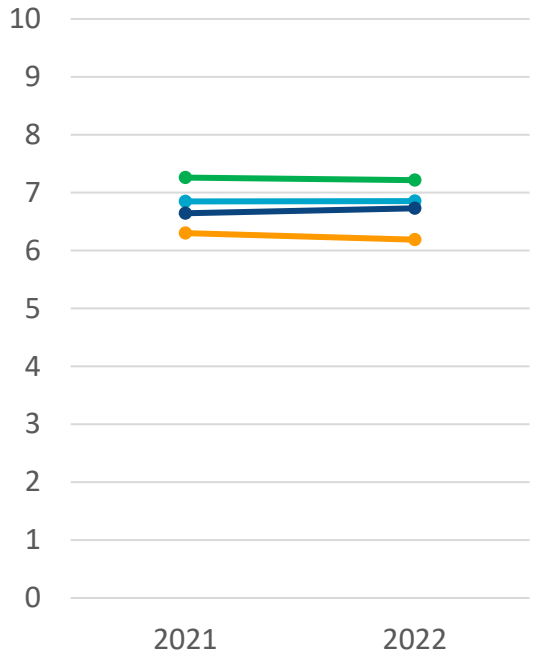
Promise element 3: We each have a voice that counts

All staff



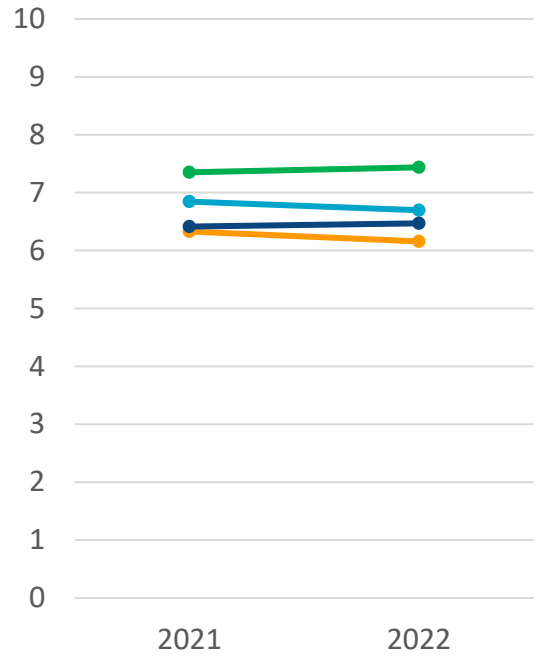
	2021	2022
Your org	6.9	6.9
Highest	7.4	7.4
Average	7.0	7.0
Lowest	6.4	6.1
Responses	2565	2518

Worked on a Covid-19 ward or specific area



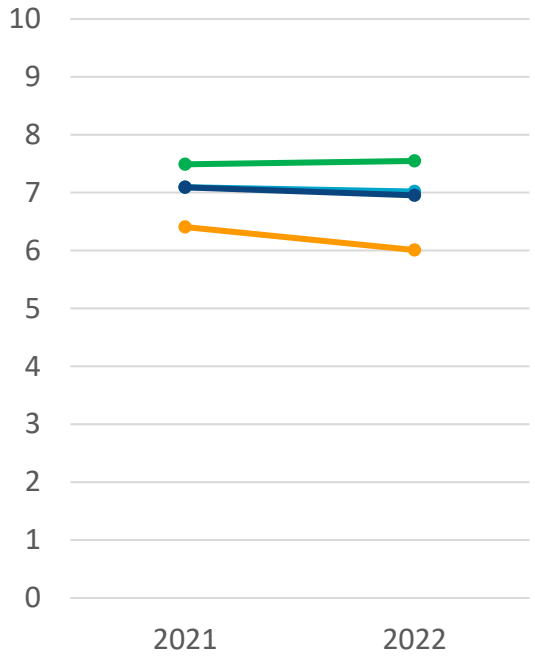
	2021	2022
Your org	6.6	6.7
Highest	7.3	7.2
Average	6.8	6.9
Lowest	6.3	6.2
Responses	616	605

Redeployed



	2021	2022
Your org	6.4	6.5
Highest	7.4	7.4
Average	6.8	6.7
Lowest	6.3	6.2
Responses	264	158

Required to work remotely / from home

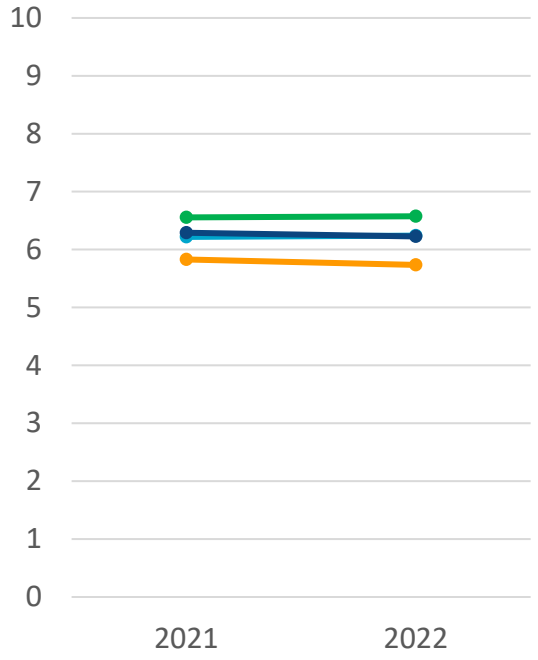


	2021	2022
Your org	7.1	7.0
Highest	7.5	7.5
Average	7.1	7.0
Lowest	6.4	6.0
Responses	1678	1400

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

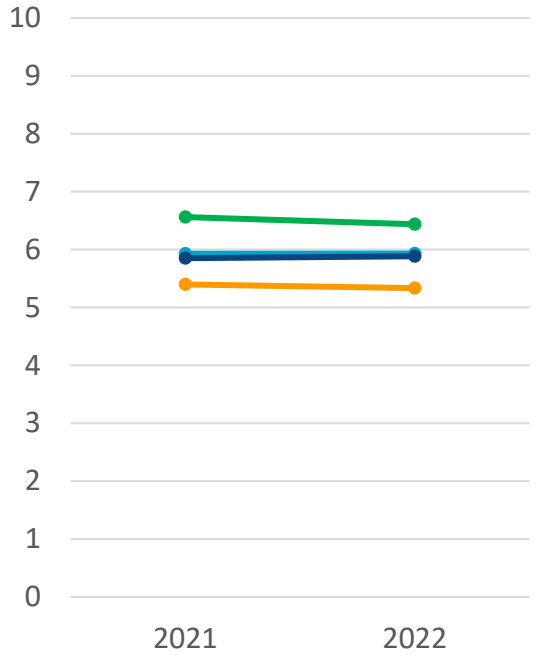
Promise element 4: We are safe and healthy

All staff



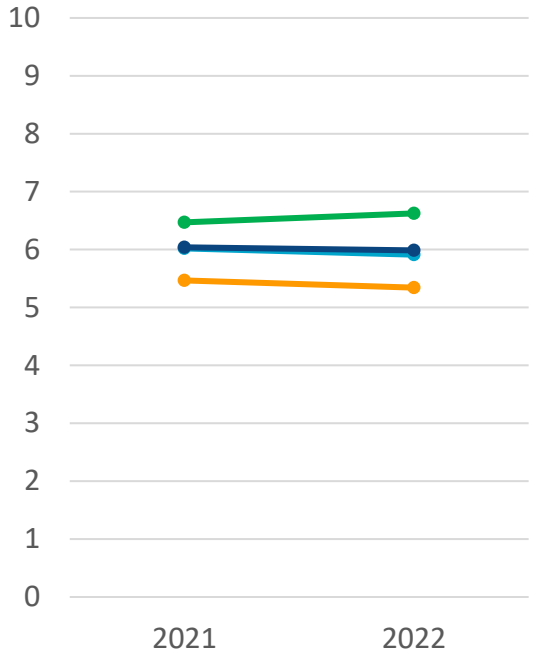
	2021	2022
Your org	6.3	6.2
Highest	6.6	6.6
Average	6.2	6.2
Lowest	5.8	5.7
Responses	2576	2528

Worked on a Covid-19 ward or specific area



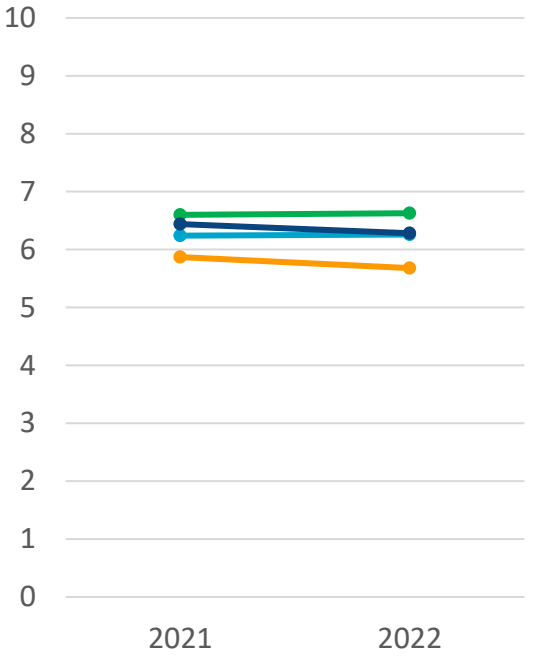
	2021	2022
Your org	5.8	5.9
Highest	6.6	6.4
Average	5.9	5.9
Lowest	5.4	5.3
Responses	615	609

Redeployed



	2021	2022
Your org	6.0	6.0
Highest	6.5	6.6
Average	6.0	5.9
Lowest	5.5	5.3
Responses	264	158

Required to work remotely / from home

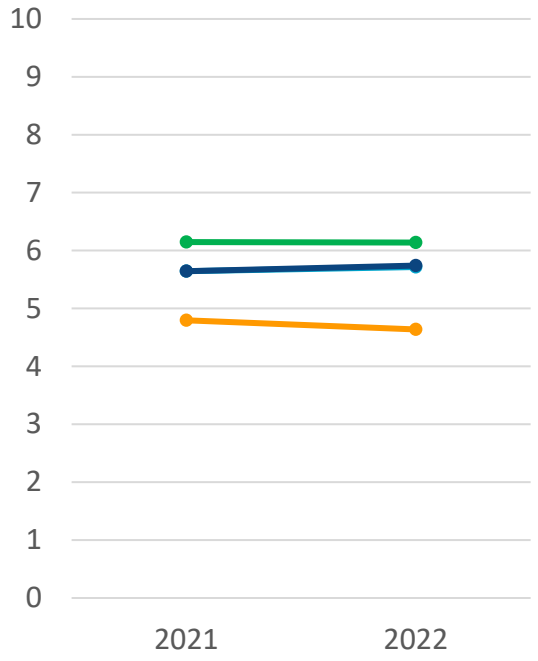


	2021	2022
Your org	6.4	6.3
Highest	6.6	6.6
Average	6.2	6.3
Lowest	5.9	5.7
Responses	1683	1410

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

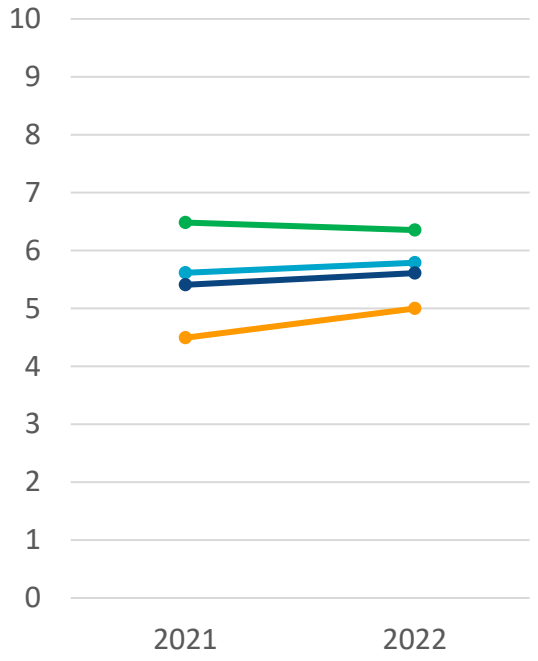
Promise element 5: We are always learning

All staff



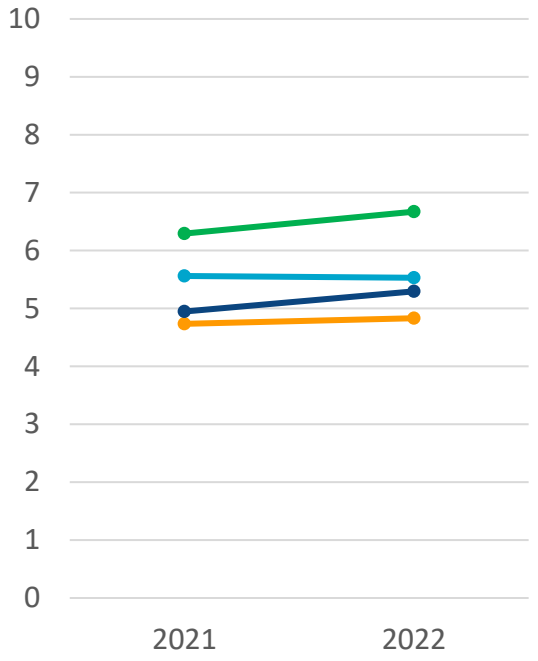
	2021	2022
Your org	5.6	5.7
Highest	6.1	6.1
Average	5.6	5.7
Lowest	4.8	4.6
Responses	2433	2411

Worked on a Covid-19 ward or specific area



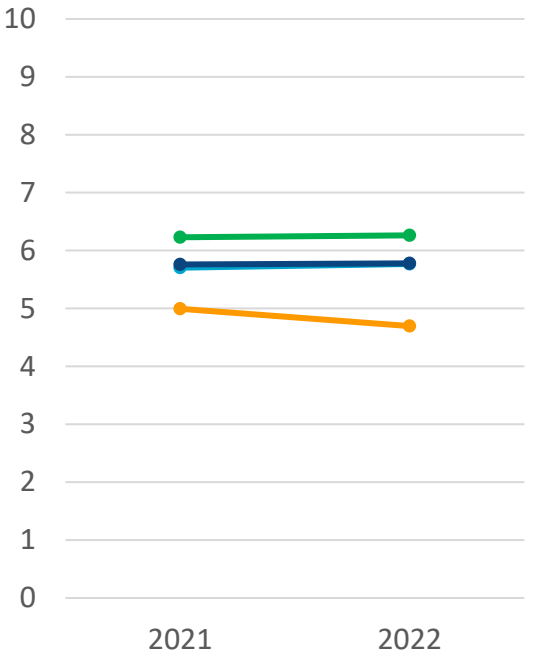
	2021	2022
Your org	5.4	5.6
Highest	6.5	6.4
Average	5.6	5.8
Lowest	4.5	5.0
Responses	575	582

Redeployed



	2021	2022
Your org	4.9	5.3
Highest	6.3	6.7
Average	5.6	5.5
Lowest	4.7	4.8
Responses	257	156

Required to work remotely / from home

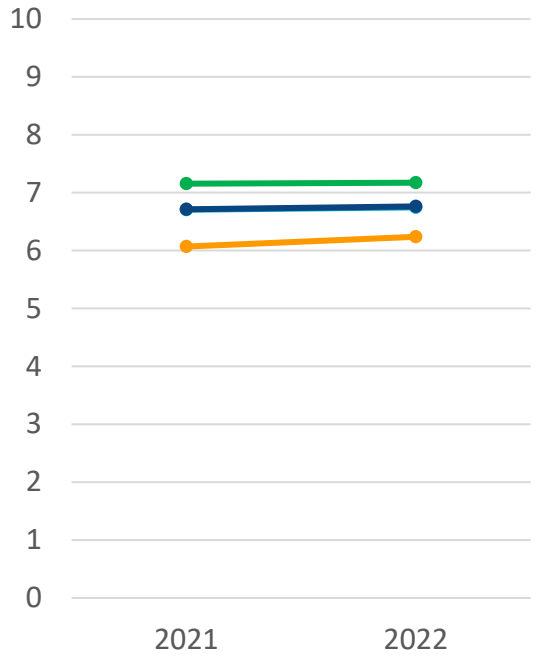


	2021	2022
Your org	5.8	5.8
Highest	6.2	6.3
Average	5.7	5.8
Lowest	5.0	4.7
Responses	1620	1352

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

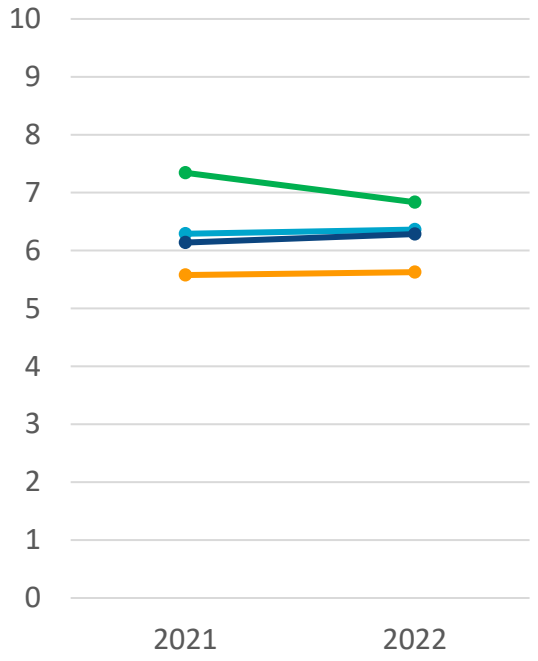
Promise element 6: We work flexibly

All staff



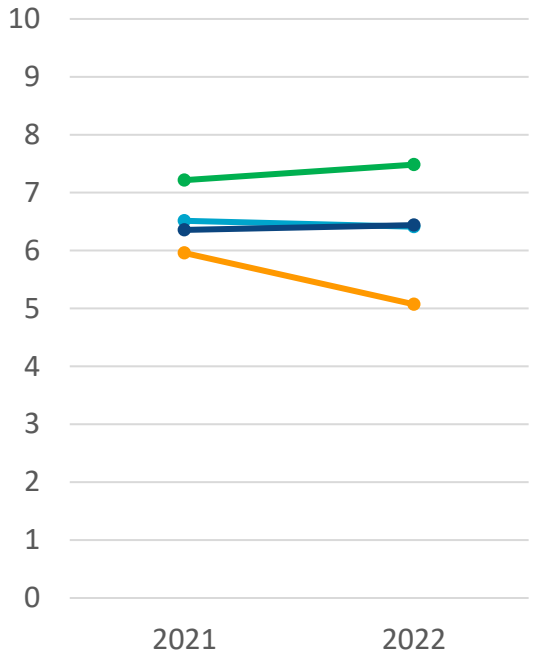
	2021	2022
Your org	6.7	6.8
Highest	7.2	7.2
Average	6.7	6.7
Lowest	6.1	6.2
Responses	2568	2522

Worked on a Covid-19 ward or specific area



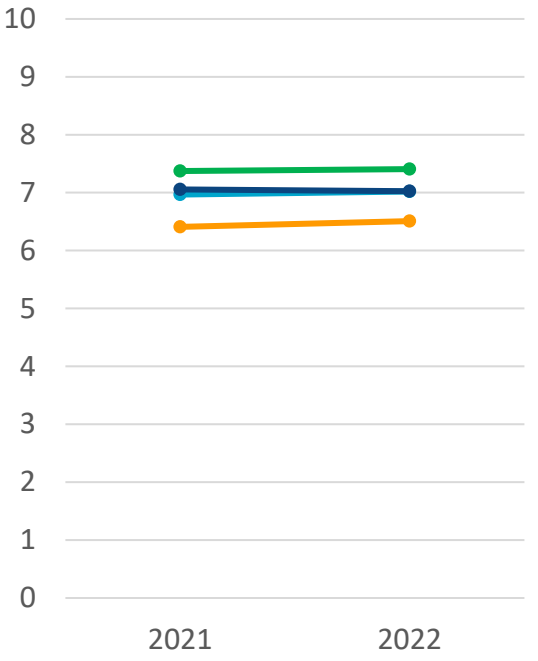
	2021	2022
Your org	6.1	6.3
Highest	7.3	6.8
Average	6.3	6.4
Lowest	5.6	5.6
Responses	614	606

Redeployed



	2021	2022
Your org	6.4	6.4
Highest	7.2	7.5
Average	6.5	6.4
Lowest	6.0	5.1
Responses	266	160

Required to work remotely / from home

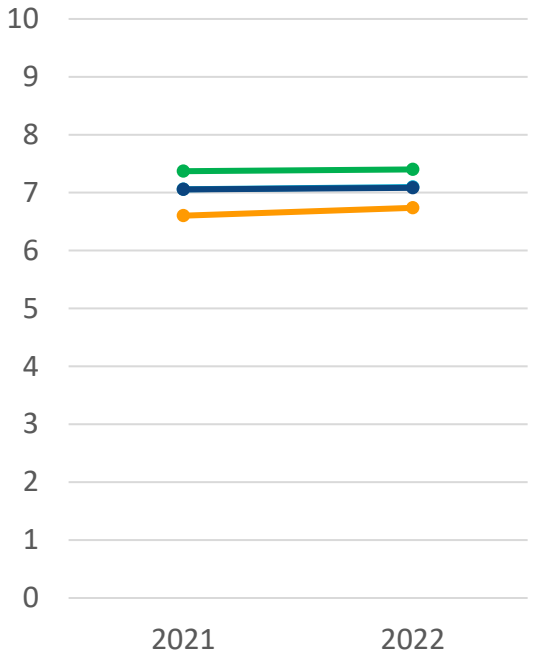


	2021	2022
Your org	7.1	7.0
Highest	7.4	7.4
Average	7.0	7.0
Lowest	6.4	6.5
Responses	1674	1405

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

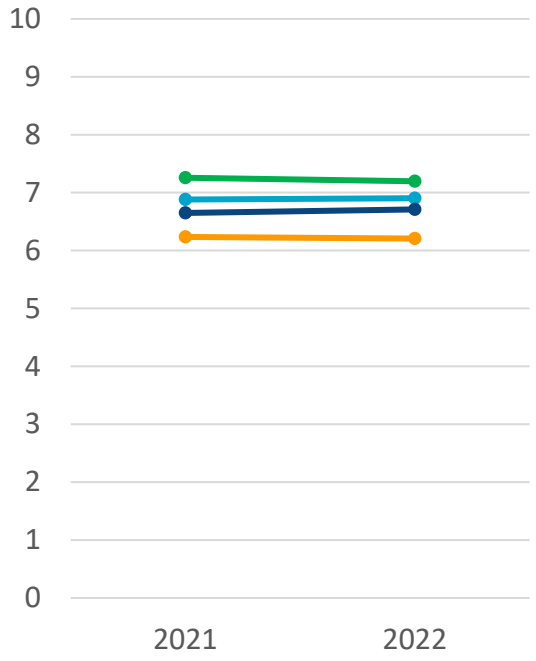
Promise element 7: We are a team

All staff



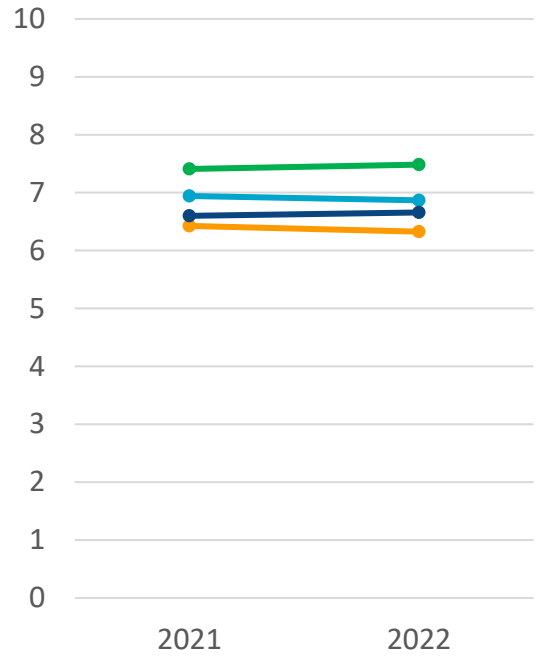
	2021	2022
Your org	7.1	7.1
Highest	7.4	7.4
Average	7.1	7.1
Lowest	6.6	6.7
Responses	2575	2535

Worked on a Covid-19 ward or specific area



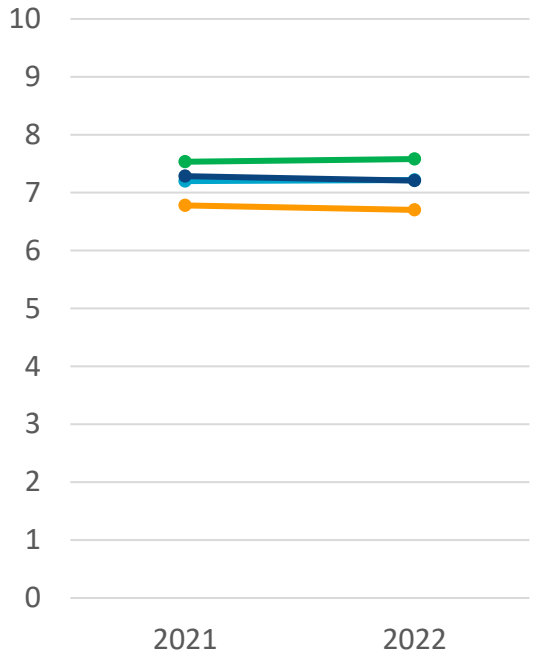
	2021	2022
Your org	6.6	6.7
Highest	7.3	7.2
Average	6.9	6.9
Lowest	6.2	6.2
Responses	615	615

Redeployed



	2021	2022
Your org	6.6	6.7
Highest	7.4	7.5
Average	6.9	6.9
Lowest	6.4	6.3
Responses	264	160

Required to work remotely / from home



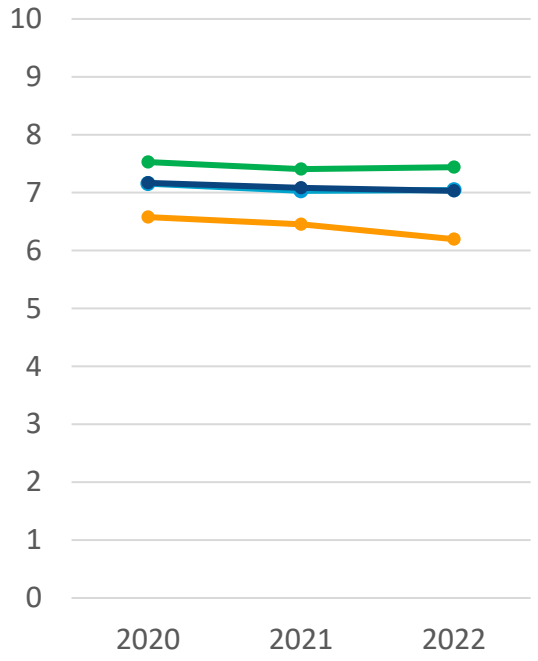
	2021	2022
Your org	7.3	7.2
Highest	7.5	7.6
Average	7.2	7.2
Lowest	6.8	6.7
Responses	1682	1412

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

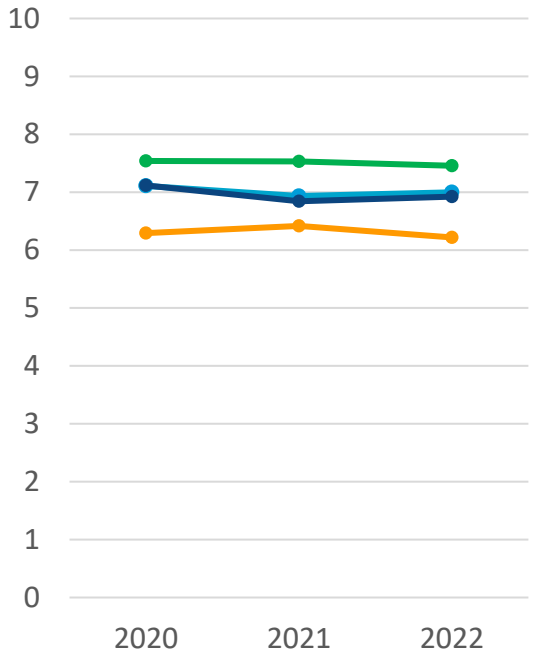
Theme: Staff Engagement

All staff



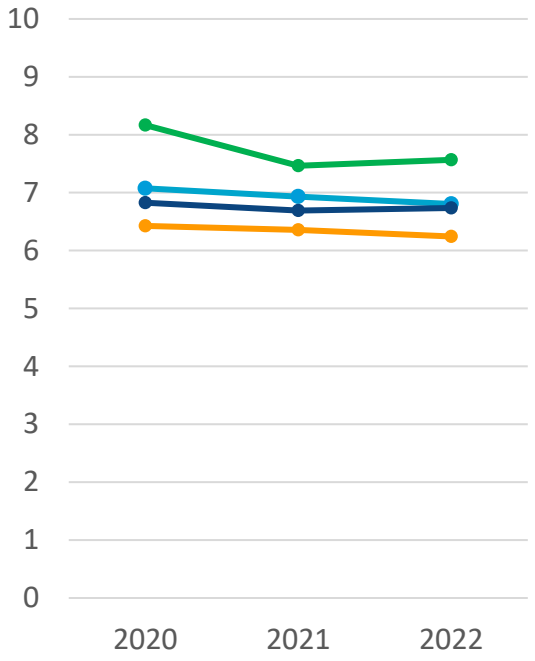
	2020	2021	2022
Your org	7.2	7.1	7.0
Highest	7.5	7.4	7.4
Average	7.2	7.0	7.0
Lowest	6.6	6.5	6.2
Responses	2303	2594	2538

Worked on Covid-19 specific ward or area



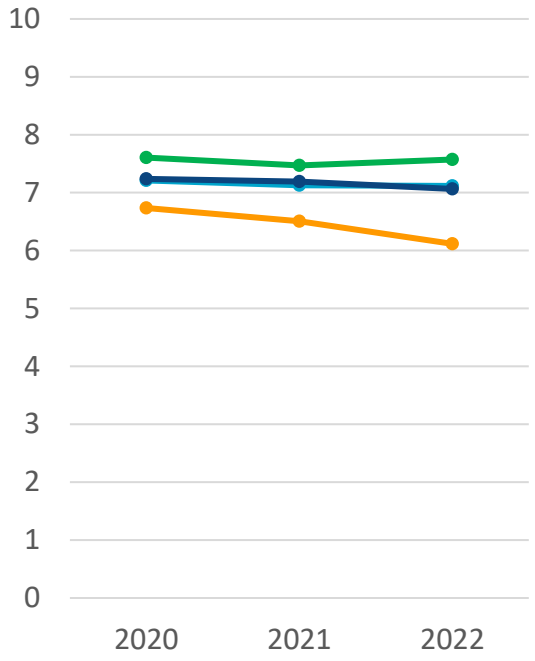
	2020	2021	2022
Your org	7.1	6.8	6.9
Highest	7.5	7.5	7.5
Average	7.1	6.9	7.0
Lowest	6.3	6.4	6.2
Responses	410	621	612

Redeployed



	2020	2021	2022
Your org	6.8	6.7	6.7
Highest	8.2	7.5	7.6
Average	7.1	6.9	6.8
Lowest	6.4	6.4	6.2
Responses	182	266	159

Required to work remotely / from home



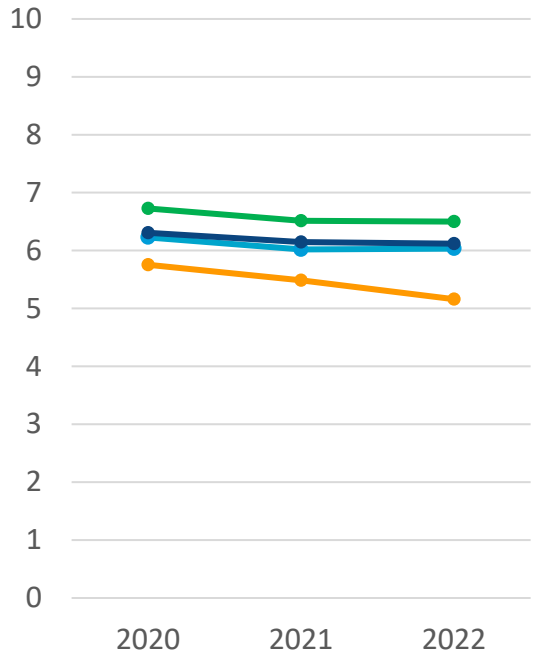
	2020	2021	2022
Your org	7.2	7.2	7.1
Highest	7.6	7.5	7.6
Average	7.2	7.1	7.1
Lowest	6.7	6.5	6.1
Responses	1503	1691	1414

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

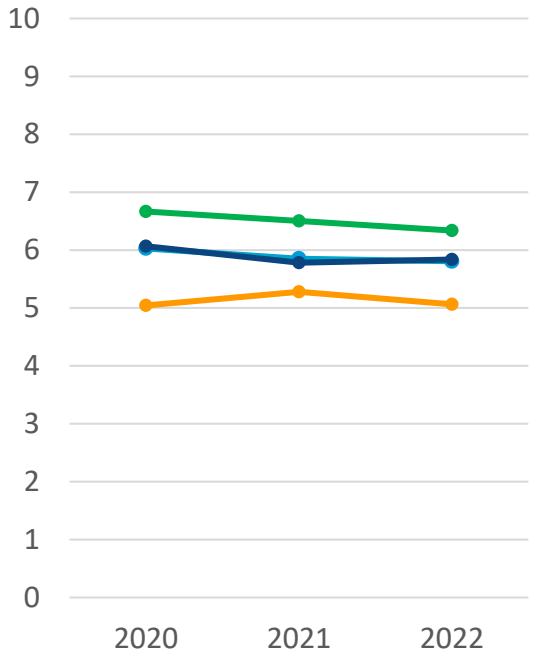
Theme: Morale

All staff



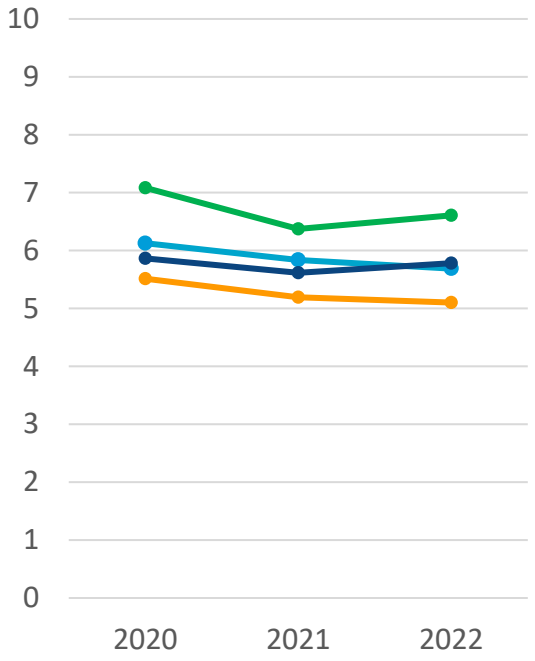
	2020	2021	2022
Your org	6.3	6.1	6.1
Highest	6.7	6.5	6.5
Average	6.2	6.0	6.0
Lowest	5.8	5.5	5.2
Responses	2303	2597	2540

Worked on Covid-19 specific ward or area



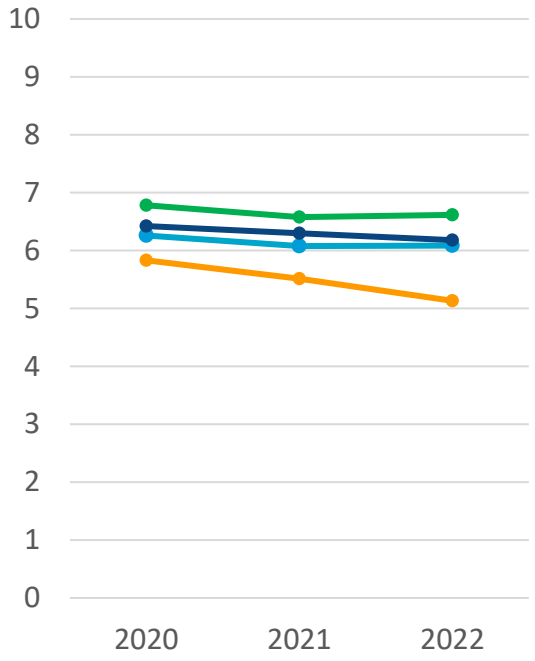
	2020	2021	2022
Your org	6.1	5.8	5.8
Highest	6.7	6.5	6.3
Average	6.0	5.9	5.8
Lowest	5.0	5.3	5.1
Responses	410	622	614

Redeployed



	2020	2021	2022
Your org	5.9	5.6	5.8
Highest	7.1	6.4	6.6
Average	6.1	5.8	5.7
Lowest	5.5	5.2	5.1
Responses	182	267	160

Required to work remotely / from home



	2020	2021	2022
Your org	6.4	6.3	6.2
Highest	6.8	6.6	6.6
Average	6.3	6.1	6.1
Lowest	5.8	5.5	5.1
Responses	1503	1691	1414

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive

Questions included:

Compassionate culture – Q6a, Q23a, Q23b, Q23c, Q23d

Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q20

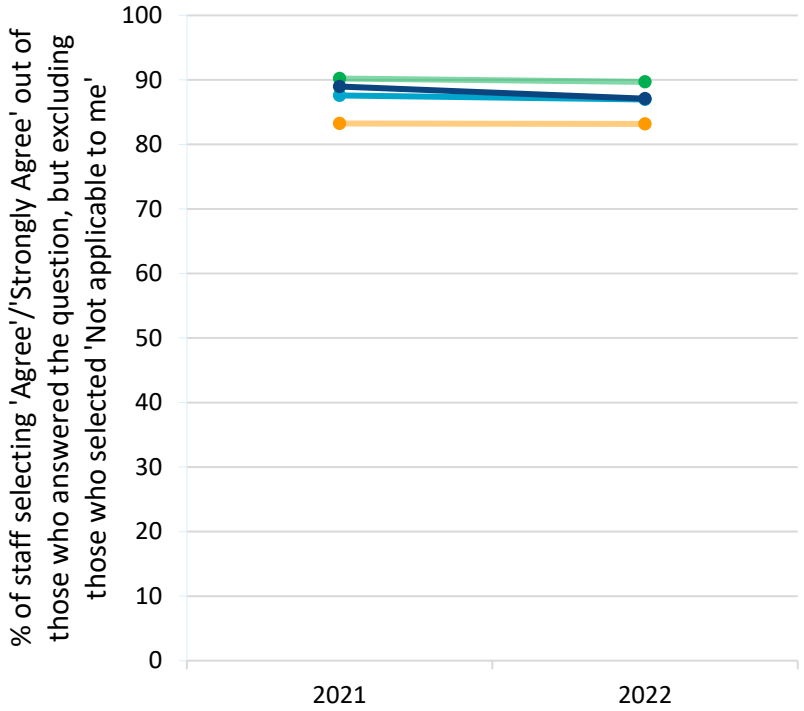
Inclusion – Q7h, Q7i, Q8b, Q8c

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

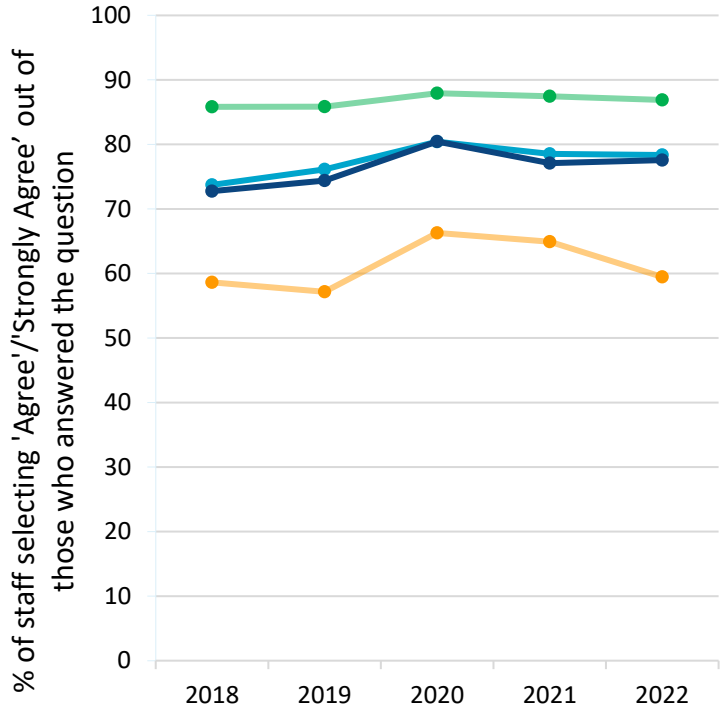
NHS

Q6a I feel that my role makes a difference to patients / service users.



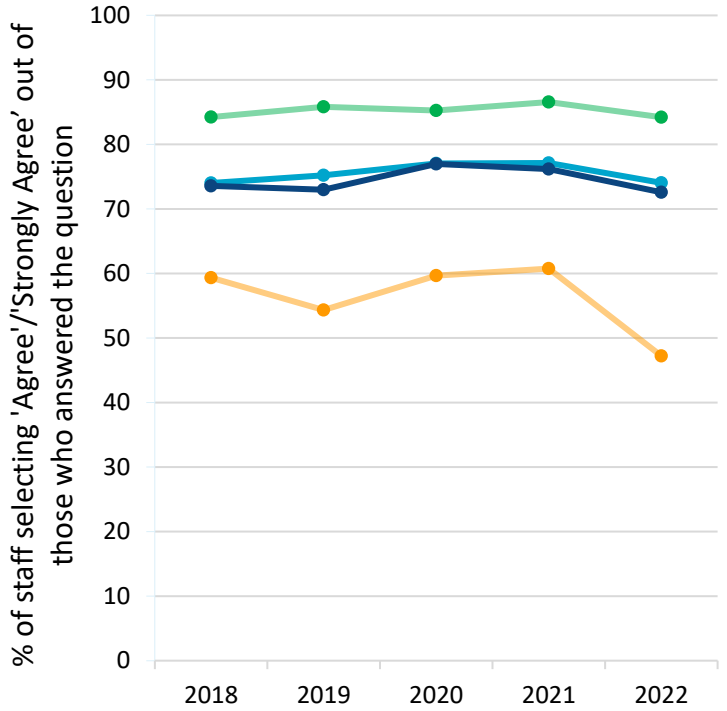
	2021	2022
Your org	89.0%	87.1%
Best	90.2%	89.7%
Average	87.6%	87.0%
Worst	83.2%	83.2%
Responses	2455	2434

Q23a Care of patients / service users is my organisation's top priority.



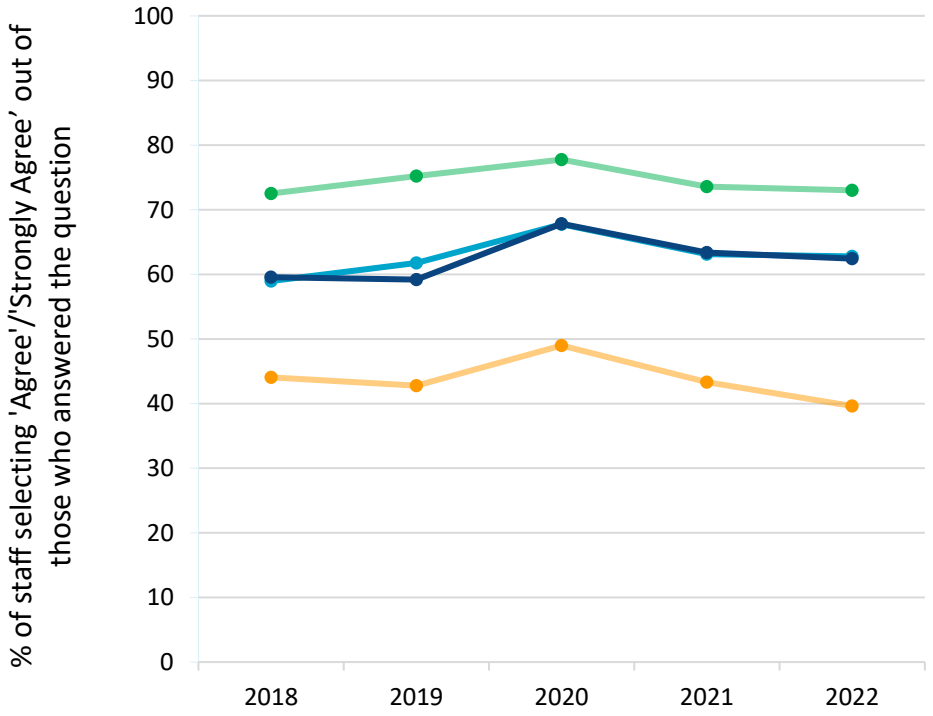
	2018	2019	2020	2021	2022
Your org	72.8%	74.4%	80.4%	77.1%	77.6%
Best	85.8%	85.9%	87.9%	87.5%	86.9%
Average	73.7%	76.1%	80.4%	78.5%	78.3%
Worst	58.6%	57.2%	66.3%	64.9%	59.5%
Responses	2070	2237	2289	2584	2529

Q23b My organisation acts on concerns raised by patients / service users.



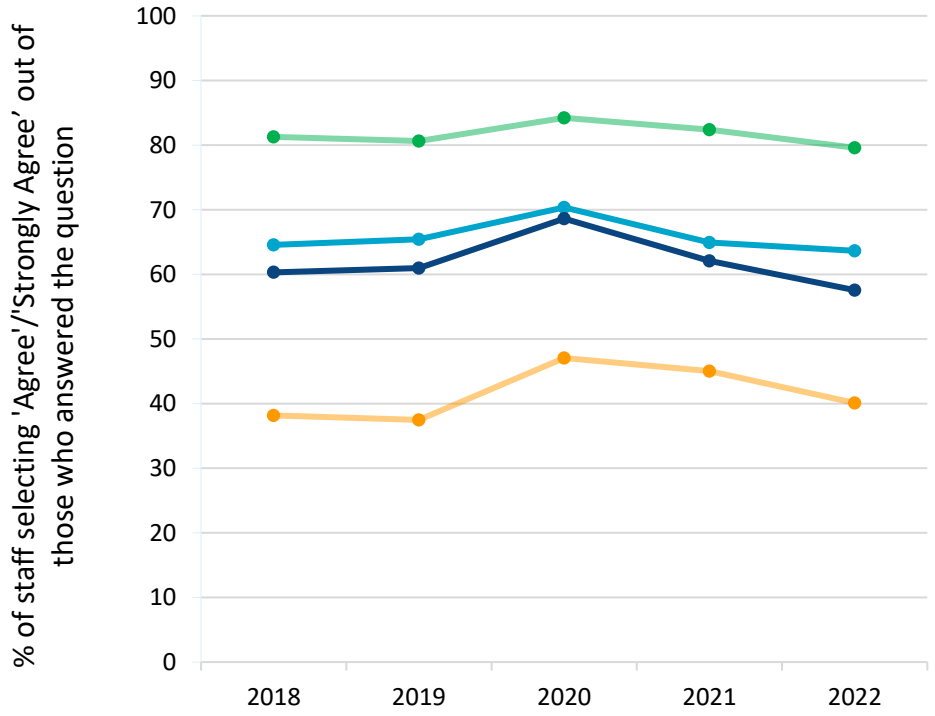
	2018	2019	2020	2021	2022
Your org	73.6%	73.0%	77.0%	76.2%	72.6%
Best	84.2%	85.8%	85.3%	86.6%	84.2%
Average	74.0%	75.2%	77.1%	77.1%	74.0%
Worst	59.3%	54.3%	59.7%	60.8%	47.2%
Responses	2064	2229	2285	2577	2529

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	59.6%	59.2%	67.8%	63.4%	62.4%
Best	72.5%	75.2%	77.8%	73.6%	73.0%
Average	59.0%	61.8%	67.8%	63.1%	62.8%
Worst	44.1%	42.8%	49.0%	43.3%	39.6%
Responses	2063	2232	2286	2580	2531

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

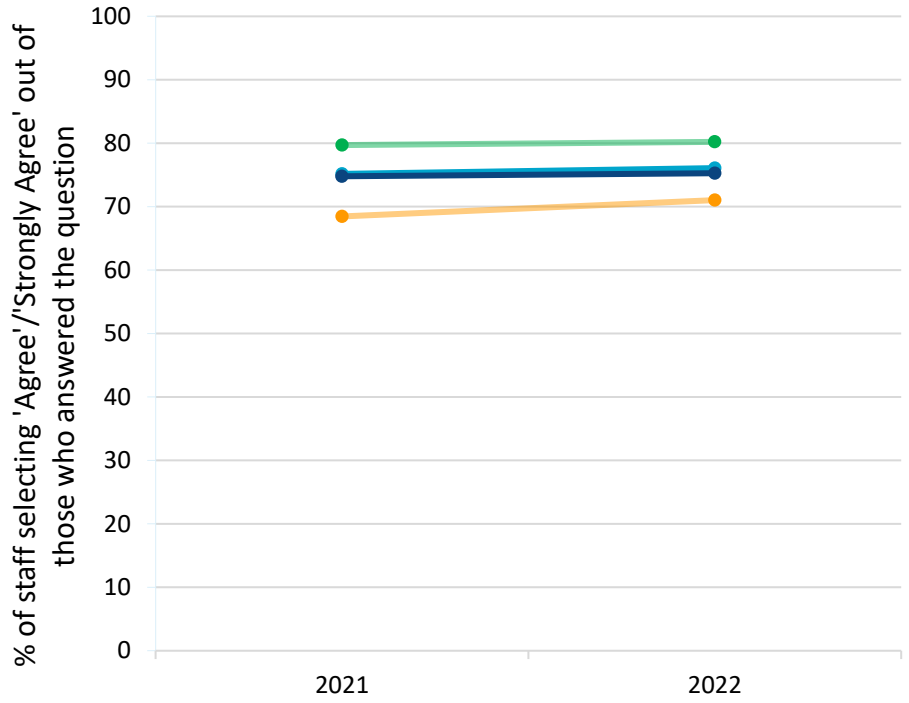


	2018	2019	2020	2021	2022
Your org	60.3%	61.0%	68.6%	62.1%	57.5%
Best	81.3%	80.6%	84.2%	82.4%	79.6%
Average	64.6%	65.4%	70.4%	64.9%	63.6%
Worst	38.2%	37.5%	47.1%	45.0%	40.1%
Responses	2056	2230	2283	2578	2532

Survey Coordination Centre

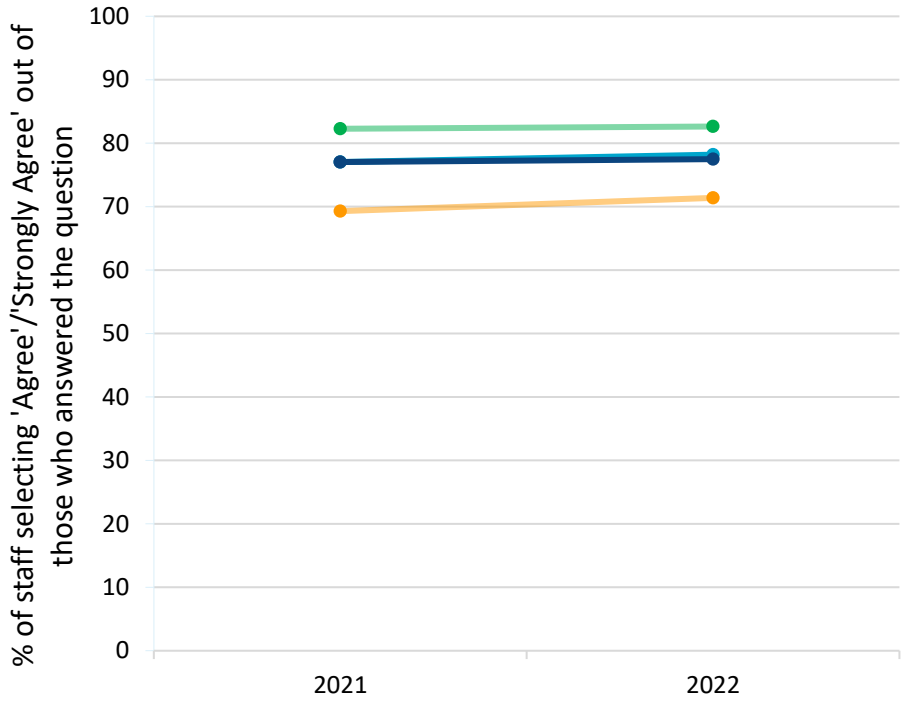
NHS

Q9f My immediate manager works together with me to come to an understanding of problems.



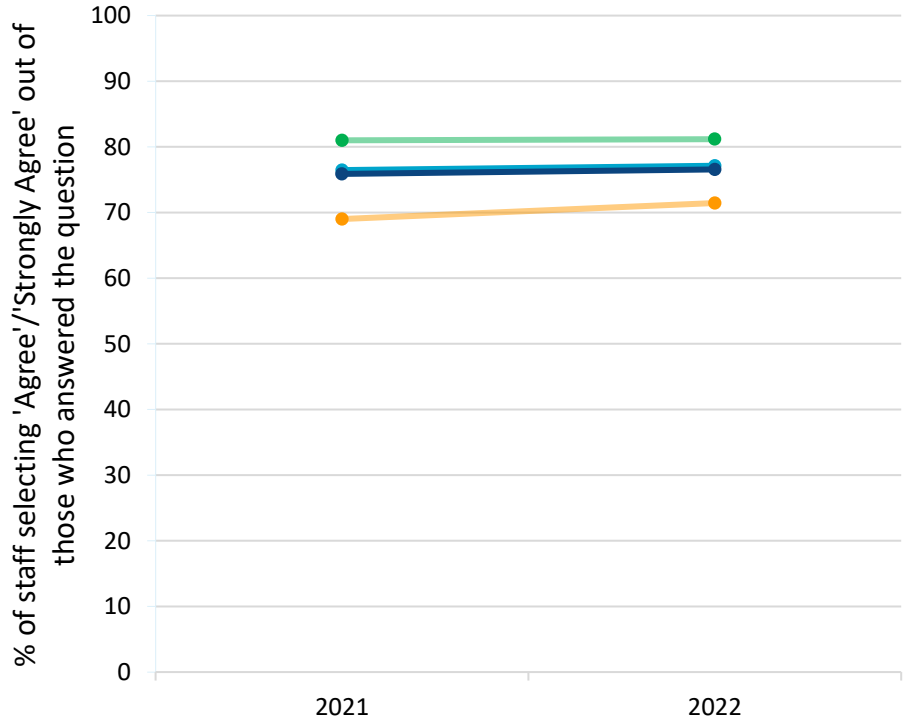
	2021	2022
Your org	74.8%	75.3%
Best	79.7%	80.2%
Average	75.2%	76.1%
Worst	68.4%	71.0%
Responses	2591	2536

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



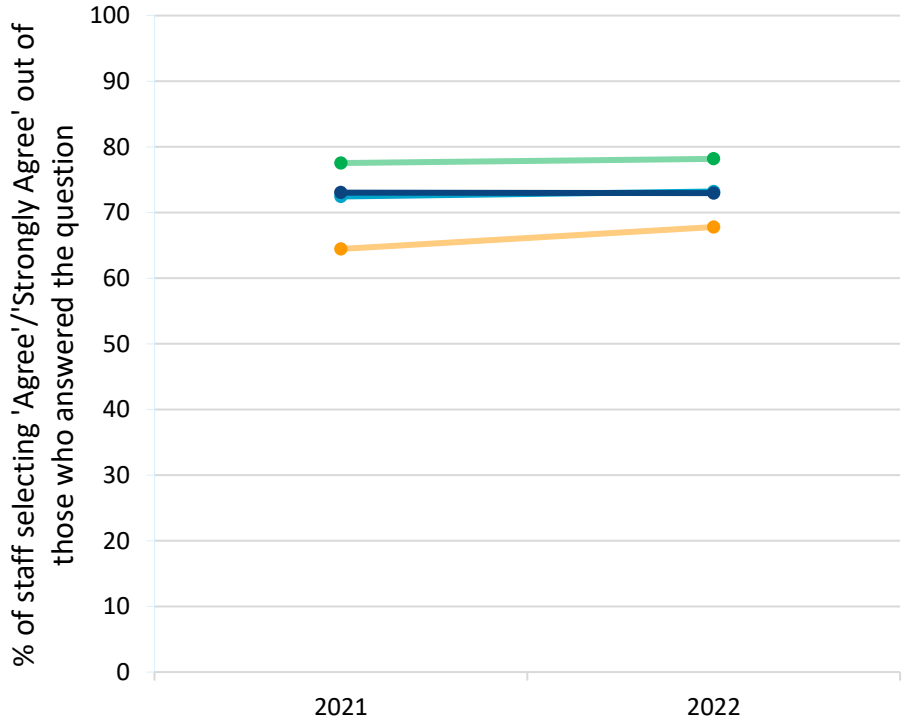
	2021	2022
Your org	77.0%	77.5%
Best	82.3%	82.6%
Average	77.0%	78.2%
Worst	69.3%	71.4%
Responses	2589	2537

Q9h My immediate manager cares about my concerns.



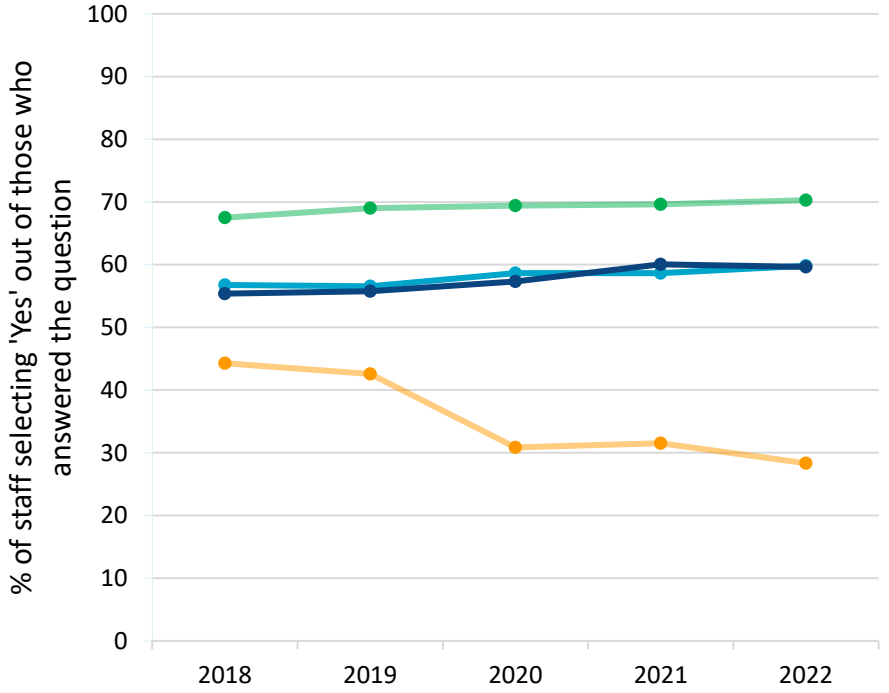
	2021	2022
Your org	75.9%	76.6%
Best	81.0%	81.2%
Average	76.5%	77.1%
Worst	69.0%	71.4%
Responses	2590	2534

Q9i My immediate manager takes effective action to help me with any problems I face.



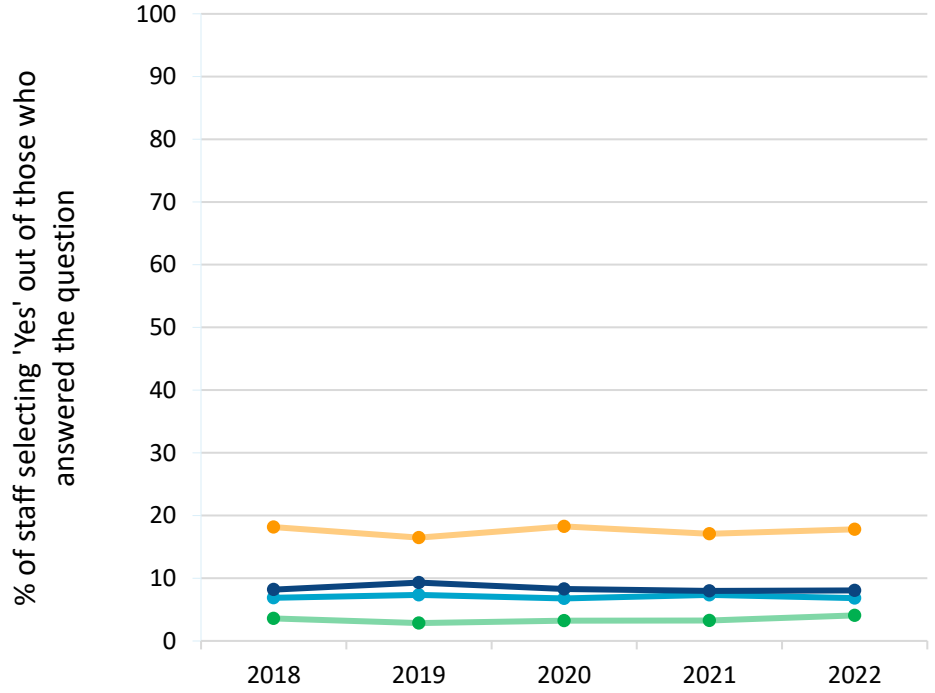
	2021	2022
Your org	73.0%	73.0%
Best	77.5%	78.2%
Average	72.4%	73.2%
Worst	64.5%	67.8%
Responses	2586	2540

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2018	2019	2020	2021	2022
Your org	55.4%	55.8%	57.3%	60.0%	59.6%
Best	67.5%	69.0%	69.4%	69.6%	70.3%
Average	56.8%	56.6%	58.7%	58.6%	59.8%
Worst	44.3%	42.6%	30.9%	31.5%	28.3%
Responses	2080	2237	2300	2583	2529

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

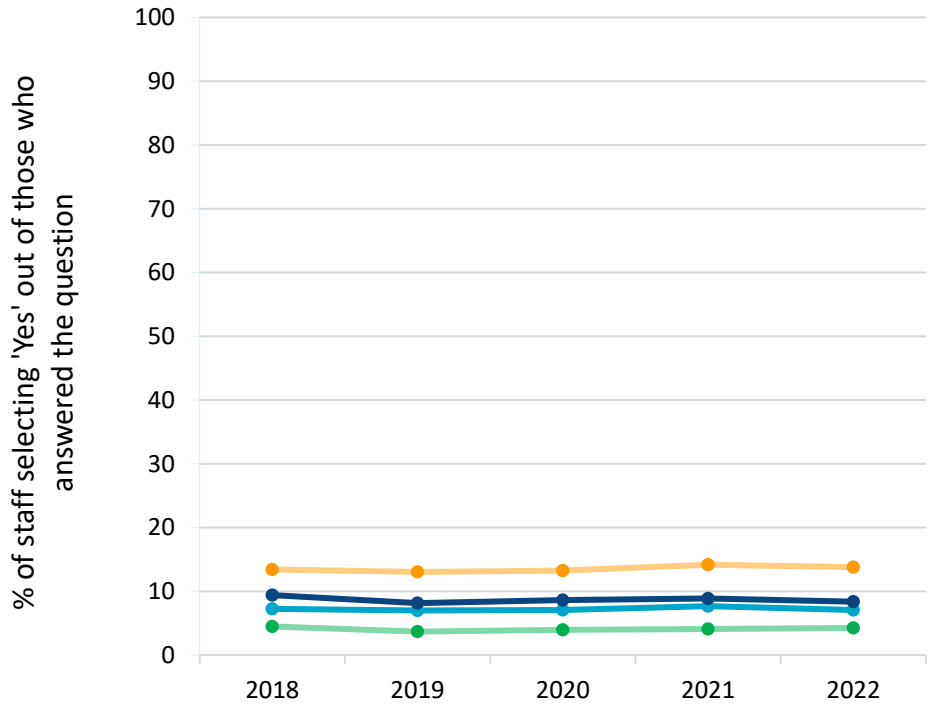


	2018	2019	2020	2021	2022
Your org	8.2%	9.3%	8.3%	8.0%	8.0%
Best	3.6%	2.9%	3.2%	3.3%	4.1%
Average	6.9%	7.3%	6.8%	7.3%	6.8%
Worst	18.2%	16.5%	18.3%	17.1%	17.8%
Responses	2069	2244	2288	2579	2527

Survey Coordination Centre

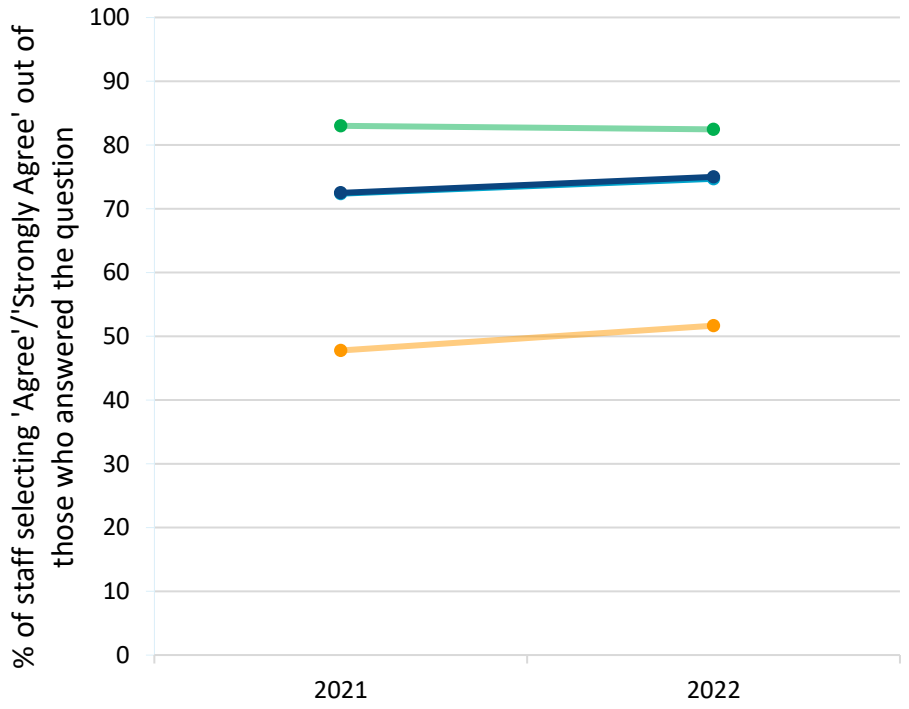
NHS

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2018	2019	2020	2021	2022
Your org	9.4%	8.1%	8.6%	8.9%	8.4%
Best	4.5%	3.7%	4.0%	4.1%	4.3%
Average	7.3%	7.0%	7.1%	7.7%	7.1%
Worst	13.4%	13.1%	13.2%	14.2%	13.8%
Responses	2047	2223	2279	2565	2507

Q20 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

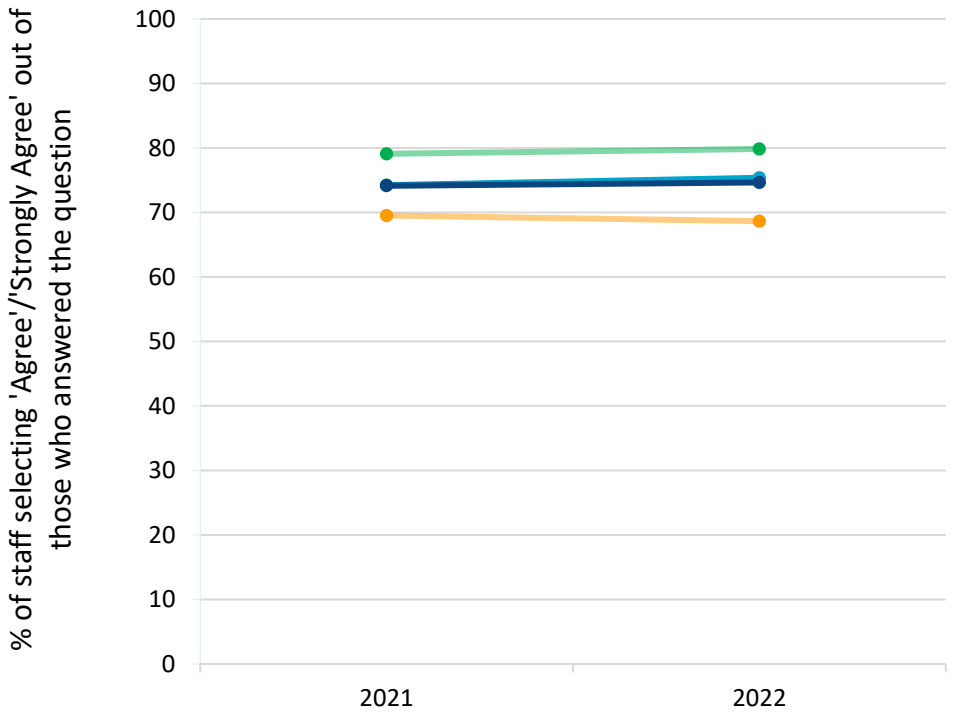


	2021	2022
Your org	72.5%	75.0%
Best	83.0%	82.5%
Average	72.4%	74.7%
Worst	47.8%	51.7%
Responses	2582	2537

Survey Coordination Centre

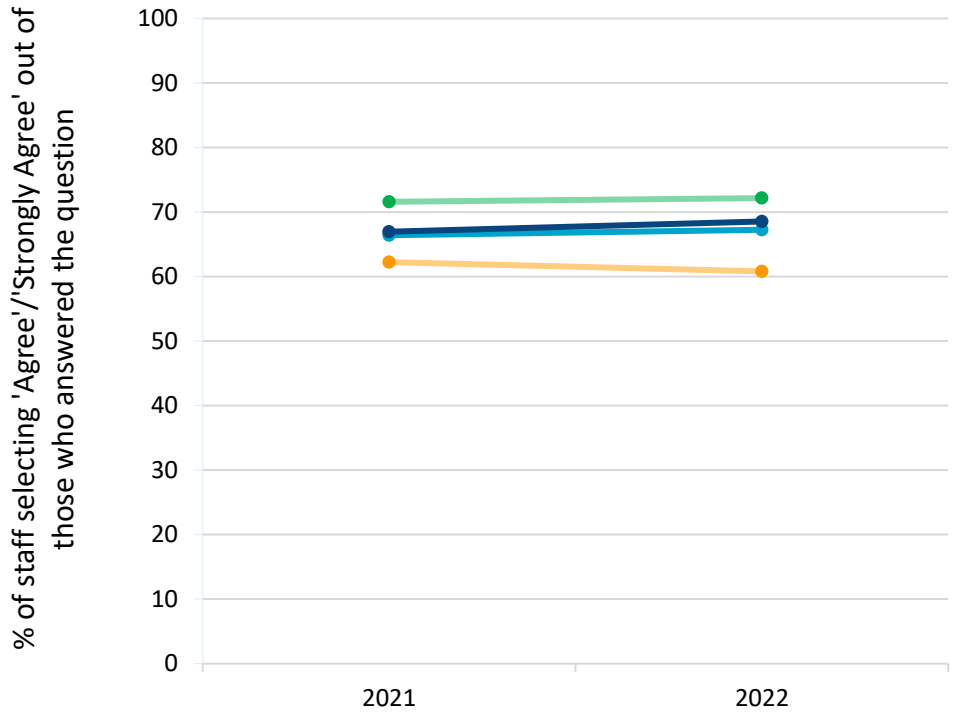
NHS

Q7h I feel valued by my team.



	2021	2022
Your org	74.1%	74.6%
Best	79.1%	79.8%
Average	74.2%	75.4%
Worst	69.5%	68.6%
Responses	2565	2535

Q7i I feel a strong personal attachment to my team.

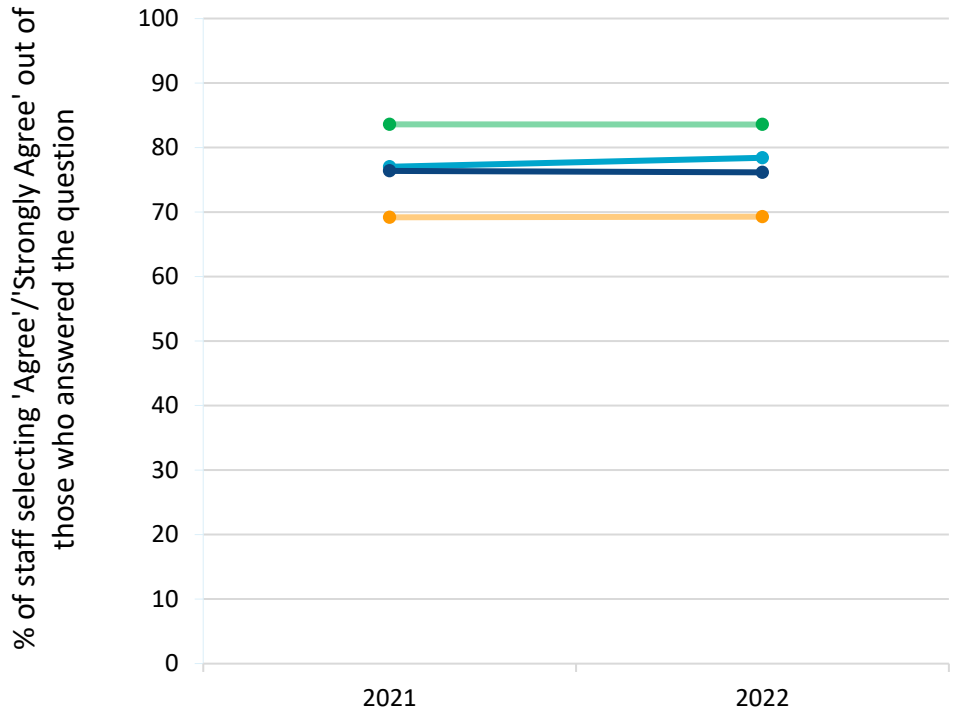


	2021	2022
Your org	66.9%	68.5%
Best	71.6%	72.2%
Average	66.4%	67.3%
Worst	62.2%	60.8%
Responses	2569	2527

Survey Coordination Centre

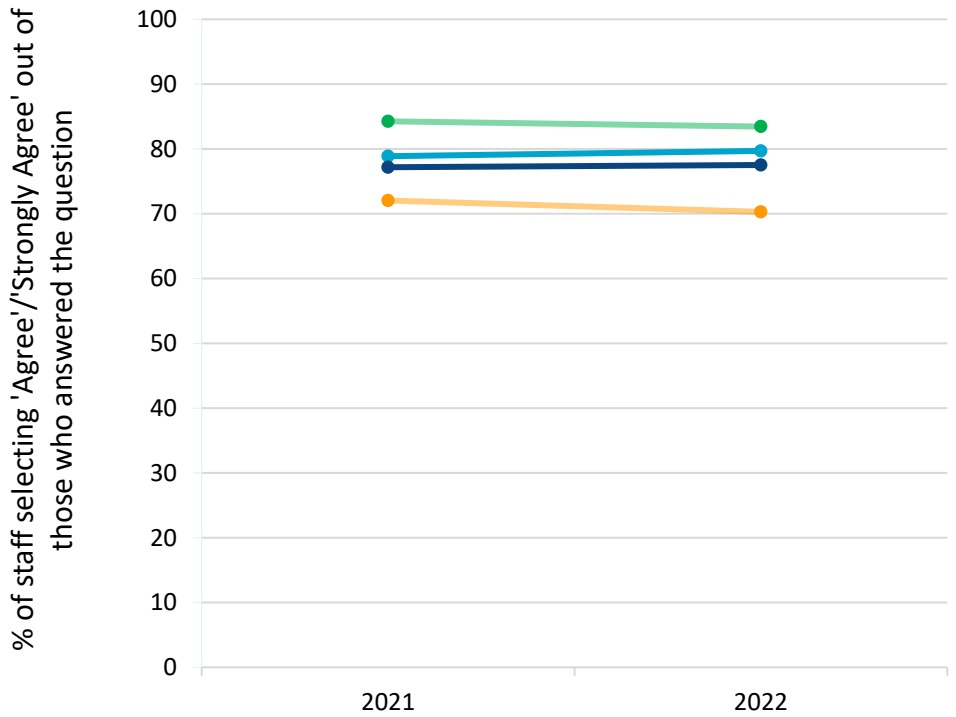
NHS

Q8b The people I work with are understanding and kind to one another.



	2021	2022
Your org	76.4%	76.2%
Best	83.6%	83.6%
Average	77.0%	78.4%
Worst	69.2%	69.3%
Responses	2569	2530

Q8c The people I work with are polite and treat each other with respect.



	2021	2022
Your org	77.2%	77.5%
Best	84.3%	83.4%
Average	78.9%	79.7%
Worst	72.0%	70.3%
Responses	2562	2530

Survey Coordination Centre

NHS

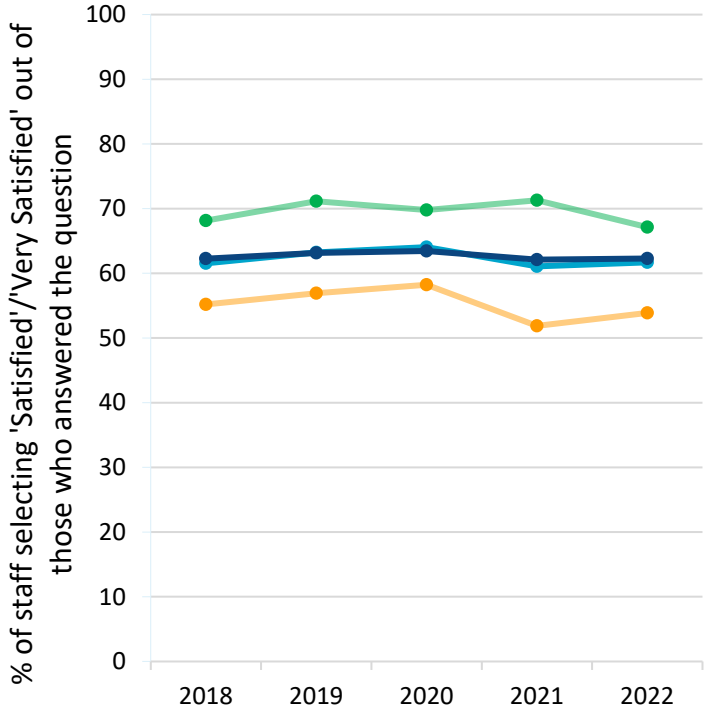
People Promise element – We are recognised and rewarded

Questions included:
Q4a, Q4b, Q4c, Q8d, Q9e

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

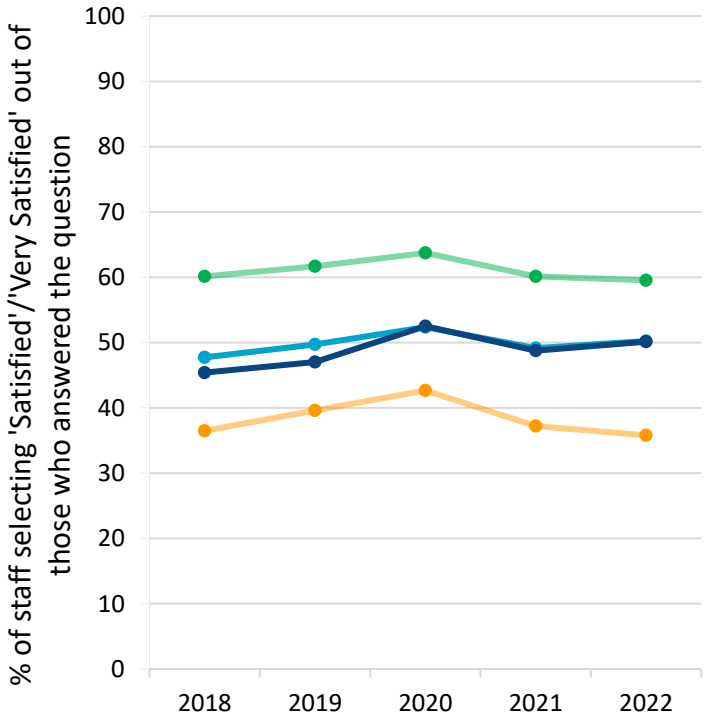
Survey Coordination Centre NHS

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



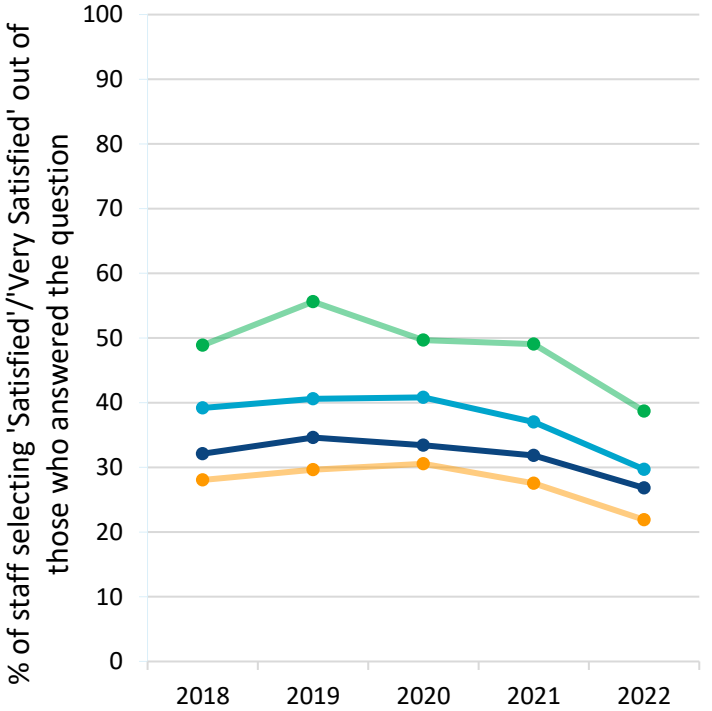
	2018	2019	2020	2021	2022
Your org	62.3%	63.1%	63.5%	62.1%	62.3%
Best	68.1%	71.1%	69.8%	71.3%	67.1%
Average	61.5%	63.2%	64.1%	61.1%	61.7%
Worst	55.2%	56.9%	58.2%	51.9%	53.9%
Responses	2089	2267	2294	2577	2530

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



	2018	2019	2020	2021	2022
Your org	45.4%	47.0%	52.5%	48.8%	50.1%
Best	60.1%	61.7%	63.7%	60.1%	59.5%
Average	47.7%	49.7%	52.4%	49.1%	50.2%
Worst	36.5%	39.6%	42.6%	37.2%	35.8%
Responses	2077	2253	2284	2576	2527

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.

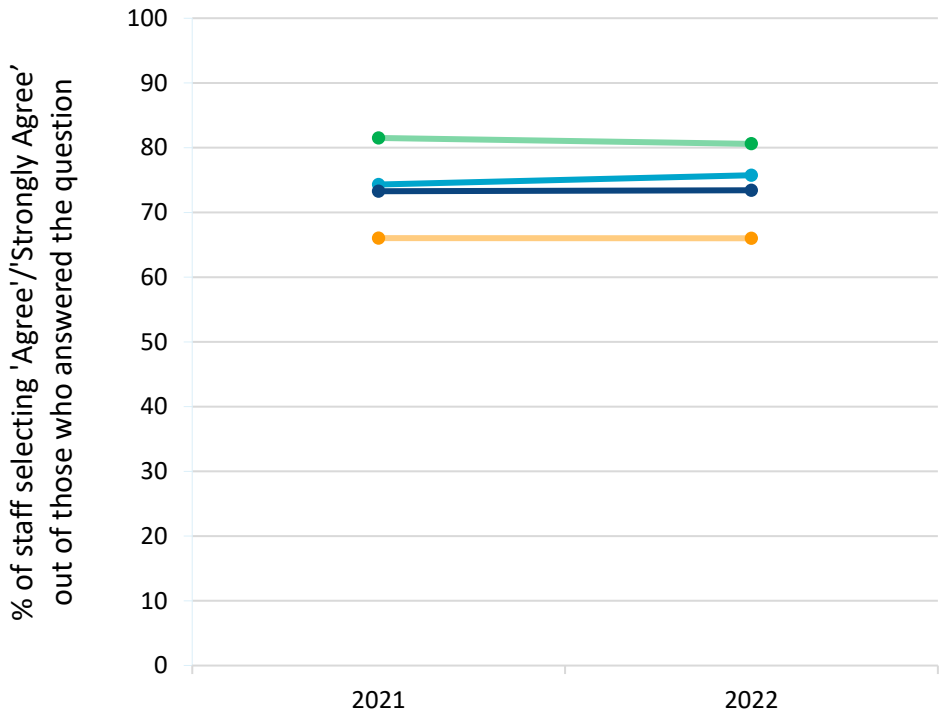


	2018	2019	2020	2021	2022
Your org	32.1%	34.6%	33.4%	31.8%	26.8%
Best	48.9%	55.6%	49.7%	49.0%	38.7%
Average	39.2%	40.6%	40.8%	37.0%	29.7%
Worst	28.1%	29.6%	30.5%	27.5%	21.9%
Responses	2081	2258	2292	2575	2528

Survey Coordination Centre

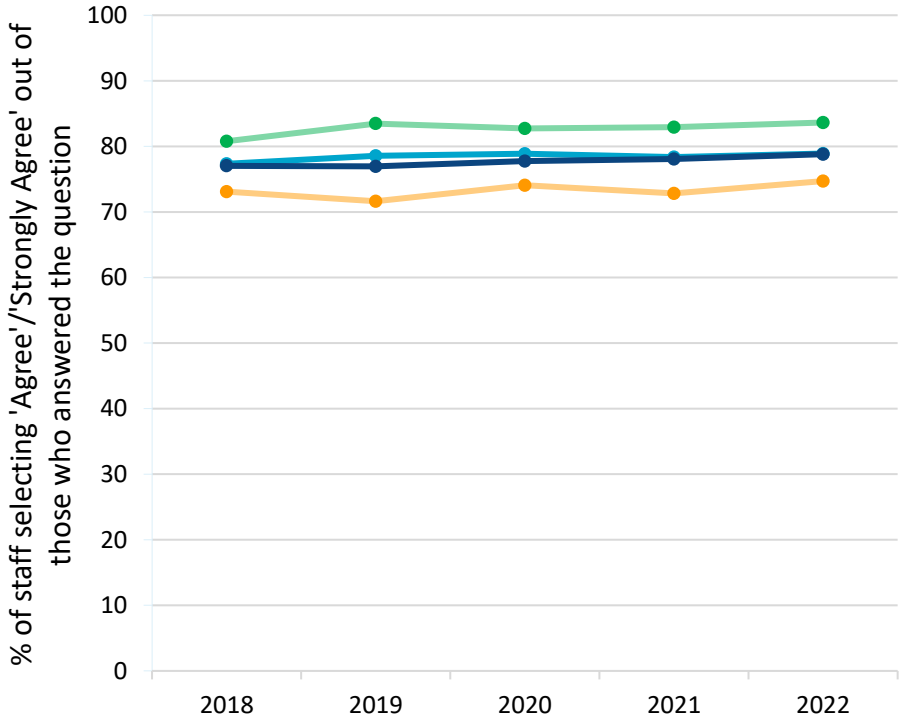
NHS

Q8d The people I work with show appreciation to one another.



	2021	2022
Your org	73.3%	73.4%
Best	81.5%	80.6%
Average	74.3%	75.7%
Worst	66.0%	66.0%
Responses	2560	2527

Q9e My immediate manager values my work.



	2018	2019	2020	2021	2022
Your org	77.0%	77.0%	77.8%	78.1%	78.8%
Best	80.8%	83.5%	82.7%	82.9%	83.7%
Average	77.3%	78.6%	78.9%	78.4%	78.9%
Worst	73.1%	71.6%	74.1%	72.8%	74.7%
Responses	2089	2238	2283	2586	2541

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

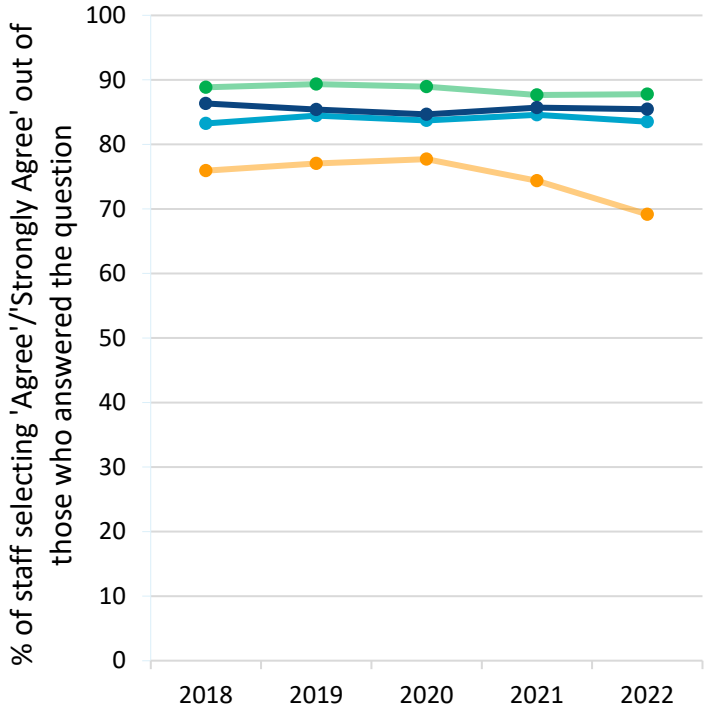
Raising concerns – Q19a, Q19b, Q23e, Q23f

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

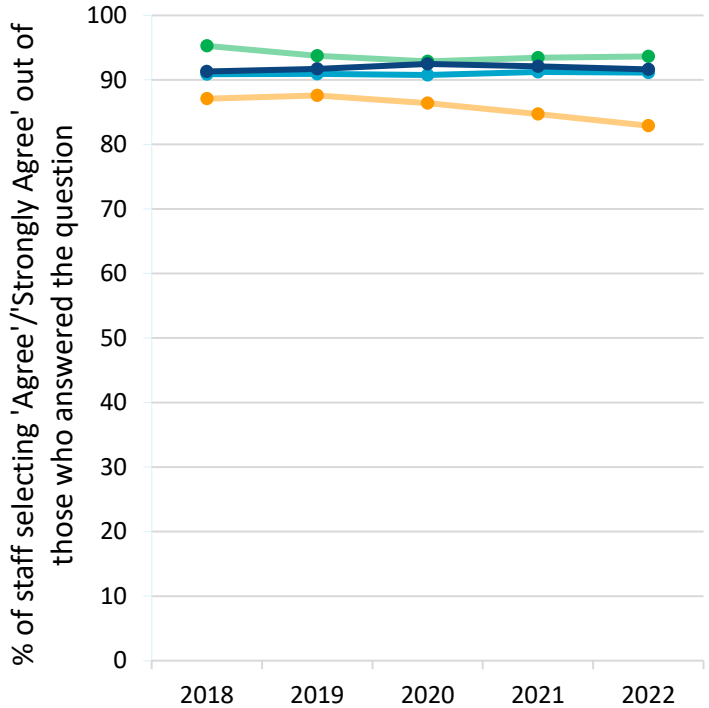
NHS

Q3a I always know what my work responsibilities are.



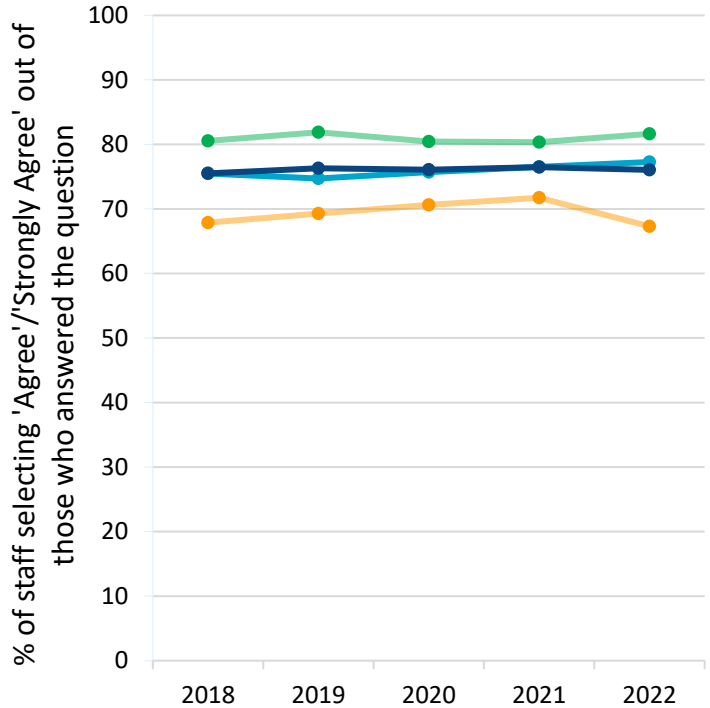
	2018	2019	2020	2021	2022
Your org	86.3%	85.4%	84.7%	85.7%	85.4%
Best	88.8%	89.3%	88.9%	87.7%	87.8%
Average	83.3%	84.4%	83.7%	84.6%	83.5%
Worst	75.9%	77.0%	77.7%	74.4%	69.2%
Responses	2074	2260	2279	2596	2537

Q3b I am trusted to do my job.



	2018	2019	2020	2021	2022
Your org	91.3%	91.7%	92.5%	92.1%	91.6%
Best	95.3%	93.7%	92.9%	93.4%	93.6%
Average	90.9%	90.9%	90.7%	91.2%	91.1%
Worst	87.1%	87.6%	86.4%	84.7%	82.9%
Responses	2071	2250	2269	2589	2537

Q3c There are frequent opportunities for me to show initiative in my role.

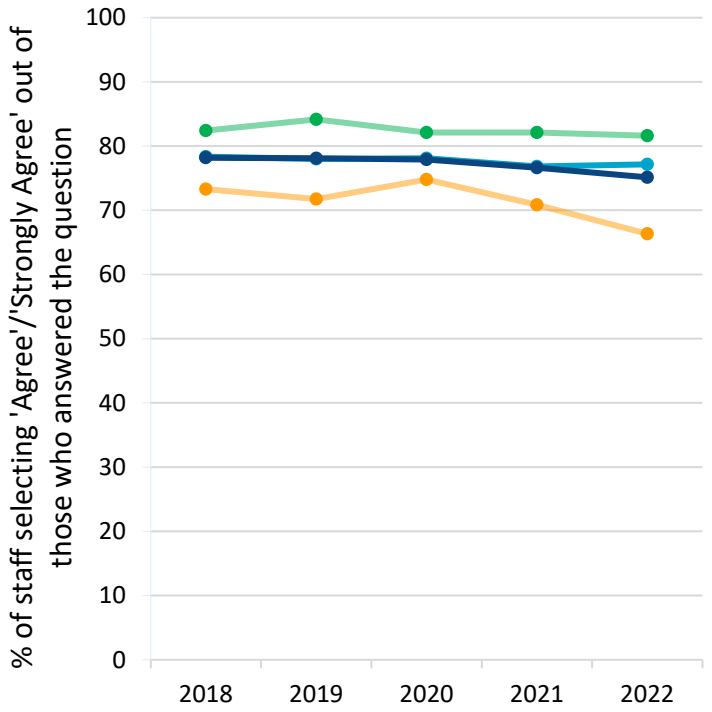


	2018	2019	2020	2021	2022
Your org	75.5%	76.3%	76.1%	76.5%	76.1%
Best	80.5%	81.9%	80.4%	80.4%	81.6%
Average	75.5%	74.7%	75.7%	76.5%	77.3%
Worst	67.9%	69.3%	70.6%	71.7%	67.3%
Responses	2101	2270	2296	2586	2529

Survey Coordination Centre

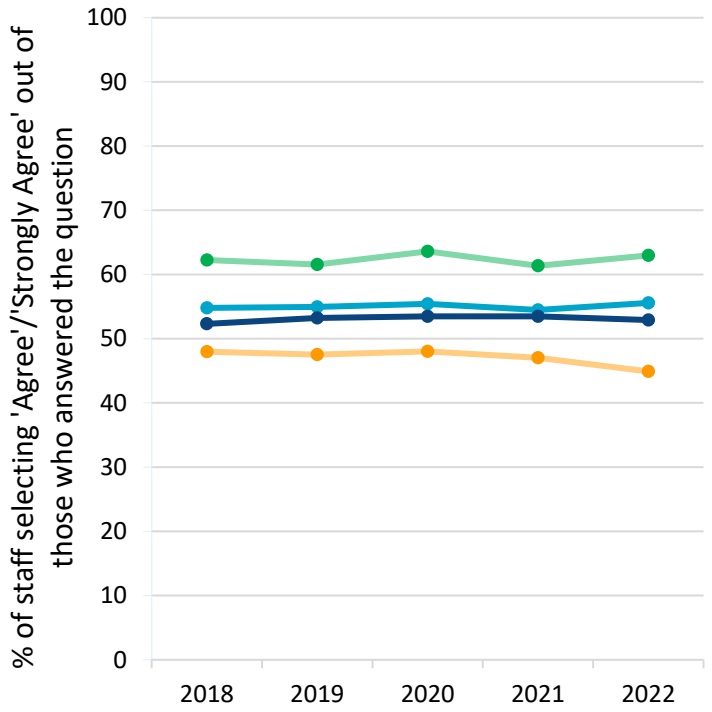
NHS

Q3d I am able to make suggestions to improve the work of my team / department.



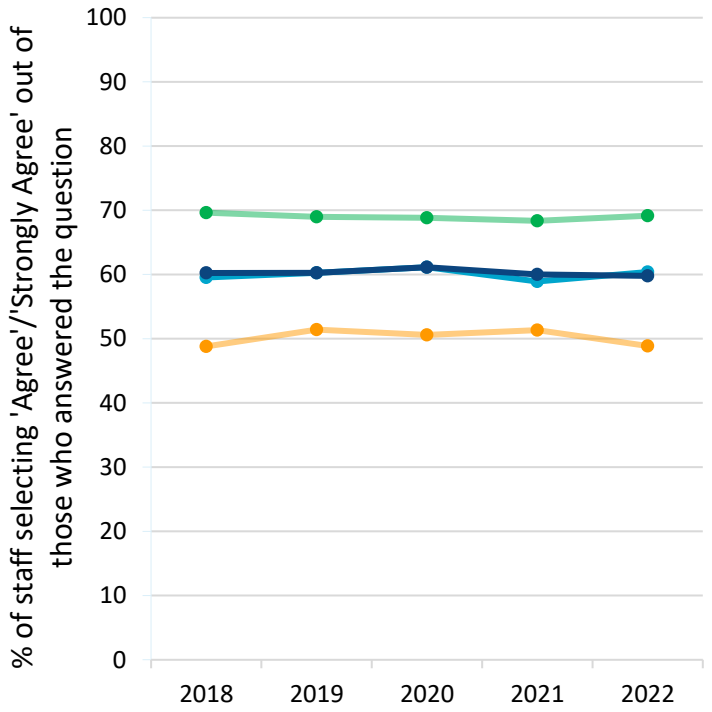
	2018	2019	2020	2021	2022
Your org	78.2%	78.1%	77.9%	76.6%	75.1%
Best	82.4%	84.2%	82.1%	82.1%	81.6%
Average	78.3%	78.0%	78.1%	76.8%	77.1%
Worst	73.3%	71.7%	74.8%	70.9%	66.3%
Responses	2099	2271	2291	2580	2532

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2018	2019	2020	2021	2022
Your org	52.3%	53.2%	53.5%	53.5%	52.9%
Best	62.3%	61.6%	63.6%	61.3%	63.0%
Average	54.8%	55.0%	55.4%	54.5%	55.6%
Worst	48.0%	47.5%	48.0%	47.0%	44.9%
Responses	2095	2264	2287	2584	2529

Q3f I am able to make improvements happen in my area of work.

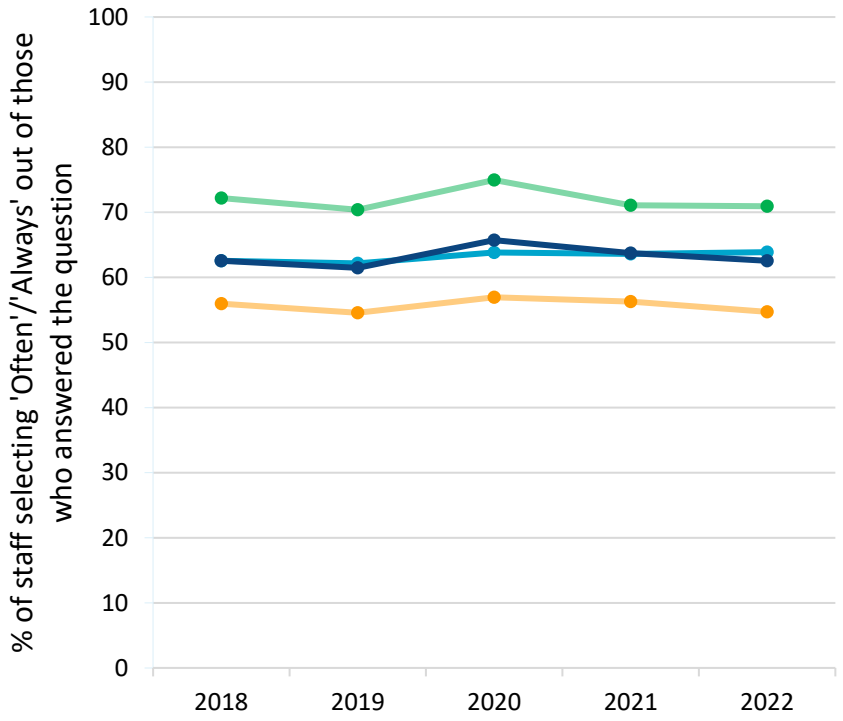


	2018	2019	2020	2021	2022
Your org	60.2%	60.3%	61.1%	60.0%	59.8%
Best	69.6%	69.0%	68.8%	68.4%	69.1%
Average	59.5%	60.3%	61.1%	58.9%	60.4%
Worst	48.8%	51.4%	50.6%	51.3%	48.9%
Responses	2093	2256	2292	2577	2521

Survey Coordination Centre

NHS

Q5b I have a choice in deciding how to do my work.

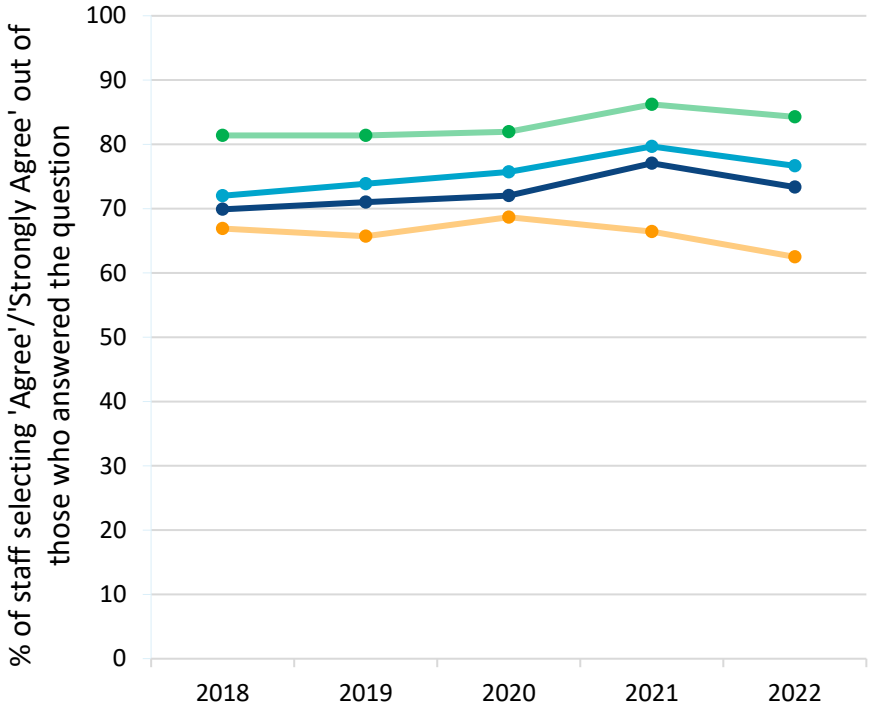


	2018	2019	2020	2021	2022
Your org	62.5%	61.5%	65.7%	63.7%	62.6%
Best	72.2%	70.4%	75.0%	71.1%	70.9%
Average	62.6%	62.1%	63.8%	63.6%	63.9%
Worst	56.0%	54.6%	56.9%	56.3%	54.7%
Responses	2059	2237	2259	2584	2533

Survey Coordination Centre

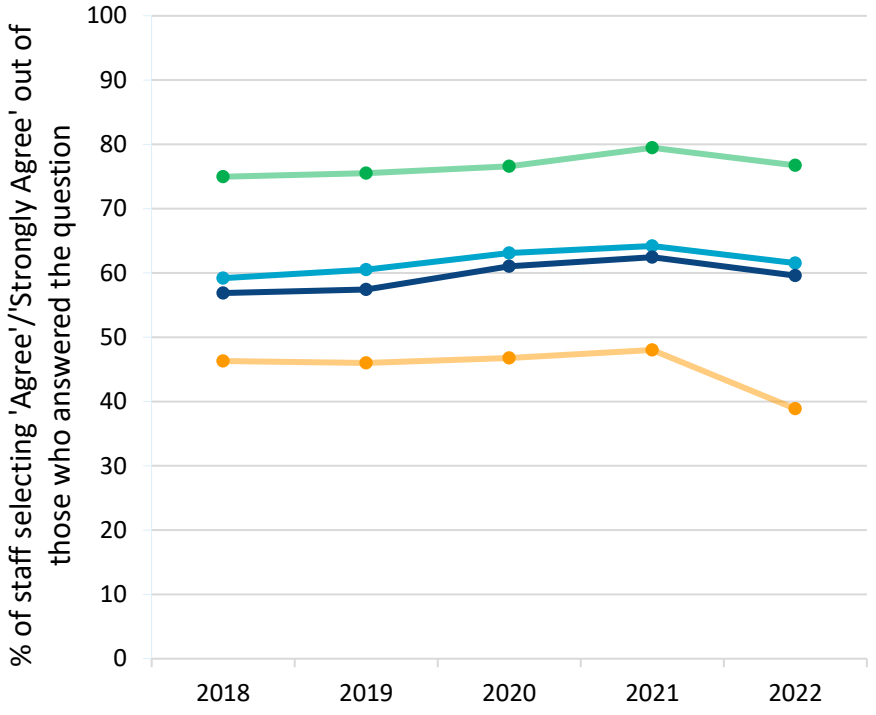
NHS

Q19a I would feel secure raising concerns about unsafe clinical practice.



	2018	2019	2020	2021	2022
Your org	69.9%	71.0%	72.0%	77.1%	73.3%
Best	81.4%	81.4%	82.0%	86.2%	84.3%
Average	72.0%	73.9%	75.7%	79.7%	76.7%
Worst	66.9%	65.7%	68.7%	66.4%	62.5%
Responses	2074	2244	2293	2575	2532

Q19b I am confident that my organisation would address my concern.

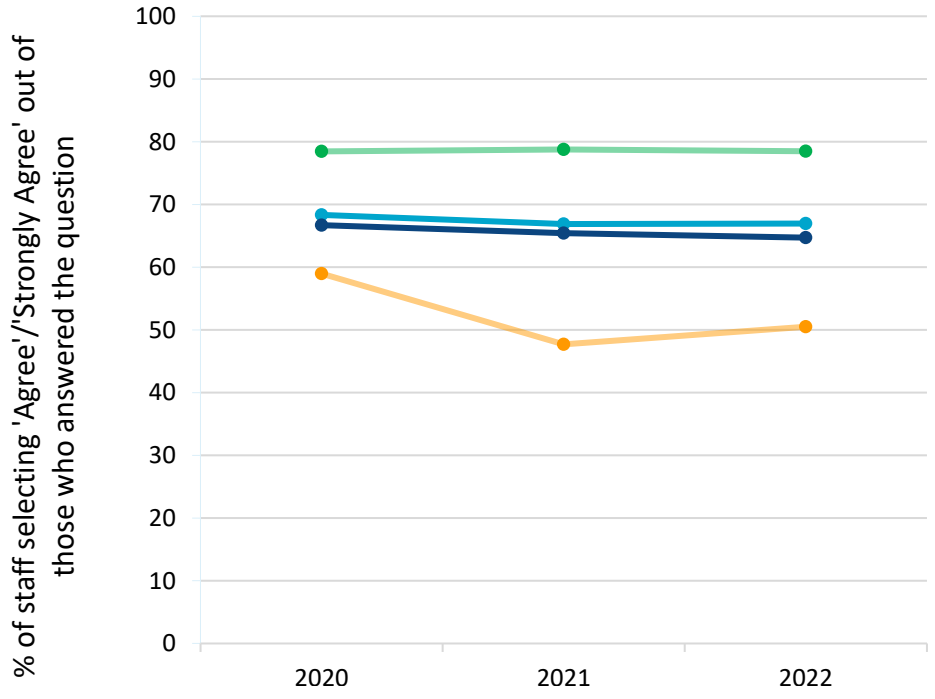


	2018	2019	2020	2021	2022
Your org	56.9%	57.4%	61.0%	62.5%	59.6%
Best	75.0%	75.5%	76.6%	79.5%	76.7%
Average	59.2%	60.5%	63.1%	64.2%	61.5%
Worst	46.3%	46.0%	46.8%	48.0%	38.9%
Responses	2070	2246	2287	2575	2530

Survey Coordination Centre

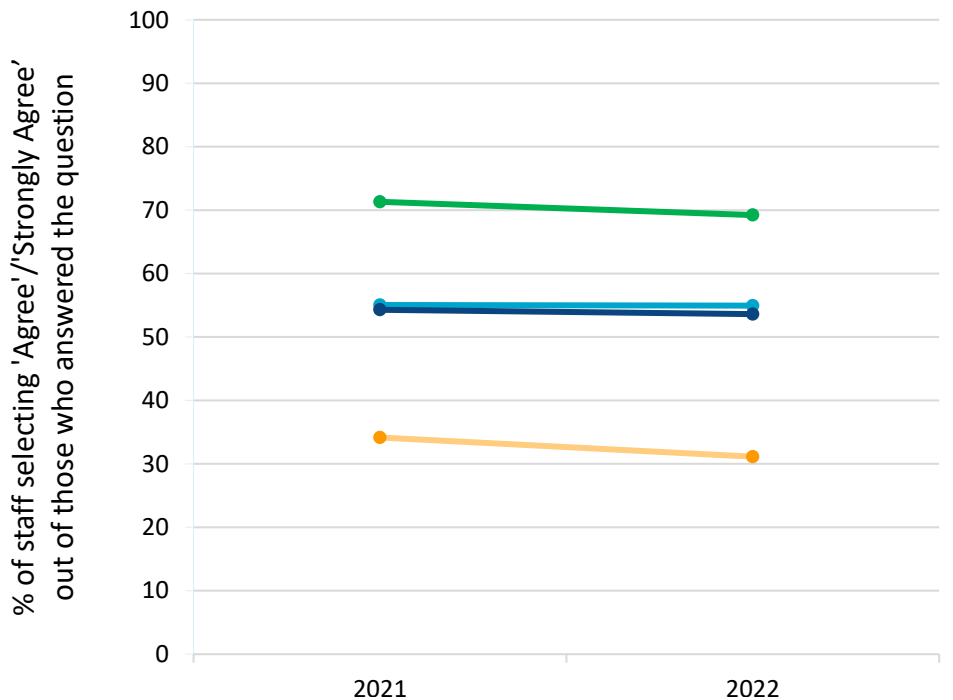
NHS

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	66.7%	65.4%	64.7%
Best	78.5%	78.8%	78.5%
Average	68.3%	66.9%	67.0%
Worst	59.0%	47.7%	50.5%
Responses	2280	2577	2531

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	54.3%	53.6%
Best	71.3%	69.2%
Average	55.0%	55.0%
Worst	34.2%	31.1%
Responses	2578	2524

Survey Coordination Centre

NHS

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

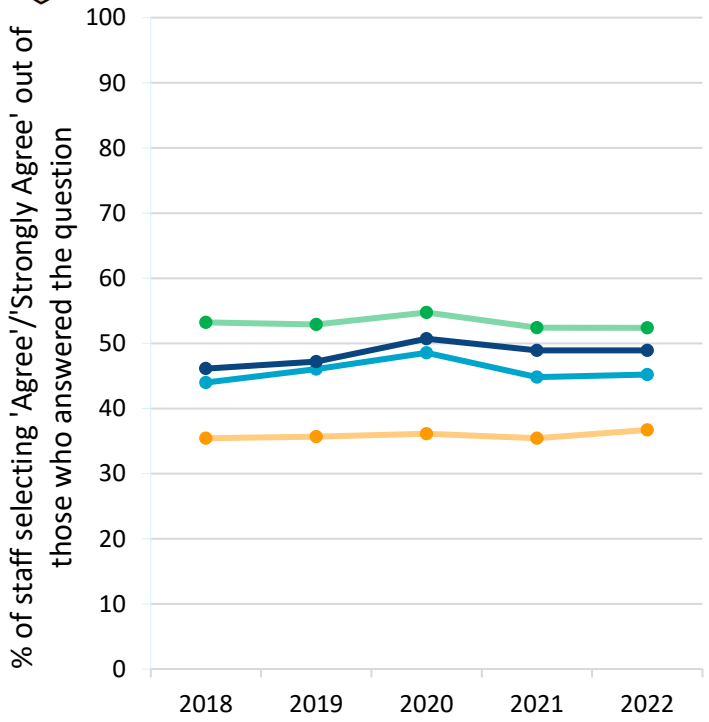
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

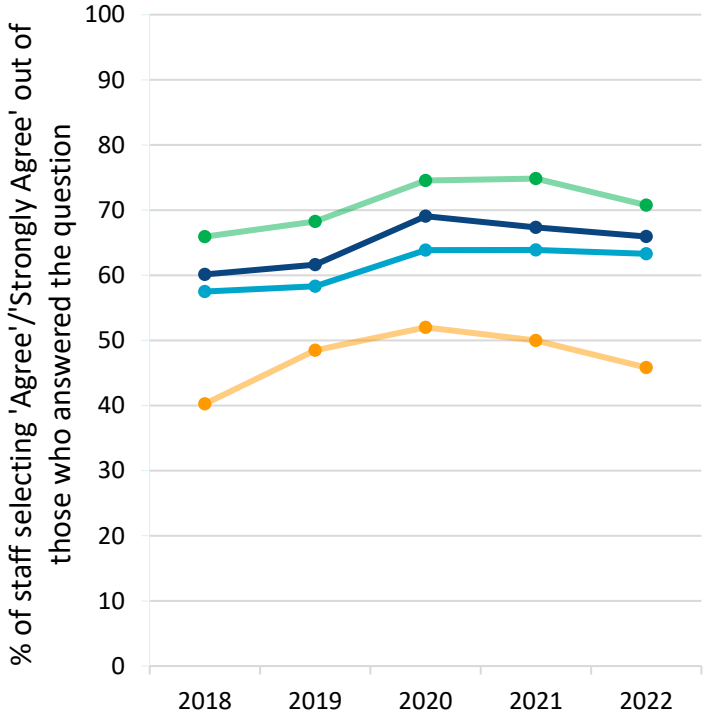
NHS

Q3g I am able to meet all the conflicting demands on my time at work.



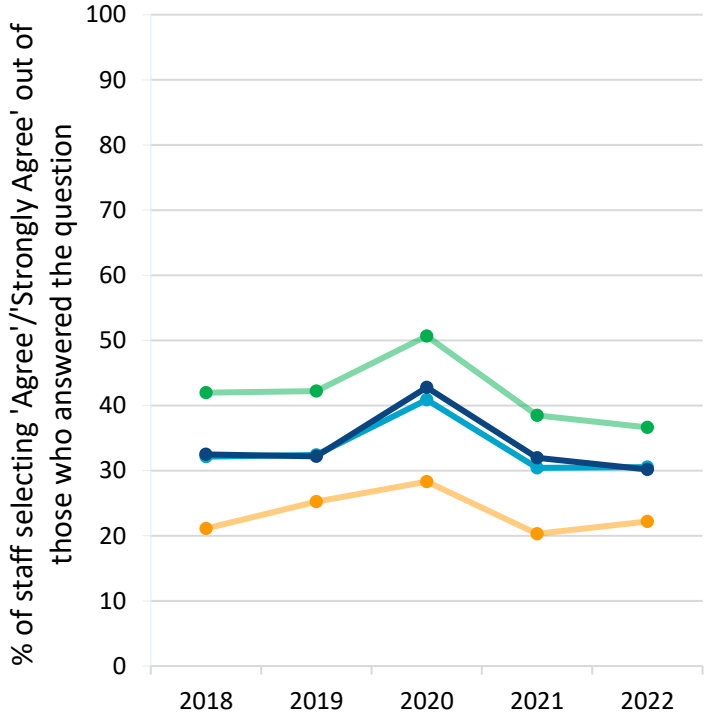
	2018	2019	2020	2021	2022
Your org	46.1%	47.2%	50.7%	48.9%	48.9%
Best	53.2%	52.9%	54.8%	52.4%	52.4%
Average	44.0%	46.0%	48.6%	44.8%	45.2%
Worst	35.4%	35.7%	36.1%	35.4%	36.7%
Responses	2095	2263	2291	2582	2521

Q3h I have adequate materials, supplies and equipment to do my work.



	2018	2019	2020	2021	2022
Your org	60.1%	61.6%	69.1%	67.3%	66.0%
Best	65.9%	68.3%	74.5%	74.8%	70.8%
Average	57.5%	58.3%	63.8%	63.9%	63.3%
Worst	40.2%	48.5%	52.0%	50.0%	45.8%
Responses	2092	2253	2285	2568	2525

Q3i There are enough staff at this organisation for me to do my job properly.

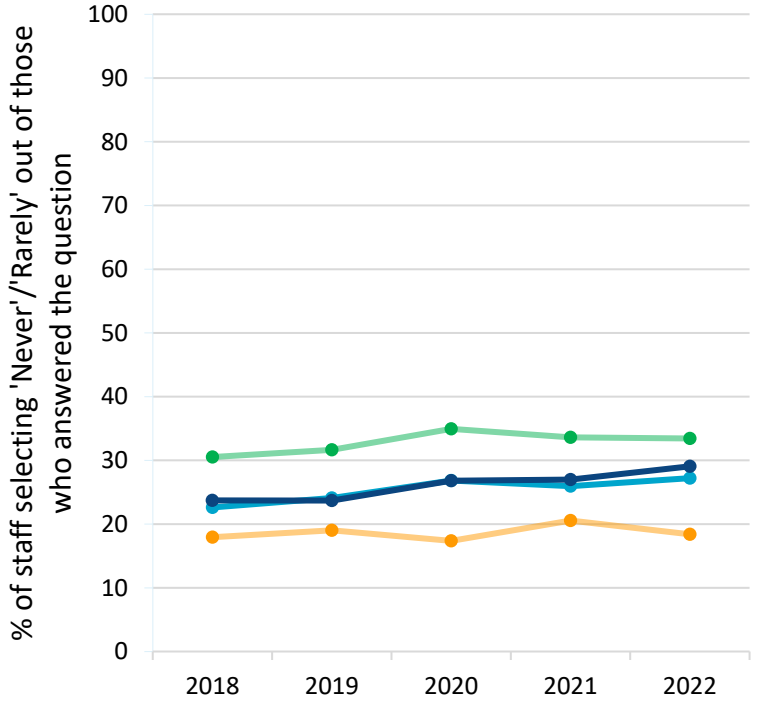


	2018	2019	2020	2021	2022
Your org	32.5%	32.2%	42.8%	32.0%	30.2%
Best	42.0%	42.2%	50.7%	38.5%	36.6%
Average	32.1%	32.4%	40.9%	30.4%	30.5%
Worst	21.1%	25.2%	28.3%	20.3%	22.2%
Responses	2092	2262	2283	2583	2533

Survey Coordination Centre

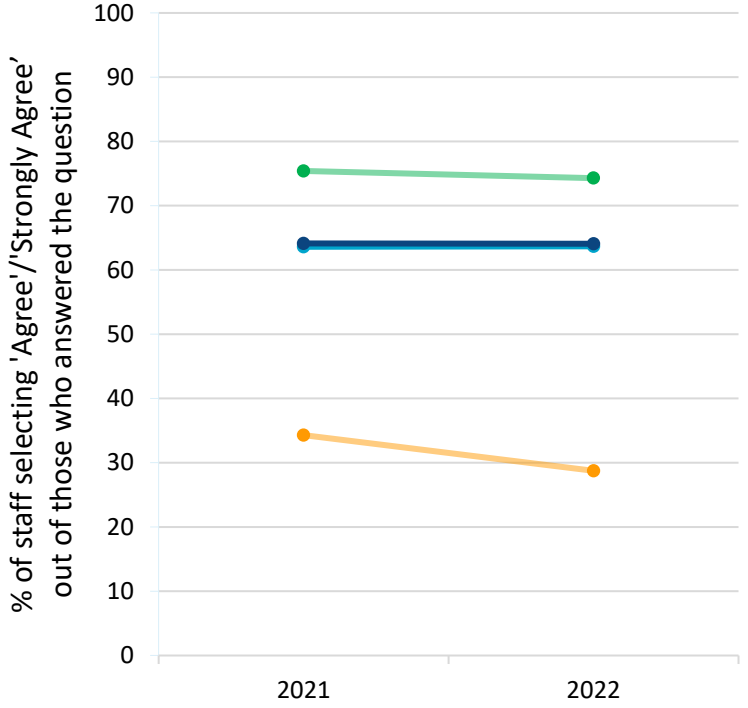
NHS

Q5a I have unrealistic time pressures.



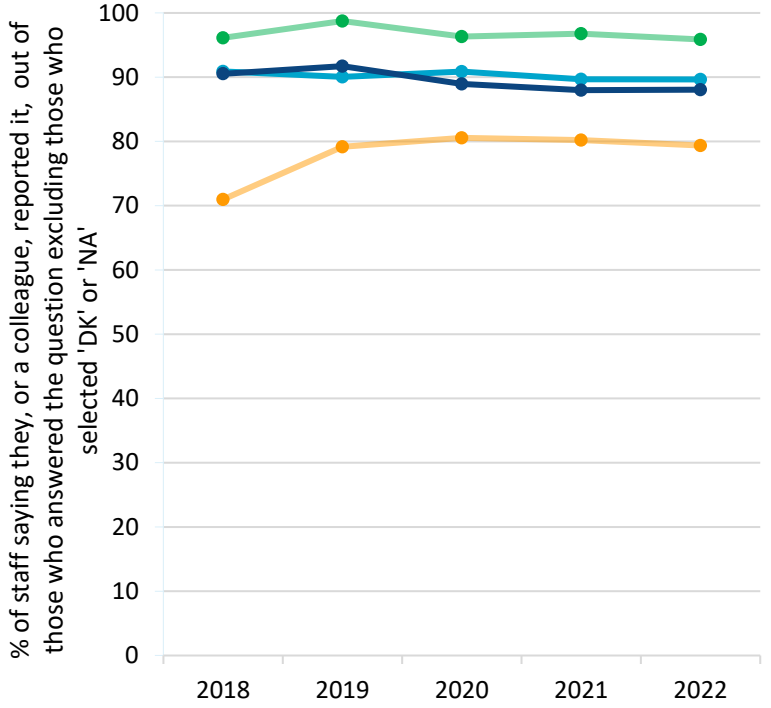
	2018	2019	2020	2021	2022
Your org	23.7%	23.7%	26.8%	27.0%	29.1%
Best	30.5%	31.6%	34.9%	33.6%	33.4%
Average	22.6%	24.1%	26.8%	26.0%	27.2%
Worst	17.9%	19.0%	17.4%	20.6%	18.4%
Responses	2071	2245	2275	2593	2539

Q11a My organisation take positive action on health and well-being.



	2021	2022
Your org	64.1%	64.1%
Best	75.4%	74.3%
Average	63.6%	63.7%
Worst	34.3%	28.7%
Responses	2562	2531

Q13d The last time you experienced physical violence at work, did you or a colleague report it?

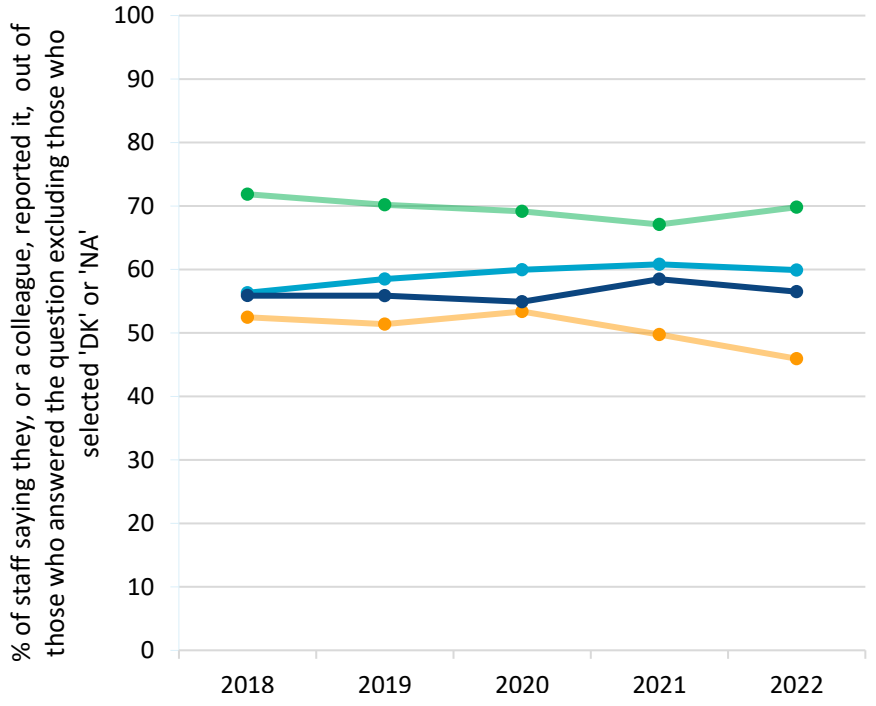


	2018	2019	2020	2021	2022
Your org	90.5%	91.7%	88.9%	88.0%	88.1%
Best	96.1%	98.7%	96.3%	96.8%	95.9%
Average	90.9%	90.0%	90.9%	89.7%	89.6%
Worst	71.0%	79.2%	80.5%	80.2%	79.4%
Responses	298	341	286	332	288

Survey Coordination Centre

NHS

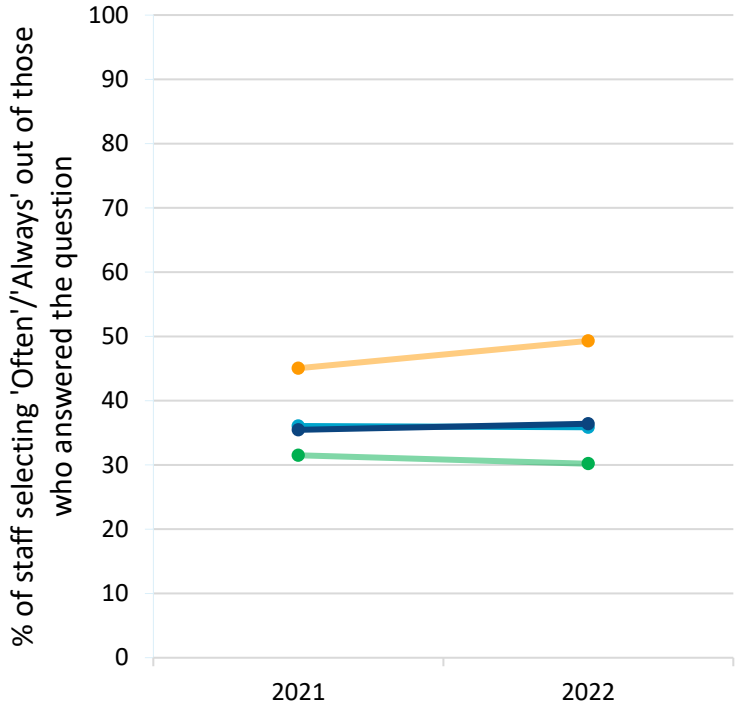
Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



	2018	2019	2020	2021	2022
Your org	55.9%	55.9%	54.9%	58.5%	56.5%
Best	71.9%	70.2%	69.2%	67.1%	69.8%
Average	56.3%	58.5%	60.0%	60.8%	59.9%
Worst	52.5%	51.4%	53.4%	49.7%	45.9%
Responses	712	868	829	905	880

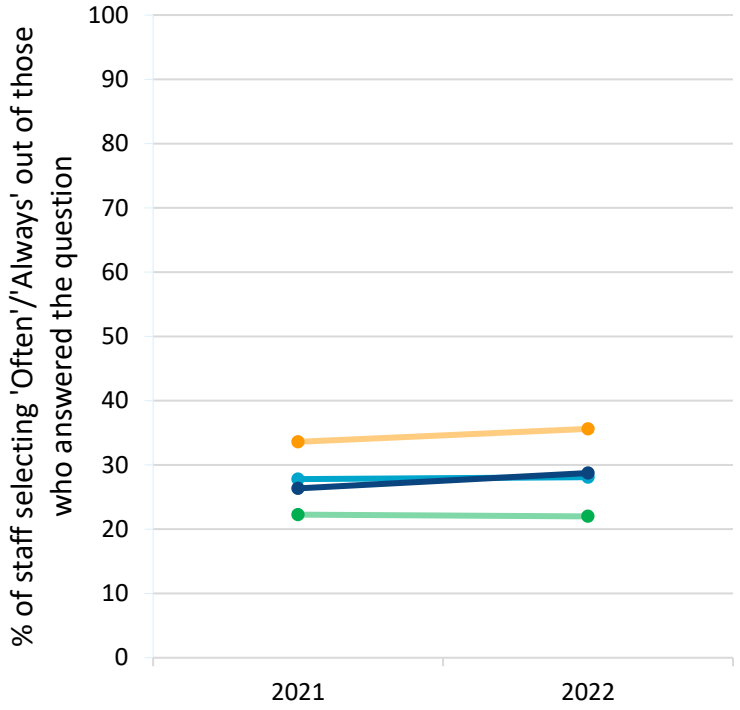
Survey Coordination Centre NHS

Q12a How often, if at all, do you find your work emotionally exhausting?



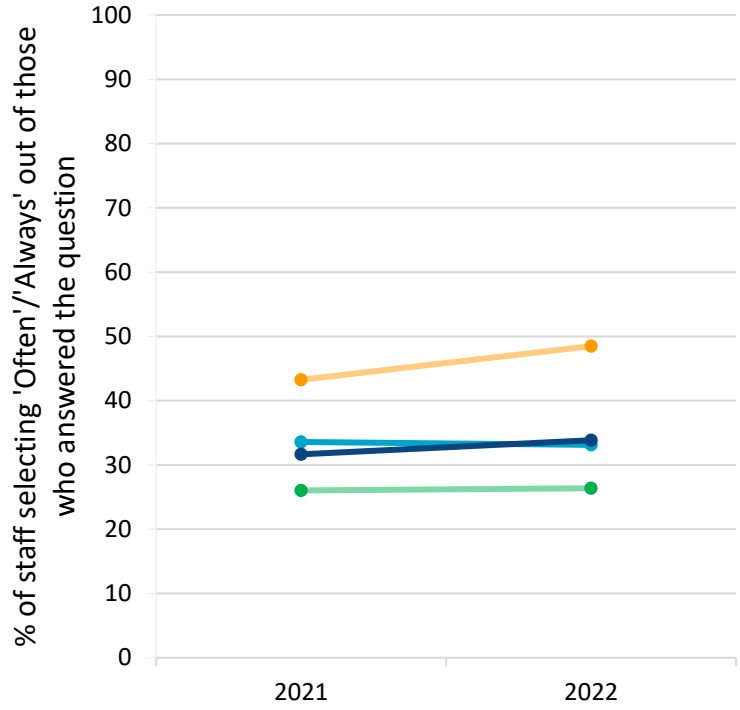
	2021	2022
Your org	35.4%	36.4%
Best	31.5%	30.2%
Average	36.1%	35.8%
Worst	45.1%	49.3%
Responses	2593	2543

Q12b How often, if at all, do you feel burnt out because of your work?



	2021	2022
Your org	26.3%	28.7%
Best	22.3%	22.0%
Average	27.8%	28.1%
Worst	33.6%	35.6%
Responses	2592	2540

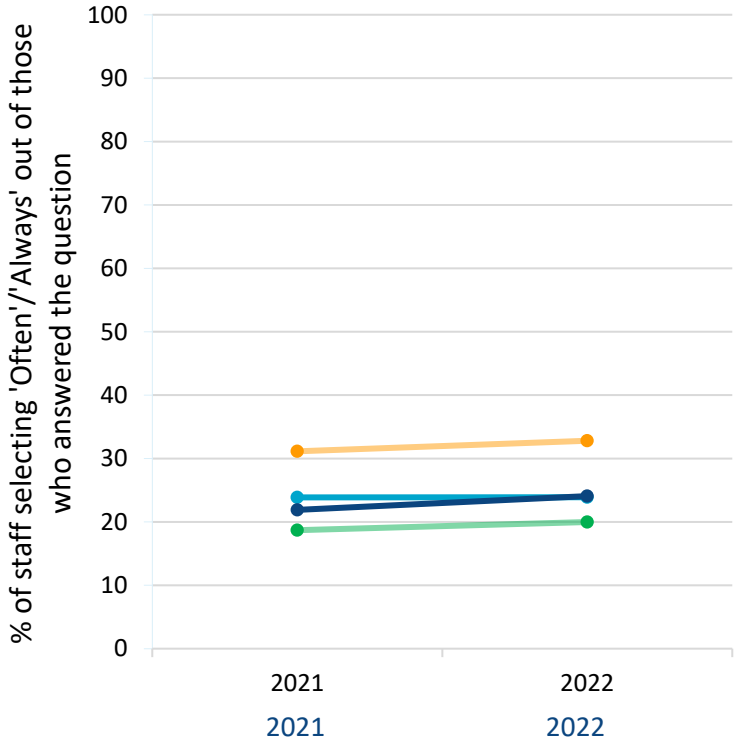
Q12c How often, if at all, does your work frustrate you?



	2021	2022
Your org	31.6%	33.8%
Best	26.0%	26.4%
Average	33.6%	33.1%
Worst	43.2%	48.5%
Responses	2588	2538

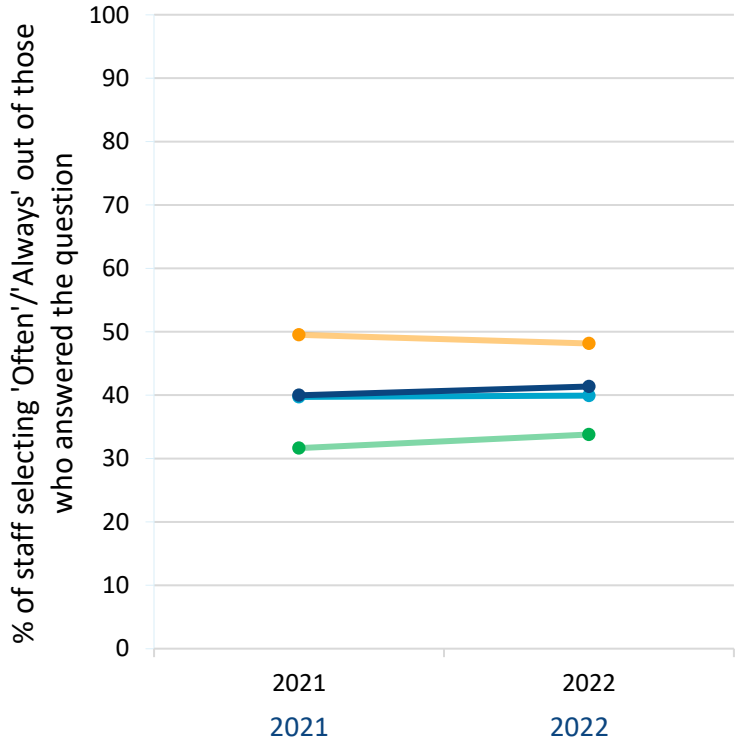
Survey Coordination Centre NHS

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



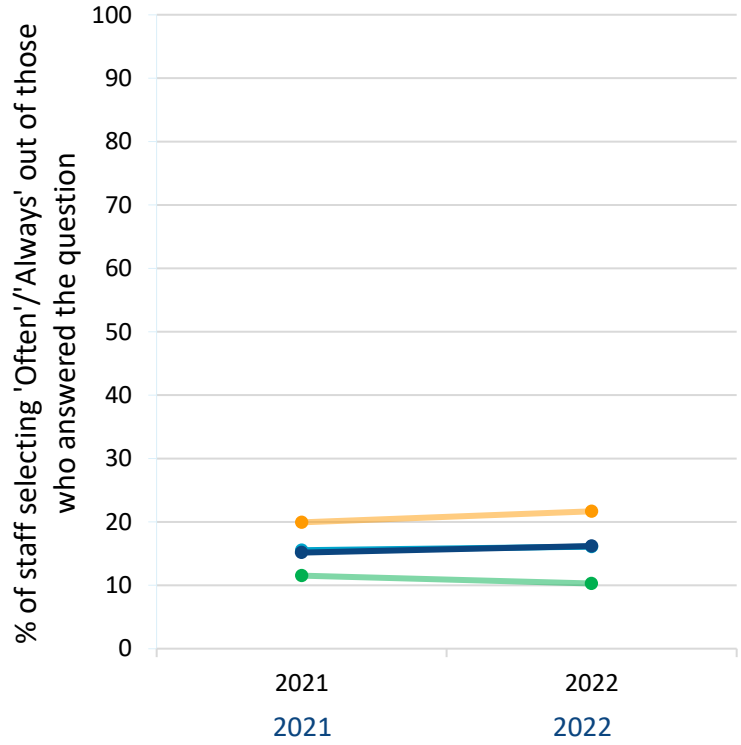
	2021	2022
Your org	21.9%	24.1%
Best	18.7%	20.0%
Average	23.9%	23.9%
Worst	31.1%	32.8%
Responses	2586	2536

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



	2021	2022
Your org	40.0%	41.4%
Best	31.6%	33.8%
Average	39.7%	39.9%
Worst	49.5%	48.2%
Responses	2588	2530

Q12f How often, if at all, do you feel that every working hour is tiring for you?

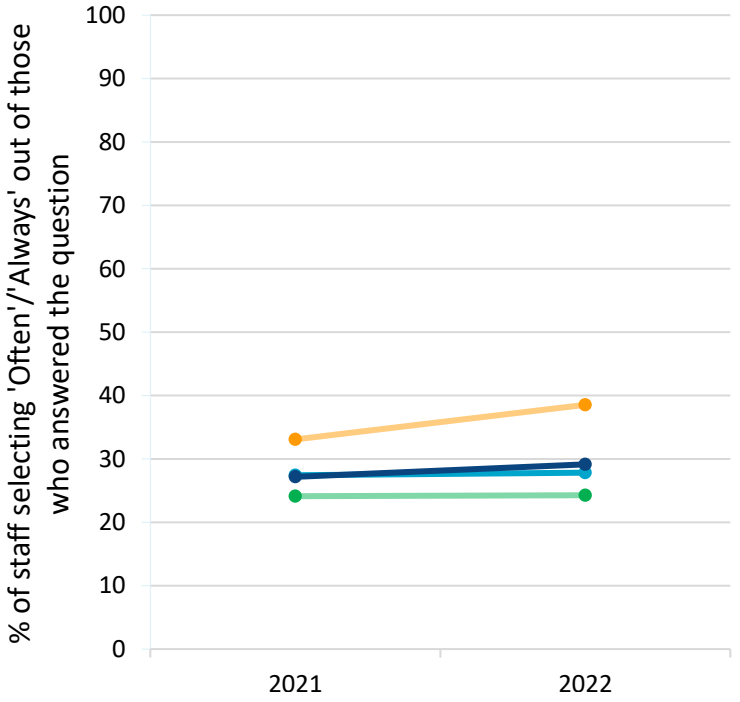


	2021	2022
Your org	15.2%	16.2%
Best	11.5%	10.3%
Average	15.5%	16.1%
Worst	19.9%	21.7%
Responses	2583	2536

Survey Coordination Centre

NHS

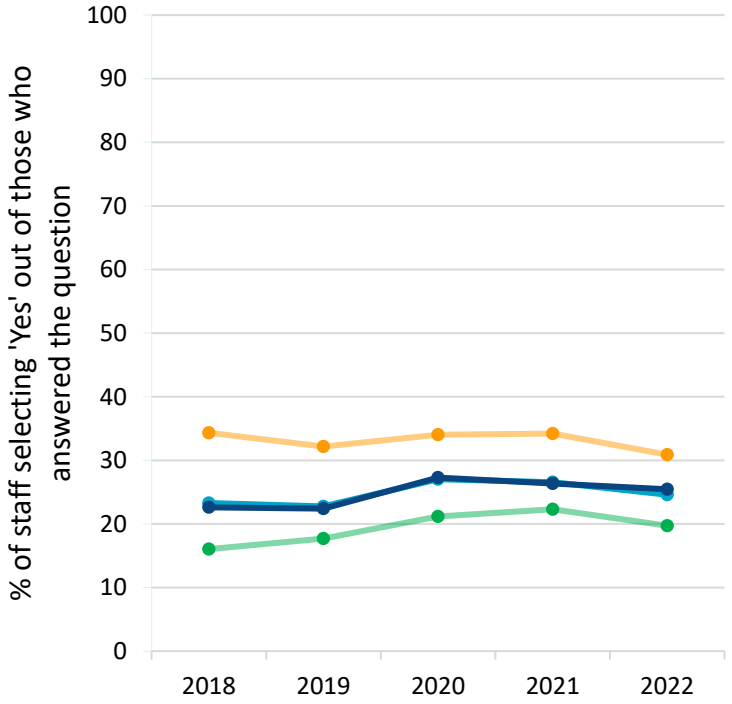
Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?



	2021	2022
Your org	27.2%	29.2%
Best	24.1%	24.3%
Average	27.4%	27.8%
Worst	33.1%	38.5%
Responses	2591	2538

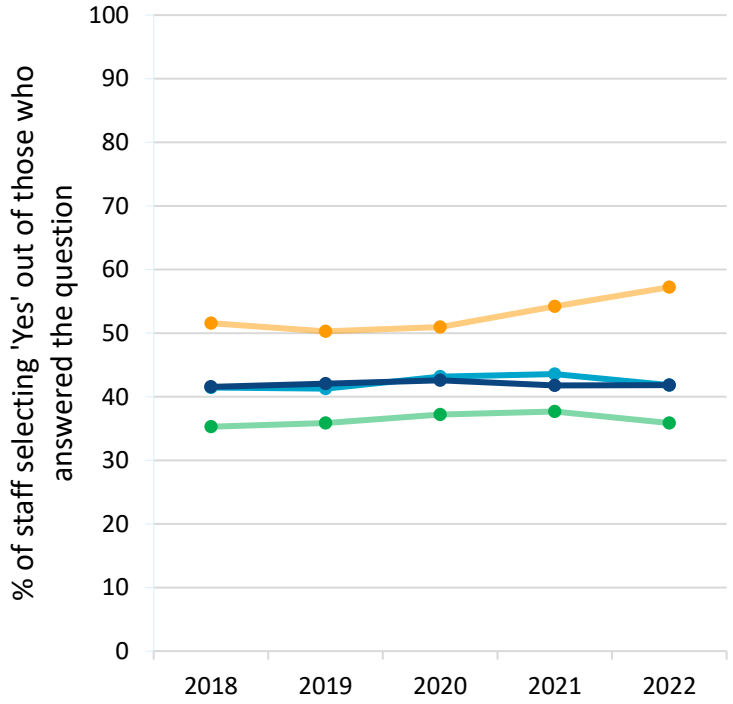
Survey Coordination Centre NHS

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



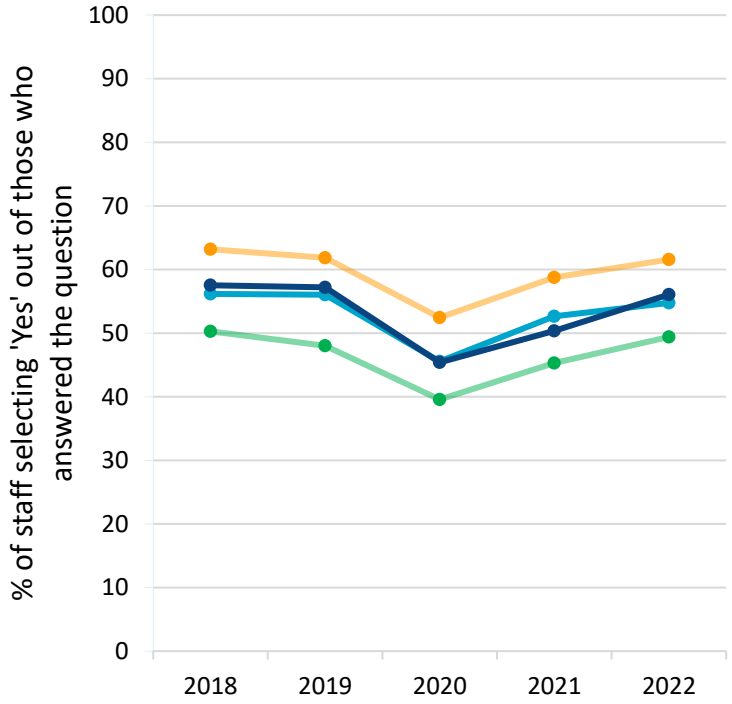
	2018	2019	2020	2021	2022
Your org	22.6%	22.4%	27.3%	26.4%	25.5%
Best	16.0%	17.7%	21.2%	22.3%	19.7%
Average	23.3%	22.8%	27.0%	26.5%	24.6%
Worst	34.3%	32.2%	34.0%	34.2%	30.9%
Responses	2076	2229	2291	2568	2531

Q11c During the last 12 months have you felt unwell as a result of work related stress?



	2018	2019	2020	2021	2022
Your org	41.6%	42.0%	42.6%	41.8%	41.8%
Best	35.3%	35.9%	37.2%	37.7%	35.9%
Average	41.4%	41.3%	43.2%	43.6%	41.8%
Worst	51.6%	50.3%	50.9%	54.2%	57.2%
Responses	2082	2241	2291	2576	2533

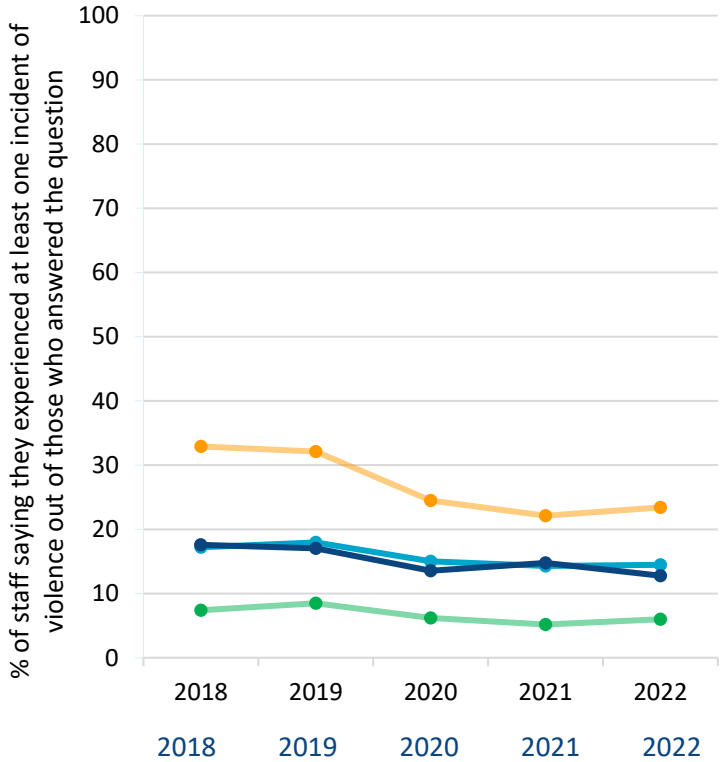
Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2018	2019	2020	2021	2022
Your org	57.5%	57.2%	45.4%	50.4%	56.1%
Best	50.3%	48.0%	39.6%	45.3%	49.4%
Average	56.2%	56.0%	45.5%	52.7%	54.7%
Worst	63.2%	61.8%	52.4%	58.7%	61.6%
Responses	2082	2242	2290	2574	2533

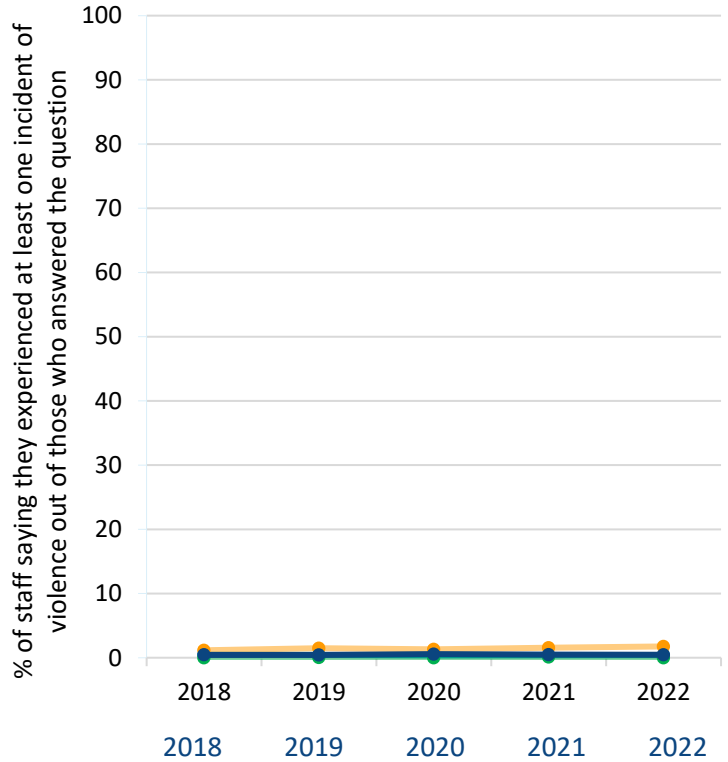
Survey Coordination Centre NHS

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



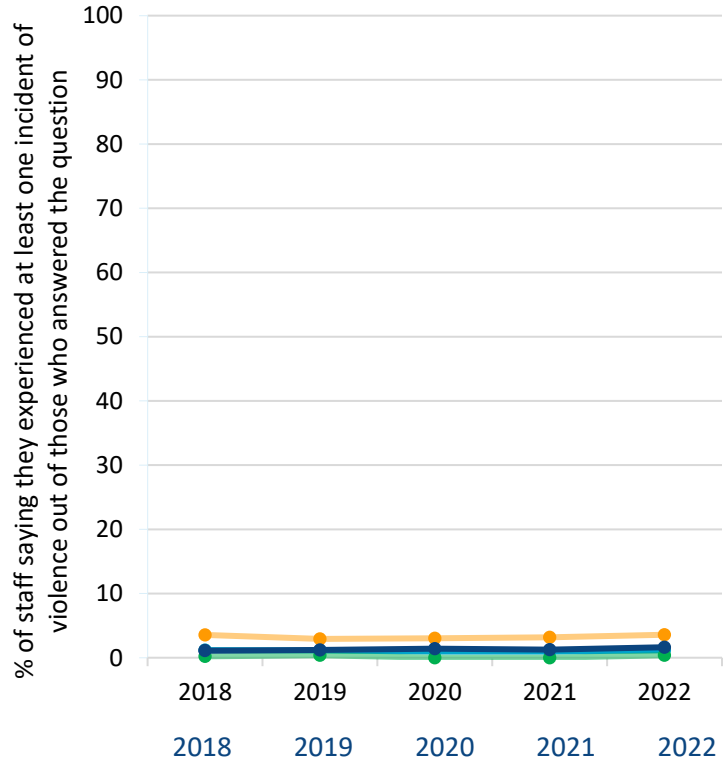
	2018	2019	2020	2021	2022
Your org	17.6%	17.0%	13.5%	14.8%	12.8%
Best	7.4%	8.5%	6.2%	5.2%	6.0%
Average	17.2%	18.0%	15.0%	14.3%	14.5%
Worst	32.9%	32.1%	24.5%	22.1%	23.4%
Responses	2062	2245	2291	2581	2537

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	0.4%	0.4%	0.6%	0.5%	0.5%
Best	0.0%	0.1%	0.0%	0.1%	0.0%
Average	0.5%	0.4%	0.4%	0.4%	0.4%
Worst	1.2%	1.5%	1.3%	1.6%	1.8%
Responses	2056	2233	2282	2563	2528

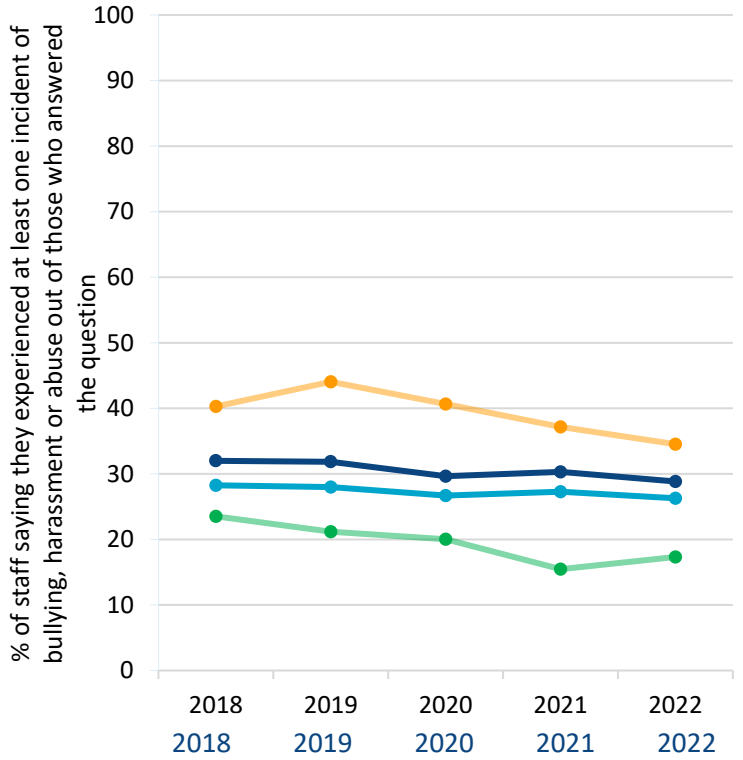
Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



	2018	2019	2020	2021	2022
Your org	1.1%	1.2%	1.4%	1.3%	1.6%
Best	0.2%	0.4%	0.0%	0.0%	0.4%
Average	1.2%	1.1%	1.0%	1.0%	1.2%
Worst	3.6%	2.9%	3.0%	3.2%	3.6%
Responses	2035	2226	2269	2541	2507

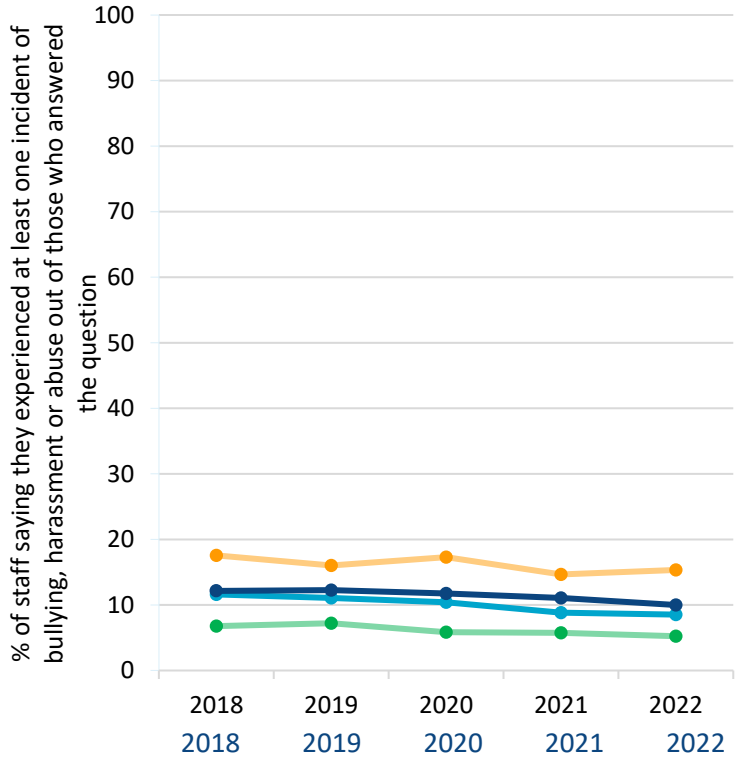
Survey Coordination Centre NHS

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



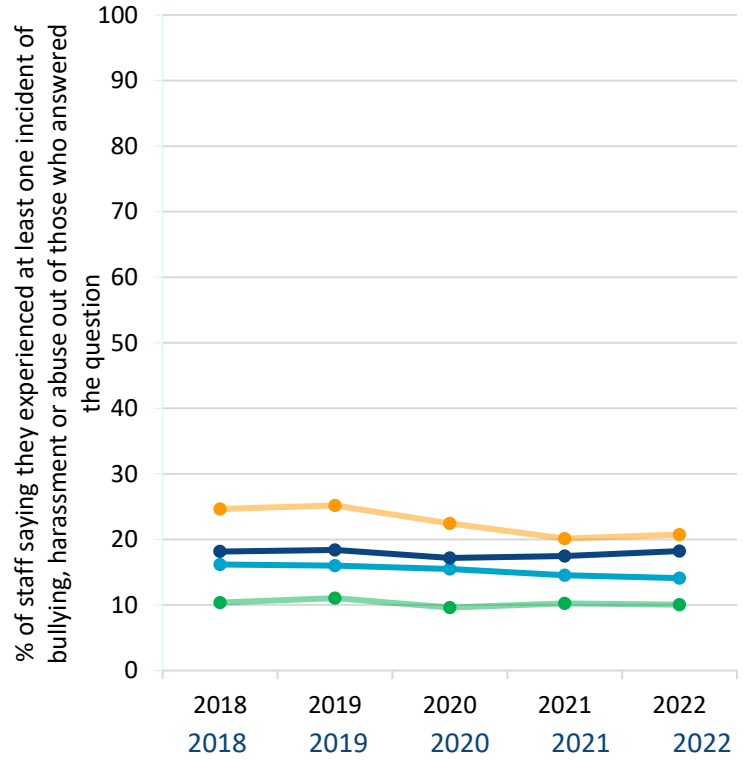
	2018	2019	2020	2021	2022
Your org	32.0%	31.8%	29.6%	30.3%	28.8%
Best	23.5%	21.2%	20.0%	15.5%	17.3%
Average	28.3%	28.0%	26.7%	27.3%	26.3%
Worst	40.3%	44.0%	40.6%	37.2%	34.5%
Responses	2074	2242	2277	2580	2525

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	12.1%	12.3%	11.7%	11.1%	10.0%
Best	6.8%	7.2%	5.8%	5.8%	5.2%
Average	11.6%	11.1%	10.4%	8.8%	8.5%
Worst	17.6%	16.0%	17.3%	14.7%	15.3%
Responses	2062	2227	2265	2558	2510

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



	2018	2019	2020	2021	2022
Your org	18.2%	18.4%	17.2%	17.5%	18.2%
Best	10.4%	11.1%	9.6%	10.2%	10.0%
Average	16.2%	16.0%	15.5%	14.5%	14.1%
Worst	24.6%	25.2%	22.5%	20.1%	20.7%
Responses	2048	2208	2253	2555	2499

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:

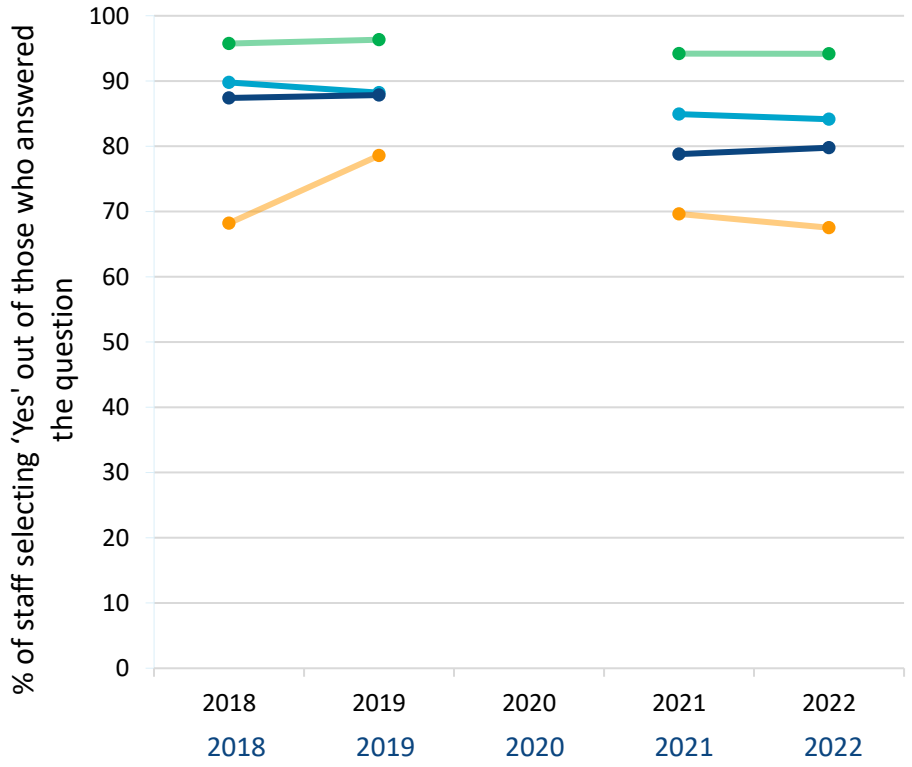
Development – Q22a, Q22b, Q22c, Q22d, Q22e

Appraisals – Q21b, Q21c, Q21d

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

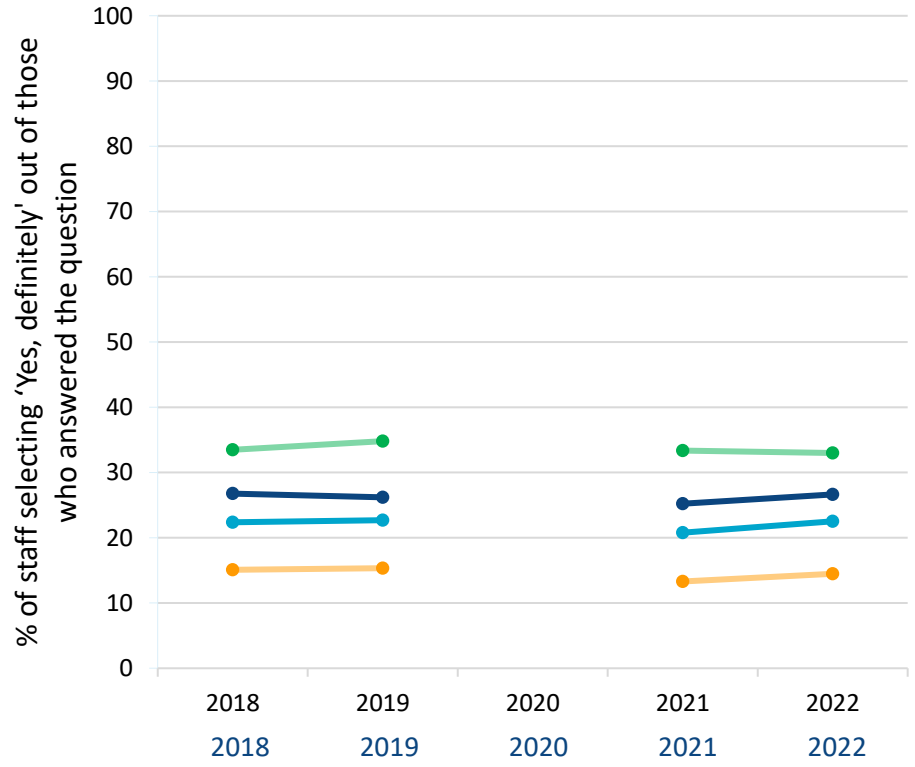
*Q21a is a filter question and therefore influences the sub-score without being a directly scored question.

Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2018	2019	2020	2021	2022
Your org	87.4%	87.8%	-	78.8%	79.8%
Best	95.7%	96.3%	-	94.2%	94.2%
Average	89.8%	88.2%	-	84.9%	84.1%
Worst	68.2%	78.6%	-	69.6%	67.5%
Responses	2062	2226	-	2560	2523

Q21b It helped me to improve how I do my job.

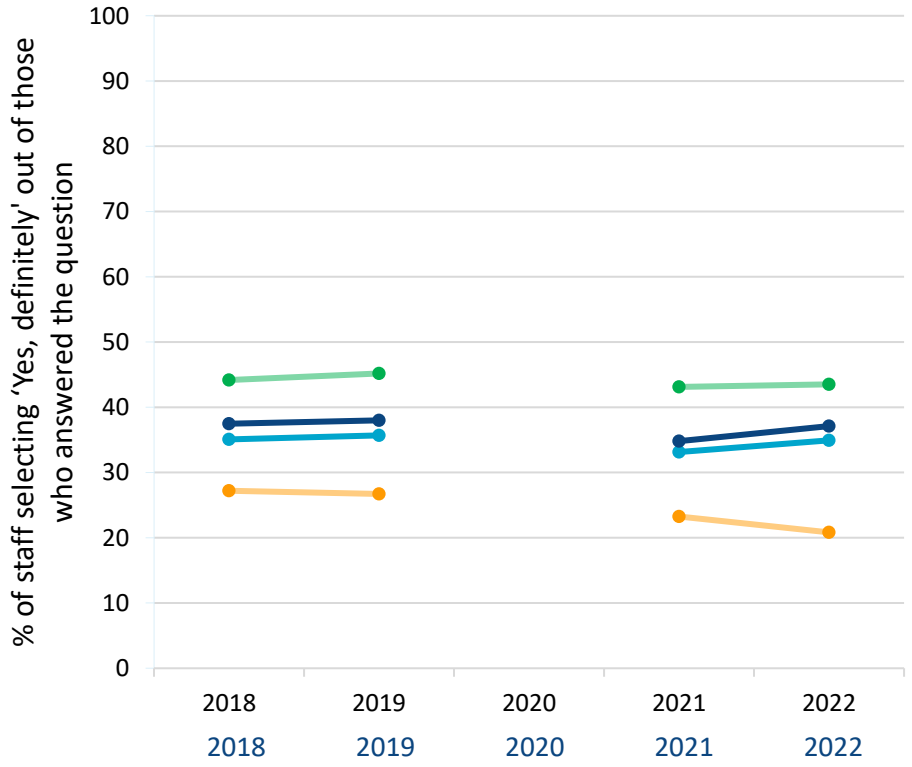


	2018	2019	2020	2021	2022
Your org	26.8%	26.2%	-	25.2%	26.6%
Best	33.5%	34.8%	-	33.4%	33.0%
Average	22.4%	22.7%	-	20.8%	22.5%
Worst	15.1%	15.3%	-	13.3%	14.5%
Responses	1798	1939	-	1997	2005

Survey Coordination Centre

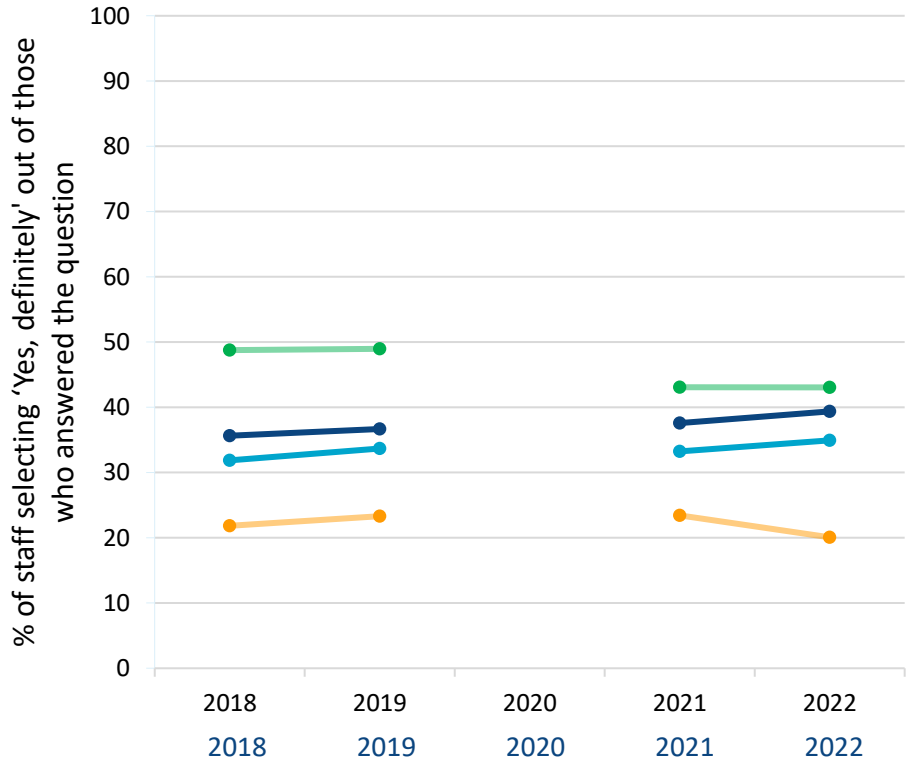
NHS

Q21c It helped me agree clear objectives for my work.



	2018	2019	2020	2021	2022
Your org	37.5%	38.0%	-	34.8%	37.1%
Best	44.2%	45.2%	-	43.1%	43.5%
Average	35.1%	35.7%	-	33.1%	34.9%
Worst	27.2%	26.7%	-	23.3%	20.8%
Responses	1787	1939	-	1992	2004

Q21d It left me feeling that my work is valued by my organisation.

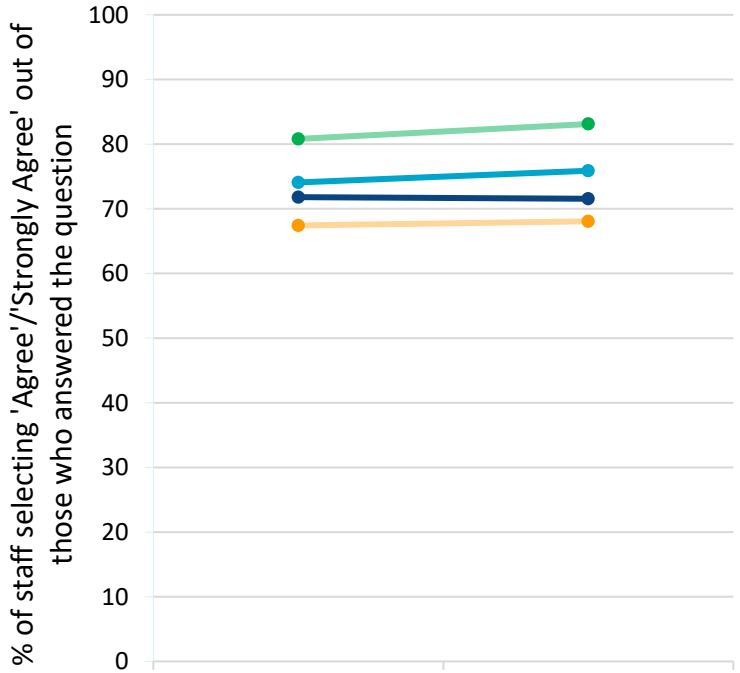


	2018	2019	2020	2021	2022
Your org	35.6%	36.7%	-	37.6%	39.4%
Best	48.7%	48.9%	-	43.1%	43.1%
Average	31.9%	33.7%	-	33.2%	34.9%
Worst	21.8%	23.3%	-	23.4%	20.1%
Responses	1790	1930	-	1998	2003

Survey Coordination Centre

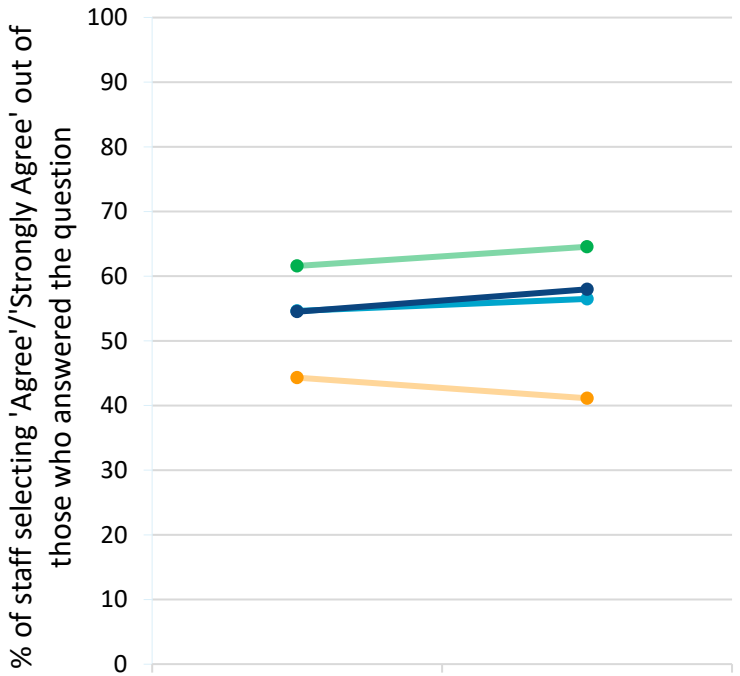
NHS

Q22a This organisation offers me challenging work.



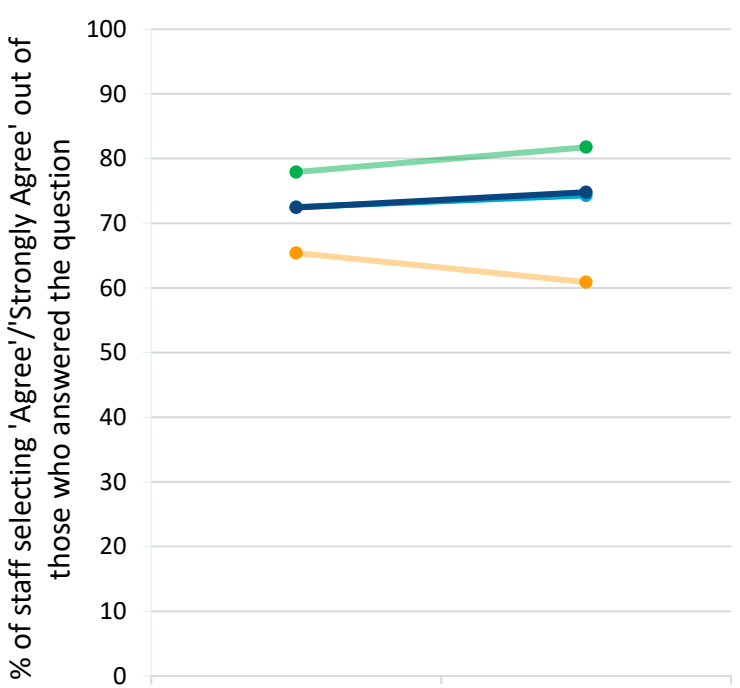
	2021	2022
Your org	71.8%	71.6%
Best	80.8%	83.1%
Average	74.1%	75.9%
Worst	67.4%	68.1%
Responses	2583	2529

Q22b There are opportunities for me to develop my career in this organisation.



	2021	2022
Your org	54.5%	58.0%
Best	61.6%	64.5%
Average	54.6%	56.5%
Worst	44.3%	41.1%
Responses	2584	2535

Q22c I have opportunities to improve my knowledge and skills.

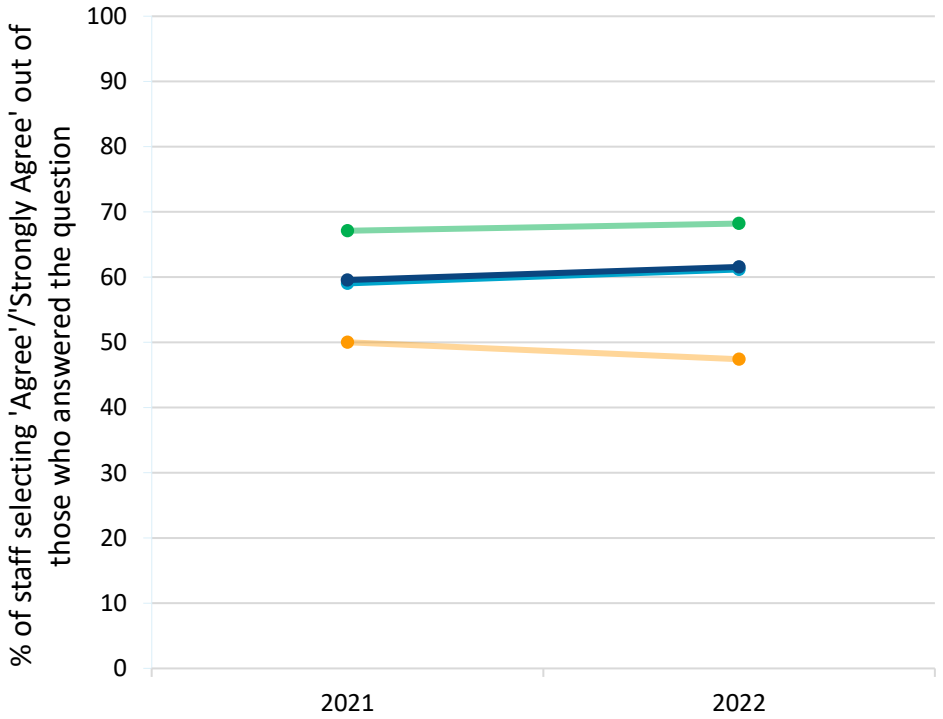


	2021	2022
Your org	72.4%	74.8%
Best	77.9%	81.8%
Average	72.5%	74.3%
Worst	65.4%	60.9%
Responses	2579	2534

Survey Coordination Centre

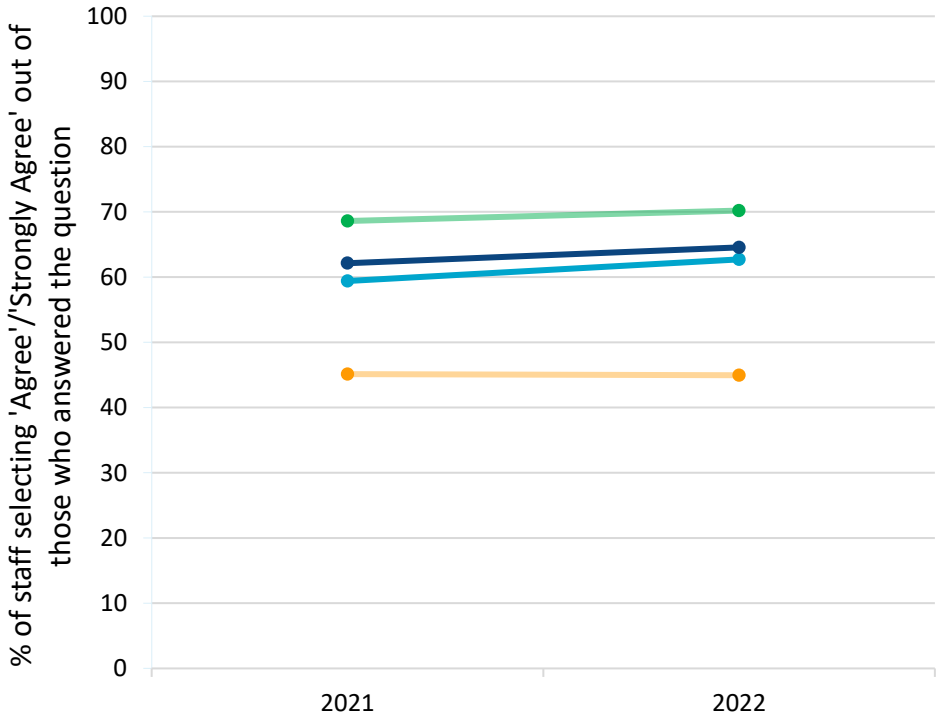
NHS

Q22d I feel supported to develop my potential.



	2021	2022
Your org	59.5%	61.6%
Best	67.1%	68.2%
Average	59.0%	61.2%
Worst	50.0%	47.4%
Responses	2576	2533

Q22e I am able to access the right learning and development opportunities when I need to.



	2021	2022
Your org	62.1%	64.5%
Best	68.6%	70.2%
Average	59.4%	62.7%
Worst	45.1%	44.9%
Responses	2574	2531

Survey Coordination Centre

NHS

People Promise element – We work flexibly

Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

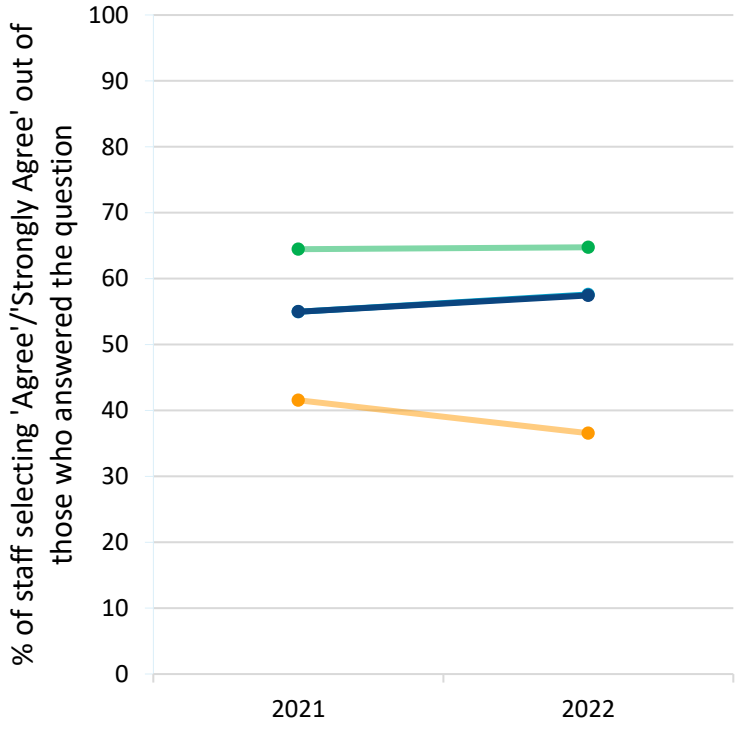
Flexible working – Q4d

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

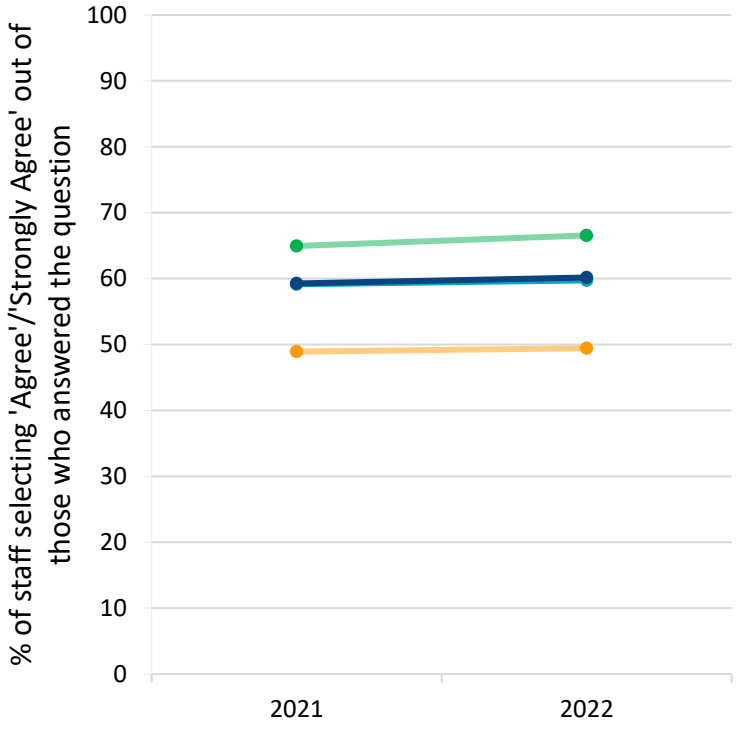
NHS

Q6b My organisation is committed to helping me balance my work and home life.



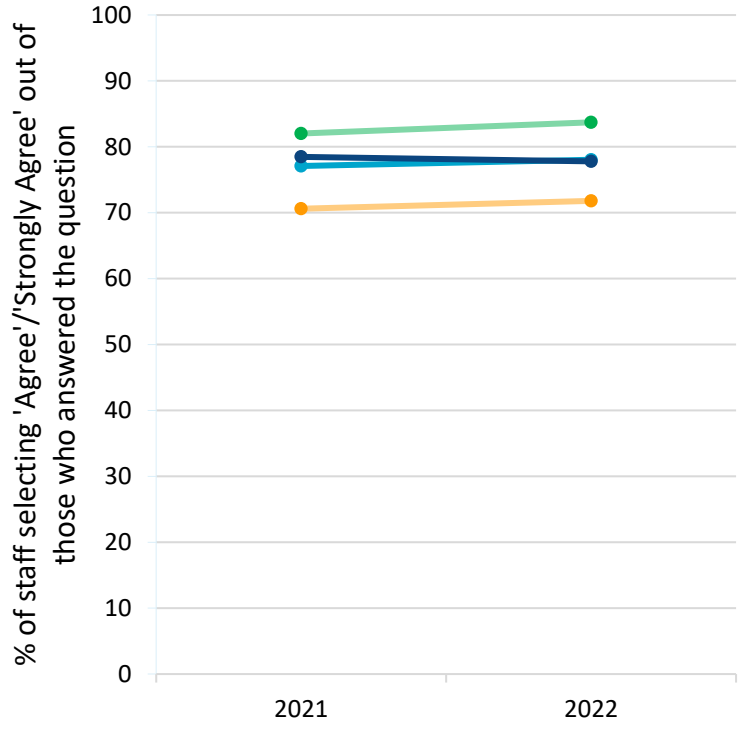
	2021	2022
Your org	55.0%	57.4%
Best	64.5%	64.7%
Average	55.0%	57.6%
Worst	41.5%	36.6%
Responses	2589	2533

Q6c I achieve a good balance between my work life and my home life.



	2021	2022
Your org	59.3%	60.2%
Best	64.9%	66.5%
Average	59.1%	59.7%
Worst	48.9%	49.4%
Responses	2584	2537

Q6d I can approach my immediate manager to talk openly about flexible working.

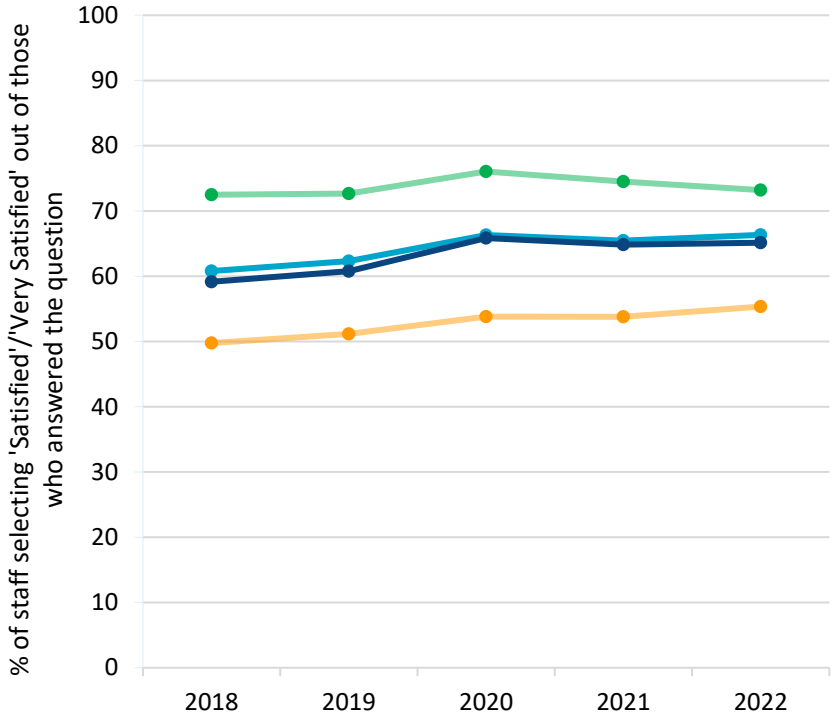


	2021	2022
Your org	78.5%	77.8%
Best	82.0%	83.7%
Average	77.1%	78.0%
Worst	70.6%	71.8%
Responses	2584	2541

Survey Coordination Centre

NHS

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.

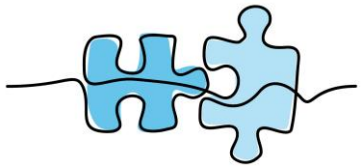


	2018	2019	2020	2021	2022
Your org	59.1%	60.8%	65.8%	64.8%	65.1%
Best	72.5%	72.7%	76.1%	74.5%	73.2%
Average	60.8%	62.3%	66.3%	65.5%	66.3%
Worst	49.8%	51.2%	53.8%	53.8%	55.4%
Responses	2074	2262	2291	2573	2524

Survey Coordination Centre

NHS

People Promise element – We are a team



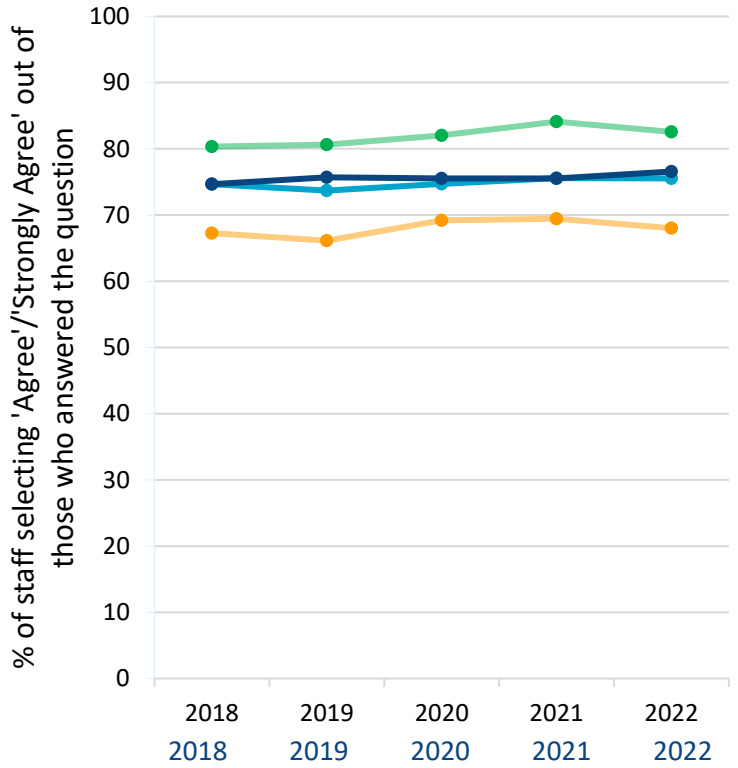
Questions included:

Teamworking – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

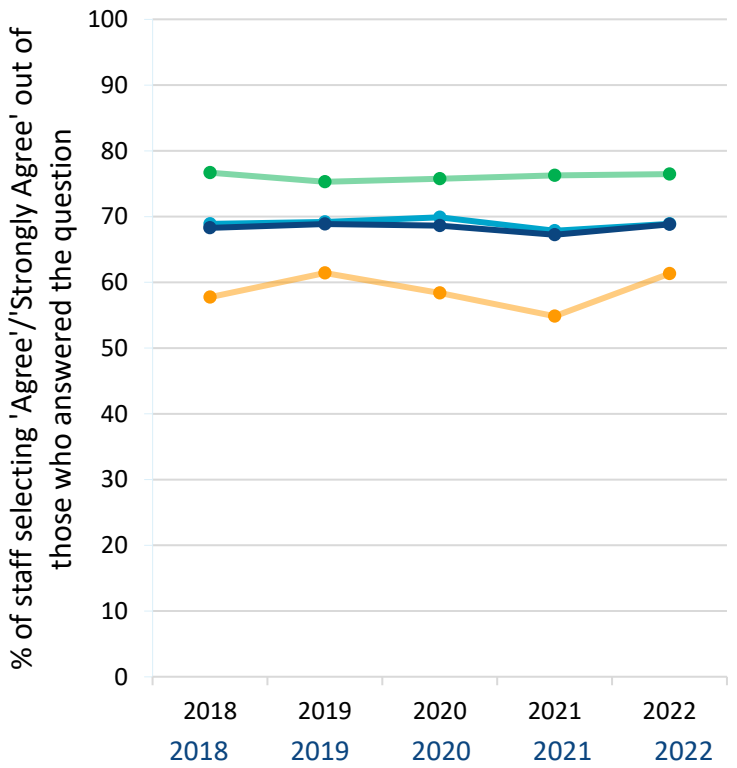
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q7a The team I work in has a set of shared objectives.



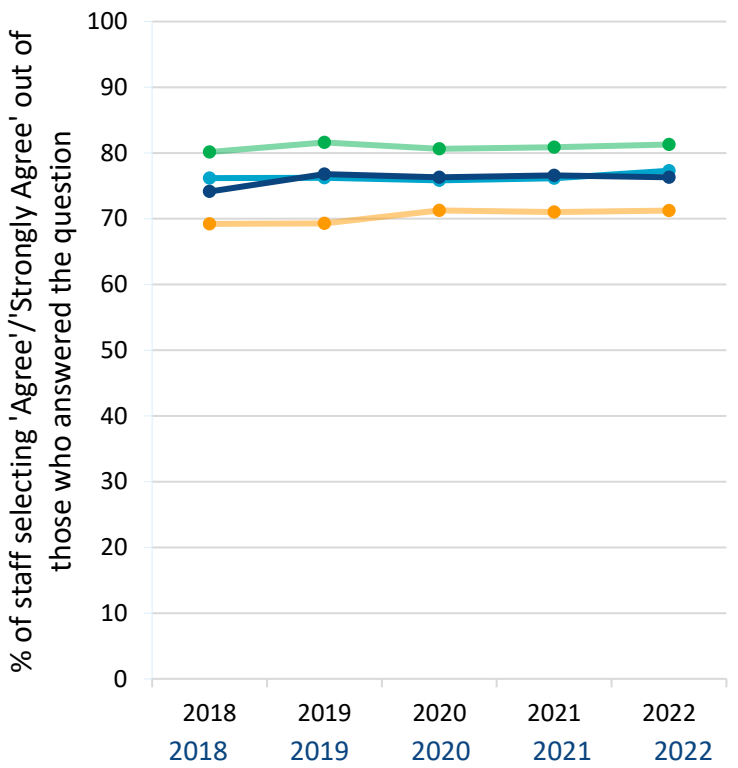
	2018	2019	2020	2021	2022
Your org	74.7%	75.7%	75.5%	75.5%	76.6%
Best	80.3%	80.6%	82.0%	84.1%	82.6%
Average	74.7%	73.7%	74.7%	75.6%	75.5%
Worst	67.3%	66.1%	69.2%	69.4%	68.0%
Responses	2081	2248	2278	2576	2534

Q7b The team I work in often meets to discuss the team's effectiveness.



	2018	2019	2020	2021	2022
Your org	68.3%	68.9%	68.6%	67.2%	68.8%
Best	76.7%	75.3%	75.8%	76.3%	76.5%
Average	68.9%	69.2%	69.9%	67.9%	68.9%
Worst	57.7%	61.4%	58.4%	54.9%	61.3%
Responses	2086	2259	2290	2570	2535

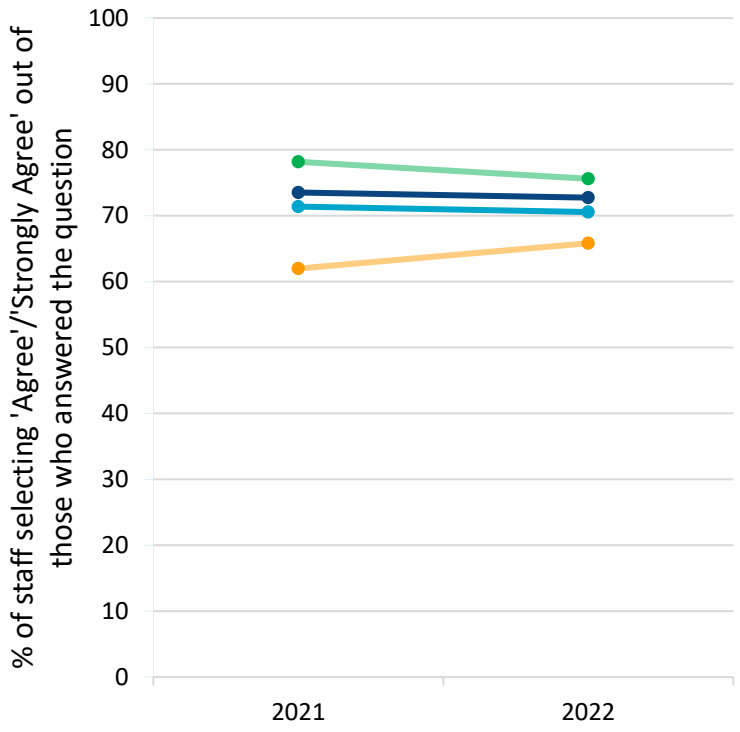
Q7c I receive the respect I deserve from my colleagues at work.



	2018	2019	2020	2021	2022
Your org	74.1%	76.8%	76.3%	76.6%	76.3%
Best	80.2%	81.6%	80.6%	80.9%	81.3%
Average	76.2%	76.2%	75.8%	76.1%	77.3%
Worst	69.2%	69.3%	71.3%	71.0%	71.2%
Responses	2094	2268	2284	2578	2537

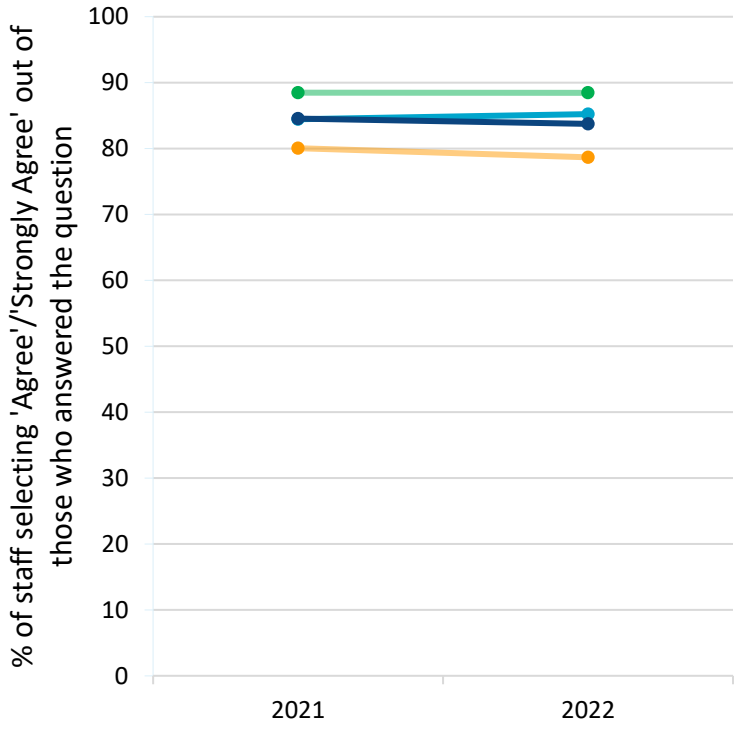
Survey Coordination Centre NHS

Q7d Team members understand each other's roles.



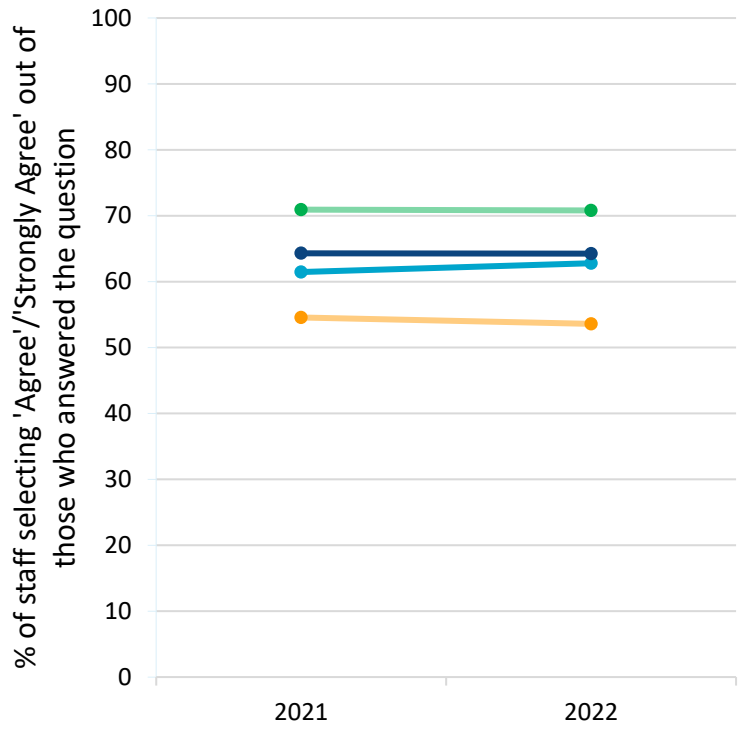
	2021	2022
Your org	73.5%	72.7%
Best	78.2%	75.6%
Average	71.4%	70.6%
Worst	62.0%	65.8%
Responses	2575	2538

Q7e I enjoy working with the colleagues in my team.



	2021	2022
Your org	84.5%	83.7%
Best	88.5%	88.5%
Average	84.4%	85.2%
Worst	80.0%	78.7%
Responses	2571	2533

Q7f My team has enough freedom in how to do its work.

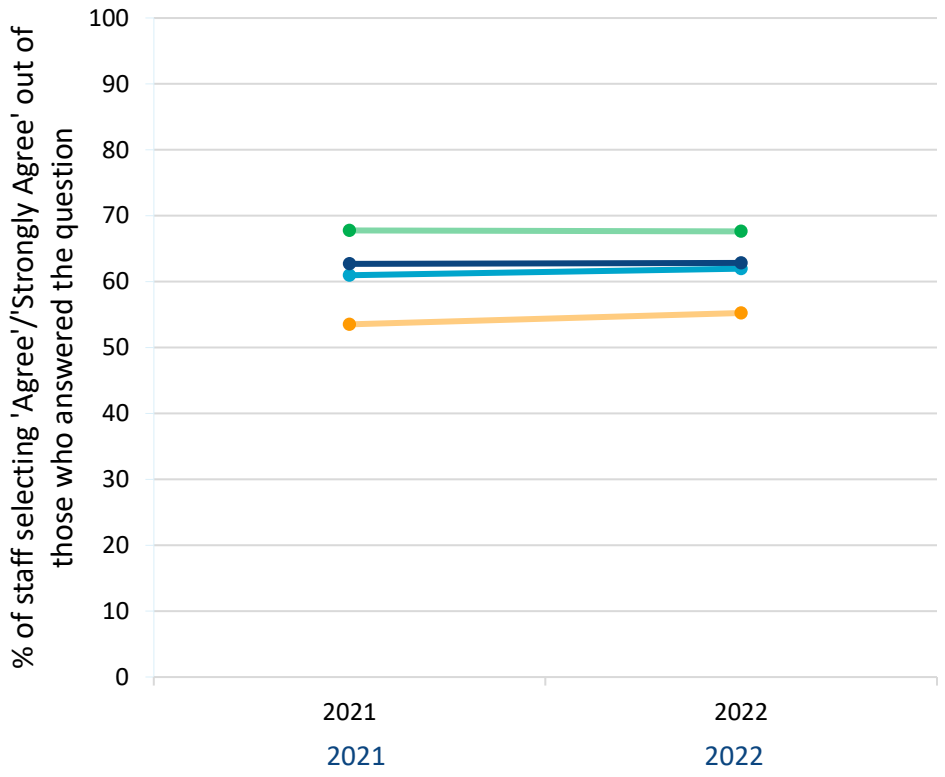


	2021	2022
Your org	64.3%	64.3%
Best	70.9%	70.8%
Average	61.5%	62.8%
Worst	54.6%	53.6%
Responses	2562	2528

Survey Coordination Centre

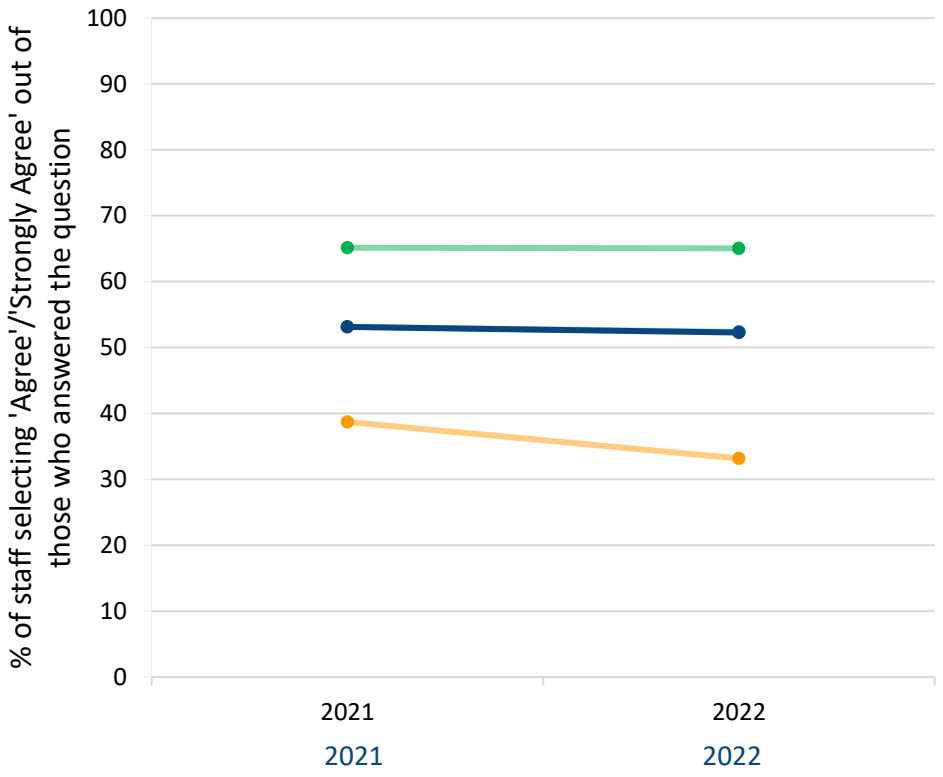
NHS

Q7g In my team disagreements are dealt with constructively.



	2021	2022
Your org	62.7%	62.8%
Best	67.8%	67.6%
Average	61.0%	62.0%
Worst	53.5%	55.2%
Responses	2569	2533

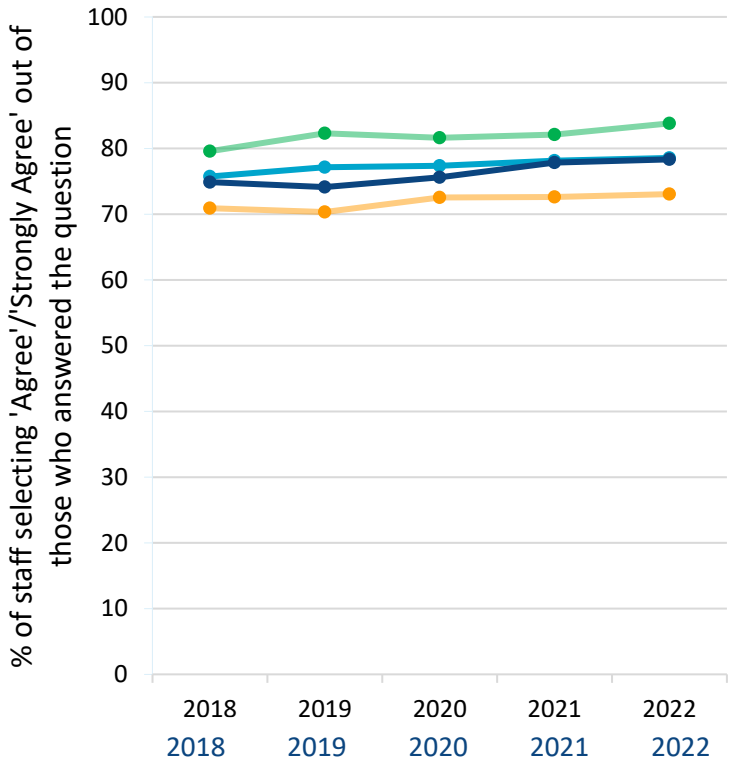
Q8a Teams within this organisation work well together to achieve their objectives.



	2021	2022
Your org	53.1%	52.3%
Best	65.1%	65.0%
Average	53.1%	52.4%
Worst	38.7%	33.2%
Responses	2567	2528

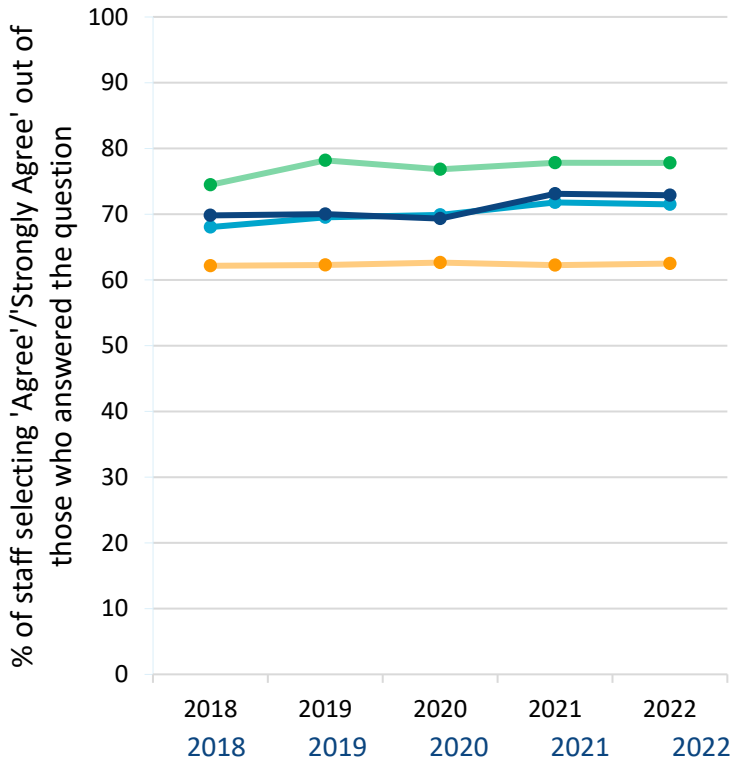
Survey Coordination Centre NHS

Q9a My immediate manager encourages me at work.



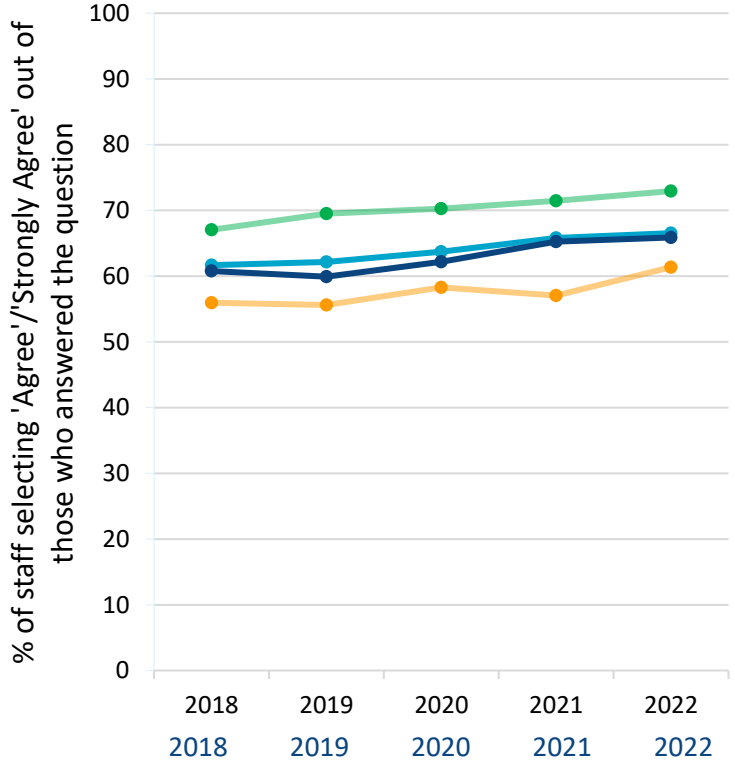
	2018	2019	2020	2021	2022
Your org	74.9%	74.1%	75.6%	77.9%	78.3%
Best	79.6%	82.3%	81.6%	82.1%	83.8%
Average	75.7%	77.1%	77.4%	78.1%	78.5%
Worst	70.9%	70.3%	72.5%	72.6%	73.1%
Responses	2095	2246	2292	2589	2542

Q9b My immediate manager gives me clear feedback on my work.



	2018	2019	2020	2021	2022
Your org	69.8%	70.0%	69.3%	73.1%	72.9%
Best	74.5%	78.2%	76.8%	77.8%	77.8%
Average	68.0%	69.5%	69.9%	71.8%	71.5%
Worst	62.1%	62.3%	62.6%	62.3%	62.5%
Responses	2093	2242	2288	2593	2537

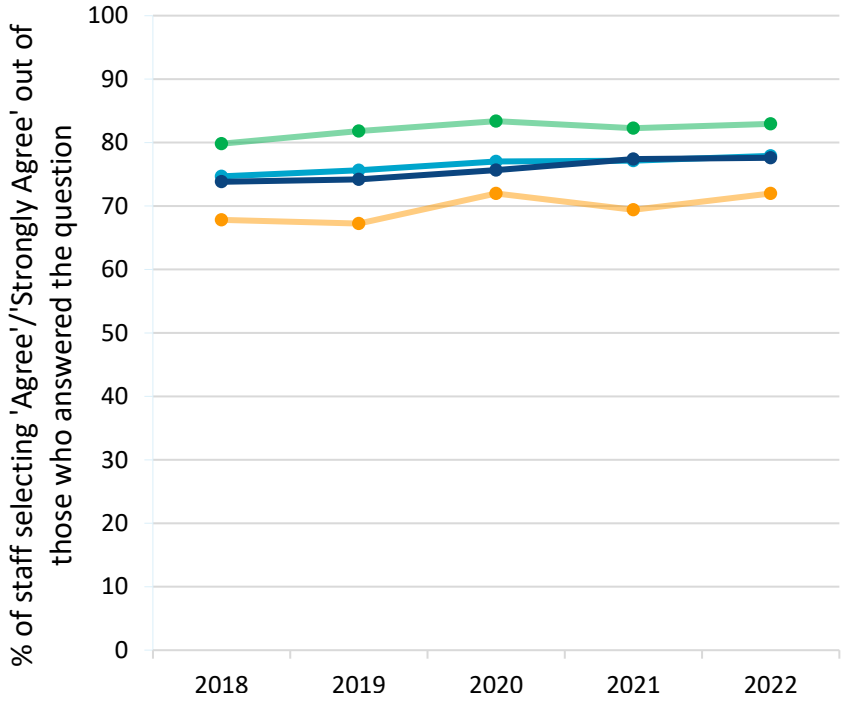
Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2018	2019	2020	2021	2022
Your org	60.8%	59.9%	62.2%	65.3%	65.9%
Best	67.0%	69.5%	70.3%	71.5%	72.9%
Average	61.7%	62.2%	63.7%	65.8%	66.6%
Worst	56.0%	55.6%	58.3%	57.0%	61.3%
Responses	2093	2241	2290	2592	2532

Survey Coordination Centre NHS

Q9d My immediate manager takes a positive interest in my health and well-being.



	2018	2019	2020	2021	2022
Your org	73.8%	74.2%	75.7%	77.4%	77.6%
Best	79.8%	81.8%	83.4%	82.3%	83.0%
Average	74.7%	75.6%	77.0%	77.2%	77.9%
Worst	67.8%	67.2%	72.0%	69.4%	72.0%
Responses	2087	2239	2289	2589	2542

Survey Coordination Centre

NHS

Theme – Staff engagement

Questions included:

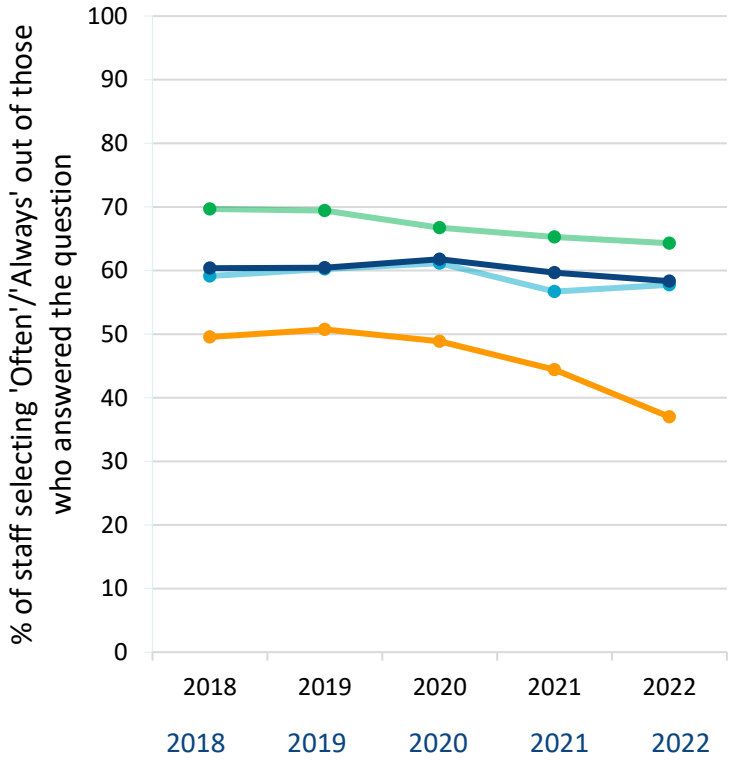
Motivation – Q2a, Q2b, Q2c

Involvement – Q3c, Q3d, Q3f

Advocacy – Q23a, Q23c, Q23d

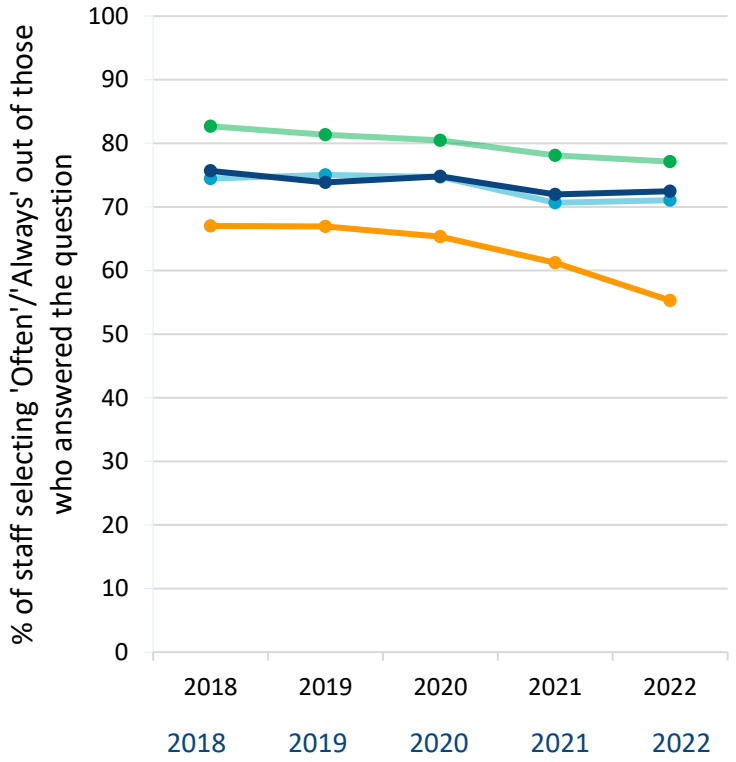
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q2a I look forward to going to work.



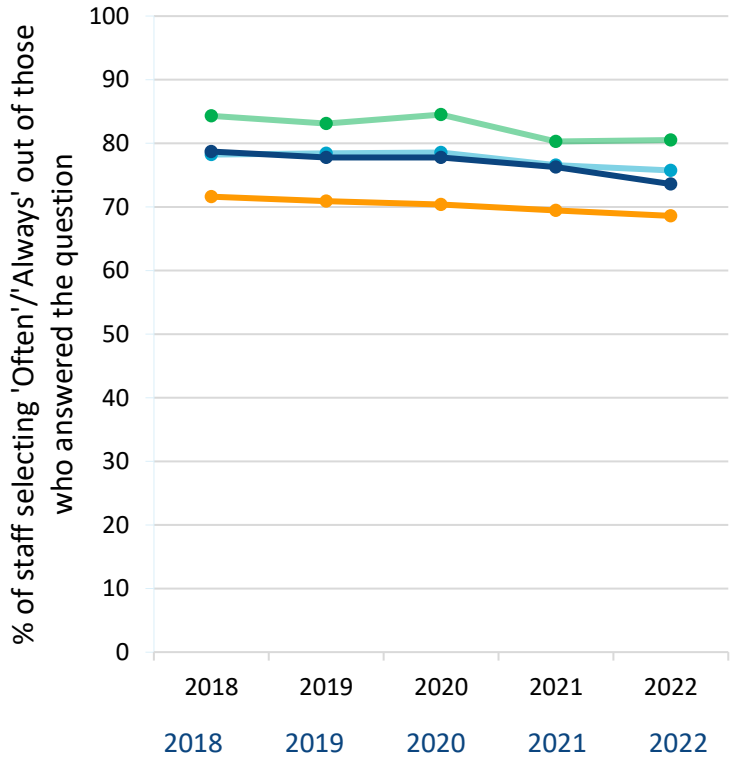
	2018	2019	2020	2021	2022
Your org	60.4%	60.4%	61.8%	59.7%	58.3%
Best	69.7%	69.4%	66.7%	65.3%	64.3%
Average	59.1%	60.2%	61.1%	56.7%	57.8%
Worst	49.5%	50.7%	48.9%	44.4%	37.0%
Responses	2102	2258	2284	2575	2509

Q2b I am enthusiastic about my job.



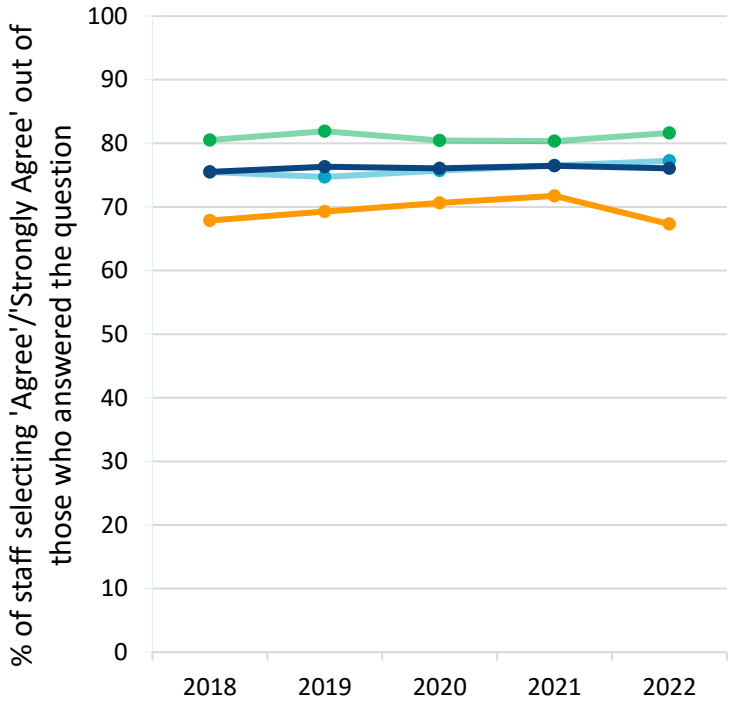
	2018	2019	2020	2021	2022
Your org	75.7%	73.9%	74.8%	72.0%	72.5%
Best	82.7%	81.3%	80.5%	78.1%	77.1%
Average	74.5%	75.0%	74.7%	70.7%	71.1%
Worst	67.0%	66.9%	65.3%	61.2%	55.3%
Responses	2095	2246	2282	2557	2499

Q2c Time passes quickly when I am working.



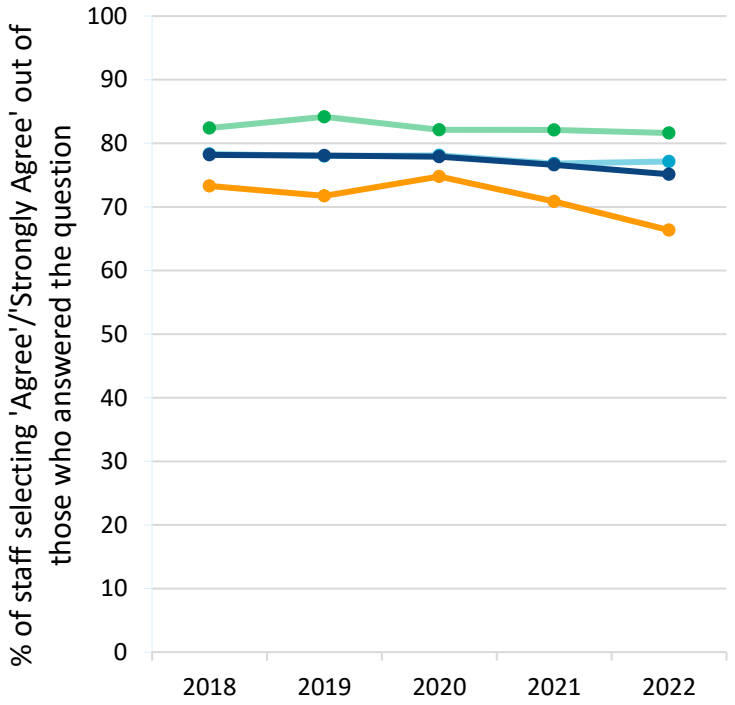
	2018	2019	2020	2021	2022
Your org	78.7%	77.8%	77.8%	76.3%	73.6%
Best	84.3%	83.1%	84.5%	80.3%	80.5%
Average	78.2%	78.4%	78.6%	76.6%	75.7%
Worst	71.6%	70.9%	70.4%	69.4%	68.6%
Responses	2090	2244	2282	2558	2506

Q3c There are frequent opportunities for me to show initiative in my role.



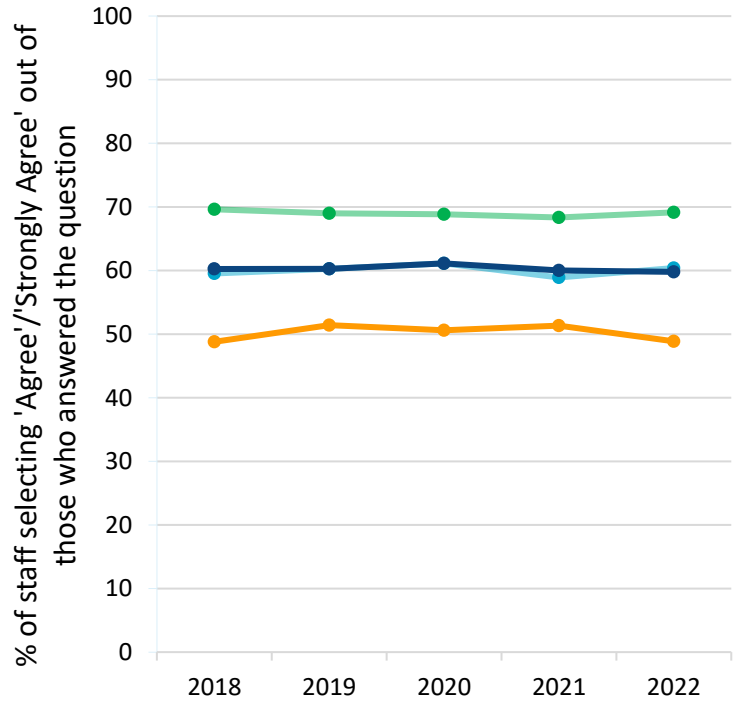
	2018	2019	2020	2021	2022
Your org	75.5%	76.3%	76.1%	76.5%	76.1%
Best	80.5%	81.9%	80.4%	80.4%	81.6%
Average	75.5%	74.7%	75.7%	76.5%	77.3%
Worst	67.9%	69.3%	70.6%	71.7%	67.3%
Responses	2101	2270	2296	2586	2529

Q3d I am able to make suggestions to improve the work of my team / department.



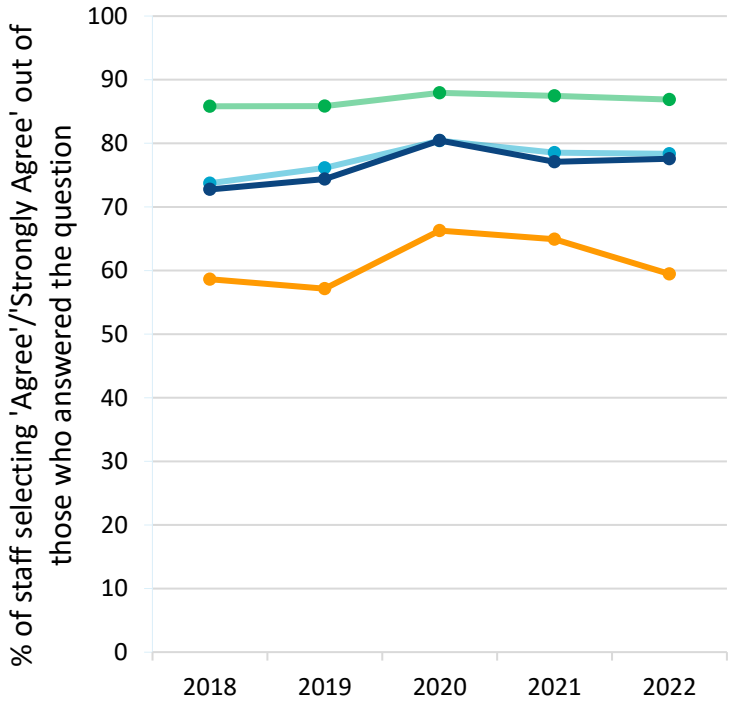
	2018	2019	2020	2021	2022
Your org	78.2%	78.1%	77.9%	76.6%	75.1%
Best	82.4%	84.2%	82.1%	82.1%	81.6%
Average	78.3%	78.0%	78.1%	76.8%	77.1%
Worst	73.3%	71.7%	74.8%	70.9%	66.3%
Responses	2099	2271	2291	2580	2532

Q3f I am able to make improvements happen in my area of work.



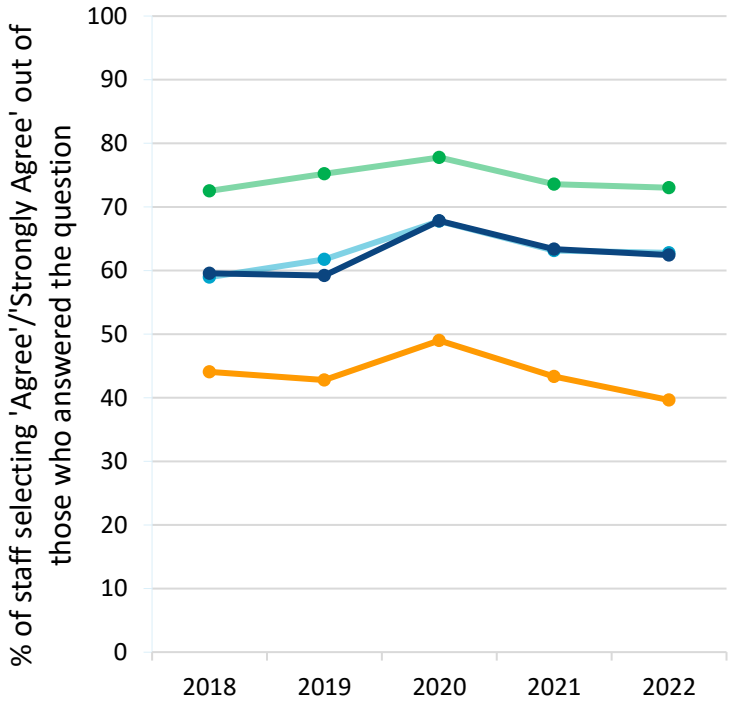
	2018	2019	2020	2021	2022
Your org	60.2%	60.3%	61.1%	60.0%	59.8%
Best	69.6%	69.0%	68.8%	68.4%	69.1%
Average	59.5%	60.3%	61.1%	58.9%	60.4%
Worst	48.8%	51.4%	50.6%	51.3%	48.9%
Responses	2093	2256	2292	2577	2521

Q23a Care of patients / service users is my organisation's top priority.



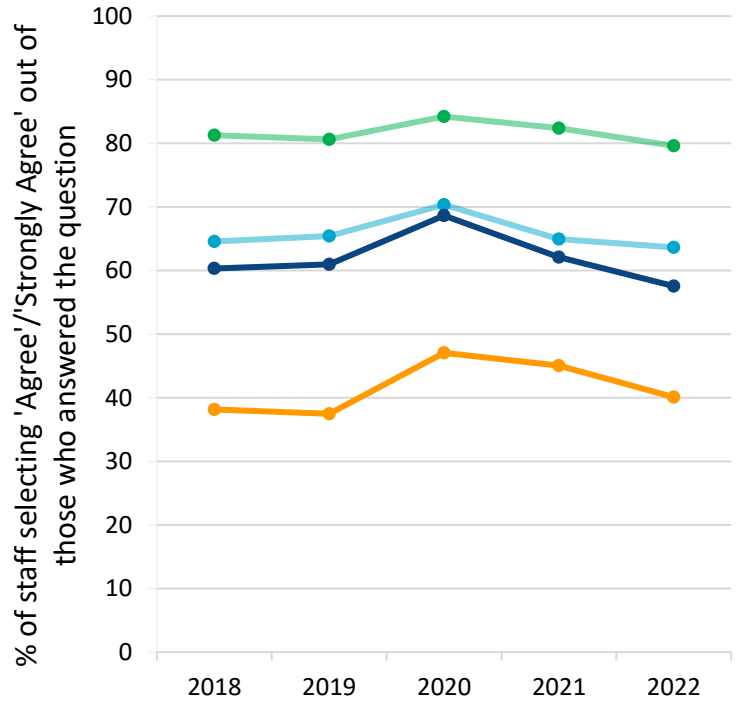
	2018	2019	2020	2021	2022
Your org	72.8%	74.4%	80.4%	77.1%	77.6%
Best	85.8%	85.9%	87.9%	87.5%	86.9%
Average	73.7%	76.1%	80.4%	78.5%	78.3%
Worst	58.6%	57.2%	66.3%	64.9%	59.5%
Responses	2070	2237	2289	2584	2529

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	59.6%	59.2%	67.8%	63.4%	62.4%
Best	72.5%	75.2%	77.8%	73.6%	73.0%
Average	59.0%	61.8%	67.8%	63.1%	62.8%
Worst	44.1%	42.8%	49.0%	43.3%	39.6%
Responses	2063	2232	2286	2580	2531

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2018	2019	2020	2021	2022
Your org	60.3%	61.0%	68.6%	62.1%	57.5%
Best	81.3%	80.6%	84.2%	82.4%	79.6%
Average	64.6%	65.4%	70.4%	64.9%	63.6%
Worst	38.2%	37.5%	47.1%	45.0%	40.1%
Responses	2056	2230	2283	2578	2532

Survey Coordination Centre

NHS

Theme - Morale

Questions included:

Thinking about leaving – Q24a, Q24b, Q24c

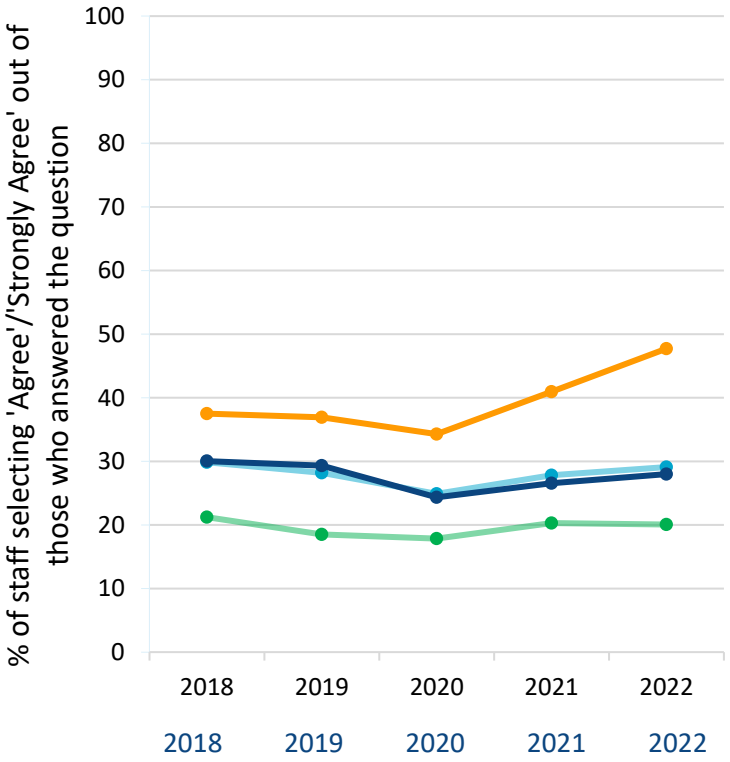
Work pressure – Q3g, Q3h, Q3i

Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

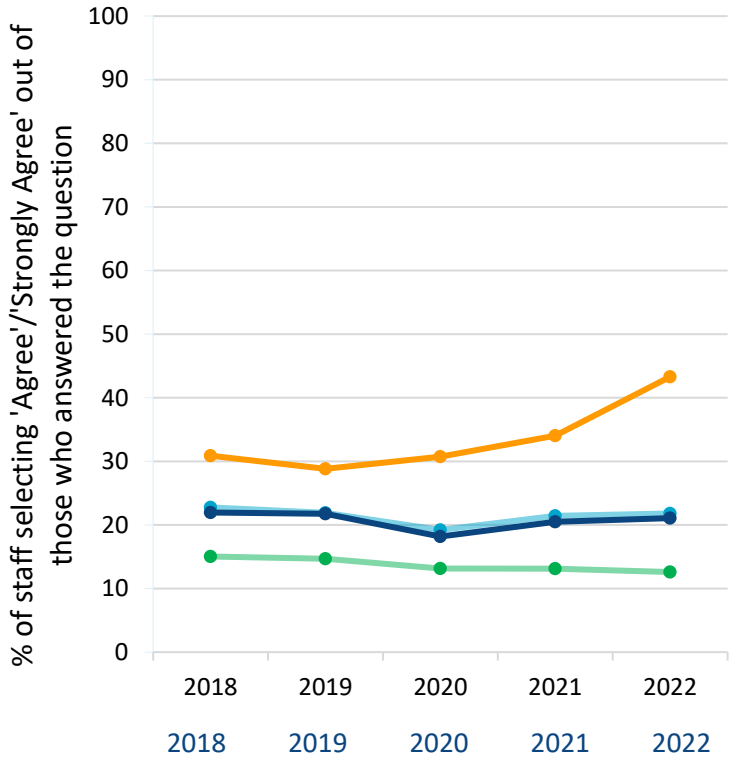
Survey Coordination Centre

Q24a I often think about leaving this organisation.



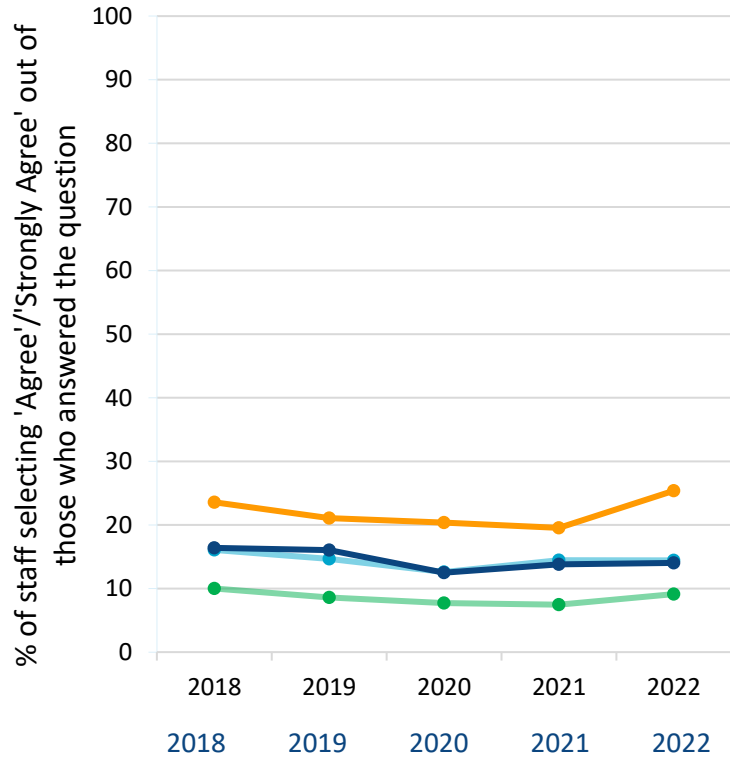
	2018	2019	2020	2021	2022
Your org	30.0%	29.3%	24.3%	26.6%	28.0%
Best	21.2%	18.5%	17.9%	20.3%	20.1%
Average	29.9%	28.2%	24.9%	27.8%	29.1%
Worst	37.5%	36.9%	34.3%	41.0%	47.7%
Responses	2072	2239	2299	2589	2539

Q24b I will probably look for a job at a new organisation in the next 12 months.



	2018	2019	2020	2021	2022
Your org	21.9%	21.8%	18.2%	20.5%	21.1%
Best	15.0%	14.7%	13.1%	13.1%	12.6%
Average	22.8%	21.9%	19.2%	21.4%	21.8%
Worst	30.9%	28.8%	30.7%	34.0%	43.3%
Responses	2065	2230	2293	2575	2536

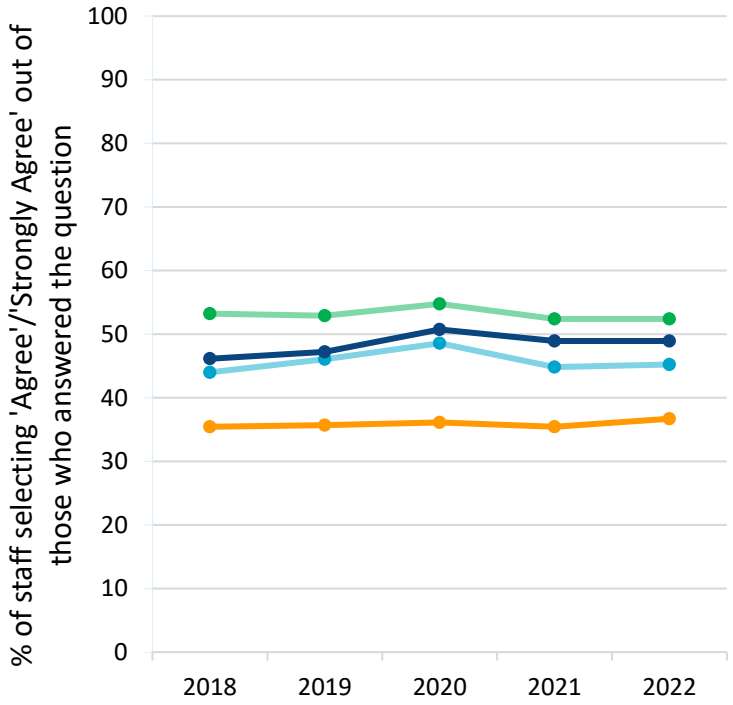
Q24c As soon as I can find another job, I will leave this organisation.



	2018	2019	2020	2021	2022
Your org	16.4%	16.0%	12.5%	13.8%	14.0%
Best	10.0%	8.6%	7.7%	7.5%	9.1%
Average	16.1%	14.7%	12.6%	14.5%	14.4%
Worst	23.6%	21.1%	20.4%	19.5%	25.4%
Responses	2052	2223	2280	2569	2534

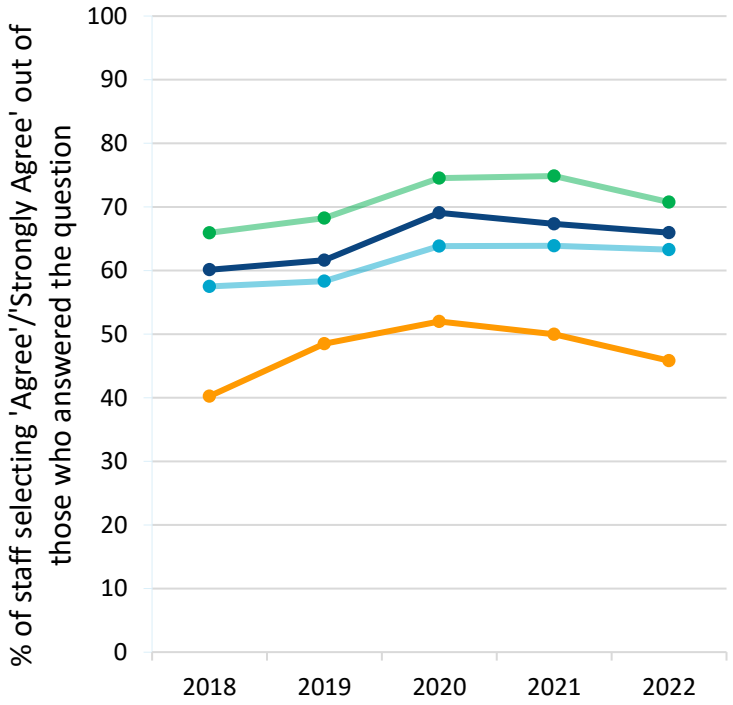
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



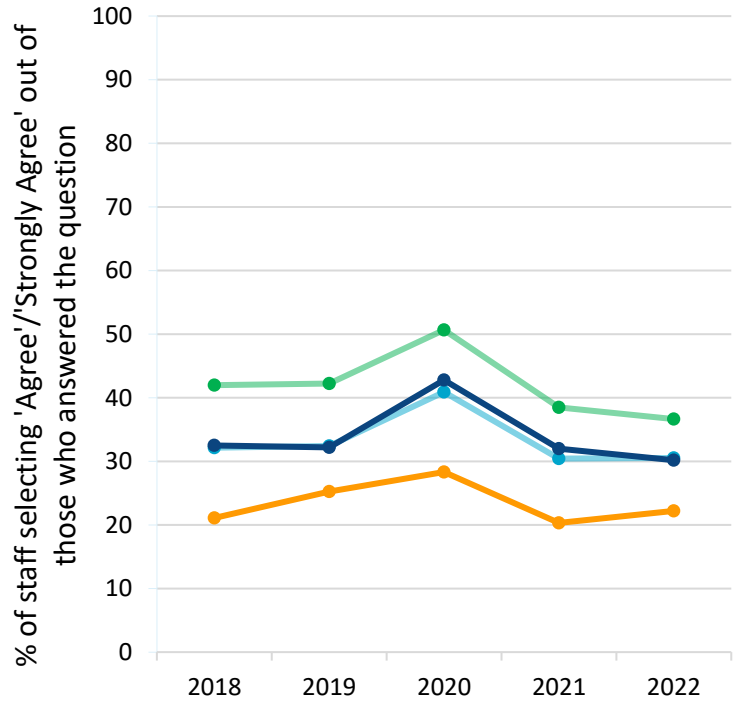
	2018	2019	2020	2021	2022
Your org	46.1%	47.2%	50.7%	48.9%	48.9%
Best	53.2%	52.9%	54.8%	52.4%	52.4%
Average	44.0%	46.0%	48.6%	44.8%	45.2%
Worst	35.4%	35.7%	36.1%	35.4%	36.7%
Responses	2095	2263	2291	2582	2521

Q3h I have adequate materials, supplies and equipment to do my work.



	2018	2019	2020	2021	2022
Your org	60.1%	61.6%	69.1%	67.3%	66.0%
Best	65.9%	68.3%	74.5%	74.8%	70.8%
Average	57.5%	58.3%	63.8%	63.9%	63.3%
Worst	40.2%	48.5%	52.0%	50.0%	45.8%
Responses	2092	2253	2285	2568	2525

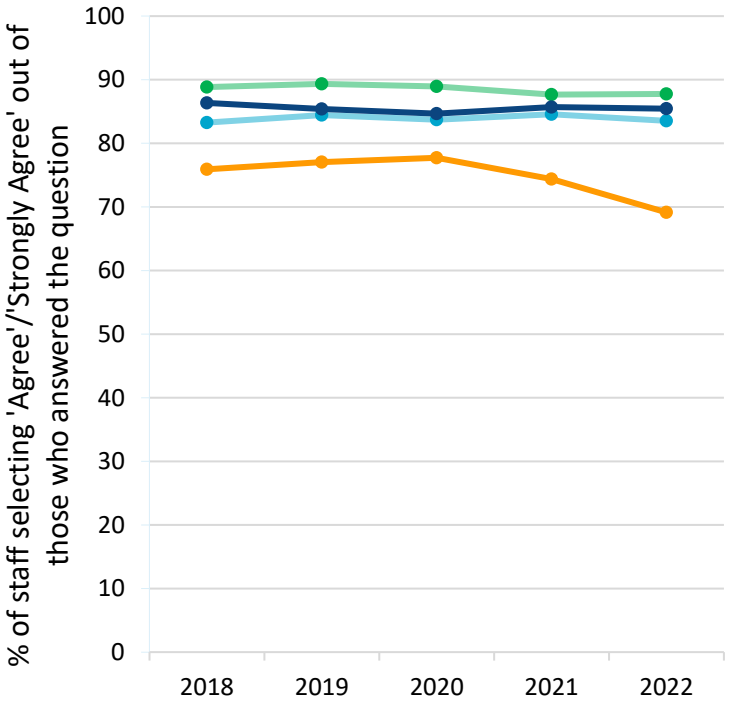
Q3i There are enough staff at this organisation for me to do my job properly.



	2018	2019	2020	2021	2022
Your org	32.5%	32.2%	42.8%	32.0%	30.2%
Best	42.0%	42.2%	50.7%	38.5%	36.6%
Average	32.1%	32.4%	40.9%	30.4%	30.5%
Worst	21.1%	25.2%	28.3%	20.3%	22.2%
Responses	2092	2262	2283	2583	2533

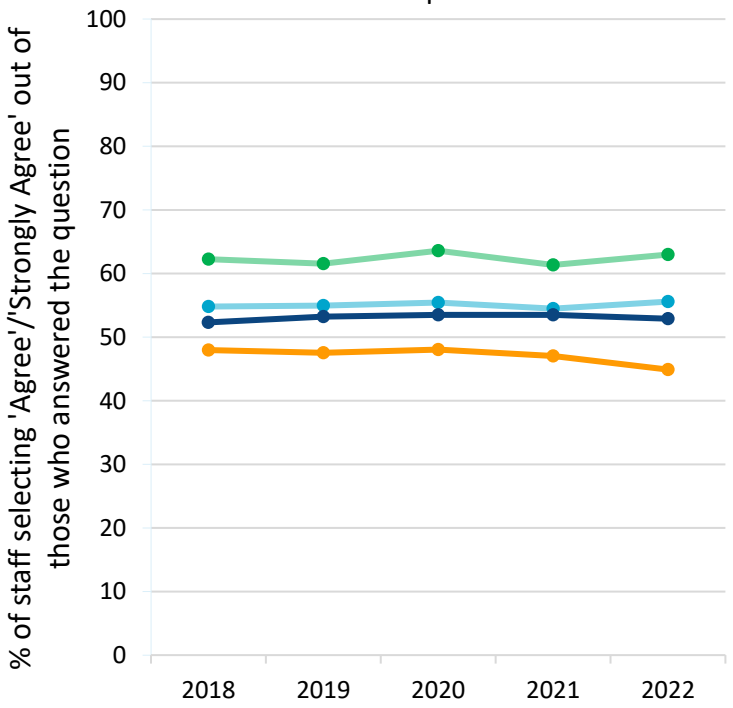
Survey Coordination Centre NHS

Q3a I always know what my work responsibilities are.



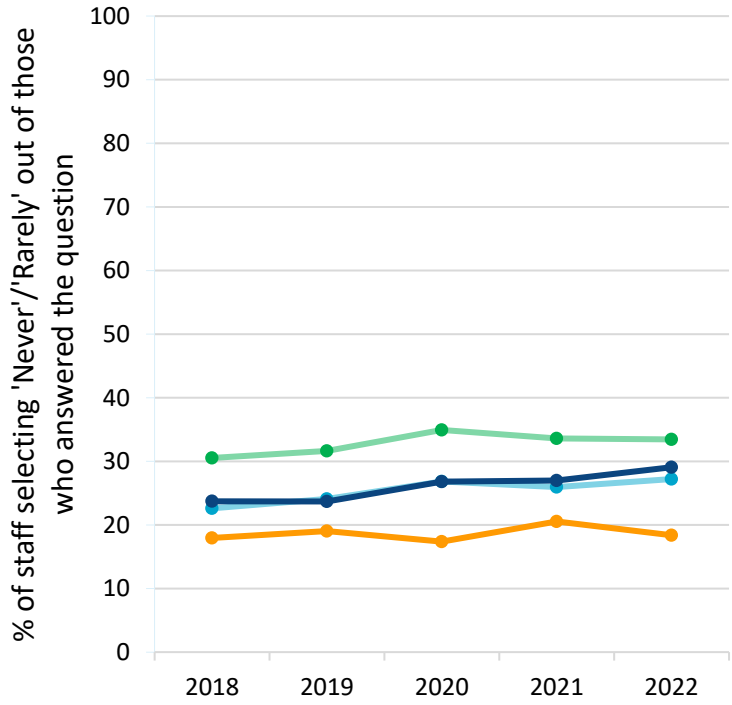
	2018	2019	2020	2021	2022
Your org	86.3%	85.4%	84.7%	85.7%	85.4%
Best	88.8%	89.3%	88.9%	87.7%	87.8%
Average	83.3%	84.4%	83.7%	84.6%	83.5%
Worst	75.9%	77.0%	77.7%	74.4%	69.2%
Responses	2074	2260	2279	2596	2537

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2018	2019	2020	2021	2022
Your org	52.3%	53.2%	53.5%	53.5%	52.9%
Best	62.3%	61.6%	63.6%	61.3%	63.0%
Average	54.8%	55.0%	55.4%	54.5%	55.6%
Worst	48.0%	47.5%	48.0%	47.0%	44.9%
Responses	2095	2264	2287	2584	2529

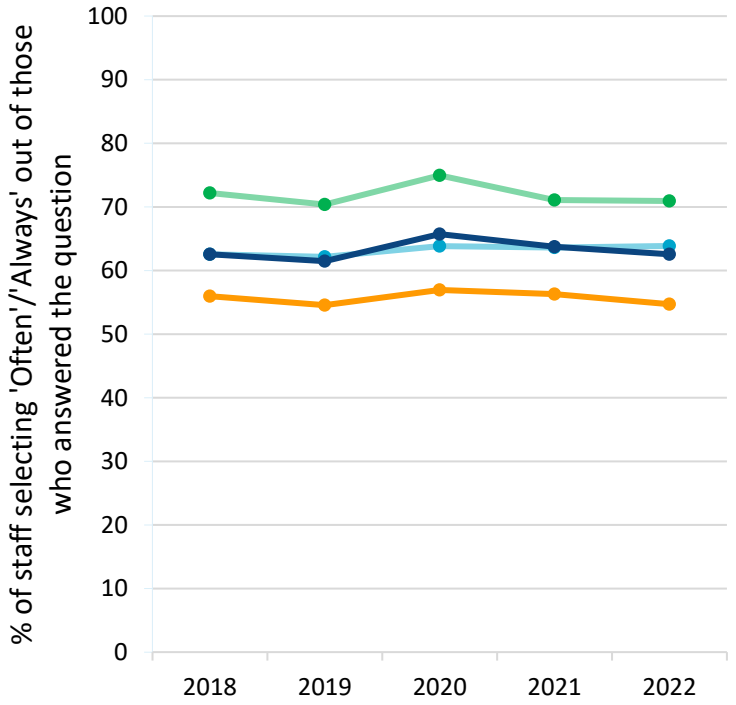
Q5a I have unrealistic time pressures.



	2018	2019	2020	2021	2022
Your org	23.7%	23.7%	26.8%	27.0%	29.1%
Best	30.5%	31.6%	34.9%	33.6%	33.4%
Average	22.6%	24.1%	26.8%	26.0%	27.2%
Worst	17.9%	19.0%	17.4%	20.6%	18.4%
Responses	2071	2245	2275	2593	2539

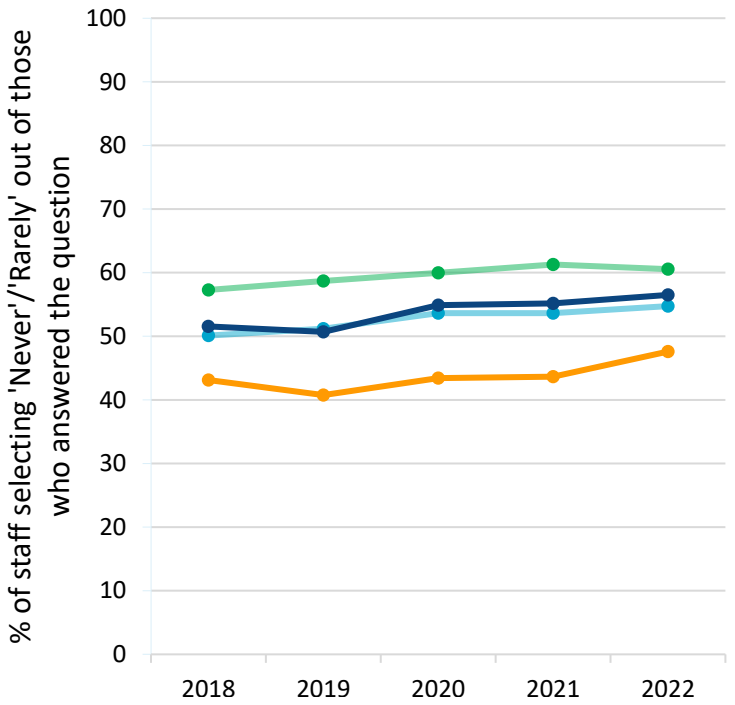
Survey Coordination Centre NHS

Q5b I have a choice in deciding how to do my work.



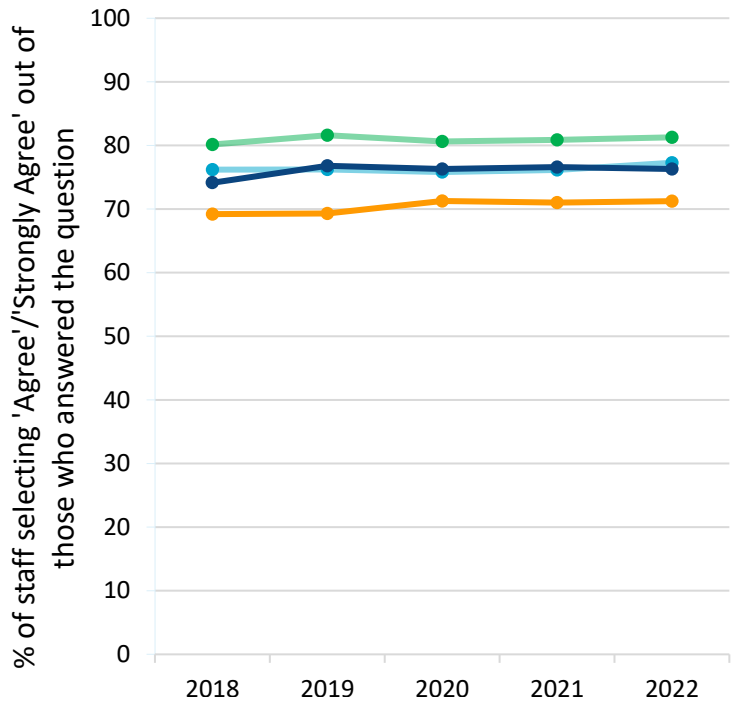
	2018	2019	2020	2021	2022
Your org	62.5%	61.5%	65.7%	63.7%	62.6%
Best	72.2%	70.4%	75.0%	71.1%	70.9%
Average	62.6%	62.1%	63.8%	63.6%	63.9%
Worst	56.0%	54.6%	56.9%	56.3%	54.7%
Responses	2059	2237	2259	2584	2533

Q5c Relationships at work are strained.



	2018	2019	2020	2021	2022
Your org	51.5%	50.7%	54.9%	55.2%	56.5%
Best	57.3%	58.7%	60.0%	61.3%	60.6%
Average	50.1%	51.2%	53.6%	53.6%	54.8%
Worst	43.1%	40.8%	43.4%	43.6%	47.6%
Responses	2065	2244	2264	2589	2533

Q7c I receive the respect I deserve from my colleagues at work.

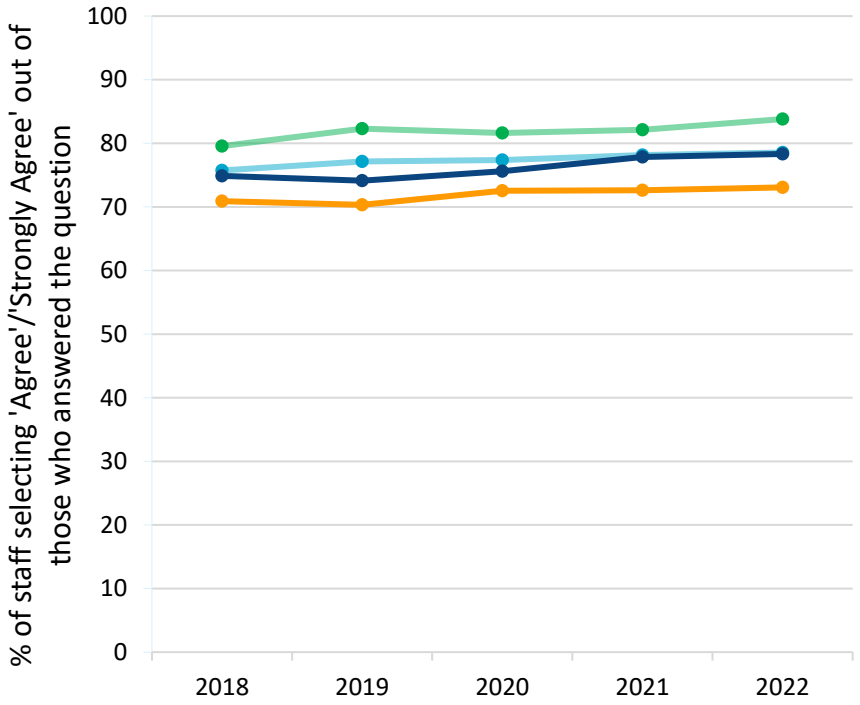


	2018	2019	2020	2021	2022
Your org	74.1%	76.8%	76.3%	76.6%	76.3%
Best	80.2%	81.6%	80.6%	80.9%	81.3%
Average	76.2%	76.2%	75.8%	76.1%	77.3%
Worst	69.2%	69.3%	71.3%	71.0%	71.2%
Responses	2094	2268	2284	2578	2537

Survey Coordination Centre

NHS

Q9a My immediate manager encourages me at work.



	2018	2019	2020	2021	2022
Your org	74.9%	74.1%	75.6%	77.9%	78.3%
Best	79.6%	82.3%	81.6%	82.1%	83.8%
Average	75.7%	77.1%	77.4%	78.1%	78.5%
Worst	70.9%	70.3%	72.5%	72.6%	73.1%
Responses	2095	2246	2292	2589	2542

Question not linked to People Promise elements or themes

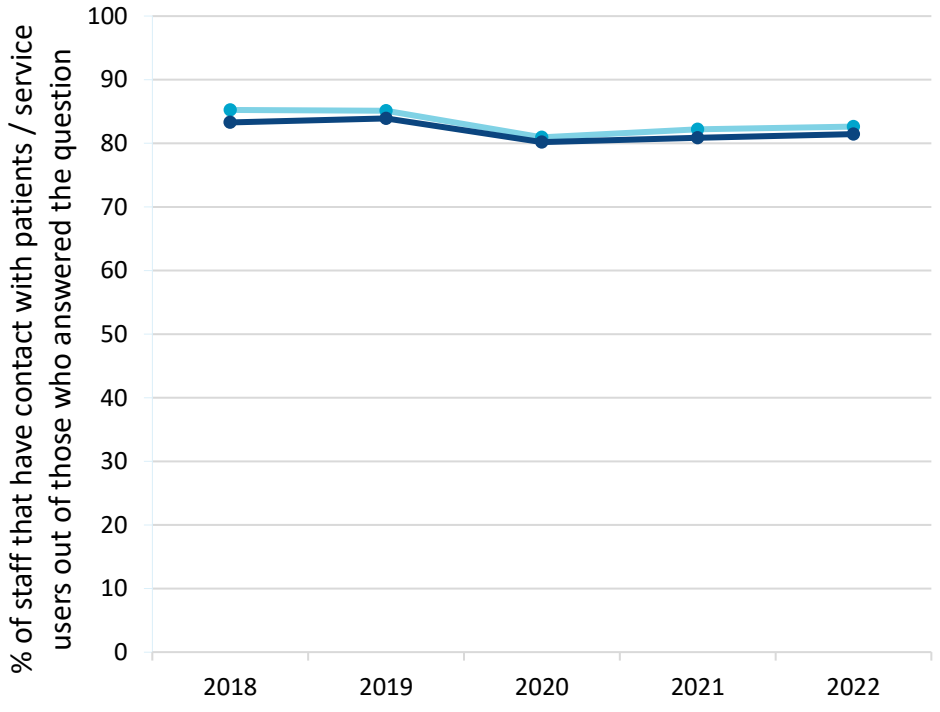
Questions included:
Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q17, Q18a, Q18b, Q18c, Q18d, Q24d, Q30b

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

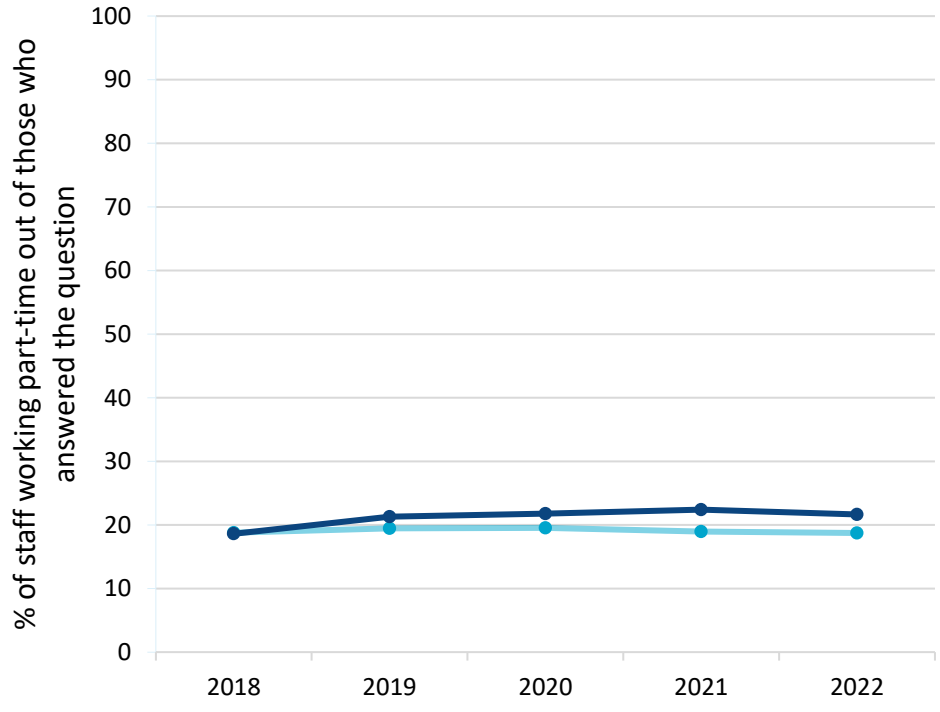
NHS

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



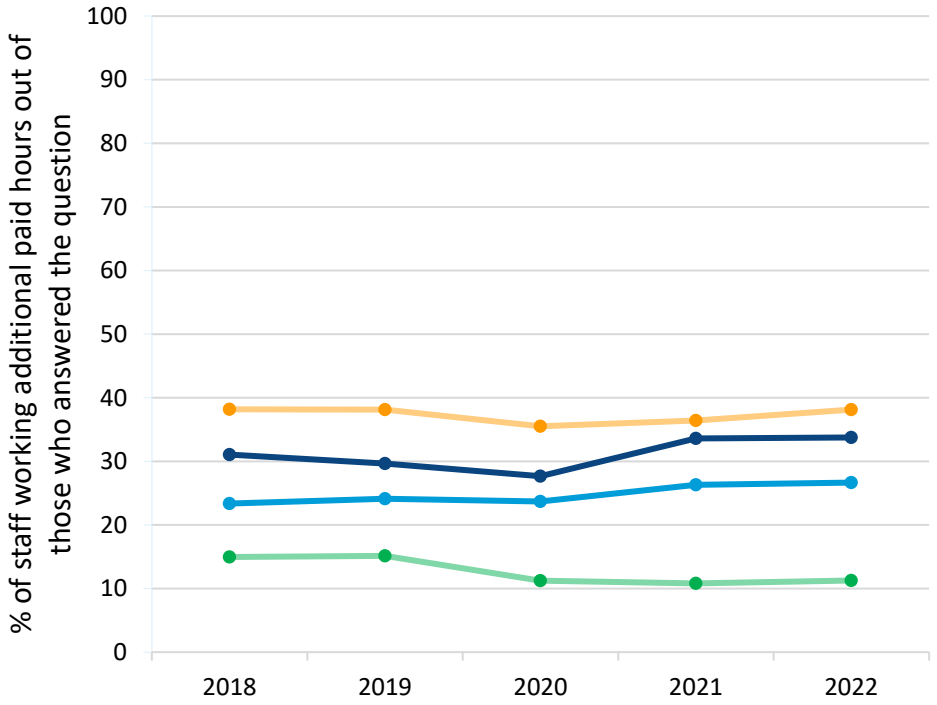
	2018	2019	2020	2021	2022
Your org	83.3%	83.9%	80.2%	80.9%	81.4%
Average	85.2%	85.1%	80.9%	82.2%	82.6%
Responses	2083	2256	2293	2588	2533

Q10a How many hours a week are you contracted to work?



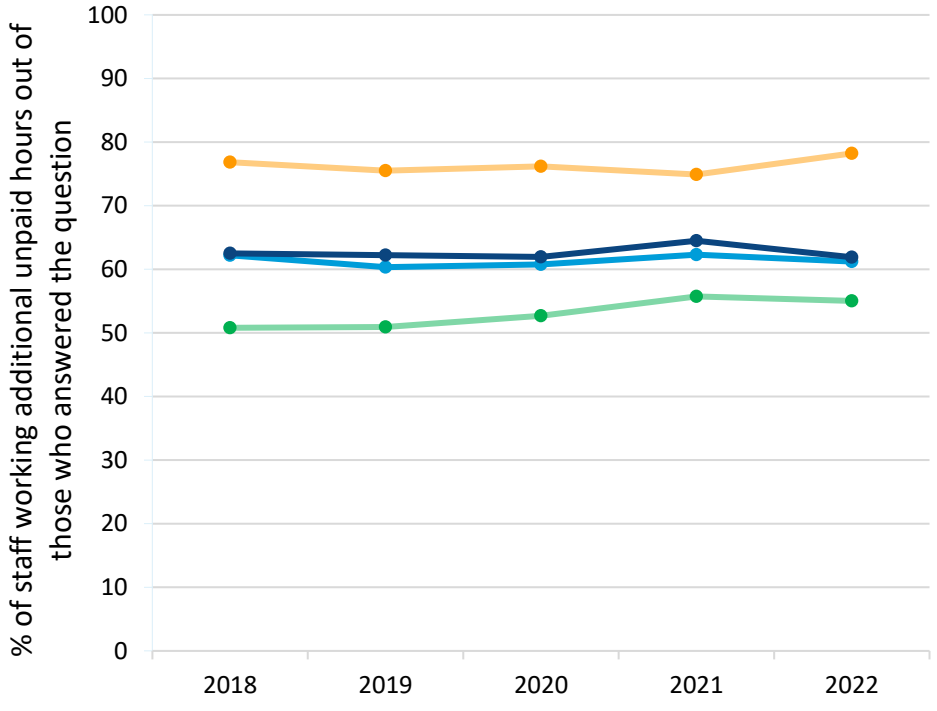
	2018	2019	2020	2021	2022
Your org	18.6%	21.3%	21.8%	22.4%	21.7%
Average	18.8%	19.5%	19.5%	19.0%	18.7%
Responses	1918	2061	2099	2392	2295

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	31.1%	29.7%	27.7%	33.6%	33.7%
Lowest	15.0%	15.2%	11.2%	10.8%	11.3%
Average	23.4%	24.1%	23.7%	26.3%	26.7%
Highest	38.2%	38.1%	35.5%	36.4%	38.1%
Responses	1993	2141	2230	2488	2472

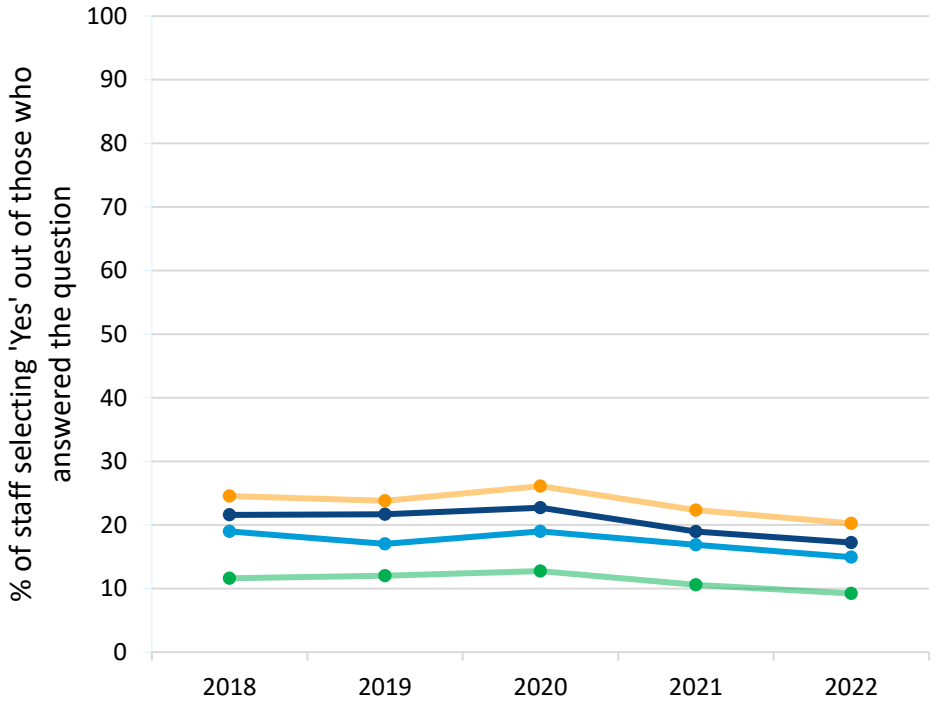
Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



	2018	2019	2020	2021	2022
Your org	62.5%	62.2%	61.9%	64.5%	61.9%
Lowest	50.8%	50.9%	52.7%	55.7%	55.0%
Average	62.2%	60.3%	60.8%	62.3%	61.2%
Highest	76.8%	75.5%	76.2%	74.9%	78.2%
Responses	2010	2157	2248	2511	2483

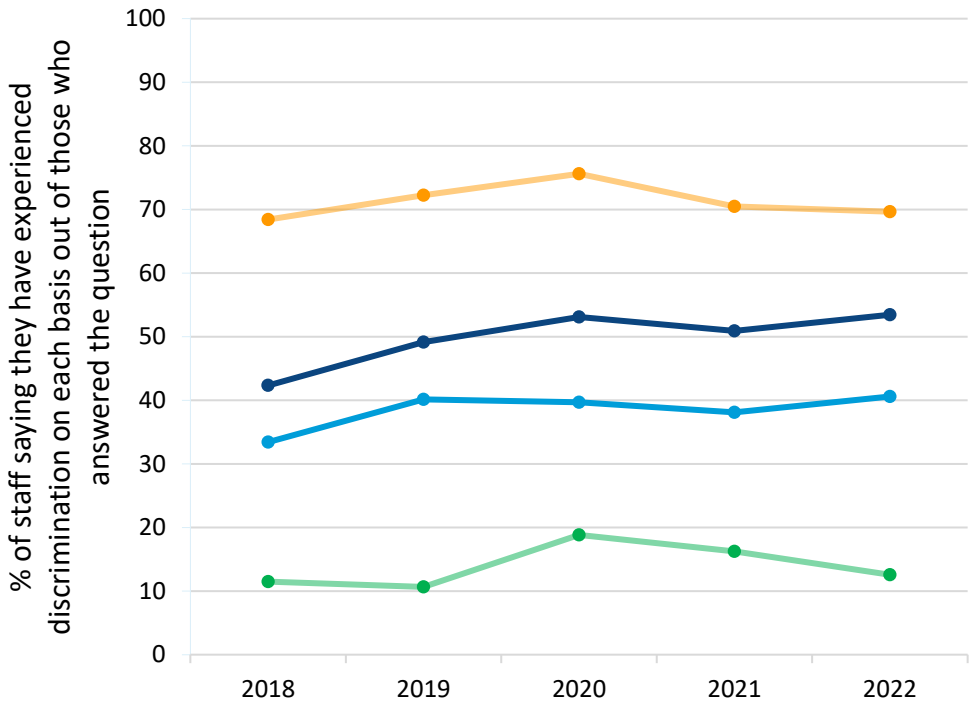
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Q11e Have you felt pressure from your manager to come to work?



	2018	2019	2020	2021	2022
Your org	21.6%	21.7%	22.7%	19.0%	17.2%
Best	11.6%	12.0%	12.7%	10.6%	9.2%
Average	19.0%	17.0%	19.0%	16.9%	14.9%
Worst	24.6%	23.8%	26.1%	22.3%	20.2%
Responses	1179	1263	1040	1261	1403

Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.

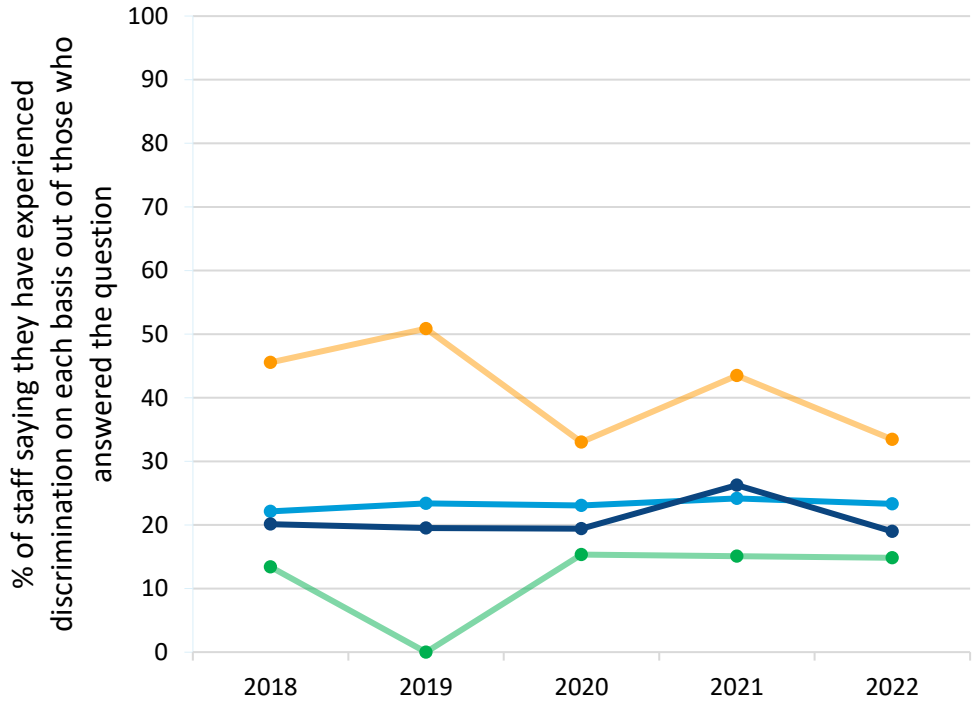


	2018	2019	2020	2021	2022
Your org	42.3%	49.1%	53.1%	50.9%	53.5%
Best	11.5%	10.6%	18.8%	16.3%	12.6%
Average	33.4%	40.1%	39.7%	38.1%	40.6%
Worst	68.4%	72.2%	75.6%	70.5%	69.6%
Responses	280	310	308	343	330

Survey Coordination Centre

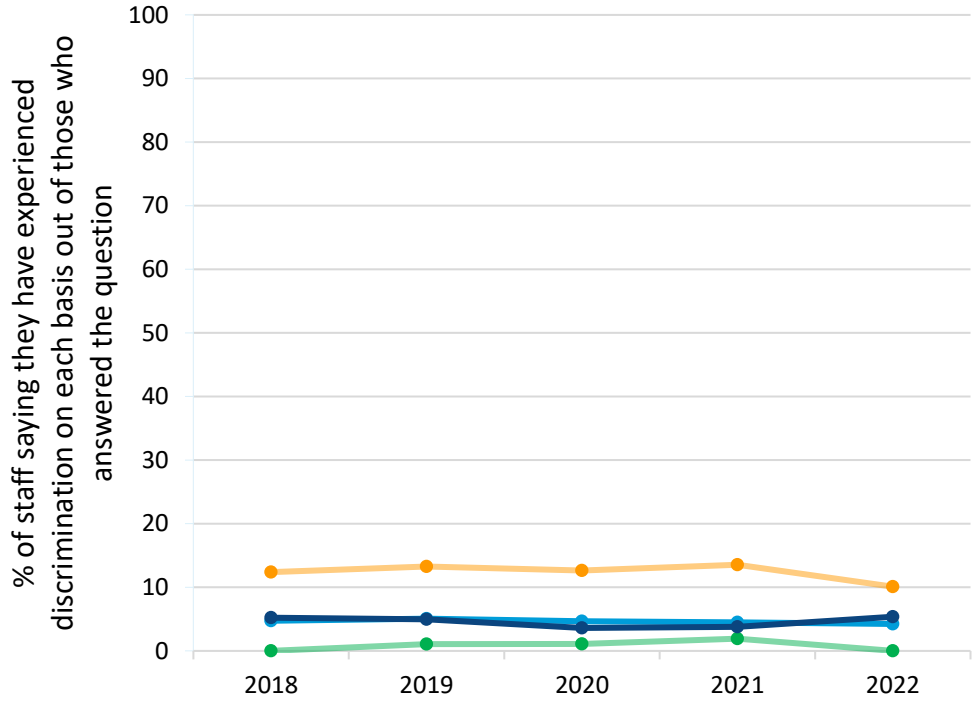
NHS

Q16c.2 On what grounds have you experienced discrimination? – Gender.



	2018	2019	2020	2021	2022
Your org	20.1%	19.5%	19.4%	26.3%	19.0%
Best	13.4%	0.0%	15.3%	15.1%	14.8%
Average	22.1%	23.4%	23.1%	24.2%	23.3%
Worst	45.6%	50.8%	33.0%	43.5%	33.4%
Responses	280	310	308	343	330

Q16c.3 On what grounds have you experienced discrimination? – Religion.



	2018	2019	2020	2021	2022
Your org	5.2%	5.0%	3.6%	3.8%	5.4%
Best	0.0%	1.1%	1.1%	1.9%	0.0%
Average	4.7%	5.1%	4.7%	4.5%	4.2%
Worst	12.4%	13.3%	12.6%	13.5%	10.1%
Responses	280	310	308	343	330

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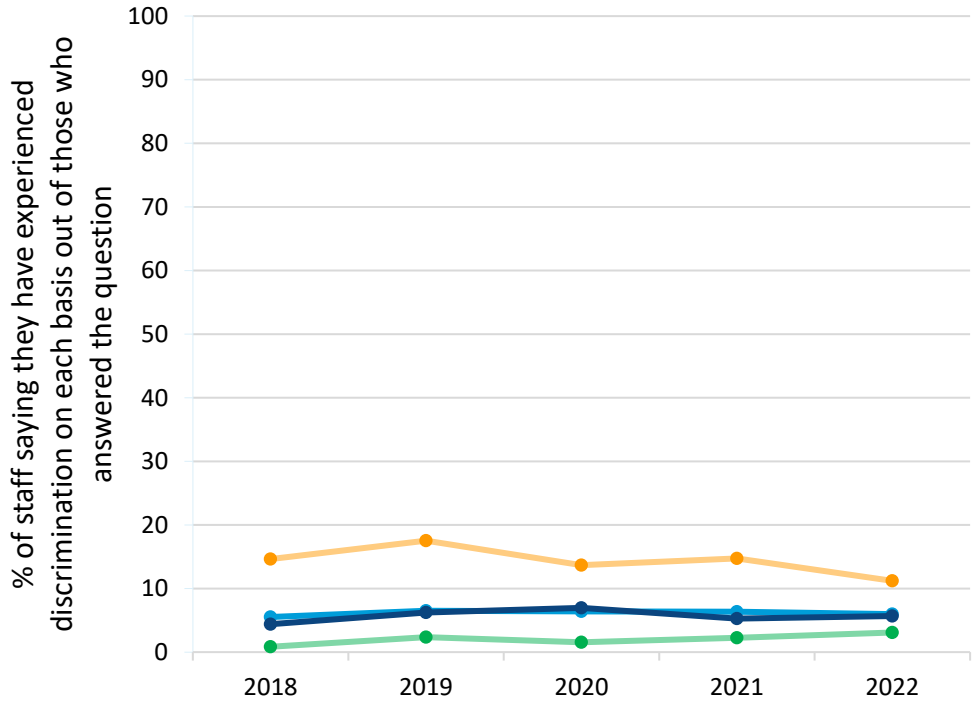
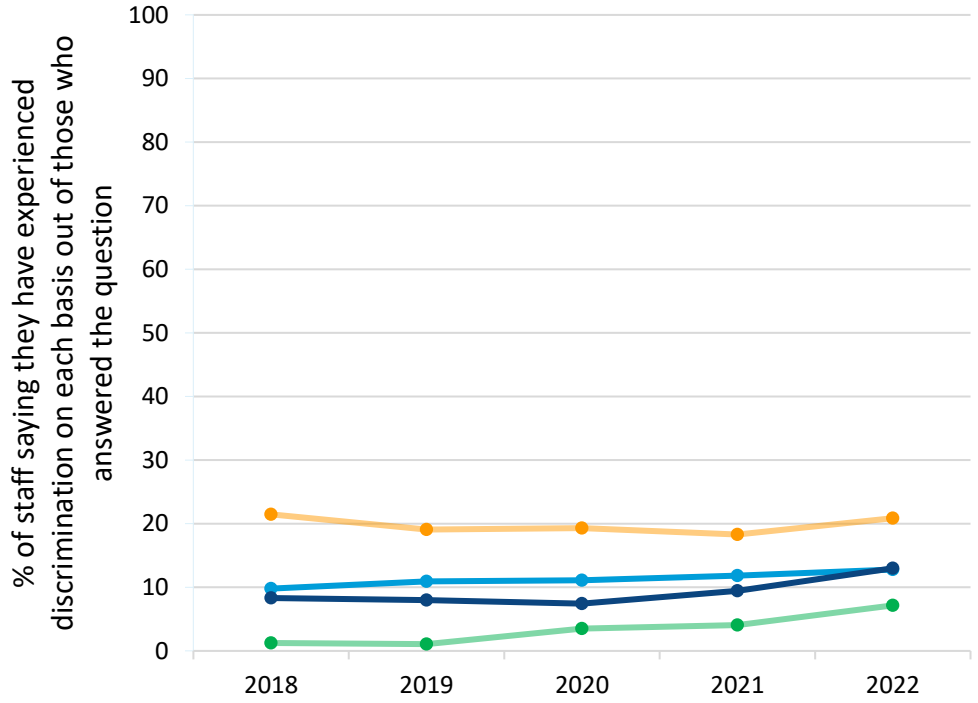
Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



	2018	2019	2020	2021	2022
Your org	4.4%	6.2%	7.0%	5.3%	5.7%
Best	0.8%	2.4%	1.5%	2.2%	3.1%
Average	5.5%	6.5%	6.4%	6.4%	6.0%
Worst	14.6%	17.5%	13.7%	14.7%	11.2%
Responses	280	310	308	343	330

Q16c.5 On what grounds have you experienced discrimination? – Disability.



	2018	2019	2020	2021	2022
Your org	8.3%	8.0%	7.4%	9.5%	13.0%
Best	1.2%	1.1%	3.5%	4.1%	7.2%
Average	9.8%	10.9%	11.1%	11.8%	12.8%
Worst	21.5%	19.1%	19.3%	18.3%	20.9%
Responses	280	310	308	343	330

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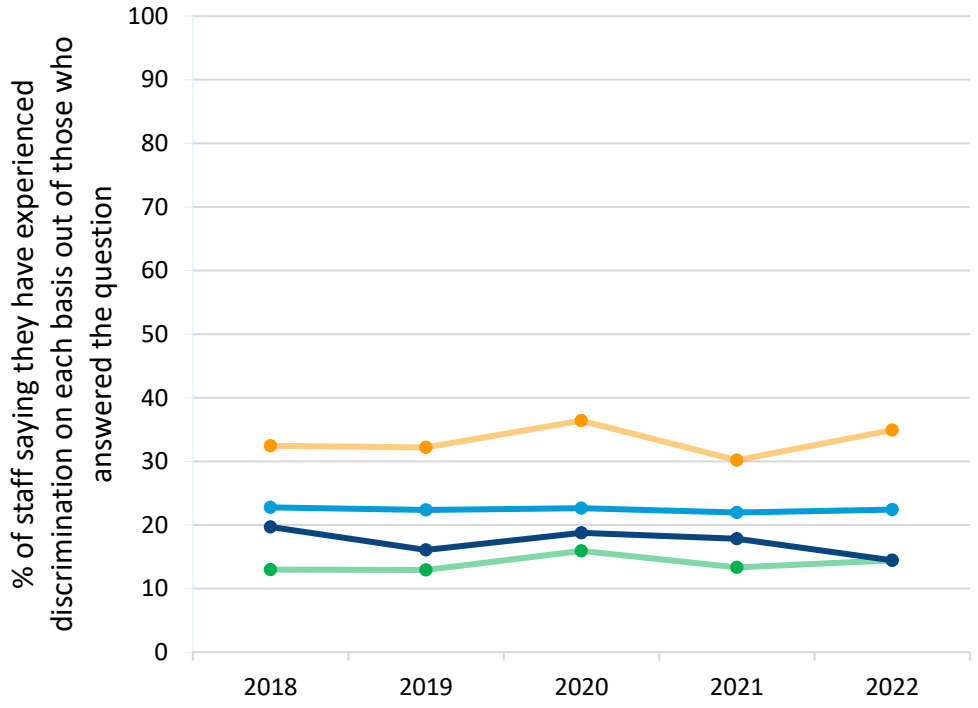
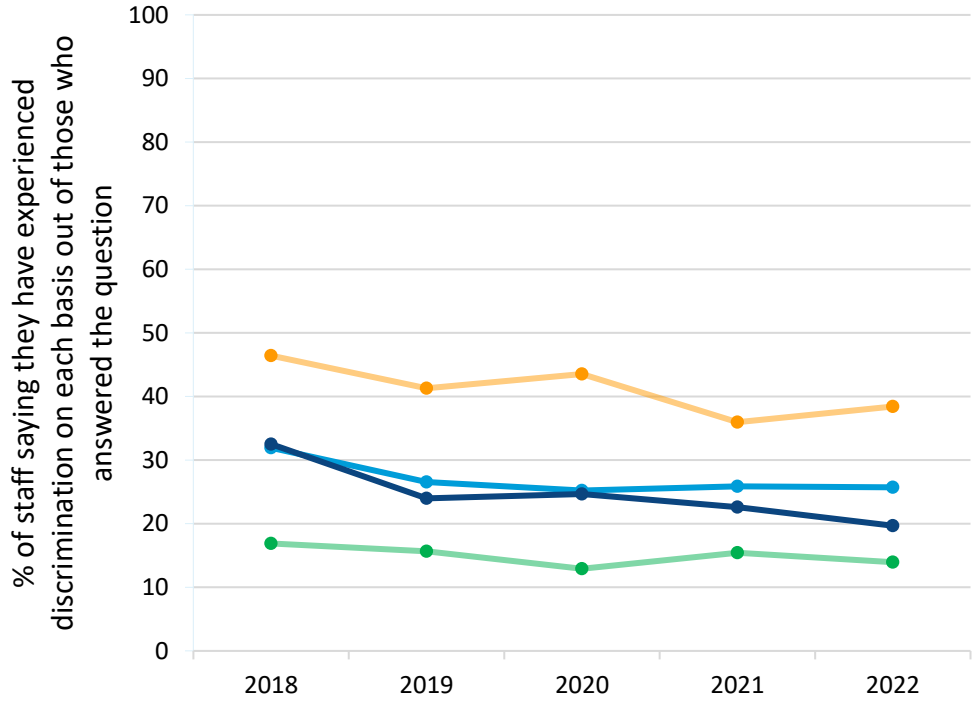
Q16c.6 On what grounds have you experienced discrimination? – Age.



	2018	2019	2020	2021	2022
Your org	19.7%	16.1%	18.8%	17.8%	14.4%
Best	13.0%	12.9%	15.9%	13.3%	14.4%
Average	22.8%	22.4%	22.6%	22.0%	22.4%
Worst	32.4%	32.2%	36.4%	30.2%	34.9%
Responses	280	310	308	343	330

Q16c.7 On what grounds have you experienced discrimination? – Other.

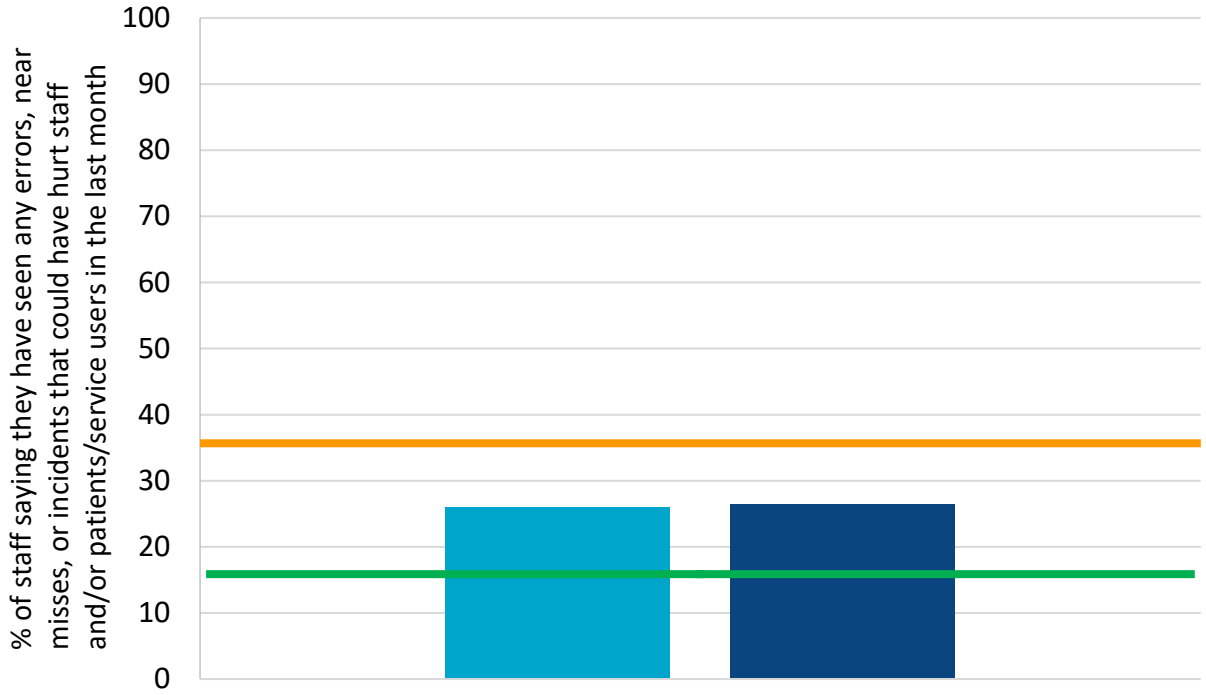


	2018	2019	2020	2021	2022
Your org	32.5%	24.0%	24.7%	22.6%	19.7%
Best	16.9%	15.7%	12.9%	15.4%	13.9%
Average	31.9%	26.6%	25.2%	25.9%	25.7%
Worst	46.4%	41.3%	43.5%	36.0%	38.4%
Responses	280	310	308	343	330

Survey Coordination Centre

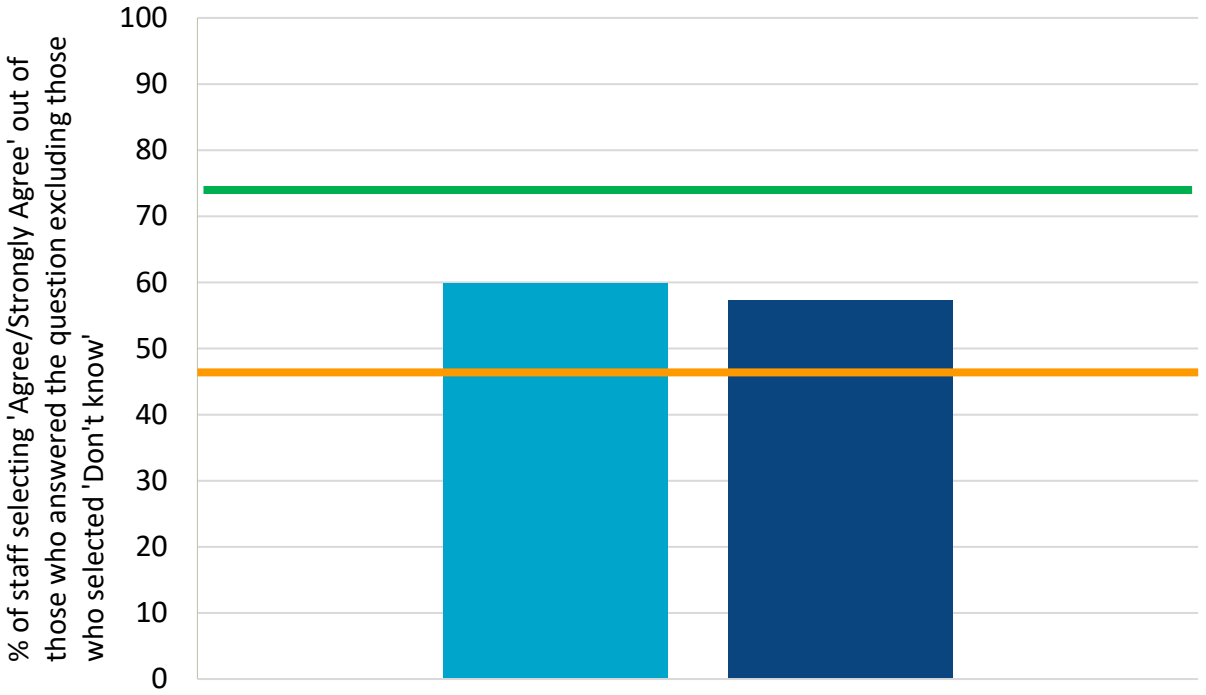
NHS

Q17 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



	2022
Your org	26.5%
Best	15.9%
Average	26.0%
Worst	35.7%
Responses	2517

Q18a My organisation treats staff who are involved in an error, near miss or incident fairly.

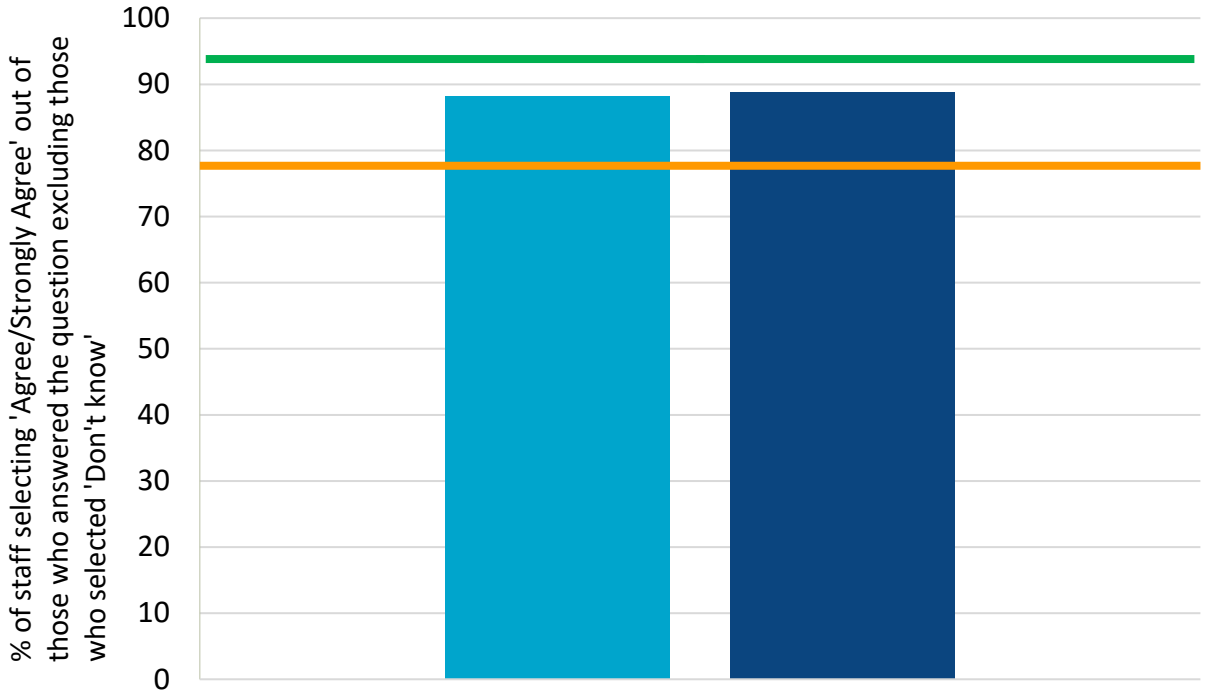


	2022
Your org	57.3%
Best	74.0%
Average	59.9%
Worst	46.4%
Responses	1843

Survey Coordination Centre

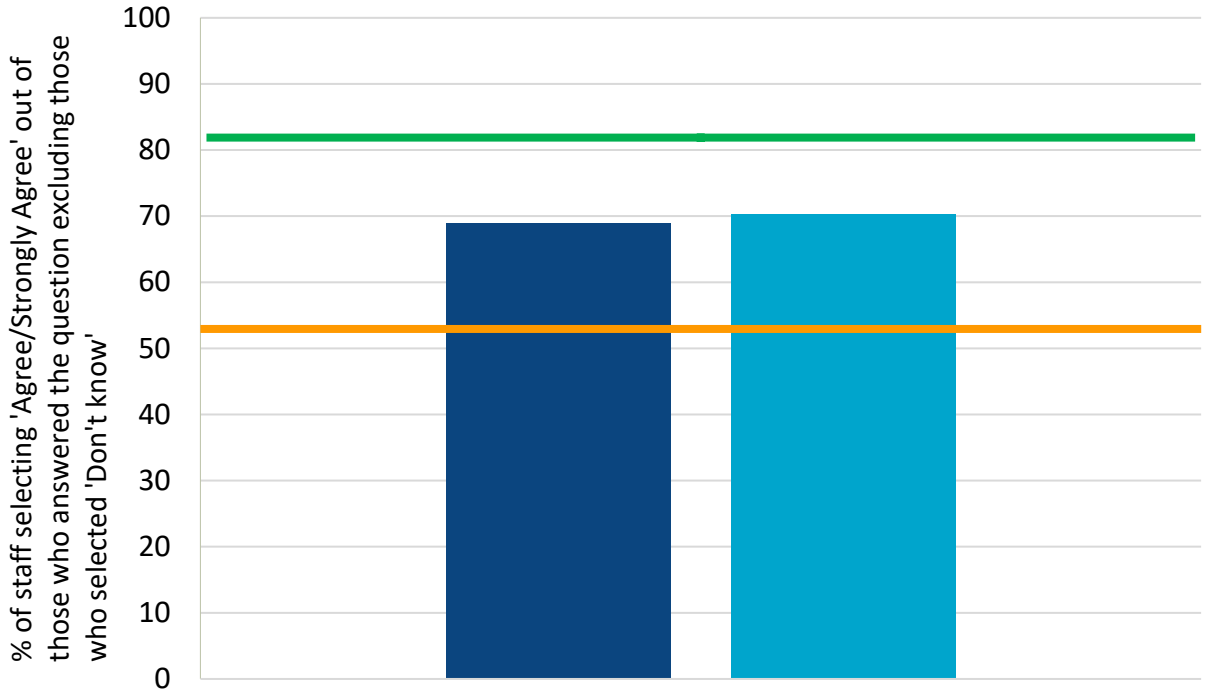
NHS

Q18b My organisation encourages us to report errors, near misses or incidents.



	2022
Your org	88.9%
Best	93.8%
Average	88.3%
Worst	77.7%
Responses	2436

Q18c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



	2022
Your org	68.8%
Best	81.9%
Average	70.3%
Worst	52.9%
Responses	2188

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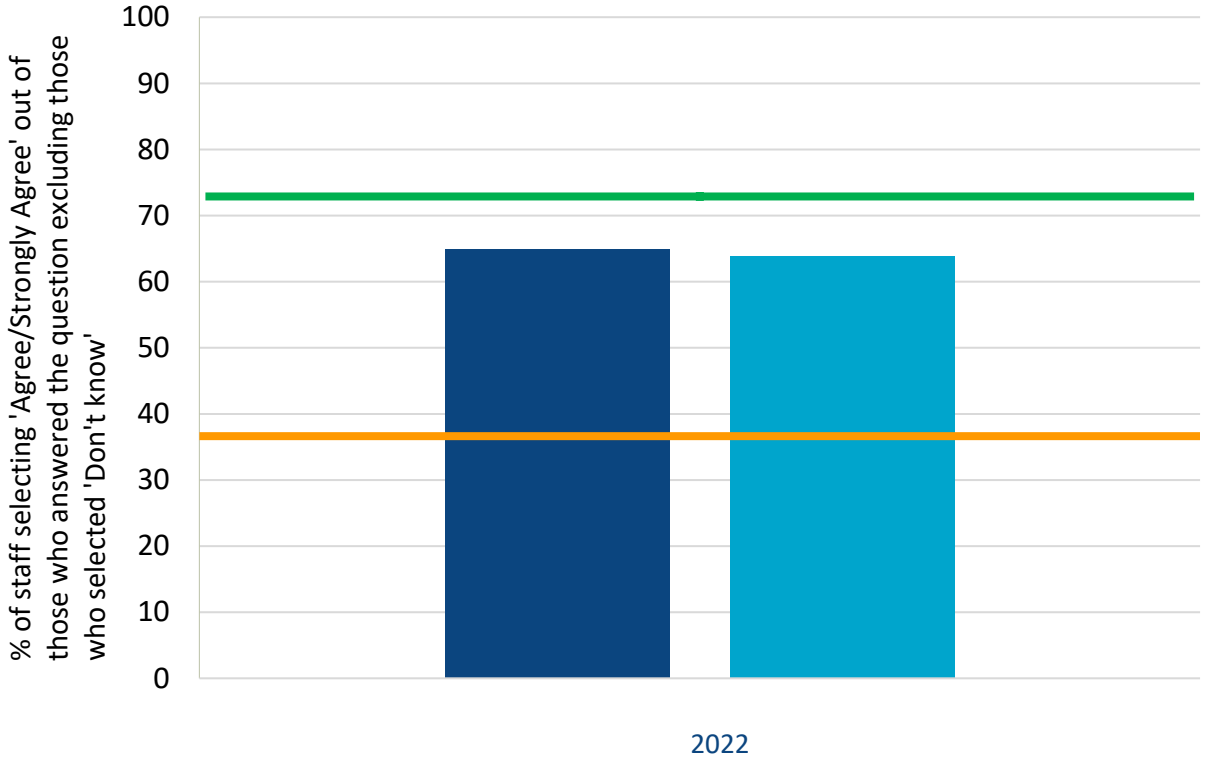
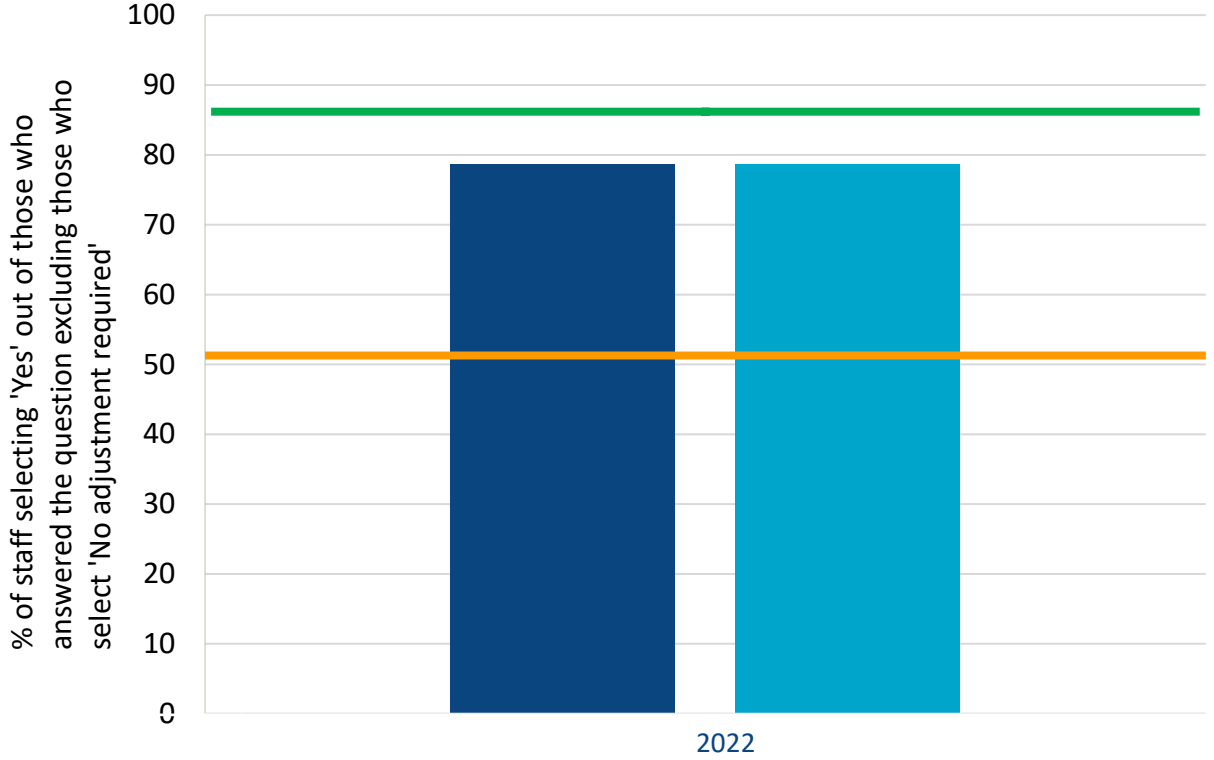
NHS

Q18d We are given feedback about changes made in response to reported errors, near misses and incidents.



Your org	64.9%
Best	72.9%
Average	63.9%
Worst	36.6%
Responses	2245

Q30b Has your employer made reasonable adjustment(s) to enable you to carry out your work?



Your org	78.7%
Best	86.2%
Average	78.7%
Worst	51.3%
Responses	452

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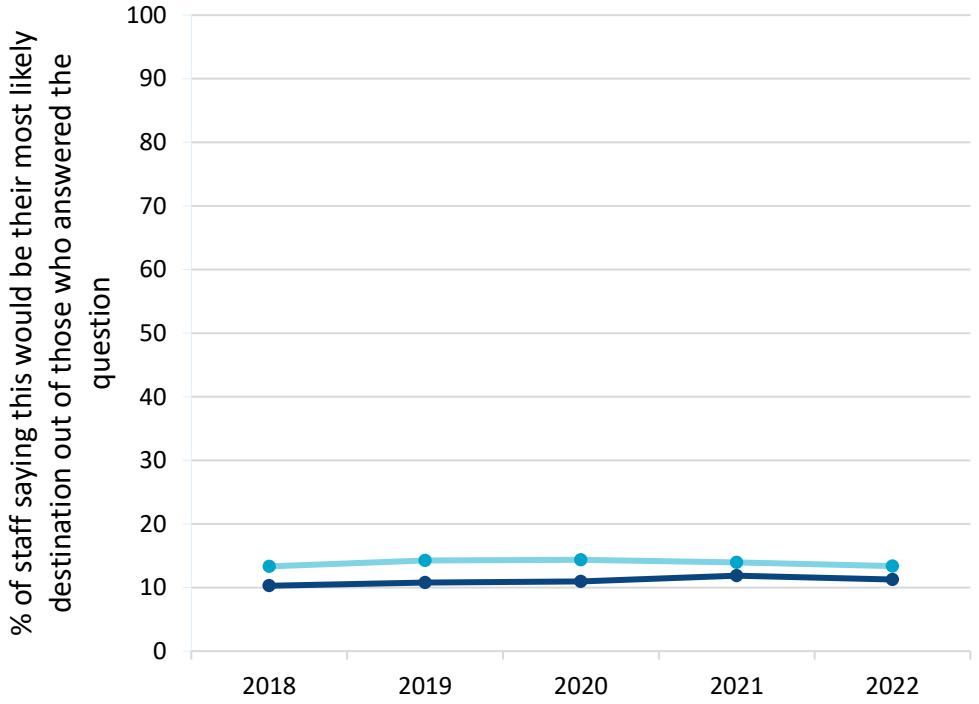
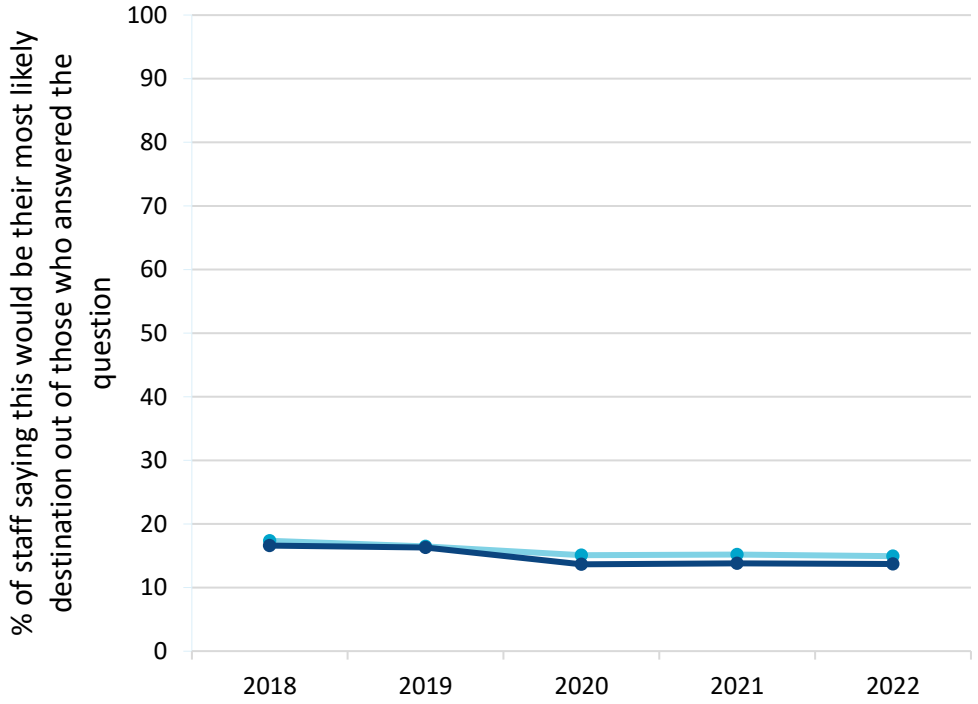
NHS

Q24d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



	2018	2019	2020	2021	2022
Your org	10.3%	10.8%	11.0%	11.9%	11.3%
Average	13.3%	14.3%	14.4%	14.0%	13.4%
Responses	1875	2002	2087	2369	2326

Q24d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.



	2018	2019	2020	2021	2022
Your org	16.6%	16.3%	13.7%	13.8%	13.7%
Average	17.4%	16.5%	15.1%	15.2%	14.9%
Responses	1875	2002	2087	2369	2326

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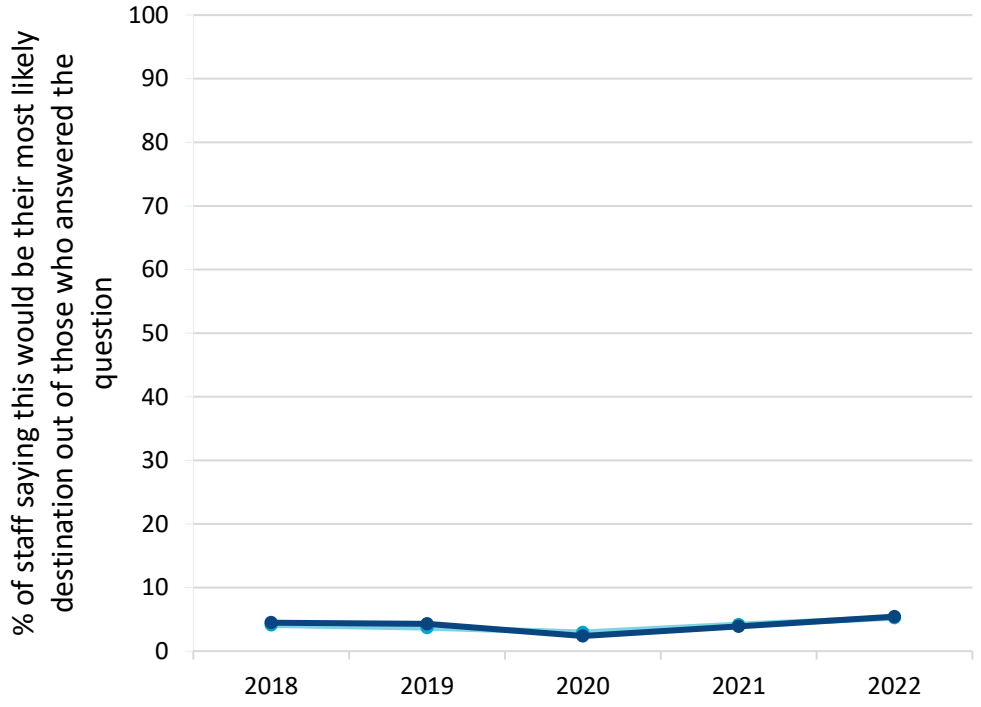
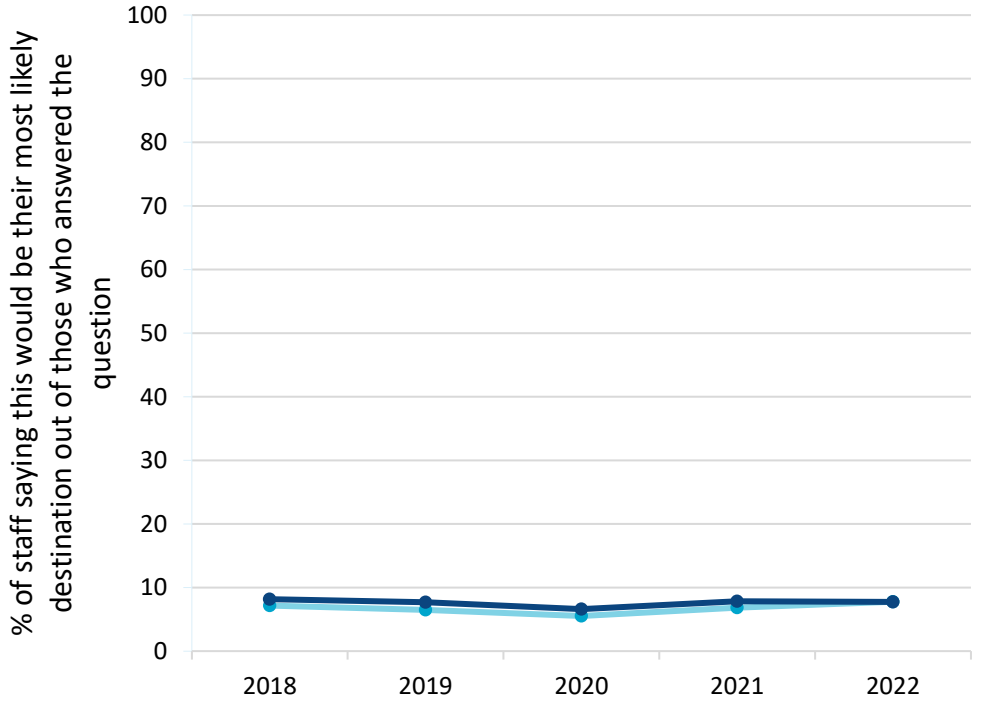
Q24d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



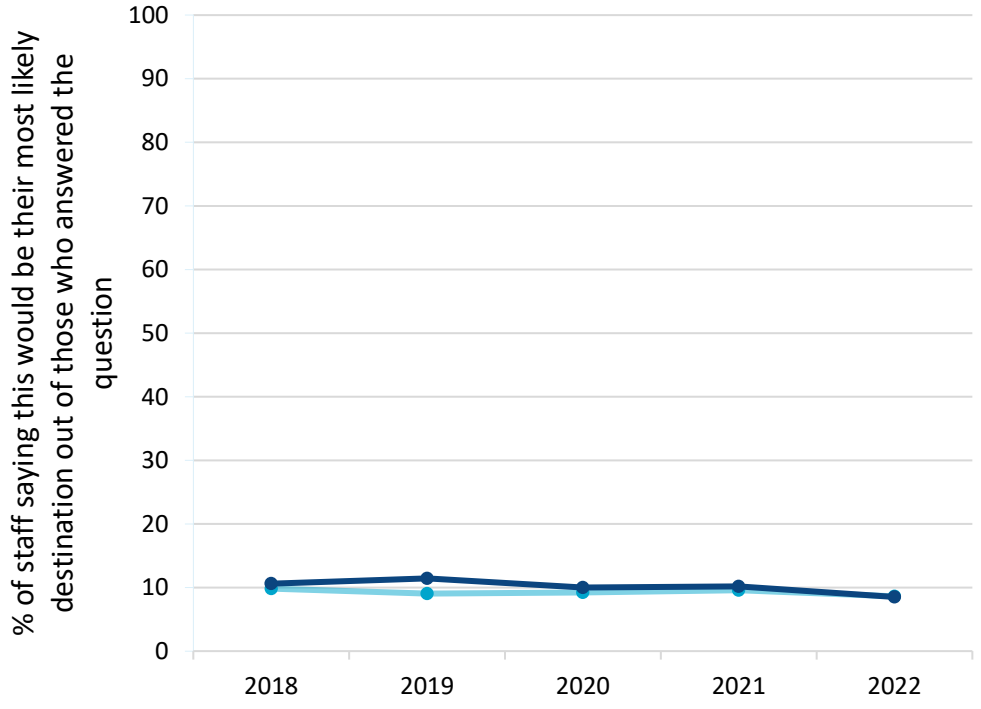
	2018	2019	2020	2021	2022
Your org	4.5%	4.3%	2.4%	3.9%	5.4%
Average	4.1%	3.7%	2.9%	4.2%	5.3%
Responses	1875	2002	2087	2369	2326

Q24d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.



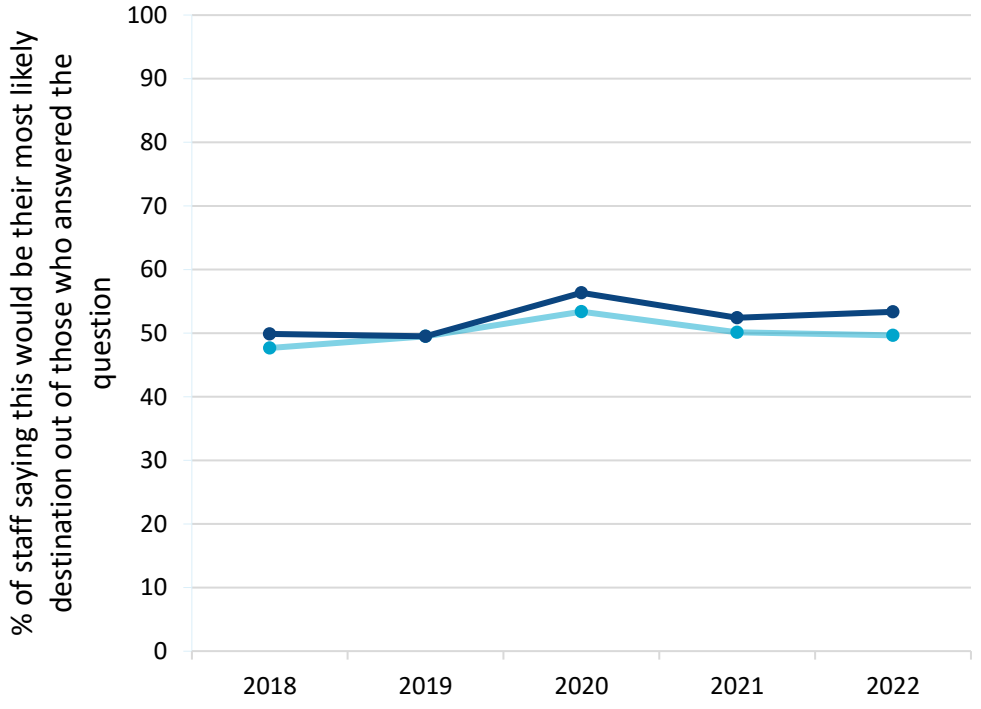
	2018	2019	2020	2021	2022
Your org	8.2%	7.7%	6.6%	7.9%	7.7%
Average	7.2%	6.5%	5.5%	6.8%	7.8%
Responses	1875	2002	2087	2369	2326

Q24d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2018	2019	2020	2021	2022
Your org	10.6%	11.4%	10.0%	10.2%	8.5%
Average	9.8%	9.1%	9.2%	9.6%	8.6%
Responses	1875	2002	2087	2369	2326

Q24d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2018	2019	2020	2021	2022
Your org	49.9%	49.5%	56.3%	52.4%	53.4%
Average	47.7%	49.5%	53.4%	50.1%	49.7%
Responses	1875	2002	2087	2369	2326

Survey Coordination Centre

NHS

Workforce Equality Standards

Please note, when there are less than 11 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Equality Standards

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2018-2022 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018-2022 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q30b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

This year, the text for q30b was updated and the word ‘adequate’ was updated to ‘reasonable’.

The WDES breakdowns are based on the responses to q30a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	14b & 14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	15	Percentage believing that their practice provides equal opportunities for career progression or promotion
8	16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Indicator	Qu No	Workforce Disability Equality Standard
		For each of the following indicators, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4ai	14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4aii	14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4aiii	14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4b	14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	15	Percentage believing that their practice provides equal opportunities for career progression or promotion
6	9e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	30b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

NHS

Workforce Race Equality Standards (WRES)

N.B.
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed.
Data shown in the WRES charts are unweighted.

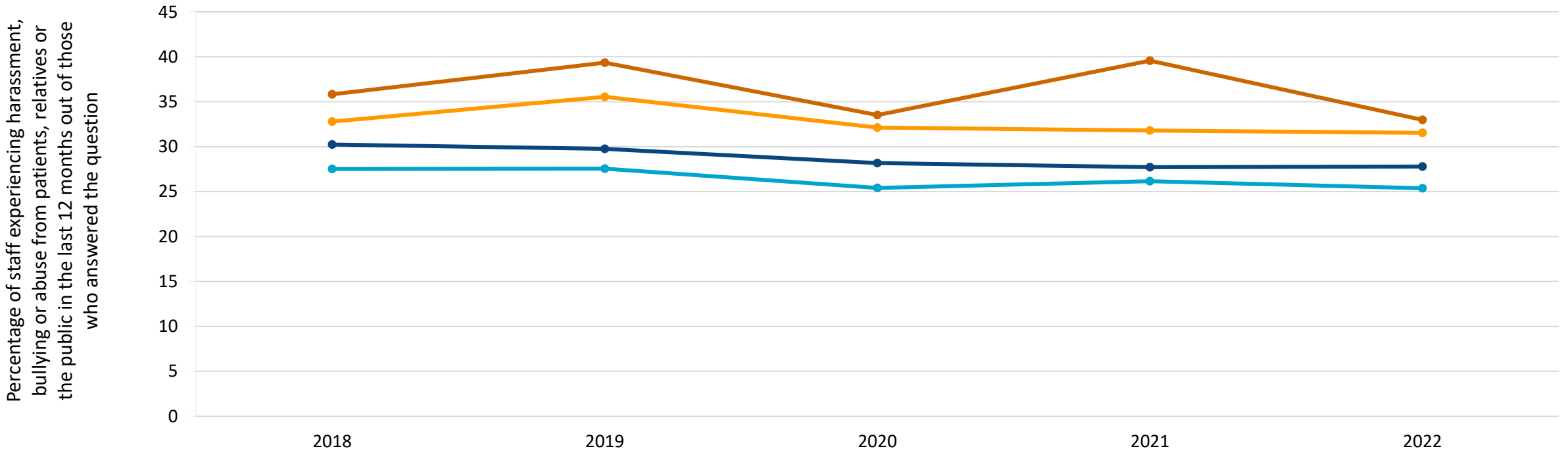
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre

NHS

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



	2018	2019	2020	2021	2022
White staff: Your org	30.2%	29.8%	28.2%	27.7%	27.8%
All other ethnic groups*: Your org	35.8%	39.3%	33.5%	39.6%	33.0%
White staff: Average	27.5%	27.6%	25.4%	26.2%	25.4%
All other ethnic groups*: Average	32.8%	35.5%	32.1%	31.8%	31.5%
White staff: Responses	1687	1825	1871	2093	2041
All other ethnic groups*: Responses	335	366	373	465	470

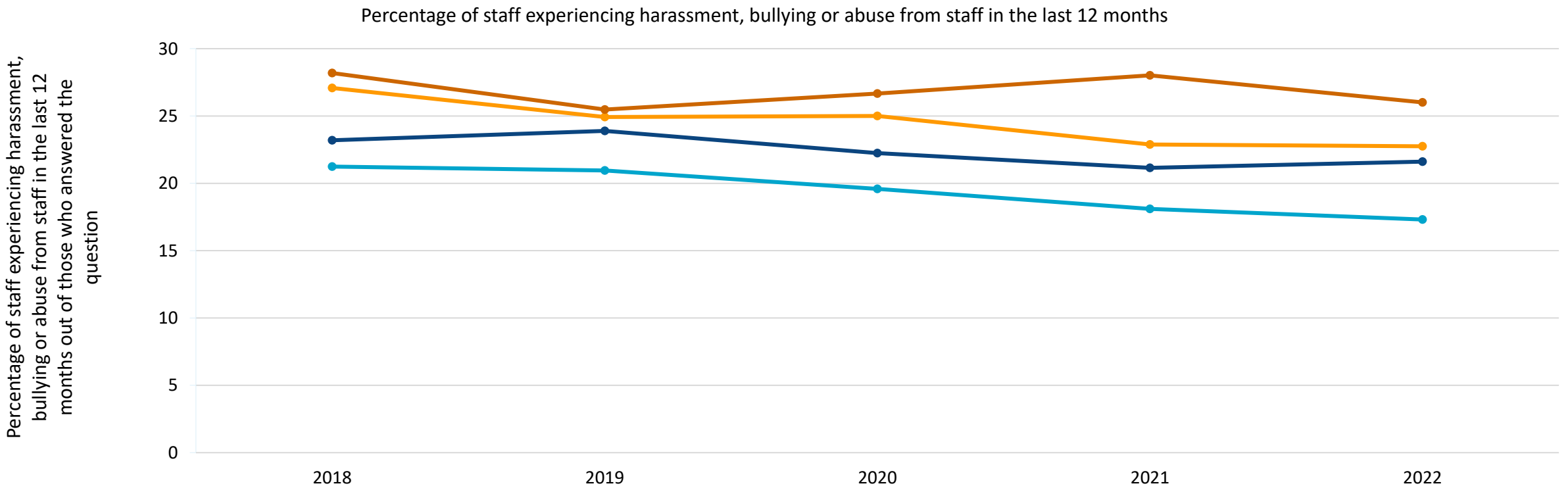
*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre

NHS



	2018	2019	2020	2021	2022
White staff: Your org	23.2%	23.9%	22.2%	21.1%	21.6%
All other ethnic groups*: Your org	28.2%	25.5%	26.7%	28.0%	26.0%
White staff: Average	21.2%	21.0%	19.6%	18.1%	17.3%
All other ethnic groups*: Average	27.1%	24.9%	25.0%	22.9%	22.8%
White staff: Responses	1690	1829	1879	2095	2045
All other ethnic groups*: Responses	337	365	375	464	469

*Staff from all other ethnic groups combined

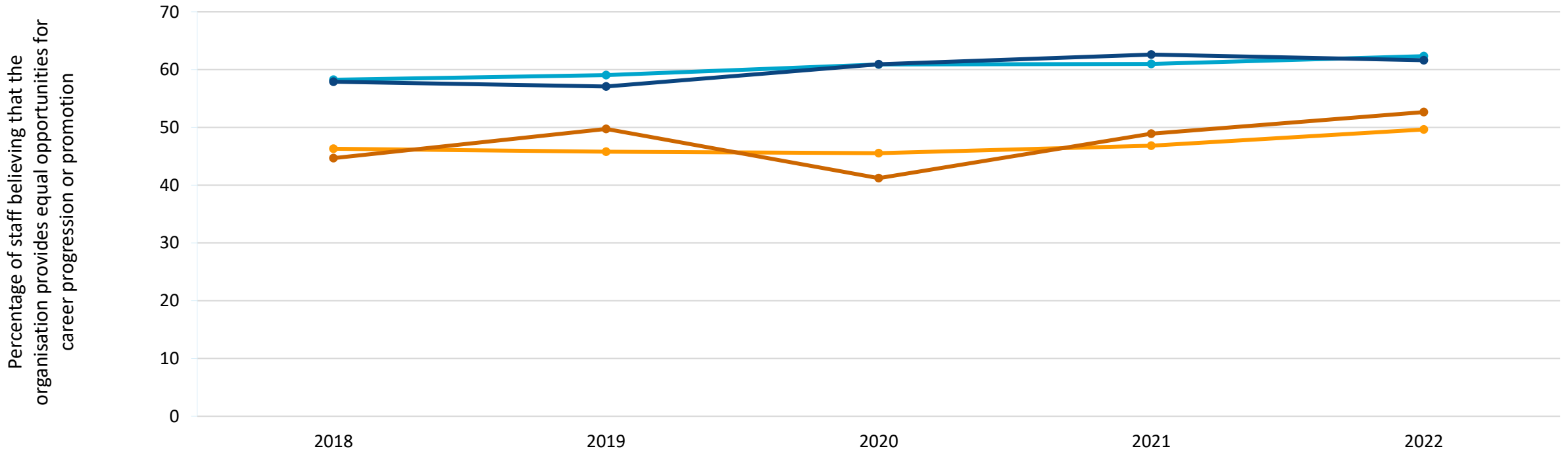
Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre

NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



	2018	2019	2020	2021	2022
White staff: Your org	57.9%	57.1%	60.9%	62.6%	61.6%
All other ethnic groups*: Your org	44.7%	49.7%	41.2%	48.9%	52.7%
White staff: Average	58.3%	59.0%	60.9%	61.0%	62.3%
All other ethnic groups*: Average	46.3%	45.8%	45.5%	46.8%	49.6%
White staff: Responses	1689	1824	1891	2099	2043
All other ethnic groups*: Responses	338	362	376	462	471

*Staff from all other ethnic groups combined

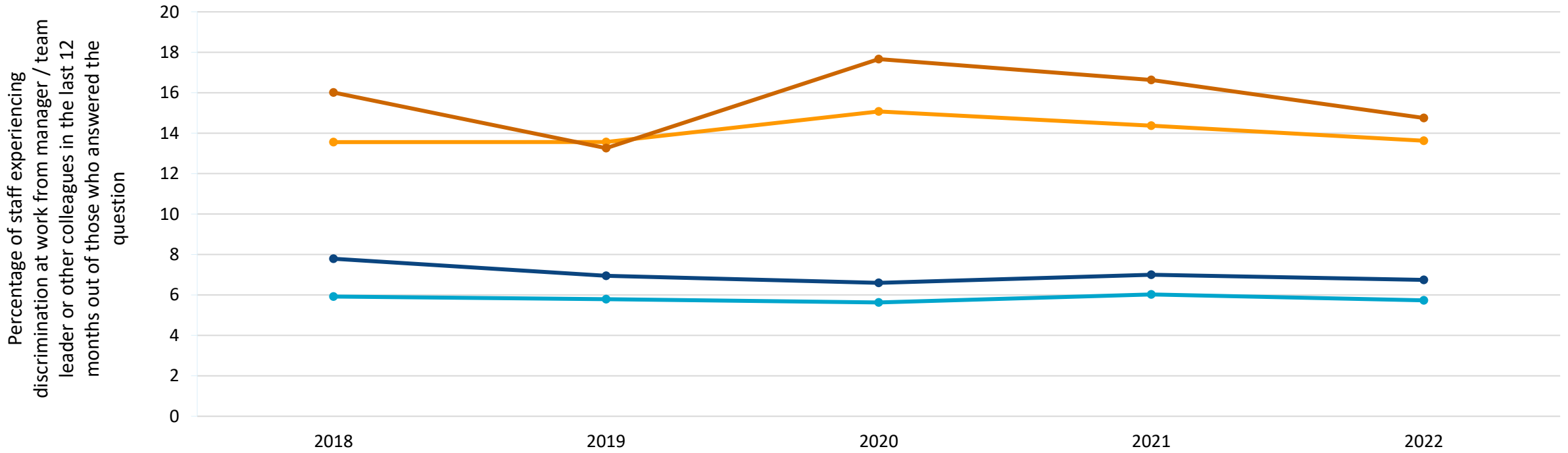
Average calculated as the median for the benchmark group

Workforce Race Equality Standard (WRES)

Survey Coordination Centre

NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2018	2019	2020	2021	2022
White staff: Your org	7.8%	6.9%	6.6%	7.0%	6.7%
All other ethnic groups*: Your org	16.0%	13.3%	17.7%	16.6%	14.8%
White staff: Average	5.9%	5.8%	5.6%	6.0%	5.7%
All other ethnic groups*: Average	13.6%	13.6%	15.1%	14.4%	13.6%
White staff: Responses	1669	1814	1880	2086	2032
All other ethnic groups*: Responses	331	362	368	457	461

*Staff from all other ethnic groups combined

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS

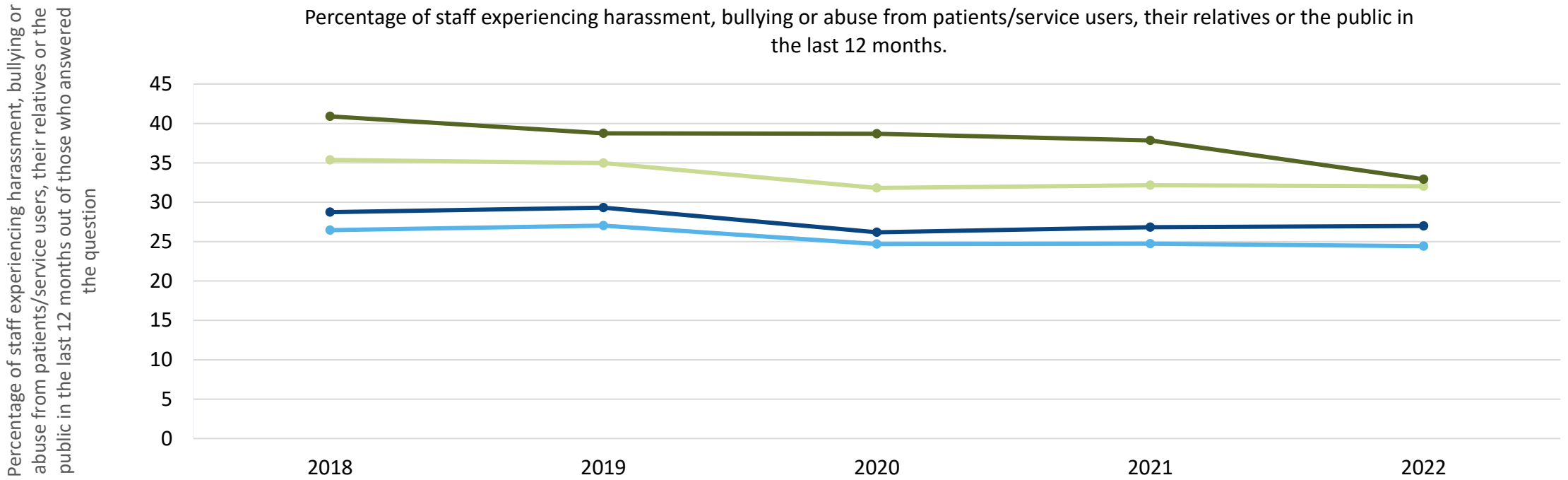
Workforce Disability Equality Standards (WDES)

N.B.
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed.
Data shown in the WDES charts are unweighted.

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

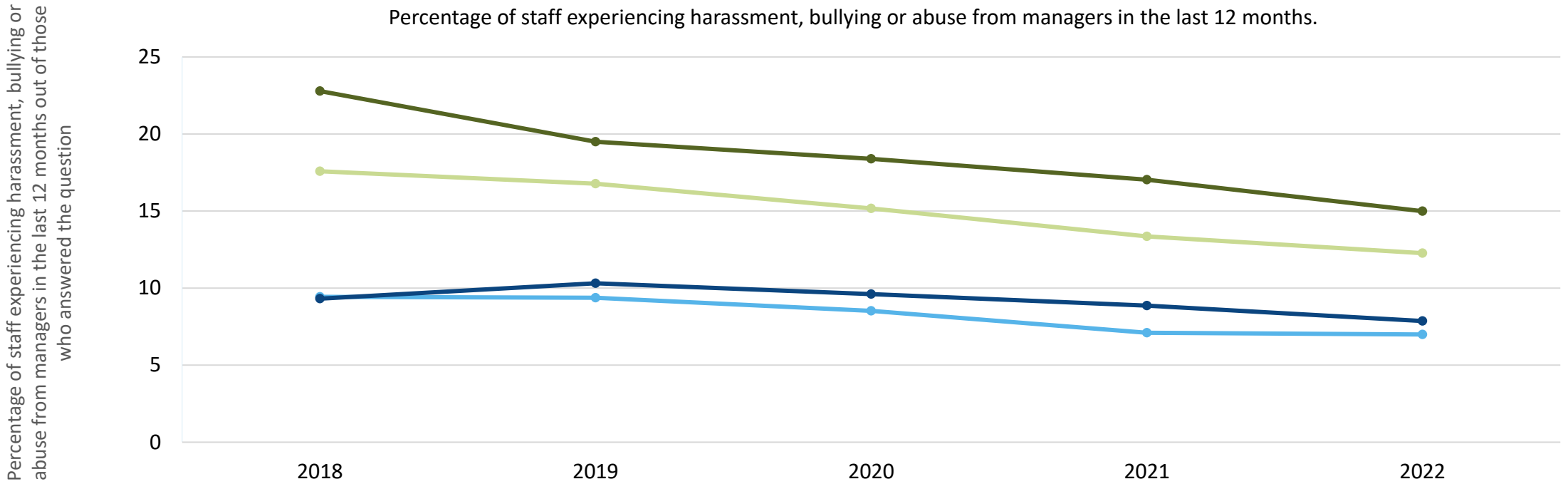
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	40.9%	38.8%	38.7%	37.8%	32.9%
Staff without a LTC or illness: Your org	28.7%	29.3%	26.2%	26.8%	27.0%
Staff with a LTC or illness: Average	35.4%	35.0%	31.8%	32.2%	32.0%
Staff without a LTC or illness: Average	26.5%	27.0%	24.7%	24.7%	24.4%
Staff with a LTC or illness: Responses	418	480	535	687	732
Staff without a LTC or illness: Responses	1621	1723	1726	1867	1778

Workforce Disability Equality Standards

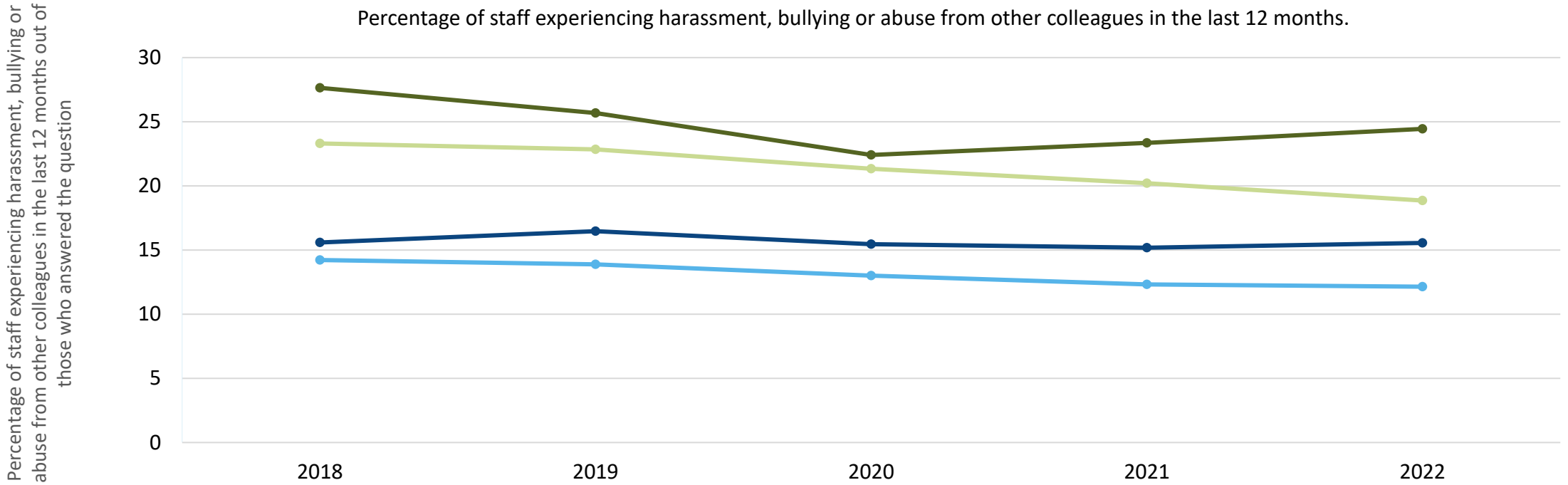
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	22.8%	19.5%	18.4%	17.0%	15.0%
Staff without a LTC or illness: Your org	9.3%	10.3%	9.6%	8.9%	7.9%
Staff with a LTC or illness: Average	17.6%	16.8%	15.2%	13.4%	12.3%
Staff without a LTC or illness: Average	9.4%	9.4%	8.5%	7.1%	7.0%
Staff with a LTC or illness: Responses	417	482	533	681	727
Staff without a LTC or illness: Responses	1610	1706	1717	1851	1768

Workforce Disability Equality Standards

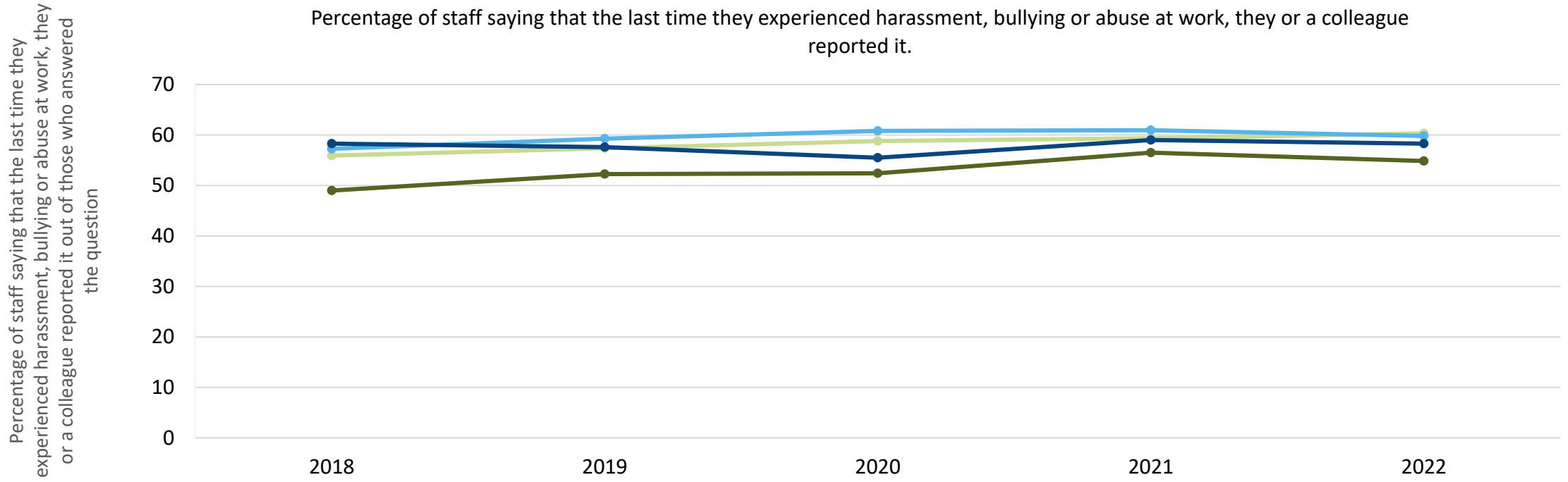
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	27.6%	25.7%	22.4%	23.4%	24.4%
Staff without a LTC or illness: Your org	15.6%	16.5%	15.5%	15.2%	15.6%
Staff with a LTC or illness: Average	23.3%	22.8%	21.3%	20.2%	18.9%
Staff without a LTC or illness: Average	14.2%	13.9%	13.0%	12.3%	12.1%
Staff with a LTC or illness: Responses	416	475	531	685	724
Staff without a LTC or illness: Responses	1597	1694	1708	1844	1761

Workforce Disability Equality Standards

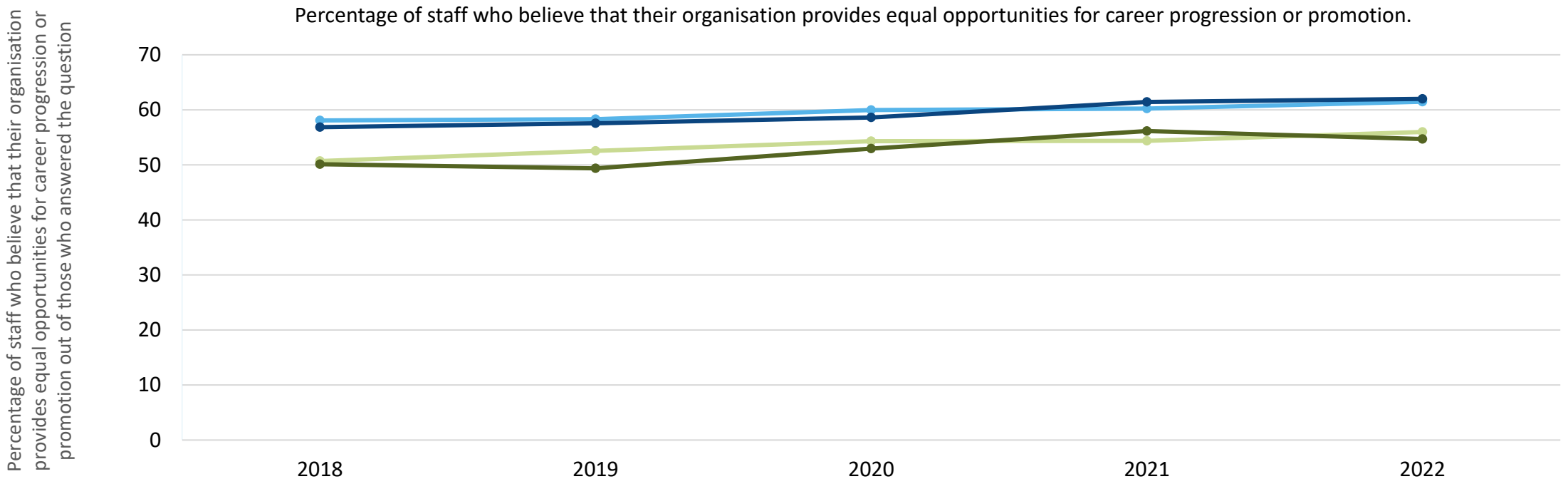
Survey Coordination Centre NHS



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	49.0%	52.3%	52.4%	56.5%	54.9%
Staff without a LTC or illness: Your org	58.3%	57.6%	55.5%	59.0%	58.3%
Staff with a LTC or illness: Average	55.9%	57.4%	58.8%	59.4%	60.3%
Staff without a LTC or illness: Average	57.3%	59.3%	60.8%	61.0%	59.8%
Staff with a LTC or illness: Responses	202	243	248	315	319
Staff without a LTC or illness: Responses	494	611	573	583	554

Workforce Disability Equality Standards

Survey Coordination Centre NHS

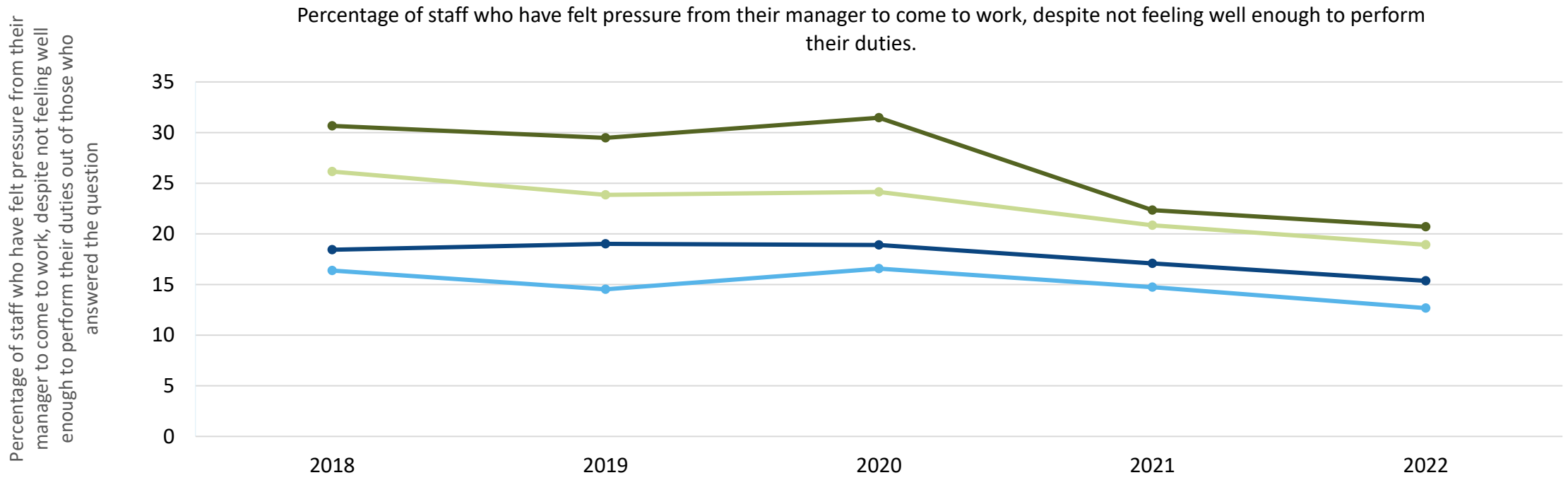


	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	50.1%	49.4%	53.0%	56.2%	54.7%
Staff without a LTC or illness: Your org	56.9%	57.6%	58.6%	61.4%	62.0%
Staff with a LTC or illness: Average	50.7%	52.5%	54.3%	54.4%	56.0%
Staff without a LTC or illness: Average	58.1%	58.3%	60.0%	60.2%	61.5%
Staff with a LTC or illness: Responses	421	480	542	691	735
Staff without a LTC or illness: Responses	1625	1718	1742	1867	1779

Workforce Disability Equality Standards

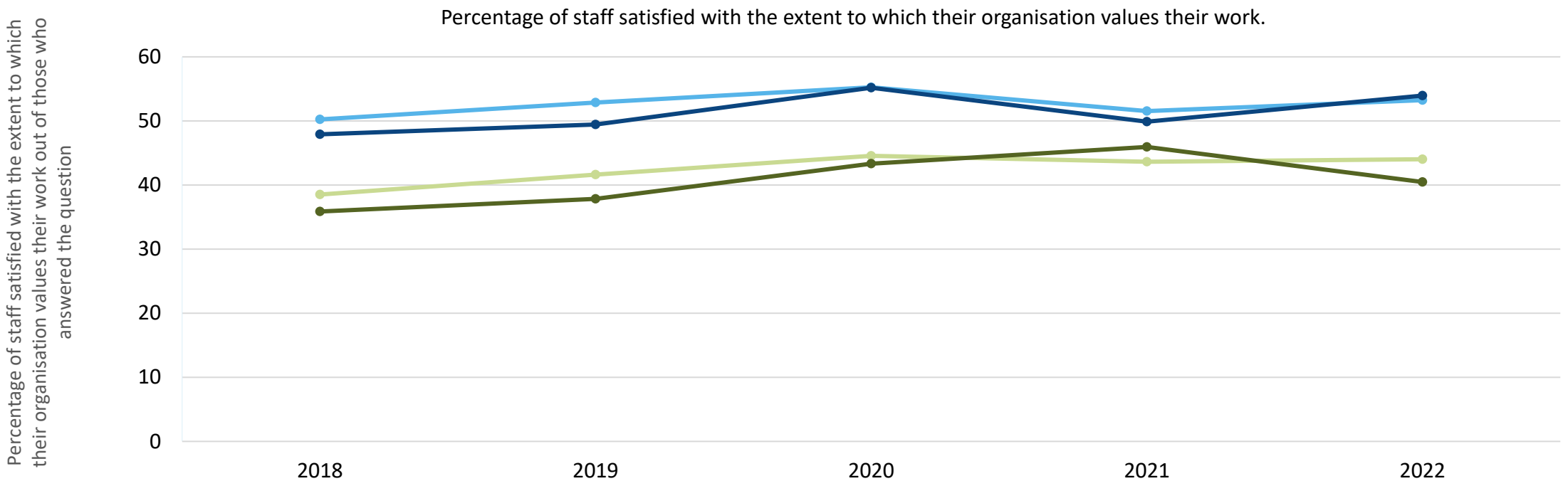
Survey Coordination Centre NHS

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	30.7%	29.5%	31.5%	22.3%	20.7%
Staff without a LTC or illness: Your org	18.4%	19.0%	18.9%	17.1%	15.4%
Staff with a LTC or illness: Average	26.2%	23.9%	24.1%	20.8%	18.9%
Staff without a LTC or illness: Average	16.4%	14.5%	16.6%	14.7%	12.7%
Staff with a LTC or illness: Responses	313	346	340	443	517
Staff without a LTC or illness: Responses	846	894	693	808	879

Workforce Disability Equality Standards

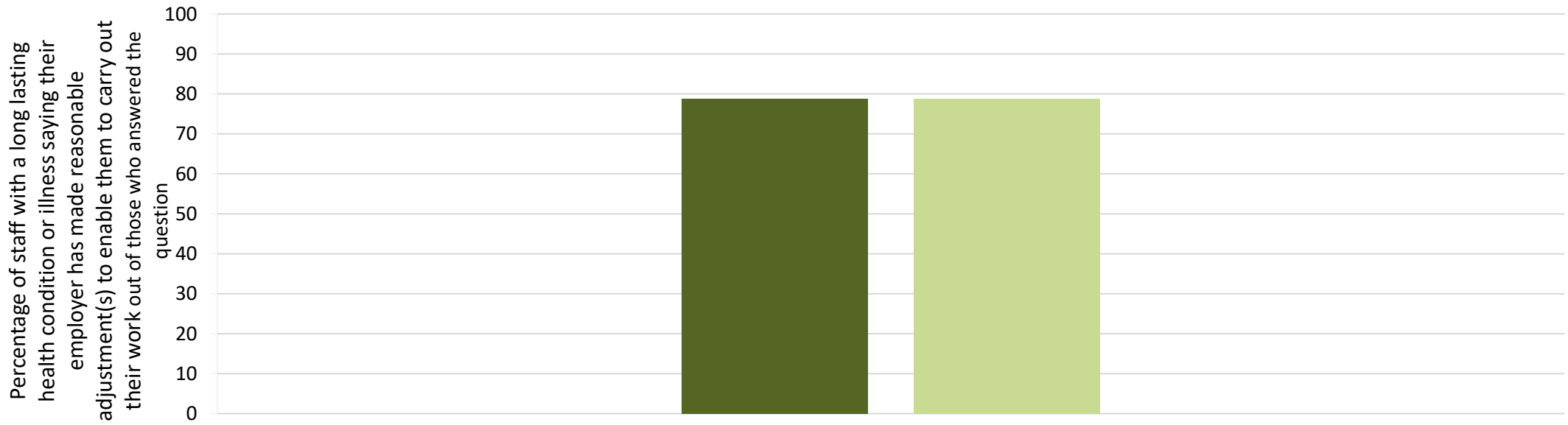


	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	35.9%	37.8%	43.3%	45.9%	40.5%
Staff without a LTC or illness: Your org	47.9%	49.4%	55.2%	49.9%	54.0%
Staff with a LTC or illness: Average	38.5%	41.6%	44.6%	43.6%	44.0%
Staff without a LTC or illness: Average	50.2%	52.9%	55.2%	51.5%	53.2%
Staff with a LTC or illness: Responses	421	481	533	690	729
Staff without a LTC or illness: Responses	1609	1717	1734	1860	1783

Workforce Disability Equality Standards

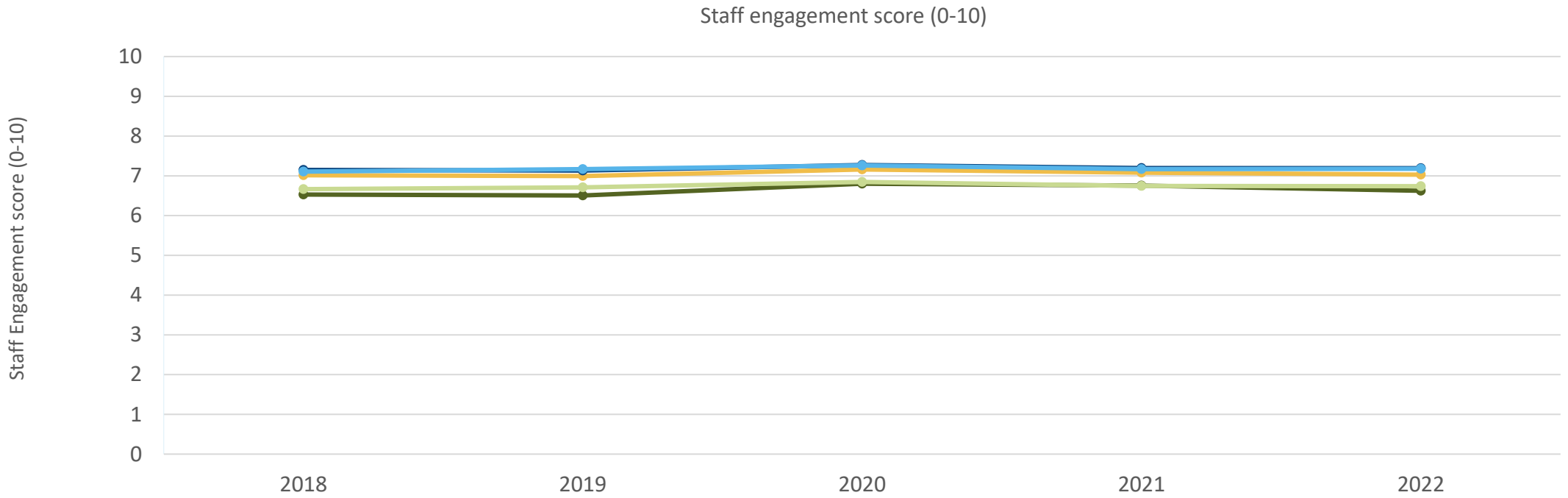
Survey Coordination Centre NHS

Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022
Staff with a LTC or illness: Your org	78.8%
Staff with a LTC or illness: Average	78.8%
Staff with a LTC or illness: Responses	452

Workforce Disability Equality Standards



	2018	2019	2020	2021	2022
Organisation average	7.0	7.0	7.2	7.1	7.0
Staff with a LTC or illness: Your org	6.5	6.5	6.8	6.8	6.6
Staff without a LTC or illness: Your org	7.1	7.1	7.3	7.2	7.2
Staff with a LTC or illness: Average	6.7	6.7	6.8	6.7	6.7
Staff without a LTC or illness: Average	7.1	7.2	7.3	7.2	7.2
Staff with a LTC or illness: Responses	424	484	542	693	737
Staff without a LTC or illness: Responses	1634	1734	1744	1873	1786

N.B. Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Survey Coordination Centre

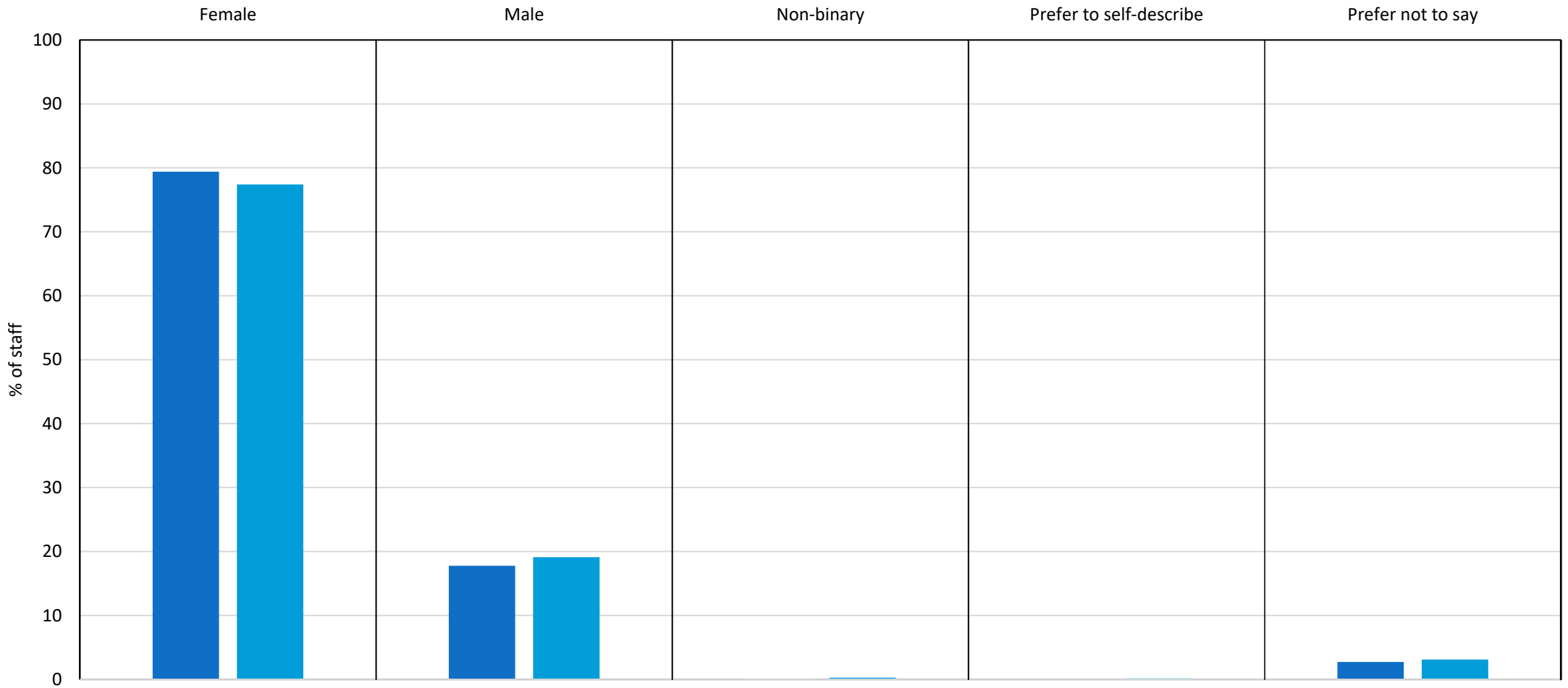
NHS

About your respondents

This section will show demographic information for 2022.

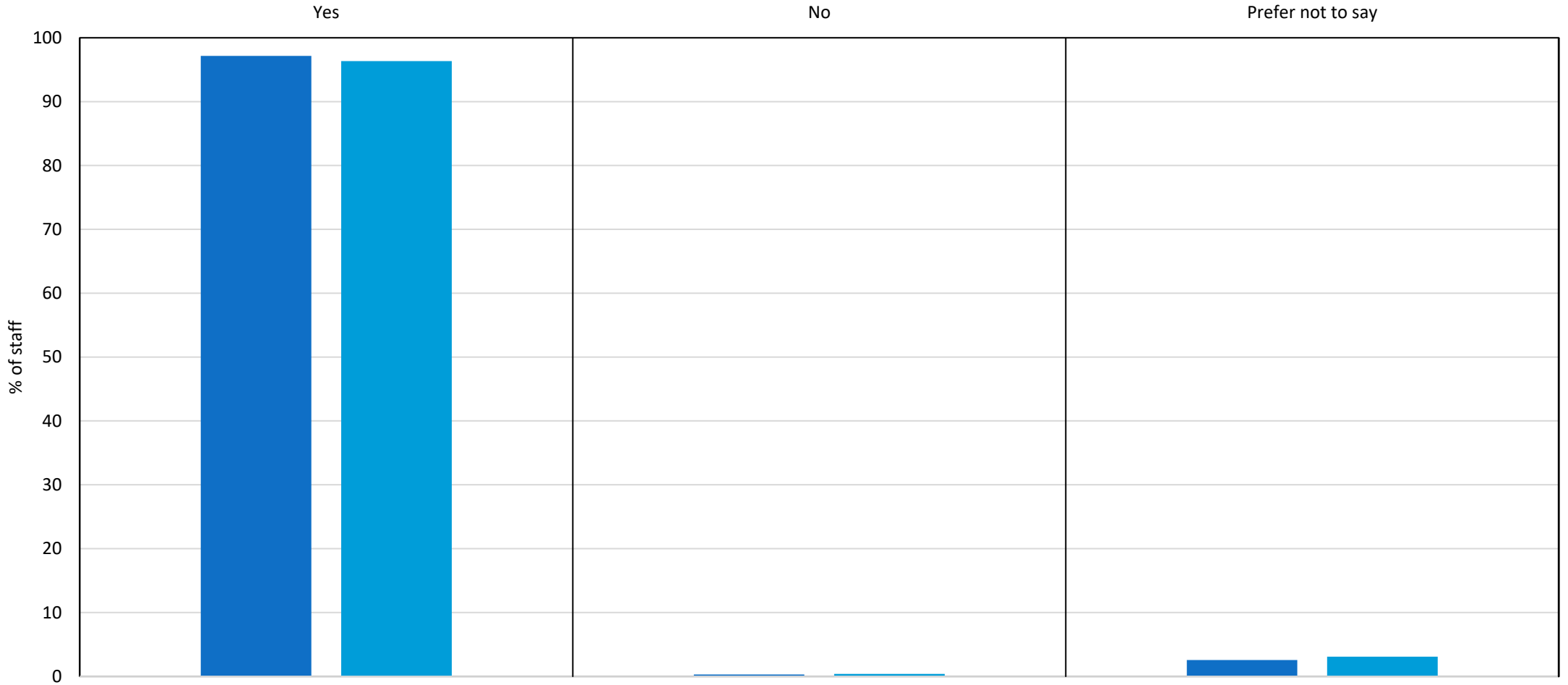
Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender



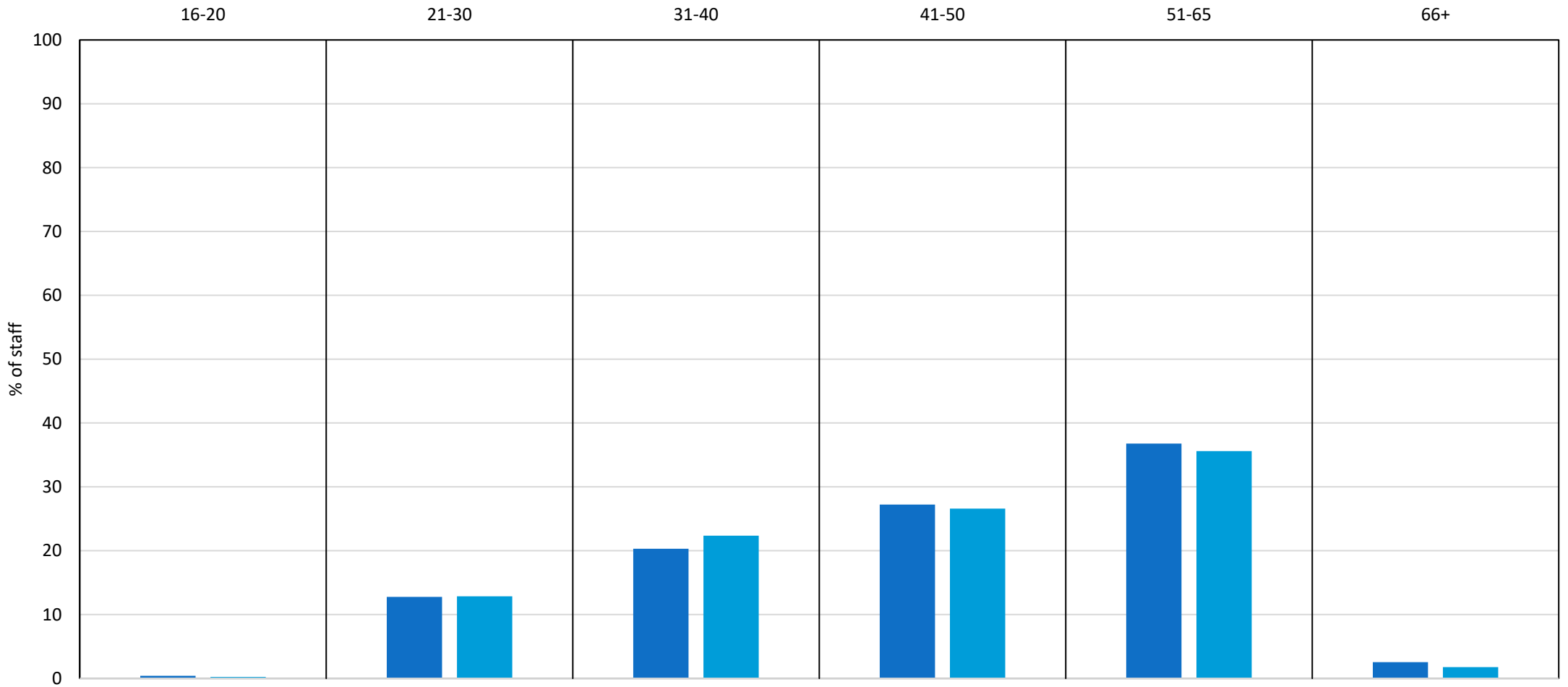
	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	79.4%	17.8%	0.1%	0.0%	2.7%
Average	77.4%	19.1%	0.3%	0.2%	3.1%
Responses	2533	2533	2533	2533	2533

Background details – Is your gender identity the same as the sex you were assigned at birth?



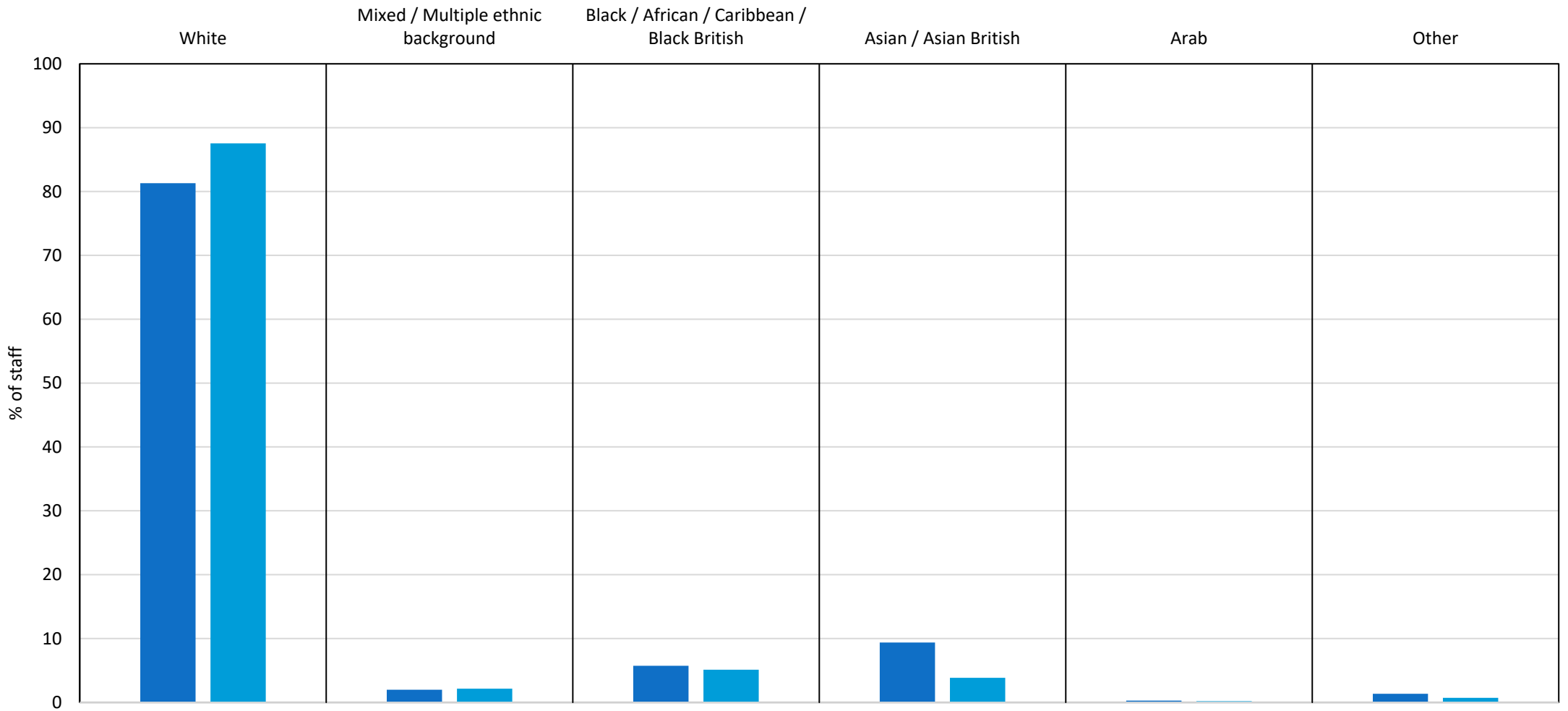
	Yes	No	Prefer not to say
Your org	97.2%	0.3%	2.6%
Average	96.4%	0.4%	3.1%
Responses	2429	2429	2429

Background details - Age



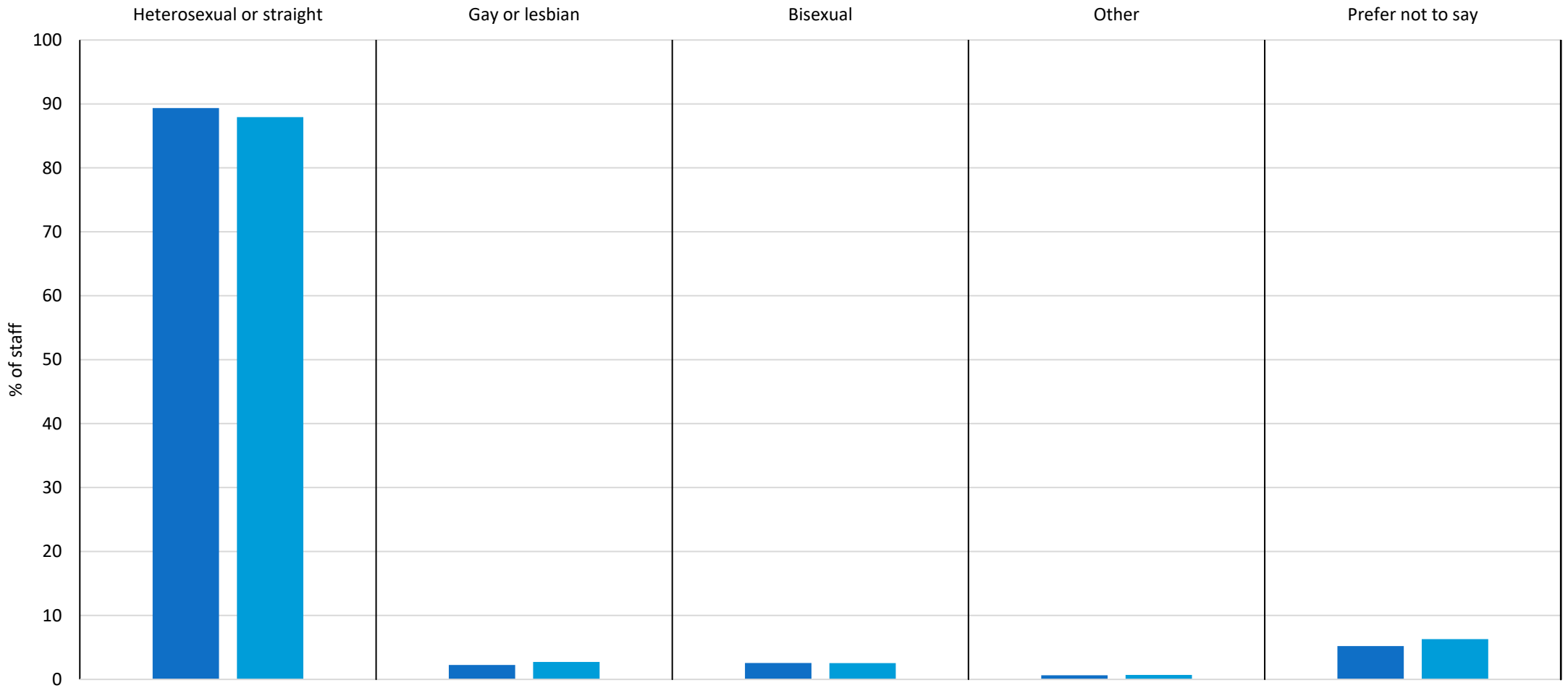
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.4%	12.8%	20.3%	27.2%	36.8%	2.5%
Average	0.2%	12.9%	22.3%	26.6%	35.6%	1.8%
Responses	2523	2523	2523	2523	2523	2523

Background details - Ethnicity



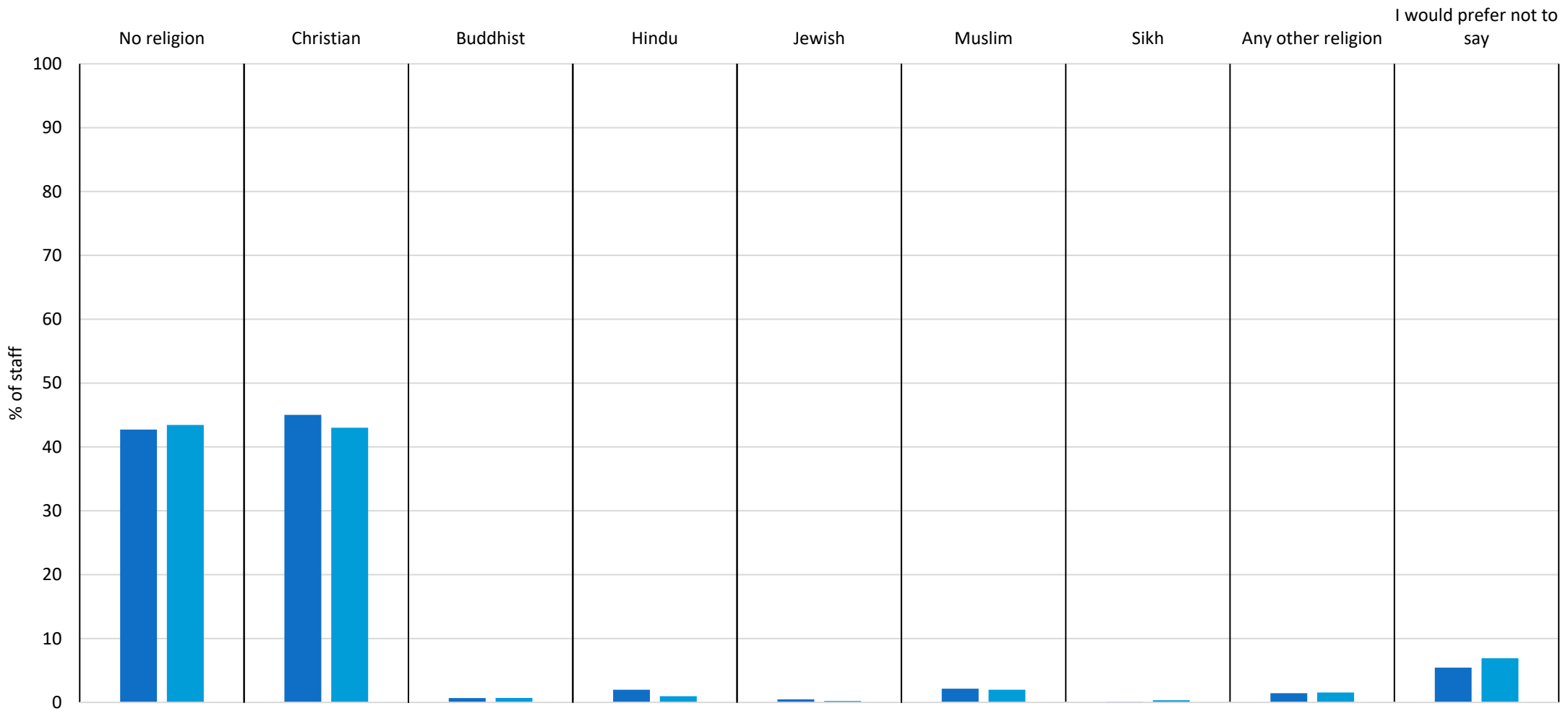
	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	81.3%	2.0%	5.7%	9.4%	0.3%	1.3%
Average	87.5%	2.1%	5.1%	3.8%	0.2%	0.7%
Responses	2531	2531	2531	2531	2531	2531

Background details – Sexual orientation



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	89.3%	2.2%	2.6%	0.6%	5.2%
Average	87.9%	2.7%	2.5%	0.7%	6.3%
Responses	2535	2535	2535	2535	2535

Background details - Religion



	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	42.7%	45.0%	0.7%	2.0%	0.5%	2.1%	0.1%	1.4%	5.4%
Average	43.4%	43.0%	0.7%	1.0%	0.2%	2.0%	0.3%	1.5%	6.9%
Responses	2523	2523	2523	2523	2523	2523	2523	2523	2523

Background details – Long lasting health condition or illness

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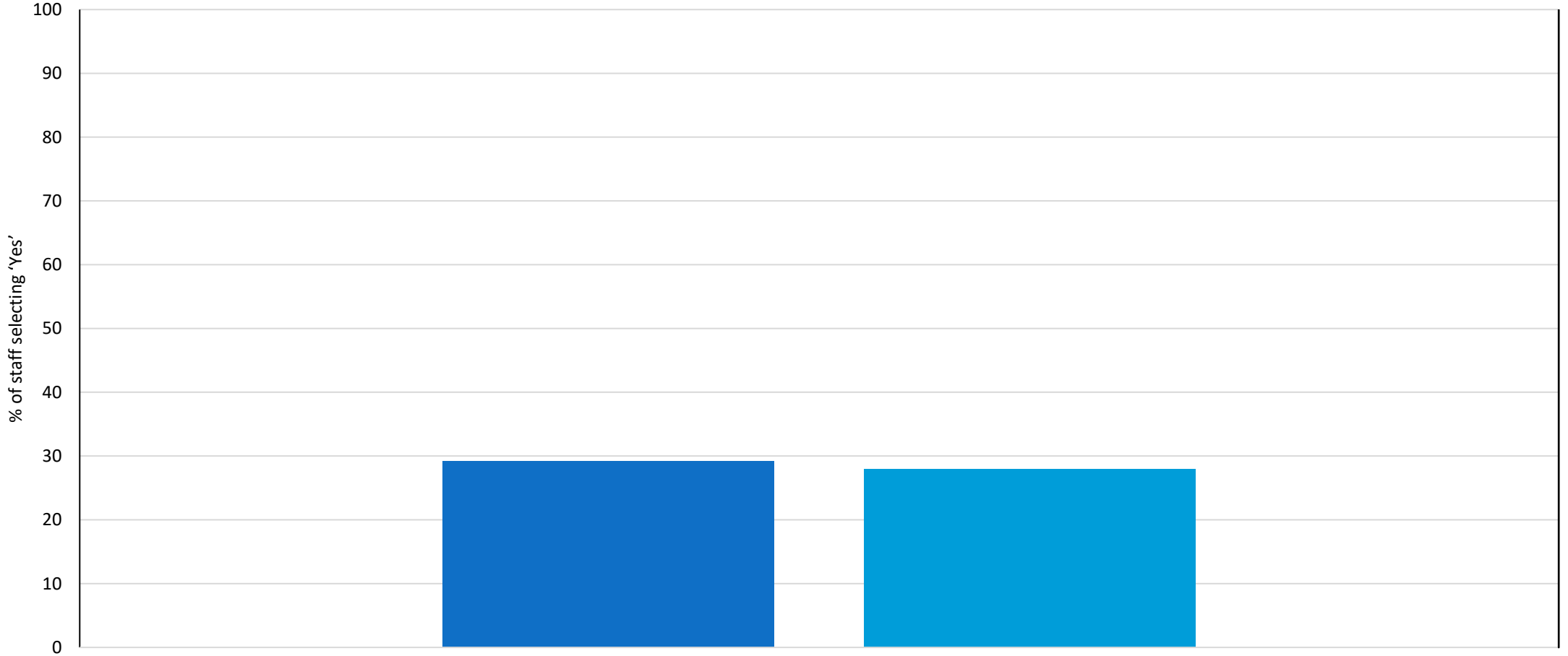
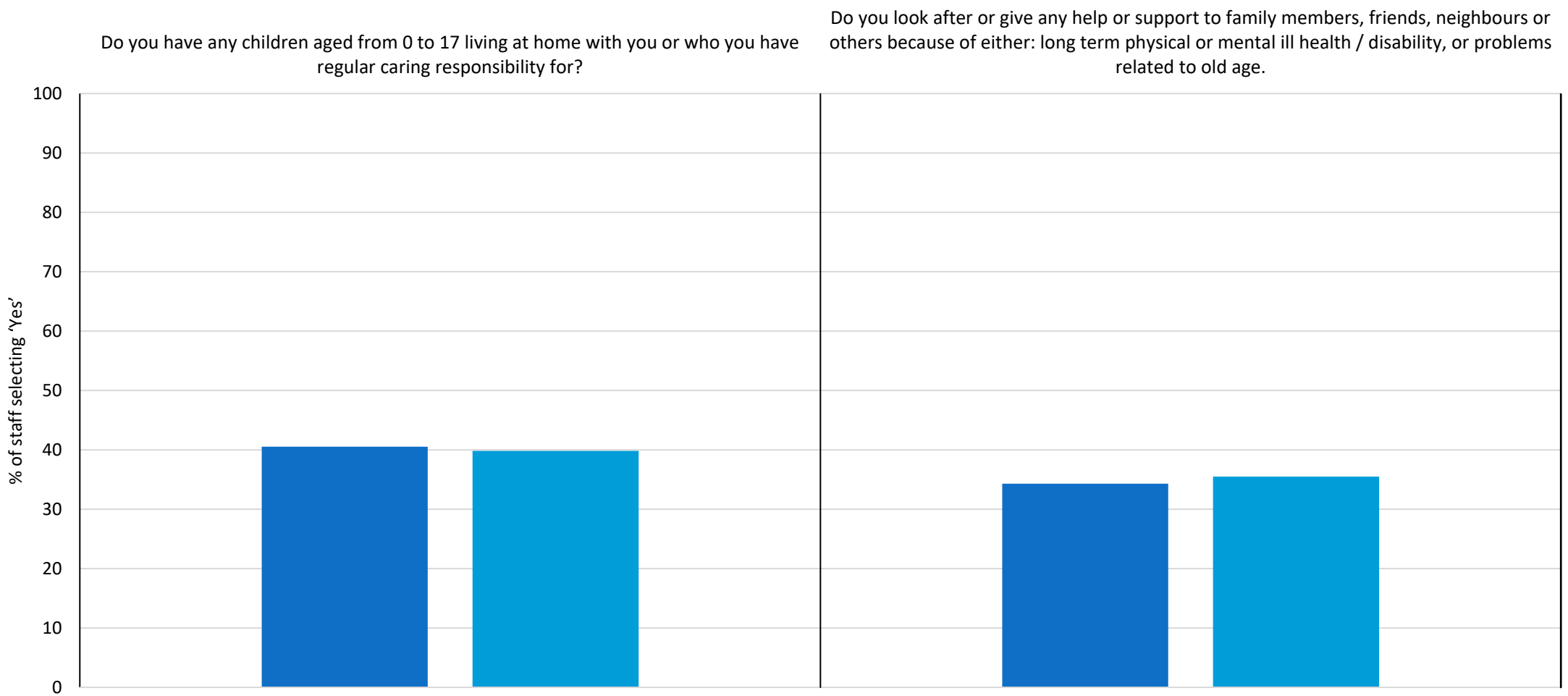
Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



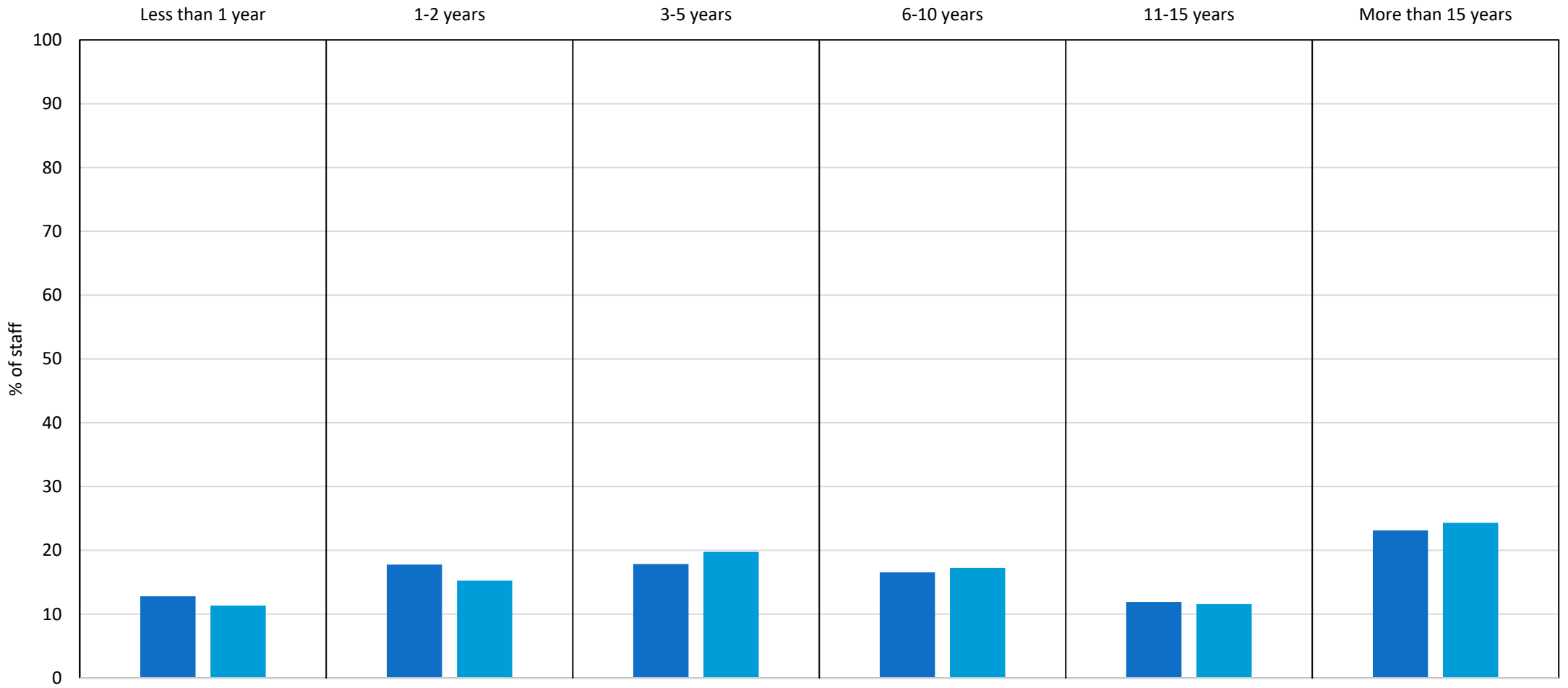
Your org	29.2%
Average	27.9%
Responses	2532

Background details – Parental / caring responsibilities



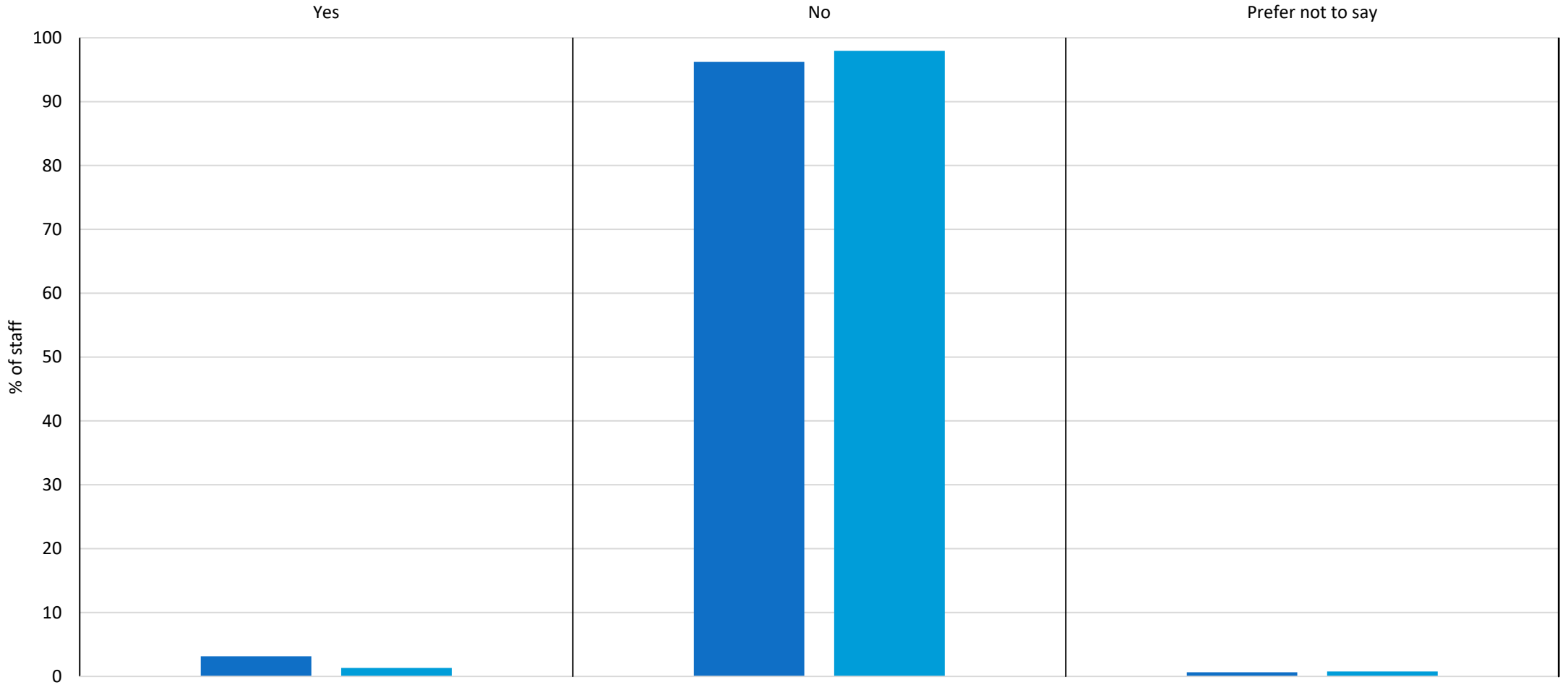
Your org	40.5%	34.3%
Average	39.8%	35.5%
Responses	2524	2513

Background details – Length of service



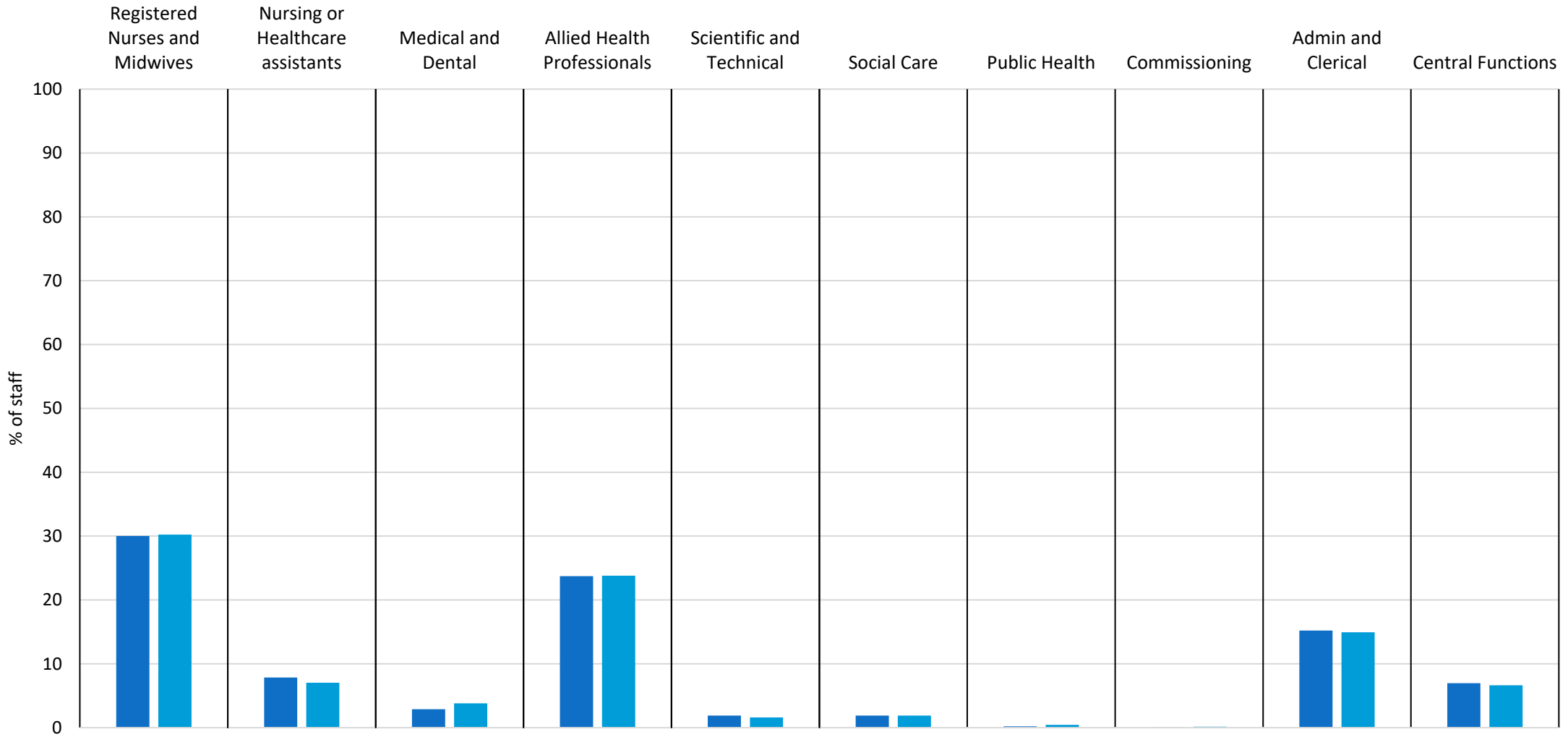
	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	12.8%	17.8%	17.8%	16.5%	11.9%	23.1%
Average	11.4%	15.2%	19.8%	17.2%	11.6%	24.3%
Responses	2538	2538	2538	2538	2538	2538

Background details – When you joined this organisation were you recruited from outside of the UK?



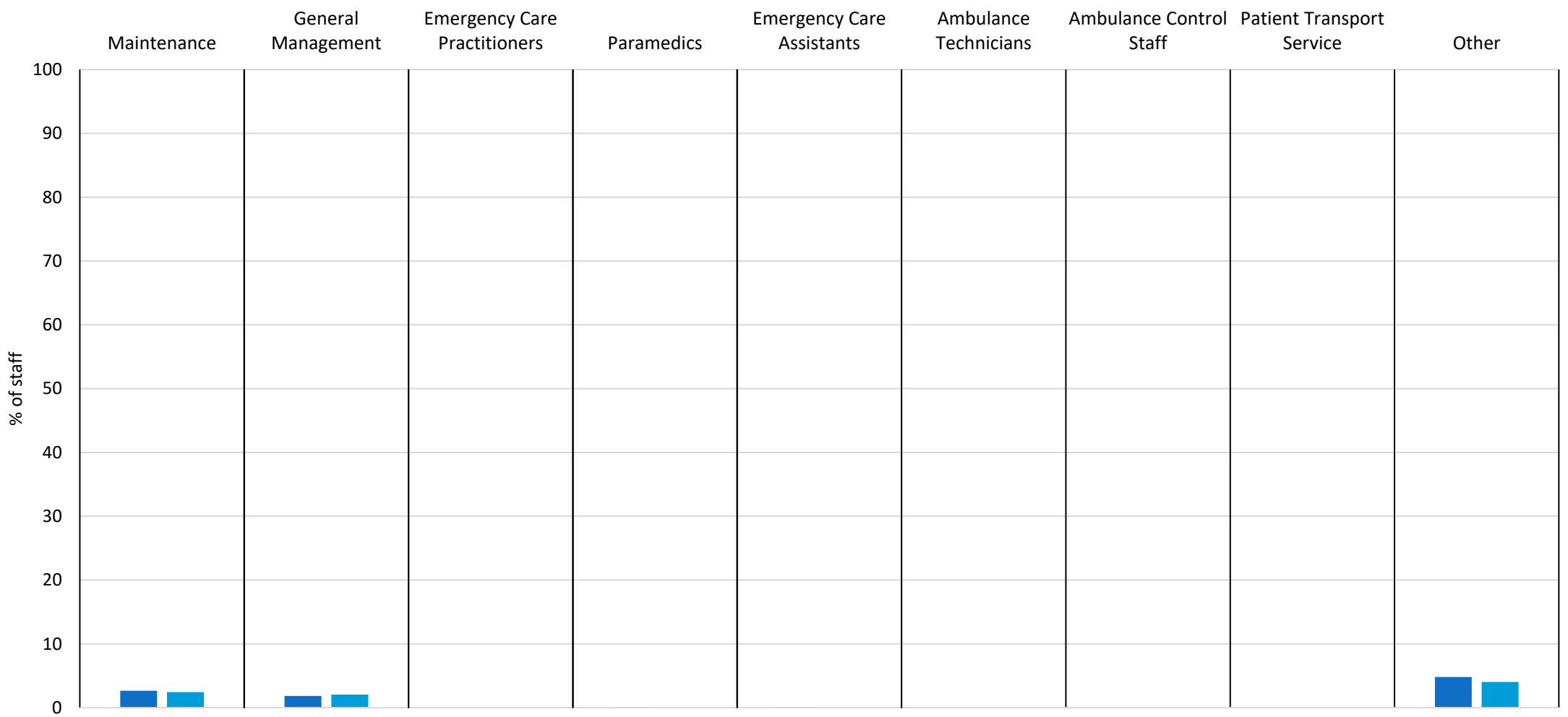
	Yes	No	Prefer not to say
Your org	3.1%	96.2%	0.6%
Average	1.3%	98.0%	0.8%
Responses	2513	2513	2513

Background details – Occupational group



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	30.0%	7.8%	2.9%	23.7%	1.9%	1.9%	0.2%	0.0%	15.2%	7.0%
Average	30.2%	7.0%	3.8%	23.8%	1.6%	1.9%	0.4%	0.2%	14.9%	6.6%
Responses	2499	2499	2499	2499	2499	2499	2499	2499	2499	2499

Background details – Occupational group



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	2.6%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.8%
Average	2.4%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.0%
Responses	2499	2499	2499	2499	2499	2499	2499	2499	2499

Survey Coordination Centre

NHS

Appendices

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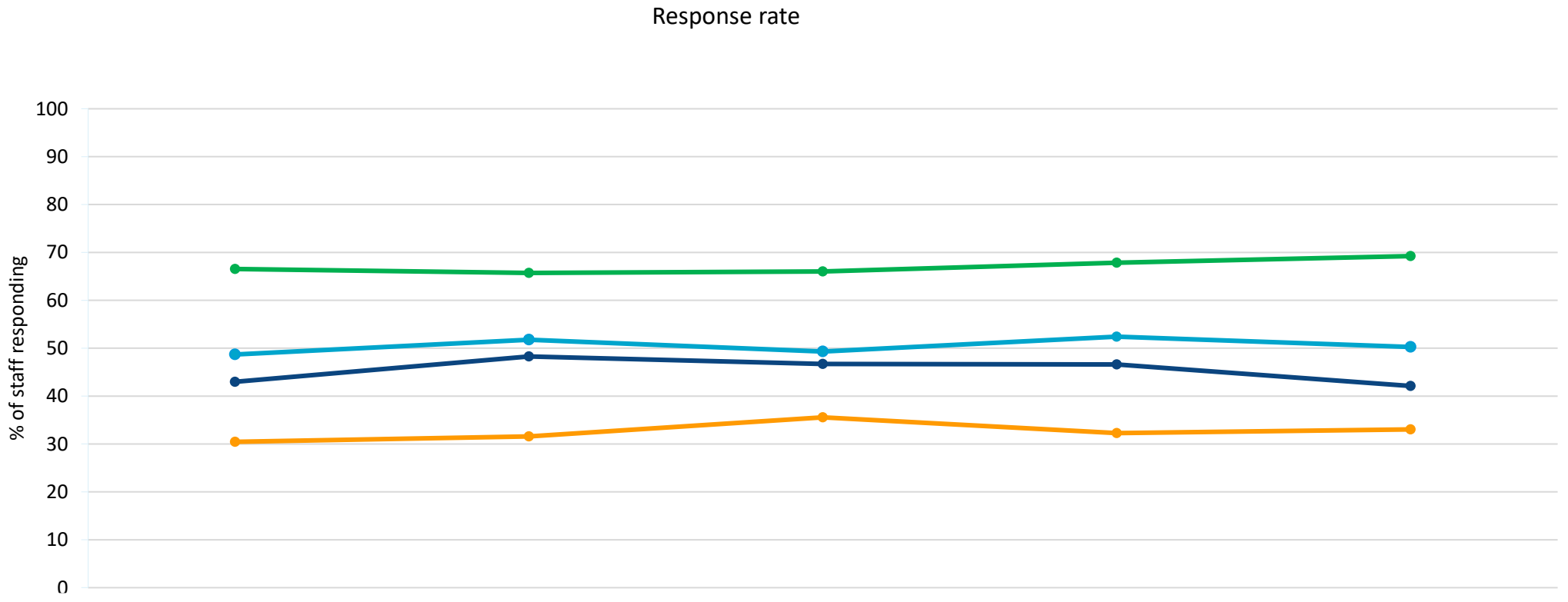
NHS

Appendix A: Response rate

Appendix A: Response rate



	2018	2019	2020	2021	2022
Your org	43.0%	48.3%	46.7%	46.6%	42.1%
Highest	66.5%	65.7%	66.0%	67.9%	69.2%
Average	48.7%	51.8%	49.3%	52.4%	50.3%
Lowest	30.5%	31.6%	35.6%	32.3%	33.0%
Responses	2108	2280	2305	2602	2547

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Appendix B: Significance testing 2021 vs 2022

Appendix B: Significance testing – 2021 vs 2022

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The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.5	2594	7.5	2541	Not significant
We are recognised and rewarded	6.3	2582	6.2	2531	Not significant
We each have a voice that counts	6.9	2565	6.9	2518	Not significant
We are safe and healthy	6.3	2576	6.2	2528	Not significant
We are always learning	5.6	2433	5.7	2411	Not significant
We work flexibly	6.7	2568	6.8	2522	Not significant
We are a team	7.1	2575	7.1	2535	Not significant
Themes					
Staff Engagement	7.1	2594	7.0	2538	Not significant
Morale	6.1	2597	6.1	2540	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence. For more details please see the technical document.

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Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the scores are calculated can be found in the technical document available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

N.B. Historical benchmarking data for 2019 has been revised for the Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trusts benchmarking groups. This is due to a revision in the occupation group weighting to correctly reflect historical benchmarking group changes. Historical data is reweighted each year according to the latest results and so historical figures change with each new year of data; however it is advised to keep the above in mind when viewing historical results released in 2022.

Appendix C: 1. Reviewing People Promise and theme results

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When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

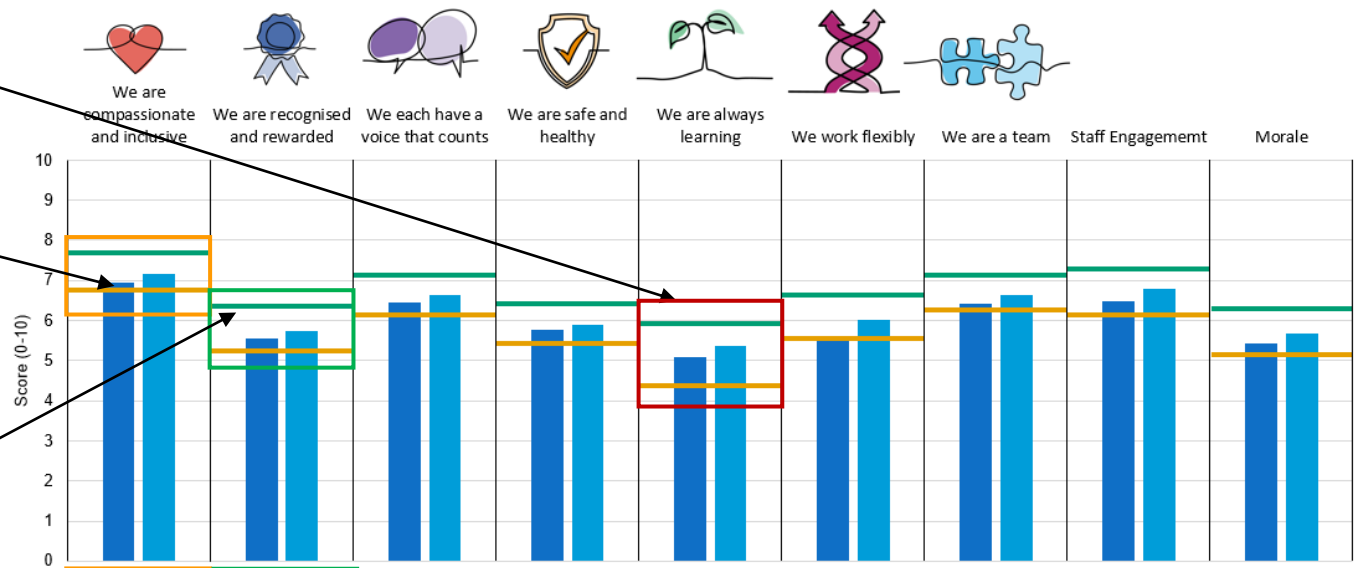
It is important to **consider each result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing People Promise element and theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

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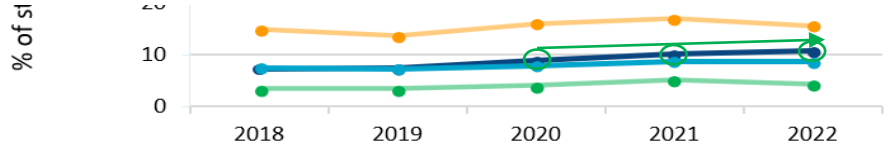
Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



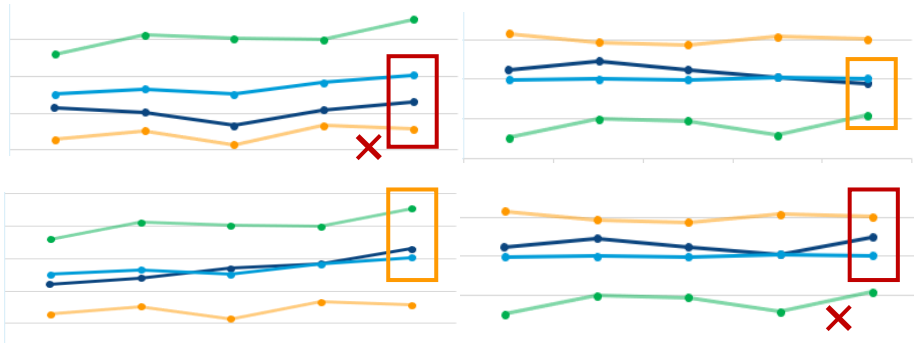
	2018	2019	2020	2021	2022
Your org	7.3%	7.4%	8.9%	10.2%	10.8%
Best	3.4%	3.4%	4.0%	5.1%	4.2%
Average	7.5%	7.3%	7.9%	8.8%	8.7%
Worst	14.9%	13.8%	16.1%	17.2%	15.7%

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme scores, you should review the sub-scores and questions feeding into these scores. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average & worst benchmarking group result for question

Appendix C: 3. Reviewing question results

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

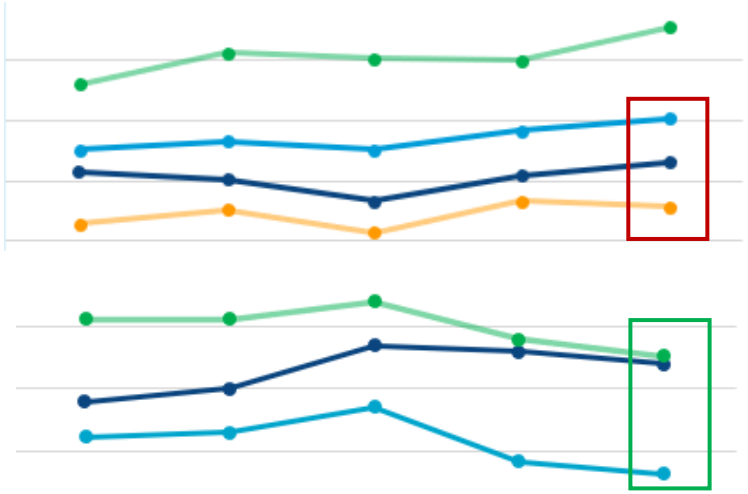
Identifying questions of interest

- **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

- **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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NHS

Appendix D: Additional reporting outputs

Please note, where there are less than 11 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

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Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other local results

Local Dashboards: Online dashboards containing results for each participating organisation, similar those provided in this report, with trend data and benchmark results for up to five years where possible. These dashboards additionally show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for Essex Partnership University NHS Foundation Trust.

National results

National Dashboards: Online dashboards containing national results for NHS trusts with trend data for up to five years where possible. These dashboards show the results for different trust types and include the full breakdown or response options for each question.

Regional / System overview and **Regional / System breakdown** Dashboards containing results for each region and each ICS.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Survey Coordination Centre

NHS

Essex Partnership University NHS Foundation Trust

2022 NHS Staff Survey

Breakdown report

Contents (1)

Contents (2)

Survey Coordination Centre NHS

People Promise element and Theme results – Breakdowns 2 14

This directorate report for Essex Partnership University NHS Foundation Trust contains results by breakdown for People Promise element and theme results from the 2022 NHS Staff Survey. These results are compared to the unweighted average for your organisation.

Please note: It is possible that there are differences between the 'Your org' scores reported in this directorate report and those in the benchmark report. This is because the results in the benchmark report are weighted to allow for fair comparisons between organisations of a similar type. However, in this report comparisons are made within your organisation so the unweighted organisation result is a more appropriate point of comparison.

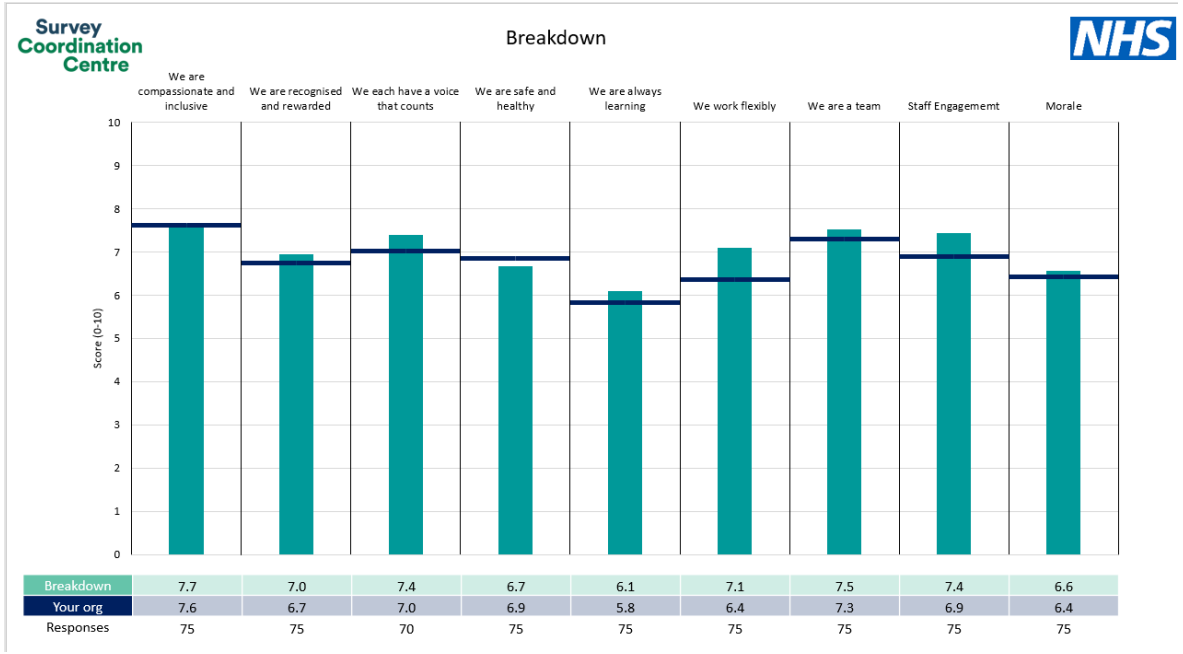
The breakdowns used in this report were provided and defined by Essex Partnership University NHS Foundation Trust. Details of how the People Promise element and theme scores were calculated are included in the Technical Document, available to download from our results website.

Key features

Breakdown type and **breakdown name** are specified in the header.

Breakdown results are presented in the context of the (unweighted) **organisation average ('Your org')**, so it is easy to tell if a directorate is performing better or worse than the organisation average. For all People Promise element and theme results, a higher score is a better result than a lower score

The **number of responses** feeding into each measures and sub-scores for the **given breakdown** is specified below the table containing the directorate and trust scores.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	7.7	7.0	7.4	6.7	6.1	7.1	7.5	7.4	6.6
Your org	7.6	6.7	7.0	6.9	5.8	6.4	7.3	6.9	6.4
Responses	75	75	70	75	75	75	75	75	75

! Note: when there are less than 11 responses in a group, results are suppressed to protect staff confidentiality, for some organisations this could mean that all breakdown results are suppressed.

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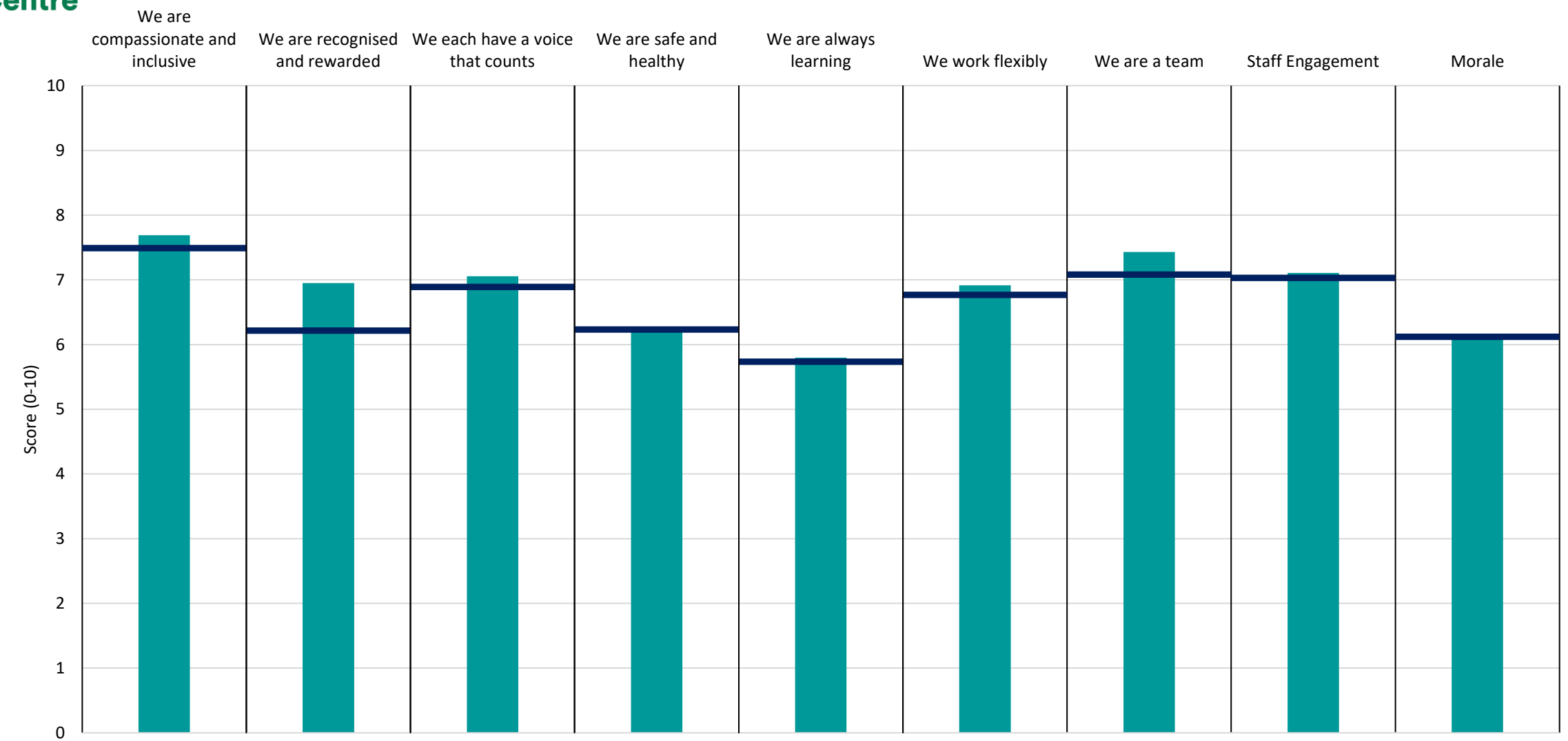
NHS

Breakdowns 1

Essex Partnership University NHS Foundation Trust

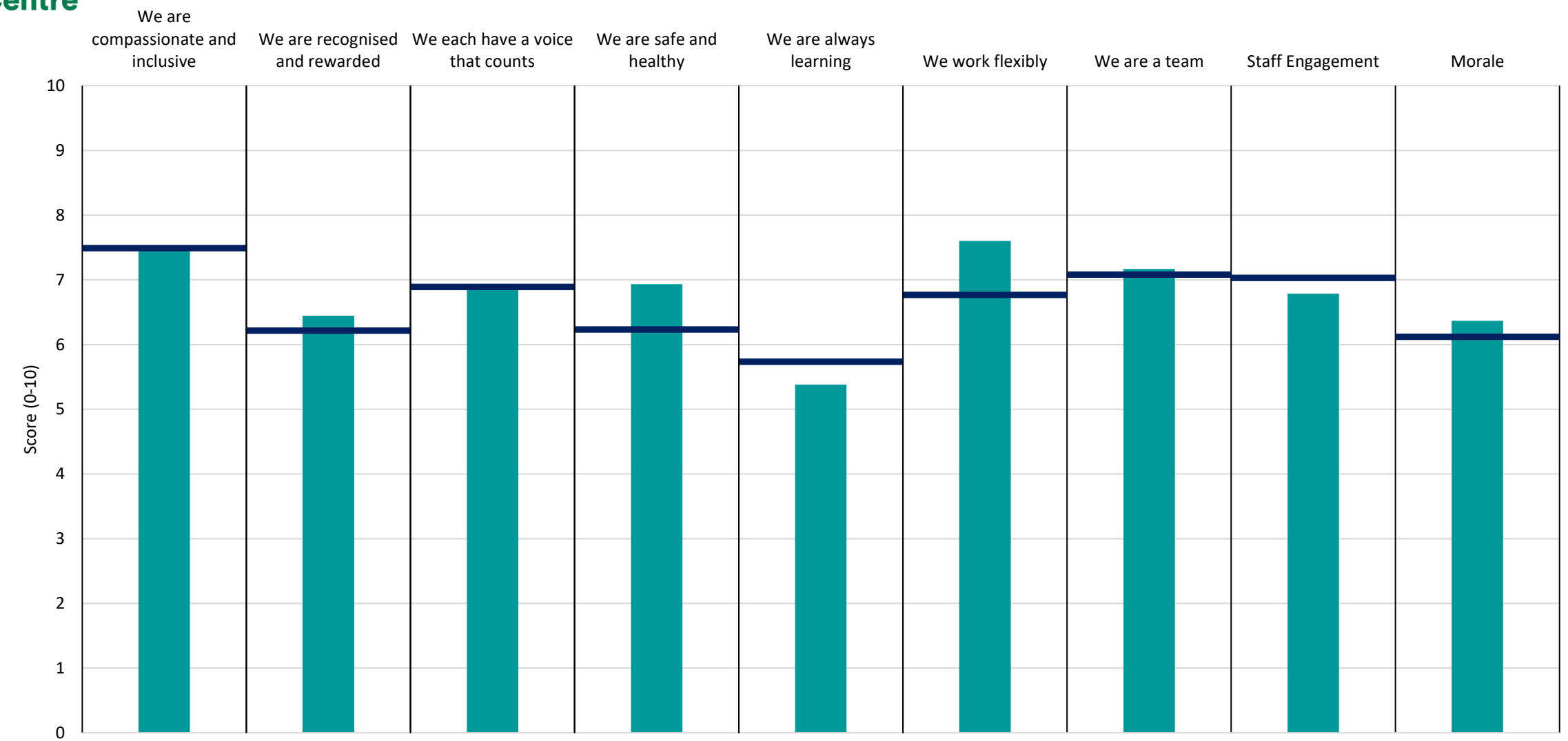
2022 NHS Staff Survey

CORPORATE GOVERNANCE



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.7	7.0	7.1	6.2	5.8	6.9	7.4	7.1	6.1
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	25	25	25	25	23	25	25	25	25

DIGITAL, STRATEGY & TRANSFORMATION



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.5	6.4	6.8	6.9	5.4	7.6	7.2	6.8	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	105	104	104	105	97	103	105	105	105

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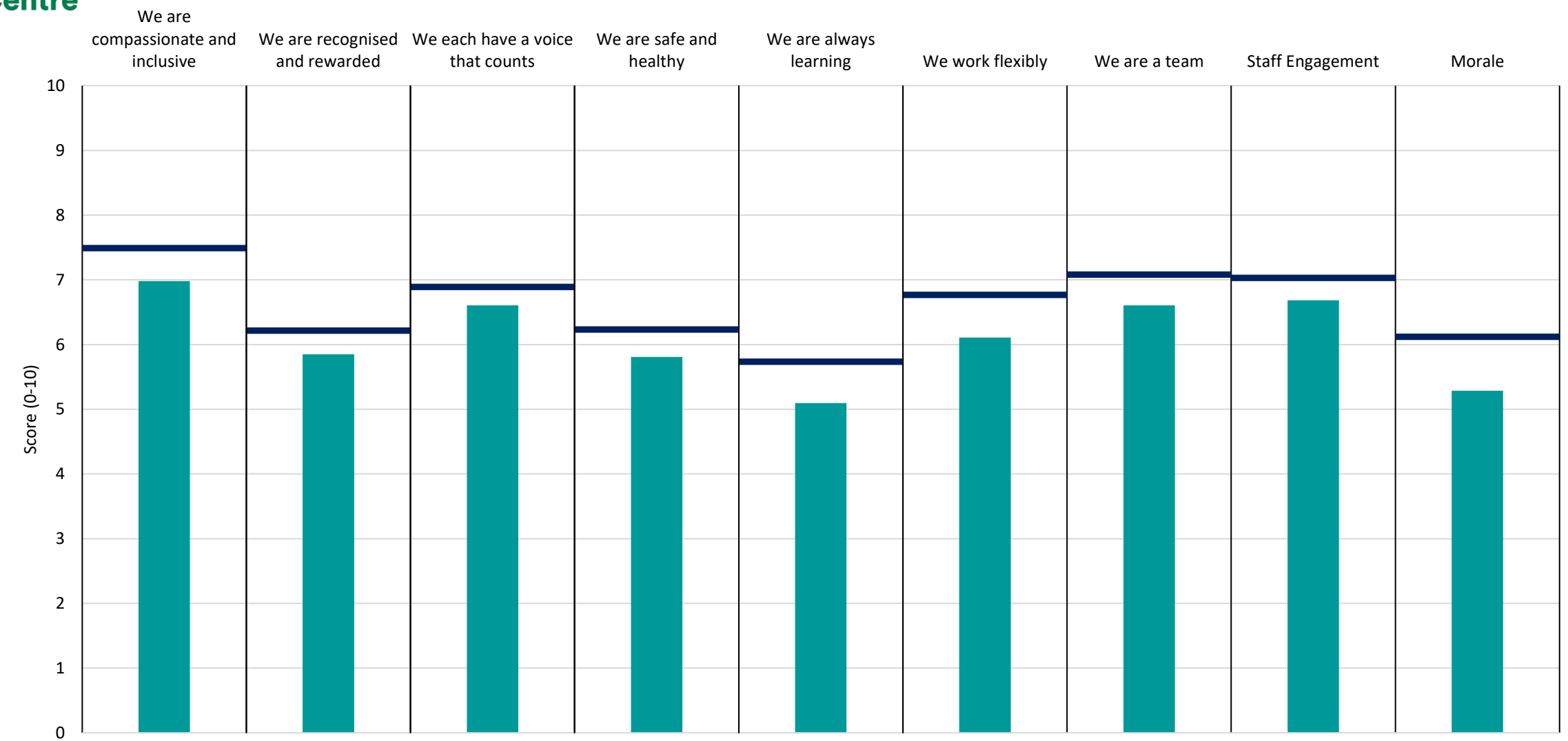
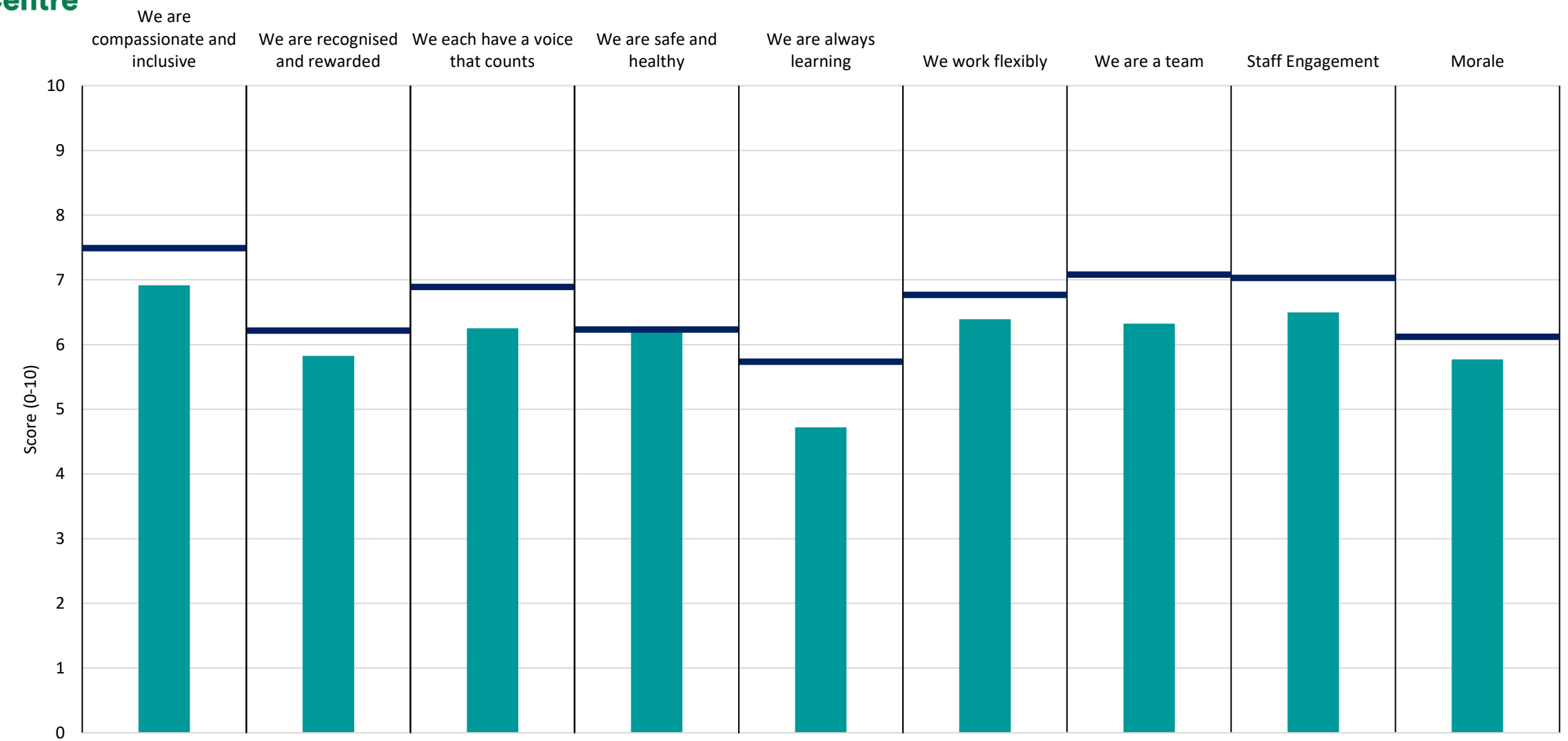
EXECUTIVE NURSE

NHS



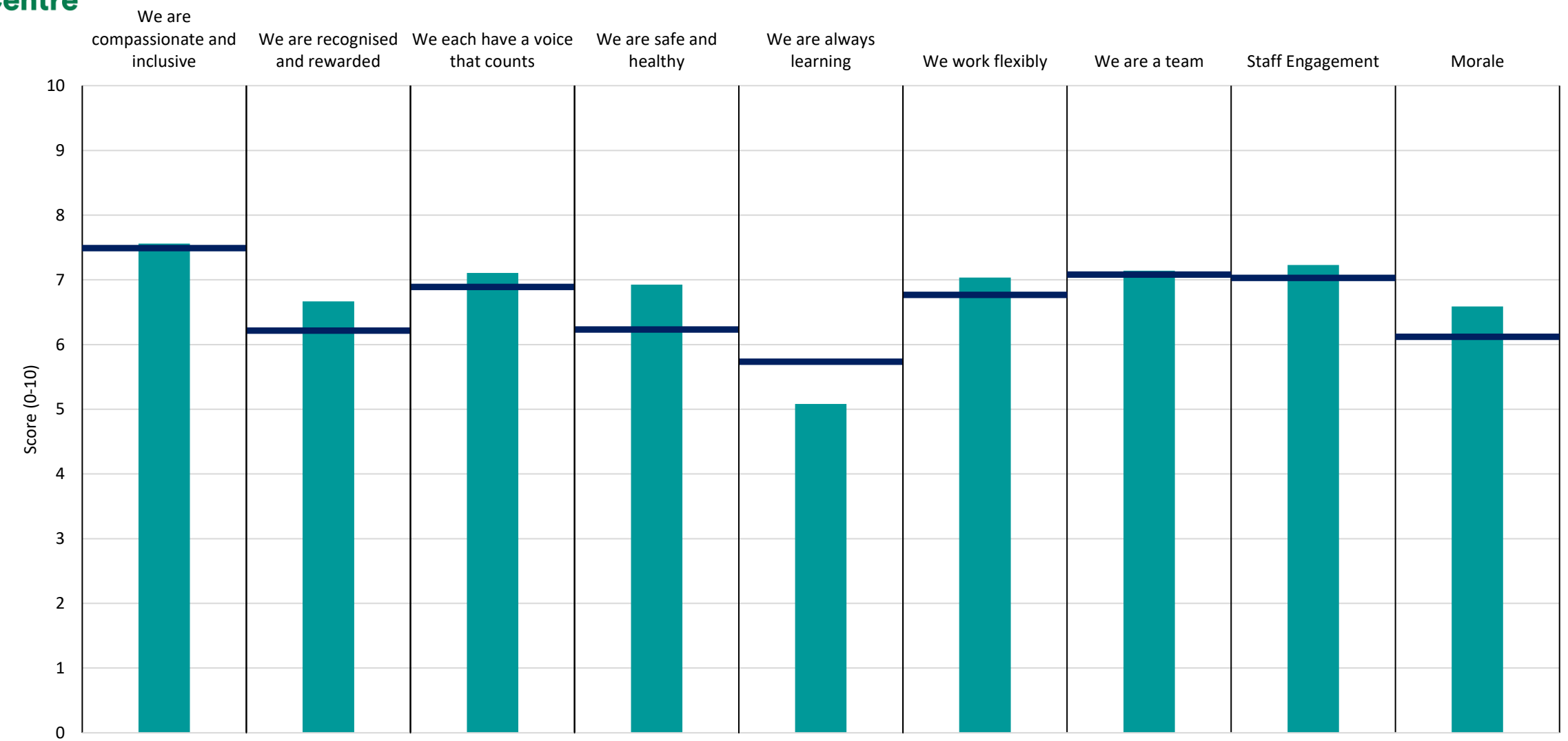
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.0	5.8	6.6	5.8	5.1	6.1	6.6	6.7	5.3
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	85	85	85	85	79	85	85	85	85

FINANCE & RESOURCES



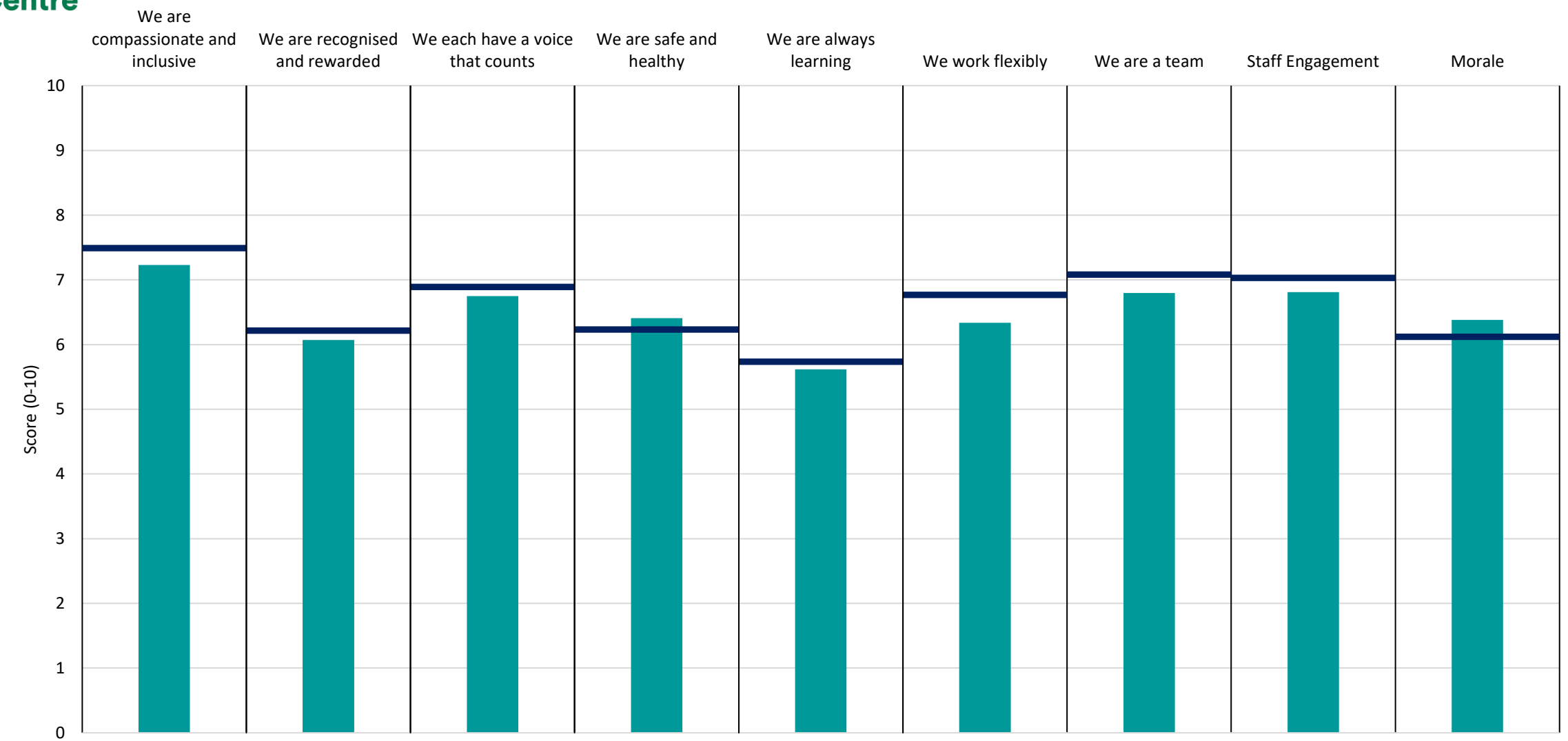
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.9	5.8	6.3	6.3	4.7	6.4	6.3	6.5	5.8
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	154	157	153	155	141	156	155	156	157

MAJOR PROJECTS AND PROGRAMMES



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.6	6.7	7.1	6.9	5.1	7.0	7.1	7.2	6.6
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	59	59	58	59	56	59	58	59	59

MEDICAL

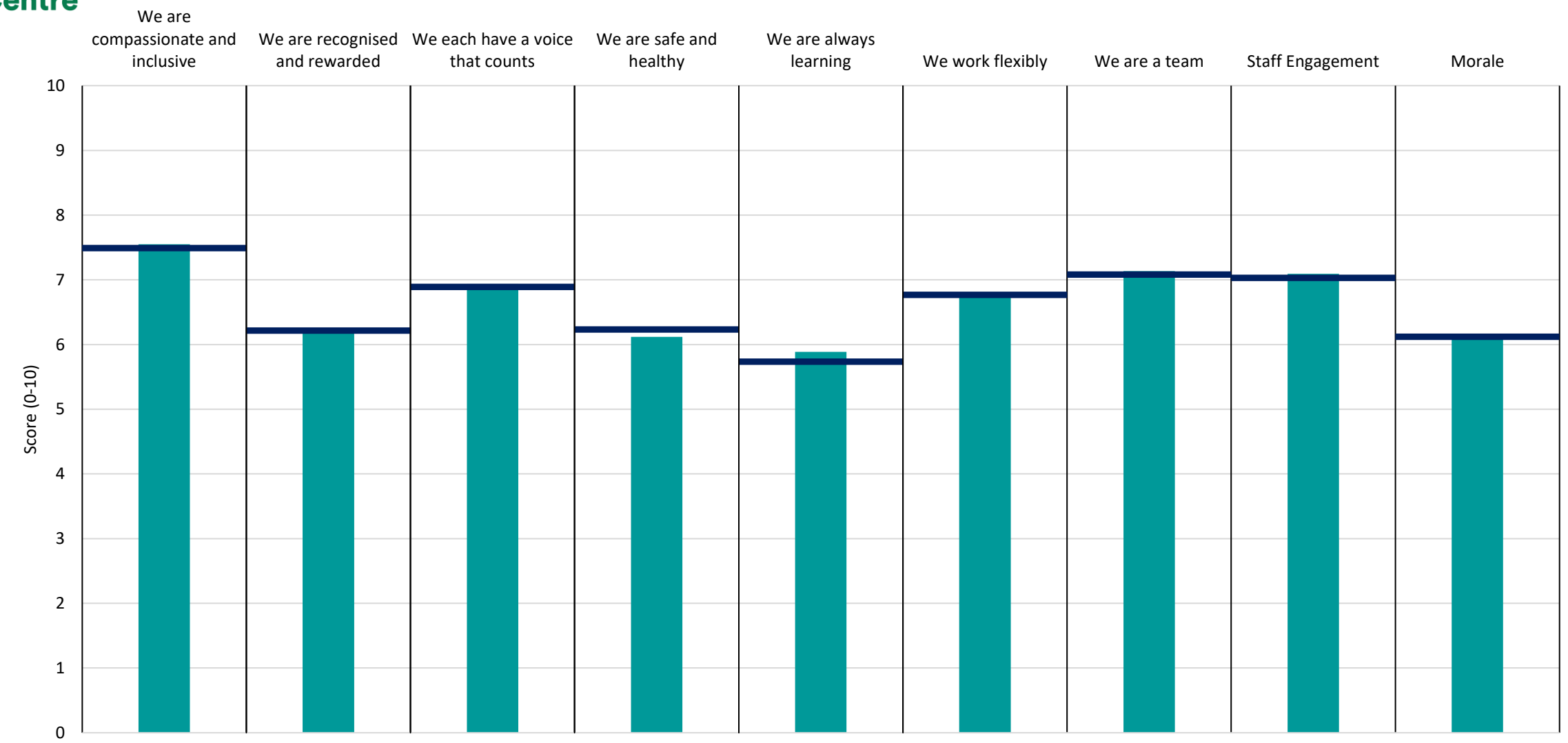


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.2	6.1	6.8	6.4	5.6	6.3	6.8	6.8	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	134	132	132	134	132	132	134	134	134

Survey Coordination Centre

OPERATIONS

NHS

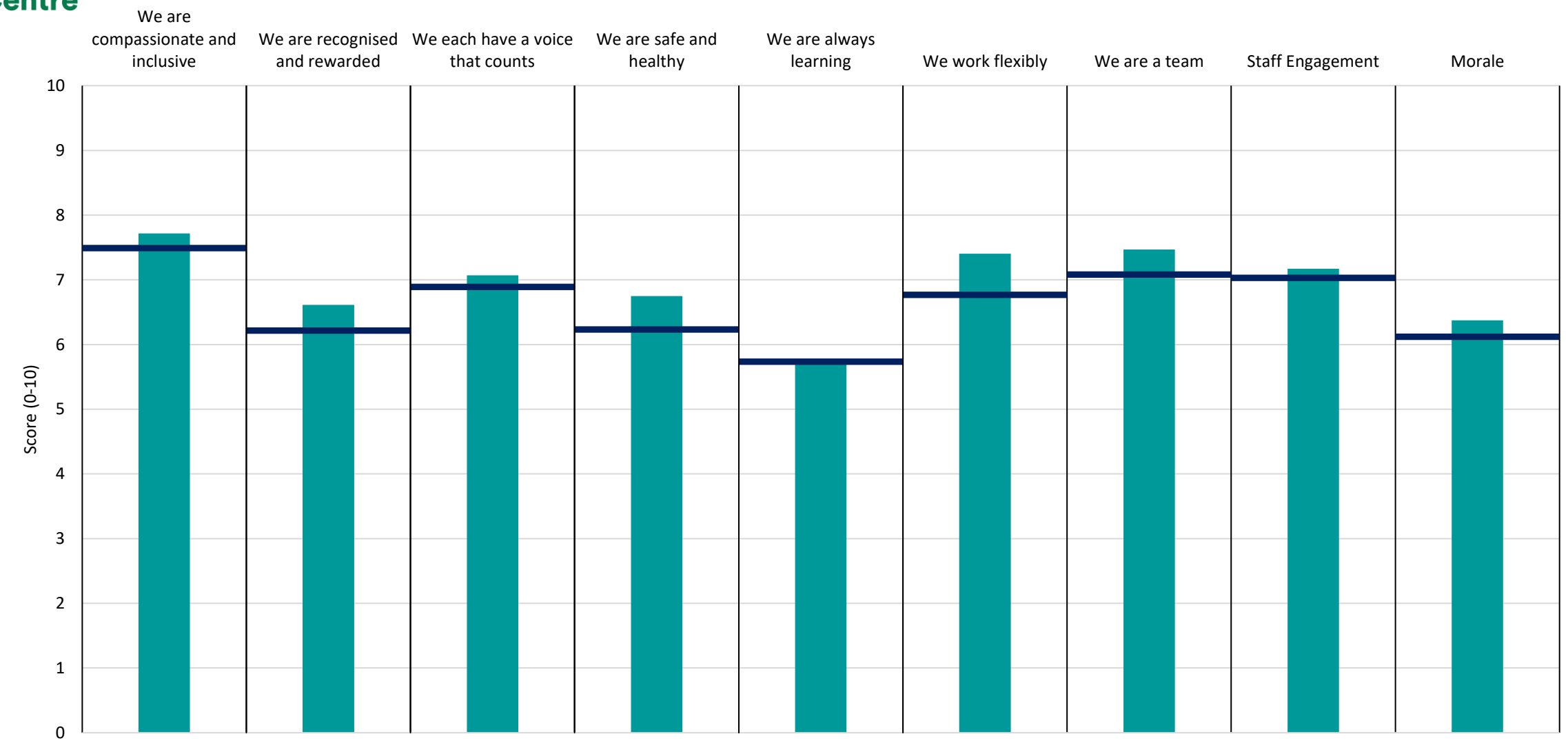


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.5	6.2	6.9	6.1	5.9	6.7	7.1	7.1	6.1
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	1801	1791	1784	1787	1721	1784	1795	1796	1797

Survey Coordination Centre

PEOPLE & CULTURE

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.7	6.6	7.1	6.7	5.7	7.4	7.5	7.2	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	168	168	167	168	152	168	168	168	168

Survey Coordination Centre

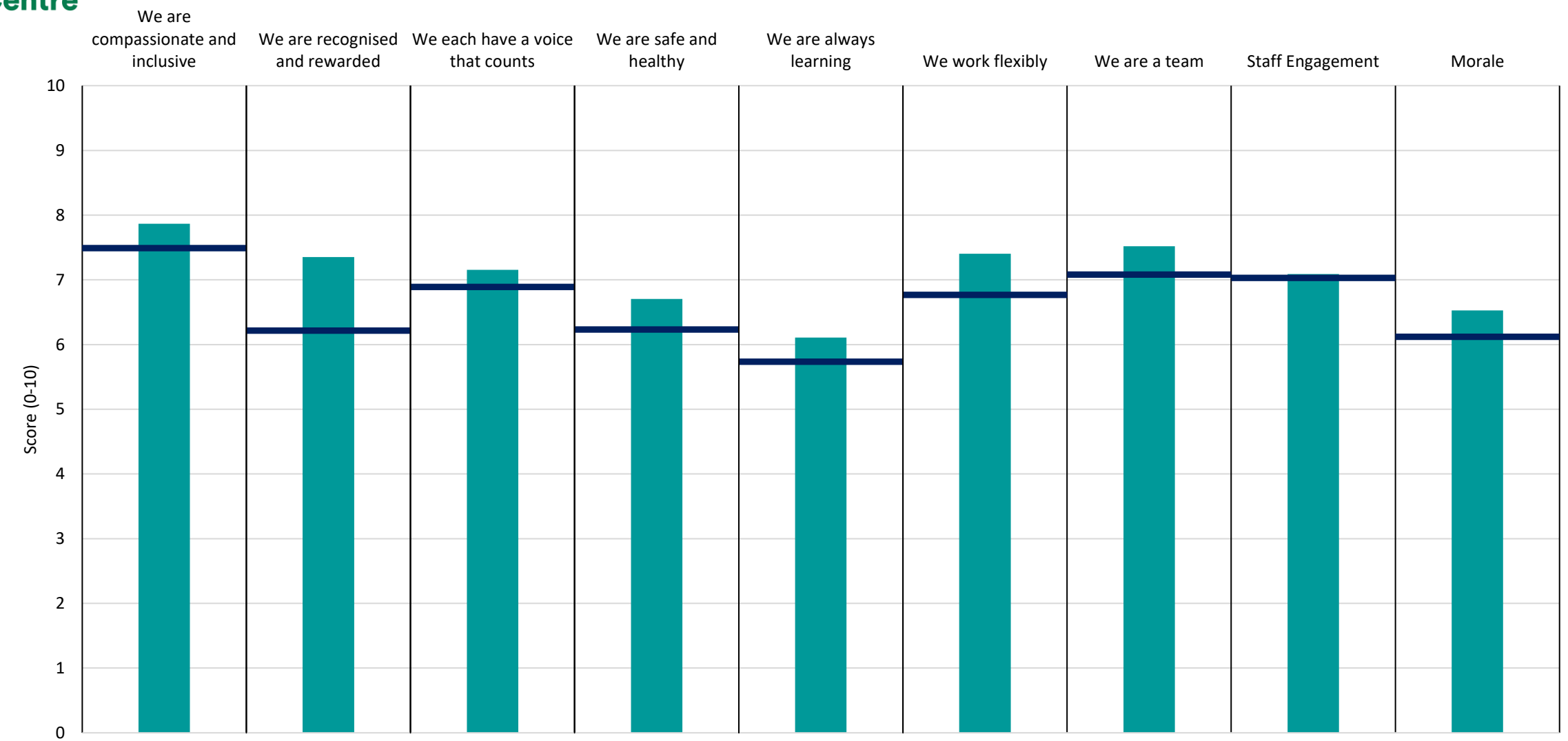
NHS

Breakdowns 2

Essex Partnership University NHS Foundation Trust

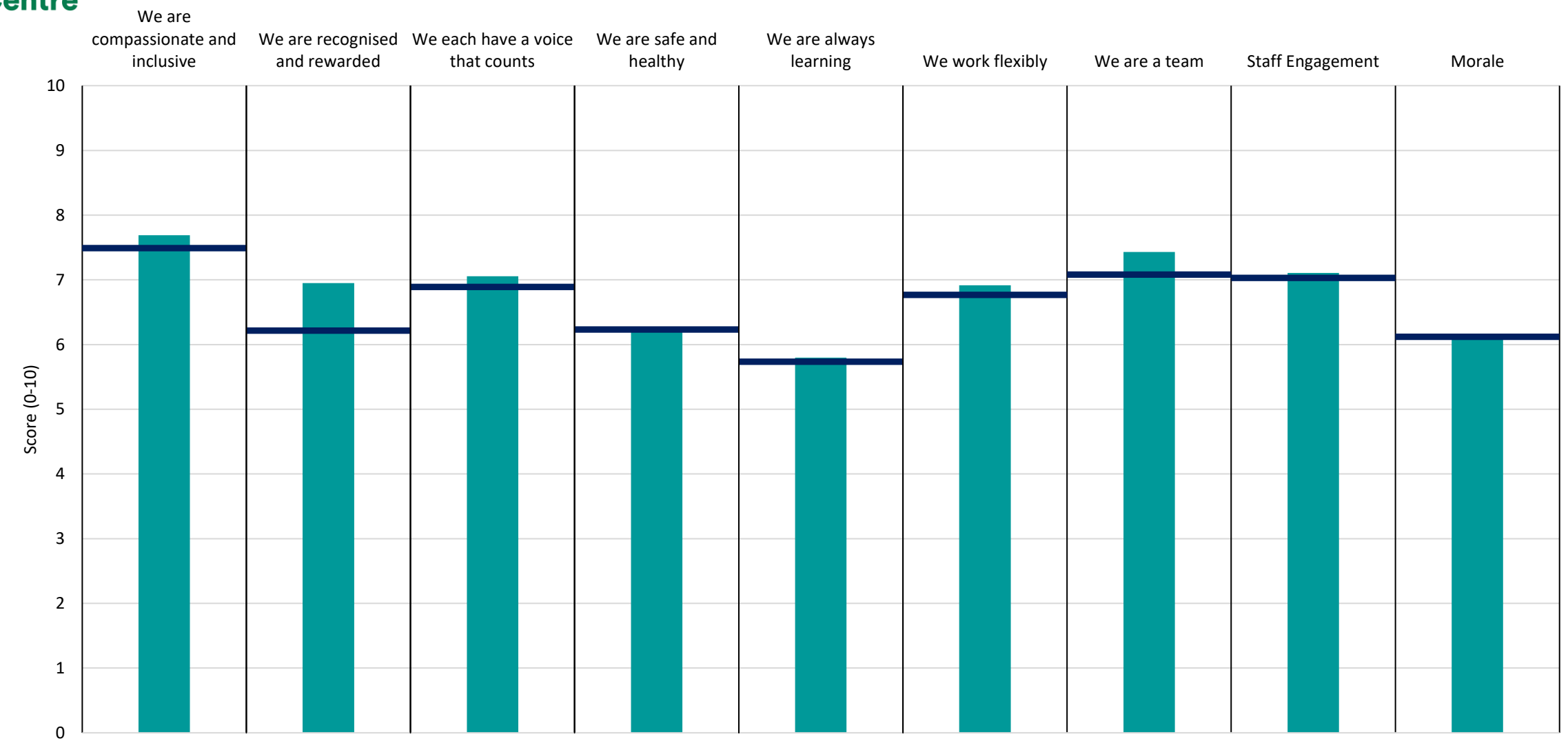
2022 NHS Staff Survey

BUSINESS DEVELOPMENT & CONTRACTING



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.9	7.4	7.2	6.7	6.1	7.4	7.5	7.1	6.5
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	17	17	17	17	17	17	17	17	17

CORPORATE GOVERNANCE

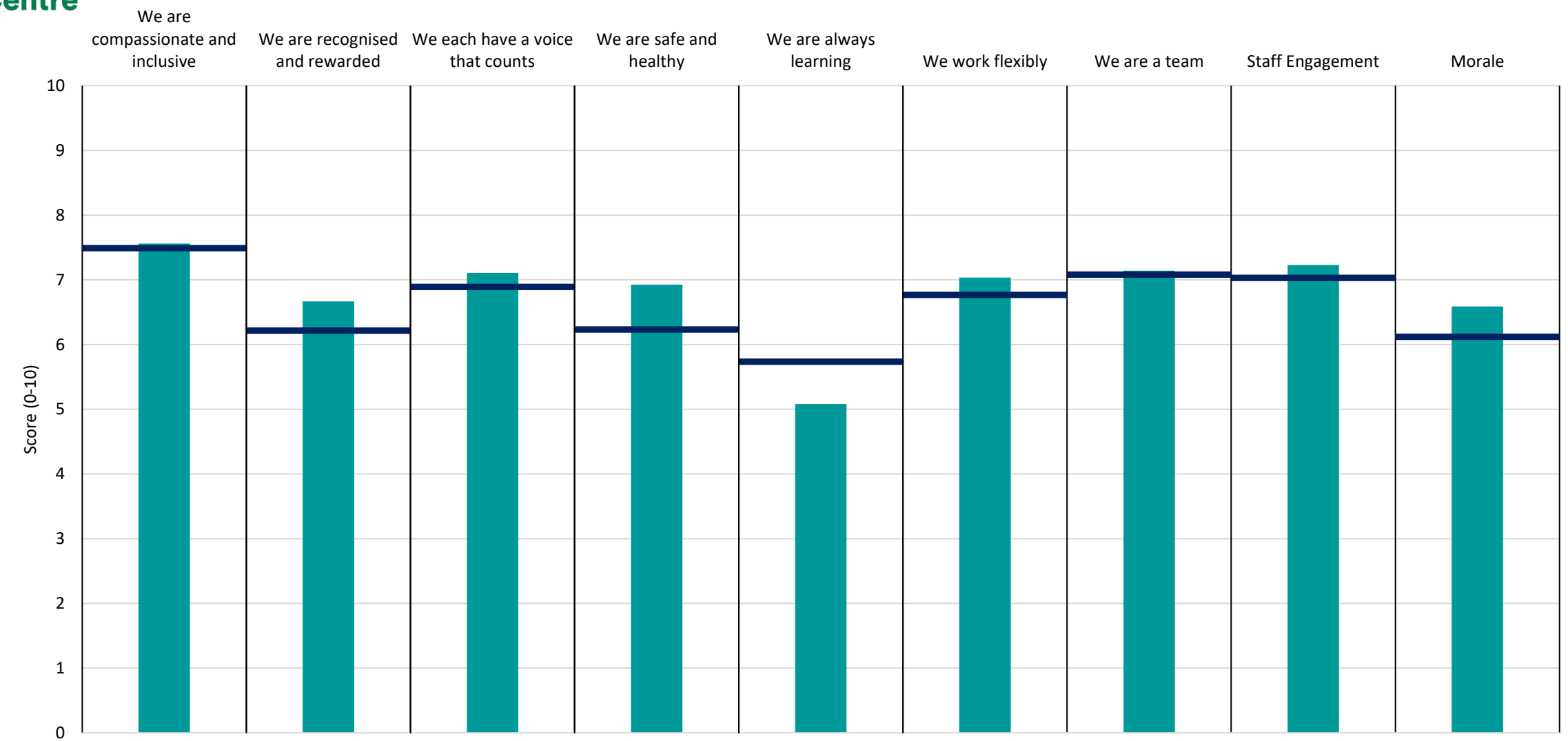


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.7	7.0	7.1	6.2	5.8	6.9	7.4	7.1	6.1
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	25	25	25	25	23	25	25	25	25

Survey Coordination Centre

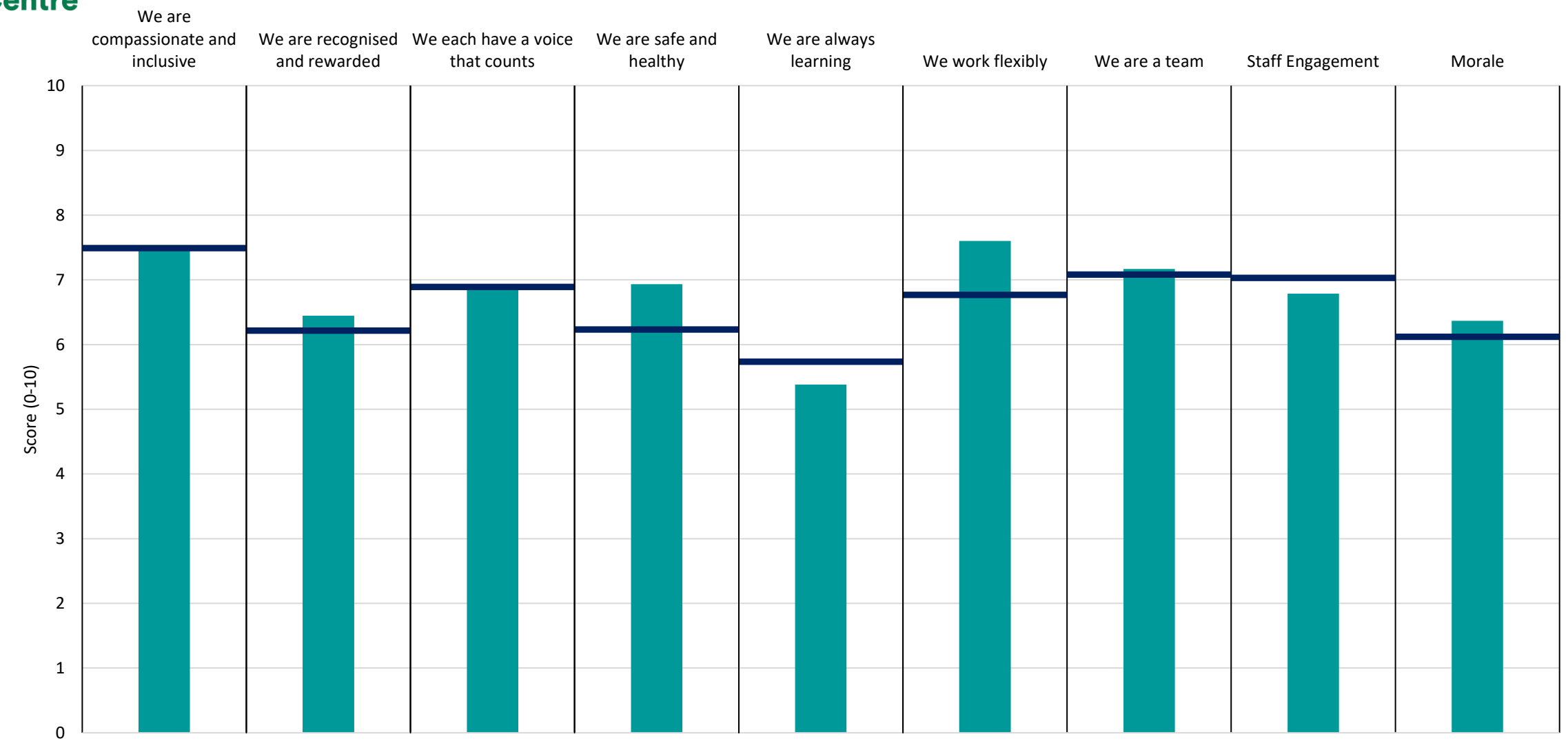
COVID-19 VACCINATION PROGRAM

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.6	6.7	7.1	6.9	5.1	7.0	7.1	7.2	6.6
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	59	59	58	59	56	59	58	59	59

DIGITAL, STRATEGY & TRANSFORMATION

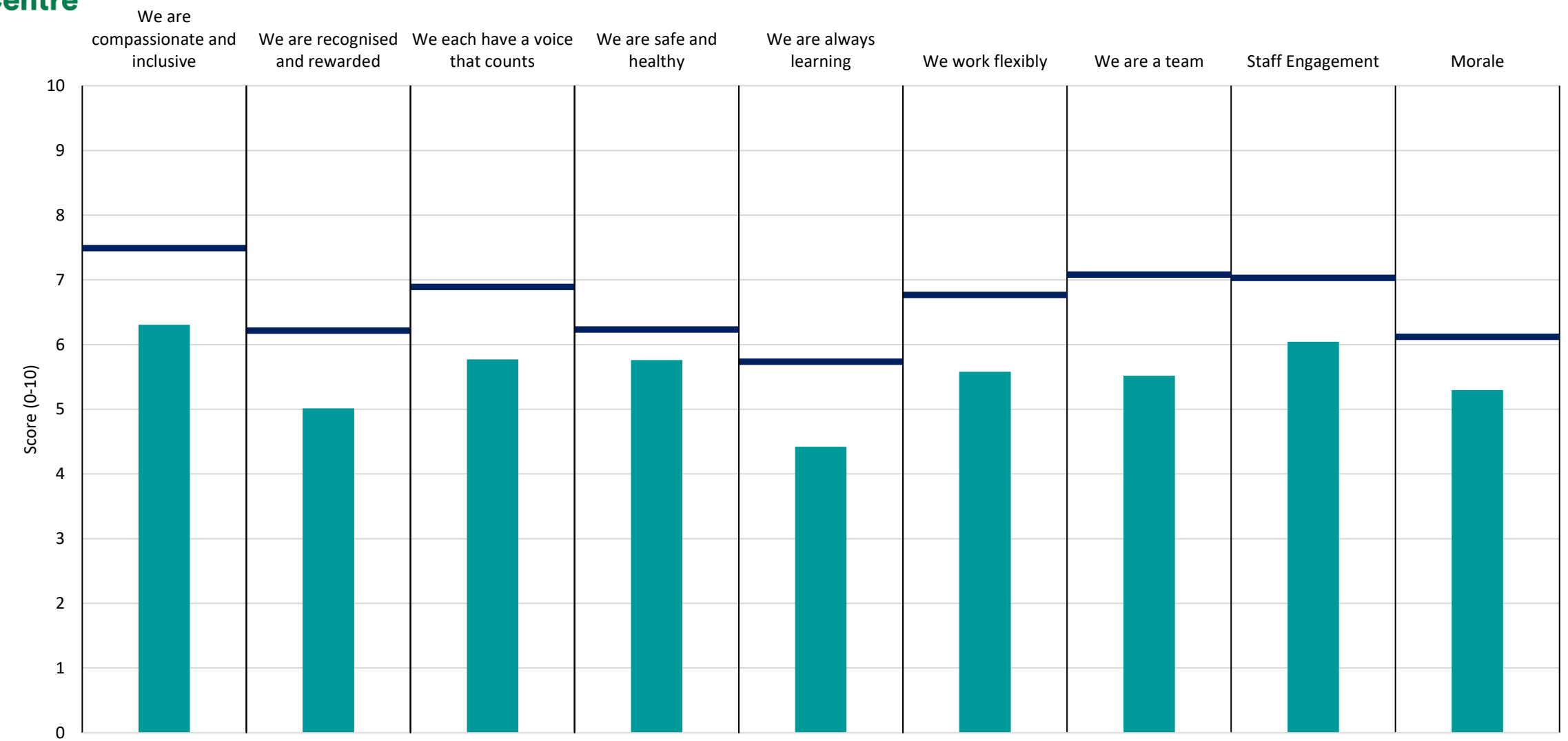


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.5	6.4	6.8	6.9	5.4	7.6	7.2	6.8	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	105	104	104	105	97	103	105	105	105

Survey Coordination Centre

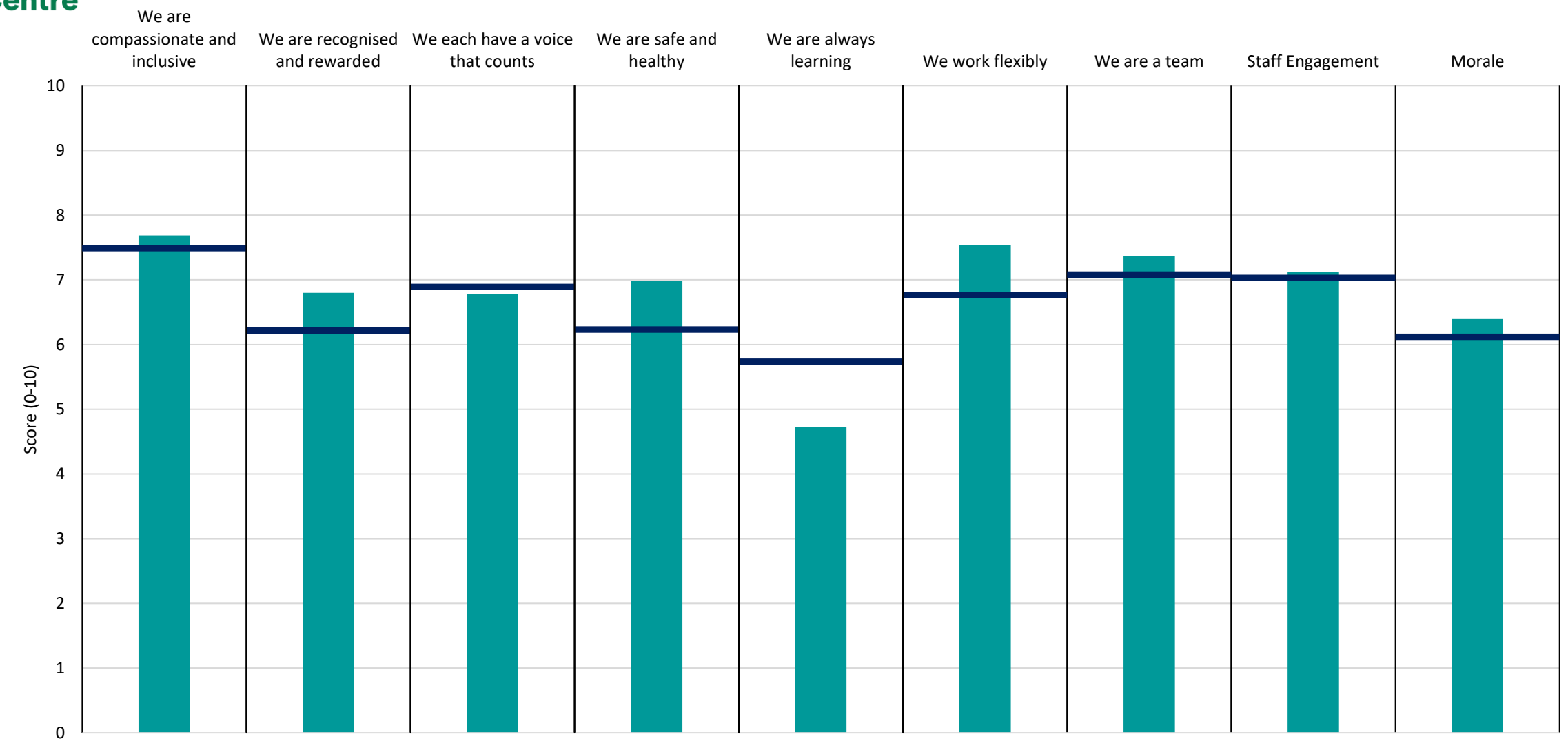
ESTATES & FACILITIES

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.3	5.0	5.8	5.8	4.4	5.6	5.5	6.0	5.3
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	88	91	87	89	79	90	89	90	91

FINANCE & RESOURCES

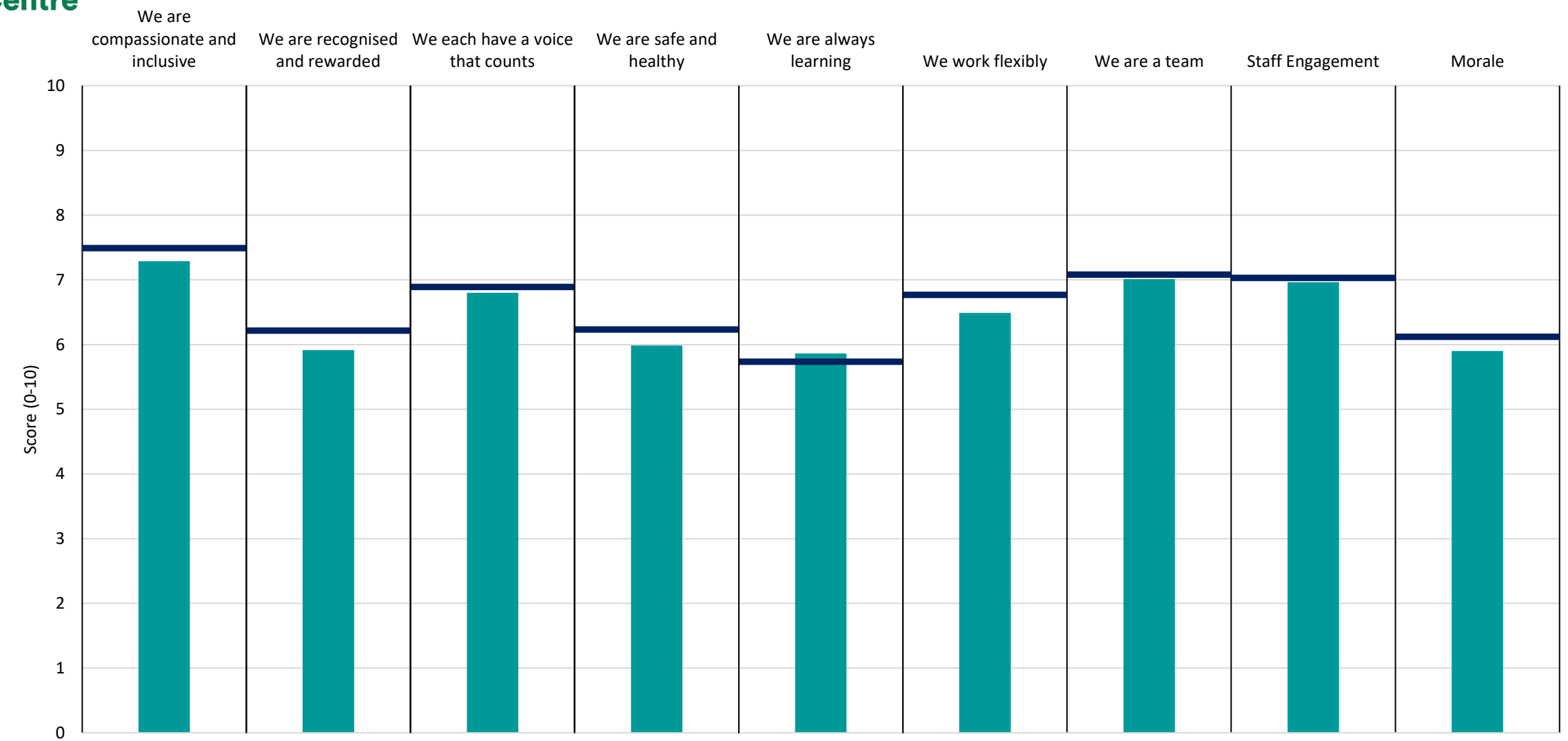


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.7	6.8	6.8	7.0	4.7	7.5	7.4	7.1	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	49	49	49	49	45	49	49	49	49

Survey Coordination Centre

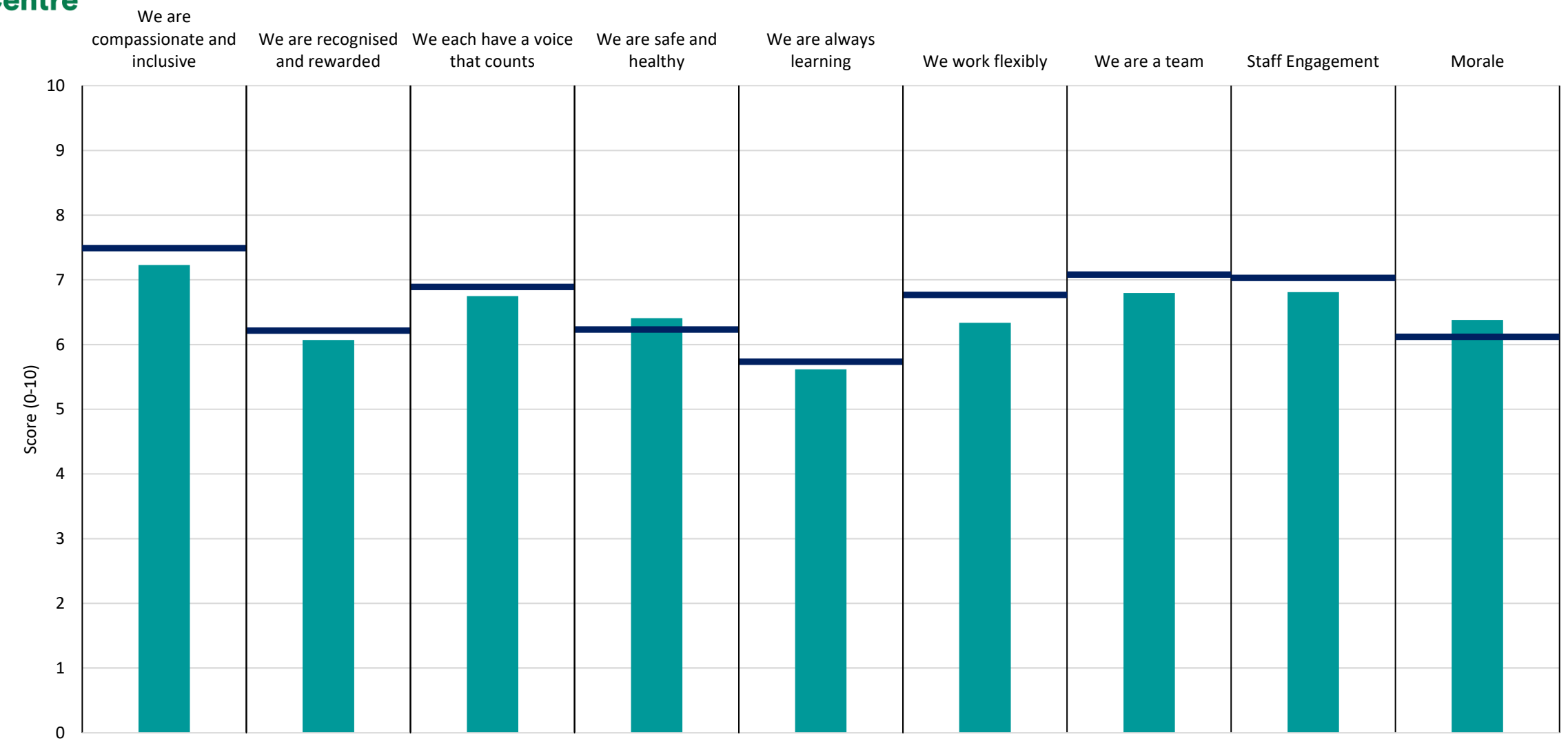
INPATIENT SERVICES

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.3	5.9	6.8	6.0	5.9	6.5	7.0	7.0	5.9
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	260	257	257	257	242	258	259	258	259

MEDICAL

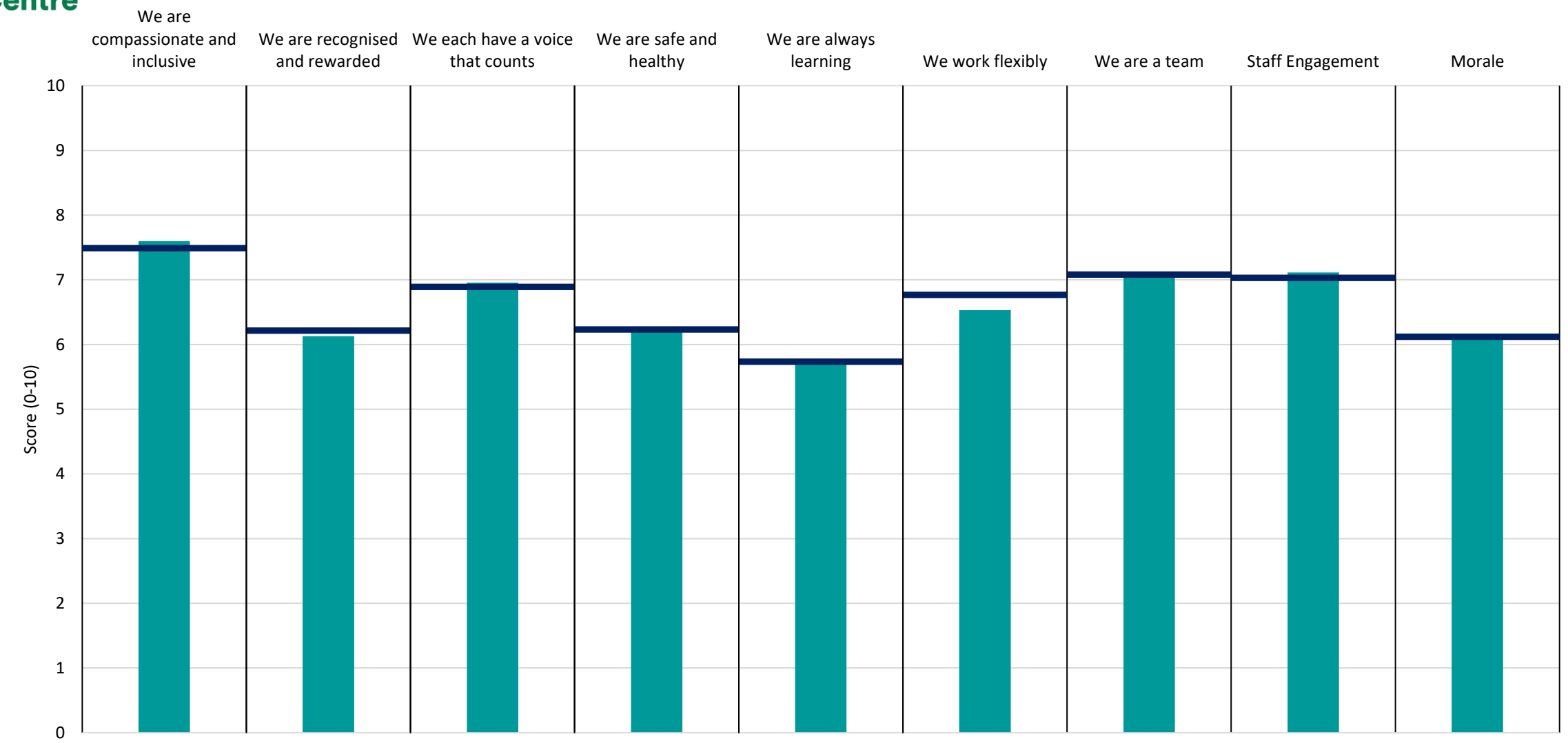


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.2	6.1	6.8	6.4	5.6	6.3	6.8	6.8	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	134	132	132	134	132	132	134	134	134

Survey Coordination Centre

MID & SOUTH

NHS

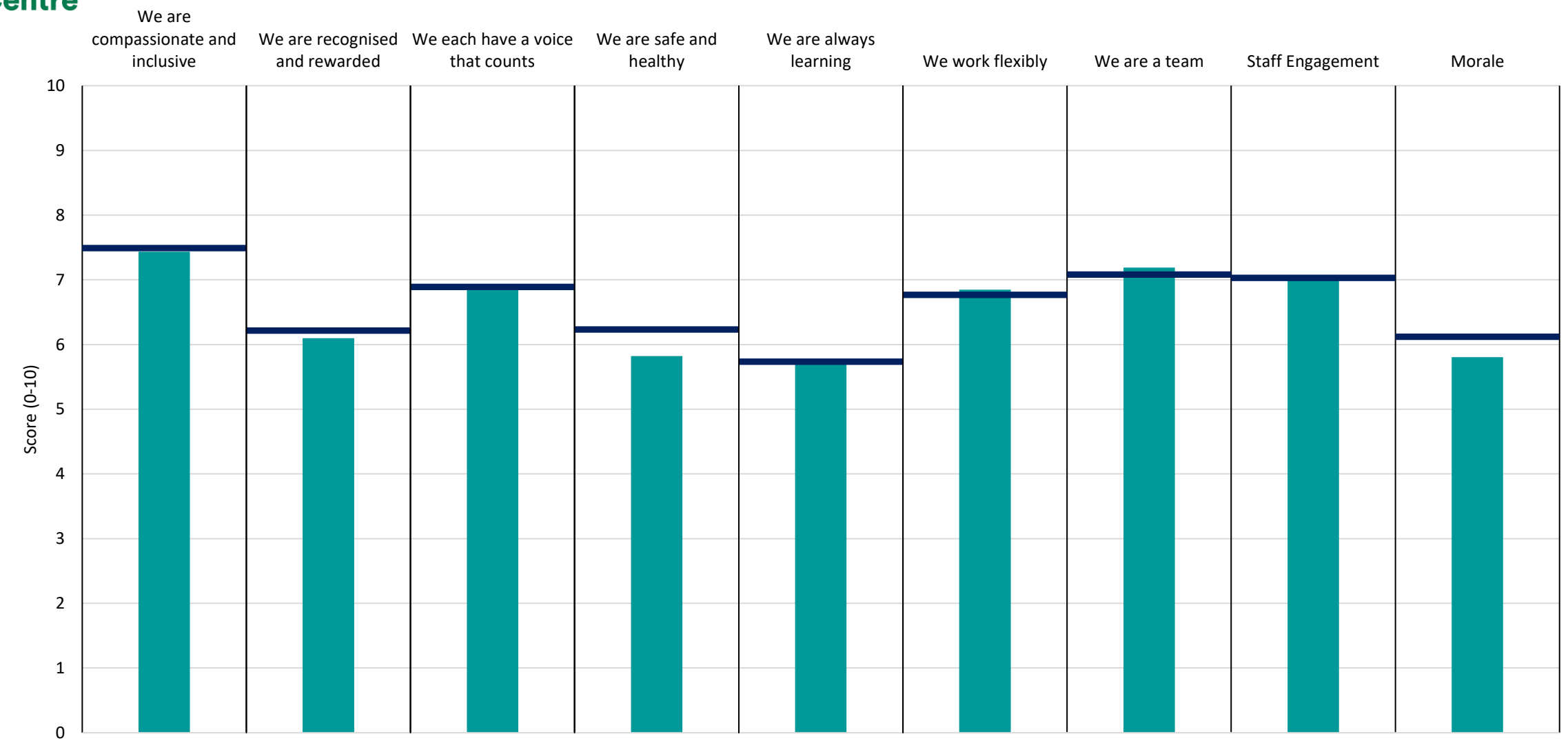


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.6	6.1	7.0	6.2	5.7	6.5	7.1	7.1	6.2
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	622	620	618	617	596	615	619	620	620

Survey Coordination Centre

NORTH ESSEX

NHS

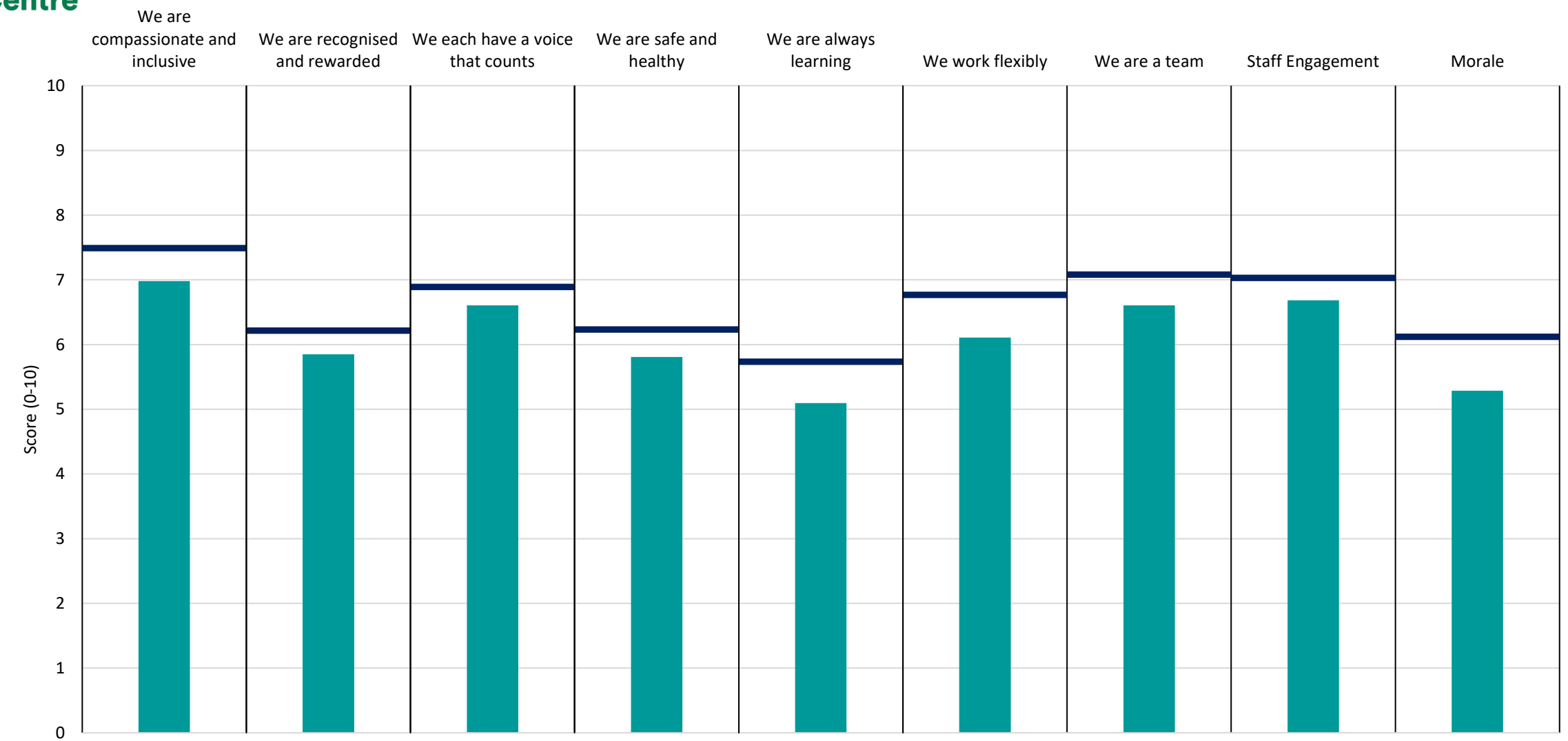


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.4	6.1	6.8	5.8	5.8	6.8	7.2	7.0	5.8
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	141	140	138	141	136	139	140	141	141

Survey Coordination Centre

NURSING

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.0	5.8	6.6	5.8	5.1	6.1	6.6	6.7	5.3
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	85	85	85	85	79	85	85	85	85

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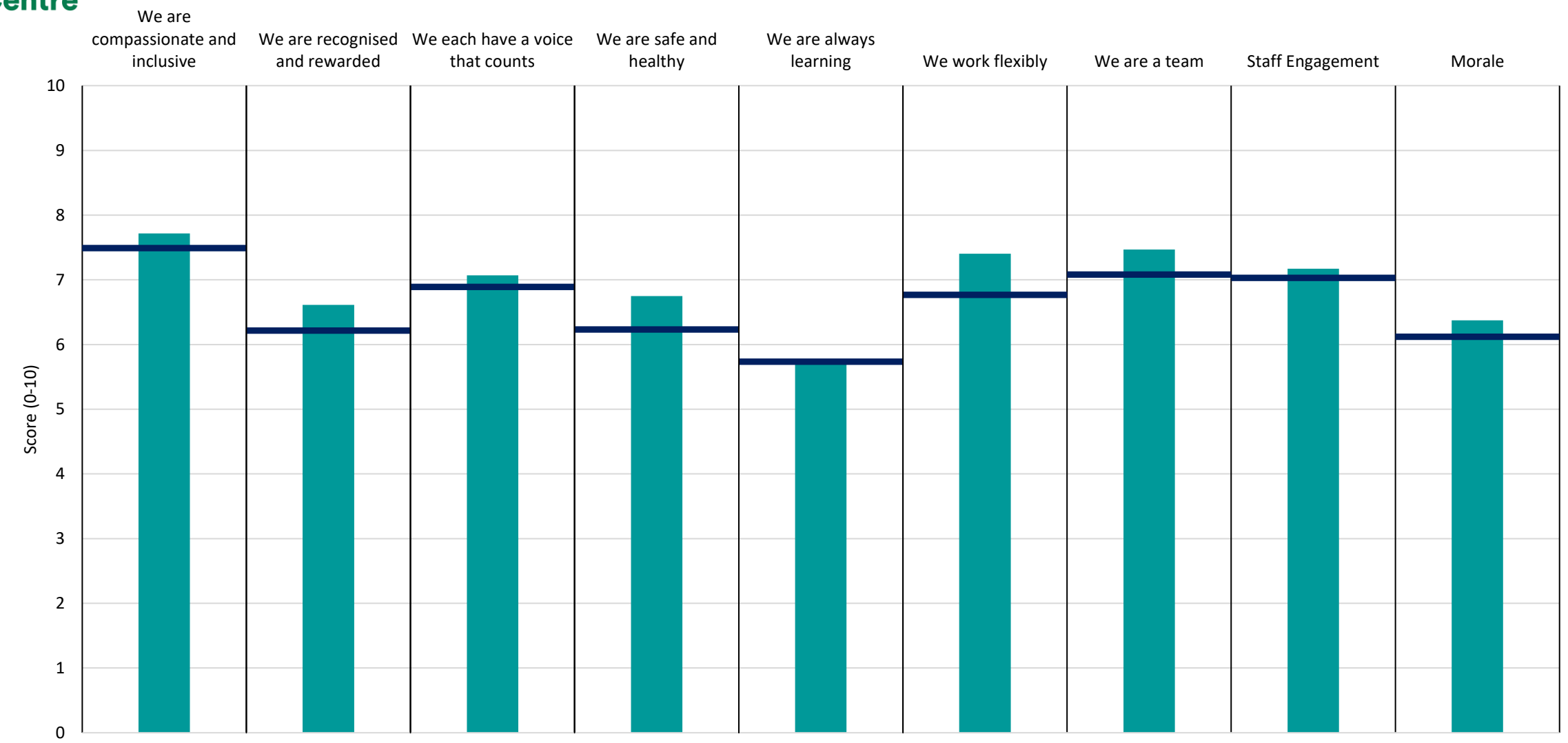
PEOPLE & CULTURE

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.7	6.6	7.1	6.7	5.7	7.4	7.5	7.2	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	168	168	167	168	152	168	168	168	168

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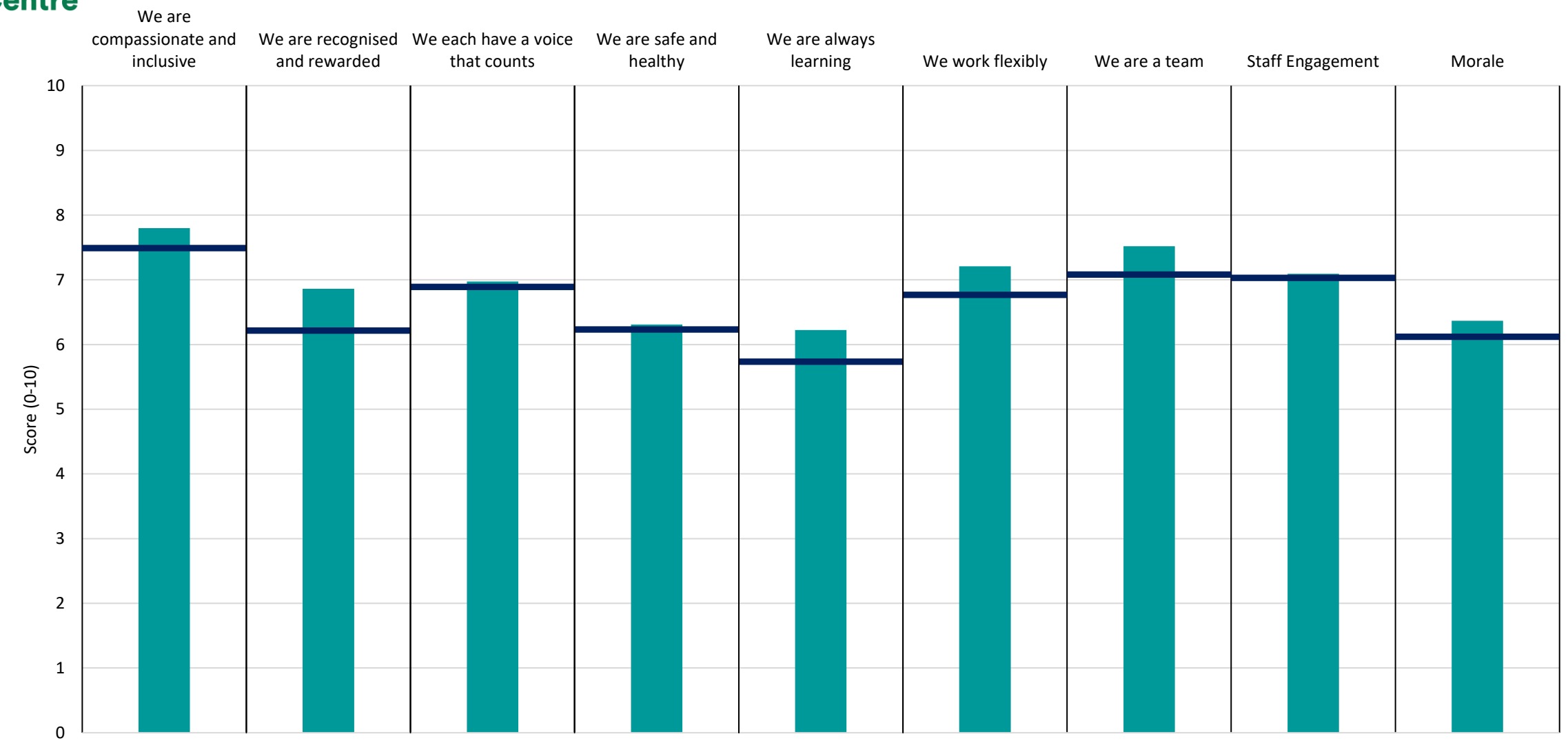
PSYCHOLOGICAL SERVICES

NHS

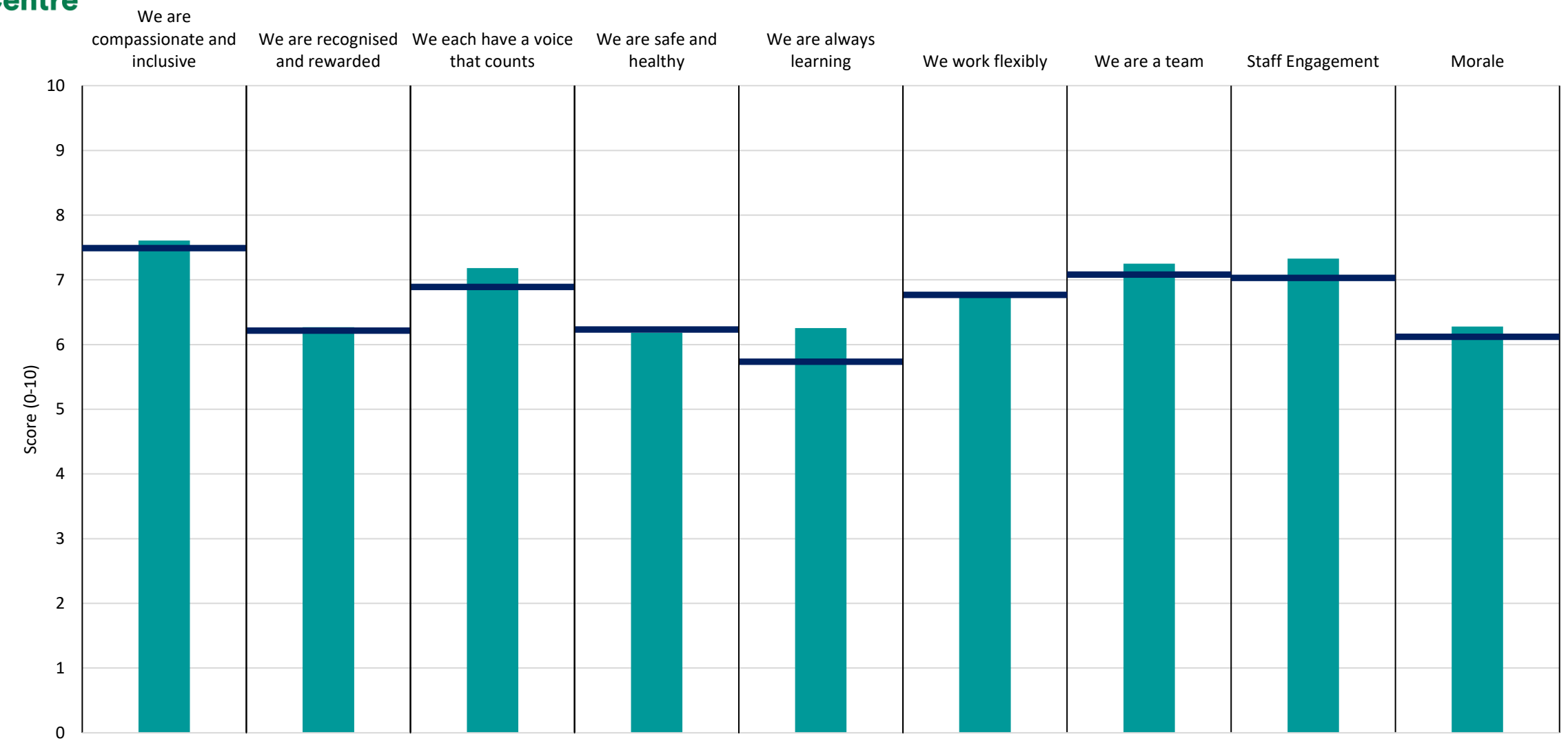


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.8	6.9	7.0	6.3	6.2	7.2	7.5	7.1	6.4
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	274	273	273	274	262	273	274	274	274

Survey Coordination Centre

SPECIALIST

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.6	6.3	7.2	6.2	6.3	6.7	7.2	7.3	6.3
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	220	217	216	216	207	216	219	219	219

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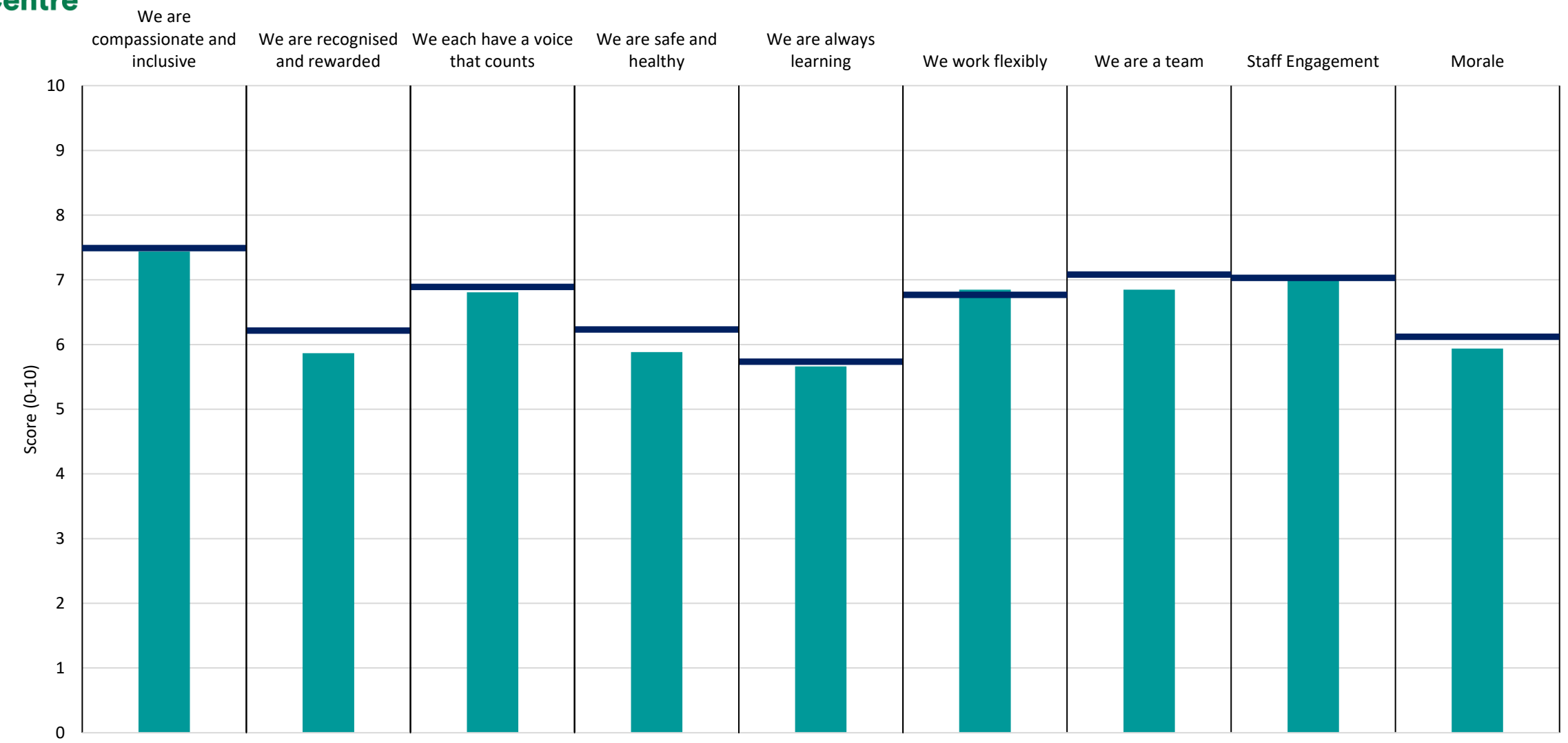
WEST ESSEX

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.4	5.9	6.8	5.9	5.7	6.8	6.8	7.0	5.9
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Responses	277	277	275	275	271	276	277	277	277

Comparison Table – NHS Staff Survey Results 2022

	Responses	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Medical	134	7.2▼	6.1▼	6.8▲	6.4▲	5.6—	6.3▼	6.8▼	6.8▼	6.4▲
Finance and Resources	154	7.7▲	6.8▲	6.8▲	7.0▲	4.7▼	7.5▲	7.4▲	7.1▲	6.4▲
Operations	1801	7.5—	6.2—	6.9▼	6.1▼	5.9▲	6.7▲	7.1—	7.1—	6.1—
People and Culture	168	7.7▲	6.6▲	7.1▲	6.7—	5.7—	7.4▼	7.5▲	7.2▲	6.4▲
Corporate Governance	25	7.7	7.0	7.1	6.2	5.8	6.9	7.4	7.1	6.1
Digital, Strategy & Transformation	105	7.5	6.4	6.8	6.9	5.4	7.6	7.2	6.8	6.4
Executive Nurse	85	7.0	5.8	6.6	5.8	5.1	6.1	6.6	6.7	5.3
Major Projects and Programmes	59	7.6	6.7	7.1	6.9	5.1	7.0	7.1	7.2	6.6
EPUT Overall	**2547**	**7.5**	**6.2**	**6.9**	**6.2**	**5.7**	**6.8**	**7.1**	**7.0**	**6.1**

▼ Worsening in score compared to 2021
▲ Improvement in score compared to 2021
— No change in score compared to 2021

Worse than EPUT Overall	Better than EPUT Overall

An Overview of the Aggregate Bank Only Survey Results 2022

NHS STAFF SURVEY COORDINATION CENTRE

Version 2

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Survey Coordination Centre

Table of Contents

1 Introduction

1.1 Background

The NHS Staff Survey (NSS) has provided essential information to employers and national stakeholders about staff experience across the NHS in England since 2003. Following changes to the survey in 2021, the questions were aligned with the NHS People Promise to track progress against its collaborative aim to improve the experience of working in the NHS for all staff.

Eligibility to participate in the NHS Staff Survey has previously been restricted to staff employed on a substantive contract at the participating organisations. To support inclusion and the People Promise commitment that "we each have a voice that counts", in 2022 NHS England extended eligibility to NHS staff who do not have a substantive contract but work for the NHS via an in-house bank.

Bank only workers are disproportionately likely to have ethnic minority backgrounds, with more than one in three bank workers being in ethnic minority groups according to data included in NHS supplementary information files, equality and diversity measures (2019).[1] NHS workforce race equality standard (WRES) data shows that currently 24.2% of all NHS staff are from ethic minority backgrounds.[2]

Expanding eligibility to take part in the NHS Staff Survey to bank only workers and thus ensuring their voices are heard will further increase understanding of working experience for this group and provide insight to any inequalities and help to promote a compassionate and inclusive culture.

For the first time in 2022, all organisations with bank only workers were invited to extend the NHS Staff Survey to their bank only workers, and those with a large bank workforce (200 or more) were strongly encouraged to do so. Bank only workers received a tailored version of the survey, with questions researched and developed to ensure they are relevant to the experience and working practices of bank workers in the NHS.

This report provides a summary of the survey results for bank workers in NHS trusts that took part in the survey, and the results provide a robust baseline measure of the experience of bank only workers, including against the seven elements of the NHS People Promise.

[1] https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/bank-staff-selected-equality-and-diversity-measures-ah2807

[2] NHS England » NHS Workforce Race equality Standard (WRES)2022 data analysis report for NHS trusts

1.2 Terminology used within this report

The following terms are used throughout this report:

1. '***Bank workers***' is used to refer to individuals within the NHS whose primary employment in is held via a casual/zero hours contract and have no additional form of permanent of employment at the participating organisation who completed the version of the NHS Staff Survey tailored for bank only workers. Results for this group may be referred to as '***NSS bank results***'.

2. '***Substantive staff***' is used to refer to those staff with a substantive contract with an NHS organisation and who completed the standard version of the NHS Staff Survey. Results for this group may be referred to as '***core NSS results***'. The full results for substantive staff are published on the NHS Staff Survey website.

Results for '***staff from ethnic minority backgrounds***' refers to the results for staff from ethnic minority backgrounds other than white ethnic minorities. '***White staff***' refers to staff from all white ethnic backgrounds including white ethnic minority backgrounds.

2 Overview of survey approach

Below is a summary of the similarities and differences between the core NHS Staff Survey (for staff on substantive contracts) and the NHS Staff Survey for bank only workers.

	NHS Staff Survey for substantive staff	NHS Staff Survey for bank only workers
Fieldwork	September – November 2022	September – November 2022
Invitations	Substantive staff were sent an email with a link to the online survey or a paper invitation along with a paper questionnaire. Paper invitations included a QR link to the online survey.	Bank only workers were sent an email with a link to the online survey or a paper invitation with a QR link to the online survey. No paper questionnaire was offered. Optional SMS text notifications were also sent.
Survey questions	The survey questions are aligned to the People Promise and two main themes of Staff Engagement and Morale.	The questions are broadly the same as the core NHS Staff Survey questionnaire and aligned to the People Promise. Some questions are removed or amended where appropriate, and a small number of questions added to measure specific aspects of the Bank only worker experience. Details of the questionnaire differences are provided in the appendix.
Reporting	There is an established suite of reporting outcomes for substantive staff including a national report, organisational reports and interactive dashboards. Data is also available at a system and regional level. See the NHS Staff Survey website for more details.	For this first year, the data for bank only workers are not weighted and benchmarking of the results for individual organisations has not been provided. The data for substantive staff and bank workers are not combined in the reporting. Work is underway to ascertain how best to report the results for bank only workers in future years. Participation by organisations was voluntary and the results for bank workers are not directly comparable to the published NHS Staff Survey results for substantive staff.

3 Technical details/advice

Results reported in this document are based on the responses from bank only workers working at 115 NHS trusts[3] that chose to extend eligibility to bank only workers for the 2022 NHS Staff Survey. Results for organisations taking part in the NHS Staff Survey on a voluntary basis, such as ICBs and social enterprises, are not included.

When reviewing the results in this report, it is important to note that the NSS bank results are not directly comparable with the core NSS results. Any comparisons between results for bank only and substantive staff should be made with caution due to differences in several areas:

- Participation by trusts was voluntary and not all trusts with eligible bank workers took part:
    - This means the data in this report is not truly representative of all NHS trusts
- Differences in the mix of staff responding:
    - The profile of staff responding to the version of the survey for bank only workers differ from the profile of staff responding to the core survey, both in terms of the mix of job roles and the demographic profiles. Since staff from different occupation and demographic groups are known to respond differently to the survey questions, this can affect comparability. See section 4.2 for more information.
- Differences in the questions asked:
    - Some questions in the core survey are adapted in the version for bank only workers to make them more applicable to bank workers' experience. Others are not relevant for bank workers and so are not included in the bank version, and this can affect how subsequent questions are answered ('context effect'). See 'Questionnaire comparability' section in the appendix for details of the differences between the two questionnaires.
- Immediate managers and team questions:
    - It is known that not all bank workers are able to identify a single immediate manager or a particular team that they work with consistently. To account for this, bank workers can choose how to answer questions related to their immediate manager, either answering about a single individual or about managers in general. Similarly, they can answer questions about team working with reference to a particular team they work in regularly, or about teams more generally. Consequently, questions relating to 'your team' and 'your immediate manager' are not directly comparable between the core and bank versions of the survey.

[3] 140 NHS Trusts invited their bank only workers to take part, but due to an issue with consistency in data collection at 25 trusts, the results are reported for the 115 trusts unaffected by this issue.

- Weighting:
    - NSS bank results are presented unweighted. The core NSS results are weighted for comparison purposes so that the occupational group profile of each organisation reflects that of a typical organisation of its type (except for questions that ask for demographic or factual information). Additionally, the aggregate core NSS results are weighted by the size of the organisation (and weighting applied historically), so that organisation's contribution to the national results is based on how large their organisation is, rather than the number of responses they received.
- Score calculations
    - The calculation of scores and sub-scores relating to the People Promise elements and themes are not directly comparable between the NSS bank results and the core NSS results, for some of the reasons detailed above. While scores and sub-scores are calculated for all People Promise elements and themes for both survey versions, in some cases a different calculation is employed for bank workers, due to differences in the set of questions which relate to that score/sub-score/theme in the survey version.

The results of the core NSS and the bank NSS are not directly comparable but allow for the fact that some users may want to contrast the results of the two surveys, but clear methodological differences exist, and those differences could be in part due to the primary reasons stated above, and these differences should be carefully considered. For example, if a People Promise score is lower in this bank NSS report than in the published core NSS results, that could be due in part to the following reasons:

- A difference in the profile of bank workers and substantive workers
- The fact that some trusts did not take part in the bank NSS
- The fact that weighting is not applied to the bank NSS
- Differences in question wording and question context

Not all these confounding factors will apply to all comparisons, however. If a question was worded in the same way in both surveys and appeared in the same position in the questionnaire, then questionnaire wording and context effect are irrelevant. In addition, if a result is not weighted in the core NSS reporting, then the fact that the bank NSS results are not weighted does not affect comparability. Certain comparisons can also be improved, for example by looking solely at subgroups. For instance, comparing the results for nurses across the two surveys would be a 'fairer' comparison than looking at the results for the complete staff composition, since the staff composition is known to be different in the two samples. The interpretation of that comparison, however, should still consider that bank nurses may work in different areas, or at different grades, so the results may still need to be interpreted with context, being fully aware of these caveats.

3.1 Summary indicators

The survey reports on three levels of results: scores, sub-scores and question level results. There are nine scores, covering the seven People Promise elements and two staff survey themes.

The **People Promise summary indicators** provide an overview of staff experience in relation to the seven elements of the People Promise:


We are compassionate and inclusive. We are recognised and rewarded


We each have a voice that counts


We are safe and healthy


We are always learning


We work flexibly


We are a team

The two **staff survey themes** are:

- Staff engagement
- Morale

Each People Promise element score and theme score is based on two to four sub-scores[4], with each sub-score calculation dependent on the responses given to between one and nine questions.

All summary indicators - the People Promise element scores, theme scores and sub-scores - are scored on a 0-10 point scale and reported as mean scores, where a higher score always equates to a more positive outcome. To achieve a 0-10 point scale for these measures, all responses for the contributing questions are re-scored to fit this scale. Details of how the responses are scored for each of the questions feeding into the summary indicators are included in the 'Calculation of summary indicators from the contributing questions' section in the appendix of this report.

Question level results are presented grouped by the sub-score they feed into. Whilst all response options for a given question feed into a sub-score, unless otherwise stated 'top-two box' response options are reported. This is, for example, the proportion of staff who either "strongly agree" or "agree" to a given question, which would be reported as "agree". Details of how the responses are aggregated for reporting are provided in the same section of the appendix.

3.2 Base sizes

Where results for more than one question are reported in a single table, the base sizes reported in the column headings (n=) represent the number of bank workers in the group, rather than the number of bank workers responding to each question, which may vary slightly.

[4] Except for the People Promise element of 'We are recognised and rewarded' which has no sub-scores.

Survey Coordination Centre

4 Survey implementation

4.1 Scope

Approximately 190 NHS trusts are thought to operate in-house banks. While trusts were not mandated to extend eligibility to their bank only workers, 140 NHS trusts in England chose to do so as part of the 2022 NHS Staff Survey.

In total, 124,263 eligible in-house bank workers were invited to participate, of whom 122,504 worked in NHS trusts. The survey was nationally administered by the Survey Coordination Centre on behalf of NHS England.

Eligibility was extended to bank workers meeting the following criteria:

- **Active** bank workers, i.e. those who, in the six months to 1 September 2022, had been paid for any work or training at the organisation, either by the organisation or by a collaborative bank of which the organisation was part. by the NHS organisation in the past 6 months

In-house bank – eligibility does not include externally funded band or agency workers, such as those paid or directly supplied by external bank provided such as NHS Professionals and Bank Partners.
Bank only – workers working on the bank who also have a substantive or fixed term contract at the organisation were surveyed using the core version of the questionnaire.

Of the 124,263 eligible bank workers invited to participate, a total of 22,677 completed the survey, representing a response rate of 18%. Within NHS trusts, 22,253 bank workers from an eligible total of 122,504 completed the survey (also 18%). For comparison, the response rate for the core NHS Staff Survey of substantive staff in 2022 was 46%.

While 140 NHS trusts invited their bank only workers to take part, due to issues identified following fieldwork with consistency in the data collection for 25 of these trusts, the results presented in this report are based on the responses from 17,702 bank workers at the 115 unaffected trusts. While the NSS bank results for this first year cannot be considered to represent all bank workers in England, since the survey was not a census and the data does not include responses from all trusts, sample sizes are still sufficiently large and robust to allow reliable analysis.

In addition to measuring performance against the scores and sub-scores for the seven People Promise elements and two themes, this report also reports on questions asked only of bank workers and examines the occupational and demographic profile of those bank workers who responded.

The bank version of the questionnaire can be downloaded from the link below.

NHS Staff Survey for bank workers

4.2 Participation

The table below shows the number and profiles of bank workers who responded to the survey, and the profiles of substantive staff responding to the core NHS Staff Survey for comparison.

		NSS Bank responses	NSS Bank	Core NSS
		n	n=17,702	n=629,286
Trust type	Acute and Acute & Community	11,752	66.4%	68.5%
	MH/LD and MH/LD & Community	4,311	24.4%	18.3%
	Community Trusts	992	5.6%	3.9%
	Ambulance Trusts	388	2.2%	4.1%
	Acute Specialist Trusts	259	1.5%	2.4%
Occupation group (summary)	Registered Nurses and Midwives	4,258	24.2%	28.4%
	Nursing or Healthcare Assistants	3,849	21.9%	7.2%
	Wider Healthcare Team	3,501	19.9%	24.2%
	Allied Health Professionals / Healthcare Scientists / Scientific and Technical	2,458	13.9%	20.6%
	Medical and Dental	1,219	6.8%	7.2%
	Ambulance	422	2.4%	3.4%
Gender	Female	13,523	76.4%	76.1%
	Male	3,559	20.1%	20.6%
	Non-binary	42	0.0%	0.2%
	Prefer to self-describe	40	0.0%	0.2%
Ethnic group	White background	12,583	72.1%	78.4%
	Black/African/Caribbean/Black British	2,265	13.0%	5.5%
	Asian/Asian British	1,796	10.3%	12.4%
	Mixed/multiple ethnic background	492	2.8%	2.2%
	Arab/Other	325	1.9%	1.5%
Long term health conditions or illnesses	Yes	3,373	19.1%	23.6%
	No	14,109	79.7%	76.4%
Time with organisation	Less than 1 year	4,600	26.0%	10.3%
	1-2 years	5,584	31.5%	14.3%
	3-5 years	3,633	20.5%	19.4%
	6-10 years	1,872	10.6%	17.9%
	11-15 years	686	3.9%	11.8%
	More than 15 years	1,218	6.9%	26.3%
Full time / part time	Full time	4,838	27.3%	81.5%
	Part time	12,629	71.3%	18.5%
Contact with patients / service users	Yes, frequently	11,290	63.8%	68.3%
	Yes, occasionally	1,771	10.0%	12.5%
	No	4,522	25.5%	19.2%

Table 1: Profile of NHS Staff Survey respondents (bank workers and substantive workers)

The profile of respondents is similar for the two groups in terms of the type of trust at which they work. Around two thirds (66.4%) of bank workers responding to the survey were working at Acute or Acute and Community trusts, while bank workers in Mental Health and Learning Disability trusts or Mental Health, Learning Disability and Community trusts make up around a quarter of respondents (24.4%).

Nursing or healthcare assistants make up a much larger proportion of the bank worker respondents than amongst substantive workers responding to the survey (21.9% of bank workers; 7.2% of substantive staff). Conversely, allied health professionals, healthcare scientists and those in other scientific and technical roles make up a notably smaller proportion of bank workers than of substantive staff responding to the survey (13.9% of bank workers; 20.6% of substantive staff).

There are also differences between the bank and substantive survey respondents in terms of ethnic background. Amongst those responding to the survey, a greater proportion of bank workers than substantive staff are from minority ethnic backgrounds. In particular, 13% of bank workers who responded were from Black African, Black Caribbean and Black British ethnic backgrounds, compared with 5.5% of substantive staff responding to the core survey.

In addition to the differences noted above, the survey found that:

- The gender profile of bank and substantive staff responding is similar.
- More than half (57.5%) of bank workers have been working for their current organisation for less than three years; by comparison, only around a quarter (24.6%) of substantive staff have worked for their current organisation for less than three years.
- Around a quarter (27.3%) of bank workers work full-time (30+ hours per week). This compares to 81.5% of staff with substantive contracts.
- Bank workers who responded were less likely than respondents on substantive contracts to have at least occasional contact with patients and service users (73.8% and 80.8% respectively).

5 Summary of headline results

5.1 Bank working patterns

- Around half (48.8%) of bank workers 'always' work in the same department or work area at their organisation and a further third (34.0%) 'usually' do.
- Two in five bank workers (40.5%) work different hours / shift patterns each week. A similar proportion (39.3%) 'usually' work the same hours each week while one in five (20.2%) said they 'always' do.
- Bank work in the NHS is the main source of paid work for 71.6% of the bank workers surveyed.

5.2 People Promise elements and their sub-scores

We are compassionate and inclusive score: 7.2

Compassionate culture sub-score: 7.2

- Most agree their role makes a difference to patients/service users (88.8%)
- Three quarters consider patient care to be their organisation's top priority (76.2%)

Compassionate leadership sub-score: 6.4

- Less than 60% of bank workers agreed with each of the questions that feed into the Compassionate leadership sub-score
- Bank workers were least likely to agree with the statements 'my immediate manager works together with me to come to an understanding of problems' (55.3%) and 'my immediate manager takes a positive interest in my health and well-being' (55.5%)

Diversity and equality sub-score: 8.1

- Around six in ten (59.0%) agree that their organisation treats workers fairly regardless of ethnic background, gender, religion, sexual orientation, disability or age; 9.0% disagree, while around a third (32.0%) don't know
- Bank workers from ethnic minority backgrounds are less likely than those from white backgrounds to agree they are treated fairly, and more likely to have experienced discrimination

Inclusion sub-score: 6.9

- More than seven in ten feel valued by their team (71.0%) and agree that colleagues are respectful (73.2%) and understanding and kind to one another (71.5%)
- A smaller proportion agree they feel a strong personal attachment to their team (57.3%)

We are recognised and rewarded[5] score: 5.9

- Many feel they are appreciated by the people they work with (69.3%)
- A smaller proportion are impressed with the recognition they receive (55.4%) and the extent to which their organisation values their work (45.6%)

[5] This element does not feature any sub-scores. question level results are reported in section 6.2 of this report.

- Three in ten (29.7%) are satisfied with their level of pay

We each have a voice that counts score: 6.5

Autonomy and control sub-score: 6.5

- Most feel trusted to do job (92.4%) and know their work responsibilities (87.5%)
- A smaller proportion agree they are able to make suggestions to improve their work (56.8%) or have a choice in deciding how to do their work (43.5%)
- A smaller proportion still feel able to make improvements happen (39.1%)
- Less than a third feel involved in deciding on changes that affect their work (31.4%)

Raising concerns sub-score: 6.4

- Two thirds feel secure raising concerns about unsafe clinical practice (69.0%)
- A smaller proportion agree they are confident their organisation will address any concerns about unsafe clinical practice (56.3%)
- Around half are confident if they spoke up about something more generally that concerned them that their organisation would address their concern (49.5%)

We are safe and healthy score: 6.5

Health and safety climate sub-score: 5.8

- Three quarters of those who had experienced incidents of physical violence say those incidents were reported (75.0%)
- Just over half agree they can meet the conflicting demands on their time (54.7%) and that their organisation takes positive action on health and well-being (52.5%)

Burnout sub-score: 5.7

- One in five often or always feel burnt out because of their work (21.4%)
- One in three often or always feel worn out at the end of their working day/shift (34.5%)

Negative experiences sub-score: 8.0

- In the last 12 months, one in four bank workers (24.9%) have experienced at least one incident of violence from patients/service users, their relatives or other members of the public
- One in three (33.1%) have experienced at least one incident of harassment, bullying or abuse from patients/service users, their relatives or other members of the public

We are always learning score: 4.8

Development sub-score: 6.0

- More than two fifths agree they have opportunities to improve their knowledge/skills (61.7%)
- Just under half believe there are opportunities to develop their career (45.9%)
- A slightly smaller proportion feel supported to develop their potential (44.0%)

Appraisals sub-score: 3.5

- Nearly two thirds of bank workers said they have not had an appraisal or annual review in the last 12 months (65.1%)
- One in four (25.8%) said they had had an appraisal or annual review in the last 12 months

- Over half of bank workers who have not received an appraisal or annual review believe that bank workers in their role are not offered an appraisal (54.2% of those who have not received an appraisal)

We work flexibly[6] score: 6.3

Support for work-life balance sub-score: 6.3

- Nearly two thirds agree they achieve a good balance between their work life and home life (65.7%)
- Just under half agree that their organisation is committed to helping them balance their work and home life (45.8%)

We are a team score: 6.5

Team working sub-score: 6.9

- Most enjoy working with their colleagues (82.4%), feel they are respected by colleagues (77.5%) and say that team members understand each other's roles (76.5%)
- A smaller proportion feel their team has enough freedom in how to do its work (55.4%)
- Around half agree that team disagreements are dealt with constructively (51.1%)
- Bank workers who do not regularly work in the same team are less likely to agree with all questions relating to the team working sub-score

Line management sub-score: 6.2

- 62.3% agree their immediate manager encourages them at work
- 53.2% agree their manager gives them clear feedback on their work but a smaller proportion (43.2%) agree their manager asks for their opinion before making decisions
- Those who do not regularly report to same manager are less likely to agree with all measures relating to this sub-score

5.2 Themes and their sub-scores

Staff engagement score: 6.8

Motivation sub-score: 7.4

- Over seven in ten bank workers agree they are enthusiastic about their job (73.3%)
- Bank workers who never, rarely or only sometimes work in the same department are less likely to agree with all of the questions relating to the Motivation sub-score

Involvement sub-score: 6.2

- Two thirds of bank workers agree there are frequent opportunities for them to show initiative (66.9%)
- Around four in ten agree they can make improvements happen at work (39.1%)
- Bank workers who do not regularly report to the same manager are less likely agree to all questions related to this sub-score

[6] On the core NHS Staff Survey, this People Promise element comprises two sub-scores – Support for work-life balance and Flexible working. The flexible working sub-score is not reported for bank workers as the question which feeds this question is not asked of bank workers.

Advocacy sub-score: 6.9

- Around two thirds (65.0%) would be happy with the standard of care provided by their organisation if a friend or relative needed treatment
- A similar proportion would recommend their organisation as a place to work (64.3%)

Morale score: 5.8

Future intentions sub-score: 5.3

- Nearly two thirds of bank workers are considering staying on bank at their trust (64.4%); around a quarter considering moving to a permanent contract (24.3%)

Work pressure sub-score: 5.7

- 61.3% agree they have adequate materials, supplies and equipment for their work
- Less than four in ten (37.1%) agree that when they are at work there are enough workers for them to do their job properly
- Bank workers who do not regularly work in the same team are less likely to agree with all questions relating to this sub-score

Stressors sub-score: 6.3

- Most bank workers (87.5%) say they always know what their work responsibilities are
- A considerably smaller proportion (31.4%) feel involved in deciding on changes that affect their work
- Just one in three (33.2%) say they 'rarely' or 'never' have unrealistic time pressures.

6 Key findings

6.1 Bank working patterns, teams and line management

The survey asked bank workers about their usual working patterns.

Most bank workers (82.8%) said they either 'always' work in the same department or work area (48.8%) or 'often' work in the same department or work area (34%). [Table 2]

Working pattern (Q1)		All bank workers
		n=17,702
Thinking about the bank work you do within this organisation, how often do you work in the same department or work area? By this we mean how often you work with the same people in the same part of the organisation	Never Rarely Sometimes Often Always	1.4% 3.2% 12.6% 34.0% 48.8%

Table 2: Working patterns (Q1)

Working patterns tend to vary by occupation group, with just 29.3% of nursing and healthcare assistants saying they 'always' work in the same area, compared with 60.2% of workers in the wider healthcare team (which includes administrative and clerical workers, corporate services and maintenance workers). [Chart 1]

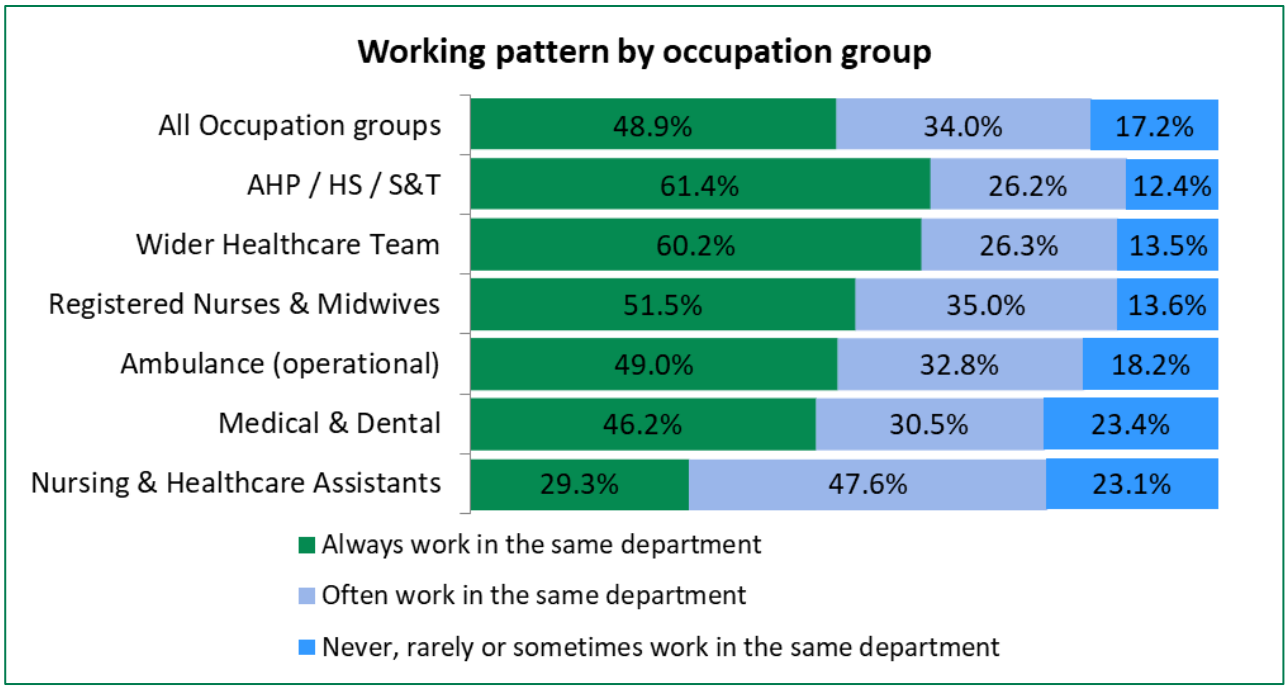

Chart 1: Working patterns by occupational group.

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

Before respondents were presented with questions relating to team working, they were asked how they would like to answer these questions (Q9). While two thirds (66.9%) of bank workers felt able to speak about the team they always/usually work in, one in three (33.1%) said they do not regularly work in the same team and so chose to answer the questions about their general experience of teamworking at the organisation instead. Again, nursing and healthcare assistants were the occupation group least likely to feel they could answer for a team they always/usually work in (46.7%).

Basis for responding about team working (Q9)		All bank workers
The next set of questions asks about your experience of teamwork at this organisation. How would you like to answer these questions (Q9)		n=17,158
	I will answer about the team I always / usually work in	66.9%
	I don't regularly work in the same team so I will answer about my general experience of teamwork at this organisation	33.1%

Table 3: Basis for responding about team working (Q9)

When it comes to regularity in shift patterns, two in five bank workers (40.5%) said they do not work the same hours / shift pattern each week. A similar proportion (39.3%) *usually* work the same hours / shift pattern each week while one in five (20.2%) said they *always* work the same hours / shift pattern each week (Q2).

Regularity of shifts/working hours (Q2)		All bank workers
Do you work the same hours / shift pattern each week		n=17,589
	Yes, I always work the same hours / shift pattern each week	20.2%
	Yes, I usually work the same hours / shift pattern each week	39.3%
	No	40.5%

Table 4: Regularity of shifts/working hours (Q2)

Before respondents were asked questions relating to immediate managers, they were asked how they would like to answer these questions (Q12). While more than six in ten bank workers (62.4%) said there was an immediate manager that they always or usually reported to, more than a third (37.6%) said they do not regularly report to the same person and so chose to answer the questions about their general experience of managers at the organisation instead.

Basis for responding about immediate managers (Q12)		All bank workers
The next set of questions asks about your immediate manager. By this we mean the person or people you report to when you're at work. This could be your line manager, placement manager, supervisor or someone else you report to directly. How would you like to answer these questions (Q12)		n=17,218
	I will answer about the manager I always / usually report to	62.4%
	I don't regularly report to the same person so I will answer about my general experience of managers at this organisation	37.6%

Table 5: Basis for responding about immediate managers (Q12)

Again, nursing and healthcare assistants were the occupation group least likely to feel they could answer in relation to an immediate manager they always or usually report to (38.7%).

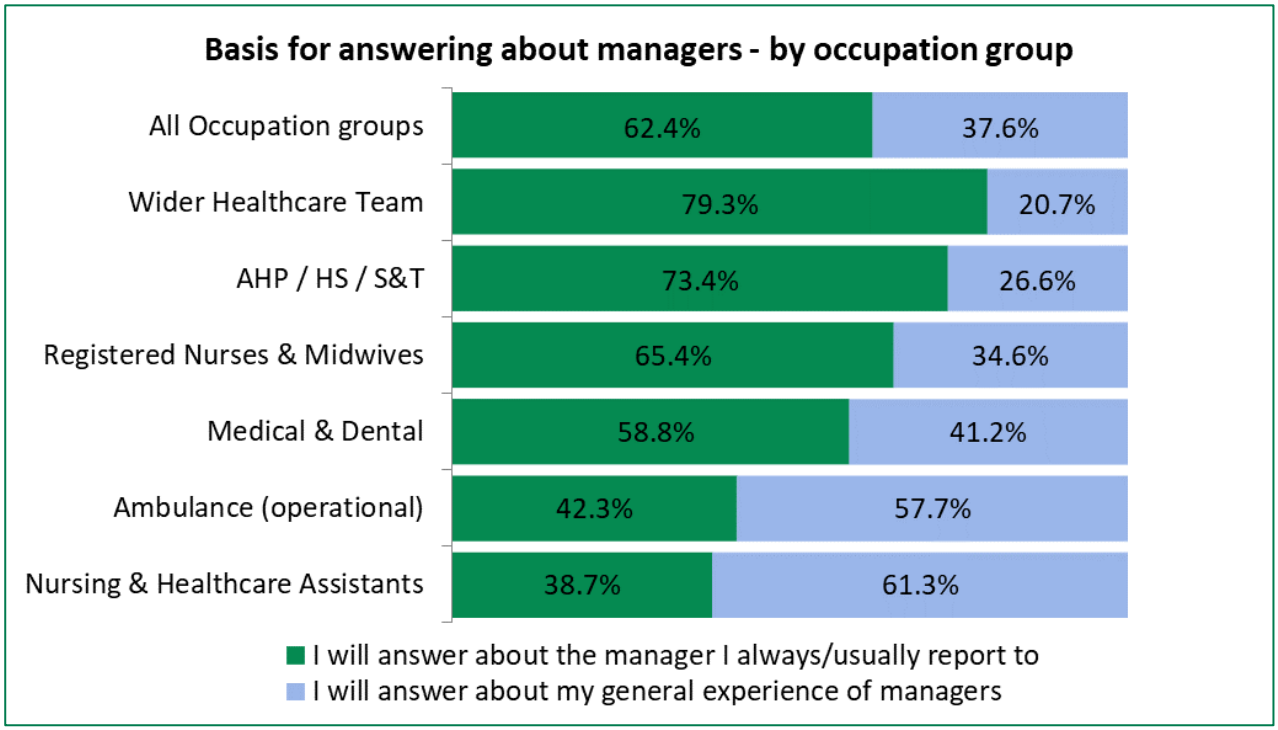

Chart 2: Basis for answering about managers - by occupational group

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

6.2 Bank work as a source of income

More than seven in ten bank workers surveyed (71.6%) said that bank work in the NHS is their main source of income. Around a quarter (24.4%) said it is not their main source of income, while 4.0% preferred not to say.

6.3 We are compassionate and inclusive 

'We are compassionate and inclusive' receives a score of 7.2 from bank workers.

6.3.1 Compassionate culture

Most bank workers believe their role makes a difference (88.8%) and around three quarters believe that the care of patients/service users is their organisation's top priority (76.2%). This positive perception is also reflected in the sub-score for Compassionate Culture (7.2).

However, a smaller proportion of bank workers are happy with the standard of care provided by their organisation; they are also less likely to recommend their organisation as a place to work (65.0% and 64.3% respectively). Nevertheless, these percentages compare favourably with the results for substantive workers (62.9% and 57.4% respectively in the core NSS results).[7]

We are compassionate and inclusive score: 7.2	All bank workers n=17,702
Compassionate culture sub-score:	**7.2**
I feel that my role makes a difference to patients / service users (Q8a)	88.8%
Care of patients / service users is my organisation's top priority (Q27a)	76.2%
My organisation acts on concerns raised by patients / service users (Q27b)	68.4%
I would recommend my organisation as a place to work (Q27c)	64.3%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Q27d)	65.0%

Table 6: Compassionate culture sub-score and contributing questions

6.3.2 Compassionate leadership

The sub-score for Compassionate leadership stands at 6.4 amongst bank workers.

Overall, between 55.3% and 59.5% of bank workers agreed with each of the questions related to this sub-score. At least a quarter of bank workers said they 'neither agree nor disagree' to each of the questions, and disagreement levels were at around 15%-16%.

Over a third of bank workers (36.5%) indicated that they do not regularly report to the same person and therefore chose to answer the Compassionate leadership questions about their general experience of managers within their organisation. Results for this group indicate they are much less likely to agree with all the questions (5.4); whereas results are more positive for those workers

[7] As stated in the technical guidance, this report is a guide and caution should be used when comparing the NSS bank results with the core NSS results due to differences in staff profile and other aspects of the data collection.

who answered the questions about the manager they usually report to (7.1).

We are compassionate and inclusive score: 7.2	All bank workers n=17,702	I will answer about the manager I always/ usually report to n=10,743	I will answer about my general experience of managers n=6,475
Compassionate leadership sub-score:	**6.4**	**7.1**	**5.4**
My immediate manager(s) works together with me to come to an understanding of problems (Q13f)	55.3%	66.6%	36.0%
My immediate manager(s) is interested in listening to me when I describe challenges I face (Q13g)	59.1%	70.7%	39.5%
My immediate manager(s) cares about my concerns (Q13h)	59.5%	70.9%	40.4%
My immediate manager(s) takes effective action to help me with any problems I face (Q13i)	56.7%	67.5%	38.2%

Table 7: Compassionate leadership sub-score and contributing questions – by all bank workers and basis for answering

Consequently, results also vary across occupation group. For example, nursing and healthcare assistants and ambulance workers, who are less likely to report regularly to the same person, are also less likely to agree with these questions when compared with other groups. For example, less than half of nursing and healthcare assistants agree that managers are interested in listening to the challenges they face (45.9%) and take effective action to help with any problems (45.1%).

6.3.3 Diversity and equality

The sub-score for Diversity and equality stands at 8.1.

The NSS bank results and core NSS results each include responses to a question asking staff whether they feel their organisation acts fairly towards staff regardless of their ethnic background, gender, religion, sexual orientation, disability, or age.[8] Overall, 59.0% of bank workers agreed that workers are treated fairly, regardless of these protected characteristics; 56.0% of substantive staff agreed with a similar statement in the core NSS results.

[8] Note the core NSS survey question wording is slightly different: 'Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?'

We are compassionate and inclusive score: 7.2	All bank workers n=17,702	White bank workers n=12,583	Bank workers from all other ethnic groups combined n=4,878
Diversity and equality sub-score:	**8.1**	**8.4**	**7.3**
Does your organisation act fairly towards staff regardless of ethnic background, gender, religion, sexual orientation, disability or age, for example with regards to career progression or development opportunities? (Q19)	59.0%	63.0%	49.8%
Experienced discrimination at work from patients / service users, their relatives or other members of the public in last 12 months (Q20a)	12.5%	7.0%	26.6%
Experienced discrimination at work from manager / team leader or other colleagues in last 12 months (Q20b)	9.7%	6.9%	16.6%
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc). (Q24)	69.1%	69.7%	68.2%

Table 8: Diversity and equality sub-score and contributing questions – by all bank workers and ethnic group

A relatively high percentage of bank workers indicate they ‘don’t know’ whether their organisation acts fairly (around 32%, which is similar to the proportion of substantive staff who say ‘don’t know’) and only 9.0% of bank workers said they ‘disagree’ or ‘strongly disagree’.

However, results are less positive when considering the perspective of bank workers from ethnic minority groups, who are less likely to perceive their organisation acts fairly towards workers regardless of their ethnic background or other protected characteristics (49.8%, compared with 63.0% of white bank workers).

Overall, one in eight bank workers claim to have experienced discrimination from patients, service users, their relatives or other members of the public in the past year (12.5%). This is higher than the figure reported in the core NSS results (8.3%). Incidence of experiencing discrimination from patients and the public over the past year is higher amongst bank workers from minority ethnic backgrounds. Over a quarter of bank workers from minority ethnic backgrounds (26.6%) indicated they have experienced discrimination from patients/service users in the past year. Incidence of this type of discrimination amongst minority ethnic staff in the core NSS results is lower, at 19.9%. Around one in six staff from ethnic minority backgrounds (16.6% on both surveys) claim to have experienced discrimination from their manager/colleagues in the past year.

Q20c On what grounds have you experienced discrimination?	All bank workers that have experienced discrimination n=3006
Ethnic background	58.8%
Gender	22.3%
Age	21.0%
Other	21.0%
Religion	7.4%
Disability	6.8%
Sexual orientation	5.5%

Table 9: Grounds of discrimination

6.3.4 Inclusion

Overall, bank workers tend to feel valued by their team and consider the people they work with to be respectful, understanding and kind to each other, with over 70% agreeing with these propositions, contributing to a sub-score of 6.9 for Inclusion.

Nearly a third of bank workers (32.1%) indicate they don't regularly work in the same team and chose to answer the Inclusion questions about their general experience of teamwork across their organisation.

We are compassionate and inclusive score: 7.2	All bank workers n= 17,702	I will answer about the team I always/ usually work in n=11,479	I will answer about my general experience of teamwork n=5,679
Inclusion sub-score:	**6.9**	**7.3**	**6.2**
I feel valued by my team (Q10f)	71.0%	77.9%	57.1%
I feel a strong personal attachment to my team (Q10g)	57.3%	68.0%	35.0%
The people I work with are understanding and kind to one another (Q11b)	71.5%	76.8%	60.8%
The people I work with are polite and treat each other with respect (Q11c)	73.2%	78.3%	62.8%

Table 10: Inclusion sub-score and contributing questions – by all bank workers and basis for team responses

Results indicate that workers who do not have a 'usual' team are less likely to agree with the questions that feed into their Inclusion sub-score (6.2). This group are less likely to feel valued by the teams they work in (57.1%) and less likely to feel a strong personal attachment to those teams (35.0%).

The results for those bank workers who identified as having a team they always or usually work in are more positive than those for bank workers who do not. They also compare favourably with the responses given to the same questions by substantive staff (of whom 71.1% describe colleagues as understanding and kind and 69.4% say they feel valued by their team).

Results vary for occupation groups. For example, nursing and healthcare assistants and ambulance workers are less likely to work in the same team and are less likely to agree they feel valued and attached to their team when compared with other occupation groups. [Chart 3]

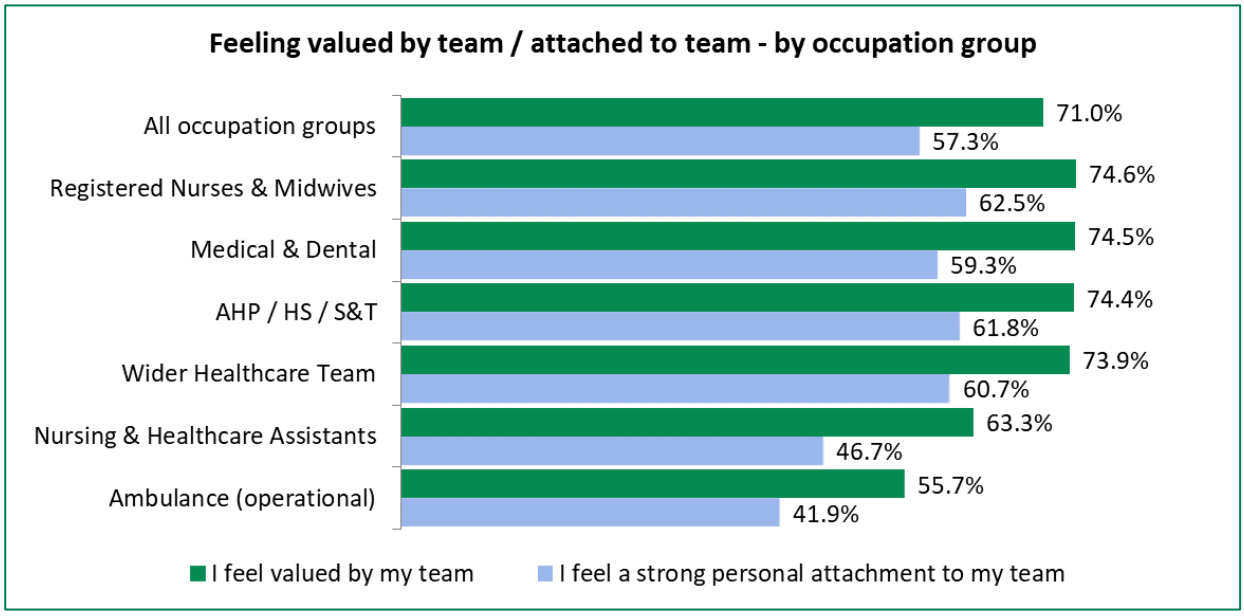

Chart 3: Feeling valued by team / attached to team - by occupational group

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

6.4 We are recognised and rewarded 

The score for the element 'We are recognised and rewarded' is 5.9.

Around two thirds of bank workers agree they are appreciated by the people they work with (69.3%) and their immediate manager values their work (66.9%). However, a smaller proportion are satisfied with the recognition they receive for good work (55.4%) and the extent to which their organisation values their work (45.6%).

29.7% of bank workers indicate they are satisfied with their level of pay, and as a result, this is likely to have a negative impact on the score for this element. The core NSS results are similar, where a quarter of staff with a substantive contract (25.6%) indicated they are satisfied with their pay.

It is notable that bank workers who have had an appraisal or review in the past year are relatively more likely than those who have not had an appraisal or review to feel their work is recognised, valued and appreciated.

We are recognised and rewarded score: 5.9	**All bank workers** n=17,702	**Had an appraisal or review** n=4,526	**Not had an appraisal or review** n=11,415
We are recognised and rewarded sub-score:	**5.9**	**6.9**	**6.3**
The recognition I get for good work (Q6a)	55.4%	62.7%	51.8%
The extent to which my organisation values my work (Q6b)	45.6%	52.0%	41.6%
My level of pay (Q6c)	29.7%	34.2%	27.9%
The people I work with show appreciation to one another (Q11d)	69.3%	74.0%	67.3%
My immediate manager(s) values my work (Q13e)	66.9%	74.4%	63.6%

Table 11: We are recognised and rewarded sub-score and contributing questions – by all bank workers and had/did not have appraisal review

6.5 We each have a voice that counts 

Results reveal bank workers feel trusted and know their responsibilities but are less likely to agree on measures around taking initiative, making suggestions for improvements and involvement in decision making (sub-score: 6.5).

6.5.1 Autonomy and control

Overall, a high proportion of bank workers feel trusted to do their job (92.4%) and always know their work responsibilities (87.5%). Around two thirds (66.9%) indicate there are frequent opportunities for them to show initiative. However, a lower proportion (56.8%) feel they can make suggestions to improve their work and only two fifths feel they can make improvements happen in their area of work (39.1%). Less than half perceive they have a choice in deciding how to do their work (43.5%) and less than a third are involved in deciding on changes that affect their team/department (31.4%).

For those bank workers who indicate they do not regularly report to the same manager, their sub-score and responses to most questions indicate they are less likely to agree with most aspects of this element when compared with workers who always or usually report to the same manager.

We each have a voice that counts score: 6.5	All bank workers n= 17,702	I will answer about the manager I always/ usually report to n=10,743	I will answer about my general experience of managers n=6,475
We are recognised and rewarded sub-score:	**6.5**	**6.8**	**5.9**
I always know what my work responsibilities are (Q5a)	87.5%	89.9%	83.5%
I am trusted to do my job (Q5b)	92.4%	94.1%	89.8%
There are frequent opportunities for me to show initiative in my role (Q5c)	66.9%	71.3%	59.6%
I am able to make suggestions to improve the work we do (Q5d)	56.8%	64.9%	43.1%
I am involved in deciding on changes introduced that affect my work (Q5e)	31.4%	38.6%	18.9%
I am able to make improvements happen at work (Q5f)	39.1%	44.8%	29.2%
I have a choice in deciding how to do my work (Q7b)	43.5%	51.1%	30.4%

Table 12: We are recognised and rewarded sub-score and contributing questions – by all bank workers and basis for responding about managers

Perceptions of autonomy and control amongst bank workers varies by occupation group. Nursing and healthcare assistants and ambulance workers are least likely to feel they have a choice in deciding how to do their work and feel involved in deciding on changes. [Chart 4]

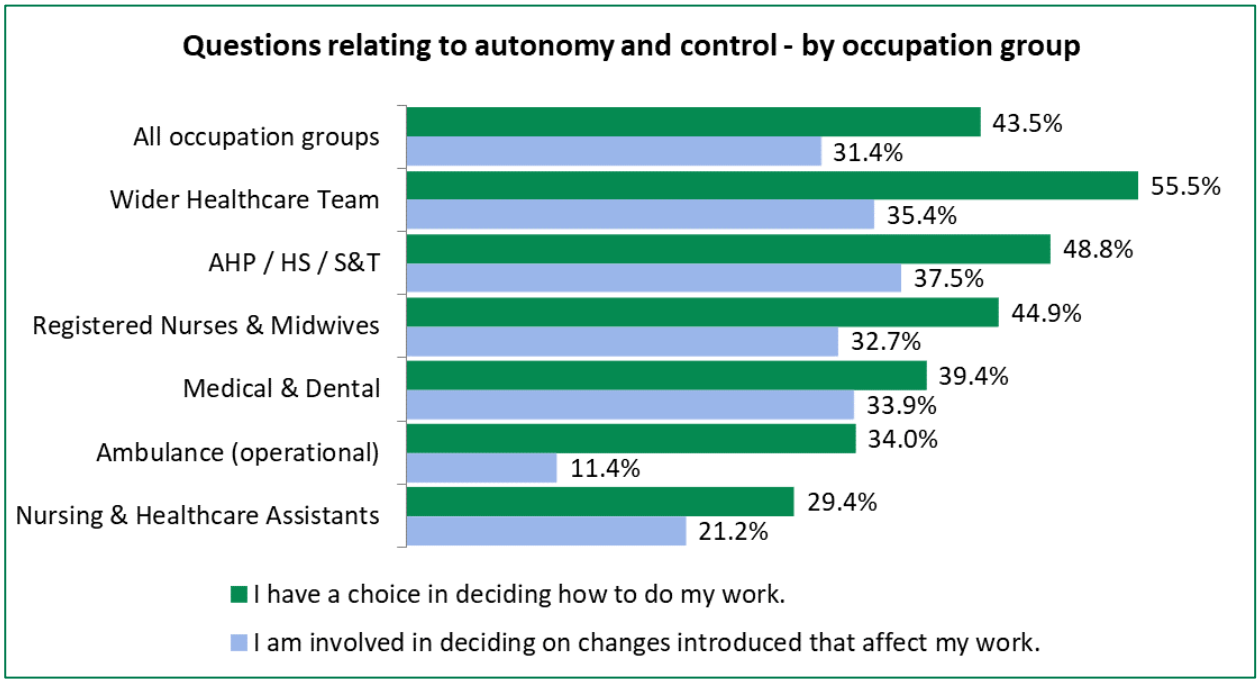

Chart 4: Questions relating to autonomy and control – by occupation group

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

6.5.2 Raising concerns

With regard to unsafe clinical practice, 69.0% of bank workers say they would feel secure raising concerns about unsafe clinical practice but a smaller proportion (56.3%) would be confident that their organisation would address those concerns. More generally, around six in ten (61.3%) would feel safe to speak up about anything that concerns them in their organisation, and around half (49.5%) would feel confident that their concerns would be addressed.

We each have a voice that counts score: 6.5	All bank workers n=17,702
Raising concerns sub-score:	**6.4**
I would feel secure raising concerns about unsafe clinical practice (Q23a)	69.0%
I am confident that my organisation would address my concern (Q23b)	56.3%
I feel safe to speak up about anything that concerns me in this organisation (Q27e)	61.3%
If I spoke up about something that concerned me, I am confident my organisation would address my concern (Q27f)	49.5%

Table 13: Raising concerns sub-score and contributing questions

6.6 We are safe and healthy

The overall score for the 'We are safe and healthy' element of the People Promise, at 6.5 amongst bank workers, is above that reported in the core NSS results (5.9).[9]

6.6.1 Health and safety climate

The sub-score for Health and safety climate for bank workers is 5.8.

Three in five bank workers (61.3%) say they have adequate materials and equipment to do their work. Meanwhile around half (54.7%) state that they can meet all the conflicting demands on their time.

Around a third (37.1%) of bank workers report that when they are at work there are enough workers for them to do their job properly and a similar proportion say they never or rarely have unrealistic time pressures (33.2%). These results appear to compare favourably with the core NSS results for similar questions around workload and staffing levels (26.4% and 23.4% respectively amongst substantive workers).

The NSS Bank results and core NSS results are more similar on the statement 'My organisation takes positive action on health and well-being'. Just over half of bank workers (52.5%) agree with this statement, compared with 55.6% of substantive staff.

We are safe and healthy score: 6.5	**All bank workers** n=17,702
Health and safety climate sub-score:	**5.8**
I am able to meet all the conflicting demands on my time at work (Q5g)	54.7%
I have adequate materials, supplies and equipment to do my work (Q5h)	61.3%
When I am at work, there are enough staff for me to do my job properly (Q5i)	37.1%
I have unrealistic time pressures (Q7a)	33.2%
My organisation takes positive action on health and well-being (Q15a)	52.5%
Whether experiences of physical violence were reported (Q17d)	75.0%
Whether experiences of harassment, bullying or abuse were reported (Q18d)	51.3%

Table 14: Health and safety climate sub-score and contributing questions

[9] Note there are some differences in the wording used for q5i on the Bank Survey when compared with the equivalent question on the core NSS survey. Caution should therefore be used when comparing the results. However, the relevant question on each survey appears to be measuring the same concept and so results are considered comparable for reporting purposes.

6.6.2 Burnout

Experience of burnout is measured by a sub-set of questions which form part of the Copenhagen Burnout Inventory and these questions are asked of both bank and substantive workers. Results are presented as the proportion of workers who responded they 'often' or 'always' feel the way described in the question. As such, a higher percentage reported for these questions represents a worse result.

Over a third of bank workers (34.5%) often or always feel worn out at the end of their working day; roughly a quarter often or always find their work emotionally exhausting (25.4%), or feel their work frustrates them (25.6%); around a fifth often or always feel burnt out because of their work (21.4%) or are often or always exhausted at the thought of another day/shift (19.8%); and 23.2% indicate they often or always do not have enough energy for friends and family during leisure time.

The overall Burnout sub-score for bank workers is 5.7. This score is higher than the Burnout sub-score for substantive staff (4.9), a higher score representing a better result. The core NSS results suggest a higher proportion of substantive staff than bank workers have experienced each aspect of burnout measured in the survey. However it should be reiterated that caution is advised in comparing the core NSS results and bank results due to differences in sample profiles and survey differences (see Section 3.1).

We are safe and healthy score: 6.5	All bank workers n= 17,702	0-15 hours per week n=6,682	16-29 hours per week n=5,947	30 hours or more per week n=4,838
Burnout sub-score:	**5.7**	**6.0**	**5.7**	**5.3**
How often you find your work emotionally exhausting (Q16a)	25.4%	22.2%	24.6%	30.8%
How often you feel burnt out because of your work (Q16b)	21.4%	17.0%	20.3%	28.7%
How often your work frustrates you (Q16c)	25.6%	23.5%	25.1%	29.1%
How often you are exhausted at the thought of another day/shift at work (Q16d)	19.8%	17.5%	18.9%	24.2%
How often you feel worn out at the end of your working day/shift (Q16e)	34.5%	32.1%	34.0%	38.6%
How often you feel that every working hour is tiring for you (Q16f)	14.2%	12.1%	13.7%	17.7%
How often you do not have enough energy for family and friends during leisure time (Q16g)	23.2%	20.6%	22.2%	27.7%

Table 15: Burnout sub-score and contributing questions – by all bank workers and hours worked

Overall, bank workers who work 30 hours or more per week (on average) are more likely to experience burnout than bank workers who work less than 30 hours. Bank workers who regularly work under 16 hours per week are less likely to feel burnt out or emotionally exhausted.

Although the number of hours worked clearly has a major influence on the likelihood of bank workers experiencing burnout, it appears to have less impact on certain occupation groups. Burnout is more prevalent amongst workers in clinical roles, who are more likely to feel worn out at the end of their shift and report they feel burnt out due to differences in the nature of their work. Registered Nurses and Midwives have a relatively low proportion of workers working at least 30 hours per week (19.5%), but these workers are relatively likely to say they often or always feel worn out at the end of their working day/shift; they are also more likely to feel burnt out because of their work when compared to the average for all occupation groups. Conversely the wider healthcare team have a relatively high proportion of workers working at least 30 hours per week (31.8%) but are least likely to experience burnout.

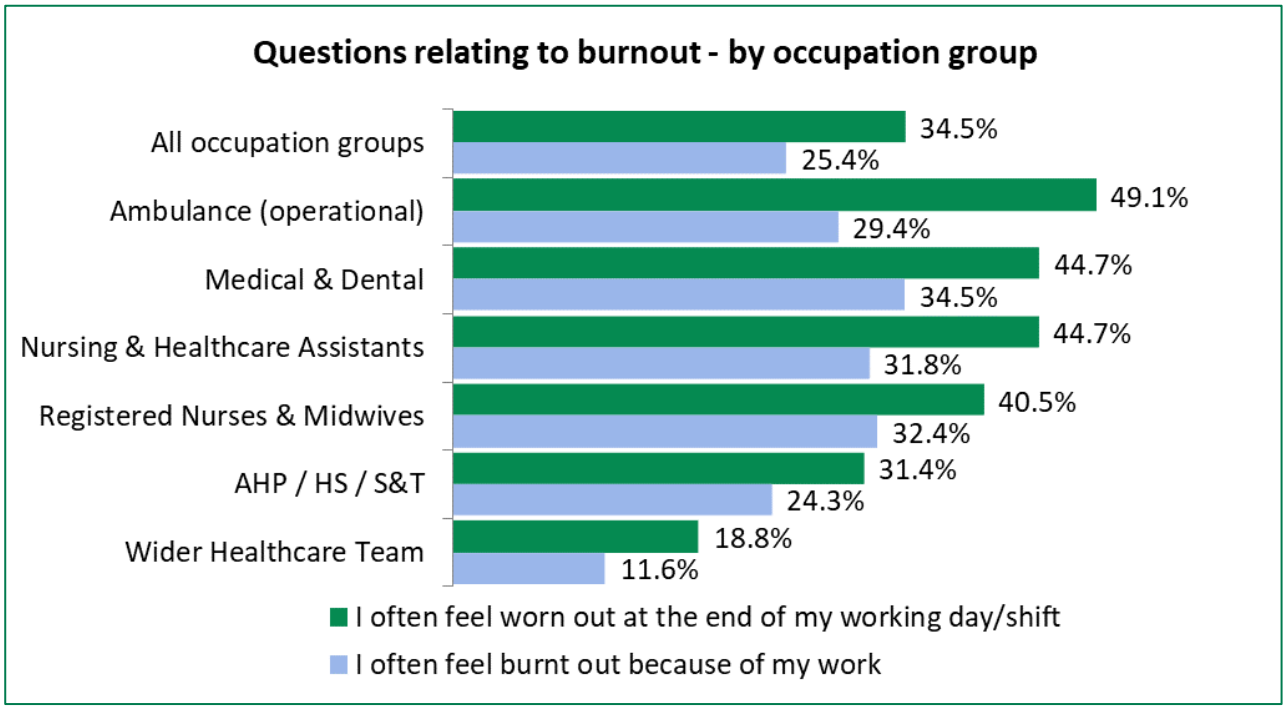

Chart 5: Questions relating to burnout – by occupation group

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

6.6.3 Negative experiences

Physical violence, harassment, bullying and abuse

Around a quarter (24.9%) of bank workers claim to have experienced at least one incident of physical violence and around a third (33.1%) have experienced at least one incident of harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months.

While it is important to bear in mind the differences in staff roles between bank and substantive workers previously noted, incidence of physical violence and harassment, bullying or abuse from patients/service users towards bank workers appears to be higher than that reported in the core NSS results for substantive staff.

We are safe and healthy score: 6.5	All bank workers n=17,702	White bank workers n=12,583	Bank workers from all other ethnic groups combined n=4,878
Negative experience sub-score:	**8.0**	**8.0**	**7.8**
Have experienced physical violence from patients/ service users in the last 12 months (Q17a)	24.9%	23.7%	27.9%
Have experienced physical violence from managers in the last 12 months (Q17b)	1.8%	1.0%	3.6%
Have experienced physical violence from other colleagues in the last 12 months (Q17c)	3.5%	2.2%	6.7%
Have experienced harassment, bullying or abuse from patients/service users in the last 12 months (Q18a)	33.1%	32.1%	35.5%
Have experienced harassment, bullying or abuse at work from managers in the last 12 months (Q18b)	10.6%	10.1%	11.5%
Have experienced harassment, bullying or abuse at work from other colleagues in the last 12 months (Q18c)	18.8%	16.9%	23.4%

Table 16: Negative experience sub-score and contributing questions – by all bank workers and ethnic group

The likelihood of experiencing at least one incident of physical violence from patients/service users is above average for workers from ethnic minority backgrounds (27.9% in the last 12 months) and nearly a quarter of workers from ethnic minorities have experienced harassment, bullying or abuse at work from other colleagues in the last 12 months (23.4%).

Nursing and healthcare assistants are particularly likely to have negative experiences, with over half (52.7%) stating they have experienced at least one incident of physical violence in the past 12 months and a similar proportion (48.1%) having experienced at least one incident of harassment, bullying or abuse from patients/service users.

Worker health

Over a third of bank workers (36.0%) said that in the last three months they had attended work despite not feeling well enough to perform their duties; 28.9% had felt unwell due to work-related stress in the last year; and a quarter have experienced musculoskeletal problems (MSK) as a result of work activities.

Over half of bank workers with long term health conditions or illnesses (54.0%) indicated they have attended work despite not feeling well enough and 43.7% of this group have felt unwell due to work-related stress.

We are safe and healthy score: 6.5	All bank workers n=17,702	Bank workers with long lasting health conditions or illnesses n=3,373	Bank workers with no long lasting health conditions or illnesses n=14,109
Negative experience sub-score:	**8.0**	**7.2**	**8.2**
Have experienced musculoskeletal problems (MSK) as a result of work activities in the last 12 months (Q15b)	25.0%	38.8%	21.7%
Have felt unwell as a result of work-related stress in the last 12 months (Q15c)	28.9%	43.7%	25.3%
Have come to work despite not feeling well enough to perform their duties in last 3 months (Q15d)	36.0%	54.0%	31.7%

Table 17: Negative experience sub-score and contributing questions – by all bank workers and whether have any long lasting health conditions or illnesses

6.7 We are always learning 

The score for 'We are always learning' is 4.8. It should be noted that this **score is not comparable** to the 'We are always learning' score in the core NSS results, which is calculated differently due to differences in the questions asked of bank and substantive staff.[10]

6.7.1 Development

Overall, around six in ten bank workers agree there are opportunities to improve their knowledge and skills (61.7%) and their organisation offers them challenging work (59.8%); a lower proportion feel able to access the right learning and development opportunities (53.2%); less than half believe there are opportunities to develop their career at the organisation (45.9%) or feel supported to develop their potential (44.0%).

The survey asks bank workers what they are planning to do in the next 12 months including whether they are planning to continue working on bank or move to a permanent contract at their organisation or another NHS organisation, or whether they are considering alternative options (Q28, see section 6.11.1). Results for questions relating to development, including amongst staff who are / are not considering a permanent contract are shown in Table 17 below.

We are always learning: 4.8	All bank workers	Only considering a permanent contract at this organisation	Considering a permanent contract at this organisation amongst other options	Considering staying on bank at this organisation, but not considering a permanent contract
	n=17,702	n=1,216	n=2,714	n=10,425
Development sub-score:	**6.0**	**6.8**	**6.4**	**6.1**
This organisation offers me challenging work (Q26a)	59.8%	65.8%	60.6%	60.8%
There are opportunities for me to develop my career in this organisation (Q26b)	45.9%	68.1%	56.8%	44.5%
I have opportunities to improve my knowledge and skills (Q26c)	61.7%	75.8%	67.2%	63.2%
I feel supported to develop my potential (Q26d)	44.0%	62.3%	52.1%	44.5%
I am able to access the right learning and development opportunities when I need to (Q26e)	53.2%	63.2%	56.6%	55.7%

Table 18: Development sub-score and contributing questions – by all bank workers and future intentions

[10] See bank questionnaire for question wording and refer to supporting information regarding the calculation in the appendix.

Bank workers who are considering a permanent contract at their organisation are more likely to feel supported and believe there are more opportunities to develop their potential/career and improve their knowledge/skills compared to bank workers who are considering staying on bank at their organisation, but not considering a permanent contract.

Bank workers who are only considering a permanent contract at their organisation have the highest sub-score for Development and are considerably more inclined to agree with most of the contributing questions. Most notably, around three quarters (75.8%) of this group believe there are opportunities to improve their knowledge and skills and over two thirds of them (68.1%) perceive there are opportunities for them to develop their career in their organisation.

6.7.2 Appraisals

The Appraisals sub-score for bank workers is 3.5. It is important to note that the calculation of this sub-score is different for bank workers from that used for the core NSS results so the Appraisals **sub-scores for bank and substantive staff are not comparable**.

Around a quarter of bank workers (25.8%) indicate they have had an appraisal, annual review, development review, or Knowledge and Skills Framework development review in the last 12 months. Nearly two thirds of bank workers (65.1%) indicated they had not had a review or appraisal. For context, 81.3% of substantive staff as measured in the core NSS results claimed to have had an appraisal in the preceding 12 months.

Nearly three quarters of Medical & Dental bank only workers (73.8%) claimed to have received an appraisal or review. Bank workers in other occupation groups are less likely to have received one. The wider healthcare team and nursing and healthcare assistants are least likely to have had an appraisal in the last 12 months (19.0% and 14.9% respectively).

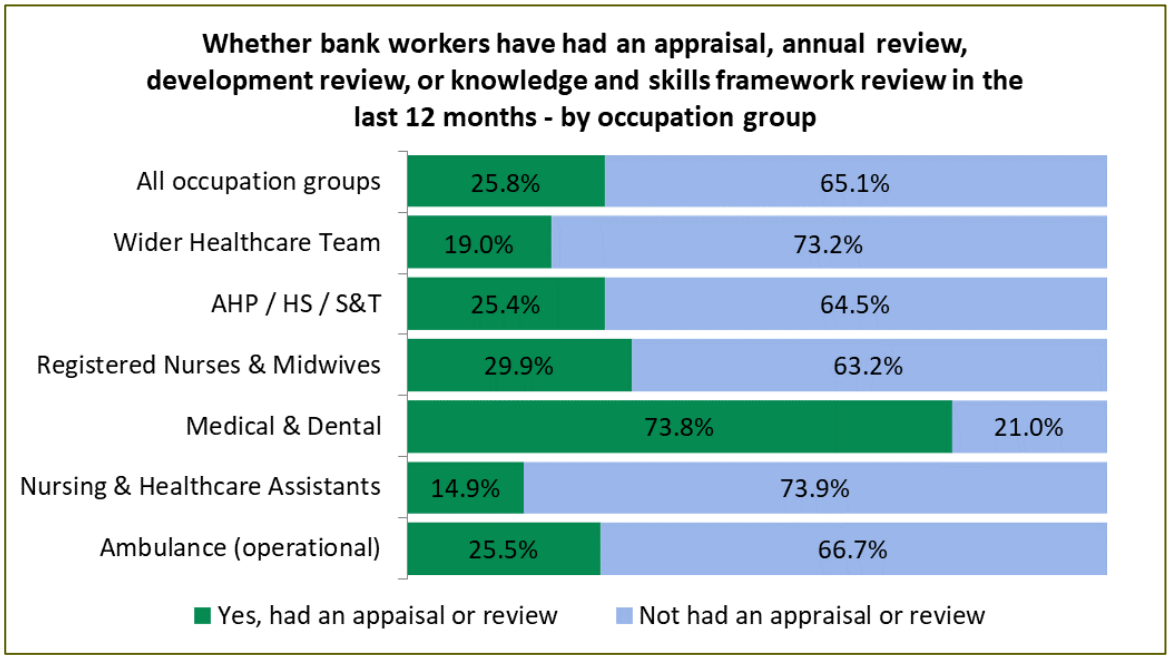

Chart 6: Whether bank workers had an appraisal in the last 12 months – by occupation group

NB for occupational base size please see section 4.2; AHP / HS / S&T = Allied health professionals, healthcare scientists and scientific & technical

Bank workers who had not had an appraisal were asked why they had not had one and over half of them (54.2%) answered that 'bank only workers in my role are not offered an appraisal'; while 10% thought that they would be offered an appraisal, but they had not been in their role long enough yet. Over a quarter of those who had not received an appraisal did not know why this was (27.9%).

We are always learning: 4.8		**All bank workers** n=17,529
Appraisals sub-score:		**3.5**
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? (Q25a)		
	Yes	25.8%
	No	65.1%
	Can't remember	9.1%
		All not receiving an appraisal n=11,308
If not, why? (Q25b)	Bank only workers in my role are not offered an appraisal	54.2%
	As a bank worker I will be offered an appraisal, but I have not been in my role long enough yet	10.0%
	Other reasons	7.9%
	Don't know	27.9%

Table 19: Appraisals sub-score and contributing questions

Those bank workers who had not received an appraisal were asked whether they felt an appraisal would help them to do their job better. Opinion was divided with around a third saying it would (35.7%), a similar proportion disagreeing (32.2%) and a similar proportion unsure (32.1% 'don't know').

6.8 We work flexibly 

The 'We work flexibly' score in the NSS bank results measure support for work-life balance. The score stands at 6.3 based on responses to two questions. Note that this score is **not comparable** with that reported for the core NSS results, due to differences in the number of questions and sub-score categories feeding into the score.

6.8.1 Support for work-life balance

The 'Support for work-life balance' sub-score is based on responses to two questions: whether workers agree their organisation is committed to helping them balance their work and home life, and whether workers achieve a good balance between their work and home life.

Overall, results indicate under half of bank workers agree their organisation is committed to helping them find a work-life balance (45.8%) which is very similar to the proportion of substantive staff agreeing in the core NSS results (45.7%). Nevertheless, over two thirds state they are still able to achieve a good work-life balance (67.5%) compared with just over half of substantive staff (52.5%).

Those bank workers who chose to answer line management questions about their general experience of managers because they do not always/usually report to the same person, are less likely to agree with both statements. Only 38.2% of this group perceive their organisation is committed to helping them balance their work and home life, while 63.2% say they achieve a good work-life balance. In comparison, half (50.2%) of workers who can answer the questions about their immediate manager agree their organisation is committed to helping them balance their work and home life, and 70.1% of them achieve a good balance.

We work flexibly score: 6.3	**All bank workers** n= 17,702	**I will answer about the manager I always/ usually report to** n=10,743	**I will answer about my general experience of managers** n=6,475
Support for work-life balance sub-score:	**6.3**	**6.5**	**6.0**
My organisation is committed to helping me balance my work and home life (Q8b)	45.8%	50.2%	38.2%
I achieve a good balance between my work life and my home life (Q8c)	67.5%	70.1%	63.2%

Table 20: Support for work-life balance sub-score and contributing questions – by all bank workers and immediate manager experience

6.9 We are a team 

The 'We are a team' score stands at 6.5. Comparisons between this score and the equivalent score for this People Promise element in the core NSS results should be made with caution, due to differences in the questions asked.

6.9.1 Team working

Overall, most bank workers enjoy working with colleagues in their team (82.4%). Many feel they receive the respect they deserve from their colleagues (77.5%) and that team members understand each other's roles (76.5%). Six out of ten bank workers (60.4%) consider teams within their organisation work well together to achieve their objectives.

A lower proportion of bank workers, however, say their team has enough freedom in how to do its work (55.4%) while around half of bank workers (51.1%) agree that team disagreements are dealt with constructively.

Around a third of bank workers (32.1%) do not regularly work in the same team/department. These workers indicated they would answer the 'Team working' questions in relation to their general experience of teamwork, rather than one particular team. The sub-score and the level of agreement amongst these workers are lower on all measures than amongst those who regularly work in the same team or department.

We are a team: 6.5	All bank workers n=17,702	I will answer about the team I always/ usually work in n=11,479	I will answer about my general experience of teamwork n=5679
Team working sub-score:	**6.9**	**7.2**	**6.3**
I receive the respect I deserve from my colleagues at work (Q10a)	77.5%	84.0%	64.6%
Team members understand each other's roles. (Q10b)	76.5%	81.1%	67.1%
I enjoy working with the colleagues in my team (Q10c)	82.4%	88.2%	70.7%
My team has enough freedom in how to do its work (Q10d)	55.4%	60.8%	44.6%
In my team disagreements are dealt with constructively (Q10e)	51.1%	56.8%	39.3%
Teams within this organisation work well together to achieve their objectives (Q11a)	60.4%	62.2%	56.6%

Table 21: Team working sub-score and contributing questions – by all bank workers and immediate team experience

Most notably, workers without a regular team are much less likely to feel the different teams they have worked in have enough freedom in how to do their work (44.6%); they are also considerably less likely to agree that those teams deal with disagreements in a constructive way (39.3%).

6.9.2 Line management

Overall, around six in ten bank workers feel their manager(s) encourage them at work (62.3%) and more than half feel they get clear feedback (53.2%) and that their manager(s) take a positive interest in their health and well-being (55.5%). A slightly smaller proportion said their manager(s) ask for their opinion before making decisions that affect their work (43.2%)

Around a third of bank workers (36.6%) had earlier indicated that they do not regularly report to the same person and so chose not to answer these questions about a single immediate manager, but instead answered them about their general experience of managers within their organisation.

Results indicate this group are less likely than average to agree with all the Line management questions. Less than a quarter agree that immediate managers ask for their opinion before making decisions that affect them (23.0%); they are also considerably less likely than those with a regular line manager to agree that managers give them clear feedback on their work (33.8%) and take a positive interest in their health and well-being (34.8%); and under half (44.3%) agree that their immediate managers encourage them at work.

We are a team: 6.5	All bank workers n= 17702	I will answer about the manager I always/usually report to n=10743	I will answer about my general experience of managers n=6475
Line management sub-score:	**6.2**	**6.8**	**5.1**
My immediate manager(s) encourages me at work (Q13a)	62.3%	72.9%	44.3%
My immediate manager(s) gives me clear feedback on my work (Q13b)	53.2%	64.5%	33.8%
My immediate manager(s) asks for my opinion before making decisions that affect my work (Q13c)	43.2%	55.1%	23.0%
My immediate manager(s) takes a positive interest in my health and well-being (Q13d)	55.5%	67.7%	34.8%

Table 22: Line management sub-score and contributing questions – by all bank workers and immediate manager experience

6.10 Staff engagement

The Staff engagement theme score for bank workers is 6.8. This is the same as the Staff engagement score in the core NSS results.

6.10.1 Motivation

Overall, the Motivation sub-score, at 7.4, is slightly higher than that reported as part of the core NSS results (6.9). Nearly three quarters of bank workers are enthusiastic about their job (73.3%) and nearly two thirds look forward to going to work (64.3%). This compares favourably with how substantive staff feel about their job (66.9% are enthusiastic and only 42.6% look forward to going to work).

When considering working patterns in terms of how often bank workers work in the same department or area, bank workers who either 'never', 'rarely' or only 'sometimes' work in the same department, who make up 16.9% of all bank workers, are less likely to respond positively to these questions. Conversely, those bank workers who 'often' or 'always' work in the same department (81.7% of the total) appear more highly motivated.

Staff engagement: 6.8	All bank workers	How often do you work in the same department/ work area?				
		Never	Rarely	Some-times	Often	Always
	n=17,702	n= 247	n=557	n=2,192	n=5,933	n=8,533
Motivation sub-score:	**7.4**	**6.2**	**6.5**	**6.8**	**7.2**	**7.7**
I look forward to going to work (Q4a)	64.3%	45.9%	46.0%	53.6%	62.1%	70.2%
I am enthusiastic about my job (Q4b)	73.3%	57.7%	60.0%	63.7%	72.6%	77.4%
Time passes Quickly when I am working (Q4c)	69.0%	55.2%	56.8%	57.5%	66.8%	74.6%

Table 23: Motivation sub-score and contributing questions – by all bank workers and working pattern in same department/work area

6.10.2 Involvement

The Involvement sub-score for bank workers is 6.2. By comparison, the equivalent sub-score in the core NSS results is 6.8.[11]

Around four in ten bank workers feel they can make improvements happen at work (39.1%, compared with 54.3% of substantive staff). They are also relatively less likely to agree they can make suggestions to improve the work done in their organisation (56.8%, compared with 70.9% of substantive staff).

[11] Note there are some differences in the question wording for some Bank Survey questions (q5d and q5f) when compared with the equivalent questions on the national survey. Caution should therefore be used when comparing the results. However, the relevant questions on each survey are measuring the same concepts and so results are considered comparable for reporting purposes.

Bank workers who do not regularly report to the same manager feel less involved than those who regularly report to the same manager. The latter group are considerably more likely to agree there are frequent opportunities for them to show initiative in their role (71.3%), make suggestions to improve their work (64.9%) and make those improvements happen (44.8%).

Staff engagement: 6.8	All bank workers n= 17,702	I will answer about the manager I always/usually report to n=10,743	I will answer about my general experience of managers n=6,475
Involvement sub-score:	**6.2**	**6.5**	**5.6**
There are frequent opportunities for me to show initiative in my role (Q5c)	66.9%	71.3%	59.6%
I am able to make suggestions to improve the work we do (Q5d)	56.8%	64.9%	43.1%
I am able to make improvements happen at work (Q3f)	39.1%	44.8%	29.2%

Table 24: Involvement sub-score and contributing questions – by all bank workers and response for managers

6.10.3 Advocacy

Advocacy receives a sub-score of 6.9 from bank workers, slightly above the equivalent sub-score in the NSS core results (6.7). Scores by type of organisation show a similar pattern to that seen amongst substantive workers, with advocacy highest amongst workers in Acute Specialist trusts, Community trusts, and Mental Health and Learning Disability and Mental Health, Learning Disability and Community trusts, but lower in Ambulance and Acute/ Acute and Community trusts.

Staff engagement: 6.8	All bank workers n=17,702	Acute and Acute & Comm-unity n=11,752	Acute Special-ist n=259	MH / LD and MH LD & Comm-unity n=4,311	Comm-unity n=992	Ambul-ance n=388
Advocacy sub-score:	**6.9**	**6.8**	**8.0**	**7.2**	**7.2**	**5.6**
Care of patients / service users is my organisation's top priority (Q27a)	76.2%	74.7%	86.5%	80.7%	80.5%	53.5%
I would recommend my organisation as a place to work (Q27)	64.3%	63.1%	73.4%	68.3%	68.6%	38.7%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Q27d)	65.0%	63.6%	88.4%	66.3%	73.6%	57.0%

Table 25: Advocacy sub-score and contributing questions – by all bank workers and trust types

6.11 Morale

The Morale theme score stands at 5.8. Comparisons with the core NSS results on this score are not recommended, as the 'Future intentions' sub-score which contributes to the score for this theme is not comparable with the 'Thinking about leaving' sub-score in the core NSS results.

6.11.1 Future intentions

The 'Future intentions' sub-score (5.3) is based on responses to the question "*In the next 12 months, which of the following are you planning to do or considering doing?*" Bank workers are invited to select multiple responses from the following list of options:

Continuing to work on the bank at this organisation
Continuing to do NHS bank work but not at this organisation
Moving to a permanent contract at this organisation
Moving to a permanent contract at another NHS organisation
Working in the NHS but paid by an external agency
Moving to a job in healthcare, but outside the NHS
Moving to a job outside healthcare
Taking a career break
Retiring
Going into full time training or studying

When reporting responses to this question, individual answers choices are combined into the answer categories shown in the table below. Overall, nearly a quarter of bank workers (24.3%) are currently considering a permanent contract at the organisation where they work. The majority of these are also considering other options (16.8%). Nearly two thirds of bank workers (64.4%) are considering staying on bank at their organisation but are not considering moving to a permanent contract; 7% are only considering options outside the NHS (including moving to agency work) and 4.3% are considering staying in the NHS (either bank or permanent) but are not intending to continue working at their current NHS organisation.

Morale score: 5.8	**All bank workers** n=17,702
Future intention sub-score:	**5.3**
% of bank workers considering a permanent contract at the organisation	**24.3%**
Only considering a permanent contract at this organisation	7.5%
Considering a permanent contract at this organisation **amongst other options**	16.8%
Considering staying on bank at this organisation, **but not considering a permanent contract**	64.4%
Considering staying in the NHS (either bank or permanent) but not at this organisation	4.3%
Only considering options outside the NHS (including agency)	7.0%

Table 26: Future intention sub-score and contributing questions – all bank workers

6.11.2 Work pressure

The 'Work pressure' sub-score stands at 5.7. This compares favourably with the equivalent sub-score in the core NSS results (5.0).[12]

Overall, 61.3% of bank workers indicate they have adequate materials, supplies and equipment to do their work. However, only 37.1% feel that when they are at work, there are enough staff for them to do their job properly. Just over half (54.7%) of bank workers claim they can meet all the conflicting demands on their time.

These proportions are somewhat higher than those reported for the same questions in the core NSS results. Most notably, 42.9% of substantive staff indicated they can meet all the conflicting demands on their time and just over a quarter of substantive staff (26.4%) stated there are enough staff at their organisation for them to do their job properly.

When comparing the responses to the 'Work pressure' questions given by those bank workers who could answer questions about the team they always/usually work in with the responses from those who often do not work in the same team, results for the latter group are considerably lower on all questions. Of most concern, only 28.0% of those bank workers who chose to respond about teams generally due to not having a regular team, say that there are enough staff for them to do their job properly and less than half (47.0%) say they are able meet all the conflicting demands on their time.

Morale score: 5.8	**All bank workers** n=17,702	**I will answer about the team I always/ usually work in** n=11,479	**I will answer about my general experience of teamwork** n=5,679
Work pressure sub-score:	**5.7**	**5.9**	**5.3**
I am able to meet all the conflicting demands on my time at work (Q5g)	54.7%	58.3%	47.0%
I have adequate materials, supplies and equipment to do my work (Q5h)	61.3%	63.9%	55.8%
When I am at work, there are enough staff for me to do my job properly (Q5i)	37.1%	41.5%	28.0%

Table 27: Work pressure sub-score and contributing questions – by all bank workers and team working

[12] Note there is a difference in the question wording for one Bank Survey question (Q5g) when compared with the equivalent question on the core NSS survey. Caution should therefore be used when comparing the results. However, the relevant question on each survey is measuring the same concept and so results are considered comparable for reporting purposes.

6.11.3 Stressors

The 'Stressors' sub-score (6.3) for bank workers recorded a score similar to that reported in the core NSS results (6.3).[13]

When comparing the overall sub-score with the sub-score for bank workers working in different roles, the sub-scores for ambulance operational staff (5.5) and nursing and healthcare assistants (5.8) are considerably below the Stressors overall sub-score, whereas the sub-score for the wider healthcare team (including clerical/administrative, corporate and maintenance staff) is above the average.

The results for questions that are used to calculate the sub-scores mostly reflect the same tendencies for these occupation groups when compared with the overall results (i.e. mostly lower for ambulance operational staff and nursing and healthcare assistants; mostly higher for the wider healthcare team). These patterns are similar to those seen in the core NSS results.

Morale score: 5.8	All bank workers	AHP / HS / S&T	Medical & Dental	Ambu-lance (opera-tional)	Reg Nurses & Midwives	Nursing & Health-care Assist-ants	Wider Health-care Team
	n=17,702	n= 2,458	n=1,219	n=422	n=4,258	n=3,849	n=3,501
Stressors sub-score:	**6.3**	**6.5**	**6.2**	**5.5**	**6.3**	**5.8**	**6.8**
Q5a - I always know what my work responsibilities are.	87.5%	89.3%	87.6%	83.4%	89.9%	86.3%	86.0%
Q5e - I am involved in deciding on changes introduced that affect my work.	31.4%	37.5%	33.9%	11.4%	32.7%	21.2%	35.4%
Q7a - I 'never' or 'rarely' have unrealistic time pressures.	33.2%	33.3%	23.5%	25.2%	24.3%	25.6%	51.8%
Q7b - I have a choice in deciding how to do my work.	43.5%	48.8%	39.4%	34.0%	44.9%	29.4%	55.5%
Q7c - Relationships at work are 'never' or 'rarely' strained.	53.9%	55.1%	57.3%	48.2%	50.9%	42.9%	66.3%
Q10a - I receive the respect I deserve from my colleagues at work.	77.5%	79.1%	81.1%	74.2%	81.4%	69.3%	80.9%
Q13a - My immediate manager(s) encourages me at work.	62.3%	67.3%	61.6%	43.6%	65.6%	50.9%	68.7%

Table 28: Stressors sub-score and contributing questions – by all bank workers and occupation group

[13] Note there is a difference in the question wording for one Bank Survey question (Q5e) when compared with the equivalent question on the national survey. Caution should therefore be used when comparing the results. However, the relevant question on each survey is measuring the same concept and so results are considered comparable for reporting purposes.

6.12 Contact with the bank team

Over half of bank workers (57.9%) find it easy to access their bank team for queries and questions, when it comes to query and question resolution just over half (54.2%) also feel they get can the required answers rapidly.

Contact with the bank team	All bank workers n=17,702
Team and information access:	
It is easy to get hold of the bank team if I have a query (Q29a)	57.9%
When I contact the bank team with a query, I can quickly get the answers I need (Q29b)	54.2%

Table 29: Contact with the bank team

6.13 Patient safety

Overall results indicate 29.5% of bank workers have seen any errors, near misses or incidents that could have hurt staff and/or patients/service users in the last month. This is a slightly lower proportion than the average reported in the core NSS results (33.5%).

A considerably higher proportion of bank workers working in Ambulance Trusts, however, have seen errors, near misses or incidents (35.3%); but a much lower proportion of bank workers from Acute Specialist Trusts (21.8%) and Community Trusts (22.1%) have observed these types of risks to staff and patient/service user safety.

Patient safety	All bank workers n=17,702	Acute and Acute & Comm-unity n=11,752	Acute Special-ist n=259	MH / LD and MH LD & Comm-unity n=4,311	Comm-unity n=992	Ambul-ance n=388
Errors, near misses and incidents						
Have seen errors, near misses, or incidents in the last month that could have hurt staff and/or patients/ service users (Q21)	29.5%	31.3%	21.8%	26.2%	22.1%	35.3%

Table 30: Errors, near misses and incidents – by all bank workers and trust type

When it comes to reporting of errors, near misses and incidents, bank workers mostly agree that their organisation encourages them to submit an incident report (82.3%). However, they are less likely to agree that their organisation treats those reporting such incidents fairly (51.9%) and that their organisation provides them with feedback about changes made in response to these types of incidents (56.3%). These proportions are generally below those reported in the core NSS results.

Patient safety	All bank workers n=17,702	Acute and Acute & Comm-unity n=11,752	Acute Special-ist n=259	MH / LD and MH LD & Comm-unity n=4,311	Comm-unity n=992	Ambul-ance n=388
Reporting of errors, near misses and incidents						
My organisation treats staff who are involved in an error, near misses or incident fairly (Q22a)	51.9%	51.6%	60.0%	52.6%	56.6%	37.2%
My organisation encourages us to report errors, near misses or incidents (Q22b)	82.3%	81.7%	85.7%	83.7%	84.9%	78.0%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (Q22c)	64.4%	63.8%	69.2%	66.3%	71.6%	42.3%
We are given feedback about changes made in response to reported errors, near misses and incidents (Q22d)	56.3%	55.7%	59.6%	58.7%	61.2%	33.8%

Table 31: Reporting of errors – by all bank workers and trust type

6.14 The Covid-19 pandemic

6.14.1 Changes to working life

Overall, 44.8% of bank workers reported having worked on a Covid-19 specific ward or area in the past 12 months, a considerably higher proportion than reported in the core NSS results for substantive staff (32.9%).

Around one in seven bank workers (14.7%) had been required to work remotely / from home in the past 12 months, which is well below the percentage of substantive staff who were required to do so according to the core NSS results (32.1%).

Bank workers are considerably more likely to have worked on a Covid-19 specific ward if they work in either an Acute and Acute & Community Trust (46.6%) or a Mental Health and Learning Disability or Combined Mental Health, Learning Disability and Community Trust (45.6%).

Overall, bank workers are considerably less likely than staff on substantive contracts to have been required to work remotely from home in the past 12 months due to the Covid-19 pandemic (14.7%). The proportion of substantive staff that have been required to do the same has been declining since 2021, but in comparison with bank workers, is still notably higher at 32.1%.

The Covid-19 pandemic	All bank workers	Acute and Acute & Community Trusts	Acute Specialist Trusts	MH & LD and MH, LD & CT	Community Trusts	Ambulance Trusts
	n=17,702	n=11,752	n=259	n=4,311	n=992	n=388
Changes to working life						
Have worked on a Covid-19 specific ward or area at any time in the past 12 months (Q30a)	44.9%	46.6%	29.3%	45.6%	32.1%	29.3%
Have been required to work remotely/from home due to the Covid-19 pandemic in the past 12 months (Q30b)	14.7%	11.0%	17.1%	23.1%	24.5%	9.1%

Table 32: Changes to working life due to the Covid-19 pandemic – by all bank workers and working Trusts

Note it is possible the results for those bank workers (and substantive staff) who have been required to work remotely/from home may be inflated because they include some staff who, whilst no longer strictly required to work remotely due to the Covid-19 pandemic, continue to do so because of changes to working practices at their organisation and staff continuing to adopt flexible working patterns following their successful adoption during the pandemic. A review of their occupation group/role may give an indication as to whether they are required or are enabled to work from home (see next section).

6.14.2 The Covid-19 pandemic in more detail

When comparing different occupation groups within all bank workers, nursing and healthcare assistants are the group most likely to have worked on a Covid-19 specific ward in the past 12 months (70.9%); a similar pattern is seen in the core NSS results for substantive staff, but not to the same extent (55.5%).

Other occupation groups are less likely to have worked on a Covid-19 specific ward or area in the past 12 months, particularly those working in ambulance operations (37.3%) and the wider healthcare team (22.5%).

Bank workers working in the Wider Healthcare Team are most likely to have been required to work remotely/from home due to the pandemic. As noted, a change in this group's working practices or the adoption of more flexible working patterns is likely to have inflated their results with a quarter indicating they have worked remotely/from home in the past 12 months. Whereas nursing and healthcare assistants and ambulance operational bank workers are more likely to be patient facing, and less likely to have been required to work from home during the pandemic.

The Covid-19 pandemic	All bank workers	AHP / HS / S&T	Medical & Dental	Ambu-lance (opera-tional)	Reg Nurses & Midwives	Nursing & Health-care Assist-ants	Wider Health-care Team
	n=17,702	n=2,458	n=1,219	n=422	n=4,258	n=3,849	n=3,501
Working remotely / from home							
Have worked on a Covid-19 specific ward or area at any time in the past 12 months (Q30a)	44.9%	41.4%	49.5%	37.3%	42.5%	70.9%	22.5%
Have been required to work remotely/from home due to the Covid-19 pandemic in the past 12 months (Q30b)	14.7%	16.1%	15.9%	5.5%	14.9%	3.0%	25.0%

Table 33: Working remotely from home – by all bank workers and occupation group

Further differences are apparent when reviewing the results for different ethnic groups. The proportion of bank workers who have worked on a Covid-19 specific ward area at any time in the past 12 months is much higher among staff from ethnic minority backgrounds (56.7%) compared to staff from white backgrounds (40.3%). Conversely, white staff are more likely to have worked remotely/from home due to the pandemic in the past 12 months (15.9%) compared to staff from all other ethnic groups combined (11.5%).

The Covid-19 pandemic	All bank workers n= 17,702	White bank workers n=12,583	Bank workers from all other ethnic groups combined n=4,878
Working remotely / from home			
Have worked on a Covid-19 specific ward or area at any time in the past 12 months (Q30a)	44.9%	40.3%	56.7%
Have been required to work remotely/from home due to the Covid-19 pandemic in the past 12 months (Q30b)	14.7%	15.9%	11.5%

Table 34: Working remotely from home – by all bank workers and ethnic group

Survey Coordination Centre

APPENDIX

Contractor data cleaning

Before submitting their data to the Survey Coordination Centre, contractors carry out data cleaning according to instructions in the contractor guidance. The cleaning process carried out by contractors is outlined below.

For most questions that require a single answer only, the data is treated as missing (i.e. left blank) if respondents have ticked more than one response option. There are a few exceptions to this general rule, as specified below.

For the occupational group question (q41), priority coding applies to multiple responses:

- Within the Registered Nurses and Midwives section, Midwives, Health Visitors or District/Community options are prioritised over Adult/General, Mental Health, Learning Disabilities and Children.
- Other types of multiple responses in the Registered Nurses and Midwives section are recoded as Other Registered Nurses.
- If General Management and another occupational group are ticked, the latter is prioritised.

For the questions on reporting physical violence (q17d) and reporting harassment, bullying and abuse (q18d), the following cleaning is applied to multiple responses:

1. If the respondent as ticked BOTH “Yes, I reported it” AND “Yes, a colleague reported it”, they are assigned a code 6, indicating “Reported both by self and a colleague”, regardless of what else they have ticked.
2. If the respondent has ticked either “Yes, I reported it” OR “Yes, a colleague reported it” and also “Don’t know” then the former two responses are prioritised.
3. If the respondent has ticked either “Yes, I reported it” OR “Yes, a colleague reported it” and also “Not applicable” then the former two responses are prioritised.
4. If the respondent has ticked either “Yes, I reported it” OR “Yes, a colleague reported it” and also “No” then this question is coded as missing (i.e. blank).
5. All other combinations of responses are coded as missing (i.e. blank).

Cleaning of the overall dataset

Data collected and cleaned by survey contractors (as outlined above) is submitted to the Survey Coordination Centre which carries out additional cleaning as described below.

Out of range responses (e.g. a value of ‘4’ for a question that only has 3 response options) are cleaned out for all questions.

For q20c, if a respondent has entered a free text comment for response option 7 (‘Other’) but did not tick the response box, this is set to ticked in cleaning.

There are also a number of filtered questions in the core questionnaire, ie questions which should not have been answered if a certain response is ticked on a preceding routing question. The Survey Coordination Centre applies a common set of editing instructions to clean these filtered questions, as detailed below:

- If the response to q15d is “No” or missing then q15e is set to missing.
- If the respondent did not select “1-2”, “3-5”, “6-10” or “More than 10” for q17a or q17b or q17c then their response to q17d is set to missing.
- If the respondent did not select “1-2”, “3-5”, “6-10” or “More than 10” for q18a or q18b or q18c then their response to q18d is set to missing.
- If the response to both q20a and q20b is 'No' or missing then q20c is set to missing.
- If the respondent did not select 'No' to q25a then their responses to q25b and q25c are set to missing.
- If respondent selects code 12 at q28 and also selects any code(s) from 1 to 11 then codes 1 to 11 are removed; if respondent selects code 11 and also selects any code(s) from 1 to 10 then code 11 is removed.
- If the response to q37a is 'No' or missing then q37b is set to missing.

Contributing questions

The questions contributing to each People Promise element and theme are shown in the table below, along with the sub-scores they feed into.

PP element 1: *We are compassionate and inclusive*

Compassionate culture

Q8a - “I feel that my role makes a difference to patients / service users.”
Q27a - “Care of patients / service users is my organisation's top priority.”
Q27b - “My organisation acts on concerns raised by patients / service users.”
Q27c - “I would recommend my organisation as a place to work."
Q27d - “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."

Compassionate leadership

Q13f - “My immediate manager(s) works together with me to come to an understanding of problems.”
Q13g - “My immediate manager(s) is interested in listening to me when I describe challenges I face."
Q13h - “My immediate manager(s) cares about my concerns."
Q13i - “My immediate manager(s) takes effective action to help me with any problems I face."

Diversity and equality

Q19 - “Does your organisation act fairly towards staff regardless of ethnic background, gender, religion, sexual orientation, disability or age, for example with regards to career progression or development opportunities?"
Q20a - “In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?"
Q20b - “In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?"
Q24 - “I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc)."

Inclusion

Q10f - “I feel valued by my team."
Q10g - “I feel a strong personal attachment to my team."
Q11b - “The people I work with are understanding and kind to one another."
Q11c - “The people I work with are polite and treat each other with respect."

PP element 2: *We are recognised and rewarded*

Q6a – “The recognition I get for good work."
Q6b – “The extent to which my organisation values my work.”
Q6c – “My level of pay.”
Q11d - “The people I work with show appreciation to one another.”
Q13e - “My immediate manager(s) values my work.”

PP element 3: *We each have a voice that counts*

Autonomy and control

Q5a - “I always know what my work responsibilities are.”
Q5b - “I am trusted to do my job.”
Q5c - “There are frequent opportunities for me to show initiative in my role.”
Q5d - “I am able to make suggestions to improve the work we do.”

Q5e - “I am involved in deciding on changes introduced that affect my work.”

Q5f – “I am able to make improvements happen at work.”

Q7b - “I have a choice in deciding how to do my work.”

Raising concerns

Q23a - “I would feel secure raising concerns about unsafe clinical practice.”

Q23b - “I am confident that my organisation would address my concern.”

Q27e - “I feel safe to speak up about anything that concerns me in this organisation.”

Q27f - “If I spoke up about something that concerned me I am confident my organisation would address my concern.”

PP element 4: *We are safe and healthy*

Health and safety climate

Q5g – “I am able to meet all the conflicting demands on my time at work.”

Q5h – “I have adequate materials, supplies and equipment to do my work.”

Q5i – “When I am at work, there are enough staff for me to do my job properly.”

Q7a – “I have unrealistic time pressures.”

Q15a – “My organisation takes positive action on health and well-being.”

Q17d – “The last time you experienced physical violence at work, did you or a colleague report it?”

Q18d – “The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?”

Burnout

Q16a – “How often, if at all, do you find your work emotionally exhausting?”

Q16b – “How often, if at all, do you feel burnt out because of your work?”

Q16c – “How often, if at all, does your work frustrate you?”

Q16d – “How often, if at all, are you exhausted at the thought of another day/shift at work?”

Q16e – “How often, if at all, do you feel worn out at the end of your working day/shift?”

Q16f – “How often, if at all, do you feel that every working hour is tiring for you?”

Q16g – “How often, if at all, do you not have enough energy for family and friends during leisure time?”

Negative experiences

Q15b – “In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?”

Q15c – “During the last 12 months have you felt unwell as a result of work related stress?”

Q15d – “In the last three months have you ever come to work despite not feeling well enough to perform your duties?”

Q17a – “In the last 12 months how many times have you personally experienced physical violence at work from...Patients / service users, their relatives or other members of the public?”

Q17b – “In the last 12 months how many times have you personally experienced physical violence at work from...Managers?”

Q17c – “In the last 12 months how many times have you personally experienced physical violence at work from...Other colleagues?”

Q18a – “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Patients / service users, their relatives or other members of the public?”

Q18b – “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Managers?”

Q18c – “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Other colleagues?”

PP element 5: *We are always learning*

Development

Q26a – "This organisation offers me challenging work."

Q26b – "There are opportunities for me to develop my career in this organisation."

Q26c – "I have opportunities to improve my knowledge and skills."

Q26d – "I feel supported to develop my potential."

Q26e – "I am able to access the right learning and development opportunities when I need to."

Appraisals

Q25a – "In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skill Framework (KSF development review)?"

PP element 6: *We work flexibly*

Support for work-life balance

Q8b – "My organisation is committed to helping me balance my work and home life."

Q8c – "I achieve a good balance between my work life and my home life."

PP element 7: *We are a team*

Team working

Q10a – "I receive the respect I deserve form my colleagues at work."

Q10b – "Team members understand each other's roles."

Q10c – "I enjoy working with the colleagues in my team."

Q10d – "My team has enough freedom in how to do its work."

Q10e – "In my team disagreements are dealt with constructively."

Q11a – "Teams within this organisation work well together to achieve their objectives."

Line management

Q13a – "My immediate manager(s) encourages me at work."

Q13b – "My immediate manager(s) gives me clear feedback on my work."

Q13c – "My immediate manager(s) asks for my opinion before making decisions that affect my work."

Q13d – "My immediate manager(s) takes a positive interest in my health and well-being."

Staff Engagement (theme)

Motivation

Q4a – "I look forward to going to work."

Q4b – "I am enthusiastic about my job."

Q4c – "Time passes Quickly when I am working."

Involvement

Q5c – "There are frequent opportunities for me to show initiative in my role."

Q5d – "I am able to make suggestions to improve the work we do."

Q5f – "I am able to make improvements happen at work."

Advocacy

Q27a – "Care of patients / service users is my organisation's top priority."

Q27c – "I would recommend my organisation as a place to work."

Q27d – "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."

Morale (theme)

Future intentions

Q28 – “In the next 12 months, which of the following are you planning to do or considering doing?”

Work pressure

Q5g – “I am able to meet all the conflicting demands on my time at work.”

Q5h – “I have adequate materials, supplies and equipment to do my work.”

Q5i – “When I am at work, there are enough staff for me to do my job properly.”

Stressors

Q5a – “I always know what my work responsibilities are.”

Q5e – “I am involved in deciding on changes introduced that affect my work.”

Q7a – “I have unrealistic time pressures.”

Q7b – “I have a choice in deciding how to do my work.”

Q7c – “Relationships at work are strained.”

Q10a – “I receive the respect I deserve from my colleagues at work.”

Q13a – “My immediate manager(s) encourages me at work.”

Calculation of summary indicators from the contributing questions

As mentioned earlier, responses for all questions contributing to the summary indicators are rescored to achieve a scale of 0-10. Table A below details the scores allocated to each response option. The scores are assigned based on outcome, so the most favourable response will be scored 10, while the least favourable will be scored 0. This means that scoring is different depending on how the question is phrased. For example a response of “Strongly agree” can either be the most positive result (for example in response to “*I feel valued by my team*”) or the least positive result (e.g. in response to “*I often think about leaving this organisation*”). Where a participant selects a response option which does not have a score assigned (labelled ‘ns‘), when reporting results they will not be included in the base size for that particular question, i.e. they are treated as if they had not answered the question.

Table A also details how the sub-scores, People Promise elements and themes are calculated from the question scores. Sub-scores are calculated where an individual has answered sufficient contributing questions. People Promise element and theme scores are calculated where sufficient sub-scores have been calculated for that individual.

Table A: Response scoring for People Promise elements, themes and sub-scores

People Promise Element / Theme	Sub-score	Q no.	Score for response option…					
			1	2	3	4	5	9
Element 1 ***We are compassionate and inclusive*** Calculated as the mean of the sub-scores where at least three of the four sub-scores have been assigned.	***Compassionate culture*** Calculated as the mean of the question scores where at least three of the five questions are answered.	Q8a	0	2.5	5	7.5	10	ns
		Q27a	0	2.5	5	7.5	10	
		Q27b	0	2.5	5	7.5	10	
		Q27c	0	2.5	5	7.5	10	
		Q27d	0	2.5	5	7.5	10	
	Compassionate leadership Calculated as the mean where at least three of the four questions are answered.	Q13f	0	2.5	5	7.5	10	
		Q13g	0	2.5	5	7.5	10	
		Q13h	0	2.5	5	7.5	10	
		Q13i	0	2.5	5	7.5	10	
	Diversity and equality Calculated as the mean where at least three of the four questions are answered.	Q24	0	2.5	5	7.5	10	
		Q19	10	0	5			
		Q20a	0	10				
		Q20b	0	10				
	Inclusion Calculated as the mean where at least three of the four questions are answered	Q10f	0	2.5	5	7.5	10	
		Q10g	0	2.5	5	7.5	10	
		Q11b	0	2.5	5	7.5	10	
		Q11c	0	2.5	5	7.5	10	
Element 2 ***We are recognised and rewarded*** Score calculated as a mean where at least three of the five questions are answered.	None	Q6a	0	2.5	5	7.5	10	
		Q6b	0	2.5	5	7.5	10	
		Q6c	0	2.5	5	7.5	10	
		Q11d	0	2.5	5	7.5	10	
		Q13e	0	2.5	5	7.5	10	

People Promise Element / Theme	Sub-score	Q no.	Score for response option…					
			1	2	3	4	5	9
Element 3 **We each have a voice that counts** Calculated as the mean of the sub-scores where both of the sub-scores have been assigned.	***Autonomy and control*** Calculated as the mean where at least five of the seven questions are answered	Q5a	0	2.5	5	7.5	10	
		Q5b	0	2.5	5	7.5	10	
		Q5c	0	2.5	5	7.5	10	
		Q5d	0	2.5	5	7.5	10	
		Q5e	0	2.5	5	7.5	10	
		Q5f	0	2.5	5	7.5	10	
		Q7b	0	2.5	5	7.5	10	
	Raising concerns Calculated as the mean where at least three of the four questions are answered	Q23a	0	2.5	5	7.5	10	
		Q23b	0	2.5	5	7.5	10	
		Q27e	0	2.5	5	7.5	10	
		Q27f	0	2.5	5	7.5	10	
Element 4 ***We are safe and healthy*** Calculated as the mean of the sub-scores where all of the sub-scores have been assigned.	***Health and safety climate*** Calculated as the mean across seven questions, but only scored where at least three of the first five questions are answered.	Q5g	0	2.5	5	7.5	10	
		Q5h	0	2.5	5	7.5	10	
		Q5i	0	2.5	5	7.5	10	
		Q15a	0	2.5	5	7.5	10	
		Q17d	10	10	0	ns		ns
		Q18d	10	10	0	ns		ns
		Q7a	10	7.5	5	2.5	0	
	Burnout Calculated as the mean where at least five of the seven questions are answered.	Q16a	10	7.5	5	2.5	0	
		Q16b	10	7.5	5	2.5	0	
		Q16c	10	7.5	5	2.5	0	
		Q16d	10	7.5	5	2.5	0	
		Q16e	10	7.5	5	2.5	0	
		Q16f	10	7.5	5	2.5	0	
		Q16g	10	7.5	5	2.5	0	
	Negative experiences Calculated as the mean where at least six of the nine questions are answered.	Q17a	10	0	0	0	0	
		Q17b	10	0	0	0	0	
		Q17c	10	0	0	0	0	
		Q18a	10	0	0	0	0	
		Q18b	10	0	0	0	0	
		Q18c	10	0	0	0	0	
		Q15b	0	10				
		Q15c	0	10				
		Q15d	0	10				

People Promise Element / Theme	Sub-score	Q no.	Score for response option…					
			1	2	3	4	5	9
Element 5 ***We are always learning*** Calculated as the mean of the sub-scores where both of the sub-scores have been assigned.	***Development*** Calculated as the mean where at least three of the five questions are answered.	Q26a	0	2.5	5	7.5	10	
		Q26b	0	2.5	5	7.5	10	
		Q26c	0	2.5	5	7.5	10	
		Q26d	0	2.5	5	7.5	10	
		Q26e	0	2.5	5	7.5	10	
	Appraisals Summary*	Q25a & Q25b	Q25a = 1 then score = 10 Q25a = 2 & Q25b = 2 then score = 10 Q25a = 2 & Q25b = 1 or 3 or 4 or missing then score = 0 Q25a = 3 or missing then no score					
Element 6 ***We work flexibly*** Calculated as the mean of both question scores.	***Support for work-life balance*** Calculated as the mean where at least both questions are answered.	Q8b	0	2.5	5	7.5	10	
		Q8c	0	2.5	5	7.5	10	
Element 7 ***We are a team*** Calculated as the mean of the sub-scores where both of the sub-scores have been assigned.	***Teamworking*** Calculated as the mean where at least five of the eight questions are answered.	Q10a	0	2.5	5	7.5	10	
		Q10b	0	2.5	5	7.5	10	
		Q10c	0	2.5	5	7.5	10	
		Q10d	0	2.5	5	7.5	10	
		Q10e	0	2.5	5	7.5	10	
		Q11a	0	2.5	5	7.5	10	
	Line management Calculated as the mean where at least three of the four questions are answered.	Q13a	0	2.5	5	7.5	10	
		Q13b	0	2.5	5	7.5	10	
		Q13c	0	2.5	5	7.5	10	
		Q13d	0	2.5	5	7.5	10	

People Promise Element / Theme	Sub-score	Q no.	Score for response option…					
			1	2	3	4	5	9
Theme ***Staff engagement*** Calculated as the mean of the sub-scores where at least two of the three sub-scores have been assigned.	***Motivation*** Calculated as the mean where at least two of the three questions are answered.	Q4a	0	2.5	5	7.5	10	
		Q4b	0	2.5	5	7.5	10	
		Q4c	0	2.5	5	7.5	10	
	Involvement Calculated as the mean where at least two of the three questions are answered.	Q5c	0	2.5	5	7.5	10	
		Q5d	0	2.5	5	7.5	10	
		Q5f	0	2.5	5	7.5	10	
	Advocacy Calculated as the mean where at least two of the three questions are answered.	Q27a	0	2.5	5	7.5	10	
		Q27c	0	2.5	5	7.5	10	
		Q27d	0	2.5	5	7.5	10	
Theme ***Morale**** Calculated as the mean of the sub-scores where at least two of the three sub-scores have been assigned.	***Future Intentions Summary****	Q28	Option 3 (only) then score = 10 Option 3 and (option 1, 2 or 4 or options 5 to 10) then score = 7.5 Option 1 and not option 3 then score = 5 Option 2 or 4 and not option 1 or 3 then score = 2.5 Options 5 to 10 and not options 1 to 4 then score = 0 Options 11 or 12 or missing then no score					
	Work pressure Calculated as the mean where at least two of the three questions are answered.	Q5g	0	2.5	5	7.5	10	
		Q5h	0	2.5	5	7.5	10	
		Q5i	0	2.5	5	7.5	10	
	Stressors Calculated as the mean where at least five of the seven questions are answered.	Q5a	0	2.5	5	7.5	10	
		Q5e	0	2.5	5	7.5	10	
		Q7a	10	7.5	5	2.5	0	
		Q7b	0	2.5	5	7.5	10	
		Q7c	10	7.5	5	2.5	0	
		Q10a	0	2.5	5	7.5	10	
		Q13a	0	2.5	5	7.5	10	

* NSS Bank sub-scores are calculated differently when compared with the calculations for same questions on Core NSS.

Appraisals Summary Score Calculation

q25a-b included in sub-score calculations as an alternative to q21a-d included in core NSS results in order to measure appraisals.

q25a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? (question type: single response)

Response option 1	Yes
Response option 2	No
Response option 3	Can't remember
Missing	Not stated / blank

q25b (IF NOT) Why not? (question type: single response)

Response option 1	Bank only workers in my role are not offered an appraisal
Response option 2	As a bank only worker I will be offered an appraisal, but I have not been in my role long enough yet
Response option 3	Other reasons
Response option 4	Don't know
Missing	Not stated / blank

	Scoring Category	Score
Had an appraisal	q25a=1	10
Not had an appraisal but expect to be offered one	q25a=2 & q25b=2	10
Not had an appraisal (not offered / other reason / don't know why / not stated)	q25a=2 & q25b=(1 or 3 or 4 or missing)	0
Can't remember / not stated	q25a=3 or missing	no score

Future Intentions Score Calculation

q28 included in subscore calculations as an alternative to q24a-c included in core NSS results in order to measure intention to leave.

q28 In the next 12 months, which of the following are you planning to do or considering doing? (question type: multiple response)

Response option 1	Continuing to work on the bank at this organisation
Response option 2	Continuing to do NHS bank work but not at this organisation
Response option 3	Moving to a permanent contract at this organisation
Response option 4	Moving to a permanent contract at another NHS organisation
Response option 5	Working in the NHS but paid by an external agency
Response option 6	Moving to a job in healthcare, but outside the NHS
Response option 7	Moving to a job outside healthcare
Response option 8	Taking a career break
Response option 9	Retiring
Response option 10	Going into full time training or studying
Response option 11	Don't know
Response option 12	Prefer not to say

SCORING CATEGORIES

A. Move to permanent contract at this organisation (option 3)
B. Stay on bank at this organisation (option 1)
C. Stay in NHS not at this organisation (option 2 or 4)
D. Do something else (including agency) (options 5 to 10)
E. Don't know / prefer not to say (option 11 or 12)

	Scoring Category	Score
Only considering a permanent contract at this organisation	A only	10
Considering a permanent contract at this organisation amongst other options	A and (B, C or D)	7.5
Considering staying on bank at this organisation, but not considering a permanent contract	B and not A	5
Considering staying in the NHS (either bank or permanent) but not at this organisation	C and not A or B	2.5
Only considering options outside NHS (including agency)	D and not A,B or C	0
Not stated	E or missing	no score

Question level results

The reporting outputs contain question level results for each question included in the questionnaire. However, in much of the reporting question level results are reported as a single percentage. While the meaning of the percentage reported for a given question is specified in the report, a more detailed explanation of how the reported percentage is calculated for each question is provided in the table below.

Question number	Calculation of results reported	Values reported (Response code in questionnaire)
Q1	% of staff selecting 'Often'/'Always' out of those who answered the question	4 & 5
Q2	% of staff selecting 'Yes, frequently' / 'Yes, occasionally' out of those who answered the question	1 & 2
Q3	% of staff that have contact with patients / service users out of those who answered the question	1 & 2
Q4a-c	% of staff selecting 'Often'/'Always' out of those who answered the question	4 & 5
Q5a-i	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q6a-c	% of staff selecting 'Satisfied'/'Very Satisfied' out of those who answered the question	4 & 5
Q7a	% of staff selecting 'Never'/'Rarely' out of those who answered the question	1 & 2
Q7b	% of staff selecting 'Often'/'Always' out of those who answered the question	4 & 5
Q7c	% of staff selecting 'Never'/'Rarely' out of those who answered the question	1 & 2
Q8a	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question, but excluding those who selected 'Not applicable to me'	4 & 5
Q8b-c	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q9	% of staff selecting 'Yes' out of those who answered the question	1
Q10a-g	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q11a-d	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q12	% of staff selecting 'Yes' out of those who answered the question	1
Q13a-i	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q14	% of staff working part-time out of those who answered the question	1 & 2
Q15a	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q15b-e*	% of staff selecting 'Yes' out of those who answered the question	1

Question number	Calculation of results reported	Values reported (Response code in questionnaire)
Q16a-g*	% of staff selecting 'Often'/'Always' out of those who answered the question	4 & 5
Q17a-c*	% of staff saying they experienced at least one incident of violence out of those who answered the question	2 to 5
Q17d	% of staff saying they, or a colleague, reported it, out of those who answered the question excluding those who selected 'DK' or 'NA'	1, 2 & 6**
Q18a-c*	% of staff saying they experienced at least one incident of bullying, harassment or abuse out of those who answered the question	2 to 5
Q18d	% of staff saying they, or a colleague, reported it, out of those who answered the question excluding those who selected 'DK' or 'NA'	1, 2 & 6**
Q19	% of staff selecting 'Yes' out of those who answered the question	1
Q20a-b*	% of staff selecting 'Yes' out of those who answered the question	1
Q20c*	% of staff saying they have experienced discrimination on each basis out of those who answered the question	1 to 7
Q21*	% of staff saying they have seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users in the last month	1
Q22a-d	% of staff selecting 'Agree/Strongly Agree' out of those who answered the question excluding those who selected 'Don't know'	4 & 5
Q23a-b	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q24	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q25a	% of staff selecting 'Yes' out of those who answered the question	1
Q25b	% of staff selecting those who answered the question (codes 1 to 3) excluding those who selected 'DK'	1 to 3
Q25c	% of staff selecting 'Yes' out of those who answered the question excluding those who selected 'DK'	1
Q26a-e	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q27a-f	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q28	% of staff saying this would be their most likely future intention out of those who answered the question excluding 'DK' or 'Prefer not to say'	1 to 10
Q29a	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q29b	% of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question	4 & 5
Q30a-b	% of staff selecting 'Yes' out of those who answered the question	1

Question number	Calculation of results reported	Values reported (Response code in questionnaire)
Q31	% of staff selecting each response option out of those who answered the question	each code
Q32	% of staff selecting each response option out of those who answered the question	each code
Q33	% of staff selecting each response option out of those who answered the question	each code
Q34	% of staff selecting a response falling into each of the following categories, out of those who answered the question Categories: White background Mixed/Multiple ethnic background Asian/Asian British Black/African/Caribbean/Black British Other ethnic group	White background: 1 to 4 Mixed/Multiple ethnic background: 5 to 8 Asian/Asian British: 9 to 13 Black/African/Caribbean/Black British: 14 to 16 Other ethnic group: 17 & 18
Q35	% of staff selecting each response option out of those who answered the question	each code
Q36	% of staff selecting each response option out of those who answered the question	each code
Q37a	% of staff selecting 'Yes' out of those who answered the question	1
Q37b	% of staff selecting 'Yes' out of those who answered the question excluding those who select 'No adjustment required'	1
Q38a-b	% of staff selecting 'Yes' out of those who answered the question	1
Q39a-b	% of staff selecting each response option out of those who answered the question	each code
Q40	% of staff selecting each response option out of those who answered the question	each code
Q41	% of staff selecting a response falling into each of the following categories, out of those who answered the question Categories: Registered nurses & midwives Nursing or healthcare assistants Medical or dental Allied health professionals (AHP) Scientific and technical Social care Public health Commissioning Admin and clerical Central functions Maintenance General management Other Emergency care practitioner Paramedic Emergency care assistant (ECA) Ambulance technician	Registered Nurses & Midwives: 24 to 31 Nursing Ass. or HCA: 32 Medical or dental: 12 to 15 AHP: 1 to 3 & 5 to 9 Sci. & technical: 4 & 10 to 11 Social care: 33 to 35 Public health: 22 Commissioning: 23 Admin & clerical: 36 Central functions:37 Maintenance: 38 General management: 39 Other: 40 Emergency care pract.: 16 Paramedic: 17 ECA: 18 Ambulance technician: 19

Question number	Calculation of results reported	Values reported (Response code in questionnaire)
	Ambulance control staff Patient transport service (PTS)	Ambulance control: 20 PTS: 21

* Question numbers marked with one asterisk are reverse scored, i.e. a lower percentage indicates a better result.
** See section on Contractor Data cleaning for how responses are cleaned/coded for these questions.

Questionnaire differences

A full list of differences and similarities between the tailored version of the questionnaire and the core NSS questionnaire can be found in table 3.

Questionnaire differences *- Core NSS Survey v NSS Bank Survey*

Core NSS	NSS Bank	2022 question wording	Same question?
	Q1	Thinking about the bank work you do within this organisation, how often do you work in the same department or work area?	**NSS Bank only question**
	Q2	Do you work the same hours / shift pattern each week?	**NSS Bank only question**
Q1	**Q3**	Do you have face-to-face, video or telephone contact with patients / service users as part of your job?	**Same question wording and response options**
Q2a	**Q4a**	I look forward to going to work.	**Same question wording and response options**
Q2b	**Q4b**	I am enthusiastic about my job.	**Same question wording and response options**
Q2c	**Q4c**	Time passes Quickly when I am working.	**Same question wording and response options**
Q3a	**Q5a**	I always know what my work responsibilities are.	**Same question wording and response options**
Q3b	**Q5b**	I am trusted to do my job.	**Same question wording and response options**

Core NSS	NSS Bank	2022 question wording	Same question?
Q3c	**Q5c**	There are frequent opportunities for me to show initiative in my role.	**Same question wording and response options**
Q3d	**Q5d**	I am able to make suggestions to improve the work we do.	**Altered question wording; same response options**
Q3e	**Q5e**	I am involved in deciding on changes introduced that affect my work.	**Altered question wording; same response options**
Q3f	**Q5f**	I am able to make improvements happen at work.	**Altered question wording; same response options**
Q3g	**Q5g**	I am able to meet all the conflicting demands on my time at work.	**Same question wording and response options**
Q3h	**Q5h**	I have adequate materials, supplies and equipment to do my work.	**Same question wording and response options**
Q3i	**Q5i**	When I am at work, there are enough staff for me to do my job properly.	**Altered question wording; same response options**
Q4a	**Q6a**	The recognition I get for good work.	**Same question wording and response option**
Q4b	**Q6b**	The extent to which my organisation values my work.	**Same question wording and response option**
Q4c	**Q6c**	My level of pay.	**Same question wording and response option**
Q5a	**Q7a**	I have unrealistic time pressures.	**Same question wording and response option**
Q5b	**Q7b**	I have a choice in deciding how to do my work.	**Same question wording and response option**
Q5c	**Q7c**	Relationships at work are strained.	**Same question wording and response option**
Q6a	**Q8a**	I feel that my role makes a difference to patients / service users.	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
Q6b	**Q8b**	My organisation is committed to helping me balance my work and home life.	**Same question wording and response option**
Q6c	**Q8c**	I achieve a good balance between my work life and my home life.	**Same question wording and response option**
	Q9	How would you like to answer these questions about your experience of teamwork at this organisation.	**NSS Bank only question**
Q7c	**Q10a**	I receive the respect I deserve from my colleagues at work.	**Same question wording and response option**
Q7d	**Q10b**	Team members understand each other's roles.	**Same question wording and response option**
Q7e	**Q10c**	I enjoy working with the colleagues in my team.	**Same question wording and response option**
Q7f	**Q10d**	My team has enough freedom in how to do its work.	**Same question wording and response option**
Q7g	**Q10e**	In my team disagreements are dealt with constructively.	**Same question wording and response option**
Q7h	**Q10f**	I feel valued by my team.	**Same question wording and response option**
Q7i	**Q10g**	I feel a strong personal attachment to my team.	**Same question wording and response option**
Q8a	**Q11a**	Teams within this organisation work well together to achieve their objectives.	**Same question wording and response option**
Q8b	**Q11b**	The people I work with are understanding and kind to one another.	**Same question wording and response option**
Q8c	**Q11c**	The people I work with are polite and treat each other with respect.	**Same question wording and response option**
Q8d	**Q11d**	The people I work with show appreciation to one another.	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
	Q12	How would you like to answer these questions about your immediate manager.	**NSS Bank only question**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
Q8d	Q11d	The people I work with show appreciation to one another.	**Same question wording and response option**
	Q14	On average, how many hours per week do you usually undertake for bank in this organisation?	**NSS Bank only question**
Q11a	**Q15a**	My organisation takes positive action on health and well-being.	**Same question wording and response option**
Q11b	**Q15b**	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	**Same question wording and response option**
Q11c	**Q15c**	During the last 12 months have you felt unwell as a result of work related stress?	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
Q11d	**Q15d**	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	**Same question wording and response option**
Q11e	**Q15e**	Have you felt pressure from the organisation to come to work?	**Altered question wording; same response options**
Q12a	**Q16a**	How often, if at all, do you find your work emotionally exhausting?	**Same question wording and response option**
Q12b	**Q16b**	How often, if at all, do you feel burnt out because of your work?	**Same question wording and response option**
Q12c	**Q16c**	How often, if at all, does your work frustrate you?	**Same question wording and response option**
Q12d	**Q16d**	How often, if at all, are you exhausted at the thought of another day/shift at work?	**Same question wording and response option**
Q12e	**Q16e**	How often, if at all, do you feel worn out at the end of your working day/shift?	**Same question wording and response option**
Q12f	**Q16f**	How often, if at all, do you feel that every working hour is tiring for you?	**Same question wording and response option**
Q12g	**Q16g**	How often, if at all, do you not have enough energy for family and friends during leisure time?	**Same question wording and response option**
Q13a	**Q17a**	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	**Same question wording and response option**
Q13b	**Q17b**	In the last 12 months how many times have you personally experienced physical violence at work from managers?	**Same question wording and response option**
Q13c	**Q17c**	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	**Same question wording and response option**
Q13d	**Q17d**	The last time you experienced physical violence at work, did you or a colleague report it?	**Same question wording and response option**
Q14a	**Q18a**	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
		patients / service users, their relatives or other members of the public?	
Q14b	**Q18b**	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	**Same question wording and response option**
Q14c	**Q18c**	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	**Same question wording and response option**
Q14d	**Q18d**	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	**Same question wording and response option**
Q15	**Q19**	Does your organisation act fairly towards staff regardless of ethnic background, gender, religion, sexual orientation, disability or age, for example with regards to career progression or development opportunities?	**Altered question wording; same response options**
Q16a	**Q20a**	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	**Same question wording and response option**
Q16b	**Q20b**	In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	**Same question wording and response option**
Q16c	**Q20c**	On what grounds have you experienced discrimination?	**Same question wording and response option**
Q17	**Q21**	In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	**Same question wording and response option**
Q18a	**Q22a**	My organisation treats staff who are involved in an error, near miss or incident fairly.	**Same question wording and response option**
Q18b	**Q22b**	My organisation encourages us to report errors, near misses or incidents.	**Same question wording and response option**
Q18c	**Q22c**	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	**Same question wording and response option**
Q18d	**Q22d**	We are given feedback about changes made in response to reported errors, near misses and incidents.	**Same question wording and response option**
Q19a	**Q23a**	I would feel secure raising concerns about unsafe clinical practice.	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
Q19b	**Q23b**	I am confident that my organisation would address my concern.	**Same question wording and response option**
Q20	**Q24**	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	**Same question wording and response option**
Q21a	**Q25a**	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	**Same question wording and response option**
	Q25b	If no, why not?	**NSS Bank only question**
	Q25c	Would an appraisal help you to do your job better?	**NSS Bank only question**
Q22a	**Q26a**	This organisation offers me challenging work.	**Same question wording and response option**
Q22b	**Q26b**	There are opportunities for me to develop my career in this organisation.	**Same question wording and response option**
Q22c	**Q26c**	I have opportunities to improve my knowledge and skills.	**Same question wording and response option**
Q22d	**Q26d**	I feel supported to develop my potential.	**Same question wording and response option**
Q22e	**Q26e**	I am able to access the right learning and development opportunities when I need to.	**Same question wording and response option**
Q23a	**Q27a**	Care of patients / service users is my organisation's top priority.	**Same question wording and response option**
Q23b	**Q27b**	My organisation acts on concerns raised by patients / service users.	**Same question wording and response option**
Q23c	**Q27c**	I would recommend my organisation as a place to work.	**Same question wording and response option**
Q23d	**Q27d**	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
Q23e	**Q27e**	I feel safe to speak up about anything that concerns me in this organisation.	**Same question wording and response option**
Q23f	**Q27f**	If I spoke up about something that concerned me I am confident my organisation would address my concern	**Same question wording and response option**
	Q28	In the next 12 months, which of the following are you planning to do or considering doing?	**NSS Bank only question**
	Q29a	It is easy to get hold of the bank team if I have a Query	**NSS Bank only question**
	Q29b	When I contact the bank team with a Query, I can Quickly get the answers I need	**NSS Bank only question**
Q25a	**Q30a**	In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?	**Same question wording and response option**
Q25c	**Q30b**	In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?	**Same question wording and response option**
Q26a	**Q31**	What of the following best describes you?	**Same question wording and response option**
Q26b	**Q32**	Is your gender identity the same as the sex you were registered at birth?	**Same question wording and response option**
Q26c	**Q33**	Age	**Same question wording and response option**
Q27	**Q34**	What is your ethnic group? (Choose one option that best describes your ethnic group or background)	**Same question wording and response option**
Q28	**Q35**	Which of the following best describes how you think of yourself?	**Same question wording and response option**
Q29	**Q36**	What is your religion? Are you...	**Same question wording and response option**
Q30a	**Q37a**	Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?	**Same question wording and response option**
Q30b	**Q37b**	Has your employer made reasonable adjustment(s) to enable you to carry out your work?	**Same question wording and response option**

Core NSS	NSS Bank	2022 question wording	Same question?
Q31a	**Q38a**	Do you have any children aged from 0 to 17 living at home with you, or who you have regular caring responsibility for?	**Same question wording and response option**
Q31b	**Q38b**	Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age?	**Same question wording and response option**
Q32a	**Q39a**	How many years have you worked for this organisation?	**Altered question wording; same response options**
Q32b	**Q39b**	When you joined this organisation, were you recruited from outside of the UK?	**Altered question wording; same response options**
	Q40	Is bank work in the NHS your main source of paid work?	**NSS Bank only question**
Q33	**Q41**	What is your occupational group?	**Same question wording and response option**
	42	What does this organisation do well to support bank workers?	**NSS Bank only question**
	43	What could this organisation do better to support bank workers?	**NSS Bank only question**

National NHS Bank Staff Survey 2022

Essex Partnership University NHS Foundation Trust

Initial Detailed Table of Results

IQVIA

Survey Results

This report sets out the initial results for the 2022 NHS National Bank Staff Survey. The National Bank Staff Survey was undertaken by IQVIA between September and November 2022 for 72 organisations.

The overall response rate for your Substantive staff is 42.1%. The response rate for your Bank staff is 23.1%, 388 responses from a usable sample of 1,678.

1. Reading the columns of figures

Results for each question are presented firstly as response breakdowns in the form of absolute numbers and percentage responses. The first two columns show your Bank survey results and the final two columns show the results for your Substantive staff. The purpose of presenting the figures in this way is to give a direct, at-a-glance, comparison between your Bank survey results and your Substantive survey results.

1.1. Conventions

Percentage responses are calculated after excluding those respondents that did not answer that particular question. All percentages are rounded to one decimal place. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

The number of respondents that did not answer a particular question is shown as the "Missing" figure at the bottom of the actual number of responses. In some cases, the "Missing" figure is quite high, because it includes respondents who did not answer that question, or group of questions, because it was not applicable to their circumstances.

On some questions there are also some figures which are italicised. These figures have been recalculated to exclude responses where the respondent has provided a non-specific response or where the question was not applicable to the respondent's circumstances. For example, questions such as Q25a ("In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?") where the "Can't remember" response and those not answering (“Missing”), are excluded.

Survey Results

2. Reading the scores

For each evaluative question, scores are presented beneath the response breakdowns. The positive and negative scores for a question are shown in the green and red bands respectively. The 'base size', or number of participants contributing to the scores, is shown in the grey band at the bottom. Scores are shown for your Bank staff and your Substantive staff.

The responses that contribute to a given score are indicated by the colour coding to the left of the response. Responses that contribute to the positive scores are colour coded green, and responses that contribute to the negative scores are colour coded red. As an illustration, if 45.2% were to respond "Often" and 24.1% were to respond "Always" to question 4a ("I look forward to going to work."), the question would receive a positive score of 69.3%. If 2.7% were to respond "Never" and 5.2% were to respond "Rarely" to the same question, a negative score of 7.9% would be arrived at.

Please keep in mind that percentage responses are shown to one decimal place. As such, they may not always equal the score when summed together.

3. Data cleaning

Data cleaning is undertaken on the raw survey data to ensure that incorrect or inappropriate responses are removed from certain questions. Data cleaning has been applied where there is routing (i.e. where respondents are directed to a subsequent question depending on their answer to the lead question). Sometimes there are conflicts in the answers that respondents give to these questions and the data is corrected to account for this. For example, respondents not answering or answering "No" to Q15d ("In the last three months have you ever come to work despite not feeling well enough to perform your duties?") are directed to go to Q16. If a respondent does not answer or answers "No" to Q15d and also answers Q15e about pressure from the organisation to come to work when unwell, then their response to Q15d will be deleted.

YOUR JOB

1. Thinking about the bank work you do within this organisation, how often do you work in the same department or work area?

	Bank		Substantive	
Never	5	1.3%	-	-
Rarely	21	5.4%	-	-
Sometimes	62	16.0%	-	-
Often	140	36.1%	-	-
Always	160	41.2%	-	-
Missing	0		-	

2. Do you work the same hours / shift pattern each week?

	Bank		Substantive	
Yes – I always work the same hours / shift pattern each week	47	12.2%	-	-
Yes – I usually work the same hours / shift pattern each week	129	33.4%	-	-
No	210	54.4%	-	-
Missing	2		-	

3. Do you have face-to-face, video or telephone contact with patients / service users as part of your job?

	Bank		Substantive	
Yes, frequently	258	67.2%	1,746	68.9%
Yes, occasionally	33	8.6%	317	12.5%
No	93	24.2%	470	18.6%
Missing	4		14	

YOUR JOB (CONTINUED)

For each of the statements below, how often do you feel this way about your job?

4a. I look forward to going to work.

	Bank		Substantive	
Never	6	1.6%	64	2.6%
Rarely	17	4.5%	198	7.9%
Sometimes	97	25.5%	786	31.3%
Often	129	33.9%	1,004	40.0%
Always	131	34.5%	457	18.2%
Missing	8		38	
Positive Score	**68.4%**		**58.2%**	
Negative Score	**6.1%**		**10.4%**	
Base	**380**		**2,509**	

4b. I am enthusiastic about my job.

	Bank		Substantive	
Never	3	0.8%	25	1.0%
Rarely	9	2.4%	111	4.4%
Sometimes	85	23.0%	553	22.1%
Often	97	26.3%	1,014	40.6%
Always	175	47.4%	796	31.9%
Missing	19		48	
Positive Score	**73.7%**		**72.4%**	
Negative Score	**3.3%**		**5.4%**	
Base	**369**		**2,499**	

YOUR JOB (CONTINUED)

4c. Time passes quickly when I am working.

	Bank		Substantive	
Never	7	1.9%	34	1.4%
Rarely	21	5.7%	92	3.7%
Sometimes	112	30.3%	537	21.4%
Often	111	30.0%	849	33.9%
Always	119	32.2%	994	39.7%
Missing	18		41	
Positive Score	**62.2%**		**73.5%**	
Negative Score	**7.6%**		**5.0%**	
Base	**370**		**2,506**	

To what extent do you agree or disagree with the following statements about your work?

5a. I always know what my work responsibilities are.

	Bank		Substantive	
Strongly disagree	6	1.6%	38	1.5%
Disagree	8	2.1%	128	5.0%
Neither agree nor disagree	30	7.8%	203	8.0%
Agree	172	44.6%	1,263	49.8%
Strongly agree	170	44.0%	905	35.7%
Missing	2		10	
Positive Score	**88.6%**		**85.5%**	
Negative Score	**3.6%**		**6.5%**	
Base	**386**		**2,537**	

YOUR JOB (CONTINUED)

5b. I am trusted to do my job.

	Bank		Substantive	
Strongly disagree	6	1.6%	23	0.9%
Disagree	4	1.0%	60	2.4%
Neither agree nor disagree	22	5.7%	130	5.1%
Agree	148	38.3%	1,034	40.8%
Strongly agree	206	53.4%	1,290	50.8%
Missing	2		10	
Positive Score	**91.7%**		**91.6%**	
Negative Score	**2.6%**		**3.3%**	
Base	**386**		**2,537**	

5c. There are frequent opportunities for me to show initiative in my role.

	Bank		Substantive	
Strongly disagree	7	1.8%	48	1.9%
Disagree	31	8.1%	157	6.2%
Neither agree nor disagree	101	26.2%	403	15.9%
Agree	160	41.6%	1,110	43.9%
Strongly agree	86	22.3%	811	32.1%
Missing	3		18	
Positive Score	**63.9%**		**76.0%**	
Negative Score	**9.9%**		**8.1%**	
Base	**385**		**2,529**	

YOUR JOB (CONTINUED)

5d. I am able to make suggestions to improve the work we do.

	Bank		Substantive	
Strongly disagree	10	2.6%	54	2.1%
Disagree	48	12.5%	189	7.5%
Neither agree nor disagree	100	26.0%	388	15.3%
Agree	144	37.4%	1,151	45.5%
Strongly agree	83	21.6%	750	29.6%
Missing	3		15	
Positive Score	**59.0%**		**75.1%**	
Negative Score	**15.1%**		**9.6%**	
Base	**385**		**2,532**	

5e. I am involved in deciding on changes introduced that affect my work.

	Bank		Substantive	
Strongly disagree	32	8.4%	168	6.6%
Disagree	117	30.5%	420	16.6%
Neither agree nor disagree	113	29.5%	607	24.0%
Agree	79	20.6%	859	34.0%
Strongly agree	42	11.0%	475	18.8%
Missing	5		18	
Positive Score	**31.6%**		**52.7%**	
Negative Score	**38.9%**		**23.3%**	
Base	**383**		**2,529**	

YOUR JOB (CONTINUED)

5f. I am able to make improvements happen at work.

	Bank		Substantive	
Strongly disagree	20	5.2%	112	4.4%
Disagree	76	19.9%	288	11.4%
Neither agree nor disagree	121	31.7%	616	24.4%
Agree	118	30.9%	1,027	40.7%
Strongly agree	47	12.3%	478	19.0%
Missing	6		26	
Positive Score	**43.2%**		**59.7%**	
Negative Score	**25.1%**		**15.9%**	
Base	**382**		**2,521**	

5g. I am able to meet all the conflicting demands on my time at work.

	Bank		Substantive	
Strongly disagree	12	3.2%	194	7.7%
Disagree	41	10.8%	506	20.1%
Neither agree nor disagree	88	23.2%	582	23.1%
Agree	172	45.3%	984	39.0%
Strongly agree	67	17.6%	255	10.1%
Missing	8		26	
Positive Score	**62.9%**		**49.1%**	
Negative Score	**13.9%**		**27.8%**	
Base	**380**		**2,521**	

YOUR JOB (CONTINUED)

5h. I have adequate materials, supplies and equipment to do my work.

	Bank		Substantive	
Strongly disagree	10	2.6%	123	4.9%
Disagree	32	8.4%	312	12.4%
Neither agree nor disagree	66	17.2%	420	16.6%
Agree	173	45.2%	1,178	46.7%
Strongly agree	102	26.6%	492	19.5%
Missing	5		22	
Positive Score	**71.8%**		**66.1%**	
Negative Score	**11.0%**		**17.2%**	
Base	**383**		**2,525**	

5i. When I am at work, there are enough staff for me to do my job properly.

	Bank		Substantive	
Strongly disagree	36	9.3%	517	20.4%
Disagree	66	17.1%	714	28.2%
Neither agree nor disagree	99	25.6%	536	21.2%
Agree	123	31.9%	574	22.7%
Strongly agree	62	16.1%	192	7.6%
Missing	2		14	
Positive Score	**47.9%**		**30.2%**	
Negative Score	**26.4%**		**48.6%**	
Base	**386**		**2,533**	

YOUR JOB (CONTINUED)

How satisfied are you with each of the following aspects of your job?

6a. The recognition I get for good work.

	Bank		Substantive	
Very dissatisfied	20	5.2%	137	5.4%
Dissatisfied	45	11.7%	288	11.4%
Neither satisfied nor dissatisfied	91	23.6%	528	20.9%
Satisfied	159	41.3%	1,116	44.1%
Very satisfied	70	18.2%	461	18.2%
Missing	3		17	
Positive Score	**59.5%**		**62.3%**	
Negative Score	**16.9%**		**16.8%**	
Base	**385**		**2,530**	

6b. The extent to which my organisation values my work.

	Bank		Substantive	
Very dissatisfied	22	5.7%	190	7.5%
Dissatisfied	51	13.2%	368	14.6%
Neither satisfied nor dissatisfied	116	30.1%	703	27.8%
Satisfied	149	38.7%	949	37.6%
Very satisfied	47	12.2%	317	12.5%
Missing	3		20	
Positive Score	**50.9%**		**50.1%**	
Negative Score	**19.0%**		**22.1%**	
Base	**385**		**2,527**	

YOUR JOB (CONTINUED)

6c. My level of pay.

	Bank		Substantive	
Very dissatisfied	60	15.6%	500	19.8%
Dissatisfied	98	25.5%	758	30.0%
Neither satisfied nor dissatisfied	118	30.6%	593	23.5%
Satisfied	88	22.9%	576	22.8%
Very satisfied	21	5.5%	101	4.0%
Missing	3		19	
Positive Score	**28.3%**		**26.8%**	
Negative Score	**41.0%**		**49.8%**	
Base	**385**		**2,528**	

For each of the statements below, how often, if at all, do these statements apply to you?

7a. I have unrealistic time pressures.

	Bank		Substantive	
Never	45	11.9%	164	6.5%
Rarely	115	30.3%	577	22.7%
Sometimes	164	43.3%	1,109	43.7%
Often	38	10.0%	502	19.8%
Always	17	4.5%	187	7.4%
Missing	9		8	
Positive Score	**42.2%**		**29.2%**	
Negative Score	**14.5%**		**27.1%**	
Base	**379**		**2,539**	

YOUR JOB (CONTINUED)

7b. I have a choice in deciding how to do my work.

	Bank		Substantive	
Never	60	15.6%	84	3.3%
Rarely	91	23.7%	224	8.8%
Sometimes	108	28.1%	640	25.3%
Often	91	23.7%	1,049	41.4%
Always	34	8.9%	536	21.2%
Missing	4		14	
Positive Score	**32.6%**		**62.6%**	
Negative Score	**39.3%**		**12.2%**	
Base	**384**		**2,533**	

7c. Relationships at work are strained.

	Bank		Substantive	
Never	90	23.6%	423	16.7%
Rarely	129	33.9%	1,004	39.6%
Sometimes	131	34.4%	769	30.4%
Often	19	5.0%	262	10.3%
Always	12	3.1%	75	3.0%
Missing	7		14	
Positive Score	**57.5%**		**56.3%**	
Negative Score	**8.1%**		**13.3%**	
Base	**381**		**2,533**	

YOUR JOB (CONTINUED)

Do the following statements apply to you and your job?

8a. I feel that my role makes a difference to patients / service users.

	Bank		Substantive	
Not applicable to me	15	3.9%	104	4.1%
* *Strongly disagree*	*6*	*1.6%*	*21*	*0.9%*
* *Disagree*	*1*	*0.3%*	*37*	*1.5%*
* *Neither agree nor disagree*	*24*	*6.5%*	*260*	*10.7%*
* *Agree*	*170*	*45.8%*	*1,184*	*48.6%*
* *Strongly agree*	*170*	*45.8%*	*932*	*38.3%*
Missing	2		9	
Positive Score	**91.6%**		**86.9%**	
Negative Score	**1.9%**		**2.4%**	
Base	**371**		**2,434**	

8b. My organisation is committed to helping me balance my work and home life.

	Bank		Substantive	
Strongly disagree	20	5.2%	117	4.6%
Disagree	32	8.3%	281	11.1%
Neither agree nor disagree	169	43.9%	677	26.7%
Agree	120	31.2%	1,082	42.7%
Strongly agree	44	11.4%	376	14.8%
Missing	3		14	
Positive Score	**42.6%**		**57.6%**	
Negative Score	**13.5%**		**15.7%**	
Base	**385**		**2,533**	

YOUR JOB (CONTINUED)

8c. I achieve a good balance between my work life and my home life.

	Bank		Substantive	
Strongly disagree	17	4.4%	138	5.4%
Disagree	20	5.2%	334	13.2%
Neither agree nor disagree	91	23.8%	535	21.1%
Agree	173	45.2%	1,162	45.8%
Strongly agree	82	21.4%	368	14.5%
Missing	5		10	
Positive Score	**66.6%**		**60.3%**	
Negative Score	**9.7%**		**18.6%**	
Base	**383**		**2,537**	

YOUR TEAM

9. The next set of questions asks about your experience of teamwork at this organisation. How would you like to answer these questions?

	Bank		Substantive	
I will answer about the team I always / usually work in.	210	55.7%	-	-
I don't regularly work in the same team so I will answer about my general experience of teamwork at this organisation.	167	44.3%	-	-
Missing	11		-	

Do the following statements apply to your experience of working as a team at this organisation?

10a. I receive the respect I deserve from my colleagues at work.

	Bank		Substantive	
Strongly disagree	3	0.8%	62	2.4%
Disagree	20	5.2%	146	5.8%
Neither agree nor disagree	64	16.8%	396	15.6%
Agree	182	47.6%	1,311	51.7%
Strongly agree	113	29.6%	622	24.5%
Missing	6		10	
Positive Score	**77.2%**		**76.2%**	
Negative Score	**6.0%**		**8.2%**	
Base	**382**		**2,537**	

10b. Team members understand each other's roles.

	Bank		Substantive	
Strongly disagree	1	0.3%	62	2.4%
Disagree	21	5.5%	246	9.7%
Neither agree nor disagree	58	15.1%	386	15.2%
Agree	207	53.8%	1,370	54.0%
Strongly agree	98	25.5%	474	18.7%
Missing	3		9	
Positive Score	**79.2%**		**72.7%**	
Negative Score	**5.7%**		**12.1%**	
Base	**385**		**2,538**	

YOUR TEAM (CONTINUED)

10c. I enjoy working with the colleagues in my team.

	Bank		Substantive	
Strongly disagree	1	0.3%	31	1.2%
Disagree	6	1.6%	58	2.3%
Neither agree nor disagree	58	15.1%	323	12.8%
Agree	192	50.0%	1,258	49.7%
Strongly agree	127	33.1%	863	34.1%
Missing	4		14	
Positive Score	**83.1%**		**83.7%**	
Negative Score	**1.8%**		**3.5%**	
Base	**384**		**2,533**	

10d. My team has enough freedom in how to do its work.

	Bank		Substantive	
Strongly disagree	4	1.0%	68	2.7%
Disagree	35	9.2%	232	9.2%
Neither agree nor disagree	124	32.5%	603	23.9%
Agree	165	43.2%	1,213	48.0%
Strongly agree	54	14.1%	412	16.3%
Missing	6		19	
Positive Score	**57.3%**		**64.3%**	
Negative Score	**10.2%**		**11.9%**	
Base	**382**		**2,528**	

YOUR TEAM (CONTINUED)

10e. In my team disagreements are dealt with constructively.

	Bank		Substantive	
Strongly disagree	11	2.9%	102	4.0%
Disagree	25	6.5%	193	7.6%
Neither agree nor disagree	145	37.9%	651	25.7%
Agree	149	38.9%	1,209	47.7%
Strongly agree	53	13.8%	378	14.9%
Missing	5		14	
Positive Score	**52.7%**		**62.7%**	
Negative Score	**9.4%**		**11.6%**	
Base	**383**		**2,533**	

10f. I feel valued by my team.

	Bank		Substantive	
Strongly disagree	6	1.6%	75	3.0%
Disagree	22	5.7%	155	6.1%
Neither agree nor disagree	75	19.5%	416	16.4%
Agree	179	46.6%	1,271	50.1%
Strongly agree	102	26.6%	618	24.4%
Missing	4		12	
Positive Score	**73.2%**		**74.5%**	
Negative Score	**7.3%**		**9.1%**	
Base	**384**		**2,535**	

YOUR TEAM (CONTINUED)

10g. I feel a strong personal attachment to my team.

	Bank		Substantive	
Strongly disagree	8	2.1%	72	2.8%
Disagree	24	6.3%	171	6.8%
Neither agree nor disagree	130	34.3%	553	21.9%
Agree	139	36.7%	1,100	43.5%
Strongly agree	78	20.6%	631	25.0%
Missing	9		20	
Positive Score	**57.3%**		**68.5%**	
Negative Score	**8.4%**		**9.6%**	
Base	**379**		**2,527**	

PEOPLE IN YOUR ORGANISATION

Do the following statements apply to your experience of working at this organisation?

11a. Teams within this organisation work well together to achieve their objectives.

	Bank		Substantive	
Strongly disagree	4	1.0%	123	4.9%
Disagree	27	7.0%	403	15.9%
Neither agree nor disagree	94	24.5%	679	26.9%
Agree	171	44.5%	1,074	42.5%
Strongly agree	88	22.9%	249	9.8%
Missing	4		19	
Positive Score	**67.4%**		**52.3%**	
Negative Score	**8.1%**		**20.8%**	
Base	**384**		**2,528**	

11b. The people I work with are understanding and kind to one another.

	Bank		Substantive	
Strongly disagree	5	1.3%	48	1.9%
Disagree	17	4.4%	158	6.2%
Neither agree nor disagree	78	20.3%	400	15.8%
Agree	172	44.7%	1,329	52.5%
Strongly agree	113	29.4%	595	23.5%
Missing	3		17	
Positive Score	**74.0%**		**76.0%**	
Negative Score	**5.7%**		**8.1%**	
Base	**385**		**2,530**	

PEOPLE IN YOUR ORGANISATION (CONTINUED)

11c. The people I work with are polite and treat each other with respect.

	Bank		Substantive	
Strongly disagree	5	1.3%	49	1.9%
Disagree	18	4.7%	140	5.5%
Neither agree nor disagree	72	18.7%	382	15.1%
Agree	175	45.5%	1,328	52.5%
Strongly agree	115	29.9%	631	24.9%
Missing	3		17	
Positive Score	**75.3%**		**77.4%**	
Negative Score	**6.0%**		**7.5%**	
Base	**385**		**2,530**	

11d. The people I work with show appreciation to one another.

	Bank		Substantive	
Strongly disagree	4	1.0%	51	2.0%
Disagree	18	4.7%	160	6.3%
Neither agree nor disagree	86	22.5%	464	18.4%
Agree	166	43.3%	1,283	50.8%
Strongly agree	109	28.5%	569	22.5%
Missing	5		20	
Positive Score	**71.8%**		**73.3%**	
Negative Score	**5.7%**		**8.3%**	
Base	**383**		**2,527**	

YOUR MANAGERS

The next set of questions asks about your immediate manager. By 'immediate manager' we mean the person or people you report to when you're at work. This could be your line manager, placement manager, supervisor or someone else you report to directly.

12. How would you like to answer these questions?	Bank		Substantive	
I will answer about the manager I always / usually report to	195	52.1%	-	-
I don't regularly report to the same person so I will answer about my general experience of managers at this organisation	179	47.9%	-	-
Missing	14		-	

To what extent do you agree or disagree with the following statements about your immediate manager(s)?

13a. My immediate manager encourages me at work.	Bank		Substantive	
Strongly disagree	9	2.4%	60	2.4%
Disagree	22	5.8%	150	5.9%
Neither agree nor disagree	93	24.3%	340	13.4%
Agree	156	40.8%	1,086	42.7%
Strongly agree	102	26.7%	906	35.6%
Missing	6		5	
Positive Score	**67.5%**		**78.4%**	
Negative Score	**8.1%**		**8.3%**	
Base	**382**		**2,542**	

YOUR MANAGERS (CONTINUED)

13b. My immediate manager gives me clear feedback on my work.

	Bank		Substantive	
Strongly disagree	10	2.6%	85	3.4%
Disagree	34	8.9%	212	8.4%
Neither agree nor disagree	118	31.0%	388	15.3%
Agree	138	36.2%	1,042	41.1%
Strongly agree	81	21.3%	810	31.9%
Missing	7		10	
Positive Score	**57.5%**		**73.0%**	
Negative Score	**11.5%**		**11.7%**	
Base	**381**		**2,537**	

13c. My immediate manager asks for my opinion before making decisions that affect my work.

	Bank		Substantive	
Strongly disagree	18	4.7%	130	5.1%
Disagree	68	17.8%	297	11.7%
Neither agree nor disagree	130	33.9%	440	17.4%
Agree	105	27.4%	955	37.7%
Strongly agree	62	16.2%	710	28.0%
Missing	5		15	
Positive Score	**43.6%**		**65.8%**	
Negative Score	**22.5%**		**16.9%**	
Base	**383**		**2,532**	

YOUR MANAGERS (CONTINUED)

13d. My immediate manager takes a positive interest in my health and well-being.

	Bank		Substantive	
Strongly disagree	10	2.6%	95	3.7%
Disagree	43	11.2%	147	5.8%
Neither agree nor disagree	106	27.7%	323	12.7%
Agree	132	34.5%	1,007	39.6%
Strongly agree	92	24.0%	970	38.2%
Missing	5		5	
Positive Score	**58.5%**		**77.8%**	
Negative Score	**13.8%**		**9.5%**	
Base	**383**		**2,542**	

13e. My immediate manager values my work.

	Bank		Substantive	
Strongly disagree	7	1.8%	79	3.1%
Disagree	29	7.6%	124	4.9%
Neither agree nor disagree	83	21.7%	334	13.1%
Agree	156	40.7%	1,065	41.9%
Strongly agree	108	28.2%	939	37.0%
Missing	5		6	
Positive Score	**68.9%**		**78.9%**	
Negative Score	**9.4%**		**8.0%**	
Base	**383**		**2,541**	

YOUR MANAGERS (CONTINUED)

13f. My immediate manager works together with me to come to an understanding of problems.

	Bank		Substantive	
Strongly disagree	13	3.4%	88	3.5%
Disagree	31	8.1%	162	6.4%
Neither agree nor disagree	122	31.9%	377	14.9%
Agree	129	33.8%	1,067	42.1%
Strongly agree	87	22.8%	842	33.2%
Missing	6		11	
Positive Score	**56.5%**		**75.3%**	
Negative Score	**11.5%**		**9.9%**	
Base	**382**		**2,536**	

13g. My immediate manager is interested in listening to me when I describe challenges I face.

	Bank		Substantive	
Strongly disagree	12	3.1%	94	3.7%
Disagree	26	6.8%	158	6.2%
Neither agree nor disagree	112	29.2%	320	12.6%
Agree	138	36.0%	1,055	41.6%
Strongly agree	95	24.8%	910	35.9%
Missing	5		10	
Positive Score	**60.8%**		**77.5%**	
Negative Score	**9.9%**		**9.9%**	
Base	**383**		**2,537**	

YOUR MANAGERS (CONTINUED)

13h. My immediate manager cares about my concerns.

	Bank		Substantive	
Strongly disagree	11	2.9%	93	3.7%
Disagree	27	7.1%	158	6.2%
Neither agree nor disagree	111	29.1%	343	13.5%
Agree	139	36.5%	1,034	40.8%
Strongly agree	93	24.4%	906	35.8%
Missing	7		13	
Positive Score	**60.9%**		**76.6%**	
Negative Score	**10.0%**		**9.9%**	
Base	**381**		**2,534**	

13i. My immediate manager takes effective action to help me with any problems I face.

	Bank		Substantive	
Strongly disagree	12	3.1%	106	4.2%
Disagree	28	7.3%	182	7.2%
Neither agree nor disagree	116	30.2%	399	15.7%
Agree	137	35.7%	991	39.0%
Strongly agree	91	23.7%	862	33.9%
Missing	4		7	
Positive Score	**59.4%**		**73.0%**	
Negative Score	**10.4%**		**11.3%**	
Base	**384**		**2,540**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK

14. On average, how many hours per week do you usually undertake for bank in this organisation?

	Bank		Substantive	
0-15 hours	164	42.6%	497	21.7%
16-29 hours	134	34.8%	-	-
30 hours or more	87	22.6%	1,798	78.3%
Missing	3		252	

Health & Well-being

15a. My organisation takes positive action on health and well-being.

	Bank		Substantive	
Strongly disagree	10	2.6%	85	3.4%
Disagree	24	6.2%	224	8.9%
Neither agree nor disagree	128	33.2%	597	23.6%
Agree	170	44.2%	1,228	48.5%
Strongly agree	53	13.8%	397	15.7%
Missing	3		16	
Positive Score	**57.9%**		**64.2%**	
Negative Score	**8.8%**		**12.2%**	
Base	**385**		**2,531**	

15b. In the last 12 months, have you experienced musculoskeletal problems (MSK) as a result of work activities?

	Bank		Substantive	
Yes	67	17.5%	641	25.3%
No	316	82.5%	1,890	74.7%
Missing	5		16	
Positive Score	**82.5%**		**74.7%**	
Negative Score	**17.5%**		**25.3%**	
Base	**383**		**2,531**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

15c. During the last 12 months, have you felt unwell as a result of work related stress?

	Bank		Substantive	
Yes	78	20.3%	1,057	41.7%
No	306	79.7%	1,476	58.3%
Missing	4		14	
Positive Score	**79.7%**		**58.3%**	
Negative Score	**20.3%**		**41.7%**	
Base	**384**		**2,533**	

15d. In the last three months have you ever come to work despite not feeling well enough to perform your duties?

	Bank		Substantive	
Yes	93	24.2%	1,422	56.1%
No	292	75.8%	1,111	43.9%
Missing	3		14	
Positive Score	**75.8%**		**43.9%**	
Negative Score	**24.2%**		**56.1%**	
Base	**385**		**2,533**	

15e. Have you felt pressure from the organisation to come to work?

	Bank		Substantive	
Yes	28	30.4%	243	17.3%
No	64	69.6%	1,160	82.7%
Missing	296		1,144	
Positive Score	**69.6%**		**82.7%**	
Negative Score	**30.4%**		**17.3%**	
Base	**92**		**1,403**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

Health & Well-being

16a. How often, if at all, do you find your work emotionally exhausting?

	Bank		Substantive	
Never	58	15.1%	101	4.0%
Rarely	107	27.8%	431	16.9%
Sometimes	167	43.4%	1,088	42.8%
Often	41	10.6%	788	31.0%
Always	12	3.1%	135	5.3%
Missing	3		4	
Positive Score	**42.9%**		**20.9%**	
Negative Score	**13.8%**		**36.3%**	
Base	**385**		**2,543**	

16b. How often, if at all, do you feel burnt out because of your work?

	Bank		Substantive	
Never	101	26.2%	220	8.7%
Rarely	118	30.6%	605	23.8%
Sometimes	121	31.4%	985	38.8%
Often	37	9.6%	603	23.7%
Always	8	2.1%	127	5.0%
Missing	3		7	
Positive Score	**56.9%**		**32.5%**	
Negative Score	**11.7%**		**28.7%**	
Base	**385**		**2,540**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

16c. How often, if at all, does your work frustrate you?

	Bank		Substantive	
Never	73	18.9%	125	4.9%
Rarely	120	31.0%	492	19.4%
Sometimes	143	37.0%	1,061	41.8%
Often	45	11.6%	736	29.0%
Always	6	1.6%	124	4.9%
Missing	1		9	
Positive Score	**49.9%**		**24.3%**	
Negative Score	**13.2%**		**33.9%**	
Base	**387**		**2,538**	

16d. How often, if at all, are you exhausted at the thought of another day / shift at work?

	Bank		Substantive	
Never	111	28.7%	340	13.4%
Rarely	123	31.8%	745	29.4%
Sometimes	118	30.5%	839	33.1%
Often	33	8.5%	502	19.8%
Always	2	0.5%	110	4.3%
Missing	1		11	
Positive Score	**60.5%**		**42.8%**	
Negative Score	**9.0%**		**24.1%**	
Base	**387**		**2,536**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

16e. How often, if at all, do you feel worn out at the end of your working day / shift?

	Bank		Substantive	
Never	53	13.7%	111	4.4%
Rarely	101	26.2%	378	14.9%
Sometimes	158	40.9%	994	39.3%
Often	59	15.3%	808	31.9%
Always	15	3.9%	239	9.4%
Missing	2		17	
Positive Score	**39.9%**		**19.3%**	
Negative Score	**19.2%**		**41.4%**	
Base	**386**		**2,530**	

16f. How often, if at all, do you feel that every working hour is tiring for you?

	Bank		Substantive	
Never	123	31.9%	493	19.4%
Rarely	148	38.4%	909	35.8%
Sometimes	90	23.4%	721	28.4%
Often	19	4.9%	327	12.9%
Always	5	1.3%	86	3.4%
Missing	3		11	
Positive Score	**70.4%**		**55.3%**	
Negative Score	**6.2%**		**16.3%**	
Base	**385**		**2,536**	

16g. How often, if at all, do you not have enough energy for family and friends during leisure time?

	Bank		Substantive	
Never	106	27.5%	286	11.3%
Rarely	106	27.5%	606	23.9%
Sometimes	115	29.9%	906	35.7%
Often	44	11.4%	579	22.8%
Always	14	3.6%	161	6.3%
Missing	3		9	
Positive Score	**55.1%**		**35.1%**	
Negative Score	**15.1%**		**29.2%**	
Base	**385**		**2,538**	

17a. In the last 12 months, how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?

	Bank		Substantive	
Never	286	74.3%	2,214	87.3%
1-2	53	13.8%	183	7.2%
3-5	29	7.5%	73	2.9%
6-10	11	2.9%	27	1.1%
More than 10	6	1.6%	40	1.6%
Missing	3		10	
Positive Score	**74.3%**		**87.3%**	
Negative Score	**25.7%**		**12.7%**	
Base	**385**		**2,537**	

17b. In the last 12 months, how many times have you personally experienced physical violence at work from managers?

	Bank		Substantive	
Never	370	96.9%	2,516	99.5%
1-2	8	2.1%	8	0.3%
3-5	2	0.5%	2	0.1%
6-10	2	0.5%	2	0.1%
More than 10	0	0.0%	0	0.0%
Missing	6		19	
Positive Score	**96.9%**		**99.5%**	
Negative Score	**3.1%**		**0.5%**	
Base	**382**		**2,528**	

17c. In the last 12 months, how many times have you personally experienced physical violence at work from other colleagues?

	Bank		Substantive	
Never	359	94.2%	2,465	98.3%
1-2	14	3.7%	25	1.0%
3-5	4	1.0%	9	0.4%
6-10	3	0.8%	3	0.1%
More than 10	1	0.3%	5	0.2%
Missing	7		40	
Positive Score	**94.2%**		**98.3%**	
Negative Score	**5.8%**		**1.7%**	
Base	**381**		**2,507**	

17d. The last time you experienced physical violence at work, did you or a colleague report it?	Bank		Substantive	
* *Yes, I reported it*	*60*	*70.6%*	*209*	*72.6%*
* *Yes, a colleague reported it*	*11*	*12.9%*	*35*	*12.2%*
* *Yes, both myself and a colleague reported it*	*9*	*10.6%*	*9*	*3.1%*
* *No*	*5*	*5.9%*	*35*	*12.2%*
Don't know	9	8.8%	17	5.1%
Not applicable	8	7.8%	31	9.2%
Missing	286		2,211	
Positive Score	**94.1%**		**87.8%**	
Negative Score	**5.9%**		**12.2%**	
Base	**85**		**288**	

18a. In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	Bank		Substantive	
Never	244	63.7%	1,799	71.2%
1-2	84	21.9%	408	16.2%
3-5	27	7.0%	169	6.7%
6-10	15	3.9%	63	2.5%
More than 10	13	3.4%	86	3.4%
Missing	5		22	
Positive Score	**63.7%**		**71.2%**	
Negative Score	**36.3%**		**28.8%**	
Base	**383**		**2,525**	

18b. In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from managers?

	Bank		Substantive	
Never	337	88.7%	2,258	90.0%
1-2	35	9.2%	175	7.0%
3-5	4	1.1%	43	1.7%
6-10	2	0.5%	13	0.5%
More than 10	2	0.5%	21	0.8%
Missing	8		37	
Positive Score	**88.7%**		**90.0%**	
Negative Score	**11.3%**		**10.0%**	
Base	**380**		**2,510**	

18c. In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

	Bank		Substantive	
Never	307	81.4%	2,043	81.8%
1-2	47	12.5%	334	13.4%
3-5	17	4.5%	68	2.7%
6-10	2	0.5%	27	1.1%
More than 10	4	1.1%	27	1.1%
Missing	11		48	
Positive Score	**81.4%**		**81.8%**	
Negative Score	**18.6%**		**18.2%**	
Base	**377**		**2,499**	

18d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

	Bank		Substantive	
* *Yes, I reported it*	*71*	*53.8%*	*444*	*50.5%*
* *Yes, a colleague reported it*	*8*	*6.1%*	*40*	*4.5%*
* *Yes, both myself and a colleague reported it*	*4*	*3.0%*	*16*	*1.8%*
* *No*	*49*	*37.1%*	*380*	*43.2%*
Don't know	9	5.6%	44	4.4%
Not applicable	21	13.0%	69	6.9%
Missing	226		1,554	
Positive Score	**62.9%**		**56.8%**	
Negative Score	**37.1%**		**43.2%**	
Base	**132**		**880**	

19. Does your organisation act fairly towards staff regardless of ethnic background, gender, religion, sexual orientation, disability or age, for example with regards to career progression or development opportunities?

	Bank		Substantive	
Yes	228	59.4%	1,511	59.7%
No	28	7.3%	264	10.4%
Don't know	128	33.3%	754	29.8%
Missing	4		18	
Positive Score	**59.4%**		**59.7%**	
Negative Score	**7.3%**		**10.4%**	
Base	**384**		**2,529**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

20a. In the last 12 months, have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

	Bank		Substantive	
Yes	71	18.5%	199	7.9%
No	312	81.5%	2,328	92.1%
Missing	5		20	
Positive Score	**81.5%**		**92.1%**	
Negative Score	**18.5%**		**7.9%**	
Base	**383**		**2,527**	

20b. In the last 12 months, have you personally experienced discrimination at work from a manager / team leader or other colleagues?

	Bank		Substantive	
Yes	46	12.1%	209	8.3%
No	333	87.9%	2,298	91.7%
Missing	9		40	
Positive Score	**87.9%**		**91.7%**	
Negative Score	**12.1%**		**8.3%**	
Base	**379**		**2,507**	

20c01. On what grounds have you experienced discrimination? Ethnic background

	Bank		Substantive	
Ethnic background	68	74.7%	174	51.2%
Not selected	23	25.3%	166	48.8%
Positive Score	**25.3%**		**48.8%**	
Negative Score	**74.7%**		**51.2%**	
Base	**91**		**340**	

20c02. On what grounds have you experienced discrimination? Gender

	Bank		Substantive	
Gender	12	13.2%	62	18.2%
Not selected	79	86.8%	278	81.8%
Positive Score	**86.8%**		**81.8%**	
Negative Score	**13.2%**		**18.2%**	
Base	**91**		**340**	

20c03. On what grounds have you experienced discrimination? Religion

	Bank		Substantive	
Religion	2	2.2%	17	5.0%
Not selected	89	97.8%	323	95.0%
Positive Score	**97.8%**		**95.0%**	
Negative Score	**2.2%**		**5.0%**	
Base	**91**		**340**	

20c04. On what grounds have you experienced discrimination? Sexual orientation

	Bank		Substantive	
Sexual orientation	2	2.2%	19	5.6%
Not selected	89	97.8%	321	94.4%
Positive Score	**97.8%**		**94.4%**	
Negative Score	**2.2%**		**5.6%**	
Base	**91**		**340**	

20c05. On what grounds have you experienced discrimination? Disability

	Bank		Substantive	
Disability	4	4.4%	44	12.9%
Not selected	87	95.6%	296	87.1%
Positive Score	**95.6%**		**87.1%**	
Negative Score	**4.4%**		**12.9%**	
Base	**91**		**340**	

20c06. On what grounds have you experienced discrimination? Age

	Bank		Substantive	
Age	8	8.8%	48	14.1%
Not selected	83	91.2%	292	85.9%
Positive Score	**91.2%**		**85.9%**	
Negative Score	**8.8%**		**14.1%**	
Base	**91**		**340**	

20c07. On what grounds have you experienced discrimination? Other

	Bank		Substantive	
Other	15	16.5%	66	19.4%
Not selected	76	83.5%	274	80.6%
Positive Score	**83.5%**		**80.6%**	
Negative Score	**16.5%**		**19.4%**	
Base	**91**		**340**	

21. In the last month, have you seen any errors, near misses, or incidents that could have hurt staff and / or patients / service users?

	Bank		Substantive	
Yes	95	24.8%	662	26.3%
No	288	75.2%	1,855	73.7%
Missing	5		30	
Positive Score	**75.2%**		**73.7%**	
Negative Score	**24.8%**		**26.3%**	
Base	**383**		**2,517**	

To what extent do you agree or disagree with the following?

22a. My organisation treats staff who are involved in an error, near miss or incident fairly.

	Bank		Substantive	
Don't know	128	33.2%	690	27.2%
* *Strongly disagree*	*6*	*2.3%*	*58*	*3.1%*
* *Disagree*	*15*	*5.8%*	*136*	*7.4%*
* *Neither agree nor disagree*	*97*	*37.7%*	*590*	*32.0%*
* *Agree*	*107*	*41.6%*	*868*	*47.1%*
* *Strongly agree*	*32*	*12.5%*	*191*	*10.4%*
Missing	3		14	
Positive Score	**54.1%**		**57.5%**	
Negative Score	**8.2%**		**10.5%**	
Base	**257**		**1,843**	

22b. My organisation encourages us to report errors, near misses or incidents.

	Bank		Substantive	
Don't know	30	7.8%	96	3.8%
* *Strongly disagree*	*9*	*2.5%*	*22*	*0.9%*
* *Disagree*	*10*	*2.8%*	*49*	*2.0%*
* *Neither agree nor disagree*	*40*	*11.2%*	*199*	*8.2%*
* *Agree*	*183*	*51.4%*	*1,431*	*58.7%*
* *Strongly agree*	*114*	*32.0%*	*735*	*30.2%*
Missing	2		15	
Positive Score	**83.4%**		**88.9%**	
Negative Score	**5.3%**		**2.9%**	
Base	**356**		**2,436**	

22c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.

	Bank		Substantive	
Don't know	75	19.5%	345	13.6%
* *Strongly disagree*	*9*	*2.9%*	*60*	*2.7%*
* *Disagree*	*13*	*4.2%*	*130*	*5.9%*
* *Neither agree nor disagree*	*78*	*25.2%*	*492*	*22.5%*
* *Agree*	*146*	*47.2%*	*1,107*	*50.6%*
* *Strongly agree*	*63*	*20.4%*	*399*	*18.2%*
Missing	4		14	
Positive Score	**67.6%**		**68.8%**	
Negative Score	**7.1%**		**8.7%**	
Base	**309**		**2,188**	

22d. We are given feedback about changes made in response to reported errors, near misses and incidents.

	Bank		Substantive	
Don't know	68	17.7%	287	11.3%
* *Strongly disagree*	*19*	*6.0%*	*93*	*4.1%*
* *Disagree*	*22*	*7.0%*	*189*	*8.4%*
* *Neither agree nor disagree*	*77*	*24.4%*	*509*	*22.7%*
* *Agree*	*133*	*42.1%*	*1,090*	*48.6%*
* *Strongly agree*	*65*	*20.6%*	*364*	*16.2%*
Missing	4		15	
Positive Score	**62.7%**		**64.8%**	
Negative Score	**13.0%**		**12.6%**	
Base	**316**		**2,245**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

To what extent do you agree with the following statements about unsafe clinical practice?

23a. I would feel secure raising concerns about unsafe clinical practice.

	Bank		Substantive	
Strongly disagree	11	2.9%	68	2.7%
Disagree	30	7.9%	165	6.5%
Neither agree nor disagree	77	20.2%	444	17.5%
Agree	165	43.3%	1,260	49.8%
Strongly agree	98	25.7%	595	23.5%
Missing	7		15	
Positive Score	**69.0%**		**73.3%**	
Negative Score	**10.8%**		**9.2%**	
Base	**381**		**2,532**	

23b. I am confident that my organisation would address my concern.

	Bank		Substantive	
Strongly disagree	13	3.4%	93	3.7%
Disagree	16	4.2%	224	8.9%
Neither agree nor disagree	118	30.9%	704	27.8%
Agree	158	41.4%	1,107	43.8%
Strongly agree	77	20.2%	402	15.9%
Missing	6		17	
Positive Score	**61.5%**		**59.6%**	
Negative Score	**7.6%**		**12.5%**	
Base	**382**		**2,530**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

To what extent does this statement reflect your view of your organisation as a whole?

24. I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

	Bank		Substantive	
Strongly disagree	8	2.1%	55	2.2%
Disagree	17	4.4%	114	4.5%
Neither agree nor disagree	91	23.6%	464	18.3%
Agree	166	43.1%	1,301	51.3%
Strongly agree	103	26.8%	603	23.8%
Missing	3		10	
Positive Score	**69.9%**		**75.0%**	
Negative Score	**6.5%**		**6.7%**	
Base	**385**		**2,537**	

25a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

	Bank		Substantive	
* *Yes*	*78*	*23.9%*	*2,013*	*83.0%*
* *No*	*248*	*76.1%*	*411*	*17.0%*
Can't remember	57	14.9%	99	3.9%
Missing	5		24	
Positive Score	**23.9%**		**83.0%**	
Negative Score	**76.1%**		**17.0%**	
Base	**326**		**2,424**	

25b. Why not?	Bank		Substantive	
Bank only workers in my role are not offered an appraisal	147	59.5%	-	-
As a bank worker I will be offered an appraisal, but I have not been in my role long enough yet	21	8.5%	-	-
Other reasons	10	4.0%	-	-
Don't know	69	27.9%	-	-
Missing	141		-	

25c. Would an appraisal help you to do your job better?	Bank		Substantive	
Yes	85	35.1%	-	-
No	82	33.9%	-	-
Don't know	75	31.0%	-	-
Missing	146		-	

To what extent do these statements reflect your view of your organisation as a whole?

26a. This organisation offers me challenging work.	Bank		Substantive	
Strongly disagree	8	2.1%	39	1.5%
Disagree	40	10.4%	135	5.3%
Neither agree nor disagree	147	38.2%	551	21.8%
Agree	161	41.8%	1,338	52.9%
Strongly agree	29	7.5%	466	18.4%
Missing	3		18	
Positive Score	**49.4%**		**71.3%**	
Negative Score	**12.5%**		**6.9%**	
Base	**385**		**2,529**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

26b. There are opportunities for me to develop my career in this organisation.

	Bank		Substantive	
Strongly disagree	23	6.0%	154	6.1%
Disagree	58	15.0%	333	13.1%
Neither agree nor disagree	127	32.9%	585	23.1%
Agree	134	34.7%	1,081	42.6%
Strongly agree	44	11.4%	382	15.1%
Missing	2		12	
Positive Score	**46.1%**		**57.7%**	
Negative Score	**21.0%**		**19.2%**	
Base	**386**		**2,535**	

26c. I have opportunities to improve my knowledge and skills.

	Bank		Substantive	
Strongly disagree	12	3.1%	79	3.1%
Disagree	31	8.1%	187	7.4%
Neither agree nor disagree	89	23.1%	380	15.0%
Agree	185	48.1%	1,390	54.9%
Strongly agree	68	17.7%	498	19.7%
Missing	3		13	
Positive Score	**65.7%**		**74.5%**	
Negative Score	**11.2%**		**10.5%**	
Base	**385**		**2,534**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

26d. I feel supported to develop my potential.

	Bank		Substantive	
Strongly disagree	16	4.2%	119	4.7%
Disagree	53	13.8%	287	11.3%
Neither agree nor disagree	141	36.7%	569	22.5%
Agree	127	33.1%	1,126	44.5%
Strongly agree	47	12.2%	432	17.1%
Missing	4		14	
Positive Score	**45.3%**		**61.5%**	
Negative Score	**18.0%**		**16.0%**	
Base	**384**		**2,533**	

26e. I am able to access the right learning and development opportunities when I need to.

	Bank		Substantive	
Strongly disagree	14	3.6%	104	4.1%
Disagree	41	10.7%	232	9.2%
Neither agree nor disagree	96	25.0%	565	22.3%
Agree	167	43.5%	1,222	48.3%
Strongly agree	66	17.2%	408	16.1%
Missing	4		16	
Positive Score	**60.7%**		**64.4%**	
Negative Score	**14.3%**		**13.3%**	
Base	**384**		**2,531**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

To what extent do these statements reflect your view of your organisation as a whole?

27a. Care of patients / service users is my organisation's top priority.

	Bank		Substantive	
Strongly disagree	2	0.5%	40	1.6%
Disagree	9	2.3%	150	5.9%
Neither agree nor disagree	52	13.5%	376	14.9%
Agree	193	50.1%	1,231	48.7%
Strongly agree	129	33.5%	732	28.9%
Missing	3		18	
Positive Score	**83.6%**		**77.6%**	
Negative Score	**2.9%**		**7.5%**	
Base	**385**		**2,529**	

27b. My organisation acts on concerns raised by patients / service users.

	Bank		Substantive	
Strongly disagree	4	1.0%	34	1.3%
Disagree	10	2.6%	113	4.5%
Neither agree nor disagree	92	23.9%	548	21.7%
Agree	174	45.2%	1,263	49.9%
Strongly agree	105	27.3%	571	22.6%
Missing	3		18	
Positive Score	**72.5%**		**72.5%**	
Negative Score	**3.6%**		**5.8%**	
Base	**385**		**2,529**	

27c. I would recommend my organisation as a place to work.

	Bank		Substantive	
Strongly disagree	8	2.1%	113	4.5%
Disagree	16	4.2%	251	9.9%
Neither agree nor disagree	98	25.5%	591	23.4%
Agree	159	41.4%	1,100	43.5%
Strongly agree	103	26.8%	476	18.8%
Missing	4		16	
Positive Score	**68.2%**		**62.3%**	
Negative Score	**6.3%**		**14.4%**	
Base	**384**		**2,531**	

27d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

	Bank		Substantive	
Strongly disagree	9	2.3%	130	5.1%
Disagree	24	6.2%	260	10.3%
Neither agree nor disagree	88	22.9%	684	27.0%
Agree	172	44.7%	1,036	40.9%
Strongly agree	92	23.9%	422	16.7%
Missing	3		15	
Positive Score	**68.6%**		**57.6%**	
Negative Score	**8.6%**		**15.4%**	
Base	**385**		**2,532**	

27e. I feel safe to speak up about anything that concerns me in this organisation.

	Bank		Substantive	
Strongly disagree	9	2.3%	106	4.2%
Disagree	24	6.3%	244	9.6%
Neither agree nor disagree	101	26.3%	545	21.5%
Agree	167	43.5%	1,184	46.8%
Strongly agree	83	21.6%	452	17.9%
Missing	4		16	
Positive Score	**65.1%**		**64.6%**	
Negative Score	**8.6%**		**13.8%**	
Base	**384**		**2,531**	

27f. If I spoke up about something that concerned me I am confident my organisation would address my concern.

	Bank		Substantive	
Strongly disagree	11	2.9%	133	5.3%
Disagree	26	6.8%	271	10.7%
Neither agree nor disagree	132	34.6%	766	30.3%
Agree	145	38.1%	1,004	39.8%
Strongly agree	67	17.6%	350	13.9%
Missing	7		23	
Positive Score	**55.6%**		**53.6%**	
Negative Score	**9.7%**		**16.0%**	
Base	**381**		**2,524**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

In the next 12 months, which of the following are you planning to do or considering doing?

28_1. Continuing to work on the bank at this organisation.

	Bank		Substantive	
Continuing to work on the bank at this organisation	287	74.0%	-	-
Missing	101		-	

28_2. Continuing to do NHS bank work but not at this organisation.

	Bank		Substantive	
Continuing to do NHS bank work but not at this organisation	37	9.5%	-	-
Missing	351		-	

28_3. Moving to a permanent contract at this organisation.

	Bank		Substantive	
Moving to a permanent contract* at this organisation	63	16.2%	-	-
Missing	325		-	

28_4. Moving to a permanent contract at another NHS organisation.

	Bank		Substantive	
Moving to a permanent contract* at another NHS organisation	29	7.5%	-	-
Missing	359		-	

28_5. Working in the NHS but paid by an external agency.

	Bank		Substantive	
Working in the NHS but paid by an external agency	23	5.9%	-	-
Missing	365		-	

28_6. Moving to a job in healthcare, but outside the NHS.

	Bank		Substantive	
Moving to a job in healthcare, but outside the NHS	14	3.6%	-	-
Missing	374		-	

28_7. Moving to a job outside healthcare.	Bank		Substantive	
Moving to a job outside healthcare	22	5.7%	-	-
Missing	366		-	

28_8. Taking a career break.	Bank		Substantive	
Taking a career break	7	1.8%	-	-
Missing	381		-	

28_9. Retiring.	Bank		Substantive	
Retiring	28	7.2%	-	-
Missing	360		-	

28_10. Going into full time training or studying.	Bank		Substantive	
Going into full time training or studying	30	7.7%	-	-
Missing	358		-	

28_11. Don’t know.	Bank		Substantive	
Don’t know	27	7.0%	-	-
Missing	361		-	

28_12. Prefer not to say.	Bank		Substantive	
Prefer not to say	16	4.1%	-	-
Missing	372		-	

BANK WORK AT THIS ORGANISATION

To what extent do you agree or disagree with the following questions about the bank team? By this we mean the admin team that you would go to to resolve queries about your bank position e.g. payroll queries, cancelling a shift, etc.

29a. It is easy to get hold of the bank team if I have a query.	Bank		Substantive	
Strongly disagree	15	3.9%	-	-
Disagree	30	7.8%	-	-
Neither agree nor disagree	101	26.3%	-	-
Agree	172	44.8%	-	-
Strongly agree	66	17.2%	-	-
Missing	4		-	
Positive Score	**62.0%**		**-**	
Negative Score	**11.7%**		**-**	
Base	**384**		**-**	

29b. When I contact the bank team with a query, I can quickly get the answers I need.	Bank		Substantive	
Strongly disagree	14	3.7%	-	-
Disagree	26	6.8%	-	-
Neither agree nor disagree	113	29.7%	-	-
Agree	167	43.8%	-	-
Strongly agree	61	16.0%	-	-
Missing	7		-	
Positive Score	**59.8%**		**-**	
Negative Score	**10.5%**		**-**	
Base	**381**		**-**	

YOUR EXPERIENCE DURING THE COVID-19 PANDEMIC

The COVID-19 Pandemic

30a. In the past 12 months, have you worked on a COVID-19 specific ward or area at any time?

	Bank		Substantive	
Yes	167	43.4%	619	24.4%
No	218	56.6%	1,917	75.6%
Missing	3		11	

30b. In the past 12 months, have you been required to work remotely / from home due to the COVID-19 pandemic?

	Bank		Substantive	
Yes	65	17.0%	1,416	56.0%
No	318	83.0%	1,114	44.0%
Missing	5		17	

BACKGROUND INFORMATION

31. What of the following best describes you?

	Bank		Substantive	
Female	292	76.0%	2,011	79.4%
Male	86	22.4%	450	17.8%
Non-binary	1	0.3%	3	0.1%
Prefer to self-describe	0	0.0%	0	0.0%
Prefer not to say	5	1.3%	69	2.7%
Missing	4		14	

32. Is your gender identity the same as the sex you were registered at birth?

	Bank		Substantive	
Yes	370	98.4%	2,360	97.2%
No	2	0.5%	7	0.3%
Prefer not to say	4	1.1%	62	2.6%
Missing	12		118	

33. Age:

	Bank		Substantive	
16-20	7	1.8%	10	0.4%
21-30	23	6.0%	322	12.8%
31-40	55	14.3%	512	20.3%
41-50	84	21.9%	687	27.2%
51-65	175	45.6%	928	36.8%
66+	40	10.4%	64	2.5%
Missing	4		24	

BACKGROUND INFORMATION (CONTINUED)

34. What is your ethnic group?	Bank		Substantive	
White				
English / Welsh / Scottish / Northern Irish / British	204	52.8%	1,899	75.0%
Irish	8	2.1%	24	0.9%
Gypsy or Irish Traveller	1	0.3%	2	0.1%
Any other White background	13	3.4%	133	5.3%
Mixed / Multiple ethnic background				
White and Black Caribbean	1	0.3%	7	0.3%
White and Black African	4	1.0%	13	0.5%
White and Asian	3	0.8%	16	0.6%
Any other Mixed / Multiple ethnic background	2	0.5%	14	0.6%
Asian / Asian British				
Indian	6	1.6%	76	3.0%
Pakistani	2	0.5%	8	0.3%
Bangladeshi	2	0.5%	10	0.4%
Chinese	3	0.8%	4	0.2%
Any other Asian background	11	2.8%	47	1.9%
Black / African / Caribbean / Black British				
African	110	28.5%	205	8.1%
Caribbean	2	0.5%	17	0.7%
Any other Black / African / Caribbean background	7	1.8%	15	0.6%
Other ethnic group				
Arab	0	0.0%	7	0.3%
Any other ethnic background	7	1.8%	34	1.3%
Missing	2		16	

BACKGROUND INFORMATION (CONTINUED)

35. Which of the following best describes how you think of yourself?

	Bank		Substantive	
Heterosexual or Straight	358	92.7%	2,265	89.3%
Gay or Lesbian	5	1.3%	57	2.2%
Bisexual	7	1.8%	65	2.6%
Other	3	0.8%	16	0.6%
I would prefer not to say	13	3.4%	132	5.2%
Missing	2		12	

36. What is your religion? Are you...

	Bank		Substantive	
No religion	80	20.7%	1,078	42.7%
Christian	254	65.8%	1,136	45.0%
Buddhist	1	0.3%	17	0.7%
Hindu	8	2.1%	50	2.0%
Jewish	3	0.8%	12	0.5%
Muslim	16	4.1%	54	2.1%
Sikh	0	0.0%	3	0.1%
Any other religion	6	1.6%	36	1.4%
I would prefer not to say	18	4.7%	137	5.4%
Missing	2		24	

37a. Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

	Bank		Substantive	
Yes	50	13.1%	739	29.2%
No	332	86.9%	1,793	70.8%
Missing	6		15	

BACKGROUND INFORMATION (CONTINUED)

37b. Has your employer made reasonable adjustment(s) to enable you to carry out your work?

	Bank		Substantive	
* *Yes*	*12*	*52.2%*	*356*	*78.8%*
* *No*	*11*	*47.8%*	*96*	*21.2%*
No adjustment required	27	54.0%	285	38.7%
Missing	338		1,810	
Positive Score	**52.2%**		**78.8%**	
Negative Score	**47.8%**		**21.2%**	
Base	**23**		**452**	

Parental / Caring Responsibilities

38a. Do you have any children aged from 0 to 17 living at home with you, or who you have regular caring responsibility for?

	Bank		Substantive	
Yes	139	36.0%	1,023	40.5%
No	247	64.0%	1,501	59.5%
Missing	2		23	

38b. Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age?

	Bank		Substantive	
Yes	146	38.4%	862	34.3%
No	234	61.6%	1,651	65.7%
Missing	8		34	

BACKGROUND INFORMATION (CONTINUED)

39a. How long have you worked for this organisation in your current role? Please only include time spent working solely on the bank.

	Bank		Substantive	
Less than 1 year	86	22.4%	325	12.8%
1-2 years	179	46.6%	451	17.8%
3-5 years	66	17.2%	453	17.8%
6-10 years	22	5.7%	420	16.5%
11-15 years	11	2.9%	302	11.9%
More than 15 years	20	5.2%	587	23.1%
Missing	4		9	

39b. Prior to working on the bank, were you recruited directly to the NHS from outside of the UK?

	Bank		Substantive	
Yes	12	3.1%	79	3.1%
No	366	95.8%	2,418	96.2%
Prefer not to say	4	1.0%	16	0.6%
Missing	6		34	

40. Is bank work in the NHS your main source of paid work?

	Bank		Substantive	
Yes	259	67.1%	-	-
No	98	25.4%	-	-
Prefer not to say	29	7.5%	-	-
Missing	2		-	

BACKGROUND INFORMATION (CONTINUED)

41. What is your occupational group?	Bank		Substantive	
Allied Health Professionals / Healthcare Scientists / Scientific and Technical				
Occupational Therapy	6	1.6%	120	4.8%
Physiotherapy	3	0.8%	50	2.0%
Radiography	1	0.3%	0	0.0%
Pharmacy	6	1.6%	39	1.6%
Clinical Psychology	2	0.5%	137	5.5%
Psychotherapy	2	0.5%	68	2.7%
Operating Department Practitioner	3	0.8%	2	0.1%
Other Qualified Allied Health Professionals (e.g. Dietetics, Speech and Language Therapy)	1	0.3%	93	3.7%
Support to Allied Health Professionals (e.g. Support Worker, Therapy Helper, Therapy Assistant or Student)	26	7.0%	123	4.9%
Other Qualified Scientific and Technical or Healthcare Scientists (e.g. Haematology, Clinical Biochemistry, Microbiology)	0	0.0%	1	0.0%
Support to Healthcare Scientists (e.g. Technicians, Assistants or Students)	1	0.3%	7	0.3%
Medical and Dental				
Medical / Dental - Consultant	3	0.8%	30	1.2%
Medical / Dental - In Training (e.g. Foundation Y1 & Y2, StRs (incl FTSTAs & LATs), SHOs, SpRs / SpTs / GPRs)	0	0.0%	23	0.9%
Medical / Dental - Other (e.g. Staff, Associate Specialist and Specialty (SAS))	3	0.8%	19	0.8%
Salaried Primary Care Dentists	0	0.0%	0	0.0%
Ambulance (operational)				
Emergency Care Practitioner	0	0.0%	0	0.0%
Paramedic	1	0.3%	1	0.0%
Emergency Care Assistant	0	0.0%	1	0.0%
Ambulance Technician	0	0.0%	0	0.0%
Ambulance Control Staff (e.g. Call Handler, Dispatchers, PTS Controllers)	0	0.0%	0	0.0%
Patient Transport Service (e.g. Ambulance Drivers, Support Staff)	0	0.0%	0	0.0%
Public Health				
Public Health / Health Improvement	1	0.3%	5	0.2%
Commissioning				
Commissioning Managers / Support Staff	0	0.0%	1	0.0%

BACKGROUND INFORMATION (CONTINUED)

41. What is your occupational group? (Continued)	Bank		Substantive	
Registered Nurses and Midwives				
Adult / General	42	11.3%	156	6.2%
Mental Health	75	20.2%	434	17.4%
Learning Disabilities	4	1.1%	18	0.7%
Children	4	1.1%	26	1.0%
Midwives	2	0.5%	1	0.0%
Health Visitors	1	0.3%	7	0.3%
District / Community	5	1.3%	90	3.6%
Other Registered Nurses	2	0.5%	18	0.7%
Nursing or Healthcare Assistants				
Nursing Auxiliary / Nursing Assistant / Healthcare Assistant (including Health / Clinical / Nursing Support Worker)	87	23.5%	196	7.8%
Social Care				
Approved Social Workers / Social Workers / Residential Social Workers	0	0.0%	27	1.1%
Social Care Managers	0	0.0%	6	0.2%
Social Care Support Staff	4	1.1%	14	0.6%
Wider Healthcare Team				
Admin & Clerical (including Medical Secretary)	51	13.7%	380	15.2%
Central Functions / Corporate Services (e.g. HR, Finance, Information Systems, Information Technology)	5	1.3%	174	7.0%
Maintenance / Ancillary (e.g. Housekeeping, Domestic Staff, Maintenance, Facilities, Estates)	6	1.6%	66	2.6%
General Management				
General Management (N.B. If you are a manager and can choose a group from elsewhere in the list, please select that 'Other Occupational Group')	3	0.8%	46	1.8%
Other Occupational Group	21	5.7%	120	4.8%
Missing	17		48	

CONTACT US

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NSS Bank Comparison Table – 2022

Item	NSS Bank	Core NSS	EPUT Bank	EPUT Substantive
Response Rate	**18%** (22,677/124,263)*	**46%**	**23.1%** (388/1678)	**42.1%** (2547/6049)

*Due to an error affecting 25 Trusts, the figures below relate to 17,702 responses from 115 Trusts

		NSS Bank Responses	NSS Bank	Core NSS	EPUT Bank	EPUT Substantive
		n		n=629,286	N=388	N=2547
Occupation group summary	Registered Nurses and Midwives	4,258	24.2%	28.4%	--	--
	Nursing or Healthcare Assistants	3,849	21.9%	7.2%	23.5%	7.8%
	Wider Healthcare Team	3,501	19.9%	24.2%	--	--
	Allied Health Professionals / Healthcare	2,458	13.9%	20.6%	--	--
	Scientists / Scientific and Technical	1,219	6.8%	7.2%	--	--
	Medical and Dental	422	2.4%	3.4%	--	--
	Ambulance					
Gender	Female	13,523	76.4%	76.1%	76.0%	79.4%
	Male	3,559	20.1%	20.6%	22.4%	17.8%
	Non-binary	42	0.0%	0.2%	0.3%	0.1%
	Prefer to self-describe	40	0.0%	0.2%	0.0%	0.0%
Ethnic group	White background	12,583	72.1%	78.4%	58.2%	81.3%
	Black/African/Caribbean/Black British	2,265	13.0%	5.5%	30.7%	5.7%
	Asian/Asian British	1,796	10.3%	12.4%	6.2%	9.4%
	Mixed/multiple ethnic background	492	2.8%	2.2%	2.6%	2.0%
	Arab/Other	325	1.9%	1.5%	2.3%	1.6%
Long term health conditions or illnesses	Yes	3,373	19.1%	23.6%	13.1%	29.2%
	No	14,109	79.7%	76.4%	86.9%	70.8%
Time with organisation	Less than 1 year	4,600	26.0%	10.3%	22.4%	12.8%
	1-2 years	5,584	31.5%	14.3%	46.6%	17.8%
	3-5 years	3,633	20.5%	19.4%	17.2%	17.8%
	6-10 years	1,872	10.6%	17.9%	5.7%	16.5%
	11-15 years	686	3.9%	11.8%	2.9%	11.9%
	More than 15 years	1,218	6.9%	26.3%	5.2%	23.1%
Full time / part time	Full time	4,838	27.3%	81.5%		
	Part time	12,629	71.3%	18.5%		
Contact with patients / service users	Yes, frequently	11,290	63.8%	68.3%		
	Yes, occasionally	1,771	10.0%	12.5%		
	No	4,522	25.5%	19.2%		

Comparison Table

Key

EPUT Bank vs. NSS

>5% worse	
>5% better	

EPUT Bank vs Substantive

>15% worse	
10-15% worse	
> +/- 10%	
<10% better	

Please note: Red/Amber/Green ratings have been intentionally set at large margins, to offset the low total number of responses returned from the Bank survey (388)

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 1 We are compassionate and inclusive	Q6a I feel that my role makes a difference to patients / service users.	88.8	91.6	87.1	
	Q23a Care of patients / service users is my organisation's top priority.	76.2	83.6	77.6	
	Q9f My immediate manager works together with me to come to an understanding of problems	55.3	56.5	75.3	
	Q9d My immediate manager takes a positive interest in my health and well-being	55.5	58.5	77.6	
	Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	59.0	59.4	59.7	
	Q7h I feel valued by my team.	71.0	73.2	74.6	
	Q7i I feel a strong personal attachment to my team	57.3	57.3	68.5	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 2 We are recognised and rewarded	Q8d The people I work with show appreciation to one another.	69.3	71.8	73.4	
	Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.	55.4	59.5	62.3	
	Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.	45.6	50.9	50.1	
	Q4c How satisfied are you with each of the following aspects of your job? My level of pay	29.7	28.3	26.8	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 3 We each have a voice that counts	Q3b I am trusted to do my job.	92.4	91.7	91.6	
	Q3a I always know what my work responsibilities are.	87.5	88.6	85.4	
	Q3d I am able to make suggestions to improve the work of my team / department	56.8	59	75.1	
	Q5b I have a choice in deciding how to do my work.	43.5	32.6	62.6	
	Q3f I am able to make improvements happen in my area of work.	39.1	43.2	59.8	
	Q3e I am involved in deciding on changes introduced that affect my work area / team / department.	31.4	31.6	52.9	
	Q19a I would feel secure raising concerns about unsafe clinical practice.	69.0	69	73.3	
	Q19b I am confident that my organisation would address my concern.	56.3	61.5	59.6	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 4 We are safe and healthy	Q13d The last time you experienced physical violence at work, did you or a colleague report it?	75.0	94.1	88.1	
	Q3g I am able to meet all the conflicting demands on my time at work.	54.7	62.9	48.9	
	Q11a My organisation take positive action on health and well-being.	52.5	57.9	64.1	
	Q12b How often, if at all, do you feel burnt out because of your work?	21.4	11.7	28.7	
	Q12e How often, if at all, do you feel worn out at the end of your working day/shift?	34.5	19.2	41.4	
	Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.	24.9	25.7	12.8	
	Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.	33.1	36.6	28.8	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 5 We are always learning	Q22c I have opportunities to improve my knowledge and skills.	61.7	65.7	74.8	
	Q22b There are opportunities for me to develop my career in this organisation.	45.9	46.1	58.0	
	Q22d I feel supported to develop my potential.	44.0	45.3	61.6	
	Staff who said they have not had an appraisal or annual review in the last 12 months	65.1	76.1	17	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 6 We work flexibly	Q6c I achieve a good balance between my work life and my home life.	65.7	66.6	60.2	
	Q6b My organisation is committed to helping me balance my work and home life.	45.8	42.6	57.4	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
People Promise 7 We are a team	Q7e I enjoy working with the colleagues in my team.	82.4	83.1	83.7	
	Q7c I receive the respect I deserve from my colleagues at work.	77.5	77.2	76.3	
	Q7d Team members understand each other's roles.	76.5	79.2	72.7	
	Q7f My team has enough freedom in how to do its work.	55.4	57.3	64.3	
	Q7g In my team disagreements are dealt with constructively.	51.1	52.7	62.8	
	Q9a My immediate manager encourages me at work.	62.3	67.5	78.3	
	Q9b My immediate manager gives me clear feedback on my work.	53.2	57.5	72.9	
	Q9c My immediate manager asks for my opinion before making decisions that affect my work.	43.2	43.6	65.9	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
Staff Engagement Theme	Q2b I am enthusiastic about my job	73.3	73.7	72.5	
	Q3c There are frequent opportunities for me to show initiative in my role	66.9	63.8	76.1	
	Q3f I am able to make improvements happen in my area of work	39.1	43.2	59.8	
	Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	65.0	68.6	57.5	
	Q23c I would recommend my organisation as a place to work	64.3	68.2	62.4	

		NSS Bank %	EPUT Bank %	EPUT Substantive %	Vs. subs
Morale Theme	Bank workers who are considering staying on bank at their trust	64.4	74.0	--	--
	Bank worker who are considering moving to a permanent contract	24.3	16. 2	--	--
	Q3h I have adequate materials, supplies and equipment to do my work.	61.3	71.8	66.0	
	Q3i There are enough staff at this organisation for me to do my job properly.	37.1	47.9	30.2	
	Q3a I always know what my work responsibilities are.	87.5	88.6	85.4	
	Q3e I am involved in deciding on changes introduced that affect my work area / team / department.	31.4	31.6	52.9	
	Q5a I rarely/never face unrealistic time pressures	33.2	42.2	29.1	

		NSS Bank %	EPUT Bank % (n=number of staff reporting experiencing discrimination)	EPUT Substantive % (n=number of staff reporting experiencing discrimination)
Discrimination • Staff who reported experiencing discrimination in past 12 months. • Breakdown of grounds under which they experienced discrimination	Ethnic background	58.8%	**61.3%** (68)	**53.3%** (174)
	Gender	22.3%	**10.8%** (12)	**19.0%** (62)
	Age	21.0%	**7.2%** (8)	**14.4%** (48)
	Other	21.0%	**13.5%** (15)	**19.7%** (66)
	Religion	7.4%	**1.8%** (2)	**5.4%** (17)
	Disability	6.8%	**3.6%** (4)	**13.0%** (44)
	Sexual orientation	5.5%	**1.8%** (2)	**5.7%** (19)
	Total	3006	**111**	**330**

NHS Staff Survey - Action Plan

This Action Plan outlines steps which will be taken to improve staff experience following the publication of the 2022 NHS Staff Survey Results. Regular monitoring will take place, with amendments being made in light of progress made and feedback from staff.

This plan aims to:

- Identify deliverable actions which will positively impact staff experience and engagement
- Act as a catalyst for a renewed focus on Employee Experience, which has seen a fall in the two most recent Staff Survey results
-

Priority Areas

This plan has been separated into four Priority Areas (order not significant):

1) Raising Concerns, Quality and Improvement
2) Creating an Inclusive Working Environment
3) Staff Wellbeing
4) Engagement, Recognition in Work and Development

Please note: This plan is in draft format until there has been contribution through three all-staff focus groups, held on 26.04.23, 28.04.23 and 02.05.23. Development of actions in this plan is ongoing with organisational stakeholders.

Key

	Not Started/Unknown
	On Track
	Behind Target Date
	Partially Completed
	Complete

Priority 1 – Raising Concerns, Quality and Improvement

Item	Action	Outcomes	Owner(s)	Date Due	Status
1.1	Strengthening of Employee Experience Report and Data Collection, with a monthly reporting frequency to Director of Employee Experience	- Greater intelligence available to Director of Employee Experience and wider team - Actions taken by the team are informed by drivers of experience	Employee Experience Managers	May 2023	
1.2	Bank Group Supervision sessions attended by Employee Experience Team, sharing Bank results and understanding what can be done to improve experience	- Bank staff have a greater sense of their voice being heard - SAFETY ISSUES ETC - Future actions and work undertaken by the Trust is informed through the experience and feedback of Bank only workers - The value of completing staff surveys is reinforced	Employee Experience Team, Temporary Staffing Team	June 2023	
1.3	Align processes which support staff following an incident being raised on Datix (VAPR-Employee Experience)	- Staff receive consistent and timely support following an incident taking place - The process for supporting staff following an incident is clear and understood by both the Employee Experience and VAPR Teams	VAPR Team, Employee Experience Team	July 2023	
1.4	Revision and relaunch of the Zero Tolerance Policy	- Name change and policy review will align policy with NHS Standards and feedback from staff (including L100) - Presented and approved at HSSC (June, 2023) - EPUT has a robust and realistic system in place for tackling unacceptable behaviour when in the workplace.	VAPR team, F2SU	July 2023	
1.5	Targeted drop-ins across services which have high/low frequency of reported incidents	- The success of VAPR drop ins held in 2022 is built upon - Improved understanding of drivers of incidents in areas of high and low incident reporting - Staff are better protected and less likely to be involved in an incident	VAPR Team, Employee Experience Team	Summer 2023	
1.6	Refresh of the inquest team handbook	- Staff are supported through having easy access to the right information If they are required to give evidence at an inquest	Tbc (Safety/Legal Services)	Summer 2023	

Priority 2 – Creating an Inclusive Working Environment

Item	Action	Outcomes	Owner(s)	Date Due	Status
2.1	Review guidance provided to Managers on Reasonable Adjustments requests	- Managers feel they have the right information needed to perform a reasonable adjustment with a member of staff - Improved perceptions amongst staff on support provided through the reasonable adjustment process	Equality Advisor, Employee Experience Team, HR	July 2023	
2.2	Review options available within ESR and Recruitment documents so staff can accurately identify disabilities and/or long term conditions	- ESR and recruitment documentation has been reviewed and where possible, amended so staff can better capture specific disabilities and/or long-term conditions	ESR Team, Employee Experience Team, Recruitment	July 2023	
2.3	Focussed work with networks to understand drivers of bullying, harassment and abuse experienced by staff from a Black, Asian or Minority Ethnic Background (BME), and staff with a disability or Long-Term Condition or Illness (LTC)	- Networks have contributed toward practical steps being identified which will reduce the likelihood and impact of bullying, harassment and abuse - Decrease in reports of bullying, harassment and abuse from staff from a BME background and staff with a Disability or LTC	Employee Experience Team, Equality Advisor	Summer 2023	
2.4	Engagement with staff who hold a faith and/or spirituality belief, and how these can be better supported	- Direct engagement with staff across the Trust to establish steps which can be taken to support staff with a religion, faith or spiritual belief - Site vists from Experience Team will consider prayer space facilities - Programme of work has been developed with the Chaplaincy Team and Faith and Spirituality Network so staff with a faith/spiritual belief are better supported	Employee Experience Team, (with support of Chaplaincy Team and Equality Advisor)	August 2023	
2.5	Promotion of Datix's and the role they play in supporting learning from experiences of discrimination	- Approach has been developed which reinforces the importance of raising Datix's following incidents of discrimination - Guidelines/Communications develop which reinforce how these support organisational learning - Staff report feeling more comfortable in raising a Datix relating to discrimination	Principal Freedom to Speak Up Guardian, VAPR Team, Datix Team	Summer 2023	
2.6	Civility and respect sessions held across the Trust, promoting C&R toolkit and importance of creating a Just and Learning Culture	- Greater awareness of civility and respect resources (including toolkit) - Engagement with staff on vehaviours not aligned to trust values, feeding back into Experience Manager Reporting - Just Learning culture principles are more widely recognised and understood across the Trust	Employee Experience Team, Equality Advisor	Sept 2023	

Priority 3 – Staff Wellbeing

Item	Action	Outcomes	Owner(s)	Date Due	Status
3.1	Stress Awareness Month – Campaign held across April to improve awareness and available support	- 4 x weekly focus areas on stress and the support available to staff shared via comms - A special mindfulness session made available to staff which provides theory and practical guidance - Communication of employee experience manager visits across sites to discuss stress and wellbeing	Employee Experience Team, Communications	April 2023	
3.2	Encourage Staff to increase their physical health and movement throughout National Walking Month (May)	- Improved awareness of the important role of activity related to health and wellbeing - Opportunity for engagement within and across teams - Staff have engaged through Input, within Teams and on Social Media	Employee Experience Team. Communications	June 2023	
3.3	Review of Away Day support provided by Employee Experience Team and EEMs to Organisational Development	- Messaging at away days is up to date and impactful - Staff leave away days with a clear understanding of the staff offer and support available - Managers know their points of contact for support	Organisational Development, Employee Experience Team	July 2023	
3.4	Review and promote the health and wellbeing toolkit, which signposts to support available to staff	- The health and wellbeing toolkit provides clear and up-to-date guidance to staff - Staff in clinical settings have greater awareness of the health and wellbeing toolkit - The health and wellbeing toolkit can be accessed from a personal device	Health and Wellbeing Lead	July 2023	
3.5	Develop a Financial Wellbeing proposal which supports staff with needs associated with the cost of living, financial wellbeing and financial education.	- Staff are better supported in meeting the increased cost of living - There is better financial education and advice available for staff to access - Discounts are meaningful and valued by staff - Financial Wellbeing proposal to be drafted and shared with Executive Team	Employee Experience Team	July 2023	
3.6	Campaign to promote underutilised digital tools which could support wellbeing (e.g. Viva Insights)	- Staff and managers are aware of digital tools which can support wellbeing - Microsoft Teams/365 features are seen to be more heavily utilised when supporting teams, particularly those which are distributed and/or remote	Health and Wellbeing Lead, Employee Experience Team	July 2023	
3.7	Revision of NHS England Health and Wellbeing Diagnostic	- EPUT has an up-to-date diagnostic on its health and wellbeing provision - The diagnostic provides insights which can be used to develop a Health and Wellbeing Strategy	Health and Wellbeing Lead	Summer 2023	
3.8	Development of a H&W Strategy which is aligned to the NHS Health and Wellbeing Framework	- Clinical and non-clinical staff feel the strategy supports their health and wellbeing in work - The strategy supports the continuous improvement of our health and wellbeing offer - There is a greater sense that the organisation is working to deliver against the NHS People Promise 'we are safe and healthy'	Health and Wellbeing Lead	Sept 2023	

Priority 4 - Engagement, Recognition in Work and Development

Item	Action	Outcomes	Owner(s)	Date Due	Status
4.1	Hosting Staff Survey Focus Group and Bank Group Supervision Sessions, gaining feedback from staff across the organisation on the results and what needs to happen	- Action plans are aligned to the views of staff on what will have most impact - Networks have had results shared and contributed feedback and ideas - Bank staff have a greater sense of their voice being heard - Future actions and work undertaken by the Trust is informed through the experience and feedback of Bank only workers The value of completing staff surveys is reinforced	Employee Experience Team	June 2023	
4.4	Increase staff events offered (e.g. Mindfulness), both in-person and virtual	- Staff have more opportunities to connect and engage with colleagues across the Trust - Increased number of events (e.g. mindfulness sessions) available to staff	Employee Experience Team	June 2023	
4.2	Ongoing work with service areas and teams with lower engagement scores in surveys (NQPS, Staff Survey etc.)	- Improved understanding of drivers of low response rate and barriers to engaging with feedback mechanisms - Increased presence across wards and sites, reinforcing the staff offer and supporting an improved understanding of causes of disengaged teams and individuals	Employee Experience Team (Experience Managers)	July 2023	
4.5	Adoption of NHS People Pulse System for administering the National Quarterly Pulse Survey (NQPS)	- Easier comparison of NQPS scores when compared against other NHS Trusts - Improved quality of data visualisation, and quicker generation of insights from survey data	Employee Experience Team	July 2023	
4.6	Increased membership and reach of the Engagement Champions Network	- Engagement Champions distributed across the majority of Trust sites - 'Ground-up' engagement initiatives contributed by Engagement Champions - Updated Terms of Reference for Engagement Champions Network including mechanism for 'E' Performers from Pen Plan being offered a space as an Engagement Champion	Employee Experience Team	July 2023	
4.7	Hosting of the Annual Staff Recognition Awards (Quality and Excellence Awards)	- Celebration of the contribution of staff from across the Trust - Improved morale and sense of feeling recognised by the organisation	Communications Team, Employee Experience Team	July 2023	
4.8	Repeat the 'You Asked, We Delivered' communication campaign which was well received following 2021 Survey Results	- Staff feel their voice counts, and feedback is listened to and acted upon - Improved communication of the positive steps which are being taken by the Trust to improve engagement and experience	Employee Experience Team, Communications	July 2023	
4.9	Explore routes within both the Management and Leadership Development Programmes to support engagement	- NQPS and Staff Survey promoted, leading to increased response rates - Managers aware of engagement support and services available - Regular feedback and ideas from managers on ways we can improve engagement at local and Trust-wide levels	Organisational Development Team, Employee Experience Team	Aug 2023	
4.10	Praise Feature including reminders, guidance and best practice (care people promise)	- Staff have more ways to praise and recognise one another - Remote and distributed teams are able to praise and recognise one another in a digital format, increasing a sense of teamwork and connectedness	Employee Experience Team, Communications Team	Aug 2023	
4.11	Update and refresh appraisal and one to one support procedure.	- Training supports rich and effective conversations at 1:1's and appraisals - Increased sense that one-to-one and appraisal procedures support development needs	Organisational Development Team	Summer 2023	
4.12	Campaign to recruit bank workers into permanent positions	- Increase in bank only workers who have moved into a substantive position - Feedback from bank only workers on barriers to transitioning into a substantive position are collected and acted upon	Recruitment, Employee Experience Team	Summer 2023	
4.13	Development and implementation of 360 feedback to inform appraisal	- Appraisal process is informed through 360 feedback, and is felt to be helpful in supporting development needs	Organisational Development Team	Autumn 2023	

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31st May 2023**

Report Title:	**Safe Working Hours of Junior Doctors Annual Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr P Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with assurance to the that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

1. No major concerns raised by Junior Doctors.
2. There were 11 Exception Reports raised by trainees between April 2022 and March 2023
3. No fines were issued in this year.
4. Refurbishment work in the on-call and doctor's room at all sites are now complete.
5. Gaps in the rota are less compared to previous years.

6. Junior Doctors participated in the industrial action in March 2023, 27 out of 30 shifts were covered with internal locum doctors, 3 consultants had to step down. Trust spent £29,454 to cover the gaps in the shifts in order to ensure patient safety and smooth running of the services.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Dr Milind Karale **Executive Medical Director**

Agenda Item 7e
Board of Directors
31st May 2023

Annual Report on Safe Working of Junior Doctors (April 2022 – March 2023)

1 Purpose of Report

The purpose of this annual report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

Quarterly Board reports were submitted from 1 April 2022 to the 31 March 2023 (Appendices 1 to 4)

Doctors in Training Data:

Number of doctors in training (average total inclusive of GP and FY1 & FY2)	**126.75**
Number of doctors in psychiatry training on 2016 Terms and Conditions (average)	**77.75**
Total number of vacancies (average over reporting period)	**14.5**
Total vacancies covered by LAS and MTI (average over reporting period)	**7.25**

Annual data summary:

Trainees within the Trust

Specialty	**Grade**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total gaps (average WTE)**
Psychiatry	CT1-3	40	49	46	48	5
Psychiatry	ST4-6	29	34	34	34	6
Total						5.5

Trainees outside the Trust overseen by the LET guardian

Specialty	**Grade**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total gaps (average WTE)**
GP trainees	ST1	14	20	21	20	3.5
Foundation	FY1	15	15	11	13	2
Foundation	FY2	14	15	13	15	0.5

Agency Usage:

The Trust does not use agency workers and relies on the medical workforce to cover the out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours ranging from sickness, the additional out of hours that less-than full time trainees can't contractually cover and vacant posts.

The total number of shifts covered in reporting period:

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness/ LTFT cover	495	495	0	5870.5	5870.5
Total	495	495	0	5870.5	5870.5

Junior Doctor Industrial Action

The BMA announced that after its members had been balloted, that the junior doctors would be taking industrial action from 6:59am on Monday 13 March 2023 through to 6:59am on Thursday 16 March 2023. The Trust put in place measures to ensure that patient safety was not compromised and a shadow rota was set up so that there was both day and night cover across all five areas of the Trust.

In total 27 out of the 30 shifts were covered by internal locums and 3 Consultants were stood down on each of the evenings, so a total of £29,454 was spent on the shadow rota.

Exception Reports:

A total of 11 exception reports were raised by trainees via the Allocate reporting system from April 2022 to March 2023.

Please refer to appendix 5 for details on Exception Reports.

Issues Arising:

1. Gaps in rota are detailed in Appendix 5 with a monthly breakdown of vacancies. The gaps at CT level are filled with internal doctors who are paid an internal locum rate. The gaps at ST level are unfilled; The Trust does not use agency locums. There are less gaps noted in the rota, as compared to the previous Annual Board Report. National recruitment seems to be an ongoing issue but these have improved in the recent intake of trainees.
2. Stepping down policy: Trainees wanted clear guidance on this and the rates offered when stepping down. A Policy was drafted and approved by the Trust via JLNC and medical management and this has been circulated to the trainees.
3. Room refurbishments: Junior Doctors raised concerns on lack of adequate facilities in their rooms/ on-call rooms. The Junior Doctors room and the on-call

rooms across the Trust on all 5 sites have been refurbished and all items such as IT equipment, furniture and facilities in rest areas are in place.

4. Funding from Health Education England (HEE) to trainees: All the money (£30,000) have been successfully spent by trainees across the Trust, the money was spent on improving facilities in the doctors' room as per their choice. Doctors are pleased with this.

Actions taken to resolve issues:

1. Rolling adverts on NHS jobs are in place. Trust has appointed International doctors, MTI and LAS doctors and all have started their posts.
   11 Fellows under the EPUT Advanced Fellowship programme have been appointed in the last year. GPs and FY2s are given an opportunity to express an interest to join the bank to do on-calls when they leave EPUT.
2. Stepping down policy is approved and is in place
3. Room refurbishments for Junior Doctors room and on-call room is now compete.
4. All the HEE funding money is now spent by junior doctors.

Key issues from host organisations and actions taken:

1. The gaps in the rota is a National recruitment issue and not an issue within this organization. There has been a significant improvement in recruitment in the last year, resulting in lesser gaps in the rota as compared to period between April2021-March 2022.

2. The junior doctors took part in the industrial action from 6.59am on 13 March until 6.59am on 16 March 2023. The Trust provided full support to the junior doctors at the same time ensured that safety to patients are not compromised. Hence the shifts were covered with internal locum doctors and 3 Consultants had to step down to cover the rota. The Trust spent £29,454 to cover the rota during this period.

3. There are no other specific key issues within the organization. The matters raised by the doctors at the Junior Doctors Forum are resolved timely and escalated to senior managers and clinical tutors when necessary.

Summary

The National recruitment of trainees is an ongoing issue.

The Board to note that there are no specific concerns related to recruitment within the Trust. There has been a significant improvement in the intake of trainees in the last year, resulting in less gaps in the rota as compared to previous years.

Trust has employed international Doctors, LAS and MTI and this helps to cover the service provision.

The Trust does not use agency locums.

The Junior Doctors participated in the industrial action that took place in March 2023. The Trust were supportive of Doctors. The gaps in the rota, ward cover and emergency cover were all filled in by internal locum doctors so that safety of patients are not compromised. The Trust spent £29,454 to cover gaps during this period.

Room refurbishments for junior doctors' room and on-call rooms across all 5 sites of the Trust is now complete.

Trainees have raised 11 Exception reports between April 2022 and March 2023. All the issues have been resolved.

Bi-monthly junior doctor's forum (JDF) is well attended by Junior Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved timely and escalated to Clinical Tutors/DME/Senior Managers where necessary.

3 Action Required

The Board is asked to note the findings on this report.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
April 2023

		Agenda Item No: 7f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**CQC Compliance Update**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Affairs					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Executive Operational Team Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
The purpose of this report is to: 1. Provide an update on the key CQC related actions being undertaken within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

- EPUT is registered with the CQC.

- The CQC have published the acute wards for adults of working age and psychiatric intensive care units inspection report, following inspection visits on 5 and 6 October 2022 to Galleywood Ward and Willow Ward. The CQC have rated this service as inadequate for safety and issued 8 Must Do and 2 Should Do actions. An action plan has been created, to capture improvements

identified within the CQC report. The action plan has received Executive Operational Team approval and following this was submitted to the CQC in line with CQC requirements.

- The Trust is awaiting CQC reports following inspection of 6 core services in November and December 2022 and the EPUT Well Led inspection January 2023. As previously reported an initial action plan has been developed and continues to be implemented, and will be revised once the CQC report is received.

- There have been two enquiries raised by the CQC in this reporting period both of which have been investigated and responded to.

- The CQC have undertaken two MHA inspections during the reporting period, for which the reports are awaited.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Service	EOT	Executive Operational Team
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
MHA	Mental Health Act	PIR	Provider Information Return
COSHH	Control of Substances Hazardous to Health	CHS	Community Health Services
MHOST	Mental Health Optimal Staffing Tool		

Supporting Documents and/or Further Reading
CQC Update Report

Appendix A: Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units Inspectin Report Appendix B: Overarching Action Plan 2022-23 Summary Report Appendix C: Report of Actions to CQC

Lead
Denver Greenhalgh **Senior Director of Governance**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC COMPLIANCE UPDATE

1. Introduction

The purpose of this report is to provide an update on the key Care Quality Commission (CQC) registration requirements and related plans within the Trust.

2. CQC Registration Requirements

EPUT is fully registered with the CQC.

Following the publication of the CQC inspection report for acute wards for adults of working age and psychiatric intensive care units on the 3 of April 2023, the CQC have rated EPUT's acute wards for adults of working age and psychiatric intensive care units as inadequate. The inspection report was following the CQC visits to Willow Ward and Galleywood Wards in October 2022.

3. CQC Inspections

3.1. Willow Ward & Galleywood Ward October 2022 (published 3 April 2023)

The report (*appendix A*) identifies the following 10 areas for improvement, with 8 of these being stated as 'must do' (meaning action the Trust must take to comply with our legal obligations):

Ref	Action	Lead
M1	The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for the recording and reporting of incidents	Deputy Director of Quality and Safety / Associate Director of Risk and Compliance
M2	The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for patient observations and engagement. The Trust must take immediate action to ensure that staff do not fall asleep when undertaking patient observations	Director of Patient Safety and Patient Safety Specialist / Director of Nursing and IPC
M3	The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so	Deputy Director of Quality and Safety
M4	The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs	HR Director Operations / Director of MH Inpatients and Emergency Services
M5	The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots)	Senior Director of Estates
M6	The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed	Director of Patient Safety and Patient Safety Specialist / Director of IM&T and Business Analysis and Reporting
M7	The trust must ensure ligature cutters are stored in line with trust policy	Director of Risk and Compliance / Director of MH inpatients and emergency Care
M8	M8 The trust must ensure that all patients have access to nurse call alarms	Director of MH inpatients and emergency Care / Senior Director of Estates
S1	The Trust should consider how to manage and record any individual patient objections to the contact-free patient monitoring and management system	Director of Patient Safety and Patient Safety Specialist / Director of IM&T and Business Analysis and Reporting
S2	The trust should ensure that actions are taken to improve staff morale	Director of MH Inpatient and Emergency Care / Deputy Director of Quality and Safety

We have set an action plan which incorporated a review of the existing actions taken / being taken in response to the associated warning notice received in October 2023. The action plan received Executive Operational Team approval and was submitted to the CQC. The action plan will be delivered by the Inpatient Clinical Support Group and monitored through the Executive Operation Committee and oversight by the Quality Committee. A summary of the action progress is included in *Appendix B and the return to the CQC Appendix C.*

As with all reports it included some good practises identified by the CQC inspectors during their visit (listed below):

- Staff had easy access to clinical information.
- It was easy to maintain high quality clinical records whether paper-based or electronic.
- Staff completed medicines records accurately and kept them up to date.

- Staff completed risk assessments for each patient on appropriately.
- Staff understood how to protect patients from abuse and who to inform if they had concerns.
- Staff had training on, and knew how to recognise and report abuse.

- Staff assessed the physical and mental health of all patients on admission.
- Individual care plans were developed and regularly reviewed.
- Manager's ensured staff had skills needed to provide high quality care.
- Staff supported with appraisals, supervision and opportunities to develop their skills.
- Managers provided an induction programme for new staff.

- Evidence of the reported incidents.
- Managers investigated reported incidents and took actions.
- Lessons learnt were identified and staff told us these were shared at team meetings.
- Managers debriefed and supported staff after any serious incident.
- Staff felt supported after incidents.
- The service had no never events on either of the two wards.

- Staff were kept up to date with mandatory training.
- Staff received regular supervision and appraisals.
- Staff felt well supported by their leaders.
- Staff assessed patients' physical health on admission and during their time on the ward.

- Staff were mostly nice, kind and helpful, especially the day-time staff.
- Staff were caring, respectful and polite.
- They knew how to make a complaint or raise a concern should they need to.
- Most carers told us they felt informed and were kept up to

- Managers accurately calculated and reviewed the staff required for each shift.
- Managers attempted to limit the use of bank and agency staff.
- There were enough staff to carry out any physical interventions.
- The mandatory training programme was comprehensive and met the needs of patients and staff.
- 100% training rates for agency staff.

- Wards were clean, well equipped, well-furnished and fit for purpose.
- Staff completed risk assessments of all wards areas and reduced any risks they identified.
- Ligature risk assessments were in place.
- Staff had easy access to ligature packs, knew about potential ligature anchor points, where ligature cutters were located and felt confident in their abilities to use these.

3.2 Comprehensive Core Service Inspection November 2022 (Report awaited)

During November 2022 the CQC undertook inspections across 6 EPUT core services. Feedback was received with some initial areas of concern for action by the Trusts' Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units and crisis pathways. Whilst the CQC report is awaited, action has been taken to address the intra-inspection feedback.

Delivery of the plan continues to be through the Inpatient Clinical Support Group and monitored through the Executive Operation Committee and oversight by the Quality Committee.

3.3 Well Led Inspection January 2023

The CQC commenced EPUT Well Led inspection on Monday 16 January, continuing until Friday 27 January 2023. The Well Led inspection consisted of interviews with Executive Directors, Directors, key Trust Experts and Staff Focus Groups. The CQC report is awaited.

3.4 CQC Mental Health Act (MHA)

The CQC has undertaken 2 MHA inspections during March 2023, these were to Alpine Ward and Wood Lea Clinic. Following each inspection, a monitoring report is received by the ward with recommendations for improvement. All wards develop action plans to address these recommendations supported by the MHA Office. The CQC monitoring reports for these visits are awaited.

3.5 CQC Enquiries

All CQC enquires received are reviewed in full and a formal response is returned following approval by the Chief Operating Officer / Executive Chief Nurse.

During March 2023, the CQC raised one enquiry in relation to Tower Ward, this was investigated by the Service Manager and a response has been provided to the CQC.

During April 2023, the CQC raised one enquiry in relation to a welfare request for a patient. The welfare check was carried out on Tuesday 4 April 2023, by the team who are leading on the care for this patient.

4. Action required

The Board of Directors is asked to:

1. Receive and note the content of the report

Report Prepared by:
Nicola Jones, Head of Risk Management and Compliance
On behalf of
Denver Greenhalgh, Senior Director of Governance

Essex Partnership University NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

Trust Head Office, The Lodge
Lodge Approach
Wickford
SS11 7XX
Tel: 03001230808
www.eput.nhs.uk

Date of inspection visit: 05 and 06 October 2022
Date of publication: 03/04/2023

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Inadequate 

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 Essex, Bedfordshire, Suffolk and Luton. Essex Partnership University NHS Foundation Trust provides acute wards for adults of working age and psychiatric intensive care across fifteen wards on five sites. The acute wards are part of the mental health services delivered by Essex Partnership University NHS Foundation Trust. These wards provide assessment and treatment in an inpatient care setting for adults either admitted on an informal basis and/or patient detained under the Mental Health Act 1983.

The Care Quality Commission (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.

Following the inspection visits on 5 and 6 October 2022, the CQC sent a Letter of Intent to the Trust. A Letter of Intent means CQC considered using potential urgent enforcement action. We asked the Trust to respond and submit an action plan as to how they would improve the quality and safety of care, by 11 October 2022. The Trust submitted their action plan within the required timeframe.

Following review of the action plan the CQC was not fully assured. On 31 October 2022 CQC issued a Warning Notice under Section 29 of the Health and Social Care Act, asking the Trust to make significant improvements by 18 November 2022 regarding:

- Patient observations
- Sufficient numbers of regular staff
- Patient consent
- Blanket restrictions
- Incident reporting
- Ligature cutters

See our website for more information about Section 29 Warning Notices:

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/enforcement-policy

What we found:

- Staff did not always follow Trust policies and procedures, despite systems being in place which provided them with training and induction.
- Staff did not always follow the Trusts' policies and procedures with regards to patient observations.
- Staff did not always follow the Trusts' policies and procedures with regards to recording and reporting of incidents.

Our findings

- There were very high levels of vacancies and sickness amongst nursing and support staff across both wards. This meant that there were many different temporary staff working on the wards that were not familiar with the patients.
- High use of bank and agency staff meant that not all staff knew the patient's individual needs, despite the trust systems to record patient risk and care plans.
- The Trust had not ensured that work was completed to address the inability of staff to observe patients from all areas (blind spots).
- The Trust had not ensured that all aspects of care and treatment of patients was provided with the consent of the relevant person.
- The Trust had a policy in place to manage restrictive practices which allowed staff to restrict access to certain areas within the ward based on risk. However, this meant that all patients on the ward were restricted from areas such as the gardens, bedrooms, bathrooms and toilets.
- The Trust did not ensure ligature cutters were consistently accessible for staff.

However

- Staff were kept up to date with mandatory training.
- Staff received regular supervision and appraisals.
- Staff felt well supported by their leaders.
- Staff assessed patients' physical health on admission and during their time on the ward.

Background to the inspection

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services. CQC were informed by Essex Partnership University NHS Foundation Trust of a scheduled broadcast on Channel 4 in October 2022.

We visited two of the Trust's fifteen acute and PICU wards, these were the two wards identified in the Channel 4 television programme.

We suspended this trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

How we carried out the inspection

Due to the focused nature of this inspection we looked at four key questions; safe, effective, caring, and well led. We did not inspect all key lines of enquiry across every key question. Because of its limited scope, we did not set out to rate at this inspection. However, during this inspection we identified breaches of regulations. This means the rating linked to the domain the breach sits under will normally be limited to 'inadequate'.

During the inspection we:

- visited 2 wards and observed how staff cared for patients;
- viewed extracts of CCTV and body camera footage;
- toured the clinical environments;

Our findings

- spoke with 9 patients who were using the service;
- interviewed 10 staff members and ward managers;
- spoke with 7 carers;
- reviewed 7 patient records;
- reviewed 11 prescription charts;
- reviewed 10 patient observation charts;
- reviewed policies and procedures, data and documents relevant to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with 9 patients who were using the service and 7 carers.

Patients told us:

- Staff were mostly nice, kind and helpful, especially the day-time staff.
- One to one therapeutic time with a named nurse didn't always happen.
- There was not always enough staff and at times there were lots of different staff working on the ward.
- Escorted leave was sometimes cancelled.
- They cannot easily access the bathrooms and gardens.
- Three patients told us night-time staff were sometimes less understanding, compassionate and helpful than day-time staff.
- Three patients told us that they had seen staff sleeping on duty.

Carers told us:

- Staff were caring, respectful and polite.
- They knew how to make a complaint or raise a concern should they need to.
- Most carers told us they felt informed and were kept up to date. However, one carer told us communication was poor and another told us it was mixed.
- Sometimes the wards were short-staffed.

Is the service safe?

Inadequate 

Our rating went down from requires improvement to inadequate. This is because we identified breaches of regulations. This means the rating linked to the domain the breach sits under will normally be limited to 'inadequate'.

Our findings

See our website for more information about rating principles: https://www.cqc.org.uk/guidance-providers/nhs-trusts/ratings-principles-nhs-trusts

Safe and clean care environments

Wards were clean, well equipped, well-furnished and fit for purpose.

Safety of the ward layout

Staff completed risk assessments of all wards areas and reduced any risks they identified. We saw both Galleywood and Willow wards had ligature risk assessments in place that identified ligature risks and blind spots. The latest ligature risk assessment for Galleywood ward was undertaken in July 2022. For Willow ward this was undertaken in September 2022.

Managers had completed plans for both wards to reduce potential risks identified in the ligature risk assessments. The manager for Galleywood ward had provided comment against each potential risk stating how that risk was being reduced. From this risk assessment several actions where identified of which, 3 were rated as high priority. The manager for Willow ward had identified 7 areas for action, none of which were high priority. Both managers had also completed an accompanying action plan, and we noted that these actions were complete.

Managers made sure that staff on the wards had easy access to ligature packs with information on environmental risks. This included a map of hotspot areas. Staff we spoke with knew about any potential ligature anchor points, where ligature cutters were located and felt confident in their abilities should they need to use these. Staff could describe mitigations taken to reduce risks to patients' safety.

During our inspection we noted that storage of ligature cutters differed on the two wards. On Willow ward all ligature cutters were stored in one bag. On Galleywood ward the different cutters were placed in individual bags in the nursing office. This was not in line with Trust policy. We were concerned that differing practice across the two wards could lead to staff being confused about the process for accessing these in an emergency.

On the day of the inspection, the manager of Willow ward told us that adjustments were being made to improve the storage of the ligature cutters. We saw maintenance work taking place during the inspection.

Staff could not always observe patients in all parts of the wards. Managers identified areas where staff could not observe patients and mitigated this by convex mirrors or staff observations. This was recorded this within the ligature risk assessments. However, we found one example where a blind spot in the lounge on Galleywood ward had been identified at the most recent ligature risk assessment of July 2022. The ward manager had requested convex mirrors to be installed. However, on the day of inspection this work had not been completed. The risk assessment showed that mitigation was in place and managers had made staff aware of the hotspots through the patient safety hotspot chart and ensured a member of staff sat in this room.

Staff had identified a potential blind spot in the garden at Galleywood ward. Staff had reduced the associated risk by keeping the garden door locked. This meant that patients could only access the garden under the supervision of staff.

We saw CCTV was used in communal areas and staff wore bodycams on both wards. The Trust had a surveillance system policy and a body worn camera protocol in place. The policy stated that bodycams should be worn during each shift and be activated when and where an incident is taking place. Staff confirmed they were encouraged to switch the body camera on to film any patient safety incidents.

Our findings

During inspection we were told that the wards had a contact-free patient monitoring and management system. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity-based alerts, warnings and reports on risk factors. Staff told us that consent was obtained from patients on admission to the ward. Whilst we saw consent forms in admission packs, four patient records reviewed at Willow ward and three records reviewed at Galleywood ward did not show evidence of patient consent to the system on admission, and there was no evidence in the patient records that the system had been revisited with patients on the ward after admission. During the inspection, two patients on Galleywood ward told us they could not remember giving consent for its use. One patient on Galleywood ward told us they were not aware of the system in their bedroom.

The ward complied with guidance and there was no mixed sex accommodation, both wards were female only.

Staff had easy access to personal alarms and could call for extra staff to support in emergencies.

Patients on Willow ward had access to nurse call alarm systems in their bedrooms. However, there were no alarms in bedrooms for patients to access nurse call systems on Galleywood ward. This meant that staff relied on the contact-free patient monitoring and management systeme to alert them to patient concerns.

Maintenance, cleanliness and infection control

Willow ward was clean, bright, well maintained, well-furnished and fit for purpose. However, Galleywood ward was tired and in need of some redecoration. Managers had made attempts to brighten the environment with colourful murals in communal areas.

On Galleywood ward we observed an over-flowing bin in the lounge and one patient told us they had bugs in their bins.

Clinic room and equipment

Clinic rooms were clean, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough permanent nursing staff, who knew the patients well and keep people safe from avoidable harm.

Nursing staff

The service did not have enough permanently employed nursing and support staff to keep patients safe.

The service had very high vacancy rates. At the time of inspection, the vacancy rate for registered nurses was 81% (Willow ward) and 56% (Galleywood ward). The vacancy rate for Nursing Support Workers was 39% (Willow ward) and 43% (Galleywood ward).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.

Our findings

We reviewed bank and agency usage from 15 August 2022 to 11 September 2022. The service had high rates of bank and agency staff. We found bank and agency staff were regularly used on both day and night shifts across both wards. We saw examples of shifts where managers had been able to book additional unregistered bank and agency staff to undertake engagement and supportive observations of patients who needed a high level of observation.

Managers attempted to limit the use of bank and agency staff by requesting and booking staff familiar with the service in advance. For example, Galleywood ward had block booked agency staff until end of January 2023. However, we reviewed the staff rosters and found during the period 15 August 2022 to 11 September 2022, 33 different registered staff worked on Willow ward. For the same time period we found 25 different registered staff worked on Galleywood ward.

During the period 15 August 2022 to 11 September 2022 169 different unregistered staff worked on Willow ward. For the same time period we found 81 different unregistered staff worked on Galleywood ward.

This meant there was a high number of different temporary staff working on the ward. Patients told us that not all staff on the wards were familiar with their individual needs.

The service had variable turnover rates. We reviewed the staff turnover rates from June 2022 to August 2022. Willow ward had the highest staff turnover rate in this time period and was 22.2% for July 2022. Galleywood ward had a 0% staff turnover rate in this time period.

Levels of sickness were high due to the low number of permanent staff and high staff vacancy rate. We reviewed sickness levels from June 2022 to August 2022. The monthly staff sickness rate in this time period ranged from 3% to 13% for Willow ward. The staff sickness rate in this time period for Galleywood ward ranged from 2% to 13%. The trust target for sickness rate was below 12%.

Patients told us they did not always have regular one to one sessions with their named nurse.

Patients told us sometimes they had their escorted leave cancelled and staff we spoke with confirmed this.

The service had enough staff to carry out any physical interventions. Staff told us they could access additional staff to support in emergencies through the rapid response procedure. Designated staff from neighbouring wards could assist to emergency call alarms. Staff told us that staff always responded to rapid response calls.

Mandatory training

Staff employed by the Trust had completed and kept up to date with their mandatory training. Training compliance rates ranged from 81% to 100%.

The mandatory training programme was comprehensive and met the needs of patients and staff. This meant the Trust provided a full suite of mandatory training courses suitable to this service.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers told us that a central team in the Trust had responsibility for ensuring that agency staff deployed on the ward had the appropriate training for the role. All agencies under the approved NHS agencies framework had full responsibility for ensuring agency workers received and were up to date with the NHS mandatory training standards. We reviewed training rates for agency staff for the period 1 April 2022 to 30 September 2022, 100% of agency staff working across both wards were up to date with the required training.

Our findings

Assessing and managing risk to patients and staff

Staff assessed and regularly reviewed patient risk. However, staff did not always manage risks to patients well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a or soon after and reviewed this regularly, including after any incident.

We reviewed 7 patient records. Staff had completed risk assessments for patients on admission or arrival. Staff regularly reviewed risk assessments at the weekly multi-disciplinary meetings and more frequently when required. However, we found two of the records on Galleywood ward where the risk assessment had not been updated following an incident. We saw these incidents had been recorded in the ward round notes.

Patients had their physical health assessed soon after admission and were regularly reviewed during their time on the ward.

Management of patient risk

Staff had not always conducted patient observation in line with trust policy. We reviewed 10 observation records and found all records were fully completed except for one that was completed incorrectly. For one patient on Willow ward, staff had recorded Level 2 (intermittent) observations every 15 minutes, instead of four times an hour at irregular intervals. This practice did not follow the Trust's own policy.

During inspection, one staff member was observed to be sitting in a chair outside a patient's bedroom on Galleywood ward, when the patient was on 'within eyesight' observations. The nurse was observed to be reading a care plan book. Following inspection, managers told us that the nurse was using the care plan book to engage with the patient.

We reviewed CCTV footage of one staff member briefly appearing to fall asleep whilst undertaking a patient's observations on Willow ward a few minutes before being replaced by another member of staff.

During our inspection we interviewed 9 patients, out of which, 3 patients told us that they had seen staff sleeping on duty. One patient told us they had heard a staff member snoring whilst undertaking their observations. Two patients told us that they had seen staff on their mobile phones. We reviewed body cam footage where another patient disclosed to staff they had seen a staff member sleeping and had recorded this on their mobile phone. We reviewed one piece of CCTV footage where we saw a member of staff using their mobile phone whilst in the nurses' office. However, managers told us the use of mobile phones in non-patient areas is within Trust policy.

We reviewed incident data for the period 1 May to 5 October 2022. During this time there were 2 reported incidents of staff sleeping whilst on observations for Willow ward.

We reviewed an incident on 19 September 2022 on Willow ward where a member of staff undertaking one to one (continuous) observations of a patient, had recorded that the patient had attempted to tie a ligature.

We reviewed incident data for the period 1 May to 5 October 2022 and found one incident where a detained patient was able to leave Galleywood ward whilst on level 3 (continuous) observations through a back door. We viewed CCTV footage of this incident where the patient reached the multi-storey car park within the hospital grounds.

Our findings

Use of restrictive interventions

Levels of restrictive interventions varied across the two wards. We viewed data from 1 May 2022 to 5 October 2022. During this time there had been 9 incidences of restraint on Galleywood ward, of which once incident resulted in staff administering rapid tranquillisation. On Willow ward, for the same time period, there had been 80 incidences of restraint of which, 8 had resulted in medication being used (10%). There had been no reported incidents of the use of prone restraint.

Staff we spoke with told us they 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. We viewed CCTV and bodycam footage for 3 restraint incidents. We found in 2 of the 3 incidences (both on Willow ward) that staff had attempted to use de-escalation techniques. However, staff attempts at de-escalation for both of these incidents had been unsuccessful and resulted in restraint.

We found that CCTV footage of the third restraint incident on Galleywood ward, had not matched the description of the incident within the incident report. The incident report described the patient as kicking the door of the nurses' office. We watched footage for an hour before the incident but whilst CCTV showed the patient as having been agitated, the patient was not observed to be physically aggressive. From the footage it was not clear the patient restraint was necessary.

We found evidence of restrictive practices on both wards. During inspection we saw on Galleywood ward that the garden was locked. Staff told us that patients needed to be supervised when outside. We also saw the ward toilets were locked (there were a total of 6 toilets of which 2 were currently out of order). One patient was observed asking to go to the toilet, however the staff member did not have keys and had to go and find another staff member with the keys. We found patient bathrooms and showers were also locked.

On Willow ward patients had to ask a staff member to go into their bedroom. The manager told us this was because patients were unwell, therefore they could lose their bedroom key fobs. We found the door to the garden was locked and staff on Willow ward told us patients were not able to go out into the courtyard unsupervised.

Safeguarding

Staff understood how to protect patients from abuse and who to inform if they had concerns. 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. Permanent staff were 100% compliant with both levels two and three safeguarding training for both adults and children. Agency staff were 100% compliant with levels one, two and three safeguarding training for both adults and children.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw posters on the safeguarding process on display in the ward.

We saw evidence that safeguarding incidents were reported, actioned and lessons learnt.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward managers were the leads for safeguarding and worked with the Trust safeguarding team who had responsibility for overseeing the safeguarding process.

Our findings

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All permanent and bank staff had a log in to access patient notes and electronic systems and records. There were guest log ins for agency staff.

Records were stored securely.

Medicines management

Staff completed medicines records accurately and kept them up to date. We reviewed 11 prescription charts across the two wards and found they were complete.

Staff stored medicines and prescribing documents safely.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff had not always recognised incidents or reported them appropriately. Managers investigated reported incidents and shared lessons learned with the whole team.

Staff we spoke with told us what incidents to report and how to report them. However, out of the 7 patient records reviewed, we found 3 examples (one incident on Galleywood ward and two incidents on Willow ward), where incidents recorded within the patient notes had not been reported on the Trust reporting system.

We reviewed incidents for both wards between 1 May 2022 and 5 October 2022. During this time Willow ward had reported 313 incidents. For the same time period Galleywood ward had reported 119 incidents. We saw evidence of the different categories of incidents staff reported and incidents were reported to the National Reporting and Learning System (NRLS).

Managers had investigated these incidents and took actions. Lessons learnt had been identified and staff told us these were shared at team meetings. Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they felt supported after incidents and that debriefs took place.

Between 1 May 2022 and 5 October 2022 one incident of a staff member sleeping whilst on patient observations been reported on Willow ward. Managers took immediate action however, no lessons learnt were recoded within the incident report.

The service had no never events on either of the two wards. Never events are serious incidents that are wholly preventable.

Is the service effective?

Inspected but not rated

Our findings

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were regularly reviewed.

We reviewed 7 patient care records and found staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Care plans were regularly reviewed, and we saw evidence of patient involvement. We saw examples of "My care, My recovery" plans.

We saw evidence that patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Records showed that staff developed a comprehensive care plan for each patient that reflected their mental and physical health needs.

Within the 7 records we viewed staff had regularly reviewed and updated care plans when patients' needs changed.

Skilled staff to deliver care

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 made sure all bank and agency staff had an induction and understood the service before starting their shift. We saw competency folders and staff checklists were in place on the wards to familiarise new staff in key areas such as patient hotspots, ligature cutters, safeguarding, medical emergencies and incident reporting.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. We reviewed training rates for agency staff for the period 1 April 2022 to 30 September 2022. During this period, 100% of agency staff working across both wards were up to date with the required training.

Managers supported staff through regular, constructive appraisals of their work. Managers had ensured that 100% of staff were up to date with their appraisal on both wards.

Managers supported non-medical staff through regular, constructive clinical supervision of their work 83% of eligible staff on Willow ward and 100% of eligible staff on Galleywood Ward. We were told the lower percentage on Willow ward was due to staff sickness absence.

Is the service caring?

Inspected but not rated

Our findings

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness.

Patients on Galleywood ward told us that staff treated them okay, but they were often busy and the ward was short of staff.

Patients on Willow ward told us that day-time staff treated them well. However, three patients told us night-time staff were sometimes less understanding, compassionate and helpful than day-time staff.

Carers told us that most staff were caring, polite and respectful and showed an interest in their friend or relative's wellbeing. However, one carer told us that night staff were not as communicative.

During our inspection we observed some positive patient and staff interaction. For example, on Willow ward, we saw the ward manger and staff speaking compassionately and calmly to a patient that was distressed.

However, during our inspection we observed staff in the garden at Galleywood ward talking amongst themselves, not engaging with patients.

We viewed a piece of CCTV footage on Galleywood ward of a distressed patient. There was minimal engagement made by staff.

Is the service well-led?

Inspected but not rated

We suspended this Trust's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about this service.

Rating remains suspended.

Leadership

Leaders were visible in the service and approachable for patients and staff.

Staff told us leaders were supportive and approachable. Staff knew who the local leaders were. Most staff knew who the most senior managers in the organisation were or where to find that information.

Culture

Staff felt respected, supported and valued. However, staff were stretched and there was low morale.

Our findings

Staff we spoke with said they felt leaders and their colleagues were supportive and felt respected and valued by their line managers.

However, some staff reported feeling stretched and there was low morale. They told us there were high levels of patients that were very unwell on the ward that was challenging. Staff raised concerns about the low levels of permanent staff and high use of temporary staff. This meant that there had been a high number of different staff working on the wards. Whilst staff reported good team working amongst permanent members of staff, some staff told us that continuity of care had been an issue on both wards.

The service had a whistleblowing policy in place. Most staff we spoke with were aware of this and were confident they would use this if required.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level.

The Trust did not have effective systems and process in place to assess, monitor and improve the quality and safety of the services or mitigate risks to patients such as not all staff were following trust policy and procedures. We saw examples of this for incident reporting and recording, patient observations and ligature storage policies.

The service had high vacancy and sickness rates. Managers were heavily reliant on the use of bank and agency staff to fill shifts.

The Trust did not have effective monitoring systems in place to ensure they are improving and learning. During a Mental Health Act Review visit of 12 and 13 April 2022 we found patients could not access the garden on Willow ward without restriction. The Trust told us they had taken action and that the door “will only be closed if there is an emergency or a potential risk that requires staff attention”. On the day of our inspection the ward environment was calm however, the garden door was still locked.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for the recording and reporting of incidents.
- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for patient observations and engagement. The Trust must take immediate action to ensure that staff do not fall asleep when undertaking patient observations.
- The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so.
- The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs.
- The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots).
- The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed.
- The trust must ensure ligature cutters are stored in line with trust policy.
- The trust must ensure that all patients have access to nurse call alarms.

Action the service SHOULD take to improve:

- The Trust should consider how to manage and record any individual patient objections to the contact-free patient monitoring and management system.
- The trust should ensure that actions are taken to improve staff morale.

Our inspection team

The inspection team included two CQC inspectors and a specialist nurse advisor. The team visited two wards, Willow ward and Galleywood ward, on 5 and 6 October 2022 and completed off-site inspection activity between 5 October to 21 October 2022.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	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

Appendix B

Quality and Safety Mental Health Adult and PICU Inpatient Services
Summary: Action Update

The action plan was developed following a CQC inspection in October (Willow and Galleywood) and November (6 Core Services including MH Adult and PICU inpatients and Crisis Services). The action plan was developed by key Trust experts and is being overseen by the Inpatient Intensive Support Group.

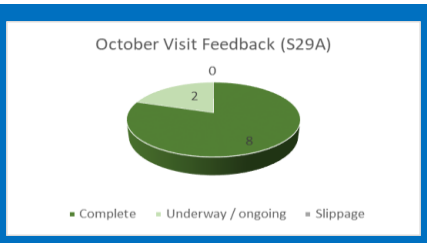
Please note the CQC have now published their inspection report following visit in October and a new action plan is being established to address the Must do and should do actions. These have mainly been address through the work undertaken in the initial action plan.

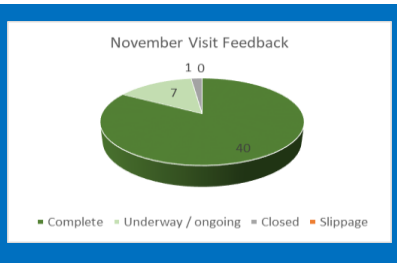
Following the inspections the Trust received key areas for immediate action:

Nov 22 feedback	October 22 Feedback
Incident Reporting	Observations
Response to Racial Abuse	Staffing
Sleeping on Duty	Consent
Restrictive Practice	Restrictive Practice
Sexual Safety	Incident Reporting
Professional Boundaries	Ligature Cutters
Acute Care Pathway	
Medicines Management	

Progress Summary

The graphs and tables below highlight progress with actions. The full action plan is attached in a separate worksheet.





Action	Action Status	Actions Outstanding (November visit)
1. Incidents	*9/9	Nil - All complete
2. Racial Abuse	*6/6	Nil - All complete
3. Sleeping on Duty	*3/5	Recruitment to final night site manager post: Schwartz rounds;
4. Restrictive Practice	*4/4	Nil - All complete
5. Sexual Safety	*4/5	Full launch new sexual safety training
6. Professional Boundaries	*3/3	Nil - All complete
7. Acute Care Pathway	*6/8	Recruitment to all discharge coordinator posts; alignment of policy with RCPSYCH guidance
8. Medicines Management	*6/8	Pharmacy establishment part of Time to Care; completion of incident deep dive

Action	Action Status	Actions Outstanding (October Visit)
9. Observations	*3/4	Timescale for roll out of E'observations to Willow and Galleywood agreed May 23
10. Staffing	*1/1	Nil – all actions complete
11. Consent	*2/2	Nil – all actions complete
12. Restrictive Practice	*0/1	New reduced ligature vent for toilets sourced and being fitted May 23
13. Incident Reporting	*1/1	Nil – all actions complete
14. Ligature Cutters	*1/1	Nil – all actions complete

Report Prepared by

Nicola Jones, Director of Risk and Compliance
On Behalf of
Natalie Hammond, Executive Nurse

Appendix C

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	R1L
Our reference	INS2-13950478781
Location name	Essex Partnership University NHS Foundation Trust

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Treatment of disease, disorder or injury**	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	Staff did not always follow Trust policies and procedures, despite systems being in place which provided them with training and induction. *Staff did not always follow the Trusts' policies and procedures with regards to patient observations.* *Staff did not always follow the Trusts' policies and procedures with regards to recording and reporting of incidents.* *High levels of vacancies and sickness amongst nursing and support staff led to high use of bank and agency staff. This meant that not all staff knew the patient's individual needs, despite the trust systems to record patient risk and care plans.* *The Trust had not ensured that work was completed to address the inability of staff to observe patients from all areas (blind spots).* *The Trust had not ensured that all aspects of care and treatment of patients was provided with the consent of the relevant person.* *The Trust did not ensure it had a system in place to ensure there were clear rationale for any restrictions in place. For example, patients could not easily access the gardens, bedrooms, bathrooms and toilets.* *The Trust did not ensure ligature cutters were consistently accessible for staff.*

M1	The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for the recording and reporting of incidents

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding incident reporting. Key actions were:

- Ward coaching and awareness raising of the importance of incident reporting
- Review of how wards discuss incidents using safety huddles, handovers and team meetings

Outlined below are further actions taken and those still planned.

1. **Promotion of Business Continuity Plan (BCP) incident short form (Action Complete)**
   All wards were reminded that they can use the BCP incident reporting short form. This provides staff with a quicker way to report an incident at times when the ward is busy or when access to the electronic system would be difficult.
2. **Review of Safety Huddles (Action Complete)**
   The safety huddle template has been revised based on national guidance with the aim to empower ward staff to have a space where they can discuss their safety concerns including incidents. Incident themes are shared and discussed in the Senior Safety Oversight Huddle.
3. **CCTV and BWV Pilot (Action Underway)**
   The Trust has completed a pilot project to explore the potential to utilise the CCTV and Body Worn Camera video footage for learning with a focus on professional standards. The aim is to celebrate and share good practice as well as identification of lessons for improvement. Following completion of the pilot a recommendation is being developed for a 'business as usual' process, with the aim to launch in May 2023.
4. **Coaching regarding Risk Assessment (Underway)**
   Work with all wards to embed practice of reviewing patients risk assessment following an incident. The aim of this is to ensure all staff follow Trust guidance on risk management and all patients risk is considered when there is a change including following an incident.
5. **System Alerts (Action Underway)**
   We are exploring if the Datix system can give a prompt to staff when completing an incident reminding them to review the patients risk assessment

Who is responsible for the action?	Deputy Director of Quality and Safety Associate Director of Risk and Compliance

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

A range of methods have been identified to monitor the impact of actions taken and ongoing assurances have been identified:

- Willow and Galleywood Incident Reporting Rates, looking for trend over time in line with national benchmark. Ongoing monitoring will be built into the Trust Risk Management report which is presented monthly to Local Quality and Safety Groups and Trust Health Safety and Security Committee. Adult and PICU Incident Reporting Rate, as above
- Audit of Patient notes against Datix, focused audit prioritising Willow and Galleywood Wards. Sample audit will be ongoing and will be added into the Trust Risk Management report.
- Quarterly Records Audit over the next year looking at if risk assessment updated following an incident, focused audit prioritising Willow and Galleywood Wards
- Audit Datix – review sample incidents against BWV / CCTV to see if recording of incident matches, focused audit prioritising Willow and Galleywood Wards

Who is responsible?	Deputy Director of Quality and Safety Associate Director of Risk and Compliance

What resources (if any) are needed to implement the change(s) and are these resources available?

The Trust Compliance and Datix Teams will support the Deputy Director of Quality and Safety in taking forward these actions. Additional resources already secured to ensure capacity.	
Date actions will be completed:	End May 2023

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The majority of actions have already been completed based on previous CQC feedback received. These have already started to make a difference which can be seen in the current reporting rates for Willow and Galleywood Ward which were both above national benchmark for February 2023.

Ward Managers and Matrons are providing further mitigation through their routine assurance processes which include checking incident reporting and that risk assessments have been updated.

M2 The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the Trusts' policies and procedures for patient observations and engagement. The Trust must take immediate action to ensure that staff do not fall asleep when undertaking patient observations.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding staff following the Trusts' policies and procedures for patient observations and engagement. Key actions were:

- Immediate Leadership Oversight and ward manager role modelling.
- Sleeping on duty safety alert issued.
- Behavioural standards discussed at handover meetings, highlighting importance of concentrating during Observation and Engagement.
- Re-circulated of the observation training video to all staff.
- Our Compliance Team and Deputy Directors of Quality and Safety time on wards and provided assurance of good practice seen.
- Audit of fit for work book completed.
- Quality improvement project focusing on Observation and Engagement. This is co-production project giving patient and staff opportunity co-design a range of ideas to be trialled.

Outlined below are further actions taken and those still planned.

1. **Ongoing Leadership Oversight (Action underway)**
   Following the immediate support put in place, we have established new band 7 night site officers at Rochford site and Linden Centre, 5 roles have already been recruited to and 1 remains open. This provides additional leadership across all shifts.
2. **Training and Awareness raising (Action complete)**
   Observation and Engagement prompt cards developed as a resource for staff on the wards.
3. **Tackling Sleeping on Duty (Action underway)**
   Staffing roster rules reviewed to ensure fit for purpose and new exception reports established. This provides managers with key information to ensure staff are not working excessive hours prior to a shift being worked within the Trust.
   The Trust process for managing sleeping on duty has been rescinded and this is now managed under disciplinary processes as potential gross misconduct (noting that this process continues to pick up on staff wellbeing in phase 1). A further safety learning briefing will be issued.

Who is responsible for the action?	Director of Patient Safety and Patient Safety Specialist. Director of Nursing and IPC

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

A range of methods have been identified to monitor the impact of actions taken and ongoing assurances have been identified:

- Patient Survey - have they seen staff sleeping on duty (in last 2 weeks)
- Audit - Observation records have they been completed correctly and undertaken in line with appropriate levels.
- Incidents of staff sleeping
- Audit of records for patients on 1:1 observations - were incidents able to happen (ligature, AWOL etc.)

Who is responsible?	Director of Patient Safety and Patient Safety Specialist. Director of Nursing and IPC

What resources (if any) are needed to implement the change(s) and are these resources available?

The Trust Patient Safety and HR Teams will support in taking forward these actions.

Date actions will be completed:	End of May 23

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The majority of actions have already been completed based on previous feedback received. Potential impact for patient safety remains if a patient is not observed and engaged as per policy.

M3 The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding blanket restrictions on the wards. Key actions were:

- Ensuring restrictions on the wards were part of risk mitigations
- Access to the gardens has been discussed in huddles with staff and the Garden Protocol recirculated. We have also held discussions in community meetings with our service users to ensure that requests can both be made and responded to in a timely manner and service users receive a positive experience.
- Commissioned Estates team to seek alternative Vent for toilets on Galleywood ward which represent a ligature risk. Vent has been identified and will be installed by end of May 2023.
- Sourced extra keys to enable all staff on duty to have a key to patient toilets.
- Both out of order toilets were subsequently fixed.
- Access to bedrooms restored on Willow ward following completion of building / maintenance works.
- Imbedding of Reducing Restrictive Practice Policy continues with reporting to the Quality Committee
- Re-circulated guidance on global restrictions and best practice.

Outlined below are further actions taken and those still planned.

1. **Understanding Restrictive Practices (Action underway)**
   Blanket restrictions are being identified and reviewed on an on-going basis through local reducing restrictive practice discussions.
   Review of restrictive practices in place on all wards was undertaken following the CQC visit. Where practice was identified, it was reviewed to consider if they were part of risk mitigations, and consideration was given to alternatives ways of mitigating the risk. A reduction plan has been developed and is underway.
   Safewards training is being offered across the Trust to reduce conflict and containment.
   A learning event for staff will be held focusing on restrictive practice, understanding what is in place and what we want to prioritise reducing.

2. **Review of Trust process (Action underway)**
   Review of the Trust's process for systematic and regular review of identified restrictions, which includes regular review of all restrictions to consider necessity and proportionality and if a plan is in place to reduce.
   One of the Trust Deputy Directors of Quality and Safety (DDQS) will lead on and undertake the Culture Of Care Review Tool across our acute inpatient services.
3. **Patient and Visitor information (Action underway)**
   Review availability of information outlining identified restrictions on the wards for patients to ensure patients have awareness of the any restrictions and the reasons for them being in place.

Who is responsible for the action?	Deputy Director of Quality and Safety

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Restrictive practice incident monitoring via Restrictive Practice Group

Who is responsible?	Deputy Director of Quality and Safety

What resources (if any) are needed to implement the change(s) and are these resources available?

Nil, review of existing processes to make more robust

Date actions will be completed:	End of July 23

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The majority of actions have already been completed based on previous feedback received. There is a small risk of unnecessary restriction while the reduction plan is fully completed and implemented.

M4 The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding numbers of regular staff working on the wards. Key actions were:

- An immediate review of staffing rosters was undertaken to increase the proportion of temporary staff who would be considered to be regular and therefore have experience of working in the Trust and would be familiar with our patient needs. Immediately transferred a substantive registered member of staff to Willow Ward to provide additional substantive cover.
- Monitored and managed through the daily sit reps meetings with escalation of issues where necessary. Mitigations may include open authorisation to staff over establishment, utilisation of the wider MDT, movement of staff from other areas and to draw on senior and corporate qualified staff to step down.
- Set a clear definition for 'regular staff' as any staff member working 2 or more shifts a week over an eight week period so this can be appropriately monitored
- Capped the number of patients on both wards aimed at managing the acuity levels on the wards with a clear process in place to review the ability to admit in line with regular, safe staffing numbers and clinical opinion / assessment of acuity.
- Initiated long line agency contracting (6-month contracts).

Outlined below are further actions taken and those still planned.

1. **Time to Care Initiative (Action underway)**

To provide long term solutions and significantly improve our ability to staff our wards appropriately, we have commissioned a ground breaking project looking at all aspects of the way in which inpatient mental health wards operate – from staffing to using innovations and technology to support patient care. This works is called 'Time to Care. Key to this is our workforce planning and model.

2. **Enhance leadership for night shifts (Action underway)**
   New clinical site manager (night) roles have been developed for the Rochford Site and the Linden Centre. Recruitment is underway with 5 posts recruited to and 1 still underway.

Who is responsible for the action?	HR Director Operations Director of Mental Health Urgent Care & Inpatient Services

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

A range of methods have been identified to monitor the impact of actions taken and ongoing assurances have been identified:

- Vacancy Rates - for registered nurses and for support workers
- Sickness Rates
- Turnover Rates
- Bank usage
- Agency usage
- Use of regular staff

Who is responsible?	HR Director Operations Director of Mental Health Urgent Care & Inpatient Services

What resources (if any) are needed to implement the change(s) and are these resources available?

Time to Care project is being supported by the Trust Project Management Office (PMO)

Date actions will be completed:	Time to Care Year 1 Business Case to be presented to the Board of Directors May 2023, then if supported by ICS Year 1 Delivery with next touch point of April 2024.

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Potential for poor patient experience and outcomes.

M.5 The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The mirrors requested following identification of the blind spot at Galleywood Ward were fitted on 15 November 2023). The Estates team undertook a review to understand why there was a delay in completing this job which identified human error.
Increased communication between estates and the wards initiated through fortnightly reviews of patient safety related orders by the Patient Safety Officer.

Who is responsible for the action?	Senior Director of Estates

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
We will use our ligature inspection programme to continue to assess ligature risks and have enhanced the organisational oversight of outstanding actions from the inspection via the Trust Ligature Risk Reduction Group.	
Who is responsible?	Senior Director of Estates
What resources (if any) are needed to implement the change(s) and are these resources available?	
No further resources needed	
Date actions will be completed:	Action complete
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
For any identified ligature risk immediate clinical mitigations are put in place to manage the risk until a different solution can be found. This ensures the safety of our patients.	

M6	The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding patient understanding of the use of the contact-free patient monitoring and management system. Key actions were:

- The Trust met and discussed the use of Oxevision with all current patients on the ward to ensure that they understood how it is used on the wards and an explanation that they are able to decline its use. These discussions have been recorded within the individual patient records.
- The SOP has been reissued to clarify the implied consent process to be followed.
- National guidance issued (3November 2022) reviewed and SOP updated.
- Compliance Team auditing of wards to check recording in patient records and posters available in patient bedrooms

Outlined below are further actions taken and those still planned.

1. **Establish ongoing assurance (Action underway)**
   Added monitoring of Oxevision discussion documentation to the Matrons Assurance audit to ensure ongoing assurance and testing. Currently embedding.

Who is responsible for the action?	Director of Patient Safety and Patient Safety Specialist Director of Mental Health Urgent Care & Inpatient Services.
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Records audit - detailing initial discussion of Oxevision on admission and detailing ongoing discussion of Oxevision Regular review of the SOP to ensure meets national guidance	
Who is responsible?	Director of Patient Safety and Patient Safety Specialist Director of Mental Health Urgent Care & Inpatient Services.
What resources (if any) are needed to implement the change(s) and are these resources	

available?	
No further resources are needed	
Date actions will be completed:	End of May 23
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
The majority of actions have already been completed based on previous feedback received.	

M7 The trust must ensure ligature cutters are stored in line with trust policy

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding storage of ligature cutters. Key actions were: • On Galleywood Ward the storage of ligature cutters was not in line with our Trust policy. Immediate action was taken to bring the unit back into line with the supply of a 'red pouch'. • The Trust has put in place additional stock of red pouches for the Health & Safety team to take with them when visiting ward areas which will enable immediate corrective action should the correct procedure not be in place • Visits for assurance oversight by Ligature Co-Ordinator and Senior Health & Safety and VAPR Manager carried out to check arrangements for ligature cutters. The focus of the visits was on cutter accessibility and discussion with staff on their understanding of the arrangements. On both Willow and Galleywood wards there were a minimum of 2 complete sets of ligature cutters, stored in the designated red pouch, clearly signposted and attached to the nurse / ward office wall in line with Trust policy. • The review found that all areas have cutters available and accessible in the Nurse/Ward office and that all staff on duty at the time of the visits were aware of where their ligature cutters were kept and how to access them in the event of an incident. • Ligature policy at a glance has been developed to highlight key points of ligature policy for staff as easy reference guide • Ligature induction training has been further enhanced	
Who is responsible for the action?	Director of Risk and Compliance Director of Mental Health Urgent Care & Inpatient Services
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
We will continue to use our ligature inspection programme which includes review of ligature cutters. Any concerns are escalated to the ward matron and to the Ligature Risk Reduction Group. Ongoing 6 month audit of ligature cutter storage to ensure compliance with policy	
Who is responsible?	Director of Risk and Compliance Director of Mental Health Urgent Care & Inpatient Services
What resources (if any) are needed to implement the change(s) and are these resources available?	
No further resources needed	
Date actions will be completed:	All actions complete
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
All actions complete.	

M8 The trust must ensure that all patients have access to nurse call alarms

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
1. **Current State Review (Underway)** A current state review of alarm calls across the trust to identify the gap in need and size of the solution required 2. **Alarm identification (Future action)** Options appraisal will be developed to consider how to give patients access to nurse call alarms in areas without them. This will also be considered by Ligature Risk Reduction Group to ensure ligature risks are mitigated. Interim solutions will be considered due to likely timescale for fitting permanent alarms 3. **Alarm Implementation (Future action)** Alarms will be put in place with roll out based on risk	
Who is responsible for the action?	Director of Mental Health Urgent Care & Inpatient Services. Senior Director of Estates
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Call alarms will be maintained via Estates Team	
Who is responsible?	Director of Mental Health Urgent Care & Inpatient Services. Senior Director of Estates
What resources (if any) are needed to implement the change(s) and are these resources available?	
There will be a cost implication, this is unknown until options appraisal is complete	
Date actions will be completed:	May 2024
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
All wards have Oxevision in place which will alert staff if a patient is in physical distress. Patients can also speak to any staff member on the ward if they need support.	

S1	The Trust should consider how to manage and record any individual patient objections to the contact-free patient monitoring and management system

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Please see Trust response letters dated 7th October 2022 and 18th November 2022 which outlined immediate action taken to address concerns regarding the management and recording of patient objections to the use of the contact-free patient monitoring and management system. Key actions were: • The Trust met and discussed the use of Oxevision with all current patients on the ward to ensure that they understand how it is used on the wards and explanation that they are able to decline the use of Oxevision. These discussions have been recorded within the individual patient records and where patients have refused Oxevision has been switched off and this has been recorded. • The SOP has been reissued to clarify the implied consent process to be followed. • National guidance issued (3/11/22) reviewed and SOP updated as necessary • Compliance Team auditing of wards to check recording in patient records and posters available in patient bedrooms Outlined below are further actions taken and those still planned. 1. **Establish ongoing assurance (Action underway)** Added monitoring of Oxevision discussion documentation to the Matrons Assurance audit to ensure ongoing assurance and testing. Currently embedding.	
Who is responsible for the action?	Director of Patient Safety and Patient Safety Specialist Director of Mental Health Urgent Care & Inpatient Services.
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Records audit - detailing initial discussion of Oxevision on admission and detailing ongoing discussion of Oxevision	
Who is responsible?	Director of Patient Safety and Patient Safety Specialist Director of Mental Health Urgent Care & Inpatient Services
What resources (if any) are needed to implement the change(s) and are these resources available?	
Nil.	
Date actions will be completed:	End of May 23
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
The majority of actions have already been completed based on previous feedback received.	

S2 The trust should ensure that actions are taken to improve staff morale

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

A range of staff support options are already available to staff including the Trust 'Here for you service' which is a confidential mental health and wellbeing service available for all staff. Here For You is a team of psychological therapists and mental health professionals. We're aware it can feel difficult to access support from those you may come into contact with in other settings, we are therefore able to offer you the choice of accessing care from clinicians based in Hertfordshire or Essex.

1. **Staff Support (Action underway)**
   Team away days have been held and action plans developed as an outcome. Follow up away days are planned.
   New process of thank your letters from the new Deputy Director of Quality and Safety to staff initiated. This has been well received by staff so far.
   Ongoing visits by Directors and Associate Directors to wards, these have been appreciated by staff.
   Chief Operating Officer has visited wards, positive feedback following visit.
   Focus on celebrating fantastic work staff do at staff sessions.
   We are now partnered with Positive Practice in Mental Health who will come and visit services across the trust, highlight positive practice and put a focus on improving staff well-being and recognition.

2. **Staffing (Action underway)**
   From CQC findings key to improving moral will be increasing permanent staffing ratios. Please see action planned under M4

Who is responsible for the action?	Director of Mental Health Urgent Care & Inpatient Services. Deputy Director of Quality and Safety

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Staff surveying and feedback

Who is responsible?	Director of Mental Health Urgent Care & Inpatient Services. Deputy Director of Quality and Safety Director of Employee Experience

What resources (if any) are needed to implement the change(s) and are these resources available?

No additional resources needed

Date actions will be completed:	Support is ongoing. Key additional actions due by Sept 23

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Impact on recruitment and retention

Completed by: (please print name(s) in full)	Nicola Jones

Position(s):	Director of Risk and Compliance
Date:	21st April 2023

NHS
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Agenda Item #8a

31 May 2023

Board of Directors Part 1

Board Assurance Framework

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

CONTENTS

Board of Directors May 2023

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Purpose of Report

The report provides a high level summary of the strategic risks and high level operational risks (corporate risk register). These risks have significant programmes of work underpinning them with longer term actions to both reduce the likelihood and consequence of risks and to have in place mitigations should these risks be realised.

- Section 2: Provides a high level summary of the Strategic Risks and the Corporate Risk Register (high level operational risks).
- Noting one change to current risk score for SR1 (Safety) with a reduction in risk score based on an assessment by the Senior Responsible Officer and the progress at the end of year 2 Safety First Safety Always Strategy.
- Section 3 / 4: Note that there are no new or closed risks in the reporting period and therefore these sections is omitted from the report.
- Section5: Provides a progress report for each strategic risk provided by the relevant senior responsible officer. The Board is asked to note that SR3 Systems / Processes and Infrastructure has been under review with the view to split into two distinct risk; with SR3 now being focused on Finance and Resource infrastructure; and a separate new risk for Digital, with a risk assessment being undertaken in line with the new strategy (expected to Board July 2023).
- Section 6: Provides a progress report for each high level operational risks contained within the Corporate Risk Register provided by the relevant senior responsible officer.
- Section 7: Provides progress on risk movement across the BAF.
- Additional Information : Internal Audit review of our risk maturity provided a positive outcome and the Risk Management Assurance Framework Annual Report set objectives to achieve further improvements in 2023/24. (see Audit Committee Report)

Recommendations/ action required :

The Board is asked to received and note the report containing progress updates.

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

02 - BAF Dashboard

May 2023

EPUT

Strategic Risks

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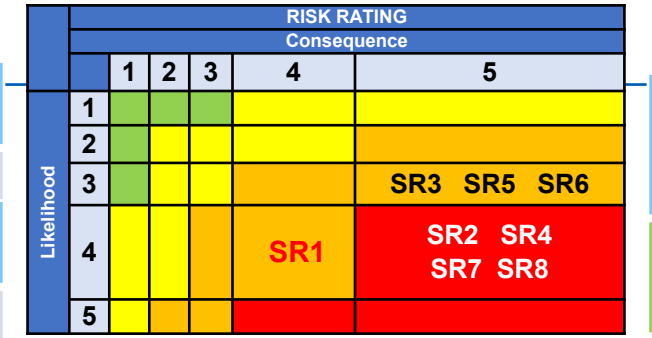
Existing Risks	Recommended New Risks	Recommended for Downgrading	Recommended for Closure
8	(Split of SR3)	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	1	7	8	6



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

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4=20	20 → 20 → 20	National challenge for recruitment and retention	• Registered nursing vacancy down from 805 in April 22 to 397 in March 23. • 7% net growth in nurses in substantive roles • 100 new starters in February 2023 (16 registered nurses) • Workforce Race Equality Standard action plan rated as outstanding by NHS England • Staff survey – decrease in staff experiencing discrimination (age/ gender), improvements in work life balance, access to learning and development and career progression • Long term sickness absence and staff turnover below target
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4=20	20 → 20 → 20	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	• Adult mental health bed occupancy below national benchmark at 88.4% • Adult mental health delayed transfers of care below national benchmark at 1.8% • Positive reduction in out of area bed days from 1,919 to 1, 743 (excluding Danbury and Cygnet appropriate beds) Feb 2023 • Patient Friends and Family Test 94.4% positive score in Feb 2023 • MH discharge follow up within 7 days of discharge above target Feb 2023
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	**5x4=20**	20 → 20 → 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Prioritised capital plan presentation to March 2023 Board as part of Operational Plan and Finance Budget • Financial outturn reports full utilisation of 2022/23 capital subject to audit. • Refreshed Estates and Digital Strategies will identify overall resource requirements (due to be presented to Board in 2023) • No further updates

Strategic Risks (continued)

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x4=20	20 → 20 → 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	• Budget setting concluded across operational, clinical and corporate functions, internal and systems. • Restructuring of finance teams progressing, Business Partner approach received positive response from operational colleagues. • Additional financial management measures being developed
SR9	All	Digital		ZT				• Risk assessment being carried out in alignment with the finalisation of the Digital Strategy (planned to be presented to Board in July '23) – the new risk will identify risk to delivery of that strategy and will be included within the BAF next reporting cycle.
Score <20 (Existing risks)								

SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	4x4=16	20 → 20 → 16	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• Significant improvements made over the first two years of the Safety First, Safety Always Strategy leading to a reduction in risk exposure and re-assessment of the score
								• Executive Nurse recommends that the score should reduce on the basis of the following assessment:
								  • Consequence 4 severe if there are workforce shortages with significant impact on service volume suicide/ incident rates which significantly exceed national average, or national adverse publicity
								  • Likelihood 4 likely (61% to 80% chance of occurring)
								• Recommend changes in target scores –at end of year 3 of strategy 4x3=12

SR3	All	Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 → 15 → 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services. Need to release clinical time.	• Extraction of Digital risk into separate strategic risk (see above proposed SR9) • EPR convergence unification project across Mid Essex and EPUT has significant operational and deployment implications as it is a major transformational journey • Business case to Board concerning the need to modernise IT as an enabler to meeting our strategic objectives
SR5	1	Independent Inquiry	Compliance, Reputation	NL	5x3=15	15 → 15 → 15	Government led independent inquiry into Mental Health services in Essex	• Inquiry in phase 2 evidence collection • Rolling programme of response to information requests • Communications to all staff encouraging evidence
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	ZT	5x3=15	15 → 15 → 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Executive Operational team financial sign off of early release of funding for purchase of replacement legacy devices (circa 750 iPhones and 150 iPads) • BDO internal audit on cyber security Dec 22 – overall outcome Moderate confidence level – action plans in place. Areas identified for upcoming BDO audit • All actions on track

Corporate Risks

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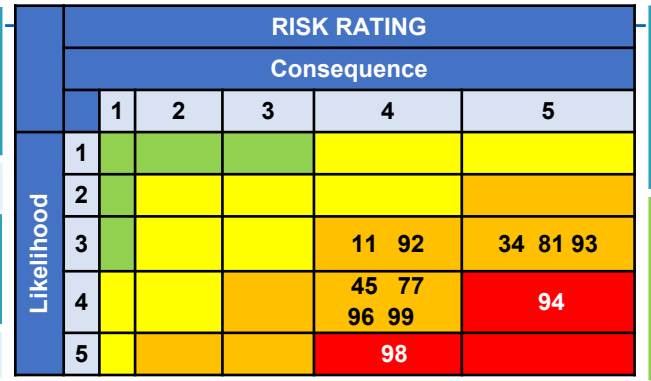
Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
11	1	0	0	1

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	11	11	8



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	18% (2)

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	• A new action plan continues to be finessed from the work being undertaken by the Engagement and Supportive Observation Workstream • Four further actions completed, six on track for completion, and two new actions added.
CRR98	Pharmacy Resource	Safety	NH	4x5=20	20 20 20	Escalation by ECN Continuous use of business continuity plan	• Further improvement on recruitment • All Datix incidents reviewed daily, documented, safety issues identified and escalated, recommendations made to reporter and handler. System working well, deep dive data for Q3 (intended for the practical use of operational leads) is part of the MSO quarterly report.
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	• Glenn Westrop appointed as DDQS with suicide prevention in portfolio • Suicide Prevention Strategy aligned with Safety First Safety Always Strategy and shared through system transformation programmes and system wide suicide prevention group • Continuous communications planning in place
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	• STORM training is a rolling programme • Discussions continue in relation to use of STORM licences for temporary staff • Expansion of the number of trainers is in progress
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	• Executive approval of incremental approach to annual training updates • Task and Finish Group in place • Executive overview of STORM training update and compliance

Corporate Risks (continued)

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ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• All actions on track for completion – deep dive exercise in progress • Business case approved by ET 14 March with recruitment process for Medical Devices Safety Officer and dedicated administrative support in progress • Policy currently under review including development of a Standard Operating Procedure
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	15 15 15	Patient safety incidents	• All actions on track, some with revised dates • Specification of work on hinge replacements completed
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 12 12	Staff Experience	• EPUT working with three providers to build comparative EDI training suites for EPUT staff to replace existing sessions, followed by funding and implementation by end of year • Additional element on Datix to improve reporting of racial discrimination/ abuse • EDI plan in place aligning with EPUT strategy. The plan sets EDI strategy until November 2024 with a key focus being the support of staff affected by discriminatory behaviour, abuse and bullying • Review of equality impact assessments and quality impact assessments to take place • Strategy from WRES and WDES presentation to Executive Team
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Safety dashboard completed and live • Governance structure in place for Learning Lessons • Consistent approach to team meeting agendas across specialist services inpatient wards • Eight actions n track for completion
CRR96	Loggists	Compliance	NL	4x4=16	15 15 15	Major incident cover	• Proposal in progress for presentation to ET in April to increase pool of loggists
CRR99	Safeguarding Referrals	Safety	NH	4x4=16	16 16 16	Escalation from operations and high increase in referrals	• A review of this risk is in progress to ensure this is a trust wide risk that encompasses all safeguarding functions • Safeguarding team at full establishment and are taking on additional caseloads through bank working • Safeguarding policies and procedures in progress for approval at May Policy Oversight and Ratification Group • Action 8 on track for completion May 23 • Action 9 job description in place for the role of safeguarding practitioners and discussions ongoing with Care Unit Directors for funding

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05 – Strategic Risks

March 2023

SR1: Safety

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At a Glance:

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

Likelihood based on: Incidence of incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions imposed historically
Consequence based on: Avoidable harm incident impact and extent of regulatory sanctions

Initial risk score	Current risk score	Target score of
C5 x 4L = 20	C4 x L4 = 16	C4 x L3 = 12

Progress since last report:

- Action 1: PSIRP draft and stakeholder consultation complete end May
- Action 2: Five Patient Safety Partners to bring lived experience and act as a voice for patients, families and carers
- Action 2: Two-year review of Safety First Safety Always:
- ✓ Outcome 1 480% increase in lived experience ambassadors since 2021; and roll out of iWantGreatCare
- ✓ Outcome 2 Safety Summits; Whole-System Approach; HSJ Awards Workforce Initiative of the year; Here for You nominated for national award
- ✓ Outcome 3 80% self-harmers saw a reduction in the urge to self-harm as a result of self-harm reduction pilot project; 94% staff say Oxevision enables identification of incidents; reviewed key themes over 20 year period informs work on preventable deaths and reduction in self-harm
- ✓ Outcome 5 80% reduction in seclusion incidents since Nov 2020; 95% reduction in use of prone restraints since Jan 20; 90% staff said Oxevision prevents incidents; sustained reduction in serious incidents
- Zero never events and safety alert breaches Feb 23 and year to date. Incident rates above target
- Action 3: Completed – new action added in relation to automation of IWGC and health roster. (New control established in terms of view of safety information to inform action).
- Action 4: In planning stages. Draft framework produced and awaiting directive from Executive Team June 23. Action 5: completed
- Action 6: Two safety improvement plans fully developed (ligature risk reduction and falls reduction). In train – review of incidents relating to transition of children and young people to adult services, and horizon scanning for multi-disciplinary team communication issues. Policy and standard operating application under review. Timescale extended.
- Action 7: Discussed in BSOG and working through constraints raised by ZT. Timescale extended.
- Action 8: Completed.
- All completed actions to move to controls following reporting round.

Key Gaps/ delayed actions:

- Action 3a: delays with vendor expected to be resolved in month.

Executive Responsible Officer: Natalie Hammond, Executive Nurse
Executive Committee: Executive Safety Oversight Group
Board Committee: Board Safety Oversight Group, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Deliver the Patient Safety Incident Response Plan	May 2023	Moriam Adekunle Director of Safety/ Patient Safety Specialist	Controls
2. Deliver the Patient Safety Strategy (Safety First Safety Always) for year 3	End March 2024	Natalie Hammond Executive Chief Nurse	Road Map / Control
3. Creation of patient safety assurance dashboard	Completed	Moriam Adekunle	Control
3a. Complete automation of two dashboard elements – IWGC and health roster	July 23	Moriam Adekunle	Control
4. Implement Quality Improvement Programme	March 24	Moriam Adekunle	Control
5. Review reducing restrictive practice framework 2022-25	Completed	Moriam Adekunle	Assurance
6. Complete safety improvement plans from thematic analyses	November 23	Moriam Adekunle	Assurance
7. Implement Lessons Identified Management System (ELIMS)	November 23	Moriam Adekunle	Control
8. Information Sharing	Completed	Moriam Adekunle	Control

SR1: Safety (Controls)

Essex Partnership University NHS Foundation Trust

Controls Assurance			
Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
Patient Safety Incident Management Team and EPUT Lessons Team	Lessons Team fully established	Report Safety First Safety Always – Leadership	PSIRF first year review of early adoption
Learning Collaborative Partnership	Established with TOR	Reporting to LOSC/ Quality	Pan Essex CQRG
Quality & Safety Champion Network	Established through soft launch	Quality Committee	Pan Essex CQRG
PSIRF; Complaints; Claims; Safety First Safety Always Strategy	Policy Register	PSIRF reports/ risk management reports/ complaints reports/ ESOG reporting cycle / Clinical Audits	IA Reviews inc PSIRF May 22 and Medical Devices Feb 22 Fundamental Standards CQC Benchmarking from NRLS
Range of learning platforms in place – thematic analysis/ EPUT Lab/ Quality Academy/ Lunchtime Learning/ Key messages / Quality and Safety Champions Network	Have been running and scheduled for future EPUT Lessons Team and Patient Safety Incident Management Team Intensive Support Groups in place	Learning collaborative partnership Group; EPUT Lessons Learned Programme; LOSC; Quality and Safety meetings chaired by DDQS Learning from deaths oversight	Pan Essex CQRG
Information Sharing	Lessons Identified Newsletter Communications strategy Induction videos	ESOG and BSOG Culture of Learning Steering Group LOSC	
Nurse Advocates/ RISE leadership	12 nurses completed advocate training; phase 2 of RISE DDQS for professional nurse advocacy and nursing/ AHP strategy delivery		
PMO Support	Overall portfolio status. Progress on delivery of essential safety improvements and transforming projects. Established and working well	PMO reporting to ESOG and BSOG and TB	
Capital investment in patient safety	Progress on delivery of essential safety improvements	Report on enhancing environments	CQC CAMHS inspection safety improvements
Insight into wellbeing		Reports to ESOG and QC Culture of Learning progress report	
Patient Incident Response Plan	Refreshed	ET Approval Shared with Quality Committee	Shared with ICB
Culture of Learning Programme	Developed	Launched with ongoing programme to embed in EPUT Quality & Safety Champion Network	Learning Collaborative Partnership Group

SR2: People

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At a Glance:

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

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:

- Action 1: Application to RoAPT made in April 2023 and is currently under review. Review period can take up to 12 weeks, timescale extended to July 2023 in recognition.
- Registered nursing vacancy down from 805 in April 22 to 397 in March 23.
- 7% net growth in nurses in substantive roles
- 100 new starters in February 2023 (16 registered nurses)
- Proportion of agency staff within EPUT reduced to 9.4% in April.
- Workforce Race Equality Standard action plan rated as outstanding by NHS England
- Staff survey – decrease in staff experiencing discrimination (age/ gender), improvements in work life balance, access to learning and development and career progression
- Long term sickness absence below target
- Staff turnover below target
- Action 8: Complete – Health and Wellbeing Toolkit available on intranet providing resources aligned with the seven domains of the NHS Health and Wellbeing Framework.

Key Gaps in Assurance:

- Preceptorship programme required to support newly qualified nurses arriving in June 2023
- Nursing vacancy rate 19.5% year end
- Overall vacancy rate 11%
- Improve experiences of minority staff (new action) – discussions to take place with CEO and NED
- 1,292 agency cap breaches and 623 shift framework breaches in April. 376 cases breached both framework and price cap.
- Staff survey areas for improvement – experience of BME and disabled staff, staff perceptions of care, burnout and speaking up
- Sickness absence above EPUT target
- Action 9 New Action : involves a huge piece of work and actions will be determined early June and resource mapped.

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

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Successful re-application to Register of Apprenticeship Training Providers	July 2023	Annette Thomas-Gregory Director of Education & Learning	Control
2. Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control
3. Develop People Commitments (strategic plan)	Sept 23	Paul Taylor, HR Director, Operations	Road Map
4. Develop, seek approval and implement Education and Learning Development Strategy	Sept 23	Annette Thomas-Gregory Director of Education & Learning	Road Map
5..Review long-term strategy for smart working	June 23	Alesia Waterman, HR Director	Control
6. Review dignity, respect and grievance policy	June 23	Debbie Prentice, Associate Director, ER	Control
7. Optimisation of electronic staff record	June 23	Kelly Gibbs, Associate Director of HR	Control
8. Framework for health and wellbeing offer	Complete	Lorraine Hammond, Director of Employee Experience	Framework
8a. Complete diagnostic (Excel tool) to benchmark areas of good practice, and needing improvement	Sept 23	Lorraine Hammond, Director of Employee Experience	Assurance
9. Complete wider piece of work to improve the experiences of minority staff	TBC	Lorraine Hammond, Director of Employee Experience	Control

See next slide for controls

SR2: People (Controls)

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Controls Assurance			
Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
HR Team/ People & Culture Directors	Top team fully established	People and Culture Structure to PECC	
HR Policies	Policy Register	Workforce Reports to PECC	Ofsted inspection on 27-29 July 2022 scoring good in all domains
Workforce Plans and strategies	Workforce Safeguards Workforce Establishment Reviews	Workforce Safeguards, Establishment Reviews and Reports to PECC; Smart Working Group	CQC inspections; NHSE Workforce Returns; System Workforce Returns / benchmarks
Employee experience road map	Developed		
Rolling recruitment programme	Recruitment team	Workforce Reports to PECC International Recruitment Steering Group	MSE System Oversight Assurance Committee
Rolling Bank to Permanent Conversion programme	219 since Nov 21 as at March 23	Workforce Reports to PECC	
Retention programme	Recruitment team Key findings triangulated from cultural reviews	Reports to F&PC and PECC Turnover rate in performance report Safer staffing data	MSE System Oversight Assurance Committee
Sit Rep Meetings	Staffing Sit-Rep	Quality and performance reports Emergency planning steering group Flow and capacity leads	CQC inspections
Use of Bank and agency Staff (when needed)	Staffing Sit-Rep	Workforce Reports to PECC	CQC inspection reports Use of Resources Assessment
Recruitment Branding	Marketing team	Direct Hire Numbers within the Workforce reporting to PECC	
Staff wellbeing	Engagement Champions Employee Experience Managers	Workforce reports to PECC EDI Sub Committee	Pulse Survey Here for You Steering Group with ICB membership
Data reporting	Staffing sitrep	Safety huddle report to ESOG	Increase in Pulse responses and key themes identified
Equality and Inclusion Framework		Executive led sponsor for networks ED&I objectives in appraisal Racial abuse guidance for staff and debriefs	
Staff Survey 2022	Competed	Actions taken forward	

SR3: Finance and Resources Infrastructure

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: the possibility of not having the right estate and facilities to deliver safe, high quality care
Consequence based on: the potential failure to meet our safety, quality/ experience and compliance ambitions

Initial risk score	Current risk score	Target risk score
C5 x 3L = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Action 1: complete, however, Senior Director has identified further gaps since restructure and is presenting case to Executive Lead. 1b added.
- Action 2: Human Engine have been undertaking a piece of work on the commercial strategy including interviewing stakeholders. Refining content for review with intention to finalise and adopt in June 23
- Action 3: Approach presented to April Strategy Steering Group and EOC. Link and integrate with organisation strategy and evolving work on demand and capacity as well as ICB infrastructure plans
- Action 4: Procurement restructure complete and recruitment to new posts in train
- Action 5: This action may need to be split as there are several actions running at different paces. Planning a review of these as part of strategy – timeline Dec 23. Both PFIs have had a deep dive over the past 6 months and we have restructured engagement with organisations and are leveraging contract terms.
- This is a first step to separating infrastructure away from systems and processes (digital) and needs further work to establish actions and controls, delivery dates and leads

Key Gaps

- Action 2: Awaiting revised timeline from meeting with Human Engine
- Action 4: Further steps in the procurement review to finalise as part of objective setting – need a timeline
- Additional work on actions and controls

Executive SRO: Trevor Smith, Executive Chief Finance and Resources Director
Board Committee: Finance and Performance Committee, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Fully recruit to all estates and facilities agreeing portfolios and jointly funded posts	Complete	Trevor Smith, Executive Chief Finance and Resources Director	Control - Full establishment
1b. Present case to Executive Lead for additional resource to fill gaps	June 23	Linda Martin, Senior Director Estates and Facilities	Control
2. Develop Commercial Strategy	June 23	Liz Brogan, Director of Contracting & Service Development Lauren Gable, Director of Finance Commercial	Roadmap
3. Develop Estates Strategy & Development Plan	December 23 (align overlays)	Lauren Gable, Director of Finance Commercial	Roadmap
4. Undertake procurement review	June 23	Liz Brogan/ Richard Whiteside	Control
5. Review tenancy responsibilities/ leased property risks, staff vs property owner accountability, PFI contract deficiencies	December 23	Lauren Gable Martin Whiteside AD Capital & Property	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
EPUT Strategy		Board approval Jan 23 *Bi annual reporting to BOD* *Touch point Nov '23* *Accountability framework*	
Operational Target Operating Model	Care Unit Leadership in place and AF Established	AF Meetings established Transformation and Finance Teams restructure to align to and support care units	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to ESOG	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register Performance Governance Framework in place	*Accountability Framework*	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO	In place	Audit Committee	
Premises Assurance		Premises Assurance Model in place with assessment	
Business Continuity Plans	In place		

SR4: Demand and Capacity

Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: Length of stay, occupancy, out of are placements etc.
Consequence based on: Mismanagement of patient care and length of the effects.
Links to both inpatient and community.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	5 x 3 = 15

Progress since last report:

- Action 2: completed
- Action 6:Transformation/ Portfolio lead support has reviewed the original overarching action plan from January and is in the process of pulling into a comprehensive Project Plan together with tabs for a risk log, whole plan, completed and ongoing, and in progress actions. Adult MH bed occupancy below national benchmark at 88.4%
- Adult mental health delayed transfers of care below national benchmark at 1.8%
- Positive reduction in out of area bed days from 1,919 to 1, 743 (excluding Danbury and Cygnet appropriate beds) Feb 23
- Patient FFT 94.4% positive score in Feb
- MH discharge follow up within 7 days of discharge above target Feb 23
- Bed modelling work is in progress supported by Deloitte

Key Gaps:

- Adult average length of stay remained consistent in April and maintains performance outside the benchmark of <35 with performance at 66.7
- April saw a further increase in out of area bed days from 1,836 to 2,077 (excluding Danbury and Cygnet contracted beds). 35 new clients placed OOA and following repatriation of 26 there were 73 remaining, continues to be higher than the previous year.
- Adult occupancy rates increased for third consecutive month to 98% in April. Surpassed benchmark of <93.4% for first time since Oct 22
- Prolonged bed closure summary outlines gaps in bed stock control (not including short-term closure for minor estates work
- Action 6: Up until very recently the overarching action plan developed in Jan 23 has not been updated – this now has high level project support and advice but is still reliant on ownership by the Flow and Capacity Lead. Not all leads have been identified. Use of this will evolve over time.

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

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control 3.
2. Development of new safety KPI dashboard	Completed	Moriam Adekunle	Assurance
3. Ensure recording of DTOCs on EPRs	May 23	Flow and Capacity Leads/ Bibi Hossenbux	Assurance
4. Analysis piece on demand vs capacity	Phase 1 May 23 with further phases to be advised	Jan Leonard/ Sue Graham	Control
5. Delivery of the overarching UEC/Inpatient MH Flow Action Plan	Dec 23	Detailed actions have individual leads	Control
6. Circulation of the overarching action plan on a regular basis to update risk and report progress on BAF – replaces previous detailed actions	Completed	Joanne Pitt/ Susan Barry	Assurance
7. Repurpose the Purposeful Admission and Therapeutic Acute Inpatient Care Steering Group to provide governance structure and clear reporting lines	June 23	Joanne Pitt Portfolio Lead	Assurance

See next slide for controls

SR4: Demand and Capacity (controls)

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Controls Assurance			
Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
Operational staff (including skilled flexible workforce via Trust Bank)	Establishment	Performance reporting to Accountability Framework meetings and F&PC Use of agency staff monitored via performance report Workforce Reports	
Recruitment and Development of the Care Unit leadership structures.	Establishment Integrated Director posts		
Target operating model/ care unit development, Accountability Framework, Safety First, Safety Always Strategy, Flow and Capacity Policy, MAST roll out	Dedicated discharge coordinator	Accountability meetings Safety First, Safety Always end of year 2 report to Board March 23	
MH UEC Project, MSE Connect Programme, Partnerships, Mutual Aid, Time to Care initiative, New ways of working and new digital solutions	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service dashboards Daily sit reps	Updated OPEL framework Essex wide daily sit reps	Performance and Quality Report to Accountability Meetings and F&PC	System oversight and assurance groups
Discharge Co-ordination Teams	Monthly reviews Clear treatment plans Multi-Disciplinary meets	Dashboard in place and reported	System escalation of DTOCs
Skilled temporary workforce via Trust Bank	Bank establishment		
Business Continuity Plans	Emergency Planning		
Purposeful Admission Group	Therapeutic offer on wards	SMT and Accountability meetings Capacity and flow work stream Overarching patient flow action plan in place and discussed in Purposeful Admission Group	
Care Unit Strategies	Developed including out of area plan	Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling		System escalation in place
Operational Plan 2023/24	Accountability outcomes	Performance reports Flow and capacity metric reporting	
MAST (Management and Supervision Tool)	CPA review performance	Performance reporting	
MSE Connect Programme	UEC in place		

SR5: Independent Inquiry

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT is not open, transparent and has the correct governance arrangements in place then it may not embed the learning from past failings resulting in undermining our Safety First, Safety Always Strategy

Likelihood based on: the possibility of not embedding the learning and poor CQC ratings as a result
Consequence based on: National media coverage, parliamentary coverage and a total loss of public confidence

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Actions 1, 2 and 3 have been developed in response to the BDO internal Audit report

Key Gaps:

- Open letter from Chair of Inquiry to Secretary of State deems that the Terms of Reference cannot be met with the level of response from staff, the majority of whom are corporate and not front line clinicians. Awaiting outcome of Chair's request for an upgrade to a Public Inquiry.
- Decision being considered by Secretary of State

Executive Responsible Officer: Nigel Leonard, Executive Director, Major Projects
Executive Committee: SMT
Board Committee: BSOG, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. The Working Group should seek further assurances from process owners that actions have been implemented and progress sustained (for example after three to six months). As the Working Group would cease to exist after the resolution of the inquiry, it should be determined where long term responsibility for this action will be held.	June 23	Gill Brice/ Working Group	Assurance
2. Submit results from follow up above to Executive Team prior to closure of action, including a proposal for how the work will be taken forward once the Project Working Group ceases to exist.	July 23	Gill Brice/ Working Group	Control
3. EPUT should assure itself that its information processes and systems are fit for purpose, and controls around data input and records management to be reviewed across the Trust to minimise risks associated with information recording and management going forward.	March 24 for completion of actions	Gill Brice/ Working Group	Control/ Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Project Team Independent Director and Independent Medical Consultant Advisor	Establishment Expanded to meet increased ask	EOC and Audit Committee oversight	Independent Director and Independent Clinical Advisor in place
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group overseeing	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	In place and used for reporting to ET Audit Committee and BOD	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	Independent Director and Clinical Advisor
Deep dive into sample of deaths in scope over 20 year period	Completed		
Deep dive in 13 prevention of future death notices	Completed		
Audit on Learning from Independent Inquiry	Completed		Moderate for Design and Effectiveness

SR6: Cyber Security

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At a Glance:

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

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.
Consequence based on: assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

Progress since last report:

- Action 1: Appointed substantive permanent Cyber Assurance Manager with 12 June start date
- Cyber Essentials Certification Achieved – moved to controls
- Action 2: Completed
- Action 3: on track
- Action 4: completed except for one outstanding risk (see below)
- Action 5: ICS Cyber Assurance Steering Group in place and overseen by interim ICS Cyber Security Manager
- Action 6: MSE ICS DSPT baseline complete. DPST BDO audit complete, recommendations accepted and in plan.
- Completed actions to move to controls

Key Gaps:

- Action 4: one outstanding risk – Windows/SQL 2008 server – highlighted to Audit Committee. Upgrades are planned, currently in use acceptance testing phase
- Business continuity plans remain a gap whilst they are in progress

Executive Responsible Officer:
Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: IG Steering Group, Digital Strategy Group
Board Committee: Finance and Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Appoint to substantive Cyber Governance Manager	Sept 23	BDO	Assurance
2. Complete recommendations from internal audit	Completed	Adam Whiting Deputy Director, ITT and BAR	Controls and Assurance
3. Develop business continuity plan and disaster recovery for each system (using third party)	Draft June 23 Dec 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
4. Complete actions from IT Security Health Check and Penetration Testing	June 23	Adam Whiting	Control
5. MSE ICS DSPT & Cyber Maturity Baseline	Completed	Adam Whiting	Control and Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Permanent post recruited to – start date 12 June	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual)
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP development plans in progress – due date Dec 23	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified

SR7: Capital Resource

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At a Glance:

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

Likelihood based on: percentage of capital programme unable to deliver / deferred
Consequence based on: what not delivered and the impact on the strategic plans.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	5 x 3 = 15

Progress since last report:
- Month 1 results reported for Trust and System

Key Gaps:
- None to report

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
1. Develop a prioirtised capital plan to maximize the use of available capital resources.	Completed	Lauren Gable Director of Finance	Road Map
2. Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	Lauren Gable Director of Finance	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	

SR8: Use of Resources

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At a Glance:

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

Likelihood based on: EPUT financial risk and opportunities profile
Consequence based on: assessed impact on long financial model for EPUT and the System

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20 increased score to 20	5 x 3 = 15

Progress since last report:

- Month 1 2023/24 results reported for Trust and System
- Actions associated with 2022/23 financial year have all be closed in the period.

Key Gaps:

- There are no gaps to identify for Month 1 2023/24

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
1. Identify remaining efficiency savings	01 July 2023	Simon Covill Director of Operational Finance	Control
2. Deliver Financial Efficiency Target	31 March 2024	Trevor Smith Executive Chief Finance Officer	Control
3. In year forecast outturn (FOT) and associated risk and opportunities assessment	End of Sept '23 and Monthly thereafter	Simon Covill Director of Operational Finance	Assurance
5. Deliver Operational Plan 2023/24	March 2024	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	SOF Rating
Budget setting	Completed mid year financial review and continues to forecast breakeven position. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2023/24			
Forecast Outturn and risk/ opportunities assessments 2023/24			

07 – Corporate Risks

May 2023

EPUT

CRR94: Engagement and Supportive Observation

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At a Glance:

If EPUT does not manage supportive observation and engagement; then patients may not receive the prescribed levels; resulting in undermining our Safety First, Safety Always Strategy

Likelihood of patients probably not received prescribed levels of observation and engagement
Consequence based on not meeting our Safety First Safety Always ambitions

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:

- Action1: 102 staff now trained and wards implementing interventions at different pace
- Action 2: training now reviewed and delivery due to start Sept 23 – new action added (2a will replace 2 once moved to controls)
- Action 3: use 1:1 support for those with no prior training. Created and signed off, will be launched with the training from action 2, and published with updated policy. (3a will replace 3 once moved to controls)
- Action 4: on track
- Action 6: now happening and will move to control
- Action 5: engagement phase complete
- Action 7: links to 2 and 3 above – will commence in September
- Action 8: on track
- Action 9: move to controls
- Action 10: filming planned for July 23

Key Gaps:

- None identified

Executive Responsible Officer: Executive Chief Operating Officer
Executive Committee: Executive Operational Committee
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Safe Wards to be implemented	Dec 23	KD and Ward Staff	Control
2. Review training for regular and non-regular staff (co-produced and delivered)	Completed	KS and LEAS's	Control
2a. Commence delivery of training for regular and non-regular staff	Sept 23	KS and LEAS's	Control
3. Evidenced based, easy grab therapy resources to be developed and placed on wards (use 1:1s with no prior training)	Completed	Katy Stafford	Control
3a. Launch the grab therapy resources in tandem with training and updated policy	Sept 23	KS and LEAS's	Control
4. Increased garden access and garden gyms	August 23	Katy Stafford	Control
5. QI project Linden Centre	July 23	Rachael Poland/ KS	Control
6. Patients to be included in any ward improvements planned	Completed	Katy Stafford	Control
7. Carers to support in production and delivery of training	Sept 23	Katy Stafford	Control
8. Patient personalised engagement boards (each patient to display a poster board of things they like to talk about/ do for staff prompts)	Completed Round 1 Pilot	All Ward Leaders	Control
9. Patient led safety huddles – Basildon assessment unit	Completed	Louise Bourton	Control
10. Patients and Carers to co-produce engagement video at same time as releasing updated policy and training	August 23	Katy Stafford	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Engagement and Observation Project	Project Group	Plan Complete/ Group Closed	
Revised Observation/ Engagement Policy		CG&QC / Accountability	
Weekly ward huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks	Tendable Audits	
Electronic observation recording tool	In trial stage		
Comprehensive audits using Tendable	Audit Results via weekly huddles		
Observation and Engagement E-Learning and Training Videos	8 week programme in place; Schwartz round pop up for inpatient areas; safety huddle week focus on TE&SO priorities; videos shared Engagement certificate for staff in encouragement Rolling programme of staff supervision and other 1:1s to improve confidence	Learning lessons report in place; Schwartz round feedback forms; reports from safety huddles Engagement prompt cards in use (patient creations)	
Engagement resources	Purchase of equipment e.g. games and newspapers for groups		
Patient led safety huddles at Basildon Assessment Unit	Complete		
Deep dive into unexpected deaths in inpatient services or within three months of discharge from inpatient admission between 2000 and 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise to address historic issues. Assurance report to Exec Team April 23	

CRR11: Suicide Prevention

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At a Glance:

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

Likelihood based on possibility of not progressing against the ten key parameters for safety mental health services
Consequence based on not taking the correct action

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:

- Action 1: updated and attributed ownership of Trust suicide prevention commitments and awaiting views of DDQS and Care Groups.
- Action 2: complete and ongoing
- Action 4: working with DDQS and Care Groups on accountability and implementation
- Action 5: updated SPG Terms of Reference, sent to DDQS and awaiting view of Care Groups
- Awaiting DDQS availability to soft re-launch the Suicide Prevention Group

Key Gaps:

- None identified

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implementation of revised strategy, work plan and dashboard	June 2023	Nuruz Zaman	Roadmap
2. Focus groups with patients and families and Research into family involvement in suicide	Complete and ongoing	Matt Sisto/ Amina Jappie	Control
3. Review approach to Safer Wards and Ligature risk	June 2023	Glenn Westrop	Control
4. Work with care groups to develop new governance arrangements around suicide prevention into SPG TOR	June 2023	NZ/SPG/GW	Control
5. Work with care groups to review and amend Suicide Prevention Group Terms of Reference	June 2023	NZ/SPG	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Identified Medical Lead	In place	Support via Human Engine and DDQS	
Annual report	Identification of four key priorities		
Suicide Prevention Strategy 2021-23 and revision of strategy	Suicide prevention group Roadmap in place	Overseen by Mortality Sub-Committee Alignment with Safety First Safety Always Governance in place Partnership with Human Engine	Feedback from ICS leads System transformation programmes and system wide suicide prevention group
Rolling communication plan and engagement with staff	Breaking the Silence Safety Plans 10 ways to improve safety	Monitoring in place National Patient Safety Day	
Local reflective sessions	In place		
Oxehealth digital monitoring	In place		
Suicide prevention training			
Suicide prevention outcome measures	Zero instances of preventable deaths 19.3% downward trend in instances of self-harm	95% patients have Personal Safety Plan 95% patients have 48 hours follow up post discharge from an in-patient ward Bio-psychosocial assessment Training trajectory Quality Committee	Monitoring delivery and annual assessment against NCISH toolkit
Self-harm reduction	Pilot project completed with success and evidence		

CRR34: Suicide Prevention - Training

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NHS Foundation Trust

At a Glance:

If EPUT does not train and support staff effectively in suicide prevention; then staff may not have the necessary skills or confidence to support suicidal patients; resulting in self-harm or death and a failure to achieve our safety first, safety always strategy

Likelihood based on the possibility of staff not having the necessary skills and confidence
Consequence based on a failure to prevent suicide and achieve our safety ambitions

Initial risk score	Current risk score	Target risk score
C3 x L3 = 9	C5 x L3 = 15	C3 x L2 = 6 Sep 23

Progress since last report:

- Action 3: Conversation with STORM licence provider on 8 June to discuss the alternatives in light of the strict licence conditions in place

Key Gaps:

- No update received

Executive Responsible Officer: Executive Medical Director
Executive Committee: ESOG
Board Committee: .Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Expand the capacity of trainers to deliver STORM training	Sep 23	AT-G	Control
2. Develop improvement trajectory and report on suicide prevention training	Jun 23	Nuruz Zaman AT-G	Assurance
3. Conversation with STORM about use of licence with temporary staff	June 23	AT-G	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trainers	Recruited 8 trainers and 8 more being trained in New Year on STORM. Licenses in place. Facilitators trained.		
Training	7 x 2 day courses held on line; schedule arranged for 2023 Interim refresher course Rolling programme on STORM training	Targeting inpatient units offering a blended approach MH/LD network discussion on suicide prevention training	
Suicide prevention strategy	Sets out training requirements overseen by Suicide Prevention Group	Reporting to Mortality Sub-Group, ESOG, QC Annual Report	
Quality improvement project	In place and addressing barriers on completing suicide prevention training		

CRR45: Mandatory Training

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At a Glance:

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

Likelihood based on possibility of compromising patient and staff safety
Consequence based on scrutiny by regulators and not meeting statutory requirements

Initial risk score	Current risk score	Interim target score 4 x 3 = 12 Dec2023 Longer-term Target risk score
C4 x 3L = 12	C4 x L4 = 16	C4 x L2 = 8

Progress since last report:

- Executive approval of incremental approach to annual training updates
- Task and finish group in place
- Executive overview of STORM training update and compliance

Key Gaps:

- Annual updates creates issue on training venues and resources
- Number of staff out of date on annual updates could cause alarm

Executive Responsible Officer: Director of People and Culture
Executive Committee: Executive Operational Team.
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implement recovery plan	Nov 23	Training Team	Assurance
2. Review mandatory training policy	September 23	Annette Thomas-Gregory	Control
3. Ensure staff do not expire on their training all at the same time by spreading compliance across the year	Nov 23	Annette Thomas-Gregory	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Training Team	Established – current resource 8.5WTE TASI trainers increased		12 month TASI accreditation from BILD
Induction and Training Policy	Policy system Current policy reflects current practice		
Training Tracker	Managers check and provide oversight.	Reporting of training to PECC	
Training recovery plan	Team switching staff incrementally to an amber rating giving 3 months to complete training Recovery plan on TASI	Training venues Executive team approval to incremental approach to annual updates Task and Finish Group Communications strategy Executive team oversight on STORM training update and compliance	BILD
Flexible workers	Equal priority on mandatory training		
Monthly reporting to ET		Accountability. F&PC and PECC, SMT and TB	
Training Venues (ongoing programme)	Training room identified at The Lodge		

CRR77: Medical Devices

At a Glance:

"If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway; then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use; resulting in a failure to achieve our safety first, safety always strategy."

Likelihood based on probability of inappropriate devices being in use
Consequence based on failure to meet our safety ambitions

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8 July 23

Progress since last report:

- Action 1 and 1a: deep dive about to be procured and will focus on the recommendations of the internal audit. MTS will work with EPUT to identify and provide sustainable solutions in order to meet the recommendations outcomes. Exercise to commence in June for three months. Regular updates during the deep dive and report produced by September. 1a will follow on from the strategy produced in 1.
- Action 2: part of deep dive, timeline extended
- Actions 3 and 4: completed and now business as usual
- Action 5: Discussions taking place on extension in light of deep dive and recruitment of MDSO
- Action 6: part of deep dive, timeline extended
- Action 7: part of deep give, timeline extended. Conversations underway with MSE colleagues to procure external quality assurance for the point of care testing devices.
- Actions 9 and 10 Recruitment process in train

Key Gaps:

- Point of care testing remains an issue – discussion underway with MSE and ICB to explore external quality assurance for point of care testing devices
- Actions 1 – 7 overdue or require new dates

Executive Responsible Officer: Executive Chief Nursing Officer

Executive Committee: Medical Devices Group
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Procure a 'Deep Dive' in order to focus actions from recommendations in internal audit report	Sep 2023	Nick Archer	Assurance
1a. Implement the solutions from the outcomes of the deep dive	Mar 2024	Nick Archer	Control
2. Options appraisal for Capital replacement programme and Medical device replacement strategy	Sept 2023	Nick Archer	Control (Resource)
3. Review Ergea contract reporting	Completed	Nick Archer	Assurance
4. Trialling process of reminder email to services before Ergea visits	Completed	Nick Archer	Control (Innovation)
5. Review of Policy and Procedure to ensure clear process and monitoring set out	June 23	Nick Archer	Control (Policy)
6. Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Sept 2023	Nick Archer	Control (training)
7. Introduce point of care testing to avoid use of equipment that is not calibrated or serviced	Sept 2023	Nick Archer	Control
8. Link in with new Deputy Directors of Quality and Safety	July 2023	Nick Archer	Control
9. Appoint Medical Devices Safety Officer Band 6	June 2023	Nick Archer	Control (Resource)
10. Appoint Administration Support Band 3	June 2023	Nick Archer	Control (Resource)

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance	Established	Funding for MDSO and admin support Executive Lead in place Nominated person for CAS	
Medical Devices Group	Established and meets regularly	Overseen by Medical Devices Group and Physical Health Sub-Committee	
Ergea contract for device maintenance	Monthly KPI Report	Overseen by Medical Devices Group KPI reporting	
Procurement process in place Medical Devices Policy	Asset Register	Medical Devices Group Assurance on medical device safety/ management Tendable audits	Internal Audit Report Q4 2021/22 (Moderate / Limited Assurance)
Management of Medical Devices	Contract in place eQuip asset register	ET approval of business case	
Asset Register	Cleansing project		
Incident Reporting	In place	Performance monitoring	
BCPs in place		BCP received from Ergea	

CRR81: Ligature

At a Glance:

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

Likelihood based on possibility of serious incidents
Consequence based on failure to meet safety ambitions

Initial risk score	Current risk score	Target risk score
C4 x L3 = 12	C5 x L3 = 15	C4 x L2 = 8 September 23

Progress since last report:

- Action 2: Slippage in phase 4 programme due to requirement to resurvey which is due for completion July 2023.
- Action 3: Identified budget for 2023/24 in respect of ligature works

Key Gaps:

- Awaiting phasing information for garden works
- Actions 2, 4 and 5 overdue or require

Executive Responsible Officer: Executive Chief Finance Officer / Executive Chief Operating Officer

Executive Committee: Executive Safety Oversight Group
Board Committee: BSOG Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Identify new system for recording ligature actions (overseen by Project Group)	September 23	Chris Rollinson Project Group Lead	Control
2. Ensure EPUT environments meet environmental standards and Review environmental risk stratification document	April 23	Lauren Gable / Tracy Abbot	Control
3. Review standards on outdoor garden furniture	August 23	Lauren Gable/Anthony Flaherty	Control
4. Further roll out of DTA to bedroom doors – most of properties now installed with PFI remaining outstanding	March 23	Lauren Gable Anthony Flaherty	Control
5. Review environmental risk stratification document	June 23	Linda Martin/ Fiona Benson	Control
6. Pilot the project for a year followed by evaluation	September 23		

Current Status

Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	Controls Assurance		
	Level 1 Function/ Department Management	Level 2 Organisational Oversight	Level 3 Independent Assurance / Internal Audit
Estates Ligature/ Patient Safety Co-ordinator **H&S Team and Compliance Team** **LRRG / EERG** **Ligature Project Group**	Teams established LRRG increased clinical focus Project group plan LRRG Terms of Reference – revitalised to improve clinical representation	Reporting to LRRG ESOG and BSOG dashboard of top four Trust priorities Accountability framework Annual ligature inspections Positive feedback from staff following refurbishment of MHU staff rest area 6 month reviews	Internal audit BDO 2021 ELFT Independent Review 2021 BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Policy and Procedure including environmental Standards	Ligature wallet audits	Reporting to LRRS ESOG and BSOG dashboard of top four Trust priorities Accountability framework Annual ligature inspections Policy review and approval March 2023 6 month reviews	Internal audit BDO 2021 (all actions complete) ELFT Independent Review 2021 Awarded Best External Environment in Best Patient Safety initiative (for Basildon) BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Training and Tidal training	138 staff trained (107 clinical) in TIDAL training with offer extended to all Band 4 staff and above to increase awareness March 2023 on target at 89% ligature training		
Trend Analysis		Ligature incident rate 45.5 Sep 22 (consistent trend in line with benchmark)	
Quality improvement project on self-strangulation	In place Heat maps with photos		Funding for North East
Review of all fixed point incidents since April 21	Ligature wallet audits in place	Annual Ligature Inspection for all MH wards 6 month support visits	

CRR81: Ligature (controls continued)

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Current Status			
Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	Controls Assurance		
	Level 1 Function/ Department Management	Level 2 Organisational Oversight	Level 3 Independent Assurance / Internal Audit
Ligature incident rates will be in line with national benchmarking – adult inpatient 42 per 10,000 bed days	40.27 Jan 2023 43.98 Feb 2023 78.2 March 2023 Ligature rate adults (benchmark 42 per 10,000 beds) Ave. 52.28 for 22/23 increase from 21/22 (42.70) and above national benchmark.		
Learning from incidents and safety alerts via Lessons Team/ ECOL/ 5 key messages		Enhanced learning within annual reporting utilising deep dive data Governance work ensures learning identified and shared across relevant groups (LRRG/ Patient Incident Team/ Inquest Team/ Clinical Support Group)	Actions completed from BDO internal audit 2021 Actions completed from the CQC Brief Guide
ELFT Independent Review	Actions completed	Closure report approved at LRRG 11 Jan 23	
Cambridge University work on management of ligature risk	Trialled on two wards	Report presented to LRRG in March 23	
Local Area Ligature Network	Network established and first meeting held	Established and ongoing	
Mitigation Statements	Effective process in place	Mitigation statements signed off by Ward Managers on acceptance of report Monitoring by Health and Safety Team	
Awareness and ownership of ligature reduction work	Local forum established, held monthly, well attended	LRRG membership reviewed to include more clinical attendance Clinical Operations staff presenting and discussing ligature inspection findings from their areas at LRRG	
Support for staff	Support package developed – debriefing facilitated by Nursing in Charge/ Ward Manager/ Matron/ Service Manager/ Clinical Lead/ Consultant (or other member of Senior Medical Team)	Here for You – signposting for individual follow up Input from Psychological Services Patient Safety Team facilitates 'cold' debrief in the form of after action review for staff support	
KPIs and Dashboard	Highlight progress on ligature reduction	Safety priorities regular reporting to ESOG, BSOG and LRRG.	
Replacement of door hinges	Specification in place	All hinges purchased and fitted end March 23	

CRR92: Addressing Inequalities

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At a Glance:

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

Likelihood based on possibility of not embedding equality and diversity
Consequence based on a failure to meet our people plan ambitions

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C4 x L3 = 12	C3 x L2 = 6 Nov 24

Progress since last report:

- Review of equality impact assessments and quality impact assessments – working group 27 April 23
- Action plans approved for WRES and WDES
- Working with VAPR and Safety Teams

Key Gaps:

- Action 3 overdue – assessing new timeline.

Executive Responsible Officer: Executive Director of People and Culture

Executive Committee: Equality and Inclusion Sub-Committee
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Improve EDI learning offer for EPUT	June 2023	Lorraine Hammond	Control
2. Provide course on 'Micro Incivilities' as a learning exercise for staff, then consider rolling out	June 2023	Lorraine Hammond	Control
3. Obtain kite mark for EPUT staff charter	April 23	Lorraine Hammond	Control
4. Develop EDI Framework RAG system	June 23	Gary Brisco/ Lorraine Hammond	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Employee Team including Director	Established and 6 Employee Experience Managers in post. Project started with single front door.	Project resource Working with VAPR and safety teams	
Equality and Inclusion Policies	Policy System	Equality and Inclusion Sub-Committee with Exec lead PECC	
Range of equality networks and staff engagement methods	Established	Equality and Inclusion Sub-Committee	WRES and WDES (actions identified)
RISE Programme	In place	3 cohorts completed	Positive staff feedback
WRES and WDES	Strategy in place	Action plans approved Executive sponsorship of plans and networks Monitoring through ED&I Sub-Committee Assurance through PECC	
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying	Alignment with EPUT Strategy	

CRR93: Continuous Learning

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At a Glance:

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

Likelihood based on the possibility of losing vital learning and patient safety incidents recurring
Consequence based on failure to meet safety ambitions and non-compliance with CQC fundamental standards

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10 March 24

Progress since last report:

- Action 1: Part of PSIRP work
- Action 2: Discussed in BSOG, working through the constraints raised by ZT
- Action 3: PSIRP draft completion this week and stakeholder consultation w/c 29/5
- Action 5: Quality priorities reducing restrictive practice, physical health deteriorating patients, suicide prevention all sit with DDQS. Human Engine are working with the DDQS to create framework and balance score card. Timescale extended.
- Action 6: Still in planning phase, draft framework produced and awaiting directive from Executive Team June 23

Key Gaps/ delayed actions:

Executive Responsible Officer:
Executive Chief Nursing Officer

Executive Committee: Executive Safety Oversight Group.
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Aug 23	Moriam Adekunle	Control
2. Develop and implement EPUT Safety and Lessons Management System (ESLMS)	Nov 23	Moriam Adekunle	Control/ Assurance
3. Review PSIRP process	May23	Moriam Adekunle	Control
4. Develop and embed Quality and Safety Champions Network to support embedding the culture of learning	May 23	Moriam Adekunle	Assurance
5. Link into UCL partnership who are implementing a range of collaboratives as part of MH Safety Programme	Sep 23	Angela Wade	Control
6. Develop QI methodology	Mar 24	Moriam Adekunle	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Incident Management Team	Established Deputy Director appointed	Governance structure in place Training in place	
Quality and Safety Champion Network	In place		
Learning Collaborative partnership meeting and Learning Oversight Committee	In place	Reporting to ESOG and Quality Committee	Pan Essex CQRG
Adverse incident policy inc PSIRF SOP and People and Culture Policies	Policy system	60% reduction in conduct cases 2021/22 Staff engagement and co-production of framework principles aligned with Trust values Co-ordinated socialisation meetings	
Range of initiatives via culture of learning project	Range of evidence in place to support (on master doc) Communications plan	Monitoring of hits on various forums Reporting to ESOG/ BSOG ECOL Steering Group etc.	Internal audit completed – on Learning from Independent Inquiry March 23. Outcome: Design Moderate; Effectiveness Moderate
Tackling bullying and harassment in the NHS	Pilot launching Nov 22 and integrate into ways of working by March 23. Funding granted		
Staff behaviour framework			
Themes allocation to clinical/ assurance/ transformation groups			
Learning information sharing	Range of evidence in place (on master doc)	Range of oversight, monitoring and reporting in place	
Patient Safety Dashboard	In place (Feb 23) Triage and early warning tool Power BI Workshops with key leads	PMO support in place IWGC optimisation project team for connection to I Want Great Care Connection to Allocate IAS pack	

CRR96: Loggists

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At a Glance:

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

Likelihood based on the probability of insufficient loggists
Consequence based on poor decision making and audit trail

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L1 = 4

Progress since last report:

- Proposal in progress to Executive Team on increasing number of loggists – currently in review
- Loggist training will be carried out in-house through the EPRR team

Key Gaps:

Executive Responsible Officer:
Executive Director of Major Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. In house training	July 23	Nicola Jones	Control
2. Present proposal to ET to increase number of loggists	May 23	Nicola Jones/ Amanda Webb	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pool of trained loggists including EPRR team and Executive Director PA's	All EPRR incidents have been logged to date	Command structure	
Training	Training now available from region and EPRR staff prioritised		
Major incident policy	In place	Board approval	

CRR98: Pharmacy Resource

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At a Glance:

If EPUT is unable to fill new and pre-existing positions within Pharmacy Services then there will be a protracted period of operating within business continuity leading to a reduced pharmacy service to our care units and potential impact on the wellbeing of our staff.

Consequence of 4 is severe due to the possibility of significant service disruption and significant workforce shortages. Possible increase in Datix reports due to a range of issues (pharmacy as a contributing factor) Complaints increasing from clinicians.
Likelihood of 5 is almost certain as our ability to deliver a comprehensive pharmacy service to EPUT patients falls far short of business as usual

Initial risk score	Current risk score	Interim target risk score
C4 x L4 = 16	C4 x L5 = 20	4 x 4 = 16

Progress since last report:

- Start dates between end May and mid-July for 3.6 WTE posts under offer
- Recruited and in post 18.4 WTE
- Number under offer (normal notice) 7.6 WTE
- Number under office (exam dependent) 5.7 WTE
- Shortlisting/ interviews pending 6.6 WTE
- Open adverts 4.0 WTE
- Action 1: raw data provided from Datix

Key Gaps/ delayed actions:

- Current number of vacancies 24.5 WTE
- Posts currently with no applicants 3.0 WTE
- Posts currently unadvertised 0.6 WTE
- Action 2 are overdue or require new dates

Executive Responsible Officer:
Executive Nurse
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Analysis into Datix raw data on pharmacy related incidents	July 23	Phil Stevens/ Datix Team/ Medical Safety Officer	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pharmacy team	Part establishment Post established to support new registrants	Report to Executive Team secured additional funding for pharmacy resources	Collaboration with HEE and HEIs to develop a sustainable pipeline of staff
Use of bank and agency staff	Support from ICB secondment of pharmacists part-time (in HR process)		
Support from patient experience team			
Rolling recruitment programme	£300k substantive staffing agreed – implementation in progress to fill posts Filling posts with trainees	Reporting to Executive Team Performance reporting	
Business Continuity Plan	Enacted		

CRR99: Safeguarding Referrals

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NHS Foundation Trust

At a Glance:

If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patients' needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8

Risk score is high based on only just being managed at present but is not sustainable. Safeguarding discussing with operational senior managers how to address the risk and resources to mitigate it.

Progress since last report:

- Action 1: date extended but on track for new date
- Action 2: on track
- Action 3: Forms agreed by Transformation Board with system design
- Action 4: Creation of Associate Safeguarding Practitioner roles
- Actions 5-7 new
- Additional training in place to bring compliance levels up
- Safeguarding Policies and Procedures on PORG agenda for May 23
- Liaison with DDQS for reporting requirements of individual care units
- Circulating monthly caseload reports to operational teams

Key Gaps:

- Additional hours using Bank unsustainable in the long-term – a resource review may be required
- Attendance at MAPPA and MARAC by EPUT professionals inadequate
- Reverting to pre-Covid levels of training compliance
- Training on sexual safety due for completion end of May 23
- Funding from ops to support the Associate Safeguarding practitioner roles
- Funding for business support in order to process increase in activity
- Southend has large number of open referrals needing to be closed – requirement by Southend UA to provide assurance on assessment and reviews by 19 May
- Southend UA requirement for an action plan to ensure future open referrals signed off, by November 23.
- Training compliance to pre-Covid levels

Executive Responsible Officer:
Executive Chief Nurse

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

	By When	By Who	Gap: Control or Assurance
1. Review issue related to Datix sign-off risk around categories	June 23	Tendayi Musundire/ Datix Team	Control
2. Undertake internal consultation on management of complex cases – review resource implications for supervision	July 23	Tendayi Musundire	Control
3. Incorporate safeguarding forms into patient records	September 23	Tendayi Musundire	Control
4. Agree funding with Care Units for Associate Safeguarding Practitioners to assist Care Co-ordinator to facilitate safeguarding (adult patients)	June 23	Tendayi Musundire and Care Unit Directors	Control
5. Provide assurance to Southend Unitary Authority on open referrals to be closed	19 May 23 deadline	Tendayi Musundire/ Deborah Payne/ Ops Leads	Assurance
6. Develop action plan to share with Southend UA to ensure all future open referrals are signed off	November 23 deadline	Tendayi Musundire/ Deborah Payne/ Ops Leads	Assurance
7. Review safeguarding establishment to resolve continuous additional hours on Bank by existing staff and business support for processing increase in activity	New action – to be agreed	To be agreed	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trust safeguarding team	Full establishment and additional caseloads Creation of Associate Safeguarding Practitioner roles	Local system to monitor child safeguarding case involvement	
Safeguarding policies and procedures	Review complete	PORG ratification expected May 23	
Prioritisation for oversight of S17, S47, MAPPA and MARAC attendance at appointments and involvement in reports as well as attendance at statutory meetings on behalf of doctors	In place	Reporting in place Monitoring in place	
Safeguarding training	In place and additional training to bring levels of compliance up to pre-Covid	Performance reporting	
Robust caseload management	Team managers monitor safeguarding caseloads Circulate monthly caseload reports to operational teams	Liaison with DDQS for reporting requirements of individual care units	
Monthly safeguarding reports	Reporting in place		
Datix reporting	Datix investigation		
CQC action plan		Sexual safety guidance embedded at clinical sites (review of current practice and improvement plans)	

08 – Risk Movement

May 2023

EPUT

Risk Movement and Milestones

NHS
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NHS Foundation Trust

Strategic Risk Movement – two year period (June 2021– May 2023)

Risk ID	Initial Score	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Risk ID
SR1 Safety	20					New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	16↓	SR1
SR2 People	20					New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3 Infrastructure	15					New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4 Demand	20					New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5 Inquiry	20	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6 Cyber	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR6
SR7 Capital	20														New	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR7
SR8 Resources	15														New	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	SR8

Strategic Risk Milestones – two year period (June 2021 – May 2023)

Risk ID	Initial Score	Time on SR/ old BAF	Jun 21	Jul 21	Aug2 1	Sep2 1	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec2 2	Jan 23	Feb 23	Mar 23	Apr 23	May 21	Risk ID
SR1 Safety	20	>1 year					New	20																		16	SR1
SR2 People	20	>1 year					New	20																			SR2
SR3 Infrastructure	15	>1 year					New	15																			SR3
SR4 Demand	20	>1 year					New	20																			SR4
SR5 Inquiry	20	>2 years						SR																			SR5
SR6 Cyber	12	>2 years							CRR	15																	SR6
SR7 Capital	20	>6 months														New											SR7
SR8 Resources	15	>6 months														New								20			SR8

Risk Movement and Milestones

NHS
Essex Partnership University
NHS Foundation Trust

Corporate Risk Movement and Milestones – two year period (June 2021 – May 2023)

Risk ID	Initial Score	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Risk ID
CRR11	16	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	9↔	CRR34
CRR45	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR77	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR81	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR92	20	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↓	CRR92
CRR93	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16		New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	CRR94
CRR95	20														15	15↔	15↔	15↔	15↔	12↓	12↓	Close				CRR95
CRR96	16																	New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR96
CRR98	20																		New	20	20	20	20	20↔	20↔	CRR98
CRR99	16																	New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR99
Risk ID	Initial Score	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Feb 23	Apr 23	May 23	Risk ID

Risk ID	Initial Score	Time on CRR or old BAF	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Risk ID
CRR11	16	> 2 years		8	12																						CRR11
CRR34	9	> 2 years			15																						CRR34
CRR45	12	> 2 years																									CRR45
CRR77	16	>1 year																									CRR77
CRR81	12	> 2 years																									CRR81
CRR92	20	>2 years								12																	CRR92
CRR93	15	>2 years																									CRR93
CRR94	16	>1 year		New	16				20																		CRR94
CRR95	20	Closed														15					12		Close				CRR95
CRR96	16	>6 months																		16							CRR96
CRR98	20	<6 months																				20					CRR98
CRR99	16	>6 months																		16							CRR99
Risk ID	Initial Score	Time on CRR or old BAF	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Risk ID

09 – Useful Information

May 2023

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Executive Lead Dashboard

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Director of Governance and Corporate Affairs	Executive Director of People and Culture	Executive Medical Director	Executive Director of Major Projects and Programmes
	1 Strategic Risk 2 Corporate Risks • SR2 People (Risk Score 20 no change) ↔ • CRR45 Mandatory training (Risk Score 16) ↔ • CRR92 Addressing inequalities (Risk Score 12) ↔	0 Strategic Risks 2 Corporate Risks • CRR11 Suicide Prevention (Risk Score 12) ↔ • CRR34 Suicide Prevention – training (Risk Score 15) ↔	1 Strategic Risk 1 Corporate Risk • SR5 Independent Inquiry (Risk Score 15) ↔ • CRR96 Loggists (Risk Score 16) ↔

Executive Director of Nursing	Executive Chief Finance Officer	Executive Director of Strategy and Transformation	Executive Chief Operating Officer
1 Strategic Risk 2 Corporate Risk • SR1 Safety (Risk Score 16) ↓ • CRR93 Continuous Learning (Risk Score 15) ↔ • CRR77 Medical Devices (Risk Score 16) ↔ • CRR99 Safeguarding referrals ↔ • CRR98 Pharmacy Resources (Risk Score 20) ↔	3 Strategic Risks 1 Corporate Risk • SR3 Infrastructure (Risk Score 15) ↔ • CRR81 Ligature (Risk Score 15) ↔ • SR7 Capital (Risk Score 20) ↔ • SR8 Revenue (Risk Score 20) ↔	1 Strategic Objective SR6 Cyber Attack (Risk Score 15) ↔ SR9 Digital (20)	1 Strategic Risk 1 Corporate Risk • SR4 Demand and Capacity (Risk Score 20) ↔ • CRR94 Engagement and supportive Observation (Risk Score 20) ↔ • CRR81 Ligature (Risk Score 15) ↔

Acronyms

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BAF	Board Assurance Framework	**SR**	Strategic Risk
SO	Strategic Objective	**CRR**	Corporate Risk Register
RR	Risk Register	**DRR**	Directorate Risk Register
ICB	Integrated Care Board	**F&PC**	Finance & Performance Committee
QC	Quality Committee	**PECC**	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	**EOSC**	Executive Operational Sub Committee
BOD	Board of Directors	**ESOG**	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	**LRRG**	Ligature Reduction Group
MHA	Mental Health Act	**HSSC**	Health Safety Security Committee
ECC	Essex County Council	**CQC**	Care Quality Commission
CxL	Consequence x Likelihood	**CRS**	Current Risk Score
SMT	Senior Management Team	**HSE**	Health & Safety Executive
CAS	Central Alert System	**NHSE/I**	NHS England/ Improvement
PMO	Project Management Office	**ESR**	Electronic Staff Record
EFIN	Electronic Finance Record	**TBA**	To be advised or agreed
PFI	Private Finance Initiative	**NHSPS**	NHS property services
CMO	Chief Medical Officer	**EDS**	Equality and Diversity Standards
BAU	Business as Usual	**PCREF**	Patient and Carer Race Equality Framework
PLACE	Patient Led Assessments of the Care Environment	**EDI**	Equality Diversity and Inclusion
EDS	Equality Delivery System	**EPRR**	Emergency Preparedness, Resilience and Reporting
VPAR	Violence Prevention and Reduction	**BAU**	Business as usual
DDQS	Deputy Director of Quality and Safety	**BDO**	Internal Auditors (up until end March 23)
FFT	Friends and Family Test	**WRES**	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	**CAMHS**	Child and Adolescent Mental Health Service
BSOG	Board Safety Oversight Group		

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Report by:
Susan Barry
Head of Assurance

On behalf of:
Denver Greenhalgh
Executive Director of Corporate Governance

EPUT

		Agenda Item No: 8b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**End of Year Governance Reviews**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors Governance Committee 18 May 2023 Council of Governors 22 May 2023 Executive Team 23 May 2023 Finance & Performance Committee 25 May 2023					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides an update and assurance on the Trust's compliance with the provisions within the *NHS Foundation Trust: Code of Governance* July 2014 and the Foundation Trust Provider Licence for EPUT. This is to allow the necessary disclosures in the annual report and publication of self-certificates.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: • Note the findings of the internal review of the Trust's compliance with the Code as a pre-requisite assurance to the Board of Directors in the preparation of the Trust's Annual Report 2022/23 and confirm acceptance of assurance given as evidence that the Trust complies with the provisions of the Code to be reported to the Board of Directors.

- Approve the detailed review of Trust compliance against the Provider Licence for the preparation of relevant submissions to NHS England.

Summary of Key Issues

Code of Governance Review

The purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and also confirm that the Trust 'complies' with the provisions, or if not, provide an explanation as to why it has departed from the Code.

The review process is as follows:

- Self-assessment against the Code of Governance (Completed)
- Internal independent assessment by the Council of Governors Governance Committee (Completed on 18 May 2023)
- Report to Council of Governors (Completed on 22 May 2023)
- Executive review (Completed on 23 May 2023)
- Assurance report to Finance & Performance Committee (Completed on 25 May 2023)

The Committees described above scrutinised the Code of Governance Self-Assessment and were satisfied there was evidence that the Trust was compliant with all provisions in the Code without exception. There are three sections of the code where the Trust is compliant, subject to ongoing work / audit. These are shaded yellow on the attached document.

The Board of Directors is asked to accept the assurance provided that the Trust complies with the provisions of the Code to be reported in the Annual Report 2022/23.

Provider Licence Review

NHS Foundation Trusts are required to make annual self-certifications under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual plan submission. The self-certifications are:

- General Condition 6 (G6) – covering compliance with 28 statements within the provider licence
- Continuity of Service 7 (CoS7) – confirmatory statement that the Trust has the resources for continuity of service available for the next 12 months (noting this is subject to external audit as part of the accounts going concern statement)
- Foundation Trust 4 (FT4) – compliance with the corporate code of governance.
- Governor Training

A detailed self-assessment review was undertaken against the requirements of G6, CoS7 and FT4 by the Trust Secretary's Office and considered by the Executive Team on the 23 May 2023 and the Finance & Performance Committee on the 25 May 2023. The detailed self-assessment against the Governor Training was taken forward and approved by the Council of Governors.

The Finance and Performance Committee submit the certificates to the Board of Directors for approval on the basis of the reviews undertaken, with the recommendation to declare compliance with all the requirements of G6, CoS7 and FT4.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Appendix 1: Code of Governance Review 2022-23 Appendix 2: Self-Certificates (FT4, Governor Training, G6, CoS7)

Lead
Denver Greenhalgh Senior Director of Corporate Governance

CODE OF GOVERNANCE REVIEW 2022/23

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
SECTION A: LEADERSHIP			
A.1: The Role of the Board of Directors			

A.1.1. The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors (as described in A.5). This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	• The Board of Directors in 2022-23 met sufficiently regularly to discharge its duties effectively:
	  ○ In 2022/23 Board met in public 6 times and 8 times in private
	  ○ Two additional extraordinary meetings were held to consider the Operational and Financial Plan; approve a time sensitive contract; and to approve the Annual Report and Accounts.
	• Matters reserved for the Board are included in the Trust's Standing Orders for Board and Council, Standing Financial Instructions, Detailed Scheme of Delegation and Scheme of Reservation & Delegation.
	• The Constitution and the Board & Council Standing Orders contain details on the function of the Board of Directors and Council of Governors.
	• There is a policy and procedure setting-out how the Board and Council of Governors work together, including handling disagreements. There is a specific section included in any Council of Governors procedures relating to disagreements between the Council of Governors and the Board, including reference to referring disputes to the Senior Independent Director (SID).
	• Statement included in Annual Report about how the Board and Council of Governors operate.
		✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
A.1.2. The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	• The Annual Report includes names of Chair, Vice-Chair, CEO, SID and members of Nominations, Audit and Remuneration Committees. • Register of Board meetings including attendance by individual Directors is kept by the Trust Secretary's Office and is available on request; details are identified in the Annual Report. • Register of Nominations, Audit and Remuneration Committees meetings including attendance by individual Directors is kept by the Trust Secretary's Office and is available on request; details are identified in identified in Annual Report.	✓	Supporting explanation/ reference
A.1.3. The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Included in the following documents which are available on the Trust's website: • EPUT Strategic Plan 2023 – 2028 and individual care unit plans. • Annual Operational Plan • Annual Report • Quality Account(Quality Priorities) • Safety First Safety Always Strategy (Safety Priorities)	✓	Publicly available
A.1.4. The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual	• Performance, quality and finance management systems in place to measure and monitor the Trust's effectiveness, efficiency and economy and quality of its healthcare delivery and safeguard patient safety. • The Board delegates responsibility for carrying out some of its performance oversight duties, particularly operational service delivery and quality, to its standing committees but without compromising collective accountabilities. • Established Board Committee Governance structure in place that focuses on strategic development and the transformation agenda. • F&P Committee undertakes a detailed scrutiny of the Trust's performance at each of its monthly meetings against the regulatory requirements and internally set KPIs through the review of detailed quality, performance and finance	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
obligations, and approved plans and objectives.	scorecard, and updates from Executive Directors. A detailed report is presented at each Board meeting identifying hotspots and mitigating actions. • The Committee has also taken deep dive exercises against specific KPI's where progress has not been made to identify possible solutions or different approaches. • Quality and Performance Scorecard presented at each Board meeting, which measures indicators against regulatory requirements, approved plans and objectives. • Executive Directors provide a summary of activities since the previous meetings as part of the CEO Report, linked to the Quality & Performance Scorecard. • Review of Board Assurance Framework (BAF) including Corporate Risk Register at Board meetings as well as by the relevant standing committees who also review the action plans. Updates also provided through the committees' assurance reports to Board. The Trusts Board Assurance Framework has been reviewed to provide greater focus on progress on actions associated with strategic risks. • Board Assurance Framework is presented to each public Board meeting. • Compliance Team tests compliance with regulatory requests, e.g. regular reports received in relation to CQC inspection activity preparation and management of resultant improvement plans. • Clinical audit function tests adherence to set standards which are set out in policy and clinical guidelines with the aim of improving care and driving up quality standards • Internal and external audit functions tests systems and processes through the annual audit programme; audit opinion provides assurance there is generally a sound system of internal control designed to meet the Trust's objectives (Annual Report details the audit activity and audit opinions) • All policies and procedures include 'monitoring' sections; these are reviewed. In 2022-23 these were approved by a multi-disciplinary Policy Oversight and Ratification Group, chaired by the Senior Director of Governance. Providing a Policy Management key controls report to both the executive team and to the Audit Committee.		

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Governance Update provided via the Chairs Report to Board of Directors which provides an update on regulation, compliance guidance / policies and information issued by NHSE, CQC, and any other relevant authority. Action is identified as appropriate. • In 2022-23 continued to embed and mature the accountability framework in providing oversight of performance and objective delivery through the Care Unit structure.		
A.1.5 The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	• See A.1.4 • The Board of Directors receive a regular Quality and Performance Scorecard for scrutiny, summarising key performance indicators and data. A comprehensive Performance Report is scrutinised at standing committee level to ensure the Board of Directors receive the right information and performance data for escalation. The scorecard is flexible to ensure any new requirements or potential risks can be added to the scorecard throughout the year to ensure the Board of Directors receive the right key information to allow the performance of the organisation to be assessed. • Performance against the agreed targets is monitored monthly by the relevant standing committee (e.g. F&P, Quality) as well as the Executive Team. The Board is advised of any outliers that give cause for concern. • The indicators that are agreed by the Board are included in performance dashboards that monitors performance at inpatient ward, community team and individual consultant level.	✓	Comply/ explain
A.1.6. The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, and the CQC. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	• The EPUT Strategic Plan 2023-2028 contains plans for each of the clinical care units, which provides information on the local approach to clinical governance. • The Trust has in place a clinical governance structure, inclusive of subject matter experts, forums and procedural documents. Reporting into a Clinical Governance subcommittee, chaired by the Director of Nursing. • Quality Committee terms of reference reflect the Trust's focus on quality and outcomes. It oversees the establishment of appropriate systems for ensuring effective clinical governance and quality management arrangements are in place throughout the Trust. • Audit Committee oversee the systems of control through its work with internal and external audit.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• The EPUT Safety First, Safety Always Strategy sets the approach to improving safety, which includes building on existing clinical governance structures and using information / data to ensure safety is put first. • The annual Quality Account details priorities. • All service developments are underpinned by quality impact assessment which are approved by the Director of Nursing.		
A.1.7. The chief executive as the accounting officer should follow the procedure set out by NHSE for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	• Chief Executive Officer is fully aware of his responsibilities as accounting officer and follows the procedures as set out in the NHS Foundation Trust Accounting Officer Memorandum: • Reports to Board on how expected outcome and goals are intended to be delivered identifying key risks and mitigation strategies • Chief Executive Officer provides briefings appropriate to Governors either at a Council general meeting or through pre-meeting briefing sessions, and will also hold additional briefings as required and/or requested by Governors. • The Executive Chief Finance Officer explains the annual accounts to the Council of Governors in a training session, which ensures Governors are able to awareness of the decisions relating to economy, efficiency and effectiveness. This was undertaken on 8 September 2022.	✓	Comply/ explain
A.1.8. The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership *(The Nolan Principles).*	• The Trust has an established Constitution. • Code of Conduct for Board Members, Code of Conduct for Governors and Capability Performance Policy/Procedure based on spirit of Nolan Principles in place. • The Trust has established vision and values and expected underpinning behaviours following consultation with staff and range of stakeholders • Conflict of Interest policy and procedure in place in line with NHS England requirements. Electronic declaration of interest system in place (CIVICA Declare) developed to meet national requirements. This is accessible via the Trust website.	✓	Comply/ explain
A.1.9. The board of directors should operate a code of conduct that	• Board Standing Orders includes standards of Business Conduct Policy and Code of Practice on Openness	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	• Chief Executive Officer's feedback on Board meetings business and actions cascaded to senior management team and through Chief Executive Officer weekly e-brief to staff • Staff, Governors, members and the public can attend Board meetings held in public • Board agenda, papers and approved minutes are available on the Trust's website • Board agendas and papers are circulated to the Council of Governors as well as approved minutes for part 1. • The Board holds a separate session for items that are considered to the commercial in confidence. • The Board has in place a conflicts of interest policy and declarations are applied at the beginning of all Board meetings and appropriate actions taken should a conflict arise. • The Board complies with and responds proactively with Freedom of Information requirements.		
A.1.10.The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is	• Covered by NHS Resolution Liability and Professional Liability insurance renewed annually. • All Non-Executive Directors are also issued with a Deed of Indemnity by the Trust to cover the reasonable actions of the Non-Executive Directors. • Indemnity for Governors and Directors included in Constitution.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
given, this can be detailed in the trust's constitution.			
A.2. Division of Responsibilities			
A.2.1. 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.	• Responsibilities of the Chair and Chief Executive Officer set-out in respective role / job descriptions. • Report presented to September 2021 Board meeting detailing the division of responsibilities between the Chair and Chief Executive Officer.	✓	Comply/ explain
A.2.2.The roles of chairperson and chief executive must not be undertaken by the same individual.	• Board Standing Orders precludes this option as it is a requirement for the Chief Executive Officer to report to the Chair; • For the year 2022/23 the Chair and Chief Executive Officer roles are undertaken by separate individuals Sheila Salmon and Paul Scott.	✓	Statutory
A.3: The Chairperson			
A.3.1. The chairperson should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	• As detailed in the Constitution • Electronic declaration of interest system (CIVICA Declare) requiring individuals, including the Chair, to make annual declarations. • Specified in Chair recruitment process and role description, and taken into account by the Council Nominations Committee in its appointment/reappointment process • Test of Independence statement is required to be signed by Chair annually.	✓	Comply/ explain
A.4: Non-Executive Directors			
A.4.1. In consultation with the Council, the Board should appoint one of the independent Non-Executive Directors to be the senior independent Director.	• Amanda Sherlock held the position of Senior Independent Director (SID) for the year 2022-23 until her term of office ended. • Dr. Mateen Jiwani appointed as Senior Independent Director (SID) in November 2022 following an expression of interest process. • Council of Governors endorsed Dr. Mateen Jiwani at its meeting on the 14 December 2022.	✓	Comply/ explain
A.4.2. The Chairperson should hold meetings with the Non-Executive Directors without the executives present.	• Regular monthly planned discussion meetings and ad hoc meetings between Chair and Non-Executive Directors throughout the year (without Executive Directors present) • Senior Independent Director held informal discussion / information gathering exercise regarding the Chair's performance evaluation.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Led by the SID, Non-Executive Directors should meet without the Chairperson present at least annually to appraise the Chairperson's performance and on other such occasions as are deemed appropriate			
A.4.3. 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.	• 2022-23 there have been no concerns raised that could not be resolved about the running of the Trust or a proposed actions. • Board meetings are comprehensively and accurately recorded in the minutes and include any concerns raised by Directors • Evidence contained in minutes that Directors seek assurance relating to concerns that they may have and request further assurance or action where it is not immediately available, e.g. through the Board governance structure and relevant standing committee.	✓	Comply/ explain
A.5: Governors			
A.5.1. The Council should meet sufficiently regularly to discharge its duties.	• Council meets formally five times per year (including the Annual Members Meeting) to discharge its duties effectively. Due to the death of Queen Elizabeth II, the Council meeting for September 2022 was postponed to November 2022 and the full meeting in December 2022 was cancelled. However, a Part 2 meeting was held in December 2022 to consider a time sensitive item. • Schedule of business and dates of meetings set in advance	✓	Comply/ explain
A.5.2. The Council should not be so large as to be unwieldy. The Council should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures for the Council should be reviewed regularly as described in B.6.5	• Review of Trust's constituency framework and composition of Council of Governors undertaken as part of Constitution review with consideration given to any changes to service provision, increased geographical spread and the integrated care systems footprint. • The Council of Governors is composed of 30 Governors • Council roles, structure, composition and procedures identified in Trust's Constitution and Standing Orders for Governors	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
A.5.3. The annual report should identify the members of the Council of Governors, 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 Council meetings and the attendance of individual Governors, and it should be made available to members on request.	• Annual report includes Governors, their constituency/organisation, if they are elected or appointed and duration of term. • Annual report identifies name of Lead Governor • Governor attendance at Council meetings recorded in minutes • The Trust Secretary's Office maintains a register of attendance and number of Council meetings and presented to each Council of Governor meeting. • Annual report includes the number of Council (and committee) meetings attended by Governors. • Non-attendance is followed in line with the Governor Meeting Attendance Procedure.	✓	Supporting explanation/ reference
A.5.4. The roles and responsibilities of the Council should be set out in a written document. The statement should include a clear explanation of the responsibilities of the Council towards members and other stakeholders, and how Governors will seek their views and keep them informed.	• Council roles and responsibilities set out in Trust's Constitution and Standing Orders for Governors	✓	Comply/ explain
A.5.5. The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the CEO to their meetings and inviting	• Professor Sheila Salmon chairs both the Board of Directors and Council of Governors. • Chief Executive Officer has a standing invitation and attends all Council meetings. Directors attend Council meetings as required to present papers or as invited by Governors. • Attendance by Chief Executive Officer and Directors at all Council meetings recorded in Council minutes	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
attendance by other executives and non-executives, as appropriate.	• Non-Executive Directors have a standing invitation and attendance at Council meetings included in their objectives		
A.5.6. The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board, compliance with the new provider licence or other matters related to the overall wellbeing of the Trust. The Council should input into the Board's appointment of a senior independent Director.	Also see A.1.1 and A.4.1 • Board and Council Standing Orders includes a section relating to the handling of disagreements between Council and Board • Policy and Procedure developed setting out the relationship between the Board and Council, including a section on resolving concerns or disagreements with the Board. • Senior Independent Director responsibilities are defined in Board's Standing Orders and in the role description; reference also included in the policy below. • Council of Governors endorsed Dr. Mateen Jiwani as SID at its meeting on the 14 December 2022. • Specific section included in Council of Governor procedures relating to disagreements between the Council and the Board, including reference to referring disputes to the Senior Independent Director. .	✓	Comply/ explain
A.5.7. The Council should ensure its interaction and relationship with the Board is appropriate and effective. In particular, by agreeing availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear unambiguous language.	• Procedure for circulation and publication of Council/Board agendas/papers – in line with the Trust's Standing Orders • Council agendas developed (based on annual schedule of business). Meetings of Chair and Lead/Deputy Lead Governors held regularly to consider future agenda items. • Format of meeting reflects business of the Council; briefing sessions held prior to each general Council meeting. Directors attend Council meetings as required. • Governors attend Board meetings and act as observers at Standing Committee meetings. • Glossary of terms for Governors provided to reduce language/ terminology issues via report summaries. • Governor Learning & Development Pathway includes modules to provide additional support and understanding, e.g. understanding performance data and accounts and finance sessions.	✓	Comply/ explain
A.5.8. The Council should only exercise its power to remove the Chairperson or any Non-Executive	• Trust's Constitution and Governors Standing Orders includes procedures for removal of the Chair/Non-Executive Directors. Further Council procedure developed setting-out the process to be followed.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Directors after exhausting all means of engagement with the Board.	• In the year 2022/23 this situation has **not** occurred within the Trust		
A.5.9. The Council should receive and consider other appropriate information required to enable it to discharge its duties.	• Council agenda includes standing items, e.g. Chief Executive Officer Report etc. • Governors attend Board meetings and receive agenda and papers, including Quality & Performance Scorecard; approved minutes for Part 1 circulated to Council. Summary of discussion for Part 2 circulated to Governors. • Governors receive relevant information and reports to support with consideration and decision-making, and in a timely manner.	✓	Comply/ explain
A.5.10. The Council of Governors has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.	• Governors attend Board meetings where they are able to observe Non-Executive Directors. • Selected Governors attend Board Standing Committees as observers. • Governors have opportunities to meet with Non-Executive Directors at different points to provide feedback and raise concerns, including: - Non-Executive Director / Governor Informal Meetings - Joint Board Seminar Sessions - Local constituency meetings - Lead / Deputy Lead Governor meetings with the Chair - Chair of Sub-Committee meetings, facilitated by the Vice Chair. - Governor Observers on Standing Committees. • Governors participate in the appraisal process for Non-Executive Directors. This includes asking Non-Executive Directors questions based on their objectives and providing an assurance report to the Council of Governors.	✓	Statutory
A.5.11. The 2006 Act, as amended, gives the Council of Governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per *the NHS Foundation Trust Annual Reporting Manual:* (a) The annual accounts	• The Annual Report and Accounts are provided at the Annual Members Meeting (AMM) which took place in September 2022 virtually. • Governors are able to attend a briefing session by the Executive Chief Finance Officer on the annual accounts to provide clarity and understanding.	✓	Statutory

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
(b) Any report of the auditor on them; and (c) The annual report.			
A.5.12. The Directors must provide Governors with an agenda prior to any meeting of the Board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of Board meetings should be exempted from being shared with the Governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	• Council are emailed agendas (parts 1 and 2) prior to Board meetings as well as all part 1 papers • Minutes of Part 1 are circulated once approved. • A summary of Part 2 minutes is developed and circulated once approved.	✓	Statutory
A.5.13: The Council of Governors may require one or more of the Directors to attend a meeting to obtain information about performance of the Trust's functions or the Directors' performance of their duties, and to help the Council of Governors to decide whether to propose a vote on the Trust's or Directors' performance.	See A.5.5	✓	Statutory
A.5.14: Governors have the right to refer a question to the independent panel for advising Governors. More than 50% of Governors who vote must approve this referral. The	• This has not been required to date • Note: February 2017 the panel has been disbanded by NHS Improvement.	✓	Statutory

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Council should ensure dialogue with the Board of Directors takes place before considering such a referral, as it may be possible to resolve questions in this way.			
A.5.15. Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the Board of Directors: • More than half of the members of the Board who vote and more than half of the members of the Council who vote to approve a change to the Trust's constitution • More than half of Governors who vote to approve a significant transaction • More than half of all Governors to approve an application by a Trust for a merger, acquisition, separation or dissolution • More than half of Governors who vote, to approve any proposal to increase the proportion of the Trust's income earned from non-NHS work by 5% a year or more • Governors to determine together whether the Trust's non-NHS work will significantly interfere with the Trust's principal	• Board and Council have agreed what constitutes a significant transaction and the process for involving Governors • For the year 2022/23 the Significant Transactions Group not been required. • Governors Standing Orders reflect opportunity for voting by post/email to ensure all Governors are provided with the opportunity to use their vote	✓	Statutory

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.			
SECTION B: EFFECTIVENESS			
B.1: Composition of the Board			
B.1.1. The Board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	• Independence statement included in annual report • All Non-Executive Director candidates are required to sign an Independence Statement • Independence reviewed by both Council of Governors Nominations and Remuneration Committees for appointments and reappointments of Non-Executive Directors. • Register of Interests available on Trust website via online link.	✓	Supporting explanation/ reference
B.1.2. At least half the Board, excluding the Chairperson, should comprise non-executive directors determined by the Board to be independent.	• Excluding the Chair there are seven Non-Executive Directors who are determined to be independent, which is representative of half of Board who hold voting rights.	✓	Comply/ explain
B.1.3. No individual should hold, at the same time, positions of director and Governor of any NHS foundation Trust.	• Details of directors and Governors included in Annual Report • Register of Interests available on Trust website via online link. • Trust Constitution includes a provision as part of Annex 6 under eligibility to be Governor that they cannot be a Director of the Trust or any other health body.	✓	Comply/ explain
B.1.4. The Board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation Trust. Both statements	• The annual report will include a biography for each of the directors. • Annual report (available on website) includes a clear statement from the Board about its own balance, completeness and appropriateness as to the requirements of the Trust • With each Board appointment process there is an assessment of the balance. For example in 2022-23 purposeful recruitment of non-executive directors sought accountancy background to provide succession plan for the Audit Committee function.	✓	Supporting explanation/ reference Publicly available

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
should be available on the Trust's website.			
B.2. Appointments to the Board			
B.2.1. The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	• The Trust has two committees responsible for Executive Director appointments and Non-Executive Directors appointments / reappointments as set out in their terms of reference: - Board of Directors Remuneration and Nominations Committee reviews the structure, size and composition of the Board of Directors, considers succession planning and makes recommendations for changes as appropriate; it is responsible for the Executive Director appointments process. - Council of Governors Nominations Committee implements the procedure for the identification and nomination of suitable candidates for Chair and Non-Executive Director appointments / reappointments (for recommendation to the full Council) that fit the succession planning criteria recommended by the Board of Director Remuneration and Nominations Committee. • External advice will be provided as required.	✓	Comply/ explain
B.2.2. Directors on the Board and Governors on the Council should meet the 'fit and proper' persons test described in the provider licence.	• All Board appointments are subject to a fit and proper person test as set out in Trust policy and regulations. All Board Directors have satisfactorily passed all fit and proper persons requirements and make an annual self-declaration. • Declaration of interest form specifically includes disqualification/fit and proper person's requirements as described in the provider licence for Governors. [Note Governors are not subject to Disclosure and Barring Service (DBS) check within the fit and proper person check as they do not meet the national DBS criteria].	✓	Comply/ explain
B.2.3. The nominations committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes where appropriate.	• See B.2.1 • Composition of the Board of Directors considered as part of appointment process for Board members. • A regular review of skills and experience is undertaken to ensure that the Board has the right skill mix to discharge its duties, including when appointing new Non-Executive Directors.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
B.2.4. The Chairperson or an independent non-executive director should Chair the nominations committee(s). *Note July 2014 addition: At the discretion of the committee, a Governor can Chair the committee in the case of the appointments of Non-Executive Directors or the Chairman.*	• Committee membership set out in terms of reference (Trust Chair Chairs both) • There is provision for the Lead Governor to Chair any meeting when discussing Trust Chair's appointment /reappointment.	✓	Comply/ explain
B.2.5. The Governors should agree with the nominations committee a clear process for the nomination of a new Chairperson and non-executive directors.	• Procedure for the appointment / re-appoint of the Chair and Non-Executive Directors developed and in place.	✓	Comply/ explain
B.2.6. Where a Trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of Governors	• Council of Governors Nominations Committee Governors are in the majority. • Details of membership included in terms of reference	✓	Comply/ explain
B.2.7. When considering the appointment of non-executive directors, the Council should take into account the views of the Board and the nominations committee on the qualifications, skills and experience required for each position.	• Arrangements in place between the Board of Directors Remuneration and Nominations Committee and Council of Governors Nominations Committee to ensure there is a dialogue between the two Committees (as detailed in terms of reference, for continuity Chair of the Trust is Chair of both committees) • Appointment process took place in 2022/23 and a report was provided to the Council of Governors Nomination Committee providing information to support discussions, including the views of the Chair / Board of Directors.	✓	Comply/ explain
B.2.8. The annual report should describe the process followed by the Council in relation to appointments	• Annual report will include a description of the process for the Chair and NEDs' appointments where relevant. This will be included in the annual report for 2022/23 following the appointment of two new Non-Executive Directors.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
of the Chairperson and non-executive directors.			
B.2.9. An independent external adviser should not be a member of or have a vote on the nominations committee(s).	• The Nominations and Remuneration Committees do not include independent external advisers on their membership • Independent external advisers are invited to meetings as required basis to provide guidance and advice; they do not attend in a voting capacity • For the year 2022/23, Harvey Nash (Alumni) were external advisors for the appointment of new Non-Executive Directors. The representatives from Harvey Nash (Alumni) were not members of the Committee and did not have a vote.	✓	Comply/ explain
B.2.10. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	• The Nominations and Remuneration Committees terms of references are available on request.	✓	Publicly available
B.2.11. It is a requirement of the 2006 Act that the Chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the Chairperson, the other non-executive directors and, except in the case of the appointment of a chief executive, the chief executive.	• As detailed in Board of Directors Nominations and Remuneration Committee terms of reference • There were no Executive Director appointments in 2022/23	✓	Statutory

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
B.2.12. It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the Council of Governors.	• As detailed in Board of Directors Remuneration and Nominations Committee terms of reference • Constitution provides for the Chief Executive Officer to be appointed and removed by Non-Executive Directors, with the appointment being approved by the majority of members of Council of Governors present and voting at a general meeting. • Procedure in place setting-out the process for Governor involvement in the process and process for the Council to approve the appointment. The procedure sets-out the minimum requirement and the actual process may change in agreement with the Council.	✓	Statutory
B.2.13. The Governors are responsible at a general meeting for the appointment, re-appointment and removal of the Chairperson and the other non-executive directors.	• Procedure for the recruitment of Chair / Non-Executive Directors in place. • Council of Governors Nominations and Remuneration Committees have clear terms of reference • Recommendations made to Council of Governors by Council of Governors Nominations Committee for appointment of Non-Executive Directors and are recorded in minutes. • Re-appointment / appointment of Non-Executive Directors undertaken in 2022/23 managed by the Council of Governors Nomination Committee and approved by the Council of Governors.	✓	Statutory
B.3. Commitment			
B.3.1. For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such	• Process is identified in Council of Governors Nominations Committee terms of reference • The Chair has a role description which defines time commitment and includes person specification • Chair appointment recommendation to Council of Governors would identify any significant commitments if applicable (part of the recruitment process) • Current Chair is not a Chair of another Trust • Chair's commitments included in the Annual Report • Chair is required to declare any interests at Board and/or Council meetings • Chair's interests also included in the register of interests available on the Trust website via a link.	✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.			
B.3.2. The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	• Non-Executive Director terms and conditions included with letter of appointment • Non-Executive Director application pack includes explicit information regarding time commitment requirements and asks for confirmation of ability to meet time commitment and disclosure of interests • Declarations of interest required as set out in the constitution and also Fit & Proper Persons Test and annual declarations of interest (see B.2.2 above) • Other significant commitments on the part of those recommended as a Non-Executive Directors are disclosed to Governors prior to appointment and when there are any significant changes.	✓	Publicly available
B.3.3. The Board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation Trust or another organisation of comparable size and complexity.	See B.1.3 above • Taking account of the changing NHS local landscape and the requirement for more integrated working the constitution provides for a director being a director of another NHS Trust or Foundation Trust to provide the opportunity for buddying arrangements/ cooperative working and enabling maximum flexibility. For example: CEO is a member of the MSE ICS Board. • No full-time Executive Director currently holds more than one non-executive directorship of another Trust or other such organisation	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Executive Directors are required to obtain permission for any other roles held concurrently with their Executive Director role at EPUT. • Evidenced in register of interests which is updated annually		
B.4. Development			
B.4.1. The Chairperson should ensure that new directors and Governors receive a full and tailored induction on joining the Board or Council. As part of this directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access to training courses and/or materials that are consistent with their individual and collective development programme.	**Director induction** • NED induction is included in NED's objectives and is monitored and reviewed by Chair • NED and ED induction programme and information pack reviewed and updated in line with good practice; induction programme is tailored to the Director's requirements based on skills and experience • All Directors new to the NED role completed the NED induction programme • NEDs encouraged to attend relevant briefings and conferences organised by NHS Providers and other national NHS-related organisations, and provide feedback at the NEDs Discussion Group meeting • EDs go through corporate induction training programme; additional induction and ongoing training requirements will be identified relevant to role. EDs induction is managed through the Trust's Supervision and Appraisal Policy and Procedure. • EDs are given a 6-month probationary period following commencement with the Trust. Objectives are set for achievement within this probationary period and these are formally reviewed at the end of the probationary period. The outcome of the review is provided to the BoD RemNom Committee. **Governor induction** • Governor induction programme reviewed and included as part of the Governor Learning & Development Schedule and regularly updated taking account of good practice and relevance to the Trust • Governor Induction Handbook based on documents developed by NHS Providers provided to any new Governors. • Feedback forms circulated following the induction programme in 2022, which received positive responses. • Individual induction sessions held with new Governors joining the Trust throughout the year due to Governor resignations and Appointed Governors.	✓	No reference in *Code.*

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
B.4.2. The Chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the Board.	• Directors individual appraisal and performance evaluations undertaken annually with six monthly reviews • Directors have individual personal objectives and professional/personal development plans • Directors have access to training courses/materials as identified in their individual personal development plan • Board of Directors Remuneration and Nominations Committee receives annual assurance report from the CEO on Directors' performance and file copy of appraisal/performance reviews are kept in Chair's office • Non-Executive Directors personal development objectives received by Council of Governors Remuneration Committee as part of review/assurance of Non-Executive Directors performance.	✓	No reference in *Code.*
B.4.3. The Board has a duty to take steps to ensure that Governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	• Learning & Development programme developed using pre-existing pathways and plans. The programme identifies all the ways Governors undertake learning, including through sessions, presentations, service visits and shared learning with each other. • The Council of Governors provide a detailed statement as part of the NHS England / Improvement self-certification process that confirms Governors have received sufficient learning and training over the previous year. The Chair of the Council of Governors Training & Development Committee develops the statement, which is submitted to the Council and provided to the Board of Directors to support the self-certification. • Council of Governors Training & Development Committee monitors and takes forward Governors' training requirements	✓	Statutory
B.5. Information and Support			
B.5.1. The Board and the Council should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	• Comprehensive reports and executive summaries (including detailed appendices) circulated prior to each Board of Directors and Council of Governors meetings, as well as Committee meetings. Standardised approach for all meetings. Information available on website/intranet • Annual meeting business schedule in place for Board of Directors and Council of Governors. • All Board of Director and Council of Governors standing committees have developed a work plan and progress against the plan is regularly monitored	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Circulation of papers requirements detailed in Board of Director and Council of Governors standing orders • Directors and Governors able to request information as necessary. • Informal confidential briefings prior to each Council of Governors meeting by the Chief Executive Officer • Governor Updates distributed regularly to all Governors		
B.5.2. The Board and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	• Non-Executive Directors have the opportunity at Board meetings and sub-committee meetings to challenge as well as at Board Development Sessions • All Board sub-committees have Non-Executive Director representation and are Chaired by a Non-Executive Director. • Advice will be sought from relevant adviser if required as detailed in terms of reference • Board of Directors Remuneration and Nominations Committee can request attendance as appropriate by the Executive Director of People & Culture (or their Deputy) to provide support and advice • Any such challenges are recorded in the minutes	✓	Comply/ explain
B.5.3 The Board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors.	• Independent professional advice is made available at the Trust's expense to directors in respect of critical or significant activities, e.g. audit, Mental Health Act Managers, legal advisors, other specialist advisors • Appointment of advisers in relation to significant transactions is approved by the Board and the process scrutinised by the Audit Committee • Board of Director Committees are provided with support as identified in their terms of reference • Board of Director Remuneration and Nominations Committee may, at the Trust's expense, appoint independent consultants or commission independent professional advice if considered necessary (included in terms of reference)	✓	Comply/ explain
B.5.4 Committees should be provided with sufficient resources to undertake their duties.	• Board of Director Committees are provided with support as identified in their terms of reference	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Board should also ensure that the Council of Governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance	• Board of Director Remuneration and Nominations Committee may, at the Trust's expense, appoint independent consultants or commission independent professional advice if considered necessary (included in terms of reference); this committee is also supported by the Trust Secretary's Office. • All Council meetings and committee meetings are supported directly by the Trust Secretary's Office • Trust Secretary's Office also provides day to day support to Governors including regular communications and updates, advice, managing queries, etc.		
B.5.5 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board, in particular making full use of their skills and experience. They should expect and apply similar standards of care and quality in their role as a non-executive director of an FT as they would in other similar roles.	• Non-Executive Directors have the opportunity at Board meetings and sub-committee meetings to challenge and/or to request 1:1 meetings with EDs to seek further clarification/assurance • Regular briefing with the CEO with NEDs. • All Board sub-committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes • Non-Executive Director skills balance considered in succession planning	✓	No reference in *Code.*
B.5.6 Governors should canvas the opinion of the Trust's members and the public, and for appointed Governors the body they represent, on the NHS foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	• Public and members meetings (Your Voice) held virtually. • 2022-23, Governors invited to participate in discussions for the new EPUT Strategy. • New agenda item included for the Council of Governors Membership Committee requesting Governors to provide any details of engaging with the membership. • Annual report outlines how Governors have 'canvassed' members/public	✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
B.5.7 Where appropriate, the Board of directors should take account of the views of the Council of Governors on the forward plan in a timely manner and communicate to the Council where their views have been incorporated in the Trust's plans and, if not, the reasons for this.	• Governors involved in the development of the new EPUT Strategic Plan, including Safety First, Safety Always and the Time to Care project.	✓	No reference in *Code.*
B.5.8 The Board of directors must have regard for the views of the Council of Governors on the NHS foundation Trust's forward plan.	• Covered under B.5.6 and B.5.7	✓	Statutory
5.6. Evaluation			
5.6.1 The Board of directors should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the Chairperson, has been conducted.	• Annual report outlined how Board performance and its committees evaluation has been conducted • Annual report outlines how directors and Chair performance evaluation has been conducted.	✓	Supporting explanation/ reference
5.6.2. Where an external facilitator is used for reviews of governance, they would be identified and a statement made as to whether they have any other connection with the Trust.	• No External Reviews of governance took place in 2022-23.	✓	Supporting explanation/ reference
5.6.3 The senior independent director should lead the performance evaluation of the Chairperson within a framework agreed by the Council and taking into account the views of directors and Governors.	• Performance evaluation framework approved by Council and using NHS England / Improvement guidance. • Senior Independent Director holds informal discussions with Non-Executive Directors on a 1:1 basis regarding Chair's performance evaluation • Feedback on the Chair gathered using an online form allowing Governors to anonymously provide feedback on the Chair as part of an overall 360 appraisal.	✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Senior Independent Director presents the report to the Council of Governors Remuneration Committee who evaluates the Chair's performance and provides feedback and assurance to the Council.		
5.6.4 The Chairperson, with assistance of the Board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as Board members.	• Non-Executive Director performance review and appraisal process and Board evaluation outcomes are used by Chair to identify and agree individual and collective professional development requirements • Requirements also reviewed at Non-Executive Director discussion meetings • Training also provided through Board of Director Development Sessions.	✓	Comply/ explain
B.6.5. Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities including impact and effectiveness on: • Holding non-executive directors individually and collectively to account for the performance of the Board • Communicating with member constituencies and the public and transmitting their views to the Board • Contributing to the development of forward plans of the Trust.	• Effectiveness review of the Council of Governors and sub-committees for 2022/23 is currently underway. • Governors report/statement included in annual report • Lead Governor end of year presentation at Annual Members Meeting providing details of achievements of the Council during the year, • Your Voice public/member meetings held providing opportunity for feedback by Governors to the Membership. • Council of Governors assurance cover report includes provides opportunity to identify how the content of the report links to Governors statutory duties.	✓	Comply/ explain Effectiveness review underway.
B.6.6. There should be a clear policy and a fair process, agreed and	• Constitution sets out the arrangements for the removal of a Governor from the Council	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
adopted by the Council, for the removal from the Council of any Governor who consistently and unjustifiability fails to attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	• Council approved procedure in place for removal of Governor who consistently and unjustifiably fails to attend Council meetings • Code of Conduct for Governors sets out meeting attendance requirements • TSO maintains a register of Governors' attendance at all Governor-related meetings		
B.7. Reappointment of directors and re-election of Governors			
B.7.1. In the case of re-appointment of non-executive directors, the Chairperson should confirm to the Governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years for a non-executive director should be subject to particularly rigorous review and should take account of the need for progressive refreshing of the Board. Non-executive directors may, in exceptional circumstances, serve longer than six years, but this should be subject to annual reappointment.	• Constitution states terms of office and reappointment arrangements of Chair and NEDs by CoG (Board of Directors Standing Orders – Annex 8). Includes particular reference to third term of office: *NEDs may in exceptional circumstances serve longer than six years subject to annual re-appointment and subject to external competition if recommended by BoD and approved by CoG;* Trust legal advisers confirmed this is in line with regulatory requirements • Non-Executive Directors are appointed by Council of Governors for a specified term of no more than three years each; any reappointment is subject to a satisfactory performance evaluation carried out in line with robust annual review process agreed by Council of Governors. • Council of Governors Remunerations Committee is responsible for the performance evaluation of the Chair and Non-Executive Directors as set out in terms of reference	✓	Available to Governors
B.7.2 The names of Governors submitted for election or re-election should be accompanied by sufficient	• Constitution provides for elections every three years for public and staff Governors. • Election programme managed by the Trust and administered by CIVICA.	✓	Available to members

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	• Nomination statements are included on the Trust's website and in election material, and in future elections will include meeting attendance records of Governors seeking re-election		
B.7.3 Approval by the Council of Governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the Chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the Chairperson and non-executive directors.	Covered under: • B.2.1 • B.2.12	✓	Statutory
B.7.4. Non-executive directors, including the Chairperson should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	Covered under: • B.2.5 • B.2.6 • B.2.7 • B.3.1	✓	Statutory
B.7.5 Elected Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	• Covered under B.7.2	✓	Statutory
B.8. Resignation of Directors			

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
B.8.1 The remuneration committee should not agree to an executive member of the Board leaving the employment of an NHS foundation Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.	• To date no Executive Directors have left the Trust outside of the terms of their employment contract.	✓	Comply/ explain
SECTION C: ACCOUNTABILITY			
C.1. Finance, Quality & Operational Reporting			
C.1.1. 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	• Annual report includes explanation of Directors' responsibility for preparing accounts and includes a statement by the auditors about their reporting responsibilities, as well as Directors approach to quality governance.	✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
the Annual Governance Statement (within the annual report).			
C.1.2. The Directors should report that the trust is a going concern with supporting assumptions or qualifications as necessary.	• Annual report will contain a statement from Directors that the Trust is a going concern. This is duly considered by the Audit Committee and Executive Operational Committee, in advance of the Board decision.	✓	Comply/ explain Pending audit opinion.
C.1.3. At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the trust and disclose sufficient information, both quantitative and qualitative, of the trust's business and operation, including clinical outcome data, to allow members and Governors to evaluate its performance.	• EPUT Strategic Plan developed and approved in March 2023, including a review of existing objectives and the development of new objectives for care units. • Annual report contains objectives and evaluates progress • Trust's operational plan, strategic objectives and annual report are available on the Trust's website • Annual report and accounts for 2022/23 will be presented at the Annual Members Meeting. • Performance, quality and financial assurance reports presented at monthly Board of Director meetings and quarterly Council of Governors meetings; papers available on the Trust's website • A performance quality and finance scorecard provides a high level summary of performance against quality priorities, safe staffing levels, financial performance and hotspots, as well as duty of candour, inpatient deaths/Serious Incident's etc. • Annual briefing to Governors by Executive Chief Finance Officer on annual accounts	✓	Comply/ explain
C.1.4. (a) The Board must notify Monitor and the Council of Governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge,	• The Board of Directors is aware that any major new developments and significant changes which may lead to a substantial change to the financial well-being, healthcare delivery performance, quality or reputation and standing of the trust should be brought to NHS England's attention and to the Council of Governors. • Council of Governors advised through briefing sessions with the Chief Executive Officer, direct correspondence from Chief Executive Officer and/or Chair as part of the wider communications plans (see above bullet point). Special Briefing sessions have also been held where incidents have taken	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
which is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. (b) The Board must notify Monitor and the Council of Governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • The trust's financial condition; • The performance of its business; and/or • The trust's expectations as to its performance which if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the trust.	place which may affect items identified above or become public to ensure Governors are informed in advance. • Performance and finance updates presented at part 1 Board meetings in public and to Council of Governors quarterly general meetings (see C.1.3 above)		
C.2. Risk Management & Internal Control			

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
C.2.1. The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	• An annual review of effectiveness of the Trust's system of internal control is undertaken by internal auditors and reported to the Audit Committee. In addition, the CEO prepares and reports the Annual Governance Statement to the Audit Committee acknowledging responsibility for systems of internal control.	✓	Supporting explanation/ reference The effectiveness review for 2022-23 is currently underway
C.2.2. A trust should disclose in the annual report: (a) If it has an internal audit function, how the function is structured and what role it performs; or (b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	• Statement on internal audit function included in the annual report and accounts for the year.	✓	Supporting explanation/ reference
C.3. Audit Committee and Auditors			
C.3.1 The Board should establish an audit committee composed of at least three members who are all independent non-executive Directors.	• Audit Committee's terms of reference includes membership of 4 Non-Executive Directors, with membership detailed in the annual report • Janet Wood, Non-Executive Director and current chair of Audit Committee has relevant recent financial experience; she has a business and accountancy degree, is a member of the Institute of Chartered Accountants (Scotland), and has had a successful career as an NHS accountant	✓	Comply/ explain
C.3.2. The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The Council of	• Audit Committee terms of reference describes the roles and delegated responsibilities of the Committee • Terms of reference reviewed March 2022 and sent to Council of Governors for comments. Current review underway and consultation with Governors has already taken place. .	✓	Publicly available

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly.	• Terms of reference are reviewed annually taking account of any legal and/or regulatory requirements. • Audit Committee ToR available on request,		
C.3.3. The Council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	• The constitution Council of Governors approves the appointment/ reappointment /removal of the trust's external auditors at a general meeting. • The contract for current External Auditors reached five-years at the end of 2021/22 and therefore a process was undertaken to market test in preparation for the 2022/23 financial year. The process involved a panel containing two Governors completing a market testing exercise and the outcome of the panel was reported to the Council of Governors on the 21 March 2022. The Council of Governors approved the appointment as recommended by the panel for a three year period, with the option to extend for a further two years. • The contract for the External Auditors contains a requirement for annual review by the Council of Governors and a market testing exercise to be conducted after five-years. The annual review will take place in 2022/23.	✓	Comply/ explain
C.3.4. The audit committee should make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable Council to consider whether or not to re-appoint them. The audit committee should also make recommendation to the Council about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor	• The Council received an update on the current auditors performance in September 2022. The paper was presented for information as the Council had already completed a detailed review as part of the market testing exercise earlier in the year (see above).	✓	No reference in *Code.*

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
C.3.5. If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	• There has not been an occasion when the Council of Governors has not accepted the Audit Committee's recommendations. It has therefore not been necessary to include any explanation in the annual report. • The Council of Governors role in the process has been outlined in the procedure as outlined in C3.3.	✓	Supporting explanation/ reference
C.3.6. The trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	• In 2022 the Trust awarded a contract for the provision of External Audit services to Ernst & Young, who have been the Trust external auditors since 2017. This was the result of a comprehensive market testing exercise. The contract was for five-years, subject to annual re-appointment by the Council of Governors. The auditors have a strong understanding of the finances, operations and forward plans of the Trust.	✓	Comply/ explain
C.3.7. When the Council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	• This situation has not occurred but due process would be followed as necessary. The newly developed procedure has referred to in C3.3 incorporates this.	✓	Comply/ explain
C.3.8. The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	• The Audit Committee terms of reference include the requirement to *'review the adequacy of arrangements by which staff of the Trust may raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters'* • Counter fraud included in Audit Committee's terms of reference • Audit Committee receives regular updates from the trust's Local Counter Fraud Specialist (LCFS) and regular updates relating to the Board Assurance Framework, which incorporates clinical and corporate governance matters.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Reports from LCFS include updates on regular investigations, recommendations and actions • Updates/presentations relating to patient safety, clinical governance or other specific areas will be requested from a senior member of the relevant teams to provide the Audit Committee with the relevant assurance. • Through regular awareness raising activities and internal communications, staff are aware how to raise, in confidence, concerns about possible improprieties through policies on Whistleblowing, Counter Fraud, etc. which are available on the intranet. Freedom to Speak-Up Guardians are n place to allow staff to raise concerns locally. • Facility on intranet for staff to anonymously raise issues via the Freedom to Speak-Up page to ensure concerns are passed to the right individual / team to respond.		
C.3.9. A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to the financial statements, operations and compliance, and how these issues were addressed. • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm	• Annual Report includes Committee's roles and responsibilities. • Both the internal and external auditors provide a range of reports to the Audit Committee. These include progress reports which address specific subjects such as financial statements, operations and compliance. The reports are reviewed by the Audit Committee and where recommendations from the reports identify significant issues, the responsible Director is required to attend Audit Committee meetings to explain how the concerns are being met. • The Trust undertakes an annual review of the external audit function which includes review of the external auditor's performance and the monitoring arrangements in place to ensure compliance with Monitor's *Audit Code for NHS Foundation Trusts.* The results of this review are reported to the Audit Committee. • Additionally the Audit Committee undertake its own *'self-assessment'* checklist, which is again reported to the Audit Committee. Information on the value of the external audit services and the length of the contract is provided to the Council of Governors annually. • There is also a section within the Annual Report to the Council of Governors for the Audit Committee to communicate annually all non-audit work performed by the Trust's external auditors and its value.	✓	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independent are safeguarded.			
SECTION D: REMUNERATION			
D.1. Level and Components of Remuneration			
D.1.1. Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	• Remuneration Policy and Procedure for Board Directors is in line with guidance published by NHSE in respect of Very Senior Managers (VSM) pay. • These requirements are clearly described in the Board of Directors Remuneration and Nominations Committee terms of reference • Limits set would be disclosed in the Annual Report • Explanation of current policy included in Annual Report	✓	Comply/ explain
D.1.2. Levels of remuneration for the Chairperson and other Non-Executive Directors should reflect the time commitment and responsibilities of their roles.	• For existing appointments on recommendation of Council of Governors Remuneration Committee, Council of Governors determines the level of remuneration for the Chair and other Non-Executive Directors, which is reviewed on an annual basis and takes account of the time commitment and responsibilities of their roles and is benchmarked against other similar Trusts. • New appointments are subject to the principles of the remuneration framework published by NHS England / Improvement. The Council of Governors agreed that the principles of the guidance would be adopted, with flexibility to ensure the Trust was in-line with other similar Trusts and considered the time commitment for the role.	✓	Comply/ explain
D.1.3. Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the	• Declarations of interest by EDs completed annually • Register of interests available on request and published on website via an online link.	□	Supporting explanation/ reference

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Annual Report should include a statement of whether or not the director will retain such earnings.	• If an Executive Director is released to serve as Non-Executive Director at another organisation, a statement will be included in the Annual Report as required		
D.1.4. The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	• Conduct and Capability Policy and Procedure and Code of Conduct for Board Directors deals with under-performance • Responsibility for the approval of termination of employment arrangements and/or the making of any extra contractual payments to Executive Directors included in Board of Directors Remuneration and Nominations Committee terms of reference (see D.1.1) • During the year no extra contractual payments have been made to Executive Directors following termination of employment	✓	Comply/ explain
D.2. Procedure			
D.2.1. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the Board of Directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS Foundation Trust.	• Board of Directors Remuneration and Nominations Committee comprises of Trust Chair and all NEDs (quorum = 4 in total) as set out in its terms of reference and in the Annual Report • BoD Remuneration and Nominations Committee's terms of reference also explains the role and delegated authority • Terms of reference are available on request • Remuneration consultants have not been appointed during the last four years; if they are appointed, a statement will be made if they have any other connection with the Trust and would be included in the Annual Report	✓	Publicly available
D.2.2. The remuneration committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of	• Board of Directors Remuneration and Nominations Committee's terms of reference comply with these requirements and clearly sets out the responsibilities • Terms of reference outlines Committee responsibility for Chief Executive and Executive Directors remuneration and terms & conditions. • Board of Directors Remuneration Committee ensures compliance with the national Very Senior Managers requirements	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
senior management for this purpose should be determined by the Board.			
D.2.3. The Council of Governors should consult external professional advisers to market-test the remuneration levels of the Chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	• Responsibilities of the Council of Governors Remuneration Committee are clearly set out in its terms of reference • Remuneration levels for the Chair/NEDs reviewed annually using benchmarking data. • Council of Governors Remuneration Committee is able to access, and does access, professional advice from Trust Deputy Director of HR • Market testing exercise took place in August 2022. • Advice will be requested as required	✓	Comply/ explain
D.2.4. The Council of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chairperson.	• Refer to D.1.2 and D.2.3	✓	Statutory
SECTION E: RELATIONS WITH STAKEHOLDERS			
E.1. Dialogue with Members, Patients and the Local Community			
E.1.1. The Board of Directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	• The EPUT Strategic Plan is centred on member, patient and local community involvement and includes a specific objective around helping communities to thrive. The Trust is currently developing Enabling Strategies, which will ensure this is fully implemented.	✓	Publicly available
E.1.2. The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between Governors and any local consultative forums.	See E.1.2 for Engagement Strategy • Examples of representing public interests of patients and local community: - Your Voice meetings: public/member meetings. These were held virtually in 2022/23 and had good attendance from members. - Public consultation documents/processes in relation to significant service changes – none this year but updates provided at Part 1 Board of Director Meetings, including information in relation to service transformation. - Public consultation on the EPUT Strategic Plan.	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	- Dedicated section on the Trust's website on how to get involved with the Trust; sections include support for carers, volunteers, etc. - Patient forums providing focus and influence on Trust services • Patient & Service User Experience Steering Group included in Board of Directors governance structure at Tier 2 and reports to Quality Committee		
E.1.3. The chairperson should ensure that the views of Governors and members are communicated to the Board as a whole.	• Chair facilitates opportunity for Governors to ask questions of the Board at Board meetings • Director/Governor Seminar sessions and joint Task & Finish Groups as required. • Directors regularly attend and present at Council of Governor meetings • Attendance of Non-Executive Directors at Council of Governor meetings included in objectives • Non-Executive Director / Governor informal meetings held during the year • Chair meets Lead / Deputy Lead Governors quarterly • SID meets Lead Governor independently if required. • Chief Executive Officer briefing sessions with Governors held quarterly at a minimum • Minutes of Board of Director and Council of Governors meetings available on Trust's website • Meetings with the public, e.g. Your Voice meetings provide opportunity for members/public to meet with Chair, Chief Executive Officer, Directors, Senior Managers and Governors, and to ask questions / provide feedback. • Full sets of Council of Governor and Board of Director part 1 meeting papers available on the Trust's website	✓	Comply/ explain
E.1.4. Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website. The Board of Directors should ensure that the NHS Foundation	• Trust website and Annual Report include details on how to contact Governors and Directors • Dedicated membership area on Trust website outlining the role of members, contact details and how to get involved • Your Voice meetings, chaired and supported by Governors, • Members invited to Annual Members Meeting. • Annual Report includes report on membership	✓	Publicly available

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
Trust provides effective mechanisms for communication between Governors and members from its constituencies.			
E.1.5. The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the non-executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	• Annual Report includes statements on how the Board of Directors have engaged with the Council of Governors, including the development of the strategic plan and stating as part of the main role of the Board to take into consideration the views of the Council of Governors.	✓	Supporting explanation/ reference
E.1.6. The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	• CoG Membership Committee reviews membership engagement, recruitment and demographic representation quarterly. • Report on membership presented to the Board of Directors in March 2023 providing details of membership engagement and current membership metrics. • Membership activity report at each Council meeting (Directors attend Council of Governor meetings) • Annual Report includes membership analysis and representation	✓	Supporting explanation/ reference
E.1.7. The Board of Directors must make Board meetings and the annual meeting open to the public. The Trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	• Part 1 Board meetings are held in public • Dates of meetings published on Trust website and on internal communications • Part 1 Board agenda and papers available on website • Part 1 and 2 agendas and part 1 papers are emailed to Governors • Agenda and papers circulated to public on request • Part 2 Board meetings held in private are provided for in constitution. Summary of Part 2 minutes are provided to Governors.	✓	Statutory

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Resolution passed at Part 1 Board meetings to exclude members of the press/public in Part 2 meetings		
E.1.8. The Trust must hold annual member's meetings. At least one of the Directors must present the Trust's Annual Report and accounts, and any report of the auditor on the accounts, to members at this meeting.	• Annual Members Meeting held annually (September 2022) • Directors attend meeting • Chief Executive Officer presents Annual Report • Executive Chief Finance Officer presents annual accounts, and report of auditor on the accounts	✓	Statutory
E.2. Co-operation with Third Parties with Roles in Relation to NHS FTs			
E.2.1. The Board should be clear as to the specific third party bodies in relation to which the Trust has a duty to co-operate.	• The Board of Directors does this implicitly through system working, attending partner organisation meetings and keeping other organisations informed. • Regular meetings are held with HOSC to inform of any changes to service provision, which requires approval. • Partner organisations are notified of material events and / or system changes. • Executive Directors undertake multi-agency working and attend meetings with partner organisations. • Collaborative working undertaken through formal arrangements (such as Mid & South Essex Collaborative) and reflected in the Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions and Detailed Scheme of Delegation (DSoD). This has increased following the introduction of ICB's / ICS's • Any new requirements from organisations (such as NHSE) are provided to the Accountable Officer and are taken through the Board of Directors as required.	✓	Comply/ explain
E.2.2. The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	• Quality Account • Contract management meetings in place with NHS commissioners • Joint bids/provision of services with local service providers • PMGs/JMGs in place with local authorities • Ad hoc meetings with NHS England • Ad hoc meetings with CQC	✓	Comply/ explain

Code of Governance 2014	Evidence of Compliance 2022-23	Compliant?	Code Requirement
	• Chair, Chief Executive Officer and Directors involvement in Integrated Care Systems and collaborative models, such as Mid & South Essex collaborative, including as Board members. • Chair and Chief Executive Officer attend senior networking meetings		

Essex Partnership University NHS Foundation Trust

CORPORATE GOVERNANCE

FT4 declaration

Financial Year to which self-certification relates 2022/23

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified (a) Action identidied to commission an independently facilitated well led review between 2022 and 2024.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risks identified
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified. (a) Covid-19 command structure to continue in place until level 4 incident is stood down for the NHS.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Section C: CQC inspection of Acute Wards for Adults of Working Age and Psychiatirc Intensive Care Units - Section 29A notice issued by the CQC October 2022. Action taken to address concerns raised. No other material risks identified
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	No material risks identified.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	No material risks identified.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Paul Scott **Name** Professor Sheila Salmon

GOVERNOR TRAINING

Training of governors

Financial Year to which self-certification relates | **2022/23**

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Scott	**Name**	Professor Sheila Salmon
Capacity	Chief Executive Officer	**Capacity**	Chair of the Trust
Date	31 May 2023	**Date**	31 May 2023

GENERAL CONDITION 6 & CONTINUITY OF SERVICE CONDITION 7

G6 & CoS7	Financial Year to which self-certification relates	2022/23

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

EPUT is not a designated CRS. However, the Trust has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. Our accounts have been prepared on a going concern which is subject to external audit.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of

Signature		**Signature**	
Name	Paul Scott	**Name**	Professor Sheila Salmon
Capacity	Chief Executive Officer	**Capacity**	Chair
Date	31May 2023	**Date**	31 May 2023

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**Complaints & Compliments Annual Report 2022/23**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital					
Report Author(s):	Claire Lawrence, Head of Complaints					
Report discussed previously at:	Executive Team Patient & Carer Experience Steering Group Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with a review of the overall performance of Complaints handling in EPUT as follows: • Number of complaints received and closed during the year. • Number of complaints referred to the Ombudsman. • Response timescales • Number of PALS enquiries • Complaint themes • Number of compliments received.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Approve the Annual Complaints and Compliments Report for EPUT 2022/23

Summary of Key Issues
• The trust received 631 complaints in 2022/23 which is a 2% increase compared to the previous year • Only 59 formal complaints (16%) were resolved within the Trust's target of 40 working days, although 91% were closed within agreed extended timescales • We have seen a 35% reductions in response times since the new complaints process was introduced in January 2023. We anticipate the new process will reduce the backlog of complaints over 2023/24. • The top category for Formal Complaints and Rapid Responses was "Unhappy with treatment (clinical)", however the top theme of complaints received via MPs was "Lack of Community Support" for the second year.

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

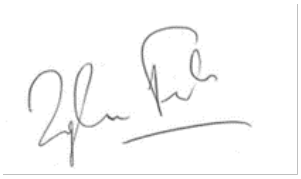
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

Acronyms/Terms Used in the Report			
PHSO	Parliamentary & Health Services Ombudsman	PALS	Patient Advice & Liaison Service

Supporting Documents and/or Further Reading
Complaints & Compliments Annual Report 2022/23

Lead



Zephan Trent
Executive Director of Strategy, Transformation and Digital

NHS
Essex Partnership University
NHS Foundation Trust

Complaints & Compliments

Annual Report 2022/2023

May 2023

Essex Partnership University
NHS Foundation Trust

Contents

PURPOSE

The purpose of this report is to provide an overview of the complaints, PALS enquiries and compliments that were received by the Trust throughout the year from April 2022 to March 2023. As well as data relating to volumes, response times, and themes of complaints, it presents an update on our new complaints process and an overview of improvement actions that have been taken because of the feedback we received from people who use the service (staff and complainants). The report also includes examples of lessons learnt from complaints and compliments, provides an update on the priorities we identified last year, and sets out our priorities for 2023-2024.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides services to more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. With more than 5,500 staff working across over 200 sites, we also provide services in people's home and community settings.

The Complaints Team is part of the Patient Experience portfolio, and provides a Complaints Service and Patient Advice and Liaison Service (PALS) for people who use the Trust services. This includes current and past service users or patients, carers, friends and relatives. We are there to help provide resolution, and rebuild relationships. We work across and with all our services.

Complaints

This year we have made some fundamental changes to the way we handle complaints within the Trust, following a comprehensive review of our process through coproduction, with services and service users, including complainants. As a group, the coproduction collectively reviewed and redesigned the complaints process, changing processes, policies and recommending the setup of a dedicated complaints liaison function in the complaints team that support the complainant, and services, from the first interactions right through to the resolution or conclusion of the complaint. Through co-design, our new complaints process is based on 5 key principles:

1. We are Service User Led and Outcome Focussed
2. Our approach is Fair and Accountable
3. We communicate and respond in a timely manner
4. Our Staff feel Supported
5. We have a Just and Learning Culture

Our new process launched in January 2023 and we are already seeing a significant improvement in our ability to respond and resolve complaints with a 35% reduction in the average response time to resolve complaints. Having said that, we continue to need the support of the services and operational teams, to respond to questions, concerns, and agree outcomes which deliver resolutions which are fair, realistic and mutual, and we thank the services for supporting us through the transformation of the service. In addition to this, as part of the new process we have changed the approval process so that we can respond faster, take accountability within the right directorates, and share ownership of when we get things wrong.

The changes to our complaints process means that data on whether these complaints are 'formal complaints' or 'rapid response' complaints is not directly comparable between years. Our new process (from 1 January 2022) provides a more complainant-led approach to resolution, and we no longer categorise complaints as either "Formal Complaints" or "Rapid Resolutions" based on pre-set criteria. Complaints received directly into the Complaints Team are now all logged as Formal Complaints, and the route to resolution is agreed collaboratively in early discussions between the Complaints Liaison Officer and the complainant. We recognise that some complaints are more complex than others to investigate, and wherever possible we take opportunities to provide faster resolutions to less complex complaints. Where we can do this without conducting a formal investigation, the outcome is recorded as "Resolved Informally", but the complaint type remains as "Formal Complaint".

- The trust received 631 complaints in 2022/23 which is a 2% increase compared to the previous year when the trust received 619 complaints.[1]
- 397 were formal complaints; 115 were rapid response (informal); 48 were local resolution; and 71 were letters from MPs.
- Only 59 formal complaints (16%) were resolved within the Trust's target of 40 working days.
- However, 91% of formal complaints were closed within agreed timescales (this includes extended timescales and delays).
- We received more formal complaints (397) that we closed (380) which led to the backlog of unresolved cases increasing from 140 as at 31 March 2022 to 157 as at 31 March 2023.
- We have seen a 35% reductions in response times since the new complaints process was introduced in January 2023. We anticipate the new process will reduce the backlog of complaints over 2023/24.
- The top category for Formal Complaints and Rapid Responses was "Unhappy with treatment (clinical)", however the top theme of complaints received via MPs was "Lack of Community Support" for the second year.
- 7 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust.

The Trust has a strong and developing culture of learning, and recognises complaints as a valuable source of feedback from which we can learn and improve our services. As part of the complaints investigation process, we consider the actions needed to prevent errors from reoccurring, or to minimize the risk. Lessons are identified and agreed by the Complaints Liaison Officer in collaboration with the person making the complaint and a clinical advisor from within the service.

After the complaint resolution is sent, the Complaints Team follow up with the service to provide assurance that improvement actions have been taken forward and embedded into everyday practice. All complaints are logged onto the Datix reporting system and are cross-referenced with incidents that have been logged separately, to highlight any incidents that are connected to the complaint.

Lessons identified are presented monthly at the Learning Oversight Committee and circulated Trust-wide in the Lessons Identified Newsletter. Learning from complaints is also discussed at monthly Quality & Safety meetings, and the Commissioners of EPUT's services receive a quarterly report containing the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

As a service, we do continue to have some challenges, constrained resource, and limited capacity in the frontline teams to support the complaints liaison team, although we have made huge progress, and we know as an organisation our perspective on complaints has shifted in the last year, and will continue to in the next year. We have a shared responsibility to address concerns and complaints when something not right. We thank those people who come forward and identify where we have it wrong, and we aim to resolve issues quickly and in a way that reasonably meets expectations, taking each learning opportunity as they come.

Our focus for the year ahead will be to continue to embed the new process, resolving complaints quickly and informally, change the culture of complaints, and support our services to improve. To do this we need the support of all our staff and services. What we do together, matters.

Patient Advice and Liaison Service (PALS)

PALS logged 1,337 enquiries and issues for resolution during the year 2022-23, which was an increase of 15% on the previous year (1,158).

The top 10 reasons for contacting PALs were Request for Information; Care; Assessment & Treatment; Unhappy with Treatment; Lack of Community Support; Medication; Communication breakdown with

relatives; Sharing of Information/Record Keeping; Discharge. These topics account for 54% of all enquiries.

The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal complaints investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 47 (3.5%) were passed to the Complaints Team as formal complaints.

In addition, PALS Officers signposted 677 enquirers for help to other services/ organisations.

Compliments

2,195 compliments were logged by the Trust in 2022/23, which is a 13% increase on the previous year (1,936), and reflects the ongoing work of the Patient Experience Team to make it more accessible for people to share their feedback with the Trust.

Services directly received 1320 compliments and 875 compliments were made via IWantGreatCare (Friends and Family Test feedback).

Priorities for 2023/2024

We have identified the following priorities for 2023/24:

- Embed new complaints process.
- Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.
- Implement self-logging facilities for staff and service to log informal complaints and compliments
- Establish an effective feedback process (service user survey, and quality feedback from NEDs and Patient & Carer Forum) for the complaints process
- Datix development so that people can self-log local resolutions (like they do with compliments)
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more meaningful
- Engagement with Deputy Directors of Quality and Safety to implement effective feedback and follow up on lessons/ actions
- Review the information on the Trust website, make it more accessible and less confusing regarding PALS or Complaints

FORMAL COMPLAINTS

Under our old process, complaints received directly into the Complaints Team were logged as a Formal Complaint if we felt they required a formal investigation in order to provide a resolution. These would then be responded to in writing by the Chief Executive.

At logging stage, if we identified that the complaint could be resolved informally (without a formal investigation), it was directed to the relevant service for resolution as a "Rapid Response".

Under our new process (implemented in January 2023) we take a more service user-led approach to complaint resolution.

All complaints received directly into the team are now logged as Formal Complaints, and allocated to a Complaints Liaison Officer (CLO) within the Complaint Team. The CLO agrees how to proceed with resolving the complaint in collaboration with the complainant. If it is possible to provide a faster resolution without conducting a formal investigation, the CLO will liaise with a clinical advisor from within the service to help facilitate this (for example, with a phone call or meeting with an appropriate service lead).

Complaints that are resolved in this way are recorded with an outcome of "Resolved Informally".

Note: as our reporting system Datix is not yet aligned to the Care Units, reporting based on care units is a complex manual process. Therefore, this report is based on the old organisational structure.

Number of Complaints Received and Closed

Total Complaints carried forward from 2021/22	Total Complaints Received 2022/23	Total Complaints Closed 2022/23	Total Complaints carried forward to 2022/23
140	397	380	157

397 formal complaints were received by the Trust during 2022/2023, which is an increase of 5.5% on the previous year's figure (376).

However, when comparing the overall total complaints received (all types) the increase is 2%:

	2021/22	2022/23	+/-
Formal Complaint	376	397	**+ 6%**
MP Letter	93	71	**- 24%**
Rapid Response (Informal)	118	115	**-3%**
Local Resolution	32	48	**+50%**
Grand Total	**619**	**631**	**+ 2%**

Improvements made to our website in 2022 could be a contributing factor to this behavioural change, as we have made it easier for people to find how to raise a complaint with us. The "Contact Us" page of our website contains information about how to contact PALS and the Complaints Team, and also provides a link directly to a page that explains the complaints process and contains a web form that can be completed and submitted directly to the Complaint mailbox.

The 50% increase in complaints that were raised and resolved within our services is an encouraging sign that the services are not only successfully resolving more complaints at the first point of contact, but they are also taking the time to complete a "Local Complaint Resolution Form" to capture the details of the complaint and identify any learning.

Formal Complaints Received by Area

Area	2021/22	2022/23	% change
Mid and South Essex	162	132	-19%
North East Essex	63	56	-11%
West Essex	38	29	-24%
Medical – Trust-wide	48	68	+ 42%
Specialist – Trust-wide	12	20	+ 67%
Psychology Services*	-	21	-
Total Mental Health	323	326	+ 0.9%
Community - South East Essex	11	42	+ 282%
Community - West Essex	15	16	+ 7%
Total Community Health	26	58	+ 123%
Corporate Services	27	13	-52%
Grand Total Received	376	397	+ 6%

* Psychology Services were previously included under the service areas (Mid & South, North Essex, and West Essex)

The table above details complaints received during 2022/23 by locality.

Due to the different volume of services delivered within these localities, the number of patient contacts vary significantly. Data for patient contacts in 2022/23 are shown below:

- Mid and South Essex : 300,162
- North East Essex : 98,893
- West Essex : 72,326

For all 3 localities for Mental Health Services, the number of complaints received constitutes between 0.5 and 0.6 complaints per 1,000 patient contacts during the year for the area.

The total number of formal complaints received for Mental Health Services remained stable compared with the previous year (+0.9%). However, Community Health Services saw a significant increase of 123%.

This uplift is largely due to 22 formal complaints relating to children's services at The Lighthouse Centre in Southend. The top complaint themes for the service were:

- Access to treatment
- Referrals / Appointments
- Medication
- Communication

EPUT took over the management of children's services at The Lighthouse Child Development Centre in Southend from Mid and South Essex NHS Foundation Trust in March 2022, and we have been working closely with the service, the patient experience team, and local partners, including commissioners, councils, schools, GPs, parent carer forums, and families to improve services at The Lighthouse. This has been a great example of how we can use the patient insight and intel from PALs, Complaints, and I Want Great Care, to drive improvements.

We have set up a new nurse-led ADHD service, which provides various diagnostic assessments for children with suspected ADHD, and treatment.

We now have more doctors working with us, and we have recruited additional administrative staff to answer phones more quickly, to support with referrals and booking appointments.

These changes are providing families with a better experience at The Lighthouse, and we expect to see a reduction in complaints for this service in 2023-24.

Other Community Health Services that saw an uplift in complaints are listed in the table below:

	2021/22	2022/23	+/-
Podiatry	1	3	**+ 200%**
Childhood Immunisation Services (combined)	2	5	**+ 50%**
District Nursing	4	7	**+ 75%**

Complaint Outcomes

When a formal complaint is investigated, we carry out a detailed review and consider all available evidence in order to determine if we can uphold the complaint. If there are multiple points raised within one complaint, each point is considered separately and each one is either upheld or not upheld. Where there is any combination of upheld/ not upheld complaint points, the overall outcome is logged as “Partially Upheld”.

380 formal complaints were closed during the year 2022-23, but a formal investigation was not completed for 32 (8.5%) for the following reasons:

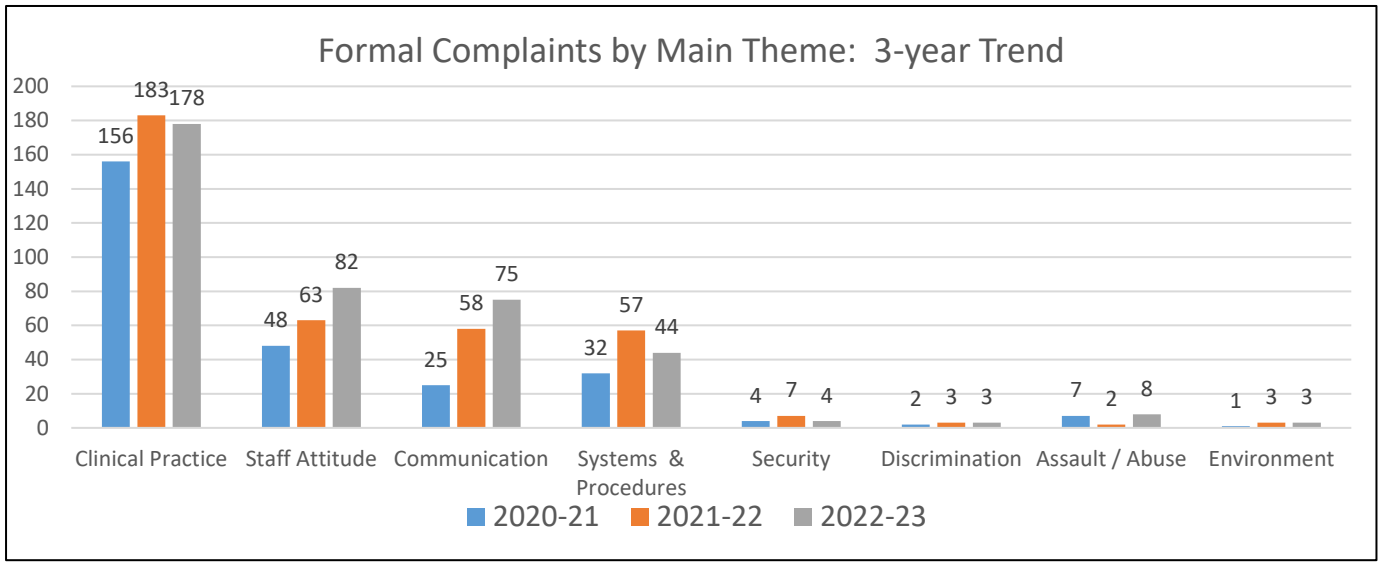
- 12 complaints were re-directed after an initial review (e.g. to another Trust)
- 13 were withdrawn by the complainant after being logged.
- 7 were initially logged as a Formal Complaint, but were subsequently resolved informally by the service (with the agreement of the person who raised the complaint) to provide a faster resolution.

Of the 348 that were formally investigated, 221 (63.5%) were either upheld or partially upheld.

	Not Upheld	Upheld	Partially Upheld	Re-directed	Withdrawn	Resolved informally	Grand Total
Mid and South Essex MHS	47	19	68	6	3	1	**144**
North East Essex MHS	17	6	17	3	3		**46**
West Essex MHS	9	9	10		1		**29**
Medical	27	8	19	1	1	3	**59**
Specialist	7	3	3		2	1	**16**
South East Essex Community Health Services	6	6	21	2	1	1	**37**
West Essex Community Health Services	2	3	10		1		**16**
Corporate Services	7	5	3			1	**16**
Psychology Services	5	2	9		1		**17**
Grand Total	**127**	**61**	**160**	**12**	**13**	**7**	**380**
%	**36.5%**	**17.5%**	**46%**	**-**	**-**	**-**	**100%**

Complaint Themes

Complaints are categorised according to the main theme of the issues raised. The chart below shows the 3-year trend of these complaint categories.



- Clinical Practice remains the highest category, but, the number of complaints logged within this category has fallen by 5 (2.5%) from the previous year.
- Complaints about Staff Attitude and Communication have both increased for the second consecutive year.
- There was an increase in complaints received about assault/abuse. 8 complaints were received in total compared to 2 in 2021/22 and 7 in 2020/21. 4 of these have so far been closed: 3 were not upheld, and 1 was not investigated as it was withdrawn. The remaining 4 are still under investigation at the time of this report.
- We have seen a significant drop in complaints relating to Systems and Procedures (25%) suggesting that we have made improvements in this area in the last year compared to 2021/22 however complaints in this area are still higher than they were in 2020/21.

Top ten sub-categories of Complaint Themes

Under each main category, there are a number of "sub-categories", which drill down further the theme of the complaint. The top ten sub-categories make up 61% of the total complaints received in 2022-23 (242 out of 397), as follows:

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Unhappy with Treatment	61	15%
Staff Attitude	Inappropriate behaviour	33	8%
Communication	Communication with patient	30	8%
Communication	Communication with relatives	25	6%
Clinical Practice	Lack of Community Support	22	6%
Clinical Practice	Assessment & Treatment	17	4%
Clinical Practice	Medication	17	4%
Staff Attitude	Unhelpful	15	4%
Clinical Practice	Referrals / Appointments	13	3%
Communication	Inaccurate written records	9	2%
	Total	**242**	**61%**

Many of these can be attributed to communication, behaviour and attitude from our staff towards patients, service users, carers, and relatives. If we focus our energies on improving communicating with these groups, and the way in which we communicate (behaviours and attitudes), this will have a significant positive impact.

Re-opened Complaints

We encourage people to let us know if they remain dissatisfied after receiving our response to their complaint, so that we can continue to seek resolution on any outstanding concerns for the complainant.

Of the 380 formal complaints closed in 2022/23, 27 (7%) were subsequently reopened. The reasons given for requesting the complaint to be re-opened are categorised below.

Reason for Re-opened Complaint	Number of complaints
Dissatisfied with investigation	10
Unhappy with outcome	8
Complaint not fully addressed	5
New questions/ information	3
Disagrees with response	1
Grand Total	**27**

A recurring theme is a mistrust of the complaints process, and the perception that the complaint investigation conducted was not impartial. Reasons for re-opening a complaint include:

"Patient feels the investigation has been misled and staff's roles within his concerns played down"

"Complainant would like an independent review of point 1 as the response was provided by the clinician involved in the patient's care, however, complainant believes she is the reason for the patient's decline".

"Complainant has no faith in the system."

Although only 7% of complaints were reopened, we are determined as a service to reduce this and increase the Trust in our complaints process. Under our new complaints process, all investigations are conducted independently by a Complaints Liaison Officer within the Complaints Team, rather than by an investigator from within the service that the complaint is about. We are confident that this increased level of impartiality will provide reassurance to people using our service of our commitment to investigating all complaints fairly.

Non-Executive Director Complaint Quality Reviews

The Trust's Non-Executive Directors (NEDs) provide an important and valuable part of the complaints process by undertaking independent quality reviews of 10% of complaints that are closed each quarter.

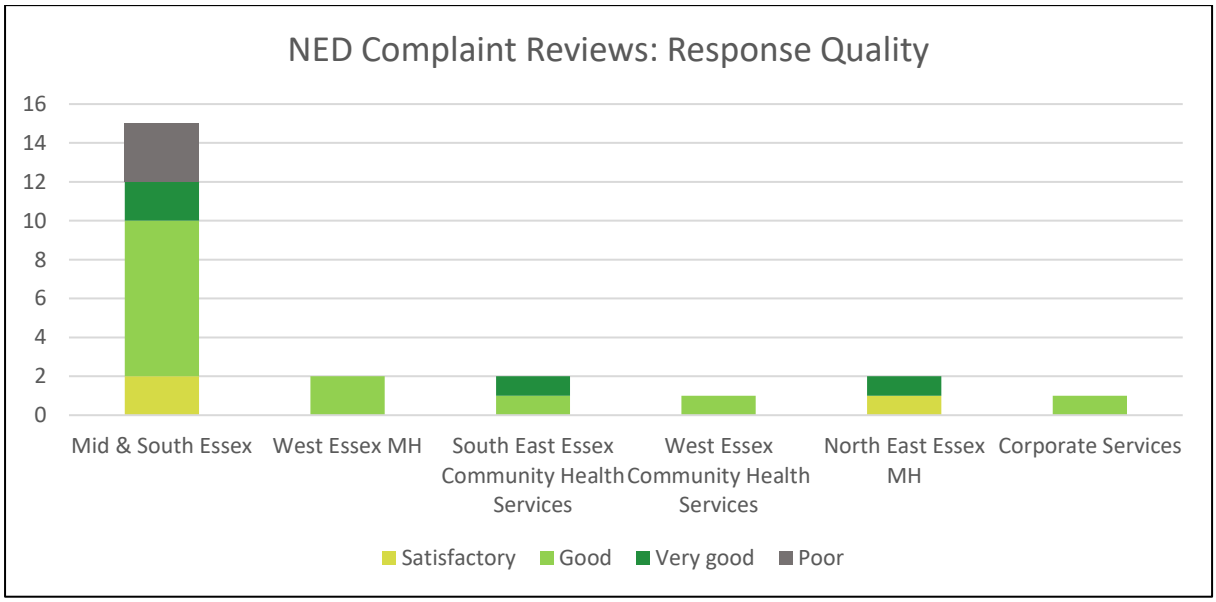
The reviewer rates the quality of the investigation and the response, and considers whether the Trust has done all it can to resolve the complaint and if appropriate lessons were identified and taken forward.

A total of 23 reviews have so far been completed for Q1-Q3 2022/23, which represents 6% of the total formal complaints closed in the whole year (380).

A further 15 reviews will be completed, to ensure that a total of 10% are reviewed.

Of the 23 reviews that have been completed:

- 65% were rated good or very good rating for 'how the investigation was handled'
- 74% were rated good or very good for the 'quality of the response'
- 100% had demonstrated lessons being learned where appropriate



3 cases (13%) were assessed as "poor" in relation to the overall quality of the complaint response.

The excessive time taken to respond to the complaint was the reason for the rating in two of these cases. The third case was rated as poor due to the lack of information recorded in the Investigation Report.

We are confident that response times will continue to show significant improvement under our new complaints process, and good communication will be maintained with the complainant throughout.

The Complaints Investigation Report is now completed by the Complaints Liaison Officer from within the Complaints Team, and is used as a working document, i.e. to record progress throughout the investigation, ensuring that all relevant information is captured and considered, rather than being filled out at the end of the investigation.

RAPID RESPONSE COMPLAINTS

Under our old complaints process, we introduced a Rapid Response approach to Complaints that met specific pre-set criteria, i.e. not complex and not spanning multiple services. Complaints meeting these criteria were logged as "Rapid Responses" and were sent directly to the service to respond to informally.

This has now changed under the new process, as we have focussed on providing a more complainant-led approach to resolution. Complaints received directly into the Complaints Team are now all logged as Formal Complaints, and the route to resolution is agreed collaboratively in early discussions between the Complaints Liaison Officer and the complainant.

We recognise that some complaints are more complex than others to investigate, and wherever possible we take opportunities to provide faster resolutions to less complex complaints. Where we can do this without conducting a formal investigation, the outcome is recorded as "Resolved Informally".

Rapid Response Complaints by Area

115 complaints received by the Trust in 2022/23 were logged as 'Rapid Responses', and 135 were resolved, including some cases that had been received the previous year

Rapid Responses	Received	Resolved
Mid and South Essex MH	44	54
North East Essex MH	12	13
West Essex MH	4	5
Medical – Trust-wide	17	16
Specialist – Trust-wide	10	13
Psychology Services	7	8
Total Mental Health	**94**	**109**
Community - South East Essex	16	20
Community - West Essex	3	3
Total Community Health	**19**	**23**
Corporate Services	2	3
Grand Total Received	**115**	**135**

Rapid Response Complaint Themes

Of the 115 Rapid Response complaints received, 45% were logged within the top 6 sub-categories. The top sub-category was "Unhappy with Treatment", which was the same as the top sub-category for Formal Complaints.

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Unhappy with Treatment	12	10%
Communication	Communication breakdown with patient	11	10%
Systems & Procedures	Referrals / Appointments	9	8%
Staff Attitude	Inappropriate behaviour	7	6%
Clinical Practice	Medication	7	6%
Clinical Practice	Lack of Community Support	6	5%
	Total	**52**	**45%**

MP COMPLAINTS

The Trust received 71 complaints from MPs on behalf of their constituents, down by 15% compared with the previous year (84). The top 4 topics for MP complaints were as follows:

- Lack of Community Support (10)
- Assessment & Treatment (7)
- Unhappy with Treatment (6)
- Medication (6)

LOCALLY RESOLVED COMPLAINTS

Wherever possible, all EPUT staff are encouraged to try to resolve complaints that are raised locally at the earliest opportunity. The details of any complaints resolved in this way should then be recorded on a "Local Complaint Resolution Form" and passed to the Complaints Team, so that any actions taken and lessons learned can be recorded, along with the details of the complaint.

We are aware that in reality, many issues are resolved locally without ever being recorded, and we are considering ways to make it easier for teams to self-log this activity so that we can capture this feedback and maximise learning.

There was a total of 48 (recorded) locally resolved complaints recorded for 2022/23 by the following areas:

Area	**Resolved Locally**
Mid and South Essex MH	7
North East Essex MH	4
West Essex MH	2
Medical	-
Specialist Services	6
Psychology Services	-
South East Essex Community Health Services	25
West Essex Community Health Services	1
Corporate Services	3
Grand Total	**48**

COMPLAINTS RESPONSE TIMES

Formal Complaints Response Times

Under our complaint process in 2022-/23, our internal target for investigating and responding to formal complaints was 40 working days. Where this was not achievable, we endeavoured to keep the complainant updated with our investigation and planned response date.

Because of formal complaint investigations being carried out by clinical staff within the service, operational pressures had a big impact on our responsiveness to complaints. Investigations were delayed where we have had to prioritise immediate clinical duties.

Out of the 380 formal complaints closed in 2022/23:

- 59 (16%) were resolved within 40 working days.
- The average time taken to respond was 93 working days (compared with 75 working days the previous year, and a pre-pandemic average of 44 working days in 2019-20)

Rapid Response Complaints Response Times

As highlighted above, the Rapid Response process was for less complex complaints that usually just involve one area. Under the old process, these were sent to the service to resolve directly with a target of 15 working days.

Out of the 135 Rapid Response complaints closed in 2022/23:

- 71 (53%) were resolved within the target of 15 working days.
- The average time taken to respond was 72 working days

Response Times under the New Complaints Process

The improvement of response times was one of our key objectives when we re-designed our complaints process. Under the new process, complaints are allocated to a dedicated Complaints Liaison Officer (CLO) from within the central Complaints Team. The CLO takes ownership of the complaint, and is responsible for completing the formal investigation and delivering a resolution in a timely manner.

The new process was implemented from January 2023, therefore at the time of producing this report we have limited data available to compare response times with the old process. However, tentative analysis of the data so far is demonstrating a very positive impact on response times:

- New process: 44 complaints were received in January 2023, and 26 (59%) were resolved by the end of March 2023, with an average response time of 22 days.
- Old process: 30 complaints were received in January 2022, and 8 (27%) were resolved by the end of March 2022, with an average response time of 34 days.

The fact that we are resolving a much greater proportion of complaints at an early stage is a strong indicator that average response times in the long-term will be significantly lower under the new process.

PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a person is dissatisfied with the response they receive and feels that all avenues to resolve it with the Trust have been exhausted, they can ask the Parliamentary & Health Services Ombudsman (PHSO) to conduct an independent review of their complaint. On all of our letter responses, we are clear and transparent about this process, and wherever possible we support complainants in their escalation to the PHSO.

PHSO Referrals

During 2022/23, seven cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust.

Of these seven referrals:

- 5 were closed without further investigation after an initial assessment by the PHSO.
- 1 referral is still awaiting an initial assessment.
- 1 case is under investigation, and a Final Report has not yet been issued.

PHSO Investigations

No PHSO investigations were completed during 2022/23, compared with 4 the previous year.

LEARNING FROM COMPLAINTS

In line with our core values (We Care, We Learn, We Empower), the Trust has a strong and developing culture of learning, and recognises complaints as a valuable source of feedback from which we can learn and improve our services.

An integral part of our complaints investigation process is to consider the actions needed to prevent errors from reoccurring, or to minimize the risk. Lessons are identified and agreed by the Complaints Liaison Officer in collaboration with the person making the complaint and a clinical advisor from within the service.

After the complaint resolution is sent, the Complaints Team follow up with the service to provide assurance that improvement actions have been taken forward and embedded into everyday practice.

Lessons identified are presented monthly at the Learning Oversight Committee and circulated Trust-wide in the Lessons Identified Newsletter. Learning from complaints is also discussed at monthly Quality & Safety meetings, and the Commissioners of EPUT's services receive a quarterly report containing the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

Examples of lessons learned

Lessons were identified from 199 (53%) of the 380 formal complaints closed during the year. Below are a few examples of learning from complaints.

1. **North East Essex MH Community Mental Health Team (Herrick House):**

A friend of a patient raised concerns about his current treatment plan. She would like a review of his case, and requested that his referral for Autism assessment be considered when completing a new treatment plan. The person raising the complaint asked how further awareness of autism could be highlighted to staff to improve understanding of how patients with this condition may not be able to interact in typical ways, and so that adjustments can be made as needed.

Learning identified:

Because of this complaint, the patient's care coordinator requested additional training on Autism for the team to support in understanding, not just this patient, but also all people who are on the Autistic Spectrum as a way to ensure that their needs are understood and appropriate accommodations can be made. Additional autism training was delivered online by the lead Autism clinician for EPUT via MS Teams to facilitate maximum clinical staff accessing this.

2. West Essex Community Health Services, Musculoskeletal Service

A complaint was received from a patient who received a steroid injection in her hand to treat carpel tunnel syndrome, which caused extreme pain and lasting nerve damage. The patient was unhappy at how the situation was subsequently handled, and asked why was the possibility of nerve damage not listed in the information sheet that she was given to read and sign?

Learning identified:

Because of this complaint, the consent form for steroid injections was updated to include the risk of nerve damage. Local team protocol was produced for (i) the administration of local steroid and (ii) the procedure to follow if there is a suspected nerve injury.

3. Mid & South Essex MH, Acute Treatment Ward, The Crystal Centre

After seeking appropriate permission, the patient ordered a food supplement product to the ward and was frustrated that when it arrived nobody would bring it to him. The patient asked multiple times for the item, and kept being told to wait, with no further explanation. Eventually the night shift staff explained that they couldn't give it to him without permission from the nurse in charge, but the patient was frustrated because he felt the nurse had already given this permission. He was left feeling de-humanised by the lack of care, and felt that the package was being withheld from him with no justification.

Learning identified:

The Crystal Centre reception has introduced a book to record patients' delivered items and to track when an item is sent to the ward and delivered to the patient to prevent a similar problem occurring. Communication is a central issue of this complaint. The patient felt de-humanised by the lack of explanation, and the reasons for the patient not being able to keep the package in his room should have been explained to him by the staff. This learning was shared at a Care Unit Meeting.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints linked to Patient Safety Incidents

All complaints are logged onto the Datix reporting system and are cross-referenced with incidents that have been logged separately, to highlight any incidents that are connected to the complaint.

Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Investigator works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2022/23, there were 29 complaints that were linked to a separate incident recorded on Datix. Of these, 3 were linked to a Patient Safety Incident.

Any joint learning from the PSI investigation and complaint is discussed at the Learning Oversight Steering Committee.

Legal Claims related to Complaints

There were 4 claims received by the Trust that related to formal complaint this year, 3 relate to alleged clinical negligence, and 1 is in relation to a patient death.

A total of 5 claims were closed that related to formal complaints (these were not any of the 4 above claims, but were received previous to this year). In 3 of the cases, damages were awarded, with a joint total of £264, 476.

FEEDBACK SURVEY ON COMPLAINTS

We send a survey link with our complaint responses, to gauge satisfaction with our complaints process. In 2022/23 we received 24 responses to the survey, and the results are shown below.

- 42% were satisfied that all aspects of their complaint was addressed (v.26% 2021=22)
- 29% believed the complaints process was fair (v. 24% 2021-22)
- 8% were satisfied with the timescale of the response (v.18% 2021-22)
- 33% were satisfied with the overall handling of their complaint (no comparable data for the previous year, as this question was added in 2022-23).

Following the redesign of the complaints process, we are changing our feedback survey to be more reflective of the new processes, systems, and team structure. We will also be looking at ways to increase the response rate, in order to ensure the feedback we receive is representative.

Based on the feedback we are receiving directly from complainants since we launched our new process in January, we are confident that we will see a significant uplift in satisfaction scores for 2023-2024.

COMPLAINANT STORIES

It is important to reflect on complainant stories, because they provide greater insight and context to the complaints data. Case studies are a powerful tool that we use in team meetings and coaching to bring real complaints "to life" and prompt discussion, reflection and learning.

Note: all case studies are anonymised to protect patient confidentiality.

Story 1:

A complaint was received from a close family member of a patient who had been under palliative care, and who subsequently died at home.

The complainant explained that plans had been agreed regarding the patient's death, and the family had been assured they would have access to "out of hours" palliative care if needed.

However, when the family called for help late in the evening, they felt that the support offered to them was inadequate, and the plans that had been agreed were not followed by attending clinicians. Additionally, when the patient died that night, the family were uncertain about how to notify someone of the death, and felt completely unsupported. The family stated that they felt let down by the system.

In our complaint response, we apologised that the actions of Trust staff had exacerbated the family's distress at such a stressful and upsetting time. Although we recognised that that we were unable to change this distressing experience for this family, it was important that we identified what had gone wrong, so that we could minimise the risk of this happening to another family.

A thorough investigation was undertaken where it was identified that there were failings in our communication with the family which led to the confusion and distress.

The District Nursing Team provides cover for the Palliative Care Team out of hours, however this had not been properly explained to the family. They were under the impression that the staff attending did not have the same level of training as the specialist team, which was not the case.

The learning from this complaint was that an open conversation needs to be held at the beginning of the episode of care to ensure that there is a clear understanding of the roles of the different teams and how they work together to ensure a 24/7 service. If this had been explained to this family, and if there had been guidance about what to do about registering the death, they would have had confidence in the actions of the staff that attended.

Story 2:

Following the changes made to the complaints process, one of the first complaints received was relating to what was interpreted to be incorrect information within a letter that had caused distress and frustration.

The complainant was extremely upset about the contents of a letter written by her doctor to another clinician, as she felt it contained inaccurate observations relating to her condition. She felt the doctor had painted a very negative picture of her in the letter.

The complaint was allocated to a Complaints Liaison Officer, who contacted the complainant to talk to them about their concerns and establish the best way forward. The complainant was grateful that they had been contacted so promptly, and commented that they felt that they had been listened to and given the space and time to offload their frustrations, which was appreciated.

It was decided that a face-to-face meeting with the doctor would enable the complainant to express how this situation had affected them. The CLO contacted the service and arranged a meeting between the doctor and the complainant, and the CLO also attended at the patient's request.

At the meeting, an honest and frank conversation took place. The doctor apologised for the way that the letter had impacted on the patient, and was able to explain the reasons for the comments in the letter. He acknowledged that the wording of his letter could have been more considered, and he would take this matter as a personal learning.

The complainant was happy for the complaint to be closed following this meeting and told the CLO that she was grateful for the chance to address her concerns directly with the doctor. She said she felt that his apology for the upset caused was heartfelt, and said, "That meant a lot to me".

PATIENT ADVICE AND LIAISON SERVICE (PALS)

The PALS service sits within the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. Our PALS service supplies confidential advice, support and information about all aspects of EPUT services, primarily to patients, their families and their carers.

PALS logged 1,337 enquiries and issues for resolution during the year 2022-23, which was an increase of 15% on the previous year (1,158).

The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal complaints investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 47 (3.5%) were passed to the Complaints Team as formal complaints.

In addition, PALS Officers signposted 677 enquirers for help to other services/ organisations.

The top 10 themes for PALS enquiries in 2022/23 made up 54% of the total enquiries for the whole year. These are shown in the table below as a percentage of the total number of enquiries received.

Top 10 PALS Categories	**Number of Enquiries**	**% of Total Enquiries**
Request for Information	144	11%
Care	121	9%
Assessment & Treatment	118	9%
Unhappy with Treatment	99	7%
Lack of Community Support	67	5%
Medication	46	3%
Communication breakdown with relatives	43	3%
Sharing of Information/Record Keeping	42	3%
Discharge	41	3%
TOTAL	**721**	**54%**

COMPLIMENTS

2,195 compliments were logged by the Trust in 2022/23, which is a 13% increase on the previous year (1,936), and reflects the ongoing work of the Patient Experience Team to make it more accessible for people to share their feedback with the Trust.

Services directly received 1320 compliments and 875 compliments were made via IWantGreatCare (Friends and Family Test feedback).

A selection of compliments are published regularly in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

Received by Area

Area	Compliments Received
Mid & South Essex MH	1011
North East Essex MH	281
West Essex MH	58
Specialist	276
Total Mental Health	**1626**
South East Essex Community Health Services	253
West Essex Community Health Services	287
Total Community Health	**540**
Corporate Services	29
Total	**2195**

Learning from Compliments

Along with complaints, all compliments received by the Trust are analysed for potential learning that can be shared, as they can provide an excellent opportunity to highlight good practice.

Below are some examples of lessons learned from compliments that were shared Trust-wide in the monthly Lessons Identified Newsletter in 2022/2023:

1. **North East Essex MH, Home First Team, The Lakes**

   "'..thank you so much for your faith in me to keep my precious daughter safe, and your support to be able to see her through her crisis at home in her own familiar surroundings. It's been a privilege to be so involved and included in her care...thank you for respecting and listening to me…you are a special bunch.'"

   Good practice shared: The importance of listening to families and carers and involving them in the patient's care.

2. **Community Mental Health (North East)**

   "I was in communication during my care with Jordan , mental health nurse. I feel her kindness and professional care attitude including her ability to listen and supportively encourage myself to explore what was best for me as a patient to self manage my condition very useful and encouraging. As a consequence I have changed my medication during her care and have been made to feel a lot more supported. Her being easily accessible at my local GP surgery has been greatly appreciated.."

   Good practice shared: Encouraging patients to consider ways to manage their own condition is supportive and empowering and demonstrates we care. .

3. **Mid and South Essex MH, Dementia Memory Service, Harland Day Centre**

   "Mother and father both have dementia and were struggling to maintain daily activities at home, even with care this was difficult. Rosie was amazing and listened to us and gave really good advice and support. Also the fact that she acknowledged how difficult this was for me and my wife was comforting and supported us to not feel guilty because we wanted to live our lives"

   Good practice shared: Acknowledging how difficult things are for the families and carers of patients is comforting and can help alleviate the feelings of guilt that can come with struggling to cope with a loved one with mental illness.

4. **South East Essex Primary Care Mental Health Team**

   " I have been given support over the last few months at a time when I needed it. Also I have been put in touch with organisations that I can contact such as Trustlinks. I felt I was given the opportunity to express myself and ask any questions I had, to which answers were offered. There was no stereotyping and I felt I was treated as an individual.."

   Good practice shared: When we allow people the opportunity to express themselves and ask questions, we can better understand their needs and offer personalised advice and support. Treating patients as individuals is noticed and valued.

UPDATE ON PRIORITIES SET IN 2021/2022 ANNUAL REPORT

Please find an update on the priorities set in the annual report for 2021/22 in the table below.

Priorities set for 2021/22	Status	**Action Taken**
Redesign our Complaints Process to improve satisfaction with outcomes and reduce unnecessary delays and extensions.	Complete	• New process launched in January 2023, already evidence of improvements in all areas.
Improve the way that Complaints and PALS drives learning and quality improvement across EPUT.	Complete	• Working with the Learning Collaborative, learnings are now frequently shared for inclusion in the trust wide. • Regularly meeting the Deputy Directors of Quality and Safety at monthly Quality and Safety meetings
Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.	Carried forward	
Improving the self-logging facilities for staff and service to log informal complaints and compliments	Partially Complete	• Compliments self logging done. • Carry forward informal complaints self-logging.
Develop a process to provide information about complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal .	Closed	On reflection, this was a redundant task due to the current process being adequate.
Explore ways to promote and publicise compliments received to the Trust.	Closed	Moving forward logging and reporting compliments will sit with the patient insight and intel team, and so this action will move there too.

PRIORITIES FOR 2023/2024

- Embed new complaints process.
- Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.
- Implement self-logging facilities for staff and service to log informal complaints and compliments
- Establish an effective feedback process (service user survey, and quality feedback from NEDs and Patient & Carer Forum) for the complaints process
- Datix development so that people can self-log local resolutions (like they do with compliments)
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more meaningful
- Engagement with Deputy Directors of Quality and Safety to implement effective feedback and follow up on lessons/ actions
- Review the information on the Trust website, make it more accessible and less confusing regarding PALS or Complaints

Report produced by:

Claire Lawrence
Head of Complaints

Matthew Sisto
Director of Patient Experience

On behalf of:

Zephan Trent
Executive Director of Strategy, Transformation and Digital
May 2023

		Agenda Item No: 8d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**Patient Experience Annual Report 2023-24**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Matthew Sisto, Director of Patient Experience					
Report discussed previously at:	Executive Team Patient and Carer Experience Steering Group Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with the Patient Experience Annual Report for 2022/2023.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the content of the report

Summary of Key Issues

- The report gives a detailed overview of all the work that's happened in the last year, reflecting on the progress against the 'Involvement Strategy' agreed in 2021
- It also sets out recommendations to take forward into the 'Working with People and Communities' strategy

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

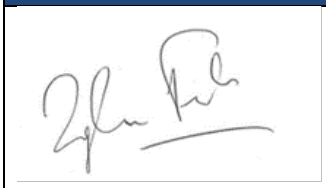
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Patient Experience Annual Report 2022/23

Lead



Zephan Trent, Executive Director of Strategy, Transformation & Digital

NHS
Essex Partnership University
NHS Foundation Trust

Patient Experience

Annual Report 2022/2023

May 2023

NHS
Essex Partnership University
NHS Foundation Trust

Contents

Purpose

The purpose of this report is to provide an update on the current position of the Patient Experience portfolio at the Trust, reflecting on the 2021-2023 Public Involvement Strategy and, the progress made against it over the last year from April 2022 to March 2023. The report also provides some recommendations for the portfolio to take forward and consider as part of the planned 'Working With People and Communities' enabling strategy referenced in the Trusts Corporate Strategy 2023 - 2028.

The Aspiration

The vision for the Patient Experience Portfolio set out in the Public Involvement Strategy in 2021 continues to be relevant as we work to develop our capability and offer in line with the strategic development plan:

'Our people (patients, carers, and families included) are involved with key decisions and engaged in driving forward meaningful change; with learning from lived experience at the heart of everything we do.

Together, we will ensure that the experience of those that use our services is valued equally to safety and quality; explicitly recognised as a golden thread throughout the organisation.'

Our Updated Position

The patient experience portfolio formed in summer of 2021, and has developed significantly since the launch of the 2021 Public Involvement Strategy. The portfolio now includes the following teams:

- Patient Advice and Liaison Service (PALS)
- Complaints
- Patient Experience
- Volunteers (including the Lived Experience Team)
- Faith Services

The collection of these services under a single portfolio has enabled the Trust to better utilize policies, processes, and tools to leverage our overall capability for involvement; enabling our service users and carers to share their lived experiences of services, and get involved more easily to drive improvements. Although each team is individually complex, we are unified under a single purpose of developing our relationship with the people and communities we serve, to collectively improve services. As the portfolio develops, the capabilities of the portfolio can largely be grouped under three headers:

1. **Lived Experience:** listening, learning, improving the access, experience, and outcome for patients and carers
2. **Participation:** involving service users, carers, and volunteers, to co-design, develop, and deliver our services
3. **Partnerships**: partnering with our services users and carers, and working with partners across the system, including VCSE, to improve access, experience, and outcomes for patients and carers

As per the 'Working with People and Communities Annual report 2022' produced by the patient experience team, it was recommended that the portfolio and its capabilities became more strategically aligned, to support and enhance the strategic development and transformation of the Trust. It must also work closely with the operations teams to deliver the new operating model launched in the spring of 2022, based around six clinical operational delivery units which will be led by multi-disciplinary and multi professional leadership teams. Because of this, the portfolio moved to the Strategy, Transformation and Digital Directorate in November 2022.

As we approach the end of the 2-year plan for the Public Involvement strategy 2021, the portfolio is well established, and better placed to continue to improve the Trusts position for working with people and communities. In the past year, we have seen involvement and engagement activity reach its highest to date and it is having an increasingly significant influence on more key decisions within the Trust. Slowly, we a shifting the balance of power through subtle and incremental developments.

Transformation

Given where the portfolio is today when compared to the spring of 2021, the portfolio has been on a remarkable transformation journey to support the delivery of the ambitions set out in the Public Involvement Strategy 2021. In summary:

- There is a clear mandate for involvement and lived experience roles embedded in the new corporate strategy, underpinned by trusts Reward and Recognition policy
    - The Reward and Recognition policy launched in summer of 2021, as a result of a co-productive redesign of the former 'Recompense Policy'
    - The policy has unlocked involvement and increased activity exponentially. It has been shared with members of the National Heads Of Patient Experience (HOPE) network and recognized as best practice by colleagues in Midlands Partnership NHS Foundation Trust and Cheshire & Wirral Partnership NHSFT
    - We know that Reward and Recognition isn't just about remuneration but it is fundamental for setting the foundations of a working relation based on reciprocity, mutuality and equality
    - Lived experience is referenced throughout the Corporate strategy 2023 -2025 as a golden thread
- Ways to get involved and engage are clear, underpinned by policy, processes, and systems
    - Updated Volunteers Policy (January 2022) [Co-designed]
    - New Reward and Recognition Policy (August 2022) [Co-designed]
    - Launch of the volunteers management system 'Kinetic' (January 2022)
- Involvement roles continue to be redefined and cover a growing range of activities across the Trust
    - A number of activities now sit within the scope of Reward and Recognition, such as the Patient Information in Plain English (PIPE) review group and Patient Led Assessments of Care Environments (PLACE). The impact of this is an increase in involvement activity across the board
- The Lived Experience Ambassador (LEA) Role is well established with clear expectations as detailed in the Reward and Recognition policy. Along with this, the Lived Experience Team is growing

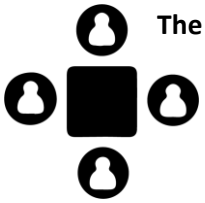
- The involvement activities are varied and the Lived Experience Team are being used on many different work streams including developing the coproduction champion network, Patient Safety Partners, Time to Care, Corporate Strategic Development work of 2022, and the developing Inpatient Peer Support Team
- Involvement roles at the principle rate (patient leadership roles) are being frequently utilised within key work streams, organisational meetings and steering groups so that people with lived experience have increasing influence in key decision making across the trust
- Policies and procedures are supportive not obstructive as evidenced by continual feedback from our Lived Experience Ambassadors and Volunteers, due to the most part of the collective effort to coproduce redesigned policies and procedures
- We have communicated the new approach and associated policies across the trust as demonstrated by an increase in the utilisation of the reward and recognition policy and the increased number of involvement activities and hours contributed by LEA's
- Giving feedback on services is now easier than ever with the launch of I Want Great Care (IWGC) in January 2022. We increased the methods of giving feedback significantly, both digital (web, mobile, tablet) and paper, with easy read forms, and multiple language options. Whilst the adoption of IWGC is still low, it continues to incremental increase month on month, but we see this as a huge growth opportunity for the Trust
    - To improve the development of IWGC we have recruited a reporting and training manager to work specifically on Patient Insight and Intel, frequently reporting to the care units, and key decision-making committees. This will ensure that Patient Insight and Intel is driving forward meaningful change
    - Another growth opportunity for forward planning is our external mechanisms for feedback to our patients and carers, sharing the improvements made as a result of patient insight and intel (externally facing 'You Said We Did' portal)
- The teams have been working closely with services and the people that use their services through coproduction. As an example, in the last 6 months we co-designed a new inpatient welcome brochure that is tailorable for each site, in partnership with our service users.
- In November of 2022, we set up the Patient, Carer and Family Collaborative (The PCFC) formed of staff, patients, carers, and partners (EPUTs equivalent to a Citizens Panel). This is co-chaired by one of our patient leaders, meets quarterly and will become a key decision making group
- In February 2023, we established the internally focused Patient and Carer Experience Steering group, chaired by the Executive Director of Strategy, Transformation and Digital. This group is inclusive of our Lived Experience team and a varied group of senior leaders across the trust whom are in a position to influence the development of the strategic ambitions for the portfolio and Trust
- We have redesigned our complaints service through coproduction. Setting up a complaints liaison team, which launched in January 2023. This is already achieving real tangible benefits for our services and service users

  - Along with the service redesign, we have redesigned policy, procedures, processes, and systems, including a more sophisticated call handling system in line with the Trusts call center
  - To streamline the core offer of the PALS and complaints team, we have reallocated the compliments logging function to the developing patient insight and intel capability within the patient experience team

- We have begun to build and strengthen strategic partnerships with voluntary/community organisations and groups across Essex. Developing our capabilities, and offer for supporting services to improve the access, experience, and outcomes of care. Some examples to date include developing working relationships with Healthwatch Essex, Essex Family Forum, Essex therapy dogs, University of Essex, University of Suffolk, Southend SEND Independent Forum, Send The Right Message, Heads2Minds, and Essex Boys Barbers
  - We see this as another huge growth opportunity for the Trust and the teams are already working with system partners to pull together a VCSE catalogue for Essex to develop our network
- Since February 2023, we have had one of our Lived Experience Leaders assume the role of the Trust-Wide Coproduction Lead. They are leading the charge in designing our coproduction offer and capability. Our coproduction lead also acts as a coach to others in the Lived Experience team that are actively leading coproduction, pulling together a network of coproduction champions. Further to this, our coproduction lead is designing our 'Service 'User Accreditation' offer, which is being piloted at our Basildon Site (April 2023). We are also planning to hold a Coproduction Conference (which will be open to all) later in 2023

Engagement methods

Since the launch of the Public Involvement Strategy in 2021, we have rationalized, and developed, our methods for engaging with the people and communities we serve:



The Patient, Carer, & Family Collaborative

- The PCFC Launched in November 2022 and meets quarterly, and is EPUT's equivalent to a Citizens Panel. It will become a key decision-making body, which has direct input from and to the executive team via a service user representative attending other key decision making groups
- Made up of staff, patients, carers, governors, execs, volunteers and partners

The EPUT forum

- Redesigned in winter of 2021, relaunched in March 2022, now aligned more closely to The NHS Constitution recommendation of 'the NHS belongs to the people'; services shaped by people, (especially those with lived experience), are more likely to be needs-led and patient-centred, resulting in better outcomes
- Communicate key initiatives and updates
- Listening channel for themes and trends of patient feedback to be established

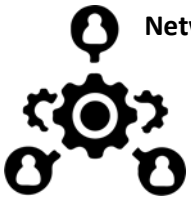
- The agenda is driven by the public, whom can raise items and queries via a Microsoft form ahead of the meetings

Patient Surveys (IWGC)

- Launched in January 2022, due to the former solution not meeting our need effectively enough.
- Has a mix of methods for people to leave feedback including paper forms, web, mobile, and tablet
- Includes both local and national requirements such as Friends and Families Test
- Since August 2022, two safety specific questions added, which we selected by our Patient Safety Partner Team, to support the 'Safety First, Safety Always Strategy'
- Imperative to understand the key themes for the experience of care across the Trust

PALS and Complaints

- Redesigned Complaints throughout the spring and summer of 2022 co-productively, with new processes and systems launched in January 2023. Now far more focused on repairing relationships, and resolving issues
- Key to capturing and addressing concerns, and repairing relationships
- Reporting has been strengthened, and now there is much closer working with the Patient Experience Team
- In addition to this, as an outcome of the National Community Mental Health Survey of 2022, we are working to develop our PALs service. Improve our advisory capacity and offer to service users.



Network of Networks

- Our networks of networks have grown, and we now have several networks for services and service users, covering a range of services and communities. These can be service specific, like The Lighthouse Parent and Carer Network, community-specific, i.e. The Lived Experience Network, or based on a group of shared characteristics such as the LD and Autism Network.
- A network aims to ensure there is fair representation of the communities we serve within EPUT, providing people a platform for sharing views, and services an opportunity to listen
- This listening platform can be integral in driving continuous improvement, and early identification of concerns before they become issues and formal complaints
- Specialist group consisting of service users and care providers (both current and not)
- We see this as another growth area for the Trust, although it does require support from services to administer the ongoing management of the network.

Additional Engagement Methods

Further to this, we have developed additional means of engaging the people and communities we serve:

- Inpatient Focus Groups and Interviews (heavily utilised in development of the Time To Care Programme in 2022)
- Podcasts launching in Spring 2023 (Coproduced)
- Newsletter (Co-designed)

Success Measures

In the Public Involvement strategy, it stated that the success of the quality of our improvements would be based on two key objectives and their supporting performance indicators:

1. Increase and elevate public involvement and engagement across the trust
2. Breed a culture that values patient experience through involvement

The table below provides an overview of progress against each objective and their performance indicators, outlined in the Public Involvement Strategy, since its launch:

#	Success Measure	September 2021	April 2023
1	Increased involvement	5 involvement activities	46 involvement activities (increase of 819%)
1	Increased attendance of forums and networks	On average, 3% of people who attended the EPUT forums 2019-2021 were members of the public.	On average 69% of people who attended the EPUT forums 2022 were members of the public.
1	Volunteering increased across the trust	133 Registered volunteers	269 Registered Volunteers (increase of 103%)
1	Better partner network that delivers real value	*No quantitative metric for this at present although there is evidence that it is improving in reference to examples detailed within this report*	
2	Evidence to support a cultural shift	5 involvement activities LEA's primarily working on staff induction	46 involvement activities (increase of 819%) People with Lived Experience working in a wide range roles and on some major transformation programmes (Time To Care, Strategy Development, Mental Health Urgent Care Department)
2	Better evidence of learning	"you said we did" collected on an adhoc basis and shared on the intranet	Monthly submission to the Learning Collaborative Partnership including "you said we did" allows routine evidence of learning to be documented and appropriate actions to be identified.
2	Improved outcomes from complaints	Average time to resolution 34 working days	Average time to completion 22 working days days (35% reduction)
2	Survey responses improved	302 IWGC responses in the last quarter	581 IWGC responses in the last quarter (increase of 93%)

Evidence of impact

	Sept 2021	% increase	September 2022	% increase	Aprl 2023
Volunteers	126	**81%**	228	**17%**	267
Lived Experience Team	10	**480%**	60	**120%**	132
Involvement activities	5	**625%**	30	**53%**	46
Hours of Involvement	297	**80%**	537	**34%**	717

Testimonials

'EPUT is a beacon in the space of coproduction' (LEA)

'Being approached and asked to take on a lead role within the Time To Care programme has increased my confidence which in turn has helped my recovery' (LEA)

'It feels authentic; it feels as though EPUT really want to make the improvements that matter most to the patients' (LEA)

'I have never worked with an organisation that have anything in place as ground breaking as EPUT's Reward and Recognition policy' (LEA)

'The team are constantly creating opportunities for people with lived experience to have a voice within EPUT' (LEA)

'It is a joy to work with a team that challenge the norm and status quo; treating and hearing people with Lived Experience with the same respect and courtesy as managers and directors' (LEA)

Key milestones

- Trialling People Participation Lead roles in Rochford and the Linden Centre in order to collect inpatient feedback, and introduce innovative modes of participation
- Partnering with Essex University in order to recruit volunteers for the PLACE visits, which resulted in successful completion of PLACE 2022 and best practices shared with NHS England
- Head of Patient Experience delivering two seminars at the University of Suffolk on coproduction
- Partnering with Essex Therapy dogs across inpatient services
- Collecting inpatient data with Deloitte through patient interviews and focus groups on the wards, which helped inform the new staffing model
- Welcoming Chaplaincy to the portfolio of Patient Experience, because this relies heavily on volunteers the alignment for this team and capability is crucial to its development
- Creating new promotional content; videos for involvement activities at EPUT and feedback
- Piloting Peer Support Worker Roles in inpatients
- Successful launch of the Patient Safety Partner role and team
- Successful launch of the Involvement lead role
- Successful redesign of PIPE group with LEA lead in place
- Successful launch of the EPUT coproduction Lead role

Performance against the success measures

In summary, and based on the evidence above, we have delivered significantly against all of the following success measures:

- ✓ Ways to get involved are clear and simple for all
- ✓ People Participation is at an all-time high
- ✓ Across the organisation, all types of involvement are being used effectively

In addition, we have developed our understanding of the interdependency of experience, safety and quality, so have pivoted our approach to the following measure by seeking greater alignment with the Safety and Quality teams. Because of this, we also consider the development in this area a success:

- ✓ Patient experience is explicitly valued equally to safety and quality by all

Challenges

Along the way, we have experienced challenges, particularly at a time of immense pressure in the NHS with constrained resources across the board. Although, nothing is insurmountable and we moved forward as an organisation significantly in the areas of involvement, participation, and coproduction. However, the following is a list of some of the key challenges we are still to overcome and therefore guide the recommendations on page 10:

- The communications approach to get people involved, and recruitment, is not always as effective as it could be
- Communicating impact of participation, internally and externally is not always as effective as it could be
- Aligning to the new care units hierarchy in our reporting systems has been difficult due to technical challenges
- Traditional processes at the Trust have at times inhibited the development of the Lived Experience team and roles like 'Patient Safety Partners' and 'Inpatient Peer Support Workers' (i.e. access to systems, training, and equipment has been challenging)
- The adoption of IWGC has been slower than we would like, and its use variable
- The utilisation of volunteers and the lived experience team is variable across care units and services, although is improving
- Posters and printed materials are outdated and not available for distributing across the services
- Support from some of the services to provide information for complaints investigations continue to be a challenge at times

In short, although we have progressed immensely to develop a strong capability for involvement, with the systems and processes in place to support it, the majority of our workforce and those that use our services are unaware of this capability. Therefore, focussing our energy on raising the profile of this service and its capabilities, and developing the lived experience team should be the focus of the incoming enabling strategy for 'Working with People and Communities'. To support this, a robust and dynamic comms and engagement plan is a key recommendation to take forward.

Recommendations

We know that we still have a long way to go to achieve the strategic ambition of being the best healthcare provider in this space, although it is our intent and ambition remains. Some recommended tactics to support the future delivery of the 'Working with People and Communities' strategy are as follows:

- Develop and deliver a comms plan to communicate both internally and externally the improvements that have happened as a result of insight, intel, and participation; and the developing capabilities we have on offer
- Grow the Lived Experience team, each service should play an active part in recruiting from the people that use the service
- Each service should has at least 1 lived experience role/activity to support the deliver and development of the service
- Mandate the use of IWGC, and set targets for services to seek feedback from services users, families, and friends
- To prevent the escalation from PALS to formal complaints, we must change our behaviours around responding to PALs. A speedy response in PALS will reduce the number of formal complaints through early intervention; it will also dramatically reduce the erosion of our relationships with the people and communities we serve
- To support the speedy resolution of formal complaints, senior managers that have a responsibility for supporting complaints responses should have a specific objective for this within their annual appraisal to ensure its regularly discussed with their line manager
- Mandate involvement from our lived experience team across all major programmes
- Mandate a person with lived experience being a panel member for interviews, in line with the BAME representation
- Mandate that the membership of key decision-making groups and committees, to include lived experience members
- Develop the people participation function, and adopt a business-partnering model with People Participation Leads (PPLs) assigned to each care unit. The PPLs will also routinely visit inpatient sites to support, develop, and improve our ability to work with people and communities

Our Commitment

Our commitments as a portfolio to the Trusts services and people whom use them remains the same and based on following five key principles:

1. We will continue to strive to be the best in everything we do, through the amplification of the service user voice, by increasing and elevating involvement and engagement across all our services.
2. We will continue to innovate and lead across our system by increasing and elevating involvement and engagement across all areas of health and social care that EPUT is a deliver partner in.
3. We will enable our services to involve and collaborate in a meaningful way with service users which breeds a culture that values patient experience through involvement
4. We will strive to add value across all of ours services through our core capabilities, through the synthesis of patient insight and by increasing and elevating public involvement and engagement across EPUT.
5. We will continuously improve our offer through evolution, and organic growth to meet the needs of the organisation and our systems by increasing and elevating public involvement and engagement across EPUT

Report produced by:

Amy Poole
Head of Volunteers and Patient Experience

Matthew Sisto
Director of Patient Experience

On behalf of:

Zephan Trent
Executive Director of Strategy, Transformation and Digital
May 2023

		Agenda Item No: 9a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 May 2023**

Report Title:	**Operational Plan 2023/24**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital Alex Green, Chief Operating Officer, Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Anna Bokobza, Director of Strategy					
Report discussed previously at:	Executive Committee Jan-March 2023 Finance & Performance Committee 23 March 2023, Board of Directors (Part 2) – 29 March 2023					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	BAF42 – Financial Plan & COVID	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report presents to the Board of Directors the final Operational Plan.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to

1. Note the Operational Plan (Appendix1) as approved in March 2023 private Board and updated by delegated authority 2nd May 2023.

Summary of Key Issues

The development and finalisation of the Operational Plan was considered at the Executive Operational Committee, Finance & Performance Committee and the Board of Directors (part 2) on the 29 March 2023.

EPUT's Operational Plan for 2023/24 sets out the commitments and priorities for the first year of delivery against our new strategic plan for 2023/24-27/28 for the Trust as a whole and for each care unit.

The Operational Plan is designed to ensure early progress against each of the Trust's four strategic objectives in a way that embodies our three values of **caring**, **learning** and **empowerment**, and will carry us further towards our vision of **being the leading health and wellbeing service in the provision of mental health and community care**.

Each care unit has developed and owns its own Operational Plan with support of the corporate teams to align activity, workforce and financial planning and other resources as closely as possible.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			N/A
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			✓
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	No	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			
CQUIN	Commissioning for Quality and Innovation	ICB	Integrated Care Board

Supporting Reports/ Appendices /or further reading
Appendix 1: Final Operational plan 2023/24

Lead		
Zephan Trent **Executive Director of Strategy, Transformation & Digital**	Trevor Smith **Executive Chief Finance Officer**	Alex Green **Executive Chief Operating Officer**

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FINAL – FOR APPROVAL

OPERATIONAL PLAN

2023-2034

EPUT

CONTENTS.

SUMMARY

EPUT's Operational Plan for 2023/24 sets out the commitments and priorities for the first year of delivery against our new strategic plan for 2023/24-27/28 for the Trust as a whole and for each care unit.

The Operational Plan is designed to ensure early progress against each of the Trust's four strategic objectives in a way that embodies our three values of **caring**, **learning** and **empowerment**, and will carry us further towards our vision of **being the leading health and wellbeing service in the provision of mental health and community care**.

Each care unit has developed and owns its own Operational Plan with support of the corporate teams to align activity, workforce and financial planning and other resources as closely as possible.

The key themes running through all aspects of the plan this year are:

- Safety strategy and continuous improvement
- Culture of learning
- Partnership with service users, families and carers
- System level collaboration in support of local delivery
- Social impact / helping our communities thrive.

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TRUST LEVEL OPERATIONAL PLAN

EPUT

25.10.21

EPUT ACHIEVED GREAT THINGS IN 2022/23

WE SHOULD BE PROUD

1. **Safe, effective, high quality, integrated services**
   - Integrated leadership posts with Thurrock, NELFT and Provide
   - >£20m investment in community services

2. **We will enable each other to be the best we can be**
   - Initiated Time to Care Programme
   - Enhanced Learning & Development offer

3. **We will work together with our partners to make our services better**
   - Multiple initiatives within MSE Community Collaborative
   - Improved sharing of resources across EoE MH collaborative

4. **We will help our communities to thrive**
   - Co-designed a range of service changes with service users
   - Delivered HeadsUp employment support programme via Enable East
   - Supporting local people to take on apprenticeships at EPUT

WE HAVE A NEW STRATEGIC PLAN FOR THE NEXT FIVE YEARS

- EPUT's new vision, purpose, values and strategic objectives were agreed in 2021.
- Care unit and Trust strategic plans were agreed in January 2023, detailing how the objectives will be delivered over the next five years and how we will measure our progress over time.
- Extensive engagement with a wide range of stakeholders – including service users and their supporters – informed the development of our strategic plans.
- Plans were also based on detailed analysis of demand trends and forecasts.
- Our strategic plan aligns with and compliments local Integrated Care Strategies, emerging Integrated Care Boards' Joint Forward Plans and the developing Southend, Essex and Thurrock all-age mental health strategy.

OUR OPERATING MODEL HAS MATURED IN THE LAST YEAR

During 2022/23, EPUT's target operating model has come into full effect.

We have appointed to the multi-professional leadership teams for each of our care units.

We have embedded our Accountability Framework with clear lines of enquiry that cover:

- Quality and safety
- Operational performance
- Workforce and culture
- Finance
- Strategy, transformation and external relations.

The monthly routine of Accountability Framework meetings provides the opportunity for care units to share progress against their operational plans with executive colleagues, share successes and seek support for management of risks.

NATIONAL REQUIREMENTS INFORM OUR PLANS

National CQUINS:

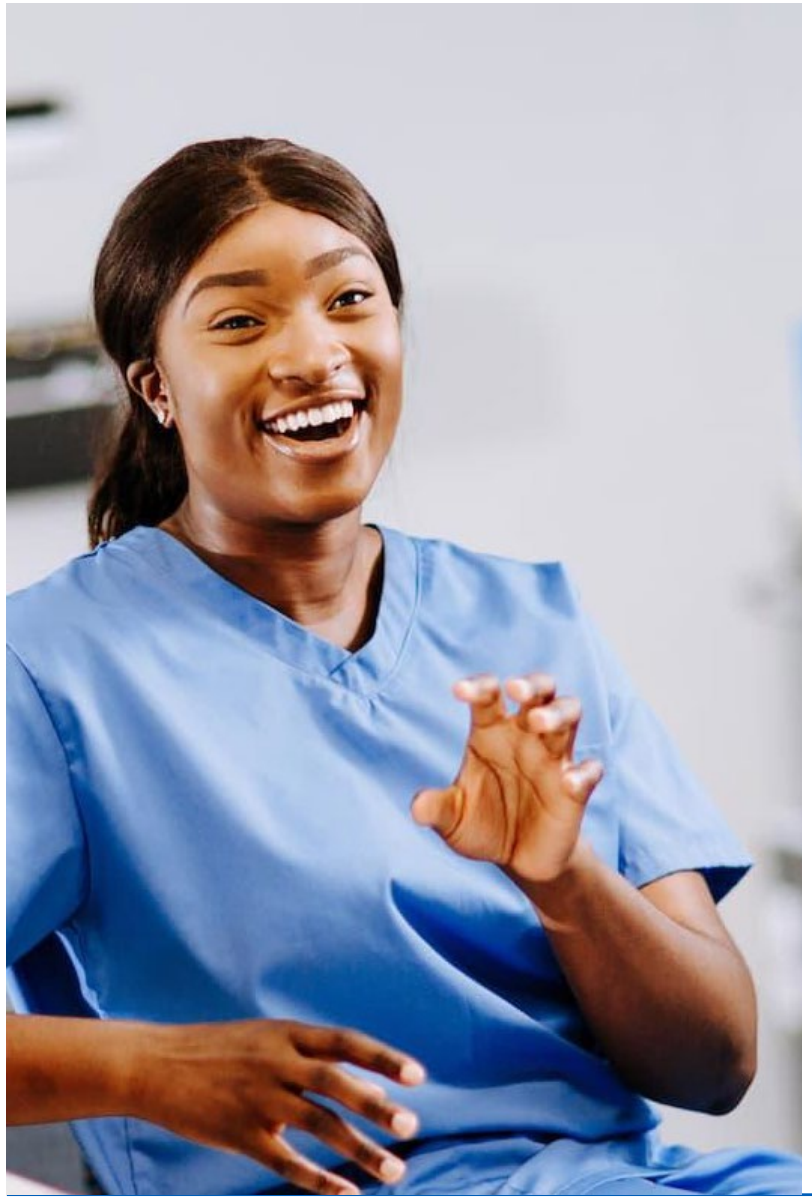
- Flu vaccination for front line staff
- Assessment & documentation of pressure ulcer risk
- Assessment, diagnosis and treatment of lower leg wounds
- Malnutrition screening for community hospital inpatients
- Routine outcome monitoring in community mental health service
- Routine outcome monitoring in CYP and community perinatal mental health services
- Routine outcome monitoring in inpatient perinatal mental health services
- Reducing the need for restrictive practice in all age inpatient settings.

NHS England Operating Framework:

- 2-hour standard for UCR (70%)
- Direct access/referrals to community services
- Improve access to CYP mental health services
- Increase number of older adults accessing IAPT
- 5% year on year increase in adults and older adults accessing community mental health services
- Progress towards eliminating adults acute Out of Area placements
- Recover dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services
- Annual health checks for over 14s on LD registers – 75% by 2024
- Reduce reliance on inpatient care for those with LD and/or autism
- Delivery on Core20Plus5 approach to tackling inequalities
- Deliver a balanced net system financial position.

OUR PRIORITIES ADDRESS THE KEY RISKS FOR 23/24

- The operational plan has been developed in alignment with the agreed mitigations for the eight strategic risks and 11 corporate risks described in the Board Assurance Framework (BAF) report of February 2023.
- Reporting monthly against the BAF will provide the opportunity to continually review the operational plan throughout the year and make adjustments as necessary to support risk management and reduction.
- Care unit priorities for 2023/24 have been agreed in direct response to local risks on which progress is reported monthly through the Accountability Framework.



WE HAVE CAREFULLY PRIORITISED OUR PLANS

Priorities that require a financial investment and feature in the Operational Plan 2023/24 have been prioritized based on relative clinical and operational need.

Service developments or other changes that require programme or project support or oversight are passed through the Single Front Door which appraises and prioritises schemes based on a framework adapted from McKinsey which has been in place since April 2022. This process currently operates all year.

EPUT is on a journey of maturation in its prioritization methodology and we aspire to appraise and prioritise 80% of new developments during the next operational planning window September-December 2023 and limit the in-year proposals via the Single Front Door to 20%.

WE ARE CLEAR ON OUR SHARED PRIORITIES FOR 23/4

We will deliver safe, high quality, integrated care services

- Finish implementation of current safety strategy and develop continuation plan
- Phased implementation of Time to Care models
- Continue to actively engage with the Essex Mental Health Independent Inquiry and respond to recommendations once concluded
- Develop clinical quality strategy

We will enable each other to be the best we can be

- Develop people and culture strategy including development of behavioural framework
- Continue to collaborate with local and regional partners on long term workforce development plan
- Improve our staff development offer and extend this to lived experience and volunteer roles

We will work together with our partners to make our services better

- Build on recent successes in the way we partner with lived experience experts, families, carers and communities to drive cultural change within EPUT
- Deepen approach to partnerships with ICSs and Local Authorities to maximize influence
- Better define EPUT's role in Population Health Management across three ICSs

We will support our communities to thrive

- Develop social impact strategy with focus on parity for people with serious mental illness, learning disability or autism
- Form local commercial and innovation partnerships
- Consolidate local recruitment plans

Finalise digital strategy and progress towards streamlined EPR
Develop estates strategy
Develop research & innovation strategy
Become a Trauma-Informed and psychologically-informed organisation

FINANCIAL PLAN 2023/24

REVENUE & CAPITAL

Overview

The Trust has submitted a balanced/breakeven revenue plan for 23/24. Both nationally and locally it is recognised the financial challenges in 23/24 will be significantly greater than those in 22/23. The local ICS is financial challenged with an expected net deficit plan of c£40m. A key focus to mitigate challenges will be robust financial control environment including scrutiny of cost base and the development efficiency plans that do not compromise patient safety of quality. In order to deliver financial targets the Trusts plan requires delivery of £23m equivalent to 4.4% of operating expenditure. Capital plans are £20.4m with a a prioritised plan in place.

Financial Performance

Revenue

- Breakeven revenue plan with Trust turnover of £499.6m.
- A key focus will be reduction in temporary staffing costs.
- Plans underpinned by £23m efficiency requirement.
- Care Unit and Corporate budgets will be monitored through the Trusts Accountability Framework model.

Capital

- £20.4m opening plan.
- Plans have been prioritised to address completion of 22/23 projects, safety, infrastructure, strategic initiatives and digital agenda including development of a converged Electronic Patient Record.
- The digital element of the capital plan will be flexed as the EPR business case progresses.

Key Risks

- Delivery of recurrent efficiency requirements and reduction in the underlying deficit.
- Local ICS is financially challenged.
- Cost escalation associated with the response to the Inquiry.
- Access to in year discretionary Capital and revenue will be extremely limited.

Financial Plan 23/24

EPUT has :-

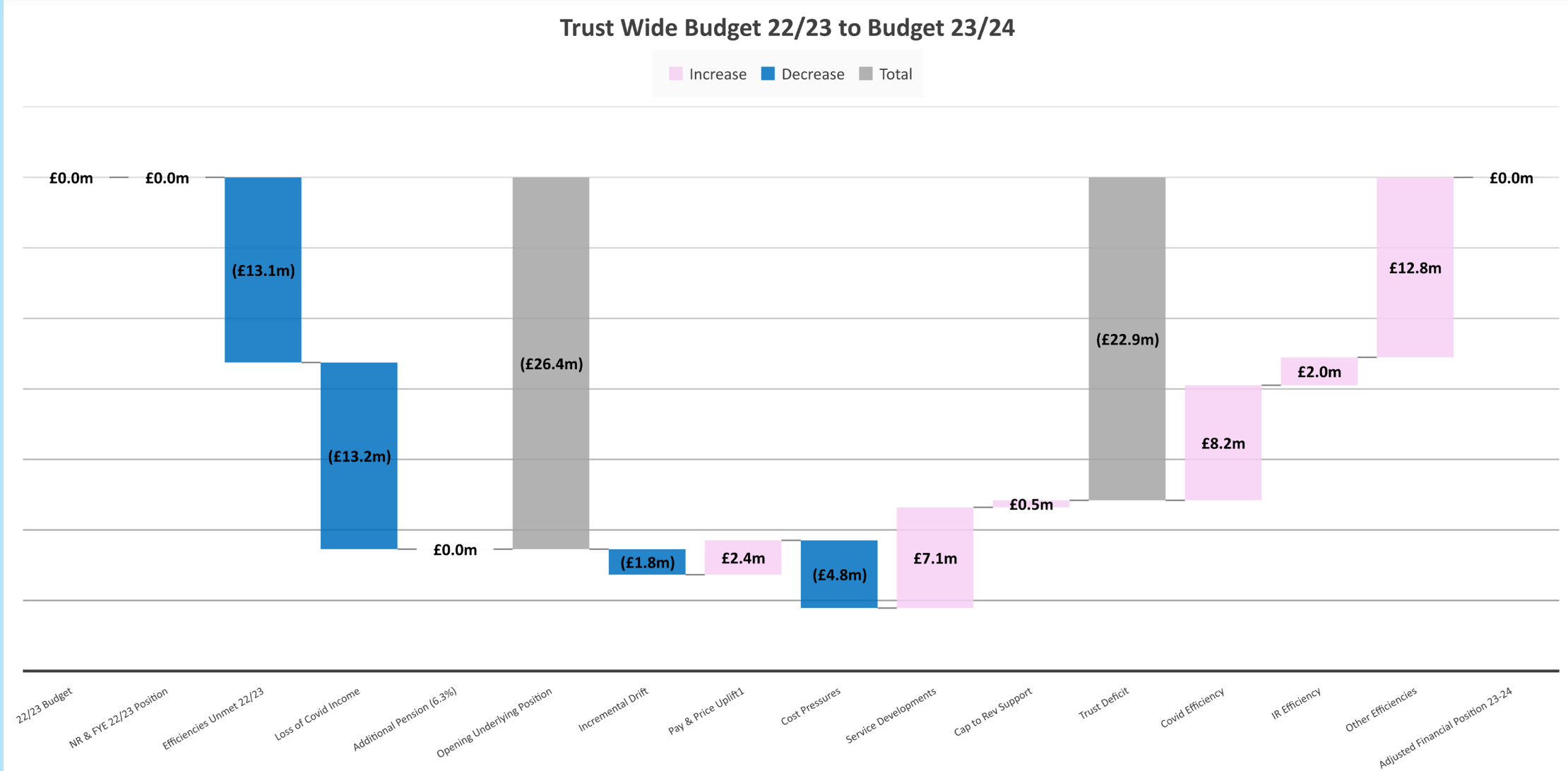
- Submitted a breakeven revenue plan for 23/24. The Trusts opening plan has a turnover of £499.6m.
- In order to deliver the plan the Trust will need to deliver at least £22.9m of efficiencies equal to 4.4% of operating expenses.
- The Trusts Capital investments are planned at £20.4m. This plan includes indicative funding for the EPR converged business case which will be subject to change as the converged EPR OBC develops. The capital plan has been prioritised to address highest priority risks and projects.

Summary - Revenue Plan 23/24

	Final Budget 23/24 *£m's*
Income	
Income From Patient Care	480.3
Other Operating Income	19.3
Sub-Total Income	**499.6**
Expenditure	
Employee expenses	(345.3)
Operating expenses	(148.5)
Sub-Total Expenditure	**(493.8)**
Non operating Inc & Exp	(5.9)
Sub-Total Net Finance Costs	**(5.9)**
Other Gains/Losses	0.0
Surplus/(Deficit)	**(0.0)**

Financial Bridge- 22/23 to 23/24

REVENUE PLAN 2023/24



Capital Plan 23/24

	Total 2023/24 £m's
Completion of 22/23 Schemes	2.9
ICT	2.3
Medical / Other Equipment	0.1
Safety & Ligature	0.5
Health & Safety	0.5
Backlog Maintenance	0.5
Refurbishment and Safety schemes	4.7
	11.5
Electronic Patient Record (EPR) [1]	6.0
MH UEC	0.2
Leases	2.6
PFI	0.1
Total	**20.4**

WORKFORCE PLAN 2023/24

Overview

Each care group has created workforce improvement plans aligned to their strategic planning developed across 22/23. To drive action and accountability, each care unit has a workforce implementation group that owns the workforce improvement actions. Care groups report progress against priorities at monthly Accountability Framework meetings and measures of success are in development including Quality Improvement methodology for specific areas of development e.g. recruitment, culture, education, leadership.

Key Workforce Priorities

Recruitment & Retention

- Localised recruitment plans aimed at increasing clinical support
- International recruitment utilising local hubs for bespoke recruitment, plus international programmes such as nursing recruitment and extension to other roles such as AHPs, pharmacy and medics
- SMART Working
- Development programmes
- Robust action planning for staff experience

Temporary Staffing

- Increasing bank work in certain care groups
- Collaboration with system partners for shared bank partnerships
- Reservists and applied planning for peak periods

Leadership & Culture

- Comprehensive approach to supporting new starters
- Employee experience feedback and action planning
- EPUT behaviour Toolkit
- Reward and Recognition
- Health and Wellbeing

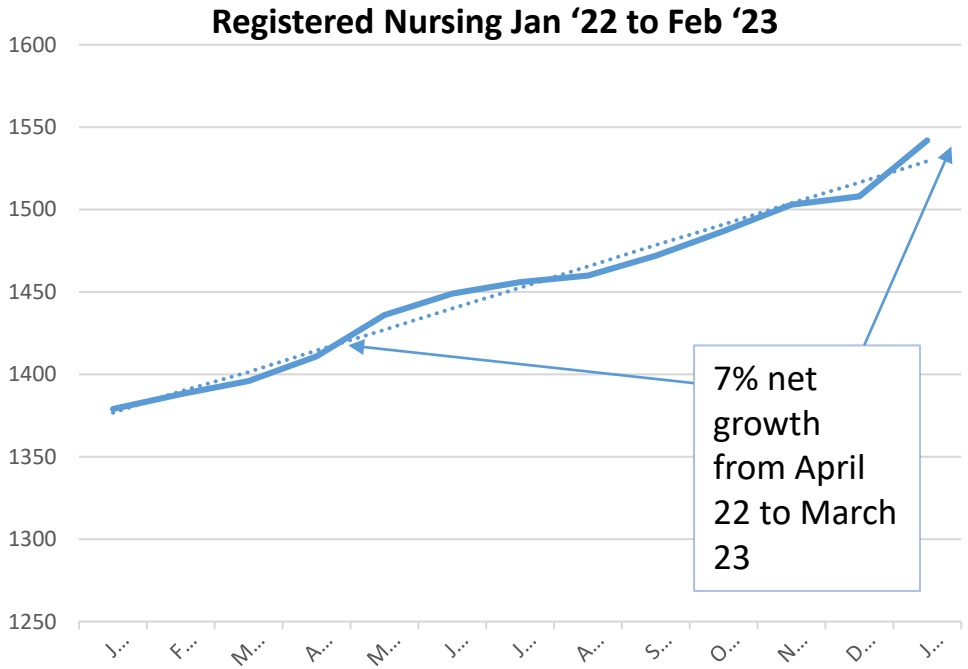
WORKFORCE POSITION 22/23

EPUT has:

- a **total registered nursing vacancy** of 21% of which MH inpatient nursing in 26% and 29% in community nursing
- Over the course of 22/23, we anticipate a **7% net growth** across all registered nursing numbers taking vacancy rate to **19.5% by March 23**
- **Total AHP vacancy** of 22% of which physiotherapy in 20.3% and 31.5% in Occupational Therapy
- **Support to clinical** vacancy is 6.4%
- **Medical** vacancies are 21% of which 26% are consultants

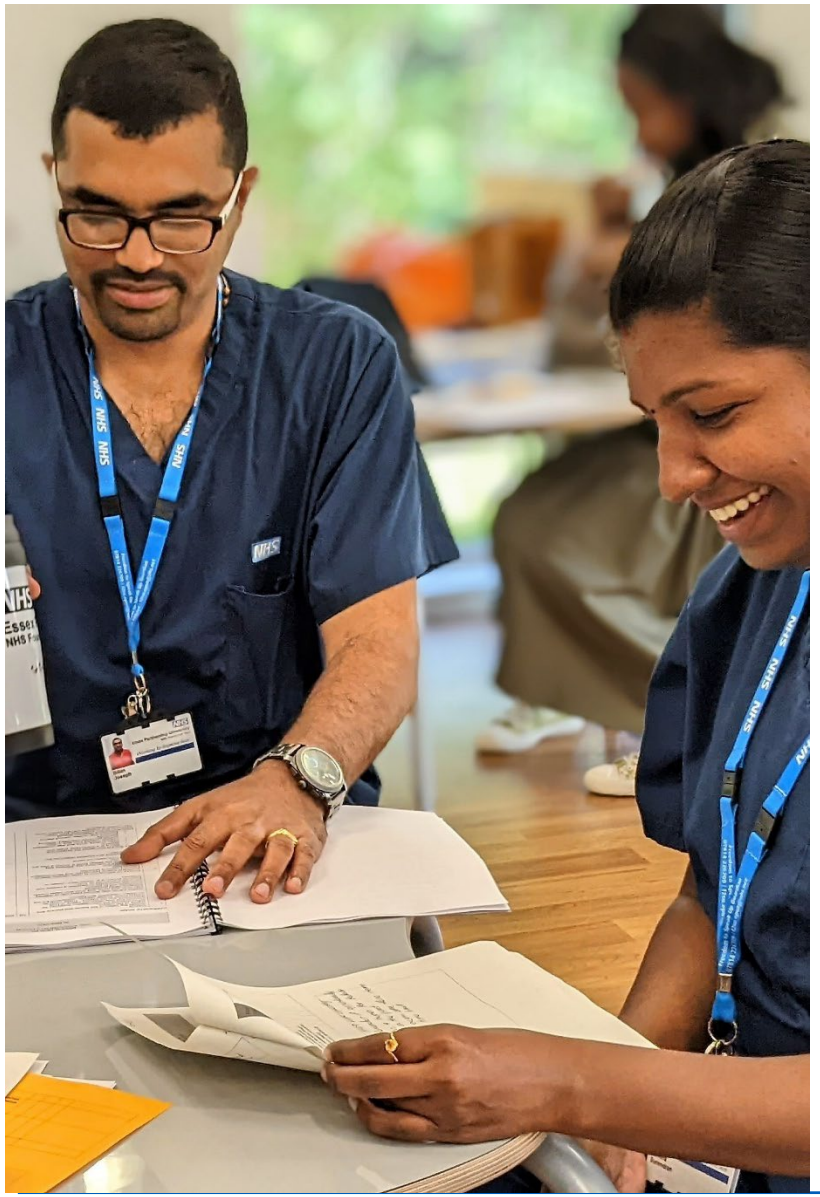
Workforce plans do not yet take into account implementation of phase one of Time to Care.

Establishment changes can occur in-year as the Time to Care workforce model is modelled and agreed with commissioners and Board.



Registered Nursing Establishment: 1958 WTE

Total current vacancy: 21 % or 416 WTE (at January 2023)



HEADLINE PLAN 23/24

EPUT has three core recruitment pipelines for registered nursing 23/24:

International: 106 WTE (further 25-50 planned*)

Student: 131 WTE (RMN & RGN) out of 280 students at local HEIs

External (domestic): 154 WTE

Leavers expected 23/24: 126 WTE (based on 6.5% turnover)

Net: 290 WTE

Vacancy rate (March 24): 6%

**International Recruitment numbers are assumed at lower number (25 WTE)*

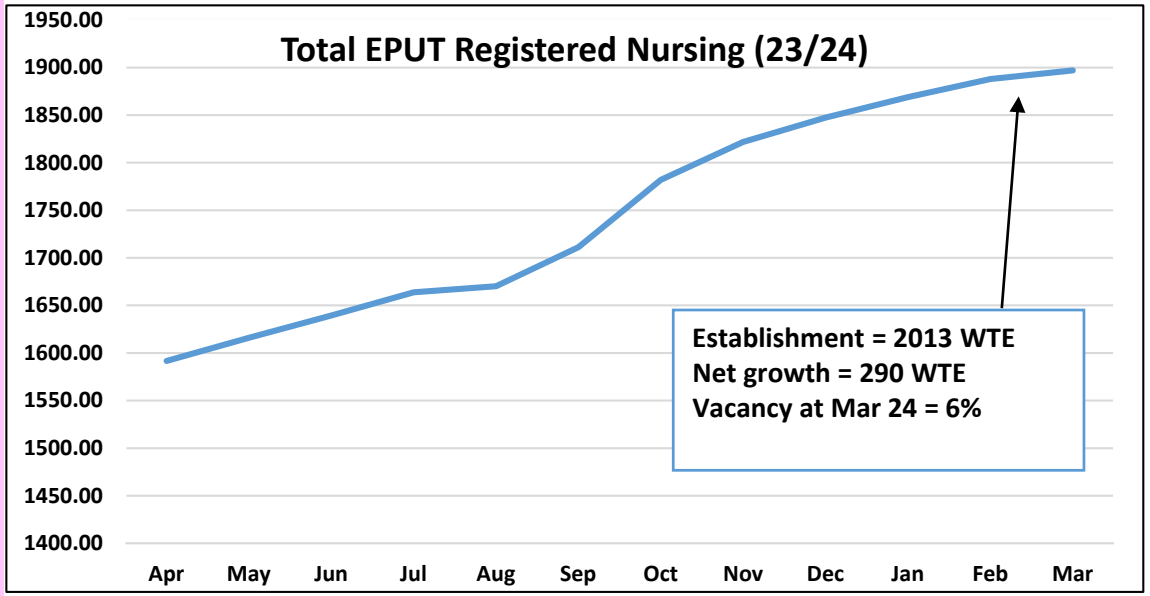
AHPs - planned 55 WTE AHPs through a combination of international, domestic and student pipelines (8.2% net growth), reducing vacancy rate to 12%.

Health Care Assistants (HCA): planned net growth = 93 WTE (5.6%) vacancy at 1.4%

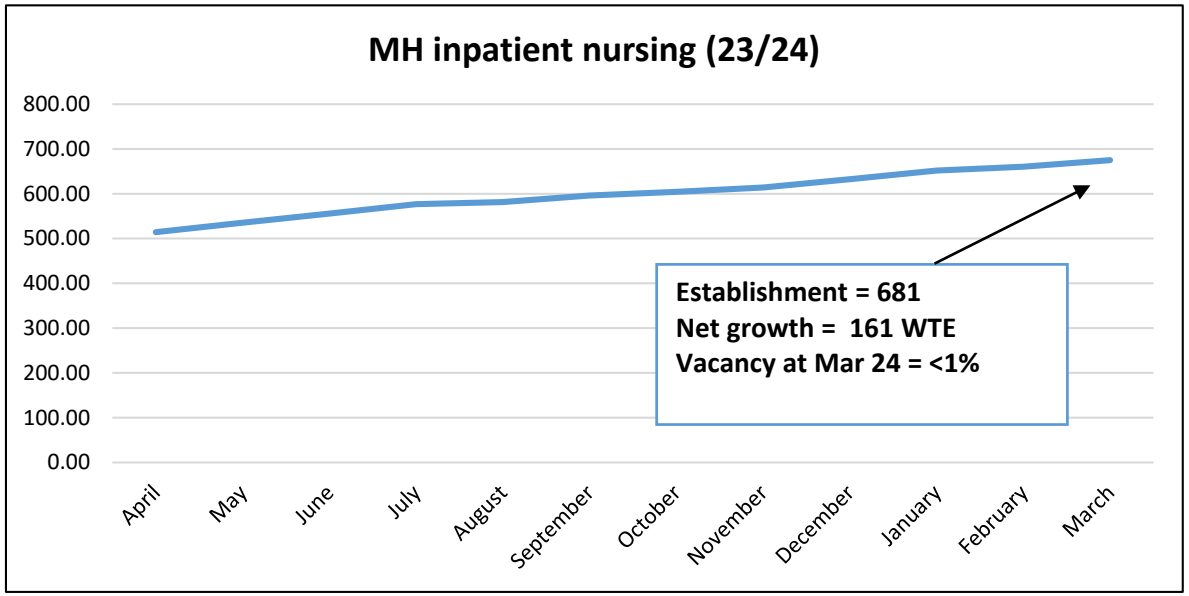
Clinical Psychologists: planned growth of 7 WTE (3.3% net growth) reducing vacancy rate to 27%

NB Time to Care staffing model is not reflected in workforce plan.

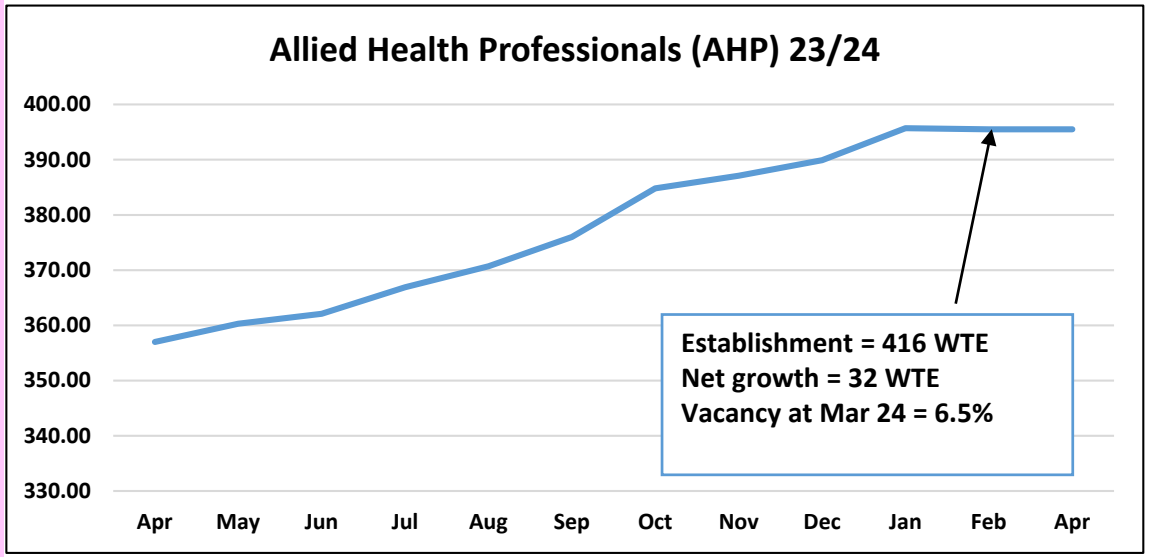
Total EPUT Registered Nursing (23/24)



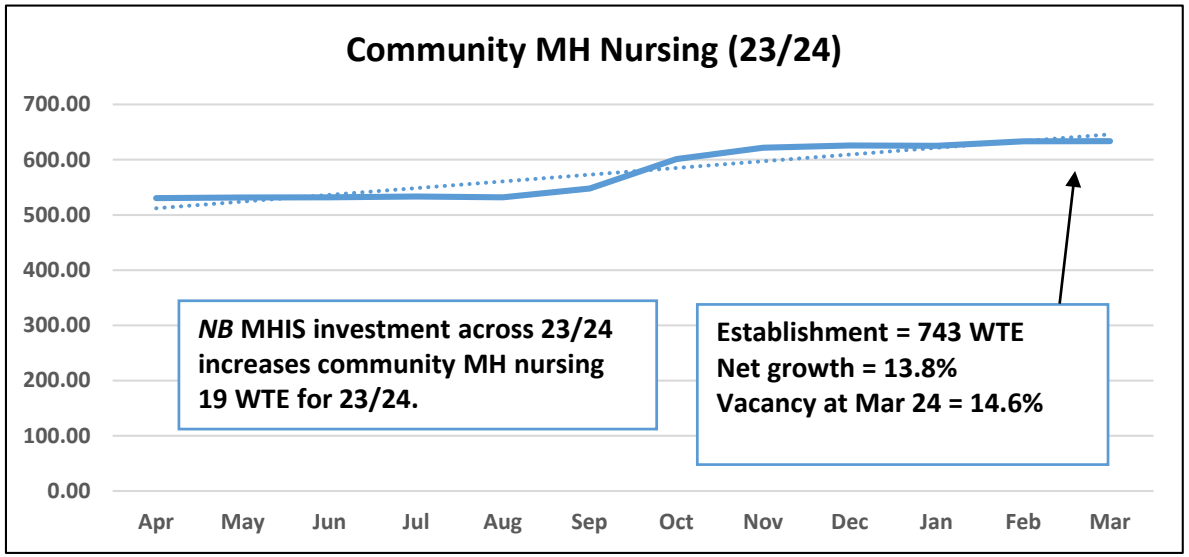
MH inpatient nursing (23/24)

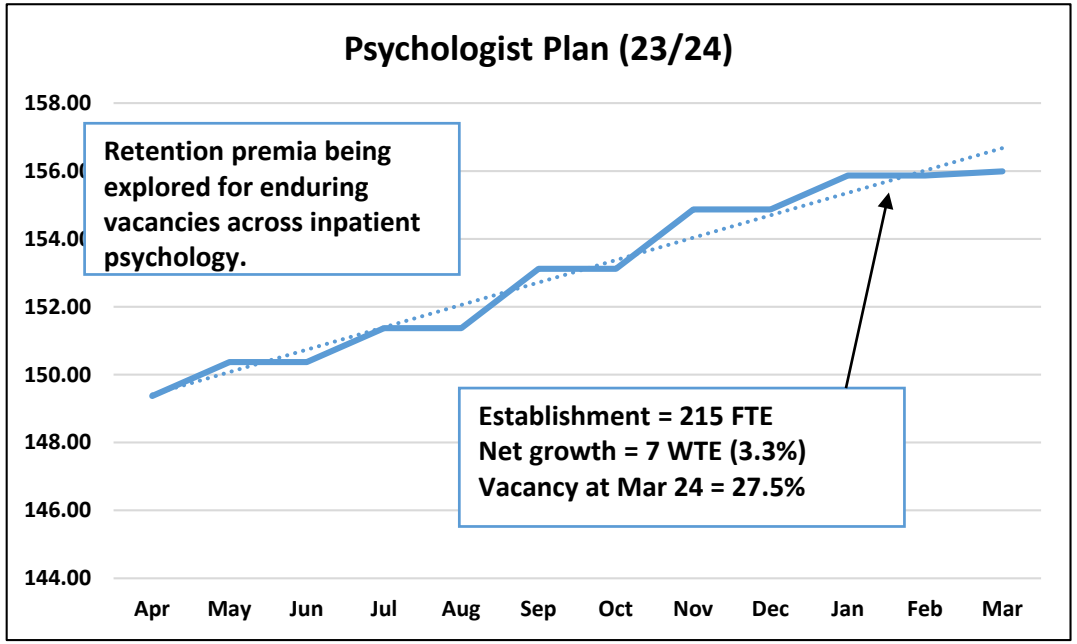


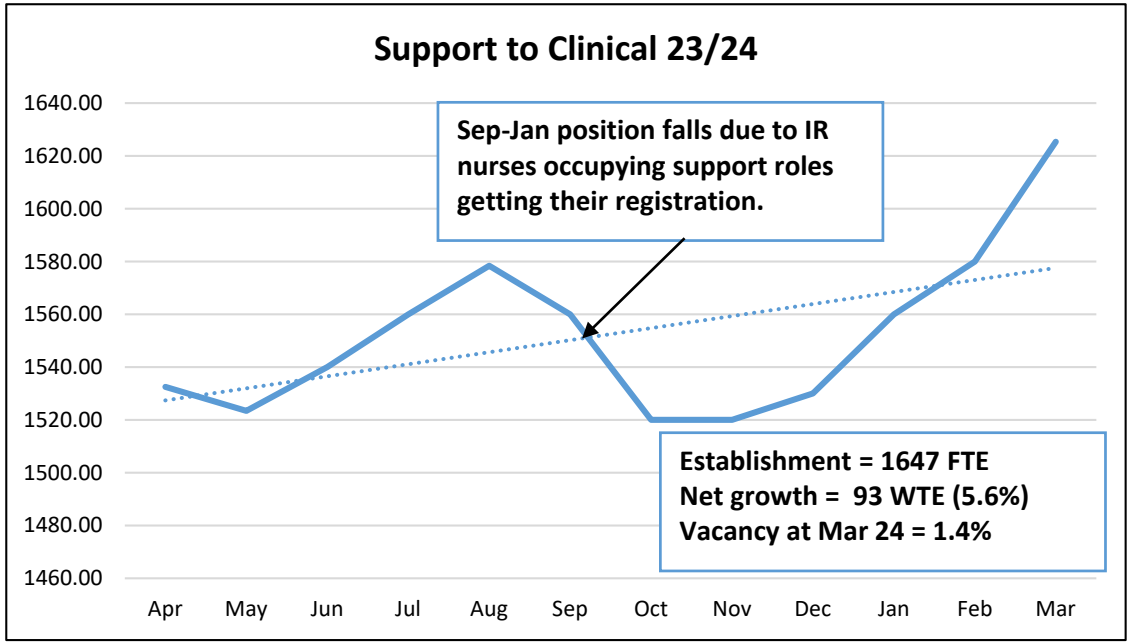
Allied Health Professionals (AHP) 23/24



Community MH Nursing (23/24)







HEADLINE NUMBERS at March 24

- Trust-wide: 4.7% (substantive staffing)
- Registered Nursing: 6%
- Inpatient Nursing: <1%
- Community MH nursing: 14.6%
- Allied Health Professionals: 12%
- Psychological Services: 27.5%
- Support to Clinical: 1.4%
- Associate Roles including Trainee Nurse Associates: 50 FTE

MEDICAL WORKFORCE UPDATE

Consultant Vacancies by Specialities – Feb 2023

Specialty	Number of vacancies
Adult Inpatient	10
Older Adult Inpatient	2
Adult Community	8
Older Adult Community	2
Specialist Services	8
Misc	1

Risks:

- Recruitment into consultant roles continues to be hard to recruit both locally and nationally
- There is a heavy reliance on agency doctors to cover vacancies at a high cost to Trust with NHSI capped rates being breached
- Hotspots for vacancies are in adult inpatient wards.

Mitigations:

- 31 vacancies in total. 29 vacancies have been covered by NHS Locums, Agency Consultants or acting up arrangements. The remaining two are currently at advert stage for agency cover
- The Medical team are currently working through the consultant recruitment process with the newly appointed Divisional Medical Directors (DMDs), with 17 vacant consultant post currently within the recruitment pipeline
- The Medical Workforce Team and DMDs have arranged acting up arrangements for higher trainees going through their specialist registrar training to gain experience and preparation for future consultant roles. One trainee who has completed this programme will go forward to a competitive consultant role in February 2023.

Junior Doctor Vacancies – Feb 2023

Specialty	Number of vacancies
Adult Community	6
Adult Inpatient	5
Learning Disabilites	1
Older Adult Community	1
Older Adult Inpatient	1
Perinatal	1

Risks:

- 15 vacancies across the Trust
- Hotspots for vacancies are in adult inpatient wards.

Mitigations:

- 15 vacancies in total: nine filled with Locum Appointment for Services (LAS) and one agency doctor
- LAS appointments are substantive doctors and contribute to training post, reducing reliance for agency doctors at a junior level
- Five vacancies are being picked up by Speciality Doctors or the appropriate consultant.

2023-24 PERFORMANCE TRAJECTORIES

Metric	Proposed approach
IAPT Access	In line with current year's access target
Perinatal Access	In line with current year's access target
Community Mental Health receiving ≤2 contacts	In line with the NHSE plan. However, we do expect our numbers to increase this year as the data for MH services that transferred onto SystmOne will start to be be included in MHSDS submissions
SEE CHS Waiting List (Adults and CYP)	Applied a slight trend reduction witnessed Apr-Dec 22 to propose expected 23/24 quarter end positions (excludes Lighthouse)
UCRT 2hr contacts	Average quarterly volume delivered over the last 12 months
Inappropriate Out of Area bed days	Ambition to return to the lowest position reported over the previous 12 months. It was agreed with commissioners and NHSE that the planning should be realistic and that for instance a zero target by Q2 would not be a realistic outlook

OOA Bed Days	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4
MSE	2891	2292	1693	1094
HWE	522	377	231	87
SNEE	955	672	389	106
EPUT Total	4368	3341	2313	1287

NHS
Essex Partnership University
NHS Foundation Trust

CARE UNIT OPERATIONAL PLANS

EPUT

25.10.21

SPECIALIST SERVICES CARE UNIT

OPERATIONAL PLAN 2023/24

PRIORITIES FOR SPECIALIST SERVICES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Staffing and Workforce Competencies	Diversifying recruitment work, Working with Secure & CAMHS T4 provider collaborative & Essex LD Partnership to develop new training and recruitment pipelines, working with TTC programme, overseas recruitment, monitoring of emerging hotspots
Capacity and Patient Flow	Working with provider collaborative partners to maximise occupancy, progress OOA repatriation and reduce OOA placement. Maximise opportunities to reduce DTOC through proactive planning for purposeful admissions and appropriate escalation routes. Work with ICB partners to share risk/needs for Asylum and Refugee groups
Environmental	Co-locate substance misuse services into the Derwent Centre & Remedial works within the Secure Estate

SPECIALIST SERVICES IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Improve care environments and use technology to improve safety
- Ensure transitions between services both within and to partners are safe effective and delivered in collaboration with our patients
- Use data and apply learning across all services to maximise safe care and decision making

We will enable each other to be the best we can be

- Develop our staff skills in leadership, applied learning and specialised skills toward a trauma informed approach and upskill staff in neurodiversity and other specialisms
- Share our expertise and knowledge with partners
- Develop training for families and carers so they feel better equipped to support their loved ones

We will work together with our partners to make our services better

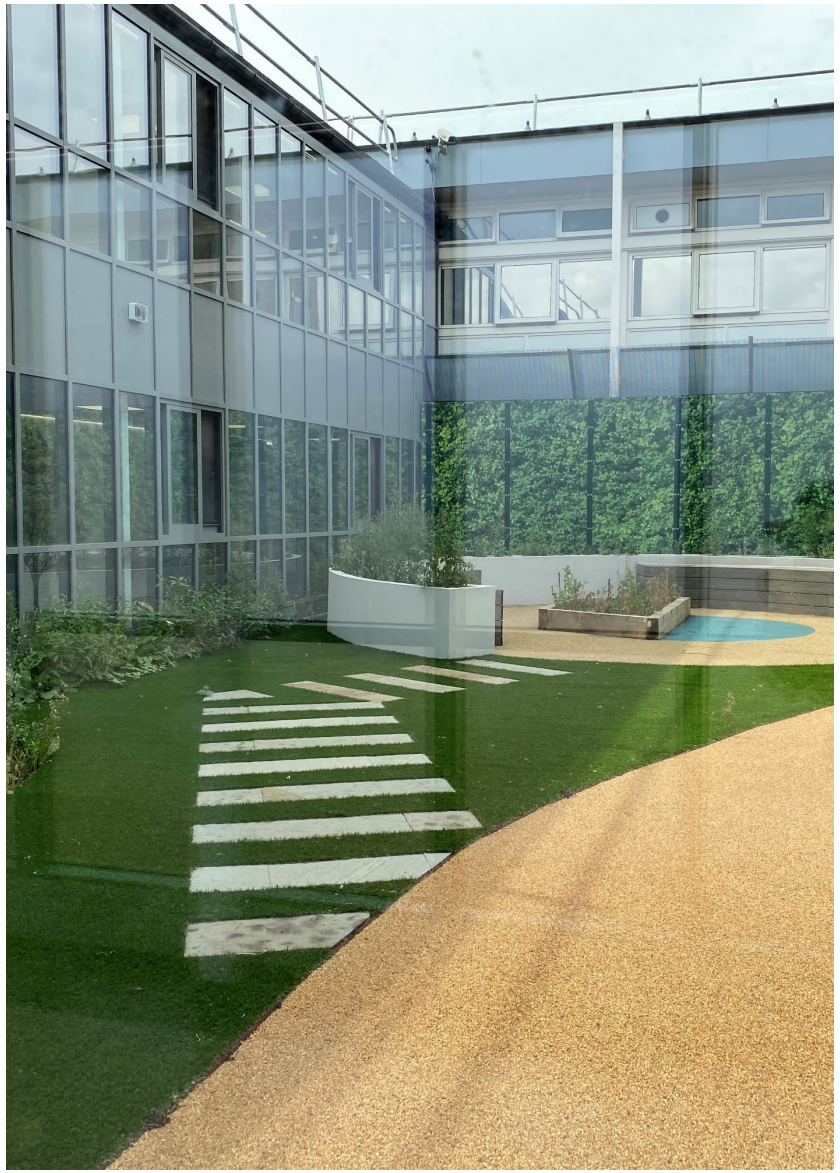
- Create meaningful ways for families and carers to be involved with service transformation and elements of regular service delivery
- Work with the provider collaborative to deliver the regional strategic priorities alongside our own in an integrated way that delivers positive change to services
- Lead a regional collaboration of NHS and Third Sector partners and service users to deliver Operation Courage in support of the mental health and wellbeing of veterans

We will support our communities to thrive

- Focus on reintegration for our patients into their communities, increasing employment, housing and educational opportunities through partner engagement
- Enhance our community offer to marginalized and disadvantaged groups improving their health outcomes and opportunities
- Enhance our workforce by offering new and innovative roles and opportunities increasing employment and volunteering opportunities for service users, carers and the wider community

URGENT CARE AND INPATIENTS CARE UNIT

OPERATIONAL PLAN 2023/24



URGENT CARE & INPATIENT PRIORITIES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Ward shift fill rates	• Recruitment & Retention Plan (IR, Students, Domestic). • 'Time to Care' /MHOST • Daily SITREPS • Good rostering management
Ability of staff to complete training	• 'Time To Care' • Area Recovery Planning
Inappropriate out of area placements	• System Flow & OAPS elimination plan • Demand & Capacity Bed Modelling • 'Getting it right first time' (GIRFT) Programme • Expanding Flow Team
Bed occupancy rates above 95%	• Daily SITREPS, Purposeful Admission & GIRFT
Average length of stay	• Weekly medical and operational Flow meetings • MADE Events • Accommodation Pathway

URGENT CARE & INPATIENTS IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Implement a new staffing model to support safe & therapeutic care; increasing our substantive staffing, which will promote flow and reduce ALOS
- Evaluate and make improvements to our urgent care pathway across Essex. We will launch Mental Health Urgent Care Department in MSE
- We will continue our focus on learning and implement a new quality improvement approach

We will enable each other to be the best we can be

- Increase leadership capability, supported through roll out of a new development programme informed by lived experience
- Therapeutic teams will be supported to take time away from the service for development
- Implement a restorative resilience model combining a focus on staff well-being and the assurance of good practice

We will work together with our partners to make our services better

- Build on good practice with service user, family/carer involvement – family ambassadors, forums, family group conferencing
- Work with system partners, building on relationships (inc VCS) to support Urgent Care Pathway, Crisis Concordat & accommodation pathway
- Continue to work with the GIRFT Programme

We will support our communities to thrive

- Have a RGN on all wards and in our UCP teams to work with MDT and improve physical healthcare provision
- Agree and implement a focused recruitment and retention plan, including actions to increase local recruitment, voluntary work, opportunities for good quality work
- Communities and the services supporting them will be more aware of signs of distress and suicidal behavior, able to direct people to the right support

WEST ESSEX COMMUNITY CARE UNIT

OPERATIONAL PLAN 2023/24

WEST ESSEX PRIORITIES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Recruitment and Staffing	Ongoing skill mix reviews Workforce implementation group to provide targeted recruitment Review use of bank and agency
Adequate and suitable estate	Optimise current utilisation Optimise digital solutions Develop West Essex strategy
Capacity to meet increased demand for services	System development to support outcome-based approach to service delivery and improve flow and capacity Increase admin support to enable optimisation of frontline interventions
Data assurance and analysis	Targeted analysis led by Care Unit
Corporate support to deliver transformation	Care unit operational managers undertaking these tasks

WEST ESSEX IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Progression of the functionality of the CCC – right care, right place, right time
- Use INT's as the vehicle to develop the proactive population health management approach & personalisation of care + support
- Improve end-of-life pathways
- Progression of MH Transformation in line with priorities of the LTP

We will enable each other to be the best we can be

- Established workforce development group for all partners led by EPUT HR BP to support R&R, development of new roles & staffing models
- We will become an employer of choice for our communities
- Continue system partnership working to deliver the WEHCP priorities

We will work together with our partners to make our services better

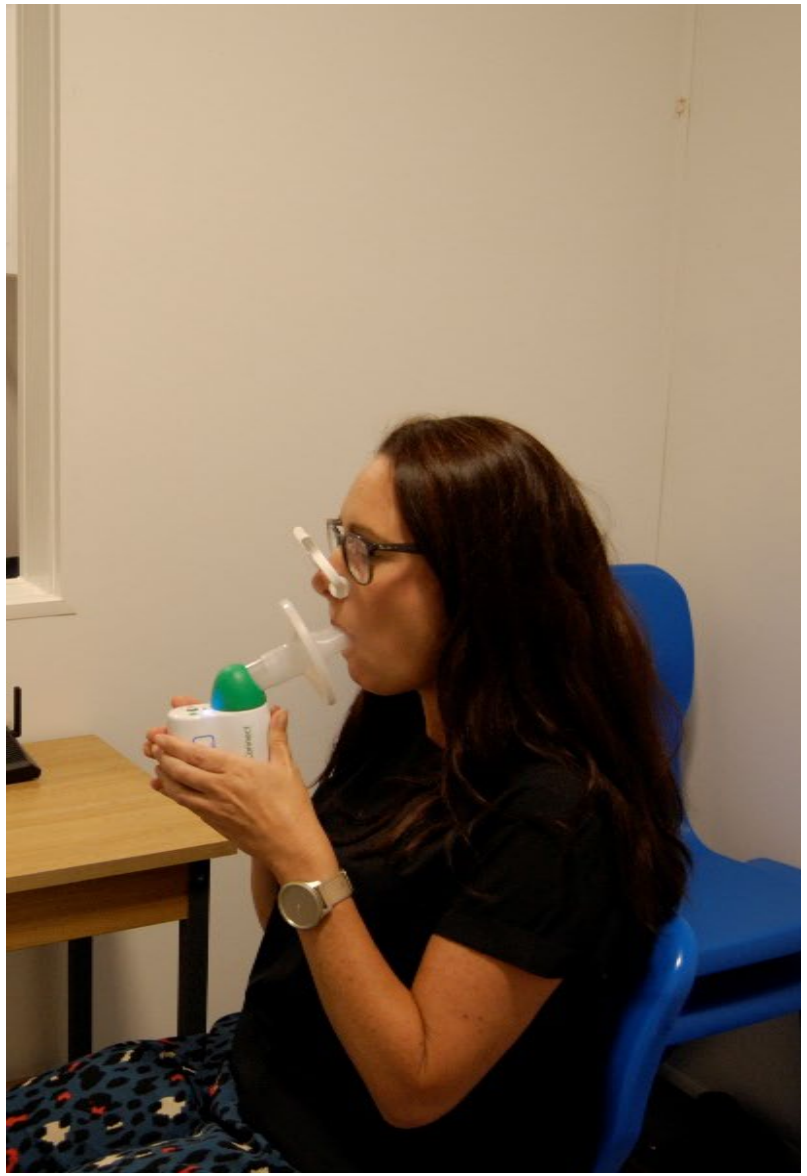
- Collaboration across HWE CHS + MH to reduce variation
- New Sec 75 with ECC for MH + focus on transitions
- Expansion of rotational roles with PAH + jointly funded roles across WEHCP + ARRS roles
- Continued support to care homes & independent care providers
- Progression of collaboration initiatives across CHS and MH with the Voluntary sector and District council partners

We will support our communities to thrive

- Support expansion of community 'hubs' across WE
- Support to the "Harlow Levelling Up" programme with ECC & Partners including Epping Forest – Debden & Waltham Abbey – Core 20 + 5 approach
- Support career opportunities across health and social care from local communities, expanding on programmes with DWP and school , 6th form colleges and FE career fairs

MID AND SOUTH ESSEX COMMUNITY CARE UNIT

OPERATIONAL PLAN 2023/24



MID & SOUTH ESSEX PRIORITIES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Recruitment and Retention	MSE workforce plan with HRBPs including targeted recruitment campaigns
Lighthouse waiting lists	Consultant recruitment Increase in administration team Harm review of long waiters in progress
CMHS High Level of acuity	Maximising skill mix to support demand MDT approach to caseload management MaST pilot at evaluation and next steps stages Whole system MH transformation

MID & SOUTH ESSEX IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Deliver the National Community Mental Health Framework Agreement with partners including Voluntary (Healthwatch and CVS) Housing Local Authority, Integrated Care Board, community and independent providers, Mind, Rethink and Trust links
- Integrated neighbourhood teams will support in-reach of specialists and support early intervention and prevention with PCNs and primary care
- Eradicate long waits for service users at the Lighthouse Children's Centre by focusing on ongoing recruitment using the recently received funding to support the clearing of the backlog

We will enable each other to be the best we can be

- Robust supervision and all staff to take part in the Pen Plan appraisals
- Make staff aware of the mechanisms of support available to them
- Create an inclusive culture of calling out poor behaviours, bullying, discrimination, and the freedom to speak up

We will work together with our partners to make our services better

- Work with our Place partners to develop effective transfer of care hubs as per national requirement which will assess patients for discharge and refer them to the best out-of-hospital setting and support package
- Agree on a common endeavour with local providers and partners to build collaborative structures at place
- Work closely with our Alliance colleagues and supporting the development of PCN strategies – Mid Essex has appointed 3 neighbourhood programme managers via Essex County Council/Provide/Alliance to deliver the neighbourhood integration.

We will support our communities to thrive

- Continued focus on levelling up and reducing health inequalities across Mid and South Essex, we will engage a variety of initiatives and support identified by place
- Actively involve carers and families in conversations about services and hearing their voices
- Make Mental Health services more accessible by offering them from an increased number of locations so people don't have to travel to a particular place

NORTH EAST ESSEX COMMUNITY CARE UNIT

OPERATIONAL PLAN 2023/24

NORTH EAST ESSEX PRIORITIES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Recruitment and Retention	Locally developed recruitment plan, recruiting from local ICS area Development of Social Care Apprentice Posts Health Community Apprentice Posts AHP rotation, apprentice posts and overseas recruitment Restorative supervision programme Senior coaching and development programme Talent development programme Trauma informed training programme
Demand and Capacity	Flow and Capacity Leads Reduction in Case Loads Integrated Primary Care Team Review of Perinatal thresholds and back to basics Review of Dementia and Frailty Pathways Implementation of Neighbourhood working Management and monitoring of waiting lists

NORTH EAST ESSEX IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Commit to aligning our mental health services to the NE Essex Alliance neighbourhood profiles in 2023/24
- Commit to trauma informed care and a restorative supervision approach at all levels of staff in our care group
- Continue to work collaboratively with all key maternity stakeholders around five Essex hubs

We will enable each other to be the best we can be

- Commit to the development of community apprentice roles and grow our own from our local community
- Commit to a learning approach to leadership, being honest when we don't get things right
- Commit to working with staff to enhance their skills in line with community transformation

We will work together with our partners to make our services better

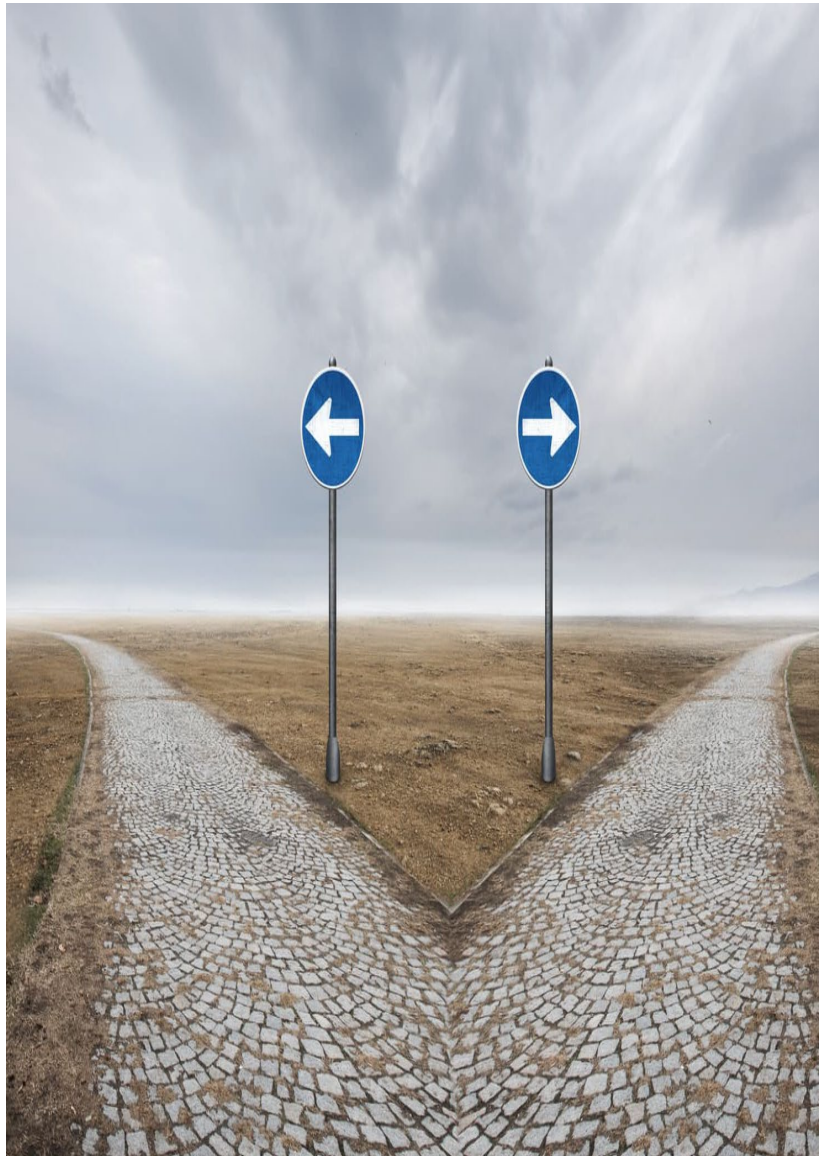
- Continue to be a key partner in the NE Essex Alliance and place based maternity services and seek opportunities for formal and informal integration
- Continue to work towards continued community transformation, recognising community assets and a recovery approach
- Continue as a leadership team to understand our impact on others and how we can best support our communities, of which our workforce is a key part

We will support our communities to thrive

- Continue to be key partners in our place based teams, recognising the third sector as trusted partners to support our communities
- Continue to encourage a no wrong door approach to compassionate care
- Strive to work as part of local place systems to identify prevention initiatives and inequalities

PSYCHOLOGICAL SERVICES CARE UNIT

OPERATIONAL PLAN 2023/24



PSYCHOLOGICAL SERVICES PRIORITIES ADDRESS THE KEY CARE UNIT RISKS FOR 23/24

Risk	Mitigation
Quality & Safety risks due to not meeting BPS/NICE minimum standards of provisioning	Development of CAP apprenticeship roles. Short-term recruitment and retention premia use to fill critical roles in In-patient & Urgent care. Focus on attracting newly qualified Psychologists and those soon to qualify. Development of Psychotherapy roles. Provision of specialist staff support through Here for You to enable retention. Development of trauma-informed approaches. Use of GPs with Extended Role to cover medical monitoring in EDS.
Waiting times for specialised interventions and assessments	Monthly contact to assess progress/wellbeing checks. Use of digital media and mobile apps utilising AI to assess changes in needs and provide psychoeducational support. Enhanced developments in Step 4 / joint working with Talking Therapies services. Use of Service User Networks for support, links to information, frequent contact. Use of EPIC approach in EIP. PT-SMHP skills development through training. Use of Multi-agency Complex Needs Forums for joint care planning.
Environmental – appropriate clinic space for group and 1:1 work	Project programmes to develop EDS day centre locality, and NEE IAPT at Hospital Rd site. Use of appropriate digital intervention, remote working and app-based interventions to reduce demand for face-to-face work. Creatively work with estates to optimise room use and consider alternative community-based opportunities.

PSYCHOLOGICAL SERVICES IS CLEAR ON ITS PRIORITIES FOR 23/24 AND HOW THESE SUPPORT THE TRUST'S OBJECTIVES

We will deliver safe, high quality, integrated care services

- Continue to explore ways to improve access to psychological interventions
- Lead on developing Trauma-informed approaches across all service areas
- Lead on delivering needs and strengths-based care plans monitored through consistent outcomes evaluation based on GAS
- Play a key role in 'growing our own', thereby supporting recruitment, and contributing to staffing levels that enable the delivery of safe, high-quality care

We will enable each other to be the best we can be

- Develop training for families and carers to they can feel better equipped to support their loved ones
- Provide responsive, psychologically led and trauma-informed support to staff through the delivery of the Here for You service across the system.
- Empower our staff to become high quality leaders through training

We will work together with our partners to make our services better

- Strengthen our links with third sector partners and provider collaboratives to ensure full system working
- Seek opportunities to expand core investment in trauma informed practices across the healthcare collaborative.
- Increase lens on diversity and enabling culturally sensitive interventions to be developed

We will support our communities to thrive

- Enhance our workforce by offering new and innovative roles and opportunities increasing employment and volunteering opportunities for people with lived experience, carers, health professionals and graduates
- Help facilitate the development and provision of the Oliver McGowan ASD training using experts by experience.
- Help develop Service User Networks to enable clinical support

MEASUREMENT FOR IMPROVEMENT

WE WILL TRACK AGREED METRICS TO MONITOR PROGRESS THROUGH OUR ACCOUNTABILITY FRAMEWORK

- Delivery of Care Unit workforce, finance, activity and quality plans will continue to be monitored via the monthly Accountability Framework process
- The AF will include a quarterly review point for each care unit against delivery of operational plan commitments, to inform quarterly reporting to the Finance & Performance Committee
- A sub-set of the metrics reported through the Accountability Framework is reviewed by the Board in the bi-monthly Integrated Performance Report
- The Accountability Framework is reviewed quarterly which will provide the opportunity for increasingly close between the metrics reported there and the reportable measures described for each objective in the Strategic Plan
- The agreed high level mapping for Q1 2023/24 is shown opposite
- Strategic development is planned for 2023/24 to ensure a focussed and co-ordinated approach to the delivery of Strategic Objective 4 (we will support out communities to thrive) including agreement of oversight and monitoring of change indicators

Trust Strategic Objective	Accountability Framework Domains
1. We will deliver safe, high quality, integrated care services	Quality & Safety Operational Performance
2. We will enable each other to be the best we can be	Workforce and culture Strategy, Transformation & External Relations
3. We will work together with our partners to make our services better	Quality & Safety Operational Performance Finance Strategy, Transformation & External Relations
4. We will support our communities to thrive	Strategy, Transformation & External Relations

Essex Partnership University
NHS Foundation Trust

Summary of EPUT Operational Plan for 2023/24

Strategic Objectives

We will deliver safe, high quality, integrated care services

Trust Priorities	Care Unit Priorities	Deliverables
Finish implementation of current safety strategy and develop continuation plan Phased implementation of Time to Care models Continue to actively engage with the Essex Mental Health Independent Inquiry and respond to recommendations once concluded Develop clinical quality strategy	• Improve care environments and use technology to improve safety • Ensure transitions between services both within and to partners are safe effective and delivered in collaboration with our patients • Use data and apply learning across all services to maximise safe care and decision making • Implement a new staffing model to support safe & therapeutic care; increasing our substantive staffing, which will promote flow and reduce ALOS • Evaluate and make improvements to our urgent care pathway across Essex. (launch Mental Health Urgent Care Department in MSE) • We will continue our focus on learning and implement a new quality improvement approach • Progression of the functionality of the CCC – right care, right place, right time • Use INT's as the vehicle to develop the proactive population health management approach & personalisation of care + support • Improve end-of-life pathways • Progression of MH Transformation in line with priorities of the LTP • Deliver the National Community Mental Health Framework Agreement with partners including Voluntary (Healthwatch and CVS) Housing Local Authority, Integrated Care Board, community and independent providers, Mind, Rethink and Trust links • Integrated neighbourhood teams will support in-reach of specialists and support early intervention and prevention with PCNs and primary care • Eradicate long waits for service users at the Lighthouse Children's Centre by focusing on ongoing recruitment using the recently received funding to support the clearing of the backlog • Commit to aligning our mental health services to the NE Essex Alliance neighbourhood profiles in 2023/24 • Commit to trauma informed care and a restorative supervision approach at all levels of staff in our care group • Continue to work collaboratively with all key maternity stakeholders around five Essex hubs • Continue to explore ways to improve access to psychological interventions • Lead on delivering needs and strengths-based care plans monitored through consistent outcomes evaluation based on GAS • Play a key role in 'growing our own', thereby supporting recruitment, and contributing to staffing levels that enable the delivery of safe, high-quality care	• Time to Care and related initiatives • Oxevision/OxeObs • Coursera • MH Urgent Care Department • ePMA • EPR • Care Coordination Centre/Virtual Hospital • Community MH Transformation • Partner and Child Safeguarding Records • Specialist Perinatal MH Transformation • Maternal MH Implementation • Integrated PCMHT • Patient Reported Outcome Measures • Community MH Transformation • Incorporate Statutory Safeguarding forms in Patient Record • Lighthouse • Essex Rough Sleeper Initiatives • Mid Essex Hub and Spoke Older Peoples model • Data Strategy

Strategic Objectives

We will enable each other to be the best we can be

Trust Priorities	Care Unit Priorities	Deliverables
Develop people and culture strategy including development of behavioural framework Continue to collaborate with local and regional partners on long term workforce development plan Improve our staff development offer and extend this to lived experience and volunteer roles	• Develop our staff skills in leadership, applied learning and specialised skills toward a trauma informed approach and upskill staff in neurodiversity and other specialisms • Share our expertise and knowledge with partners • Develop training for families and carers so they feel better equipped to support their loved ones • Increase leadership capability, supported through roll out of a new development programme informed by lived experience • Therapeutic teams will be supported to take time away from the service for development • Implement a restorative resilience model combining a focus on staff well-being and the assurance of good practice • Established workforce development group for all partners led by EPUT HR BP to support R&R, development of new roles & staffing models • We will become an employer of choice for our communities • Continue system partnership working to deliver the WEHCP priorities • Robust supervision and all staff to take part in the Pen Plan appraisals • Make staff aware of the mechanisms of support available to them • Create an inclusive culture of calling out poor behaviours, bullying, discrimination, and the freedom to speak up • Commit to the development of community apprentice roles and grow our own from our local community • Commit to a learning approach to leadership, being honest when we don't get things right • Commit to working with staff to enhance their skills in line with community transformation • Develop training for families and carers to they can feel better equipped to support their loved ones • Provide responsive, psychologically led and trauma-informed support to staff through the delivery of the Here for You service across the system. • Empower our staff to become high quality leaders through training	• Time to Care and related initiatives • Coursera • EDI Cultural And Organisational Review • EPUT Culture of Learning • Care Coordination Centre/Virtual Hospital • Community MH Transformation • Mandatory Training Review • Community MH Transformation • Dementia First • Approved/Responsible Clinician • Retire and Return Process Transformation • Recruitment and Retention Programme • Medical Recruitment Fair • International Recruitment • People Charter

Essex Partnership University
NHS Foundation Trust

Summary of EPUT Operational Plan for 2023/24

Strategic Objectives

We will work together with our partners to make our services better

Trust Priorities	Care Unit Priorities	Deliverables
Build on recent successes in the way we partner with lived experience experts, families, carers and communities to drive cultural change within EPUT Deepen approach to partnerships with ICSs and Local Authorities to maximize influence Better define EPUT's role in Population Health Management across three ICSs	• Create meaningful ways for families and carers to be involved with service transformation and elements of regular service delivery • Work with the provider collaborative to deliver the regional strategic priorities alongside our own in an integrated way that delivers positive change to services • Lead a regional collaboration of NHS and Third Sector partners and service users to deliver Operation Courage in support of the mental health and wellbeing of veterans • Build on good practice with service user, family/carer involvement – family ambassadors, forums, family group conferencing • Work with system partners, building on relationships (inc VCS) to support Urgent Care Pathway, Crisis Concordat & accommodation pathway • Continue to work with the GIRFT Programme • Collaboration across HWE CHS + MH to reduce variation • New Sec 75 with ECC for MH + focus on transitions • Expansion of rotational roles with PAH + jointly funded roles across WEHCP + ARRS roles • Continued support to care homes & independent care providers • Progression of collaboration initiatives across CHS and MH with the Voluntary sector and District council partners • Work with our Place partners to develop effective transfer of care hubs as per national requirement which will assess patients for discharge and refer them to the best out-of-hospital setting and support package • Agree on a common endeavour with local providers and partners to build collaborative structures at place • Work closely with our Alliance colleagues and supporting the development of PCN strategies • Continue to be a key partner in the NE Essex Alliance and place based maternity services and seek opportunities for formal and informal integration • Continue to work towards continued community transformation, recognising community assets and a recovery approach • Continue as a leadership team to understand our impact on others and how we can best support our communities, of which our workforce is a key part • Strengthen our links with third sector partners and provider collaboratives to ensure full system working • Seek opportunities to expand core investment in trauma informed practices across the healthcare collaborative. • Increase lens on diversity and enabling culturally sensitive interventions to be developed	• Specialist Perinatal MH Transformation • Maternal MH Implementation • Partner and Child Safeguarding Records • GIRFT Programme • Family Group Conferencing • Approved/Responsible Clinician • Community MH Transformation • Mid Essex Hub and Spoke Older Peoples model • Essex Rough Sleeper Initiatives • I Want Great Care • Lived Experience Ambassador Network

Strategic Objectives

We will support our communities to thrive

Trust Priorities	Care Unit Priorities	Deliverables
Develop social impact strategy with focus on parity for people with serious mental illness, learning disability or autism Form local commercial and innovation partnerships Consolidate local recruitment plans	• Focus on reintegration for our patients into their communities, increasing employment, housing and educational opportunities through partner engagement • Enhance our community offer to marginalized and disadvantaged groups improving their health outcomes and opportunities • Enhance our workforce by offering new and innovative roles and opportunities increasing employment and volunteering opportunities for service users, carers and the wider community • Have a RGN on all wards and in our UCP teams to work with MDT and improve physical healthcare provision • Agree and implement a focused recruitment and retention plan, including actions to increase local recruitment, voluntary work, opportunities for good quality work • Communities and the services supporting them will be more aware of signs of distress and suicidal behaviour, able to direct people to the right support • Support expansion of community 'hubs' across WE • Support to the "Harlow Levelling Up" programme with ECC & Partners including Epping Forest – Debden & Waltham Abbey – Core 20 + 5 approach • Support career opportunities across health and social care from local communities, expanding on programmes with DWP and school , 6th form colleges and FE career fairs • Continued focus on levelling up and reducing health inequalities across Mid and South Essex, we will engage a variety of initiatives and support identified by place • Actively involve carers and families in conversations about services and hearing their voices • Make Mental Health services more accessible by offering them from an increased number of locations so people don't have to travel to a particular place • Continue to be key partners in our place based teams, recognising the third sector as trusted partners to support our communities • Continue to encourage a no wrong door approach to compassionate care • Strive to work as part of local place systems to identify prevention initiatives and inequalities • Enhance our workforce by offering new and innovative roles and opportunities increasing employment and volunteering opportunities for people with lived experience, carers, health professionals and graduates • Help facilitate the development and provision of the Oliver McGowan ASD training using experts by experience. • Help develop Service User Networks to enable clinical support	• Time to Care and related initiatives • Approved/Responsible Clinician • Community MH Transformation • Retire and Return Process Transformation • Recruitment and Retention Programme • Mid Essex Hub and Spoke Older Peoples model • Essex Rough Sleeper Initiatives • Medical Recruitment Fair • International Recruitment • Lived Experience Ambassador Network

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS Part 1**	**31 May 2023**

Report Title:	**Duty of Candour Annual Review**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Fiona Thomas, Head of Patient Safety Incident Management					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides: • An annual position on Duty of Candour compliance • An updated summary of associated work streams for the year 2022/23	**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 Duty of Candour actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standard.
- A number of areas of work are in place to support staff in encouraging an open and transparent culture. This includes a training programme, family involvement in investigations and reviews under PSIRF.
- The Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2022/23

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

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

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

Acronyms/Terms Used in the Report			
DoC	Duty of Candour	CQC	Care Quality Commission
PSIRF	Patient Safety Incident Response Framework	FLO	Family Liaison Officer

Supporting Reports/ Appendices /or further reading

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DUTY OF CANDOUR

1.0 PURPOSE OF REPORT

To provide the Board of Directors with an annual position on Duty of Candour compliance and an updated summary of associated work streams for the year 2022/23.

2.0 CQC REGULATION 20 – THE DUTY OF CANDOUR

The Duty of Candour regulation puts a legal duty on all health and social care providers to be open and transparent with people using services and their families in relation to their treatment and care. It also sets out some specific actions that providers must take when a notifiable patient safety incident occurs:

- Informing the people affected about the incident
- Offering reasonable support
- Providing truthful information and a timely apology

In March 2021, the CQC updated the guidance to make it clear what providers must to do meet the requirements of the regulation and the circumstances in which it must be applied. The updated guidance gives a more specific explanation of what is defined as a notifiable safety incident and *"makes clear that the apology required to fulfil the duty of candour does not mean accepting liability and will not affect a provider's indemnity cover".*

A notifiable safety incident **must** meet all three of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity regulated by the CQC.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death or severe or moderate harm to the person receiving care.

It is important to note that the presence or absence of fault on the part of a provider has no impact on whether or not something is defined as a notifiable safety incident. ***Saying sorry is not admitting fault.*** Even if something does not quality as a notifiable safety incident, there is always an overarching duty of candour to be open and transparent with people using services.

Definitions of harm:

Moderate harm
Harm that requires a moderate increase in treatment and significant, but not permanent, harm.

Severe harm

A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Moderate increase in treatment
An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

Prolonged pain
Pain that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged psychological harm
Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Duty of Candour and PSIRF
The duty of candour requirements are referred to in the PSIRF and PSIRP. The EPUT Being Open & Duty of Candour Policy has been amended to reflect the updated guidance.

3.0 WORKSTREAMS

The Patient Safety Incident Management Team have two dedicated Band 7 Family Liaison Leads, whose role includes:

- To lead and co-ordinate the role of the Family Liaison Officer across the Trust, ensuring that staff have adequate training and support to enable them to carry out their role effectively.
- To ensure that patients/families/carers are fully involved in the investigation and review processes and are adequately supported by their allocated Family Liaison Officer.
- To support the appointed Family Liaison Officers to attend inquest to accompany the family in which they have established contact with throughout the review/investigation process.
- To support the patient/families/carers to access appropriate support as and when required, fulfilling Duty of Candour principles.
- To undertake the role of Family Liaison Officer for more complex and/or sensitive cases.

In addition to this, the following work streams are also in place:

- Mandatory Being Open/Duty of Candour training for staff via e-learning and within the Trust induction programme.
- Family Liaison Officers are included within all correspondence around reviews/investigations and informed of timeframes and scope in order to facilitate transparency and involvement of patients/families in the review/investigation.
- Patients/families are central to the review/investigation process as detailed in the PSIRF and the Trust's PSIRP.
- Weekly review of moderate harms and incidents for escalation to confirm if they meet Duty of Candour criteria and to identify further investigation/review required.
- Commissioning of case note reviews and monitoring via the Learning from Deaths Group and presentation of learning to the Mortality Review Sub-Committee.

4.0 COMPLIANCE

The following table confirms that all applicable incidents have followed Duty of Candour

requirements.

Directorate	Total applicable cases	DoC timeframe achieved	Total
North Essex MH	21	21	**21**
South Essex MH	30	30	**30**
Specialist Services	2	2	**2**
South Essex CHS	0	0	**0**
West Essex CHS	0	0	**0**
EPUT TOTAL	53	53	**53**

5.0 RECOMMENDATIONS

It is recommended that the Board of Directors:

1. Note the content of this report
2. Recommend any further actions as required

Fiona Thomas
Head of Patient Safety Incident Management

On behalf of:

Natalie Hammond
Executive Nurse

Agenda Item No: 10b

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 May 2023

Report Title:	**Trust Constitution Review**					
Report Lead:	Professor Sheila Salmon, Chair of the Trust					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Trust Constitution Task and Finish Group Council of Governors Governance Committee Council of Governors					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
The report confirms that a review of the Essex Partnership University NHS Foundation Trust Constitution has been undertaken and proposes amendments for approval by the Board of Directors following consultation and agreement with the Council of Governors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the review process
2. Approve the amended Constitution following consultation and agreement with the Council of Governors.

Summary of Key Issues

It is recognised good governance to undertake a review of the Trust's constitution on an annual basis. The previous review took place in February 2022. Following the publication of a new Code of Governance for NHS Providers, which came into effect on the 1 April 2023, it was agreed to extend the Constitution to allow a full review to be undertaken against the new code.

The Council of Governors and the Board of Directors are required to approve any recommended amendments to the Constitution.

The Trust Constitution was reviewed by an external legal services, with a view to review the Constitution against the new code of governance, the Health and Care Act 2022 and other good practice examples. The review proposed a set of amendments. The proposed amendments were reviewed by a Task and Finish Group on the 17 May 2023, which included the Chair, Governors, Non-Executive Directors (including the Audit Chair), the Senior Director of Corporate Governance and the Assistant Trust Secretary. The Constitution was also reviewed by the Council of Governors Governance Committee on the 18 May 2023 to agree recommended amendments to the Council of Governors.

The Council of Governors considered the revised Constitution on the 22 May 2023 and approved the following amendments:

Section	**Amendment**
Section 1.18: NHS England / Improvement Section 1.19: NHSTDA	These two sections have now been removed as it is now incorporated into Section 1.17: NHS England.
Section 4.4 / 4.5: Powers	This section has been added in line with the Code of Governance for NHS Providers to allow joint working and the establishment of joint committees with other bodies. This is in line with system working and Integrated Care Boards / Systems / Collaborative Working.
Section 26.2: Board of Directors – General Duty	Section added to reflect the new duty for Foundation Trust's to act with due regard to the wider health economy.
Section 33.11: Board of Directors – Disqualification	The words "including Clinical Commissioning Groups" has been removed to allow Board members to be members of commissioning boards as part of system working. The section has also been amended to refer to "conflict of interest" to clarify the Board / Council are reviewing and agreeing an appointment to ensure there is no conflict of interest. Any other issues, such as time commitment, can be reviewed on an ongoing basis as part of internal processes, such as appraisals and therefore does not need to be explicit in the Constitution.
Annex 2 – The Staff Constituency Annex 4 – Composition of the Council of Governors	The section has been amended to include Healthcare Professionals and Social Workers to the Staff Clinical constituency, rather than non-clinical. The Non-Clinical

	constituency has also been amended to clarify this as Corporate Staff. The section has also been amended to split the Staff Clinical between Mental Health (3 Governors) and Physical Health (1 Governor) to ensure there a voice at Council for Physical Health services provided by the Trust.
Section 5.6: Termination of Office and Removal of Governors	The section has been amended to remove reference to referring to the Independent Assessor. This was originally included as organisations did not have internal processes for appeal of termination of office and there was an independent panel to refer such cases. The panel has since been disbanded and the Trust has internal processes which do not require an independent assessor to be appointed.
Annex 6: Section 4.1: Eligibility to be a Governor Annex 9: Section 2: Termination of Membership	Inclusion of an additional restriction to holding position of Governor / Member – in that if a person has been expelled from other NHS Bodies and / or holds views that are not supportive of the Trust vision, objectives and values.
Other Amendments	Other minor amendments have been made to the document, such as adding references to the new code of governance, the Health & Care Act 2022.

The Board of Directors is asked to approve the revised Trust Constitution.

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

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

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

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

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Appendix 1: Trust Constitution

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

20230531

Essex Partnership University NHS Foundation Trust

Constitution

Approved by Council of Governors 21 March 2022 and
Board of Directors 30 March 2022
Next Review Date: 30 June 2023

TABLE OF CONTENTS

Paragraph

1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the 2022 Act.

1.2 Words importing the plural shall import the singular and vice-versa.

1.3 The **2006 Act** is the National Health Service Act 2006

1.4 The **2012 Act** is the Health and Social Care Act 2012

1.5 **The 2022 Act is the Health and Care Act 2022**

1.6 **Annual Members' Meeting** is defined in paragraph 13 of the Constitution

1.7 **Board of Directors** or **Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with this Constitution

1.8 **Board of Directors Nominations Committee** means a committee of the Board described in paragraph 30.4 of the Constitution

1.9 **Constitution** means this constitution which has effect in accordance with Section 37(1) of the 2006 Act

1.10 **Council of Governors or Council** means the Council of Governors of the Trust as described in paragraph 14 of this Constitution

1.11 **Chair** is the person appointed as Chair of the Board of Directors (and Chair of the Council of Governors) under paragraph 28 of this Constitution

1.12 **Chief Executive** is the person appointed as the Chief Executive Officer of the Trust under paragraph 31 of this Constitution

1.13 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.14 **Executive Director** means a member of the Board of Directors appointed under paragraph 25 of the Constitution

1.15 **Member** means a person registered as a member of one of the constituencies set out in paragraph 5 of this Constitution

1.16 **Model Election Rules** means the Model Election Rules published by Department of Health and/or NHS Providers

1.17 **NHS England** is the body corporate as provided by Section 1H of the 2012 Act

1.18 **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

1.19 **Officer** means an employee of the Trust or any person holding a paid appointment or office with the Trust

1.20 **Regulated Activities Regulations** means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended

1.21 The **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

1.22 The **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.23 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30.1 and 30.3 of this Constitution

1.24 **Acting Chair** means the Non-Executive Director appointed under paragraph 30.2 and 30.3 of this Constitution.

1.25 **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried out for profit

1.26 **Working Day** means a day of the week which is not a Saturday, Sunday or public holiday in England.

2. Name

2.1 The name of the foundation trust is Essex Partnership University NHS Foundation Trust (the Trust).

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision 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

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.4 In accordance with section 65Z5 of the 2006 Act the Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following—

(a) a relevant body as defined under section 65Z5(2) of the 2006 Act;

(b) a local authority (within the meaning of section 2B of the 2006 Act);

(c) a combined authority.

4.5 Where the Trust arranges for any functions exercisable by it to be exercised jointly the bodies by whom the function is exercisable jointly may—

(a) arrange for the function to be exercised by a joint committee of theirs;

(b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the constituencies in paragraph 5.2

5.2 The constituencies of the Trust shall be:

5.2.1 a Public Constituency

5.2.2 a Staff Constituency.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust subject to paragraphs 8 and 12 below

6.2 An applicant will become a member when the Trust has received and accepted the application, and the name of the applicant has been entered in the Trust's Register of Members (see Annex 9: Further Provisions paragraph 2).

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the Trust

7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 Individuals who are employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months

8.1.3 For the avoidance of doubt permanent staff are eligible to be members of the staff constituency. Temporary Staff can be a member of a Public Constituency if the criteria is met.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency; each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default – Staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10. NOT USED

11. NOT USED

12. Restriction on Membership

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency

12.3 An individual must be at least 12 years old to become a member of the Trust

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9: Further Provisions paragraph 2.

13. Annual Members' Meeting

13.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public

13.2 Annual Members' Meetings shall be conducted in accordance with paragraph 27A of Schedule 7 of the 2006 Act (and as set out in paragraph 46 of this constitution) and the standing orders for the practice and procedure of Annual Members' Meetings as set out in Annex 10: Annual Members' Meeting.

14. Council of Governors – Composition

14.1 The Trust is to have a Council of Governors, which shall comprise both

elected and appointed Governors

14.2 The composition of the Council of Governors is specified in Annex 4

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

15. Council of Governors – Election of Governors

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules adopting Single Transferable Vote (STV)

15.2 The Model Election Rules are attached at Annex 5 but they do not form part of this constitution

15.3 A variation of the Model Election Rules by the Department of Health or NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution)

15.4 An election, if contested, shall be by secret ballot

15.5 Where a vacancy arises from 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 vacancy for the unexpired balance of the former 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.

15.6 Governors must be at least 16 years of age at the date they are nominated for election or appointment

16. Council of Governors – Tenure

16.1 An elected Governor may hold office for a period of up to three Years. The period of office shall be known as the 'term'

16.2 Elected Governors shall cease to hold office if they cease to be a member of the constituency or class by which they were elected

16.3 Elected Governors shall be eligible for re-election at the end of their term

16.4 Appointed Governors may hold office for a period of up to three Years

16.5 Appointed Governors shall cease to hold office if the appointing organisation withdraws its sponsorship of them or if the appointing organisation ceases to exist and there is no successor in title to its business

16.6 Appointed Governors shall be eligible for re-appointment at the end of their term

16.7 A Governor may serve a maximum of three terms of each up to three years in office and shall be eligible to stand for election or appointment as a Governor again following a break of at least a Year

16.8 ''Year' in this clause 16 means the period commencing on the date of election or appointment (as the case may be) and ending 12 months after such election or appointment.

17. Council of Governors – Disqualification and Removal

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

17.1.3 people who have made a composition or arrangement with, or granted a Trust deed for their creditors and have not been discharged in respect of it

17.1.4 people who within the preceding five years have been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

17.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and for the removal of Governors are set out in Annex 6 paragraphs 4 and 5.

18. Council of Governors – Duties of Governors

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public

18.2 Further provision as to the roles and responsibilities of the Council of Governors is set out in Annex 6

18.3 The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – Meetings of Governors

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 of this constitution) or, in their absence the Vice-Chair or Acting Chair (appointed in accordance with the provisions of paragraph 30 of this constitution), shall preside at meetings of the Council of Governors except as otherwise provided pursuant to the standing orders for the Council of Governors as at Annex 7

19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Council of Governors if that person is interfering with or preventing the proper conduct of the meeting

19.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

20. Council of Governors – Standing Orders

20.1 The standing orders for the practice and procedure of the Council of Governors are referenced at Annex 7

20.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of this constitution.

21. NOT USED

22. Council of Governors – Conflicts of Interest of Governors

22.1 If Governors have a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, Governors shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – Travel Expenses

23.1 The Trust may pay travelling and other expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust. These expenses are to be disclosed in the Trust's annual report

23.2 Governors do not receive remuneration when undertaking their duties and role as a Governor.

24. Council of Governors – Further Provisions

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – Composition

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors

25.2 The Board of Directors is to comprise:

25.2.1 a Non-Executive Chair

25.2.2 not less than five and not more than eight other Non-Executive Directors; and

25.2.3 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 in a voting capacity.

25.3 One of the Executive Directors shall be the Chief Executive

25.4 The Chief Executive shall be the Accounting Officer

25.5 One of the Executive Directors shall be the Finance Director

25.6 One of the Executive Directors is to be a registered Medical Practitioner or a registered Dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is to be a registered Nurse or a registered Midwife.

26. Board of Directors – General Duty

26.1 The general duty of the Board of Directors 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.

26.2 In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to—

(a) the health and well-being of the people of England;

(b) the quality of services provided to individuals—

(i) by relevant bodies, or

(ii) in pursuance of arrangements made by relevant bodies,

for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

(c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

27. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if:

27.1 they are a member of a Public Constituency, or

27.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

27.3 they are not disqualified by virtue of paragraph 33 of this constitution.

28. Board of Directors – Appointment and Removal of Chair and Other Non-Executive Directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors

28.2 Appointment of the Chair or another Non-Executive Director shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors

28.3 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors

28.4 The Council of Governors shall adopt a procedure for appointing/removing the Chair and/or other Non-Executive Directors in accordance with any guidance issued by NHS England.

29. NOT USED

30. Board of Directors – Appointment of Vice-Chair, Acting Chair, Senior Independent Director and Deputy Chief Executive

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as the Vice-Chair

30.2 When the absence of the Chair has or will exceed a period of 3 months the Council of Governors at a meeting shall appoint one of the Non-Executive Directors as the Acting Chair.

30.3 Before a resolution for such appointments is passed, the Chair shall be entitled to advise the Council of Governors of the Non-Executive Director 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.

30.4 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors as the Senior Independent Director to act in accordance with NHS England's *Code of Governance for NHS Provider Trusts (*as may be amended and replaced from time to time) and the Trust's standing orders.

30.5 The Board of Directors Remuneration and Nominations Committee, which comprises of all the Non-Executive Directors, shall appoint an Executive Director as the Deputy Chief Executive in line with agreed procedure.

31. Board of Directors – Appointment and Removal of the Chief Executive and Other Executive Directors

31.1 The Non-Executive Directors shall appoint or remove the Chief Executive

31.2 A committee consisting of the Chair and Non-Executive Directors shall appoint the Chief Executive.

31.3 The appointment of the Chief Executive shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors in accordance with the procedure agreed by the Council of Governors from time to time

31.4 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors

31.5 An Executive Director's post may be held by two individuals on a job share basis (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). Where such an arrangement is in force, the two individuals may only exercise one vote between them at any meeting of the Board of Directors as in the standing orders.

32. NOT USED

33. Board of Directors – Disqualification

The following may not become or continue as a member of the Board of Directors:

33.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

33.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

33.3 people who have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it

33.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

33.5 a person who is subject of a disqualification order made under the Company Directors Disqualification Act 1986 and/or who is disqualified from being a trustee of a charity under the Charities Act 2011

33.6 people where disclosures revealed by a Disclosure & Barring Service check against such people are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute

33.7 people whose tenure of office as Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest

33.8 a person who has within the preceding two years been dismissed: otherwise than by reason of redundancy or for ill health, from any paid employment with;

33.8.1 a health service body or a local authority;
33.8.2 any other public body; or
33.8.3 a private provider or health or social care services;

unless approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.9 a person who is the subject of a Sexual Offenders Order under the Sexual

Offences Act 2003

33.10 a person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

33.11 a person who is a Director or Governor or Governing Body member or equivalent of another NHS body, unless any conflict of interest has been reviewed and approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.12 a person who is a member of the Council of Governors

33.13 in the case of Non-Executive Directors, a person who is no longer a member of one of the public constituencies

33.14 in the case of Non-Executive Directors, a person who has refused without any reasonable cause to fulfil any training requirement established by the Board of Directors

33.15 a person who is a member of a Local Authority's Overview & Scrutiny Committee covering health matters or of a Local Healthwatch Board or of a Health & Wellbeing Board

33.16 a person who is the spouse, partner, parent or child of a member of the Trust's Board of Directors

33.17 a person who has displayed aggressive or violent behaviour at any NHS establishment or against any of the Trust's staff or persons exercising functions for the Trust

33.18 a person who fails to satisfy the requirements of the Regulated Activities Regulations

33.19 a person who has failed to sign and return to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for the Board of Directors

33.20 a person who has acted in a manner inconsistent with or who has failed to comply with the Trust's terms of authorisation, standing orders, standing financial instructions and/ or the code of conduct for the Board of Directors.

34. Board of Directors – Meetings

34.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Board of Directors if that

person is interfering with or preventing the proper conduct of the meeting

34.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the Part 1 minutes of the meeting to the Council of Governors. A summary of Part 2 minutes will be provided to the Council of Governors.

35. Board of Directors – Standing Orders

35.1 The Board of Directors has adopted the standing orders for the practice and procedure of the Board of Directors referred to at, Annex 8.

35.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of the constitution.

36. Board of Directors – Conflicts of Interest of Directors

36.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

36.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust

36.1.2 a 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

36.2 The duty referred to in sub-paragraph 36.1.1 is not infringed if:

36.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 the matter has been authorised in accordance with the constitution if it has been considered and approved by the Board of Directors

36.3 The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest

36.4 In sub-paragraph 36.1.2, “third party” means a person other than:

36.4.1 the Trust, or

36.4.2 a person acting on its behalf

36.5 If a Director of the Trust 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

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made

36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement

36.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question

36.9 A Director need not declare an interest:

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest

36.9.2 if, or to the extent that, the Directors are already aware of it

36.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

36.9.3.1 by a meeting of the Board of Directors, or

36.9.3.2 by a committee of the Directors appointed for the purpose under the constitution

36.10 The standing orders for the Board of Directors make further provision for the disclosure of interests.

37. Board of Directors – Remuneration and Terms of Office

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors

37.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

38. Registers

The Trust shall have:

38.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong

38.2 a register of members of the Council of Governors

38.3 a register of interests of Governors

38.4 a register of Directors, and

38.5 a register of interests of the Directors.

39. Admission to and Removal from the Registers

39.1 The Trust Secretary shall be responsible for fulfilling the obligations of the Trust in relation to the maintenance of, admission to and removal from the registers under the provisions of this constitution and as set out in paragraph 38.

39.2 Directors and Governors shall advise the Trust Secretary as soon as practicable of anything which comes to their attention or of which they are aware and which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 38.

40. Registers – Inspection and Copies

40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances prescribed below or as otherwise prescribed

40.2 The Trust may withhold all or part of the registers from inspection where disclosure of information could give rise to a real risk of harm or is prohibited by law.

40.3 So far as the registers are required to be made available:

40.3.1 they are to be available for inspection free of charge at all reasonable times, and

40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract

40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. Documents Available for Public Inspection

41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution,

41.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

41.1.3 a copy of the latest annual report

41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

41.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act

41.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

41.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act

41.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

41.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy

41.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. Auditor

42.1 The Trust shall have an auditor

42.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors

42.3 The auditor shall comply with Schedule 10 of the 2006 Act in auditing the accounts of the Trust.

43. Audit Committee

43.1 The Board of Directors shall establish a committee comprising Non-Executive Directors (at least one of whom has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate

43.2 The Audit Committee as a whole shall have competence relevant to the NHS sector.

44. Accounts

44.1 The Trust must keep proper accounts and proper records in relation to the accounts

44.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

44.3 The accounts are to be audited by the Trust's auditor

44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct

44.5 The functions of the Trust with respect to the preparation of the annual accounts, as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

45. Annual Report, Forward Plans and Non-NHS Work

45.1 The Trust shall prepare an annual report and send it to NHS England

45.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England

45.3 The forward plan shall be prepared by the Directors

45.4 In preparing the forward plan, the Directors shall have regard to the views of the Council of Governors

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so

45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on 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

45.6.2 notify the Directors of the Trust of its determination

45.7 A Trust which 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 purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

46. Presentation of the Annual Accounts and Reports to the Governors and Members

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

46.1.1 the annual accounts

46.1.2 any report of the auditor on them

46.1.3 the annual report

46.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one Board Director in attendance

46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

47.1 The Trust shall have a seal

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the Constitution

48.1 The Trust may make amendments of its constitution only if:

48.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

48.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments

48.2 Amendments made under sub-paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act

48.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

48.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

48.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. Actions taken by the Trust under the amended constitution, prior to the amendment ceasing to have effect, remain valid

48.4 Amendments by the Trust of its constitution are to be notified to NHS England.

49. Mergers, etc., and Significant Transactions

49.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors

49.2 The Trust may enter into a significant transaction unless it is a merger, acquisition, separation or dissolution only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction

49.3 The definition of “significant transaction” for the purposes of paragraph 49.2 and section 51A of the 2006 Act is set out in Annex 9 paragraph 1.

50. Indemnities

50.1 Members of the Board of Directors, members of the Council of Governors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust

50.2 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Board of Directors, the Council of Governors and the Trust Secretary.

ANNEX 1: THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

THE PUBLIC CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Essex Mid & South	The electoral wards covered by: • Basildon Borough Council • Braintree District Council • Brentwood Borough Council • Castle Point Borough Council • Chelmsford Borough Council • Maldon District Council • Rochford District Council • Southend on Sea Borough Council • Thurrock Borough Council	9	60
North East Essex & Suffolk	• Colchester Borough Council • Suffolk County Council • Tendring District Council	3	60
West Essex & Herts	• Borough of Broxbourne Council • East Herts District Council • Epping Forrest District Council • Harlow Council • North Herts District Council • Stevenage Borough Council • Uttlesford District Council • Welwyn Hatfield Borough Council	5	60
Milton Keynes, Bedfordshire & Luton, and Rest of England	• Bedford Borough Council • Central Bedfordshire Council • Luton Borough Council • Milton Keynes Council • Any other Council in England unless named in Annex 1 to the Trust's Constitution	2	60

ANNEX 2: THE STAFF CONSTITUENCY

(Paragraph 8.4 and 8.5)

THE STAFF CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Clinical (Mental Health)	• Registered medical practitioners and registered dentists • Registered nurses and registered midwives • Healthcare professionals • Social workers	3	60
Clinical (Physical Health)		1	60
Non-Clinical	• Support staff • Corporate Staff	2	60

ANNEX 3: NOT USED

ANNEX 4: COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

Public Governors		**19**
Essex Mid & South	9	
North East Essex & Suffolk	3	
West Essex & Herts	5	
Milton Keynes, Bedfordshire & Luton, and Rest of England	2	
Staff Governors		**6**
Clinical (Mental Health)	3	
Clinical (Physical Health)	1	
Non-Clinical	2	
Appointed and Partnership Governors		**5**
Essex County Council	1	
Southend Borough Council	1	
Thurrock Council	1	
Anglian Ruskin and Essex Universities (joint appointment)	1	
Third Sector / Voluntary Sector	1	
Total Council of Governors		**30**

ANNEX 4.1: NOT USED

ANNEX 5: THE MODEL ELECTION RULES

(Paragraph 15.2)

The Model Election Rules 2014 are included as a separate document to this constitution. (https://nhsproviders.org/resource-library/briefings/model-election-rules)

ANNEX 6: ADDITIONAL PROVISION – COUNCIL OF GOVERNORS

(Paragraphs 17.3, 18.2 and 24.1)

1. Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution, the Trust's license and NHS England's *Code of Governance for NHS Provider Trusts* include

1.1 General Duties

1.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts so that the Trust does not breach the terms of its license. "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

1.1.2 to represent the interests of the members of the Trust and the interests of the public

2.1 Non-Executive Directors, Chief Executive and Auditor

2.1.1 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 of Governors

2.1.2 to appoint the Chair and Non-Executive Directors

2.1.3 to remove the Chair and the Non-Executive Directors. However, 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

2.1.4 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 of Governors. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors

2.1.5 to decide 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 having regard to the recommendations of the Remuneration Committee of the Council of Governors

2.1.6 to approve the appointment of the Chief Executive of the Trust

2.1.7 to approve the criteria for the appointment, removal and reappointment of the auditor

2.1.8 to appoint, remove and reappoint the auditor, having regards to the recommendation of the Audit Committee

3.1 Strategy Planning

3.1.1 to provide feedback to the Board of Directors on the development of the strategic direction of the Trust, as appropriate

3.1.2 to collaborate with the Board of Directors in the development of the forward plan

3.1.3 where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purposes of the NHS in England, to determine whether it is satisfied that the carrying on 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 of Directors

3.1.4 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 purposes of the NHS in England, approve such a proposal

3.1.5 to approve the entering into of any significant transaction (as

defined in this constitution) in accordance with the 2006 Act and the constitution

3.1.6 to approve proposals from the Board of Directors for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

3.1.7 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

3.1.8 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 of Governors

3.2 Representing Members and the Public

3.2.1 to prepare and from time to time review the Trust's membership engagement strategy and policy

3.2.2 to notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its license, and if these concerns cannot be resolved at local level

3.2.3 to report to the members annually on the performance of the Council of Governors

3.2.4 to promote membership of the Trust and contribute to opportunities to recruit members in accordance the membership strategy

3.2.5 to seek the views of stakeholders and feed back to the Board of Directors.

(Paragraphs 17.3 and 24.1)

4. Eligibility to be a Governor

4.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

4.1.1 they are a Director of the Trust, or a director of another health service body

4.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors for the Trust

4.1.3 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986

4.1.4 they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003

4.1.5 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

4.1.6 they are undergoing a period of disqualification from a statutory health or social care register

4.1.7 they have been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

4.1.8 they have been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body

4.1.9 they are a vexatious complainant as determined in accordance with the Trust's complaints procedure

4.1.10 within 5 years prior to his nomination for election or appointment to the Council of Governors, they have had their office of Governor terminated for the reasons set out in paragraphs 5.1.4 – 5.1.9 of this Annex 6.

4.1.11 they have been expelled from other NHS Bodies and /or demonstrably hold views / act in ways that are inconsistent with Trust vision, objectives and values.

(Paragraph 17)

5. Termination of Office and Removal of Governors

5.1 People holding office as a Governor shall cease to do so if:

5.1.1. they resign by notice in writing to the Trust Secretary

5.1.2 in the case of elected Governors, they cease to be member of the area of the constituency or class of the constituency by which they were elected

5.1.3. in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

5.1.4. they consistently and unjustifiably fail to attend the meetings of the Council of Governors in line with the Governor attendance policy as agreed by the Council of Governors

5.1.5. they have refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake

5.1.6. they have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors

5.1.7. they have failed to complete a submission identifying any conflict of interest or they have knowingly provided false or misleading information in this regard.

5.1.8. they have committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders

5.1.9. they have acted in a manner detrimental to the interests of the Trust

5.1.10. they have expressed opinions which are incompatible with the values of the Trust

5.1.11. they are incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

5.2 Governors who are to be removed under any of the grounds set out in paragraph 5.1 above (with the exception of sub-paragraph 5.1.1 – 5.1.3) above shall be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present and voting

5.3 There shall be a working group/committee of the Council of Governors whose function shall be to:

5.3.1 receive and consider concerns about the conduct of any governor and/or

5.3.2 consider whether there are grounds to remove a Governor from office and to make recommendations to the Council of Governors. Membership of the working group/committee shall be determined from time to time

5.4 If the Council of Governors receives a complaint in writing about any Governor or is asked to consider whether an individual is eligible to

become or remain a Governor, the working group shall investigate the matter and make a recommendation to the Council of Governors, which may include a recommendation that a Governor is removed from office pursuant to paragraph 5.2 above

5.5 The Council of Governors may decide that whilst the working group is carrying out its investigation, the Governor concerned shall be suspended from office. Suspension is a neutral act and any decision to suspend the Governor concerned shall not be seen as an indicator of, or have any bearing on, the eventual recommendation of the working group

5.6 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until seven (7) days after the date of decision

5.7 The Governor shall be suspended from office (if they have not already been suspended from office pursuant to paragraph 5.5 above) with effect from the date of the Council of Governors' decision until the of the date set out in paragraph 5.5 above

ANNEX 7: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 19.1 and 20)

Standing Orders For The Practice And Procedure Of The Council Of Governors are included as a separate document to this constitution.

ANNEX 8: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 35)
Standing Orders For The Practice And Procedure Of The Board Of Directors are included as a separate document to this constitution.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph 49)

1. SIGNIFICANT TRANSACTIONS

1.1 In accordance with section 51A of the National Health Service Act 2006, the Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction

1.2 For the purpose of this paragraph 1 and subject to paragraph 1.4 below, "Significant Transaction" means a "transaction" as defined in paragraph 1.3 below which meets any one of the following tests:

1.2.1 the assets which are the subject of the transaction exceed 25% of the total fixed assets of the Trust (Asset Test); or

1.2.2 the income of the Trust will increase or decrease by more than 25% following the completion of the relevant transaction (Income Test); or

1.2.3 the gross capital of the company or business being acquired or divested represents more than 25% of the total capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities plus the excess of current liabilities over current assets, and the Trust's capital is determined by reference to its balance sheet) (Gross Capital Test); or

1.2.4 the Asset Test, the Income Test and the Gross Capital Test are not satisfied but the transaction, in the reasonable opinion of the Board of Directors:

(a) would impact on the manner in which health services are delivered by the Trust and/or the range of health services the Trust delivers; or

(b) exceeds a total value of £10,000,000 (£10 million) and has an overall risk rating which in the reasonable opinion of the Board of Directors is considered to be significant. The Board of Directors will assess the significance of the overall risk of the transaction against the applicable Trust's own risk management framework in force at the time the risk assessment is conducted by the Board of Directors

1.3 "Transaction" means any agreement (including an amendment to an agreement) entered into by the Trust in respect of a merger, demerger, joint venture, divestment, or any other arrangement for the acquisition, disposal or delivery of health services, but, for the avoidance of doubt, it does not include:

1.3.1 an agreement entered into or changes to the health services carried out by the Trust following a reconfiguration of the health services led by the commissioners of such health services; or

1.3.2 a grant of public dividend capital or the entering into a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust

1.3.3 For the purpose of this paragraph 1.3 the following definitions apply:

(a) "merger" means a transaction that involves one organisation acquiring / transferring the assets and liabilities of another, either wholly or in part;

(b) "demerger" means a transaction that involves the disaggregation of a single corporate body into two or more new corporate bodies;

(c) "joint venture" means a transaction involving an agreement between two or more parties to undertake economic activity together which establishes a separate legal entity.; and

(d) "divestment" means a transaction that involves the disposal, in whole or in part, of an organisation's business, services or assets and liabilities where the Board of Directors has made a decision to do so.

1.4 A transaction is not a Significant Transaction if it is:

1.4.1 a transaction which is a statutory merger, acquisition, separation or dissolution under sections 56, 56A, 56B or 57A of the National Health Service Act 2006; or

1.4.2 a transaction in the ordinary course of current business from time to time (including the expiry, termination, renewal, extension of, or the entering into an agreement in respect of the health services carried out by the Trust).

1.4.3 a transaction that involves the disposal, in whole or in part, of an organisation's business services or assets and liabilities where the Board of Directors has not made a decision and therefore is outside Trust control.

(Paragraphs 6.2 and 12.4)

2. TERMINATION OF MEMBERSHIP

2.1 A member shall not become or continue to be a member if:

2.1.1 it is reasonably suspected by the Board that in the five years prior to the individual's application for membership of the Trust or during the

period of their membership of the Trust, they have been involved as a perpetrator in what the Board reasonably considers to be a sufficiently serious incident of intimidation, threat, harassment, assault or violence against:

a) any of the Trust's employees or other persons who exercise functions for the purpose of the Trust, or against any volunteers; or
b) any employee of another health service body or any person who exercises functions for the purposes of another health service body or against any person who volunteers with another health service body; or
c) any service user or carer or visitor to the Trust or any service user, carer or visitor to any other health service body

2.1.2 they have been excluded from the Trust's premises within the previous five years

2.1.3 they are expelled from membership by resolution of the Council of Governors

2.1.4 they cease to be eligible under this Constitution to be a member

2.1.5 they die

2.1.6 they have been expelled from other NHS Bodies and /or demonstrably hold views / act in ways that are inconsistent with Trust vision, objectives and values.

2.2 It is the responsibility of members to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. Members who become aware of their ineligibility shall inform the Trust as soon as practicable and their names shall be removed from the Register of Members

2.3 Where the Trust has reason to believe that members cease to be eligible for membership or their membership can be terminated under this constitution, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

ANNEX 10: ANNUAL MEMBERS' MEETING

(Paragraphs 13 and 46)

1. Interpretation

1.1. Save as permitted by law, the Chair shall be the final authority on the interpretation of these standing orders (on which the Chair shall be advised by the Chief Executive and the Trust Secretary)

2. General Information

2.1. The purpose of the standing orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings

2.2. All business shall be conducted in the name of the Trust

3. Attendance

3.1. Each member shall be entitled to attend an Annual Members' Meeting

4. Meetings in Public

4.1. Meetings of the Annual Members' Meetings must be open to the public subject to the provisions of paragraph 4.2 below

4.2. The Chair may exclude members of the public from an Annual Members' Meeting if they are interfering with or preventing the reasonable conduct of the meeting

4.3. Annual Members' Meetings shall be held annually at such times and places as the Chair may determine

5. Notice of Meetings

5.1. Before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an officer of the Trust authorised by the Chair to sign on their behalf, shall be served upon every member at least 10 clear days before the meeting and posted on the Trust's website and displayed at its headquarters

5.2. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the Trust Secretary and shall be available for inspection by a member free of charge at the place of the meeting

6. Setting the Agenda

6.1. The Chair shall determine the agenda for Annual Members' Meetings which must include the business required by the Act

7. Chair of Annual Members' Meetings

7.1. The Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or Acting Chair shall preside. If neither the Chair, Vice-Chair nor Acting Chair is present the Directors and Governors shall elect one of their number to act as Chair

8. Chair's Ruling

8.1. Statements of members made at Annual Members' Meetings 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

9. Voting

9.1. Decisions at meetings shall be determined by a majority of the votes of the members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote subject to the Act

9.2. All decisions 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

9.3. In no circumstances may an absent member vote by proxy

10. Suspension of Standing Orders

10.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of suspension

10.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting

10.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members

10.4. No formal business may be transacted while the standing orders are suspended

10.5. The Trust's Audit Committee shall review every decision to suspend the standing orders

11. Variation and Amendment of Standing Orders

11.1. These standing orders may be amended in accordance with paragraph 48 of the constitution

12. Record of Attendance

12.1. The Trust Secretary shall keep a record of the names of the members present at an Annual Members' Meeting

13. Minutes

13.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it

13.2. 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 meeting

13.3. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 members are present.

Board of Directors 31 May 2023