Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

2 April 2025

13:00 GMT+1 Europe/London

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

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AGENDA

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Only PDFs are attached

Part 1 BoD Agenda 2 April 2025 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 2 April 2025 at 13:00

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	HLD	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	HLD	Verbal	Noting
Individual Placement & Support **Shanif Ansi, Vocational Manager & James Sawtell, Associate Director of Social Care, EPUT**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 5 February 2025	HLD	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	HLD	Attached	Noting
5	Chairs Report (including Governance Update)	SS/HLD	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	National Staff Survey (2024): Benchmarked Results, Analysis & Trust-wide Priorities	AM	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Learning from Deaths Q3 2024/25 Report	AS	Attached	Noting
9	**REGULATION AND COMPLIANCE**			
9.1	Essex Partnership University NHS Foundation Trust Constitution	DG	Attached	Approval

10	**OTHER**			
10.1	Correspondence circulated to Board members since the last meeting.	HLD	Verbal	Noting
10.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
10.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
10.4	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
11	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
13	**DATE AND TIME OF NEXT MEETING** Wednesday 4 June 2025 at 10.00, The Lodge Training room 1			
14	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 6 August 2025 at 10:00, The Lodge Training room 1 Wednesday 1 October 2025 at 10:00, The Lodge Training room 1 Wednesday 3 December 2025 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item | HLD | 1

2. DECLARATIONS OF INTEREST

Standing item | HLD | 1

PRESENTATION - INDIVIDUAL PLACEMENT & SUPPORT SHANIF ANSI, VOCATIONAL MANAGER & JAMES SAWTELL, ASSOCIATE DIRECTOR OF SOCIAL CARE, EPUT

Information Item | JS/SA | 10

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 5 FEBRUARY 2025

Decision Item HLD 2

REFERENCES

Only PDFs are attached

Board Part 1 Minutes 05.02.2025.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 05 February 2025
Training Room 1, The Lodge, Lodge Approach, Runwell, SS11 7XX

MEMBERS PRESENT:

Professor Sheila Salmon	SS	Chair
Paul Scott	PS	Chief Executive Officer
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Denver Greenhalgh	DG	Senior Director of Corporate Governance
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director (joining virtually)
Dr Milind Karale	MK	Executive Medical Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Non-Executive Director
Elena Lokteva	EL	Non-Executive Director
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Zephan Trent	ZT	Executive Director of Digital, Strategy and Transformation

IN ATTENDANCE:

Angela Laverick	AL	EA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
James Lakey	JL	Principal Psychologist
Mamade Auckburally	MA	Interim Associate Director

There were six member of the Public / Staff Members present.

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

The meeting commenced at 10am.

001/25 APOLOGIES FOR ABSENCE
Jenny Raine, Associate Non-Executive Director
Nigel Leonard, Executive Director of Major Projects and Programmes

002/25 DECLARATIONS OF INTEREST
There were no declarations of interest.

003/25 PRESENTATION – COMPLEX HOUSING INTERVENTION PROGRAMME (CHIP)
AG introduced JL and MA to deliver a presentation regarding the Complex Housing Intervention Programme (CHIP) which an excellent example of integrated working.

The presentation provided the following key points:

- The programme was established to look at a different approach to caring for residents, listening to their needs and adjusting what is provided.
- The programme was developed following an approach for the local authorities regarding a cohort of individuals where there were challenges placing due to complex needs and behaviours. This had the dual impact of individuals not getting what they needed and a cost pressure on the system.
- The programme was established in September 2023, through joint funding with EPUT, Forward Housing, Mid and South Essex NHS Foundation Trust (MSEFT) and Thurrock Council. The programme was not established to work in isolation, but to work in partnership and enhance services already in place. The programme received further funding in September 2024 to extend it for another two years.
- The aim of the programme was to prevent homelessness by offering intensive support to residents in council housing at risk of eviction due to mental health concerns.
- Details were provided of the current caseload, noting the purpose of the programme to work intensively with a closely managed caseload.
- Work was undertaken to establish outcome reporting, to determine the impact the programme was having. The presentation showed a significant drop in costs for individuals receiving support from the programme. This demonstrated that complex individuals required the involvement of multiple services, with the programme helping the individuals to have a better experience and create savings for the system.
- The presentation provided a number of case studies demonstrating the success of the programme.

Questions & Discussions

- MK commented that the cohort of patients supported by the programme would have previously been under assertive outreach. MK queried whether working as part of a wider assertive outreach service, support may be provided for a wider cohort of individuals. JL advised there was a difference with assertive outreach as it has a different approach and is co-located with council housing teams, which provides greater integration.
- EL queried a chart in the presentation demonstrating referrals that have been accepted and not accepted. EL asked what happened to the referrals that were not accepted. JL advised these individuals would be referred to a different more appropriate pathway. The programme works on a focussed caseload.
- AS commented on the positive integrated working and the programme being an example of a different way of working that could be replicated elsewhere.
- LL commented that the programme was a good example of patient centred integrated care. The challenge was to understand how these types of programmes can be scaled-up and funded sustainably. The Board discussed this challenge and suggested actions such as working with the Strategic Implementation Group around how to promote the service and maximise collaborative working by demonstrating the programme as an excellent example of out of hospital care.
- RJ queried if there was any indication of the impact on individuals over the longer term or if it was too early for this to be realised. MA advised the individuals supported by the programme had not always engaged, so any period of sustained contact was a positive. The important part of the programme was to have investment from other services to help individuals move on from the programme.

SS thanked MA and JL for the presentation and noted the service is a key part of the Trust values in supporting individuals impacted by health inequalities.

MA left the meeting at this point.

004/25 MINUTES OF THE PREVIOUS MEETING HELD ON 04 DECEMBER 2025

The Board of Directors reviewed the minutes of the meeting held on the 04 December 2025 and agreed these as an accurate record.

005/25 ACTION LOG AND MATTERS ARISING

There were no outstanding actions.

006/25 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

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

- The progress made around lived experience and the patient involvement strategy.
- The increase in I Want Great Care responses and the positive outcome of the reviews.
- Congratulations to staff who had received awards.
- An NHS roundtable discussion about the role of the chair in NHS boards, reflecting on the challenges across the NHS and public sector on securing board leadership.

SS reflected on her time as Chair as her term of office nears its conclusion. This included areas that have developed over the period, including co-production and community focus.

The Board received and noted the report.

007/25 CEO REPORT

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

- A visit from an MP who is a member of the House of Commons Health Select Committee to Thurrock where the range of services provided by EPUT were demonstrated. The services were able to share integrated working, patient voice and the ambition for the future.
- The introduction of new roles and approaches in practice through the Time to Care programme, with a good level of scrutiny and support to ensure the benefits were realised from the programme.

The Board received and noted the report.

008/25 QUALITY AND PERFORMANCE SCORECARD

PS presented the report, in conjunction with a summary provided in the CEO report and invited Executive Directors to provide any updates within their remits. PS highlighted the operational pressures within EPUT and the wider NHS driven by the flow of patients and financial pressures. PS therefore proposed the Board discussion focused on these operational pressures and the work underway to manage the pressures and improve the position.

Operations (AG)

- Operational pressures continued with a higher proportion of adults admitted under the Mental Health Act. This impacted out of areas placements, length of stay and the temporary staffing position. This was reflected in the Board Assurance Framework (BAF) Strategic Risk 4.

- The focus has been on ensuring safety is maintained and patients experience a good level of care on wards. This was coupled with clarity regarding the pressure on resources and the clear accountability within leadership teams.
- There had been processes established to maintain control, including Executive Directors scrutiny of rotas at ward level. Any issues were escalated to Accountability Framework meetings, there was a focus on short focused actions being delivered and risks mitigated.
- Following Executive escalation Accountability Meetings with In-patient Mental Health and Specialised Services had increased in frequency focused on temporary staff utilisation.
- The Time to Care Programme continued to be rolled out and monitored via a steering group and Board Standing Committees.
- A consultant had been appointed to focus on flow and length of stay, which had supported the capacity for Hadleigh PICU and the repatriation of patients from out of area.
- There are governance measures in place with the ICB and Local Authorities to manage the shared out of area risk.

Questions & Discussions

- LL noted the discussions with the Local Authorities and queried if there had been any progress on the impact of delayed discharges. AG advised there had been an initial positive impact on system delays. The delays associated with the availability of supported accommodation continued to be a concern, but the presentation today has demonstrated the possibility of working closely with the local authorities and need to see if this can be rolled-out to the rest of Essex.
- RJ noted the positive oversight of staffing issues and queried the sustainability of short interventions and whether managers should be educated and supported to continue applying established principles. AM advised the short interventions were needed at this time to manage the current pressures, but there was ongoing work to be able to create a more sustainable solution, such as the appointment of new staff and the leadership development programme helping managers to engage in a positive way and have a level of accountability. AS advised there was also the opportunity to work with local leaders around the solutions and supporting ownership and accountability.
- AG advised the short interventions would continue until there is confidence in the improvements and the ongoing delivery in the reduction of temporary staffing. TS advised there is a better depth of information available and external support is being considered which will be discussed further towards the end of the financial year.

The Board of Directors received and noted the report.

009/25 COMMITTEE CHAIRS' REPORT

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

Finance and Performance Committee (DL)

- The Committee had received a paper on the benefits realisation of Time to Care, which provided a framework for identifying and tracking benefits as the programme rolled-out.

People, Equality and Culture Committee (RJ)

- There had been progress noted regarding the reshape of the People Team, which was vital in setting the framework for the future and engagement with staff.
- The quality of the papers and data had allowed robust scrutiny to take place at the meeting.

Quality Committee (MJ)

- The Committee had discussed patients with autism, which provided a good example of where the quality of data is allowing the understanding of hotspots and where focus is needed.

Questions & Discussions

- AS highlighted the development of Quality Metrics which should be available by the end of the financial year. Following work with performance colleagues, there would be the ability to review a number of quality metrics together to allow for greater triangulation.

The Board of Directors:

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

010/25 CQC ASSURANCE REPORT

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

- The CQC had completed an unannounced inspection of adult inpatient services which concluded in January and a report was now awaited. There had also been an unannounced inspection of Clifton Lodge completed in January and the report was awaited.
- A meeting had been held with CQC colleagues recently and it was understood the report on the inspection of Brockfield House completed in March was due to be received shortly.
- The meetings with ICB colleagues to provide external assurance on the improvement plan were now taking place on a fortnightly basis. The improvement plan was now 95% complete, with details provided of four actions outstanding and the action taken to progress these.

Questions & Discussions

- DG highlighted the trajectory chart in the report had a gap for January as the scrutiny meeting had not taken place at the time the report was written. DG advised the meeting had now taken place and the plan was on target.
- EL asked if the Board would receive feedback from the Quality Assurance Visits and if this would form part of the CQC assurance report. DG advised that the pilot had now concluded and the outcome would be taken through Quality Committee, with a thematic report included as part of the CQC assurance report going forward, when sufficient numbers had been completed to enable thematic review.

The Board of Directors:

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

011/25 CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS

DG presented a report providing details of the annual review of the Code of Conduct. The code had been reviewed and minor amendments made in references to guidance and legislation.

Questions & Discussions

- LL noted the table of contents listed Duty of Candour as "Candour of Duty". DG confirmed this would be rectified.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Approved the reviewed Code of Conduct for the Board of Directors, subject to the minor amendment above.**

012/25 GENDER AND RACE PAY GAP REPORT

AM presented the report which provided the Board of Directors with information about the Gender Pay Gap report. The report had been discussed at the People Equality and Culture Committee in December, with actions identified following the analysis of data.

Questions & Discussions

- LL queried the actions and whether this would have an impact on the pay gap identified. AM advised that NHS pay is established via a national framework, but that action could be taken such as promoting diversity and encouraging career development to provide diversity in senior roles.

The Board of Directors:

1. **Received, noted the contents of the report and approved for publication on the Trust website.**

013/25 EQUALITY AND DELIVERY SYSTEM 2024

AM presented a report which provided an overview of the Equality Delivery System (EDS). The report was discussed at the People Equality and Culture Committee in December.

The Board of Directors:

1. **Approved the report.**
2. **Approved the proposed actions in response to stakeholder feedback.**
3. **Approved the submission of the report and appendices to Mid and South Essex Integrated Care Board (MSE ICB).**

014/25 Public Sector Equality Duty (PSED)

AM presented a report which provided oversight of Trust performance relative to the workforce and the local demographics against the PSED. The report had been discussed at People Equality and Culture Committee in December and AM highlighted the following:

- The PSED was a mandated requirement with the aim of addressing disparities for those with protected characteristics.
- The report highlighted areas of focus, such as EPUT EDI networks and work to reduce bias and support diversity in recruitment.

The Board of Directors:

1. **Approved the publication of our PSED Report for 2023 – 2024 following standing committee approval.**

015/25 BOARD ASSURANCE FRAMEWORK

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

- There had been a number of changes in risk scores included in the report, and the number of proposed de-escalations discussed at the Board in December had taken place. DG advised that whilst de-escalated from the Corporate Risk Register these were continually monitored through relevant directorate risk registers.
- Details were provided of a number of changes to risk scores, which the Board were asked to note.

Questions & Discussions

- RJ noted the positive progress made around staff retention, given the data from the national pipeline showing a decline, which meant retention would become increasingly important.
- LL commented positively on the report, noting the progress made to improve the structure, transparency, mitigations and timeframe, which had the effect of improving the understanding of the Trust risk profile.
- PS noted the positive effort for the BAF to lead conversations in view of risk, creating a common language and succinct way of presenting information. It also helped support conversations about future risks, by providing clarity around risks that are current.
- EL commented positively on the document as a live tool for assurance, and asked whether there was any development in ensuring there is the right level of oversight at Standing Committee level for risks within its remit. DG advised this was part of the development of the Risk Management Framework, which would set unified processes across the Trust and would also form part of training and development for standing committees over the next year.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the reduction in risk scores for:**
   - **SR10 Workforce Sustainability**
   - **SR11 Staff Retention**
3. **Noted the closure of SR1 Safety and the formal de-escalation of the following:**
   - **CRR77 Medical Devices**
   - **CRR81 Ligature (Fixed) and note the risk of self-harm addition to CR11.**
   - **CRR93 Continuous Learning**
   - **CRR94 Engagement and Supportive Observation**

016/25 END OF LIFE ANNUAL REPORT

AS presented a report providing the Board of Directors with an overview of work undertaken by services providing care to those at end of life and during the last days of life during 2023/2024. AS highlighted the following:

- The annual report linked with the Board Assurance Framework around experience of care.
- The service had recruited two lived experience ambassadors and there were a number of End of Life champions across EPUT services.

- Details were provided of the work of the service and the changes made during the year.

Questions & Discussions

- AG noted the link with partnership working, with the service working consistently across the Trust and working flexibly with partners at place level.

The Board of Directors:

1. **Noted the content of the report.**
2. **Approved the End of Life Annual Report**

017/25 LEARNING FROM DEATHS Q2 REPORT

AS presented a report providing details of the Learning from Deaths Quarterly Overview of Learning for Quarter 2 2024/25, which included information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths Arrangements, Mortality data relating to Q2 2024/25 and an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result.

Questions and Discussions

- RJ noted the rich source of data and the importance of being able to identify learning and determine if there has been effective change as a result. AS advised there was support from Anglia Ruskin University to help provide greater analysis.

The Board of Directors:

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

018/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

019/25 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.

020/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

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

- The agenda had demonstrated a focus on equalities throughout and this had been enhanced by the presentation at the beginning of the meeting.
- The Chair's report had highlighted lived experience ambassadors and the work undertaken to put service users at the heart of what the Trust does.
- There were a number of equality reports presented, which recognised positive improvement, whilst also acknowledging there was more to be done.

021/25 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIREMENT)

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

022/25 ANY OTHER BUSINESS

There was no other business.

PS noted this would be the last Board meeting with SS as Chair. PS reflected on SS's term of office, including support to bring two organisations together and helping support the Board through a period of scrutiny. SS had helped shape a high performing Board and would leave the organisation in a good position. SS is well respected across the system and has left a legacy through input into wider education and partnership agendas.

SS thanked PS for the words and looked forward to continue working with colleagues. SS was proud to be chair of the organisation and can see the organisation going from strength-to-strength in the future.

023/25 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.

024/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 02 April 2025.

The meeting closed at 11:51am

Signed: Date: 2025

Professor Sheila Salmon, Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 023/25)

Governor / Member of the Public	Query	Response
John Jones, Lead Governor (submitted ahead of the meeting)	Average Length of Stay clearly affects a number of metrics including out of area placements. When I've asked about this figure before and why (currently at 69) it is twice the national target of 35 days I have been told that it is because of increased acuity of service users. This has been going on for a long time and, assuming that there is nothing unusual about our area, then the national target needs possible revision. What action is being taken to get this revised?	The Trust reports against the NHS Benchmark for treatment wards and assessment units. The two assessment units had experienced difficulty in operating as pure assessment units due to bottlenecks and pressures. When these units are removed from the data, the length of stay decreases, although remains outside the national target. The Trust is not an outlier in this regard and the detail provided during the meeting with operational pressures reflects the challenges and the action being taken. The above reflects the comment made regarding the potential revision of the target, given EPUT is not a significant outlier. Any potential changes to the national target will emerge as planning guidance becomes apparent for the next year. There is a possibility the target may move towards an improvement trajectory instead. It was agreed that JJ would meet with AG / AS outside of the meeting to discuss this further.

4. ACTION LOG AND MATTERS ARISING

Standing item | HLD | 2

No actions

REFERENCES

Only PDFs are attached

Action Log 02.04.2025.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 5 February 2025

Lead	Initials	Lead	Initials	Lead	Initials
Denver Greenhalgh	DG				

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
011/25 February	Amend “Candour of Duty” in the table of contents for the Code of Conduct for Board Members to “Duty of Candour”	DG	April 2025	Document amended.	Closed	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | SS/HLD | 5

REFERENCES

Only PDFs are attached

Chair's Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

Report Title:	**Chair's Report (including Governance Update)**					
Executive/ Non-Executive Lead / Committee Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Professor Sheila Salmon, Chair					
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		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
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		
Are you requesting approval of financial / other resources within the paper?	~~Yes/~~No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Chair Report (including Governance Update)

Executive/ Non-Executive Lead / Committee Lead:
Professor Sheila Salmon **Chair**

CHAIR 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 Reflections from Sheila Salmon

As my term of office comes to an end, I would like to take the opportunity to reflect on the past seven years which have seen significant challenge and change.

Since joining EPUT as a newly established organisation following the merger of the former NEP and SEPT with a new Board of Directors appointed, we have seen changes within the Board of Directors; public scrutiny in light of HSE prosecution, Independent and Statutory Inquiries; and a global pandemic. In this challenging context, EPUT has grown from strength to strength providing many community health, mental health and learning disability services to support more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk.

The creation of a new leadership team under Paul Scott, has led to the Trust focussing on a number of areas to embed lessons and continuously improve care; central to this is collaboration with partners, patients, careers and families. While we have made progress of over the last few years, there is more to do and we look forward with our transformation centred on radical transformation of our inpatient wards (via Time To Care), the creation of a unified Electronic Patient Record across acute, community and mental health and the continued focus on working with patients, families and carers.

I sincerely congratulate my successor, Hattie Llewelyn-Davies, on her appointment and wish her well for the coming months and years, where I am sure EPUT will continue to develop and further improve under her leadership.

It has been a privilege to Chair EPUT, I am immensely proud of our dedicated staff and volunteers, and I would like to thank Paul Scott, the wider Board and of course our Council of Governors for their continued focus on safety and quality, placing the service user, carers and family voice at the heart of our services, both in design and delivery.

2.2 EPUT Shortlisted for two HSJ Digital Awards

The Trust has been shortlisted for two HSJ Digital Awards which recognise innovation in the transformation of healthcare delivery. Congratulations to our West Essex Hospital at Home Service, which has been shortlisted in the category of Improving Out of Hospital Care and to our Primary Care Mental Health Practitioner service in Basildon and Brentwood who are down to the final few in the category of Reducing Health Inequalities.

The Hospital at Home service provides urgent care for people who can be safely treated at home, helping them avoid unnecessary admission to hospital. Patients are monitored every day through a combination of home visits and phone calls and remote monitoring equipment that tracks blood pressure, pulse, temperature, and blood glucose and sends readings straight back to the team to assess.

Our Primary Care Mental Health Practitioner Service has significantly reduced waiting times for patients through the introduction of a single patient care IT system. Since April last year, the service has provided more than 17,000 primary care mental health appointments, with many patients seen by a mental health nurse within 24 hours of contacting their GP surgery. Best of luck to both teams for the awards ceremony in June.

2.3 Covid-19 Vaccination Programme Ends at EPUT

As of April, EPUT will no longer be providing the COVID-19 vaccination programme across Essex and will now be delivered by Hertfordshire Community Trust (HCT) who provide various immunisation

services across a large part of the eastern region. Since the national COVID-19 programme launched in December 2020, we have administered more than 1.6 million COVID-19 vaccinations to help protect the local community and frontline staff caring for patients. This is a significant achievement and on behalf of the Board of Directors, I would like to extend thanks to all of our staff and volunteers who contributed to this tremendous achievement.

3.0 Legal and Policy Update

3.1 The Trade Union and Labour Relations (Consolidation) Act 1992 (Amendment of Schedule A2) Order 2024 is due to come into force on 20 January 2025 (first attachment). This Order given Employment Tribunals the power to increase or reduce any protective award by up to 25% for unreasonable failure follow the statutory code of practice on dismissal and re-engagement in collective consultation cases (second attachment) **For Information:** The Trade Union and Labour Relations (Consolidation) Act 1992 (Amendment of Schedule A2) Order 2024 Dismissal and re-engagement: code of practice - GOV.UK

3.2 Procurement Act 2023
Please see the link below for a copy of the changes to the legislation that comes into force on 23 February 2025. **For Information: Procurement Act 2023**

3.3 National State of Patient Safety 2024
Please see the link below for a copy of the report published on 22 January 2025 that calls for a renewed and more focused set of key patient safety priorities. **For Information: National State of Patient Safety 2024**

3.4 Medicines and Healthcare Products Regulatory Agency Pilot New Regulatory Approach for Artificial Intelligence ("AI") Technologies
Please see the link below for a copy of the report published on 17 January 2025. The Medicines and Healthcare products Regulatory Agency (MHRA) continue work on transforming the regulatory approach for innovative AI technologies. The AI Airlock pilot scheme is helping test and improve the rules for AI medical devices to streamline their route to market. **For Information: MHRA trials five innovative AI technologies as part of pilot scheme to change regulatory approach - GOV.UK**

3.5 Urgent Action Needed to Address Rise in Hospital Admissions for Young People with Mental Illness, says RCPsych
Please see the link below for a copy of the study dated 23 January 2025 that helps us understand the scale of the challenges affecting children and young people, as well as the factors driving these issues. For Information Urgent action needed to address rise in hospital admissions for young people with mental illness, says RCPsych

3.6 Annual Assessment of Integrate Care Boards 2023/2024
Please see below for a copy of the report published on 16 January 2025. Under the terms of the NHS Act 2006, amended by the Health and Care Act 2022, NHS England is required to assess the performance of each integrated care board (ICB) and publish a summary of the outcomes of its assessments. This report does so for 2023/24, the first full year of ICBs being in operation. **For Information: NHS England » Annual assessment of integrated care boards 2023/24**

3.7 Mental Health Services: The NHS Trust Perspective
Please see the link below for a copy of the briefing. This briefing provides an outline of mental health services in the NHS, the current levels of demand that NHS trusts are facing, and what trusts need in order to deliver a more proactive and coordinated community based model of mental health care. **For Information: mh-parliamentary-explainer_january25_final.pdf**

3.8 Care Beyond Beds: Exploring Alternatives to Hospital Based Mental Health Care
Please see the link below for a copy of the report that suggests an overhaul of mental health care is needed to achieve the government's goal of shifting treatment from hospitals to communities. It finds that inpatient care is too often characterised by unsafe levels of bed occupancy, chronic staffing shortages and dilapidated facilities that risk re-traumatising patients. Black people, neurodivergent

people and children are among the most poorly served. It concludes that the NHS 10-year plan must boost investment across the mental health system to drive a 'safe and sustained shift' towards community care, and to provide inpatient care that is high quality, close to home and adequately staffed. **For Information: CentreforMH_CareBeyondBeds.pdf**

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 5

REFERENCES

Only PDFs are attached

CEO Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

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

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
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		
Are you requesting approval of financial / other resources within the paper?	~~Yes/~~No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Chief Executive Officer (CEO) Report

Executive/ Non-Executive Lead / Committee Lead:
   **Paul Scott**   **Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Welcome Trust Chair Hattie Llewelyn-Davies

I am pleased to welcome Hattie Llewelyn-Davies to EPUT, and I eagerly anticipate collaborating with her as we advance the transformation of mental and community health services for the residents of Essex and beyond. I would like to extend my heartfelt gratitude to Professor Sheila Salmon for her exceptional leadership during her seven-year tenure as Chair at EPUT. Sheila has been a fervent advocate for the local community, tirelessly championing the need for enhancements in patient care across EPUT's diverse range of services.

While we have made significant strides over the past few years, our work is far from complete. We remain committed to our ambitious agenda, which includes a comprehensive transformation of our inpatient wards through the Time to Care initiative, the development of a unified Electronic Patient Record system encompassing acute, community, and mental health, and an unwavering dedication to collaborating with patients, families, and carers.

Together, we will continue to build on our achievements and strive for excellence in the care we provide.

1.2 Clifton Lodge Improved CQC Rating

I am delighted and immensely proud of the recent improved CQC rating for Clifton Lodge, from 'Requires Improvement' to 'Good'. The upgraded CQC rating for Clifton Lodge is a testament to the unwavering dedication and excellence demonstrated by our staff and underscores our commitment to providing high-quality care and maintaining a positive environment where residents can thrive. We will continue to build on this success and strive for further improvements in the future.

1.3 Lampard Inquiry – List of Issues Update

The Lampard Inquiry first published a draft List of Issues, which provides a more detailed approach to investigating issues raised in the Lampard Inquiry Terms of Reference, in July 2024. The Inquiry have recently updated the List, taking into account the Opening Statements by Core Participants and issues that have arisen as a result of the Inquiry's investigation. The List is a working document and may evolve while the Inquiry receives evidence and undertakes its investigation with issues added, removed or amended as appropriate. Baroness Lampard, the Chair of the Inquiry, will decide the extent to which the issues should be investigated to meet the Inquiry's Terms of Reference. The Inquiry recognises that during the 24 years being considered, standards, practices, policies, procedures, as well as the legislative and regulatory framework under which mental health care and treatment was provided has changed and that there may be issues which, due to the passage of time and / or lack of available evidence cannot be addressed fully or in part. More information is available on the Lampard Inquiry website.

1.4 Increase in Clinical Staff

As part of our Time to Care programme, which focuses on our inpatient sites with a novel approach to staffing and updates to our operating model, we have implemented a comprehensive plan to increase staffing levels for critical clinical roles. This plan also includes initiatives such as the enhanced recruitment of additional Health Care Assistants, among other efforts. While there is still work to be done in the coming months, it is an opportune moment to reflect on our progress and plan the next steps.

Between April 2024 and February 2025, the Trust successfully appointed staff to the following positions:

- 201 Qualified Nurses
- 65 Allied Health Professionals
- 14 Substantive and 5 NHS Locum Consultant Psychiatrists
- 169 Health Care Assistants

This staffing increase allows us to reduce reliance on agency staff and minimize our use of bank staff. This shift provides greater consistency and quality of care for our patients, as well as improved financial stability, which in turn supports greater investment in the quality of care and future services.

We have collaborated closely with Care Unit management teams and clinical leaders to establish safe staffing levels for each ward and unit. This process enables us to review staffing levels to ensure the delivery of high-quality, safe care for our patients while operating efficiently. These efforts will help us continue to drive improvements in care and services across the Trust.

1.5 New Combined Electronic Patient Record

I am delighted to be able to announce that Oracle Health have been awarded the contract to deliver the new unified Electronic Patient Record (EPR) system across the hospitals, mental health and community services delivered by Mid and South Essex NHS Foundation Trust (MSEFT) and EPUT. Oracle Health are one of the leading healthcare IT systems in the world, and this new system will be a 'first of type' covering services provided by both MSEFT and EPUT in the Mid and South Essex Integrated Care System, along with EPUT services in the Hertfordshire and West Essex and Suffolk and North East Essex systems. This will completely change the way our clinicians view and record our patients' health and care information, giving them access to each patient's information in one place. The new system will improve patient safety and experience and will support better coordination and collaboration between teams across the services it covers. It will also reduce the amount of time our clinicians spend on processes and administration, enabling to spend more time with patients.

We expect the new EPR to launch in 2026/27 and are working closely with colleagues in MSEFT, EPUT, primary and social care, and also involving our Lived Experience Ambassadors, people with direct experience of using our services, and their families to ensure that the design of the new system takes our patients' needs into account.

2. UPDATES

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

Crisis call reached the highest average of call volumes per day in 2025 continuing the trend of increased demand. This represents the highest average call volumes per day in 2025 thus far and continues the trend of increased demand since October. There was a reduction in calls answered within 60 seconds. Oversight and close monitoring of calls in place.

Inpatient MH services reported OPEL 4 for a sustained period during the month. Admissions under the Mental Health Act continued to be higher than the threshold. Average length of stay for adult mental health was outside of the national benchmark of 35 days, reducing to 53 days when including the assessment units. Patients with a delayed transfer of care on Adult mental health wards remained outside the 5% target at 5.2%, although a significant improvement from the 10% reported in late 2024. The number of patients placed in inappropriate out of area beds reduced.

A number of controls and actions are in place to support improved flow including the appointment of a consultant lead role. In addition to enhanced internal scrutiny, system delays are overseen by the Southend Essex and Thurrock Strategy Implementation Group. The Time to Care Operating Model implementation continues to progress, supporting purposeful admission and a great focus on proactive and timely discharge planning. Plans are in place to implement a more localised approach to flow.

Cardio metabolic for SMI patients in EIP services continues to report above target at 96%, with inpatient areas and community teams are both improving month on month towards target.

There was a reduction in virtual ward occupancy in South East Essex. Occupancy for West Essex was unchanged. Care unit leads continue to work with system colleagues to improve utilisation.

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

- Income and Expenditure M11 £10.4m deficit to plan with an agreed forecast outturn deficit of £12m (excluding Inquiry restatement and central support funds). Significant improvement in temporary staff utilisation in month11, including bank expenditure reduction £0.7m. Key financial challenge continues to be high level of in-patient demand and acuity for Mental Health services including out of area placements.

- Capital expenditure totals £10.8m year to date with cash balances totalling £28.5m.

- Final 25/26 operating plan and budget approved by Finance and Performance Committee with delegated authority of the Board.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

EPUT Quality Dialogue 2025-2026: Shaping Our Future Together
In February, we came together to shape the future quality priorities across EPUT. Colleagues, partners and people with lived experience of our services met to review our progress and discuss the next steps in enhancing the quality of care we provide, continuing to improve experiences, effectiveness and safety of care across our services. The ideas and feedback shared at the event has guided us into the year ahead. This has shown that through collaboration and clear focus, we can make our care safer and more effective, and are looking forward to taking the next steps and the ongoing journey to provide the best possible care for our patients and families.

Quality measurement
We want to empower teams to utilise quality metrics and information to gain insight and support clinical decision making, to recognise the impact of the care we provide and proactively make changes if early indicators show there is a need to. We also want quality data to provide us with assurance that we are achieving quality improvement trajectories and if necessary, where focus is needed to learn, change and improve. We have been developing a Quality dashboard for the Trust to enable this to be achieved. The Performance team, with key stakeholders from the delivery programme for Quality of Care, have focused on key priority metrics for the first iteration of the dashboard to be available in April 2025. The Director of Nursing, and SRO for Effectiveness of Care Group, has been working closely with the NHSE team who are developing quality early warning indicators, and is part of accelerator workshops for mental health metrics in March to support our local development.

SOPHIA
EPUT have been working with Cardale Futures SOPHIA platform which allows standard operating procedures to be developed in a way that is interactive, intuitive, and easily accessible and useable for staff. The platform went live in October 2024 and to date, we have a total of 33 published standard operating procedures, with a further 56 in draft. Staff are really engaging with the platform with 5,309 confirmed users accessing to date. All policies and clinical guidelines have now been uploaded onto the platform.

Allied Health Professional (AHP) Retention Initiative
Since the launch Initiative pilot in November 2024, People Promise Team have explored and identified 3 areas of improvement needed to retain AHPs at EPUT based on data collated and from ESR; Retention (Rescue) meetings, career development focus and recognising AHP contribution. Progress has so far been positive with an increased number of rescue calls taking place and action taken following feedback provided by staff. Plans are being drawn up to respond to January's career development feedback, and providing development opportunities, leadership, coaching/mentoring support.

2.4 People and Culture – Andrew McMenemy, Executive Chief People Officer

<u>Workforce Performance</u>

Substantive Staffing – Recruitment initiatives continue with a focus on qualified nursing, Allied Health professionals and HCA roles and workforce growth. The plan for substantive staff as at

February was to have 6344.78 wte staff in post. The actual staff in post for February was 6308.76 wte, therefore being under target by 36 wte. Since December workforce has grown by 87 WTE.

Temporary Staffing – The Trust has seen significant reduction of temporary staffing use in February reporting a 280 WTE reduction compared when compared to January figures. The use of agency staff has continued to decline with approximately 26 wte reduction between January and February. The plan for agency staff use at December was 101.43 wte with actual use at 116.89 wte.

The use of bank staff continues to be consistently high but a significant reduction of 240 WTE reported between January and February. This represents a 21% decrease. The plan for bank use in February 2024 was 704.77 WTE with actual use at 953.38.

25/26 temporary staffing targets have now been set. These targets align to the 10% cost saving for agency and 30% cost saving for bank as set out in the NHS operational planning guidance. Adherence to these operating levels should deliver approx. £17m saving on bank and agency spend.

February position against the 25/26 target EPUT is operating 6% above planned target

Absence Management – The absence rate at the Trust as expected did increase in January from 5.8% to 6.14%, however February is reporting an improved position of 5.52% which is likely one of the contributing factors on the demand for temporary staff.

Staff Turnover – Further improvements have been seen in the Trust turnover rate which as at February is showing a further decrease to 7.3%. The Trust is now reporting one of the lowest turnover rates across NHS Trusts in the East of England region.

Staff Appraisals – The appraisal rate has remained static at 83% for January 2025. Discussions are being held at Care Group Accountability Framework Meetings to ensure appraisals are being completed and recorded appropriately.

Mandatory Training Compliance – There are further small improvements in the mandatory compliance rate now reporting at 87%.

Organisational Development & Culture

People Promise Exemplar Programme
The People Promise Exemplar Programme is in its seventh month of delivery, which aims to retain our very best staff. The programme has focussed on Allied Health Professionals, Health Care Assistants and creating greater flexibility in how colleagues work across the Trust. EPUT is now recording the lowest turnover rates (7.3%) and the next phase of work will build on the learning from the programme to ensure it is sustainable and relevant for the organisation.

Staff Survey
On 13th March, the National Staff Survey benchmarked results were received. We had made a strong start in the early part of the year with care unit and corporate business unit engagement and action planning and these benchmarked results will now allow us to analyse and take further action on the qualitative data and gain insights across our benchmarked group. Furthermore, the National Quarterly Pulse Survey (NQPS) opens to staff in April, which will provide further insights and build upon our work on the National Staff Survey in how we best support our workforce.

Education Overview

Placement assurance and capacity: Placement capacity is stretched, and this risks the quality of the student experience. The Practice Education Governance Committee on April 1st should allow us to explore why we are getting such short notice of additional students needing placements from ARU. Short notice on Placement requirements doesn't help with planning or management of the learner experience – which then leads to escalations and reports of poor experience within our placements. On a positive note: Brockfield House - reactivation is now back on schedule with 3rd year ARU students in April and Essex students in June.

NHSE Practice Placement Provider: Self-Assessment 2024: We have a meetings with colleagues scheduled for 08 May and a Pre-meeting on 25 April to ensure that EPUT is appropriately represented by key leads that reflect Multi – disciplinary perspectives.

Apprenticeships: We currently have 57 apprentices undertaking their courses at EPUT – supported by 13 wte staff members across the training team and Psychology care unit. What is also notable is that not only are the numbers small – but the completion / withdrawal rates are also variable (withdrawal rates ranging from 6% - 33%) – this means we are doing an awful lot of work (teaching, assessing and administration, sustaining regulatory requirements) for very small numbers.

Preparation for Ofsted: Ofsted could visit EPUT to inspect our education provision at any point from April. Current preparation needs accelerating to ensure we have a clear readiness plan, governance structure which demonstrates direct executive oversight and contingency for staff sickness / absence.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS 15

REFERENCES

Only PDFs are attached

Quality Performance Scorecard 02.04.2025 (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

Report Title:	**Quality & Performance Scorecard**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Janette Leonard, Director of ITT					
Report discussed previously at:	Finance and Performance Committee Clinical Governance & Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Full Report

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

Summary of Key Points

Mental Health Inpatient Capacity:
Adult occupancy continues to report high against the benchmark (98% in February). Investigation into the 100%+ occupancy reported erroneously in Dec-Jan identified an issue with discharges being recorded incorrectly and forms part of a data quality improvement plan.

Psychiatric Intensive Care Unit (PICU) occupancy reports are at 69% (against <88% target). There is an increasing trend over the past 12 months, with the past 6 months stabilising between 68-73%.

Specialist occupancy reports are in line with the historical average at 75% in February. The performance shows little variation month to month against the 95% target, in part due to the actual number of beds available being fewer than reported. Refurbishment works on Woodlea have now been completed.

For Adult inpatients, the average length of stay in February remains outside the national benchmark of 35 days, reducing from 76 days to 53 days when including the Assessment Units. There were 81 patients discharged (this was 20 more than in January); 35 of these had stays over 60 days, 3 were between 200-300 days and 2 others that were between 1-2 years.

In February, Older Adult inpatients length of stay on discharge was on average 142 days against the target threshold of 74 days. There were 34 discharges of which 25 were long stays.

As of end of Feb, Average Length of Stay (ALOS) of current inpatients on Older Adult wards is reporting at 115 days. This is the shortest ALOS in the last 12 months.

PICU average length of stay has spiked in February reporting outside of the 50 day target at 159 days. There were 8 patients discharged, with 4 being long stays (2 of which were between 400-600 days).

Inappropriate Out of Area Placements (OOAP):
There has been a reduction in the number of placements in February (16 Adult and 5 PICU). Following the repatriation of 18 patients (14 Adult and 4 PICU), there were 60 patients remaining (53 Adult and 7 PICU) OOAP at the end of the month.

All out of area cases are reviewed and the majority now have estimated discharge dates and repatriation plans. Director level sign off is in place prior to any out of area placement decision.

OPEL Status:
There were 23 days at OPEL 4 status in February. OPEL 4 was declared on 2nd February due to demand on Adult wards. This was stepped down to OPEL 3 on 4 occasions (8th, 12th, 27th and 28th Feb).

Virtual Ward Occupancy:
Overall occupancy for February has reduced to 54%, (against a target of 80%). Mid and South Essex decreased in February to 74% (from 95% in January).

Whilst West Essex reports at 50% (on par with January, down from the 60% in December). An improvement plan is being worked up with Care Unit leads.

NHS Talking Therapies:
Access Rates in February are below target for each of the 3 teams. For the Castle Point and Rochford (CPR) and the Southend teams, this is due to the target having a historical increment in Q4. On a year to

date view, the access is above target for both teams (CPR +4% and Southend +7%). North East Essex reports at 80% of its target, which has been the average reported across the year to date for them.

Crisis Call Response Times:
4308 calls were received in February, averaging 154 per day. This represents the highest average call volume per day in 2025 thus far and continues the trend of increased demand since October.

As a result of the increased call volumes, a reduction in the number of calls answered within 60 seconds has been observed, reporting 79% in February against the target of 95%.

Following a review of the call metrics between November and January, a small variation in the pattern of calls was identified. Calls between 9pm–9am have increased whereas, calls between 3pm–9pm have decreased. The difference however is not significant enough to trigger service changes.

Call volumes and handover between contact centre and crisis agents are being closely monitored with service manages from both teams collaborating to support service efficiency.

Temporary Staffing:
February reports the fewest ever number of booked Agency shifts (1619). All Care Units are reporting reductions on previous months. Mid and South Essex and West Essex account for half the booked shifts.

The booking of Bank shifts continued its marked reduction over the last several months, with a further notable drop in February, reporting a lowest number booked since reporting commenced in April 2022. The reduction in February was largely driven by the Inpatient and Urgent Care unit, which saw a 22% reduction on its own position from January.

Time To Care continues to focus on reducing temporary staffing, with Agency request requiring senior authorisation.

There are 245 roles in the recruitment pipeline with near two thirds of these at either the offer or starting stage.

Training:
Mandatory Training compliance has reported above the 85% target for the past 3 months now with February at 87%. The Essential courses are also reporting on target at 85% in February.

For the mandatory training courses with a 90% target, February reports 84%, however 4 Care Units are at target (improvement on 2 in January), 3 others are marginally short (Medical and Corporate being the outliers).

1 to 1 Support:
Staff Supervision compliance reports at 75% for February against 90% target. In previous months, assurance was given in Accountability Framework meetings that this performance is not reflective of support activity with Staff but of the administrative activity associated with recording it and that Staff were very much receiving 1-1 support. In February, this was raised by ward staff from Inpatient and Urgent Care teams that the performance is now reflecting the inability to provide meaningful support to staff.

Appraisals:
February performance reports at 82% against 90% target. This is among the highest reported compliance over the last 2 years. Doctors appraisal rate is 97%.

Trust Financial Position

Income & Expenditure:
Month 11 £10.4m deficit to plan with an agreed forecast outturn deficit of £12m (excluding Inquiry restatement and central support funds). Significant improvement in temporary staff utilisation in month 11, including bank expenditure reduction £0.7m. Key financial challenge continues to be high level of in-patient demand and acuity for Mental Health services including out of area placements.

Temporary staffing:
Temporary Staffing spend reduced by £0.7m with bank usage reducing by 256 whole time equivalent (wte) to 953 wte. Agency improvements are being sustained.

Efficiency:
Year to Date (YTD) efficiency delivery of £21m, £5.1m behind plan. The position has improved due to improvements in temporary staffing reductions.

Capital and Cash
YTD Capital of £10.8m with a forecast of £17.1m. Cash balances £28.5m better than plan.

25/26 Plan :
Final 25/26 operating plan and budget approved by Finance and Performance Committee with delegated authority of the Board.

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

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

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

Acronyms/Terms Used in the Report			
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
		YTD	Year to Date

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

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Information Item | Chairs | 10

REFERENCES

Only PDFs are attached

Committee Chairs Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

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

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required
The Board of Directors is asked to note the report and assurance provided.

Summary of Key Points
The Board of Directors regularly delegates authority to the standing committees of the Board in line with the Trust's Governance arrangements (SoRD, SFIs etc.). Standing Committees present regular reports to the Board of Directors, providing assurance on the key items discussed and progress made to resolve any identified issues. For each Board meeting, Chairs of standing committees will provide details of meetings held and report: • Assurance – any key assurances to be provided to the Board. • Information – any issues previously identified which have now been resolved, including lessons learned. • Alert – any issues / hotspots for escalation to the Board. • Action – any issues where the Standing Committee is requesting action from the Board. The attached report provides updates in relation to the following Standing Committees: 1. Audit Committee (Elena Lokteva) 2. Finance & Performance Committee (Diane Leacock) 3. People Committee (Ruth Jackson) 4. Quality Committee (Dr Mateen Jiwani)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report.

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

NHS
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NHS Foundation Trust

Committee Chairs Report

Board of Directors Part 1

2 April 2025

EPUT

INTRODUCTION

Purpose of the report

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

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

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

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

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1. AUDIT COMMITTEE

Chair of the Committee: Elena Lokteva, Non-Executive Director

Committee meeting held: 7 March 2025

Assurance

Waiver of Standing Orders
- The Committee received a report on Waivers covering the period November 2024 to January 2025.The Executive Director of Digital & Transformation presented a report providing assurance on the use of Waivers for digital systems.

Clinical Audit Annual Report
- The Executive Medical Director presented a report providing assurance that the Trust has adequate processes in place to deliver a clinical audit plan. (*link to BAF SR13 Quality Governance*).

Internal Audit Progress
- The Committee received an update on progress against the Internal Audit Plan.
- Four audits have been finalised:
  - Temporary Staffing: Reasonable Assurance. (*link to BAF SR8 Use of Resources*).
  - Cyber Security: Reasonable Assurance. (*link to BAF SR6 Cyber Security*).
  - Mortality Review Processes: Reasonable Assurance. (*link to BAF SR13 Quality Governance*).
  - E-Rostering: Limited Assurance (The Executive Chief People Officer attended to discuss the E-Rostering audit).
- One Risk Management audit recommendation remained outstanding due to timing only, with the outstanding report for the introduction of risk management key controls being scheduled for Audit Committee in May 2025.
- The overall plan is progressing and on track for completion by 31 March '25.

External Audit Progress (*link to BAF SR8 Use of Resources*)
- The Committee received an update on external audit.
- There were nine Audit Risks and Areas of Focus, including two new items:
  - Accounting for Unified Electronic Patient Record System.
  - Provider Collaborative Income/Expenditure.

Information

Anti-Crime Progress
- E-learning compliance is progressing well.
- The National Fraud Initiative exercise has commenced.

Internal Audit Plan 2025/26
- The Committee approved the Draft Internal Audit Plan for 2025/26.

Anti-Crime Work Plan 2025/26
- The Committee approved the Anti-Crime Work Plan for 2025/26.

Draft Year End Timetable 2024/25
- The Committee received and noted the draft Year End Timetable 2024/25.

Committee Work Plan & Terms of Reference 2025/26
Committee members approved the Committee Work Plan and review its Terms of Reference in preparation for 2025/26. These will be presented to the Board as an integral component of the Committee's Annual Report in June 2025.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 20 March 2025

Assurance

Performance Report
- The Committee received assurance on the Trust's performance during February 2025.
- Areas of performance discussed included:
  - Crisis Call Response Times
  - Mental Health Inpatient Capacity (*link BAF SR4 Demand and Capacity*)
  - Rates of Patients Clinically Ready for Discharge (*link BAF SR4 Demand and Capacity*)
  - Inappropriate Out of Area Placements (*link BAF SR4 Demand and Capacity; and SR8 Use of Resources*)
  - Admissions Under Mental Health Act
  - OPEL Status
  - NHS Talking Therapies
  - Cardio Metabolic
  - Virtual Ward Occupancy.

Financial Report (*link BAF SR8 Use of Resources and SR7 Capital*)
- The Committee received an update on the Trust's Revenue, Capital and Cash position.
- Committee members noted that a number of 'moving parts', including property services, the Lampard Inquiry and large upcoming tenders, would cause challenges during 2025/26.

Board Assurance Report
- Received the BAF risks aligned with the Committee.

Information

Committee Work Plan & Terms of Reference 2025/26
Committee members approved the Committee Work Plan and reviewed its Terms of Reference in preparation for 2025/26. These will be presented to the Board as an integral component of the Committee's Annual Report in June 2025.

Action

No Actions for the Board.

Alert

Revenue and Cash
A number of 'moving parts' are expected to cause challenges to cash flow during 2025/26, including: property services disputes; the Lampard Inquiry; and upcoming large tenders.

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3. PEOPLE COMMITTEE

Chair of the Committee: Ruth Jackson, Non-Executive Director

Committee meeting held: 27 February 2025

Assurance

Temporary Staffing Levels
- Bank and Agency staffing levels are both above plan but demonstrating improvements. (link to BAF SR8 Use of Resources).
- Additional controls have been put in place, and daily monitoring will continue into the 2025/26 financial year. (link to BAF SR8 Use of Resources).

Appraisal Compliance
- Appraisal compliance is behind plan, however the position is now improving.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Time to Care Programme.
  - Workforce Performance.(link to BAF SR12 Organisational Development)
  - Practice Education Student Placements. (link to BAF SR12 Organisational Development)
  - National Staff Survey & Pulse Survey.(link to CRR92 Addressing Inequalities)
  - Equality, Diversity and Inclusion.(link to CRR92 Addressing Inequalities)
  - People Promise and Flexible Working. (link to BAF SR11 Staff Retention)
  - Freedom to Speak Up.
  - Operational Human Resources.
  - Board Assurance Framework – Workforce.

Action

People Committee
Committee members agreed to request the Board to rename to People Committee, with effect from 1 April 2025.

Alert

No Alerts for the Board.

Information

Staff/Student Story
- The Committee received the verbal account of a trainee physiotherapist currently in year three of a four-year apprenticeship programme at the Trust. (link to BAF SR12 Organisational Development)
- Committee members feel apprenticeships offer excellent opportunities to students, as well as enabling the Trust to grow its future workforce.

Directorate and Trust Reviews
- A number of reviews are currently underway, including:
  - People & Culture Directorate Stage 2 operational review. (link to BAF SR11 Staff Retention)
  - Trust cultural review. (link to Well Led)
  - Recruitment process review.
  - Leadership Development Programme review.

National Memorial Tree Planting Campaign
- As part of the National Memorial Tree Planting Campaign, a tree will be planted outside The Lodge in memory of doctors and nurses who have taken their own life.

Consultant Recruitment Deep Dive
- The Committee received a report on actions to fill 25 Consultant Psychiatrist vacancies.

Committee Work Plan & Terms of Reference 2025/26
Committee members approved the Committee Work Plan and review its Terms of Reference in preparation for 2025/26. These will be presented to the Board as an integral component of the Committee's Annual Report in June 2025.

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4. QUALITY COMMITTEE

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

Committee meeting held: 13 February & 13 March 2025

Assurance

Safety Improvement Plans (SIPs)
- Updates were received on the SIP for:
  - Discharge & Transfer Safety.
  - Ligature Risk Reduction.

Assurance Reports (*link to BAF SR13 Quality Governance)*
- The following Assurance Reports were received by the Committee:
  - Quality of Care Groups Progress Reports
  - Mental Health Act Report
  - Patient & Service User Experience Report
  - Clinical Audit & NICE Report
  - Patient Safety Incident Response Framework Report
  - Time to Care Operating Model Local Implementation Plan
  - Quality Priorities Progress Report
  - CQC Assurance Report
  - Board Assurance Framework
  - Safeguarding Work Plan & Quarterly Report
  - Infection Prevention & Control Quarterly Report
  - Clinical Audit & NICE Quarterly Report
  - Physical Health Quarterly Report
  - Research & Innovation Strategy Delivery Update

Alert

Committee members approved:
- Quality of Care Strategy content for inclusion in the Quality Account 2024/25.
- Reducing Health Inequalities Annual Plan 2025/26 (subject to Executive Team approval).
- Quality Committee Terms of Reference 2025/26.

Information

Deep Dive Into Self Harm Incidents Relating to Drugs & Alcohol
- The Committee received a deep dive into self harm incidents relating to Drugs & Alcohol.
- This report outlined improvements made since the establishment of a Multi-Agency Mortality Review Group, including: reduction in drug related mortality in Essex; strengthened partnerships; shared learning; and commissioning of new services.

Staff Story on Multi-Disciplinary Team (MDT) Systems
- A Clinical Psychologist provided their account of MDT Systems.
- Overall, they were supportive of the model.
- There is ongoing work to standardise terminology and processes used across the Trust.

Flow & Capacity Team – Reflections on Winter Pressure Actions & Mitigations (*link to BAF SR4 Demand and Capacity*)
- A member of the Flow & Capacity Team provided their reflections on Winter 2024/25, and discussed lessons learned during this period.
- Committee members agreed to reflect on the findings again prior to the winter period.

Quality Priorities 2025/26
- Committee members approved the Quality Priorities for 2025/26:
  - Patient Experience
  - Clinical Effectiveness
  - Patient Safety

Committee Work Plan & Terms of Reference 2025/26
Committee members approved the Committee Work Plan and reviewed its Terms of Reference in preparation for 2025/26. These will be presented to the Board as an integral component of the Committee's Annual Report in June 2025.

Action

- Learning from Deaths Report and endorsed for full presentation to the Board.

7.3 CQC ASSURANCE REPORT

Information Item AS 10

REFERENCES

Only PDFs are attached

CQC Assurance Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Comfort Sithole, Head of Compliance and Emergency Planning					
Report discussed previously at:	Quality Committee 13 March 2025					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report

Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Lampard Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data Strategy	✓
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	~~Yes~~/No	

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

Purpose of the Report

This report provides the Board of Directors with: 1. An update on CQC related activities that are being undertaken within the Trust.	**Approval**	
	Discussion	✓
	Information	✓

2. An update and escalations as required on progress made against the Trust CQC improvement plan. 3. Internal Assurance against the CQC Quality Statements		

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Points

- EPUT continues to be fully registered with the Care Quality Commission.
- The Trust received the draft report following the March 2024 CQC unannounced inspection of Forensic / Secure Services at Brockfield House. The report highlighted that the service retained a Good rating. Factual accuracy check was completed and submitted within timescales. The Trust is awaiting publication of the final report.
- An unannounced inspection was undertaken at Clifton Lodge Nursing Home on the 9th January 2025. The draft report was received with a re-rating of Good. Factual accuracy check was completed and the minor amendments were accepted by the CQC. The final report has been published raising the rating of the Nursing Home to Good in all domains and Good overall.
- The Trust awaits the CQC report following the unannounced focussed inspection for the Safe and Well Led domains on our Adult Acute and PICU Services in November / December 2024.
- The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made with the implementation of actions with 95% of actions reported completed by action owners and 53% having been agreed for closure through the Evidence Assurance Process.
- There were fourteen CQC enquiries raised during this reporting period.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
ICB	Integrated Care Board	EAG	Evidence Assurance Group
CAMHS	Child and Adolescent Mental Health Services		

Supporting Reports and/or Appendices
CQC Assurance Report Appendix 1 - CQC Improvement Plan Spotlight Report March 2025

Executive/ Non-Executive Lead / Committee Lead:
 **Ann Sheridan** **Executive Chief Nurse**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC ASSURANCE REPORT

1. Purpose of the report

This report provides the Board of Directors with:

- An update on CQC related activities that are being undertaken within the Trust.
- An update and escalations as required on progress made against the Trust CQC action plan.
- Internal assurance of CQC Quality Statements.

2. CQC Registration Requirements

2.1. Registration

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

2.2. Forward View

The Trust was expecting the routine CQC request for an Adult Social Care Provider Information Return (PIR) for Rawreth Court and Clifton Lodge nursing homes, with a one month period for responding. Although we await the requests work has commenced in preparation.

3. CQC Inspections and Improvement Plans

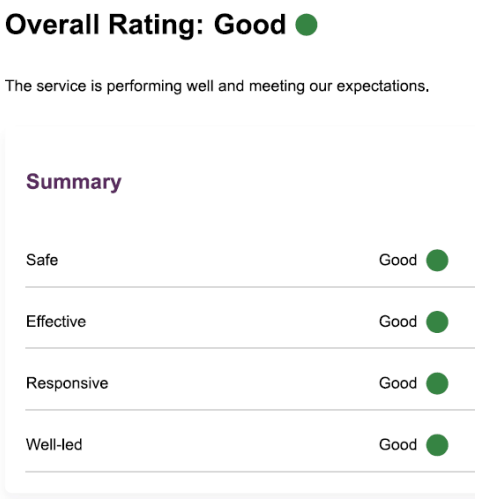
3.1. Unannounced CQC Inspection

3.1.1. Forensic Inpatient/Secure Wards – Brockfield House

The Trust received the draft report following the March 2024 unannounced inspection of our Forensic / Secure Services at Brockfield House, for factual accuracy. Receipt of the final report is awaited. (Note: outcome is embargoed until publication formally by the CQC)

3.1.2. Clifton Lodge

The CQC published its inspection report for Clifton Lodge Nursing Home in February 2025. The CQC rated the service as **GOOD**. This is an improvement from the previous inspection in 2019 where the service was rated as 'requires improvement'.



Attached is a link to the CQC website for those that would like to read the full report - Clifton Lodge HTML report for assessment AP7149 - Care Quality Commission

3.1.3. **Adult Acute and PICU services**

The Trust awaits the CQC draft report following the unannounced focused inspection of Safe and Well Led domains of our Adult Acute and PICU Services in November / December 2024.

3.2. **CQC Improvement Plan**

As at 21 March 25:

- 41 (53%) of our improvement plan has been closed following the Evidence Assurance Group (EAG) process.
- Of the other actions pending this process, 75 (96%) have been reported as completed by our care unit leaders.

There are two 2 sub-actions past their original stated timescale (associated with 2 overall actions):

1. The review with ICB colleagues of the service specification and aligned CQC registration for our nursing homes. This was an action the Trust took rather than a direct result of the CQC inspection to clarify whether the registration under social care was the correct one. Discussions continue.

2. The replacement of the current CCTV retrieval process to one that is more accessible to designated staff at each site to improve the access time. This requires a change over from an external contract to an in-house solution utilising new IT software. The software has passed our cyber security tests and is now part of business planning prioritisation.

During the reporting period, the EAG met on three occasions (28 January, 12 February and 12 March respectively), chaired by EPUT Executive Nurse with ICB representatives and approved eleven actions for closure. EPUT operational and corporate staff in attendance to present evidence in support of improvement action having been achieved and sustained through into business as usual.

A full update on action progress is provided in appendix 1.

3.3. **CQC Enquiries**

During the period the CQC raised fourteen (14) enquiries:

Received	Service	Enquiry Related to
06/01/2025	Specialist Mental Health Team Chelmsford and Essex (C and E) Centre	Clinical Practice - Medication
07/01/2025	Grays Hall (CMHT) Grays Hall, Thurrock	Clinical Practice - Medication
08/01/2025	Mental Health Liaison Team The Lakes	No bed availability
10/01/2025	Mental Health Liaison Team Basildon Mental Health Unit (MHU)	Mental Health Act Detention
13/01/2025	Kelvedon Ward Basildon Mental Health Unit (MHU)	Inadequate provision of care/services
21/01/2025	Primary Care Network Mental Health The Linden Centre	Clinical Practice - Lack of Community Support

Received	Service	Enquiry Related to
24/01/2025	Ardleigh Ward The Lakes	Patient to patient physical assault / abuse
27/01/2025	Ardleigh Ward The Lakes	Patient to patient physical assault / abuse
03/02/2025	Alpine Brockfield House, Wickford	Clinical Practice - Medication
04/02/2025	Southend Older Peoples CMHT Harland Day Centre, Westcliff	Clinical Practice - Lack of Community Support
04/02/2025	Dune Brockfield House, Wickford	Security of Patients belongings
13/02/2025	Galleywood Ward The Linden Centre	Staff concerns regarding service cutbacks and impact on patient safety
18/02/2025	Peter Bruff Ward The King's Wood Centre	Clinical Practice - Discharge / Follow Up
24/02/2025	St Aubyns Centre	Use of LTS / Seclusion

3.4. **CQC Notifications**
During the reporting period the Trust has made forty two (42) notification submissions to the CQC including:

- Death of a detained MH patient (1),
- Allegations of abuse (24),
- Serious injury to a person using the service (17).

4. Annual Programme 2024-25

4.1 In support of our quality governance and proactively deliver on our commitments to deliver safe and effective care we developed the Quality Assurance Framework. The framework consists of four quadrants:

- Quality Planning
- Quality Improvement
- Quality Control
- Quality Assurance

4.2 **Internal Assurance**
At the end of February 2025, the Trust is reporting internally ‘Good’ compliance across all the five domains following internal assurance processes. This means that a good level of assurance has been provided by core services during compliance visits. Identified good practice has been shared with services and care unit leadership via the service reports.

4.3 **Quality Assurance Visits**
In 2024, we piloted our new Quality Assurance Visit Framework, with the aim of implementing a programme of joint Quality Assurance Visits between EPUT and our ICBs. The pilot has now concluded and an evaluation session held (attended by ICB, NED, and Governor Representatives with members of the Compliance Team who coordinate the programme). Further comments were received verbally / via emails which was also taken into the evaluation.

Overall, the feedback from the pilot is that this is a positive approach to seeking assurance from patients, their families and staff. It also, reduced duplication of visit from both internal and ICB colleagues separately. As with all new processes continuous reflection and adaptation is required, with some feedback received felt that there needed to be clearer understanding of roles

and responsibilities for leading a visit and to guard against being conducted as a 'tick box' approach.

Visits have continued during the reporting period with six visits in January and February 2025. Positive feedback has been shared following visits including:

- Leadership knowledgeable and approachability
- Improved staffing levels leading to established team working to provide and deliver good patient care
- Positive engagement between patients and staff
- Good working relationships between inpatient and community mental health teams
- Good staff development and career progression
- Good range of information made available for service users

Recommendations from visits are provided back to teams and then followed up via the Accountability Framework meetings. Once we have completed a significant sample of visits we will undertake a thematic review.

5 Recommendation

The Board of Directors is asked to:

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

Report Prepared by:

Comfort Sithole
Head of Compliance and Emergency Planning

On behalf of

Ann Sheridan
Executive Chief Nurse

EPUT

CQC Compliance Spotlight Report

21 March '25

Appendix 1

Introduction

The purpose of this report is to provide an update on key CQC compliance requirements including implementation and assurance status against those actions within the CQC improvement plan which are past the original stated timeline and have a recovery plan in place.

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

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

- Initial s29 plan (Willow and Galleywood Wards – Oct '22)
- Intra-inspection feedback of acute wards for adults and PICU (Nov '22)
- Internal report for 2 Adult Acute Wards (Jan '23)
- CQC report Acute Wards for Adults and PICU (published Apr '23)
- CQC report Core Services and Well Led (published July 23)
- CQC report Rawreth Court (published Nov '23)

Level of Assurance: Level 1

Key Messages

There are currently 78 'must do' / 'should do' actions being taken forward (Note: combination of some actions into one), with 348 sub-actions (as at 21 March 2025) associated with CQC activity.

Overview as of the 21 March 2025:

- 75 (96%) of the Must do / Should do actions have been completed.
- 41 (53%) have been closed through the evidence assurance process
- 344 sub-actions complete

2 sub-actions past timescale as at 21 March 2025 (associated with 2 overall actions status) with recovery plans are in place.

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

Action Progress Update

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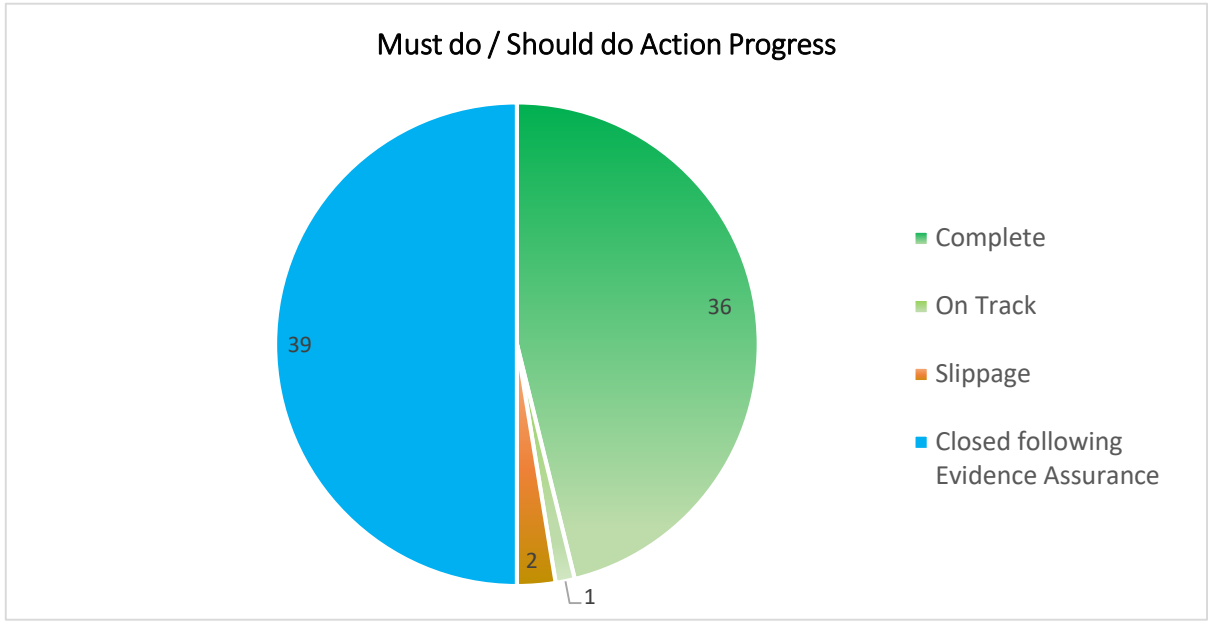
Summary of implementation status

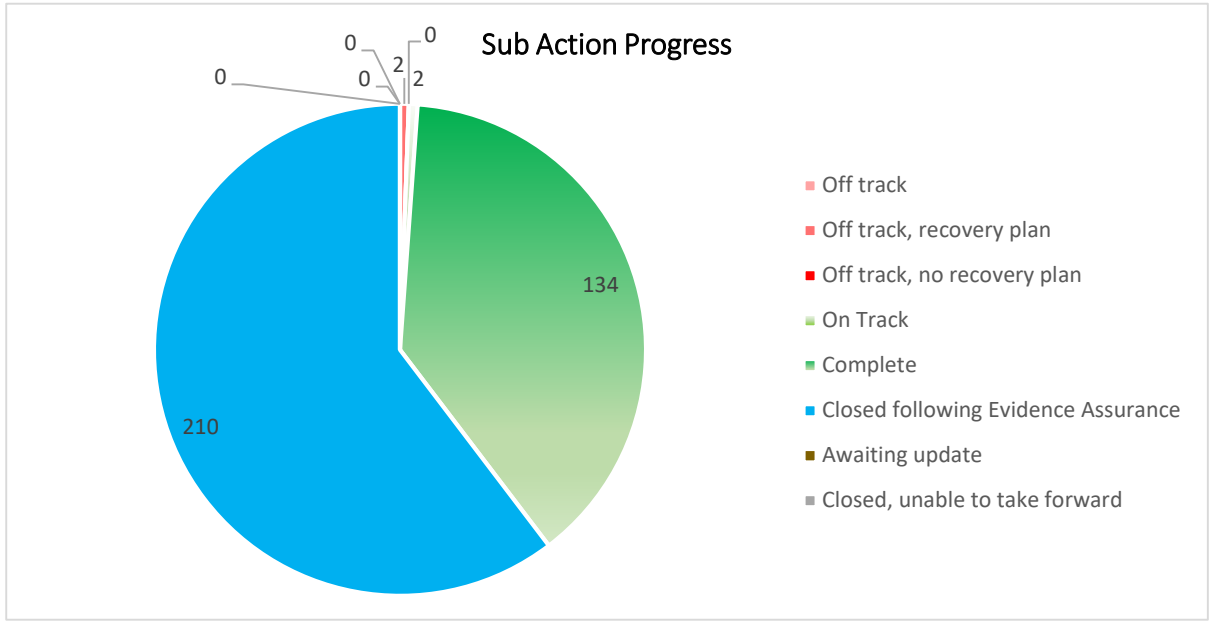
- 78 Must do / Should do actions
- 74 (95%) of the Must do / Should do actions have been reported as completed.
- 344 sub-actions complete
- 41 (53%) have been closed following the Trust assurance Evidence Assurance Process
- 2 sub-actions past timescale as at 19 March 2025 (Nb. Associated with 2 overall actions status) recovery plans are in place

Summary of key activities completed and Actions Closed in the reporting period

11 Actions closed following evidence assurance process in the reporting period (39 closed in total), including:

- M10 Staffing
- M7 and M37 Oxevision
- M8 Sleeping on Duty
- M9 and M26 Restrictive Practice
- M22 Ward Environments
- M31 and S11 Medicines Management
- M35 Emergency Equipment
- RC06 Staff Behaviours and Culture





CQC Action Recovery Plan

Action Recovery Plan				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
RC10: Queries – Nursing Home admission criteria	RC10.3: To review home admission criteria	Review underway. Requires wider discussion with ICB partners	Meeting held with ICB. Service Specification and CQC Registration to be reviewed. Identify impact prior to any changes being made **Weekly touchpoint to review**	Tendai Ruwona
M6: M1 (April 2023) and M6 (May 2023) The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts' policies and procedures for the recording and reporting of incidents	M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning	Work continues for remote access can be uploaded to current ward IT equipment. New software identified and has passed cyber security processes. Identifying funding options to take forward. Current mitigation of access at current location in place.	New software identified and passed as Cyber Compliant. The CCTV software procurement decision has been escalated to Director of Estates for a decision. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona

CQC Evidence Assurance Sign off Timeline

Actions with Evidence Assurance sign off to date	Actions Awaiting Evidence Assurance	Actions On track	Actions In Recovery
41	33	1	2

A trajectory has been set to achieve closure of actions through EAG sign off, based 3 actions per meeting. The EAG is prioritising review of 'must do' actions (those associated with a breach in regulation at inspection).

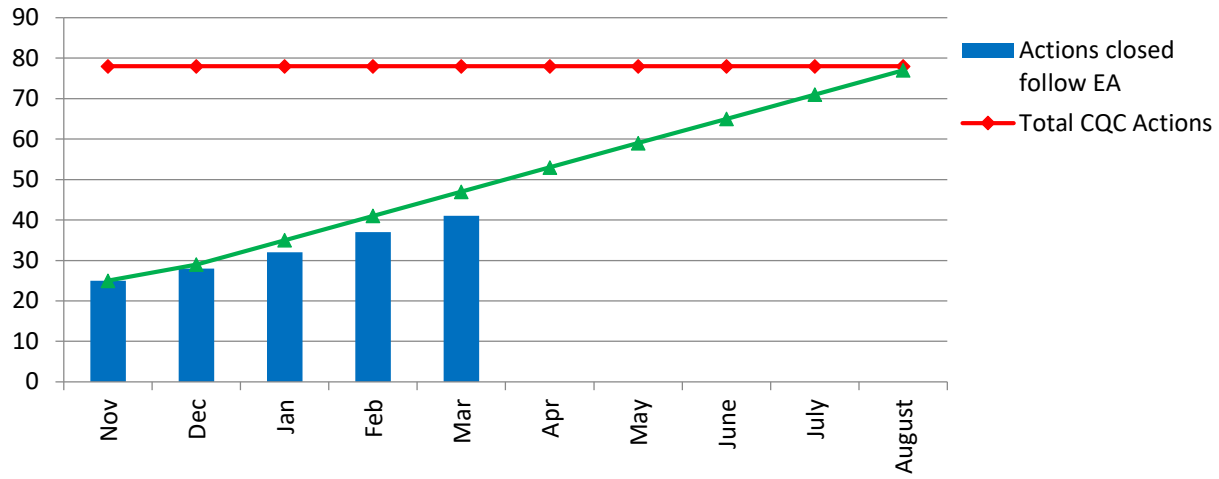
There as been some slippage against the trajectory one EAG meeting being cancelled due to quoracy in February 2025.

The 'should do' actions (those associated with potential to breach regulation if not addressed) continue to be taken through CQC Leads Meeting for evidence assurance.

Based on the trajectory set the improvement plan for all historic CQC inspections will be concluded by the end of September 2025.

Note: One action sits outside the trajectory. This being the development of the EPR with a timeline of March 2026 for delivery.

Note: CQC inspection outcomes is currently awaited for our Inpatient Mental Health Service. Where independent assurance is received from inspection it will be utilised for the EAG assurance process, alongside our internal evidence.



** A further EAG is scheduled for end of March at which 2 actions are being presented for closure. The third item for this meeting is a PDF action plan.*

7.4 NATIONAL STAFF SURVEY (2024): BENCHMARKED RESULTS, ANALYSIS & TRUST-WIDE PRIORITIES

Information Item | AM | 5

REFERENCES

Only PDFs are attached

NHS Staff Survey Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

Report Title:	**National Staff Survey (2024): Benchmarked Results, Analysis & Trust-wide Priorities**					
Executive/ Non-Executive Lead / Committee Lead:	Andrew McMenemy – Executive Chief People Officer					
Report Author(s):	Paul Taylor – Director for OD & Culture Charlotte Thomas – Engagement Lead					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report				
Summary of risks highlighted in this report				
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR3 Finance and Resources Infrastructure			
	SR4 Demand/ Capacity			✓
	SR5 Lampard Inquiry			
	SR6 Cyber Attack			
	SR7 Capital			
	SR8 Use of Resources			✓
	SR9 Digital and Data Strategy			
	SR10 Workforce Sustainability			✓
	SR11 Staff Retention			✓
	SR12 Organisational Development			✓
Does this report mitigate the Strategic risk(s)?	Yes			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.				
Describe what measures will you use to monitor mitigation of the risk				
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

Purpose of the Report		
This report provides the Committee with an updated set of results following the embargo lift including benchmarked data and national average comparisons.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The committee is asked to:

1. Note and discuss the benchmarked results, analysis and priority areas of the National Staff Survey (2024) & NQPS results.

Summary of Key Points

- The initial results from Picker of the 2024 National Staff Survey indicated 2789 surveys were returned giving a response rate of 42% however after analysis by the NHS Coordination Centre, a figure of 2785 surveys were returned giving a response rate of 41%. This remains a decrease in response rate in comparison to 2023, where 2795 surveys were returned giving a response rate of 44%.

- 19 scores are significantly worse compared with 2023 with only 1 score significantly improving. A total of 80 responses were not significantly different to last year.

- EPUT is benchmarked against other Trusts who are categorised as 'Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts'. EPUT placed 1st in one element ('We are always learning'), 3rd place in seven elements and 4th place in one element. When benchmarked against Trusts facing similar levels of scrutiny EPUT places 1st place in 7 elements and 2nd in 2 elements (slide 9, main report).

- The free text comments are currently being analysed and common themes will be shared with care unit and corporate leads for information and incorporation into their action plans. A series of videos are planned in which leaders will discuss results, share progress and address free text comment themes and these will be shared in line with the staff survey communications plan.

- To address the cross-cutting themes that have been analysed, a set of five Trust-wide priorities have been identified:

    1) Leadership and Accountability: compassionate and inclusive leadership & management
    2) Teamwork and Recognition: celebrating collaboration
    3) Workload and Well-Being: addressing burnout
    4) Inclusive and safe working culture: creating psychological safety
    5) Career Development and Growth: enhancing appraisals & clinical supervision

    - 'You Said, We Did' – the campaign will be expanded this year to embed and make explicit the changes that staff have commented upon in the staff survey. A communications and engagement plan has been developed which will share results and progress across the year leading up to the staff survey window in October 2025. Messaging will be tailored for Trust-wide and care unit/corporate teams. We will be maximising various media to share progress on actions including videos, EPUT screens in operational areas and paper copies, where required.

    - To maximise engagement this year, all budget holders and managers within the trust will be sent a 'one-pager' copy of their local team results alongside a Staff Survey toolkit developed by the Staff Engagement Team which details how leaders and staff can use their results to improve staff and patient experience. Furthermore, a set of options are being developed to incentivise engagement for this year's survey, which will go beyond what the Trust has actioned historically.

    - Lastly, the latest results of the National Quarterly Pulse Survey (NQPS) Quarter 4 are also included in this report. There have been deteriorations in both response rate and all but one of the scores however some remain above the national benchmarked average. Results will be analysed and shared with care unit/corporate area leads.

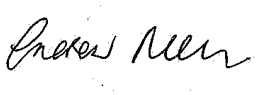
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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			
NQPS	National Quarterly Pulse Survey		

Supporting Reports and/or Appendices
National Staff Survey Report 2024 – Summary, analysis and Trust-wide themes. Appendix 1: Care Unit and Corporate Business Unit Action Plans.

Executive/ Non-Executive Lead / Committee Lead:
 **Andrew McMenemy** **Executive Chief People Officer**

NHS
Essex Partnership University
NHS Foundation Trust

NHS National Staff Survey 2024

Results & Analysis

EPUT

Executive Summary

Organisation details

Survey Coordination Centre NHS

Essex Partnership University NHS Foundation Trust

2024 NHS Staff Survey

Organisation details

Completed questionnaires	2785
2024 response rate	41%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

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

2024 benchmarking group details

Organisations in group: 50

Median response rate: 54%

No. of completed questionnaires: 135986

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

*The initial results from Picker of the 2024 National Staff Survey indicated 2789 surveys were returned giving a response rate of 42% however after analysis by the NHS Coordination Centre, a figure of 2785 surveys were returned giving a response rate of 41%. This remains a decrease in response rate in comparison to 2023, where 2795 surveys were returned giving a response rate of 44%.

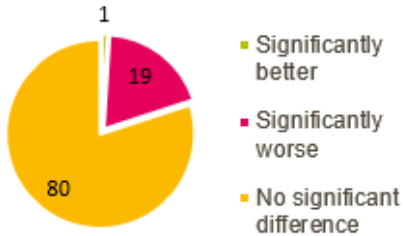
Executive Summary

Below summarises the findings from the core NHS Staff Survey 2024* carried out by Picker, on behalf of Essex Partnership University NHS Foundation Trust.

A total of 119 questions were asked in the 2024 survey, of these, 113 can be compared to 2023 and 101 can be positively scored. Your results include every question where your organisation received at least 10 responses (the minimum required).

61%	q25c. Would recommend organisation as place to work
57%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
76%	q25a. Care of patients/service users is organisation's top priority

Comparison to 2023**



Comparison with average**

*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Executive Summary

Below highlights the five most improved scores *vs*. the five most declined scores.

Most improved scores	Org 2024	Org 2023
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	71%	67%
q22. I can eat nutritious and affordable food at work	58%	55%
q4c. Satisfied with level of pay	33%	31%
q5a. Have realistic time pressures	33%	31%
q23d. Appraisal left me feeling organisation values my work	43%	42%

Most declined scores	Org 2024	Org 2023
q3h. Have adequate materials, supplies and equipment to do my work	62%	68%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	75%	81%
q11a. Organisation takes positive action on health and well-being	60%	65%
q2b. Often/always enthusiastic about my job	71%	75%
q25a. Care of patients/service users is organisation's top priority	76%	80%

Tables are based on absolute % differences, not statistical significance

People Promise Scores

Below shows the difference in EPUT's scores over a 3-year period. Most scores have shown declines when compared to the previous year. Most scores have performed less favourably when compared to the benchmarking average.

People Promise Scores

3 year Overview

People Promise Element/Theme	2022	2023	2024	Benchmarking Average
We are compassionate and inclusive	7.49 -	7.56 + 0.07	7.46 - 0.10	**7.55**
We are recognised and rewarded	6.22 -	6.37 + 0.15	6.31 - 0.06	**6.35**
We each have a voice that counts	6.90 -	6.99 + 0.09	6.86 - 0.13	**6.94**
We are safe and healthy	6.23 -	6.46 + 0.23	6.30 - 0.16	**6.40**
We are always learning	5.74 +	5.96 + 0.26	5.97 + 0.01	**5.93**
We work flexibly	6.77 +	6.85 + 0.08	6.78 - 0.07	**6.83**
We are a team'	7.09 +	7.21 + 0.12	7.11 - 0.10	**7.15**
Staff Engagement	7.04 -	7.17 + 0.17	6.97 - 0.20	**7.07**
Morale	6.12 -	6.29 + 0.17	6.13 - 0.16	**6.20**

Below shows the difference in EPUT's scores over a 3-year period.
All 2024 scores have shown declines when compared to the previous year.

Engagement & Morale Scores

3 year Overview

People Promise Element/Theme	2022	2023	2024	Benchmarking Average
Staff Engagement Overall Score	7.03	7.17 + 0.14	6.97 - 0.20	**7.07**
Motivation Sub Score	7.23	7.31 + 0.08	7.12 - 0.19	**7.14**
Involvement Sub Score	7.08	7.30 + 0.22	7.08 - 0.22	**7.09**
Advocacy	6.78	6.90 + 0.12	6.71 - 0.19	**6.97**
Morale Overall Score	6.12	6.29 + 0.17	6.13 – 0.16	**6.20**
Thinking about leaving Sub Score	6.21	6.27 + 0.06	6.10 - 0.17	**6.29**
Work Pressure Sub Score	5.47	5.81 + 0.34	5.57 - 0.24	**5.62**
Stressors Sub Score	6.69	6.79 + 0.10	6.71 - 0.08	**6.72**

Below shows how EPUT compares against other Trusts within the Mid & South Essex ICS. EPUT performed significantly better in all People Promise elements/themes.

Benchmarking

Mid & South Essex ICS

Response Rate – 35%

People Promise Element/Theme	Mid & South Essex NHS FT *(Acute & Acute Community)*	EPUT 2024
We are compassionate and inclusive	6.61	7.46
We are recognised and rewarded	5.24	6.31
We each have a voice that counts	5.95	6.87
We are safe and healthy	5.54	6.30
We are always learning	4.76	5.97
We work flexibly	5.65	6.78
We are a team'	6.26	7.11
Staff Engagement	5.98	6.97
Morale	5.13	6.13

Below shows how EPUT compares against other local trusts within our benchmarking group, **EPUT placed 1st in one element, 3rd place in seven elements and 4th place in one element.**

Benchmarking

Other local MH & LD, and MH, LD, & Community

People Promise Element/Theme	Hertfordshire NHS FT Response Rate: 58%	North East London NHS FT Response Rate: 55%	East London NHS FT Response Rate: 33%	EPUT 2024 Response Rate: 41%
We are compassionate and inclusive	7.65	7.58	7.42	7.46 3rd
We are recognised and rewarded	6.48	6.33	6.26	6.31 3rd
We each have a voice that counts	7.09	7.00	6.87	6.87 3rd
We are safe and healthy	6.43	6.42	6.19	6.30 3rd
We are always learning	6.26	5.91	5.95	5.97 1st
We work flexibly	6.94	6.80	6.46	6.78 3rd
We are a team'	7.19	7.15	7.09	7.11 3rd
Staff Engagement	7.28	7.20	7.04	6.97 4th
Morale	6.32	6.20	5.95	6.13 3rd

Below shows how EPUT compares against other trusts facing the same levels of scrutiny as EPUT. **EPUT placed 1st in most elements, and 2nd place in two elements.**

Benchmarking

Other Trusts facing similar levels of scrutiny

People Promise Element/Theme	Norfolk & Suffolk NHS FT Response Rate: 46%	Tees, Esk & Wear Valleys NHS FT Response Rate: 44%	EPUT 2024 Response Rate: 41%
We are compassionate and inclusive	7.03	7.46	7.46 1st (joint)
We are recognised and rewarded	6.05	6.32	6.31 2nd
We each have a voice that counts	6.18	6.81	6.87 1st
We are safe and healthy	6.00	6.34	6.30 2nd
We are always learning	5.11	5.78	5.97 1st
We work flexibly	6.59	6.57	6.78 1st
We are a team'	6.80	6.94	7.11 1st
Staff Engagement	6.32	6.86	6.97 1st
Morale	5.68	6.06	6.13 1st

Below shows how EPUT ranks when compared against all 50 trusts within our benchmarking group. Our highest ranking is 'We are always learning'.

Benchmarking

Ranking against all MH & LD, and MH, LD, & Community Trusts

People Promise Element/Theme	Ranking against all 50 MH & LD, and MH, LD & Community Trusts
We are compassionate and inclusive	**34**/50
We are recognised and rewarded	**37**/50
We each have a voice that counts	**36**/50
We are safe and healthy	**37**/50
We are always learning	**21**/50
We work flexibly	**32**/50
We are a team'	**33**/50
Staff Engagement	**34**/50
Morale	**32**/50

People Promise Scores

The table below summarises a number of the scores that have declined since 2023:

People Promise Element	Sub-Theme	Notes
We are compassionate and inclusive	Compassionate Culture	3 out of 5 measures significantly worse than 2023 scores. 3% decline in q25c 'Would recommend organisation as place to work'
We each have a voice that counts	Autonomy and Control	Q3c and q3d (showing initiative and making improvements) have significantly declined.
We are safe and healthy	Health and safety climate	Very significant declines in both q3h (materials and resources) and q11a (positive action on health and wellbeing). This corresponds to q11d, which shows increase in the number of staff reporting coming to work unwell in past 3 months.
We are a team	Team working	Respect from colleagues and working together to achieve objectives have both significantly declined (q7c, q8a)
Engagement	Motivation Involvement Advocacy	Every score has worsened across all three sub-themes. All but one of these have significantly worsened.
Morale	Thinking about leaving	4% worsening score for q26c – 'I am not planning on leaving this organisation'

61% of staff would recommend EPUT as a place to work.

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	58.40%
Medical & Dental	69.9%
Registered Nurses & Midwives	59.3%
Additional Clinical Services	65.2%
Admin & Clerical	60.6%
Allied Health Professionals	64.8%
Estates & Ancillary	43.5%

57% would be happy with the standard of care provided if a friend or relative needed treatment.

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	45.20%
Medical & Dental	59.6%
Registered Nurses & Midwives	60.7%
Additional Clinical Services	65.4%
Admin & Clerical	55.1%
Allied Health Professionals	55.6%
Estates & Ancillary	40.9%

92% did not experience unwanted behaviour of a sexual nature from patients, services users, their families or members of the public.

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	94.4%
Medical & Dental	90.4%
Registered Nurses & Midwives	88.6%
Additional Clinical Services	86.9%
Admin & Clerical	98.4%
Allied Health Professionals	89.3%
Estates & Ancillary	89.8%

96.5% did not experience unwanted behaviour of a sexual nature from other colleagues.

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	98.0%
Medical & Dental	98.5%
Registered Nurses & Midwives	95.6%
Additional Clinical Services	94.7%
Admin & Clerical	97.8%
Allied Health Professionals	96.9%
Estates & Ancillary	90.5%

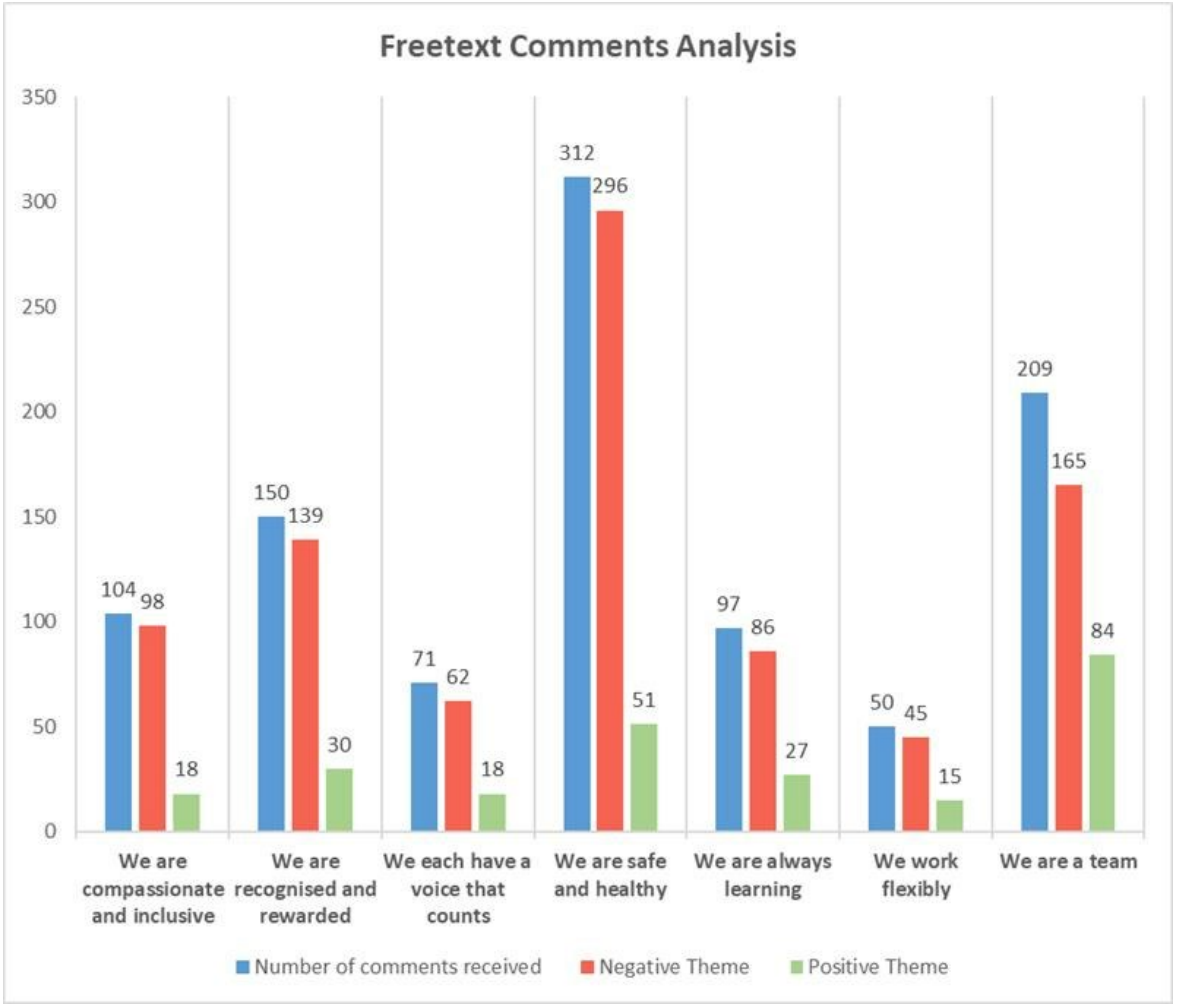
National Staff Survey 2024

Free Text Comments Analysis

639 Total comments received

*We are awaiting breakdown of comments by team & directorate to identify any hotspots.

Comments were themed into People Promise elements and tagged negative and positive.
Most common comments were relating to staff feeling safe & healthy with majority having negative themes.



Operational Care Unit

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Staff Survey People Promise Comparator

People Promise Element	Comparator (Organisation Overall)	EPUT Operational Management	Inpatient Services	Medical	Mid & South	North Essex	Psychological Services	Quality & Safety	Specialist	West Essex
We are compassionate and inclusive	7.5	7.5	7.0	7.3	7.7	7.5	7.8	7.3	7.6	7.3
We are recognised and rewarded score	6.3	6.4	5.8	6.3	6.4	6.3	7.1	6.6	6.4	5.9
We each have a voice that counts score	6.9	6.9	6.7	6.6	7.1	6.9	7.0	6.8	7.2	6.6
We are safe and healthy score	6.3	6.2	5.9	6.3	6.4	6.2	6.4	6.1	6.5	6.1
We are always learning score	6.0	5.7	5.8	5.9	6.1	6.0	6.5	6.1	6.1	5.9
We work flexibly score	6.8	6.3	6.2	6.4	6.9	6.8	7.3	6.8	7.0	6.6
We are a team score	7.1	7.2	6.7	6.9	7.3	7.2	7.7	7.2	7.3	6.7
Staff Engagement score	7.0	6.9	6.9	7.0	7.3	7.0	7.1	6.8	7.3	6.8
Morale score	6.1	5.9	5.8	6.2	6.4	6.0	6.3	5.8	6.4	5.8

Corporate Area Snapshots

Staff Survey People Promise Comparator

People Promise Element	Comparator (Organisation Overall)	Business Development & Contracting	Chief Executive	Corporate Governance	Digital, Strategy & Transformation	Estates & Facilities	Finance & Resources	Major Projects & Programmes	People & Culture
We are compassionate and inclusive	7.5	8.4	8.6	7.2	7.4	6.4	7.8	8.4	7.4
We are recognised and rewarded score	6.3	7.7	8.2	6.2	6.3	5.2	6.9	7.9	6.2
We each have a voice that counts score	6.9	7.9	8.3	6.5	6.7	5.9	7.2	7.7	6.7
We are safe and healthy score	6.3	7.4	7.5	6.3	6.6	6.2	7.1	7.2	6.6
We are always learning score	6.0	5.6	8.0	5.8	5.2	4.4	6.2	7.5	5.4
We work flexibly score	6.8	8.3	8.8	6.7	6.8	6.0	6.9	7.9	7.4
We are a team score	7.1	7.8	8.4	6.8	7.1	5.9	7.5	8.4	7.1
Staff Engagement score	7.0	8.1	8.1	6.6	6.6	6.1	7.2	7.5	6.6
Morale score	6.1	7.4	7.4	6.0	6.1	5.8	6.7	7.3	5.9

Bank National Staff Survey 2024

17% of Bank staff completed the survey

294 responses were received from an eligible sample of 1708 bank staff.

This is a decrease from the previous years response rate of 22%.

The benchmarking for Bank survey results is not yet available. Below is a snapshot of initial scores. Focus will be given to Nursing Registered Bank who's results show some negative areas when compared to the rest of EPUT Bank Staff. Morale is considerably low in this staff group.

Free text comments: The bank free text comments are currently being themed and analysed for action. A total of 110 free text comments were received.

Essex Partnership University NHS Foundation Trust
NSS24 People Promise report – Engagement Report
Breakdown: Staff group
Suppression Threshold: 10

Key:
10.0
>0.4 ppt above
<0.4 ppt below
In between

Staff group	Comparator (Organisation Overall)	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Nursing and Midwifery Registered
Description	n = 294	n = 2	n = 164	n = 55	n = 3	n = 15	n = 55
We are compassionate and inclusive score	7.3	·	7.2	7.7	·	7.5	7.1
We are recognised and rewarded score	6.3	·	6.1	7.1	·	6.6	5.9
We each have a voice that counts score	6.8	·	6.8	7.0	·	6.4	6.7
We are safe and healthy score	6.9	·	6.8	7.7	·	7.0	6.5
We are always learning score	6.4	·	6.5	6.3	·	6.0	6.2
We work flexibly score	6.8	·	6.7	7.2	·	7.4	6.2
We are a team score	6.8	·	6.6	7.4	·	7.3	6.5
Staff Engagement Score	7.3	·	7.5	7.2	·	7.0	6.9
Morale score	6.3	·	6.3	6.9	·	6.1	5.7

*confidentiality threshold of 10 responses not met.

National Quarterly Pulse Survey (NQPS)

9 Core Questions Overview

Below shows the difference in EPUT's scores over the previous quarters. All questions have seen declines when compared to the previous quarter except one question which positively increased (I am enthusiastic about my job).

Question	Q1 – Apr 2024 390 Responses	Q2 – Jul 2024 696 Responses	*(Most Recent Quarter)* Q4 – Jan 2025 492 Responses
Time passes quickly when I am working (Motivation)	63.8%	69.1% **+5.3**	66.5% **- 2.6**
I am enthusiastic about my job (Motivation)	60.6%	60.9% **+ 0.3**	62.1% **+ 1.2**
I look forward to going to work (Motivation)	45.1%	49.0% **+3.9**	47.4% **- 1.6**
There are frequent opportunities for me to show initiative in my role (Involvement)	60.6%	67.6% **+7.0**	64.2% **- 3.4**
I am able to make suggestions to improve the work of my team / department (Involvement)	62.4%	71.6% **+9.2**	68.4% **- 3.2**
I am able to make improvements happen in my area of work (Involvement)	50.6%	57.9% **+7.3**	55.3% **- 2.6**
I would recommend my organisation as a place to work (Advocacy)	45.7%	51.4% **+5.7**	48.1% **- 3.3**
Care of patients / service users is my organisation's top priority (Advocacy)	56.9%	67.8% **+10.9**	65.6% **- 2.2**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Advocacy)	44.0%	47.2% **+3.2**	46.3% **- 0.9**

National Quarterly Pulse Survey (NQPS)

Latest Update

Q4 Jan 2025

The most recent NQPS ran from 2nd January – 2nd February.
In total, 492 responses were received.

The engagement score has decreased by 0.18 however still remains 0.03 above average when compared to Trusts of a similar type.

All **3 employee engagement themes have shown slight declines** when compared to previous quarter however **2 themes still score above the benchmarking average (Motivation & Involvement). Advocacy scores 0.10 below benchmarked average** and is consistent with the low scores received in the Initial NHS Staff Survey.

54% of colleagues felt positively about their current experience at work this quarter with the most selected for this feeling being 'general positivity' – 29%.

46% felt negatively about their current experience at work, with the most selected reason being 'Having a high workload/competing demands/being overworked' – 30% .

Freetext comments are being further analysed however the biggest emerging theme is surrounding 'Improving Management'.

Next steps: results will be shared with care group/corporate areas with results discussed and incorporated into Staff Survey Action planning.

NHS
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Trust-Wide Priorities

EPUT

1. Leadership and Accountability: Compassionate and Inclusive Leadership & Management

Why? Compassionate and effective leadership builds trust and promotes an environment where staff can effectively learn and care for our patients and their families.

How:

We Learn: Integrate development opportunities into leadership forums (e.g. L300 and SLG), enabling leaders to develop emotional literacy, professional leadership behaviours and robust decision-making.

We Care: Provide senior leaders with training to recognise signs of burnout and implement supportive interventions.

We Empower: Link leadership development to measurable outcomes, such as improved team satisfaction or reduced grievances, to empower leaders to take ownership of their growth.

		Historical				External	
		2021	2022	2023	2024	Average	Organisation
q25a	Care of patients/service users is organisation's top priority	77%	78%	80%	**76%**	77%	76%
q25b	Organisation acts on concerns raised by patients/service users	76%	73%	75%	73%	74%	73%
q25c	Would recommend organisation as place to work	63%	62%	64%	**61%**	63%	61%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	62%	58%	60%	**57%**	61%	**57%**

2. Teamwork and Recognition: Celebrating Collaboration

The Why: Recognising and valuing contributions from our staff will nurture a caring and compassionate culture and reinforces the importance of working together within teams.
How:

We Learn: Share success stories from high-performing teams at our leadership forums so development and learning can be shared.

We Care: Refresh and update recognition categories reflecting EPUT's values for annual awards and develop a new plan/system for reward and recognition.

We Empower: Empower teams to regularly nominate peers and vote on awards, encouraging ownership and collaboration.

		Historical				External	
		2021	2022	2023	2024	Average	Organisation
q8a	Teams within the organisation work well together to achieve objectives	53%	52%	53%	**50%**	52%	50%
q7b	Team members often meet to discuss the team's effectiveness	67%	69%	71%	69%	71%	**69%**
q7c	Receive the respect I deserve from my colleagues at work	76%	76%	78%	**75%**	76%	75%

3. Workload and Well-Being: Addressing Burnout

Why: Protecting staff well-being reflects a caring and compassionate ethos and creates conditions where empowerment and learning can flourish.
How:

We Learn: Give staff the tools and opportunities to support their emotional, social and work-life balance using clinical supervision and restorative approaches.

We Care: Introduce "Well-Being Ambassadors" trained to provide peer support and promote available resources.

We Empower: Enable staff to create flexible working solutions beyond existing measures and policy through enhanced rostering practices and developing leadership capability in this space.

		Historical				External	
		2021	2022	2023	2024	Average	Organisation
q2a	Often/always look forward to going to work	60%	58%	62%	59%	57%	59%
q2b	Often/always enthusiastic about my job	72%	72%	75%	71%	70%	71%
q2c	Time often/always passes quickly when I am working	76%	74%	75%	72%	73%	72%
q11a	Organisation takes positive action on health and well-being	64%	64%	65%	60%	60%	60%

4. Inclusive and safe working culture: creating psychological safety

Why: Addressing unprofessional behaviours that create unsafety demonstrates a commitment to the care of our workforce and is a foundation for empowerment and learning.
How:

We Learn: Identify systemic issues and deliver targeted OD interventions including sexual safety. Create new opportunities for investigation training/learning.

We Care: Develop organisational-wide plan to address preventable (i.e. non-egregious) unprofessional behaviours at work, reducing 'last resort' channels (e.g. Freedom to Speak Up or formal HR routes) and improving outcomes for our staff.

We Empower: Train core staff in two key areas that addresses prevention and accountability – peer messengers (Vanderbilt model) and investigation training so HR processes are conducted appropriately and in a timely way.

		Historical				External	
		2021	2022	2023	2024	Average	Organisation
q14c	Not experienced harassment, bullying or abuse from other colleagues	83%	82%	83%	84%	85%	**84%**
q25c	Would recommend organisation as place to work	63%	62%	64%	**61%**	63%	61%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	62%	58%	60%	**57%**	61%	**57%**

5. Career Development and Growth: Enhancing Appraisals & Clinical Supervision

The Why: Opportunities to learn and grow empower individuals and demonstrates our commitment to supporting the workforce.

How:

- **We Learn:** Integrate continuous professional development into appraisal discussions, aligning individual goals with organisational needs.
- **We Care:** Provide targeted development plans for staff who feel underutilised in their current roles through 3 year succession and talent management plans.
- **We Empower:** Develop a revised clinical supervision process and practice that enables managers to successfully cover all three elements of effective supervision so that staff well-being and development are equally supported.

			Historical				External	
			2021	2022	2023	2024	Average	Organisation
q24f	Able to access clinical supervision opportunities		-	-	-	71%	76%	**71%**
q23a	Received appraisal in the past 12 months		79%	80%	82%	83%	87%	**83%**

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NHS National Staff Survey 2024

Care Group/Corporate Area Updates

EPUT

Operational Care Unit

Green Score > +3% better than EPUT overall
Red Score > -3% worse than EPUT overall

Staff Survey People Promise Comparator

People Promise Element	Comparator (Organisation Overall)	EPUT Operational Management	Inpatient Services	Medical	Mid & South	North Essex	Psychological Services	Quality & Safety	Specialist	West Essex
We are compassionate and inclusive	7.5	7.5	7.0	7.3	7.7	7.5	7.8	7.3	7.6	7.3
We are recognised and rewarded score	6.3	6.4	5.8	6.3	6.4	6.3	7.1	6.6	6.4	5.9
We each have a voice that counts score	6.9	6.9	6.7	6.6	7.1	6.9	7.0	6.8	7.2	6.6
We are safe and healthy score	6.3	6.2	5.9	6.3	6.4	6.2	6.4	6.1	6.5	6.1
We are always learning score	6.0	5.7	5.8	5.9	6.1	6.0	6.5	6.1	6.1	5.9
We work flexibly score	6.8	6.3	6.2	6.4	6.9	6.8	7.3	6.8	7.0	6.6
We are a team score	7.1	7.2	6.7	6.9	7.3	7.2	7.7	7.2	7.3	6.7
Staff Engagement score	7.0	6.9	6.9	7.0	7.3	7.0	7.1	6.8	7.3	6.8
Morale score	6.1	5.9	5.8	6.2	6.4	6.0	6.3	5.8	6.4	5.8

Corporate Area Snapshots

Staff Survey People Promise Comparator

People Promise Element	Comparator (Organisation Overall)	Business Development & Contracting	Chief Executive	Corporate Governance	Digital, Strategy & Transformation	Estates & Facilities	Finance & Resources	Major Projects & Programmes	People & Culture
We are compassionate and inclusive	7.5	8.4	8.6	7.2	7.4	6.4	7.8	8.4	7.4
We are recognised and rewarded score	6.3	7.7	8.2	6.2	6.3	5.2	6.9	7.9	6.2
We each have a voice that counts score	6.9	7.9	8.3	6.5	6.7	5.9	7.2	7.7	6.7
We are safe and healthy score	6.3	7.4	7.5	6.3	6.6	6.2	7.1	7.2	6.6
We are always learning score	6.0	5.6	8.0	5.8	5.2	4.4	6.2	7.5	5.4
We work flexibly score	6.8	8.3	8.8	6.7	6.8	6.0	6.9	7.9	7.4
We are a team score	7.1	7.8	8.4	6.8	7.1	5.9	7.5	8.4	7.1
Staff Engagement score	7.0	8.1	8.1	6.6	6.6	6.1	7.2	7.5	6.6
Morale score	6.1	7.4	7.4	6.0	6.1	5.8	6.7	7.3	5.9

People Promise Scores

Below shows the difference in EPUT's scores over a 3-year period and all 2024 scores have shown declines when compared to the previous year.

People Promise Scores

3 year Overview

People Promise Element/Theme	2022	2023	2024	Benchmarking Average (Not available yet)
We are compassionate and inclusive	7.49 -	7.56 + 0.07	7.46 - 0.10	
We are recognised and rewarded	6.22 -	6.37 + 0.15	6.32 - 0.05	
We each have a voice that counts	6.90 -	6.99 + 0.09	6.86 - 0.13	
We are safe and healthy	6.23 -	6.46 + 0.23	6.32 - 0.14	
We are always learning	5.74 +	5.96 + 0.26	5.95 - 0.01	
We work flexibly	6.77 +	6.85 + 0.08	6.78 - 0.07	
We are a team'	7.09 +	7.21 + 0.12	7.11 - 0.10	
Staff Engagement	7.04 -	7.17 + 0.17	6.97 - 0.20	
Morale	6.12 -	6.29 + 0.17	6.14 - 0.15	

Care Unit Name: Chief Executive

Experience Lead: Hannah Beckwith

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Chief Executive
We are compassionate and inclusive	7.5	8.6
We are recognised and rewarded	6.3	8.2
We each have a voice that counts	6.9	8.3
We are safe and healthy score	6.3	7.5
We are always learning score	6.0	8.0
We work flexibly score	6.8	8.8
We are a team score	7.1	8.4
Staff Engagement score	7.0	8.1
Morale score	6.1	7.4

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Staff feeling their role makes a difference to patients	No people promise alignment (q6a)	1. All leads to feedback care group results to their teams and ask for feedback on what actions staff would like to see taken forward.	Actions developed as a result of the feedback.	First initial meeting held 17.01.25 and actions developed. Next meeting 14.02.25 to feedback after sharing results with their staff. 30.01.25 - Comments and ideas were shared following feedback from a staff meeting where the survey results / actions were shared.
Staff working additional unpaid hours over and above contracted hours	No people promise alignment (q10c)	2. Back to the floor. More site visits, working collaboratively within the care group to support each team, learning about other departments and visiting the front line. Team meetings to be held at other onsite locations so staff feel more connected to EPUT services.	Feedback received from staff on visibility. NQPS results analysed.	
Staff feeling they have realistic time pressures	Morale (q3g, q3h, q3i)	3. Improving the outcome of appraisals. Asking team members what they would like out of their appraisal to help improve their career/time at EPUT.		
		4. Making sure that staff are aware of Managers support around time pressures and unrealistic deadlines. Using MS Teams Planner to monitor workloads/priorities. Checking staff are taking breaks and taking time back in Lieu if appropriate.		

Care Unit Name: Finance & Resources

Experience Lead: Kimberley Morley

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Finance & Resources**
We are compassionate and inclusive	7.5	7.8
We are recognised and rewarded	6.3	6.9
We each have a voice that counts	6.9	7.2
We are safe and healthy score	6.3	7.1
We are always learning score	6.0	6.2
We work flexibly score	6.8	6.9
We are a team score	7.1	7.5
Staff Engagement score	7.0	7.2
Morale score	6.1	6.7

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Feeling enthusiastic about work	Staff Engagement (q2a, q2b, q2c, q3c, q3d, q3f q25a, q25c, q25d)	1. Organise a team development away day with the OD team, with a focus on boosting positivity and work experience.	Full attendance at away day. Evaluation of the day carried out to gain feedback from staff.	First initial meeting held on the 22nd January. Actions were agreed and sent to the working group along with suggestions to take forward. Support has been offered to help progress with the actions. A further drill down at department level of the survey results were sent to the leads as requested. Second meeting originally scheduled for the 12th February. Re-arranged for the 19th February (postponed by leads), next date TBC.
Raising concerns & feedback	We each have a voice that counts (q20a, q20b, q25e, q25f)	2. Promotion of the completion of mandatory training (F2SU) and organise a follow up session with F2SU guardian.	Mandatory training checked to ensure all staff are up to date. Full attendance of F2SU follow up session.	
Staff working additional unpaid hours over and above contracted hours	No people promise alignment (q10c)	Ensure all staff have supervision and appraisals booked, with a focus on workload/capacity and individual objectives.	100% attendance rate recorded for appraisals and supervision. Flexible working opportunities discussed with staff.	

Care Unit Name: Estates & Facilities

Experience Lead: Zisan Abedin

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Estates & Facilities
We are compassionate and inclusive	7.5	6.4
We are recognised and rewarded	6.3	5.2
We each have a voice that counts	6.9	5.9
We are safe and healthy score	6.3	6.2
We are always learning score	6.0	4.4
We work flexibly score	6.8	6.0
We are a team score	7.1	5.9
Staff Engagement score	7.0	6.1
Morale score	6.1	5.8

Respondents: 115

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
YOUR PERSONAL DEVELOPMENT	q23b Appraisal helped me improve how I do my job q23c Appraisal helped me agree clear objectives for my work	- Mandatory attendance for line managers & supervisors at MDP Programme ensure completion of Appraisal, Career Development, and Flexible Working modules. - Assess post-programme impact on knowledge, confidence, and application of learning through feedback.	- Number of line managers attending MDP Programme - Improvement in NSS score. - Confidence improvement survey post-training (qualitative data)	- 1st Meeting (Action Planning) Care Group Directors, EEM 04/02/2025 Completed - 2nd Meeting (Progress Review) Action Group Team – Pending - 6-Month Review Checkpoint Action Group Team August 2025 – Pending - 12-Month Review Checkpoint Action Group Team February 2026 - Pending - Regular 4 weekly Check-ins as a Action Group. - Create a wellbeing and survey discussion forum for all staff to ensure inclusive approach. - Team Engagement & Well-being Support (EEM & Managers) - Conduct site visits to meet teams and assess morale and collect qualitative data. - Plan to include well-being support and recognition discussions as part of regular team meetings. - Embedding Action Plan into Accountability and business Meetings. - Compile a list of line managers and supervisors for the MDP Programme attendance. - Review impact via feedback and ESR data at 6-month and 12-month checkpoints. - Encourage managers to record Flexible Working Arrangements - Care group leaders to send monthly recognition messages to staff. - Recognition discussions to be a standing agenda item in Accountability Framework meetings. - Celebrate National Estate and Facility Day trust wide.
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	q12c Never/rarely frustrated by work	- Build relationships through team visits to assess team morale and challenges by the EEM. - Utilise available well-being resources and ensure staff are aware of them. - Introduce Restorative Supervision sessions.	- Number of staff engaging in Restorative Supervision sessions. - Collect qualitative data through visits and engagements. - Increased engagement with well-being resources (measured via NSS Data).	
YOUR PERSONAL DEVELOPMENT	q24b There are opportunities for me to develop my career in this organisation	- MDP focus on Career Development - Assess post-programme outcomes (knowledge gain, confidence improvement). - Connecting teams and individual with OD	- Track the number of line managers attended the programme, with a target of 95% attendance by the next staff survey. - NSS Survey Improvement.	

Care Unit Name: West Essex

Experience Lead: Sonia Lollia

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**West Essex**
We are compassionate and inclusive	7.5	7.3
We are recognised and rewarded	6.3	5.9
We each have a voice that counts	6.9	6.6
We are safe and healthy score	6.3	6.1
We are always learning score	6.0	5.9
We work flexibly score	6.8	6.6
We are a team score	7.1	6.7
Staff Engagement score	7.0	6.8
Morale score	6.1	5.8

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Recognition	Q4a - Q4ab- Q6B - Q47h	1- More active staff recognition via various engagement tools - huddles - team meeting - praise pages - awards etc. 2- Directors and Deputy Directors out in the Teams once a month 3- Environment 4- Louise Knight –Bingo night out, Monthly bake off 5- HRBP to discuss project progress and actions at Quality of Care meeting on monthly basis.	National Quartely Pulse Survey result analysis Employee Experience Manager dashboard - Visits Praise page utilisation	Improve engagement on Pulse survey and National staff survey 2026.
Managers & team	Q3c -Q3 e, Q7b - Q9a to Q9c -Q9e- Q9f	1- Team staff survey analysis & share results to relevant Manager/Matron to discuss at 1-1 2- Review MDP programme and suggest improvement ideas i.e. role plays 3- Effective use of one to one to identify areas of good work/achievements and positive feedback. 3-Team meeting agenda to include areas suggestions for improvement and followed up by the action plan.	Training evaluation results Output of appreciative enquiry questionnaire.	
Safety	Q13d	Appreciative enquiry by March 2025 to review improvement	Survey analysis to be communicated to the team.	
Supplies, Equipment and Materials	Q3h	1- Managers to ask team for feedback and address issue at Quality Care meeting. 2 - EEM visits and report staff feedback to Managers. 3- Continue to submit charitable funding request to EPUT and League of friends.	Resolution issues and completed actions.	

Care Unit Name: North Essex

Experience Lead: Zisan Abedin

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**North Essex**
We are compassionate and inclusive	7.5	7.5
We are recognised and rewarded	6.3	6.3
We each have a voice that counts	6.9	6.9
We are safe and healthy score	6.3	6.2
We are always learning score	6.0	6.0
We work flexibly score	6.8	6.8
We are a team score	7.1	7.2
Staff Engagement score	7.0	7.0
Morale score	6.1	6.0

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	q12a Never/rarely find work emotionally exhausting q12e Never/rarely worn out at the end of work q12b Never/rarely feel burnt out because of work q12c Never/rarely frustrated by work	- Continue with Restorative Supervision to provide structured emotional support. - Build relationships through team visits to assess team morale and challenges by the EEM to collect qualitative data. - Utilise available well-being resources and ensure staff are aware of them.	- Improve number of staff engaging in Restorative Supervision sessions by next NSS. - Staff feedback from team visits. - Improvement on next NSS.	- 1st Meeting (Care Group Directors, HRBP, People Promise Manager, EEM) 04/02/2025 Completed - 2nd Meeting (Action Group Team) - Pending - 6-Month Review Checkpoint Action Group August 2025 – pending - 12-Month Review Checkpoint Action Group February 2026 - Pending Key Actions & Accountability - Regular 4 weekly Check-ins as a Action Group to review progress. - Team Engagement & Well-being Support (EEM & Managers): Conduct site visits to meet teams and assess morale and collect qualitative data. - Embedding Action Plan into Accountability Meetings (HRBP) - Ensure updates are included as a standing agenda item in all business meetings. - Compile a list of line managers and track their MDP Programme attendance - Tracking MDP Attendance (HRBP, EEM & Service Managers) three key areas (Appraisals, Career Development, Flexible Working) - Request ESR data on number of staff on Flexible Working & Reasonable Adjustments (FW/RA) and track progress at 6-month intervals. - EEM to assess the effectiveness of Flexible Working initiatives.
Recognition	q23b Appraisal helped me improve how I do my job	- Identify all line managers & ensure completion of Appraisal, Career Development, and Flexible Working modules. - Assess post-programme impact on knowledge, confidence, and application of learning.	- Percentage of line managers attending MDP Programme. - Improvement in NSS.	
Work Life Balance	q4a Satisfied with recognition for good work	- Regular recognition emails from Directors & ADs. - Add staff recognition as a standing agenda item in Accountability Framework meetings. - Use staff feedback to enhance and refine recognition efforts.	- Number of recognition emails sent. - Minutes reflecting recognition discussions in meetings.	

Care Unit Name: Psychological Services

Experience Lead: Hannah Beckwith

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Psychological Services**
We are compassionate and inclusive	7.5	7.8
We are recognised and rewarded	6.3	7.1
We each have a voice that counts	6.9	7.0
We are safe and healthy score	6.3	6.4
We are always learning score	6.0	6.5
We work flexibly score	6.8	7.3
We are a team score	7.1	7.7
Staff Engagement score	7.0	7.1
Morale score	6.1	6.3

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Staff working additional unpaid hours over and above contracted hours	No people promise alignment (q10c)	Actions still to be agreed	Flexible Working applications to be analysed.	Results and detailed breakdown shared with working group. Category breakdown of scores for the care unit and results for whole service requested. Immediate action – the care unit senior leadership team will be engaging in a discussion with the Heads of Service group to explore their views and interpretations of the results.
Negative experiences at work including emotional exhaustion	We are safe and healthy (q11b, q11c, q11d, q13a, q13b, q13c, q14a, q14b, q14c)	Promotion of wellbeing initiatives in place, Schwartz Rounds, EAP, etc.	Monitor EAP and Occ health statistics.	
Advocacy	Staff Engagement (q25a, q25c, q25d)	Appraisals undertaken with meaningful objectives for each staff member.	Monitor NQPS results and free text comments for service info.	
Response rate to be improved	No people promise alignment	Increase response rate	An increase in the amount of staff completing the survey.	

Care Unit Name: People & Culture

Experience Lead: Charlotte Thomas

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**People & Culture**
We are compassionate and inclusive	7.5	7.4
We are recognised and rewarded	6.3	6.2
We each have a voice that counts	6.9	6.7
We are safe and healthy score	6.3	6.6
We are always learning score	6.0	5.4
We work flexibly score	6.8	7.4
We are a team score	7.1	7.1
Staff Engagement score	7.0	6.6
Morale score	6.1	5.9

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Appraisals & Development Both sub scores scored less favourably when compared to EPUT overall.	'We are always learning'	Ensuring all staff have objectives that are clear and achievable with clear learning and development opportunities at all levels of the directorate. Develop a career development pathway for all staff, including 3 year succession plan and talent management	Monitor appraisal tracker. Training requests monitored. Review how development opportunities are promoted.	HRBP roles out to advert to enhance the operational and corporate partnering across the Trust. Senior team objectives agreed and being tracked monthly as part of SMT meetings. Timeline for new P&C structure being established so the four pillars of P&C can be developed for all levels of the directorate and clarity on function/form. Regular all staff meetings to update and ensure colleagues across P&C are supported with future developments.
Feeling teams within the organisation work well together to achieve objectives Staff working additional unpaid hours over and above contracted hours	'We are a team'	Developing a P&C structure that is able to meet the demands of the wider organisation and within agreed financial budget.	NQPS results analysed to monitor colleague mood.	
Advocacy	Staff Engagement Advocacy scores including care of patients is top priority, would recommend EPUT as a place to work or receive treatment.			

Care Unit Name: Mid & South

Experience Lead: Zisan Abedin

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Mid & South
We are compassionate and inclusive	7.5	7.7
We are recognised and rewarded	6.3	6.4
We each have a voice that counts	6.9	7.1
We are safe and healthy score	6.3	6.4
We are always learning score	6.0	6.1
We work flexibly score	6.8	6.9
We are a team score	7.1	7.3
Staff Engagement score	7.0	7.3
Morale score	6.1	6.4

Respondents: 576

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	- q12e Never/rarely worn out at the end of work - q12a Never/rarely find work emotionally exhausting - q12c Never/rarely frustrated by work - q12b Never/rarely feel burnt out because of work - q10c Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	- Conduct employee experience visits to individual teams and offer well-being support to staff and managers to capture qualitative data.	- Assess impact on morale, engagement, and sickness absence through ESR Data. - Track improvements through the next staff survey.	- 1st Meeting Action Group - 13/02/2025 - 2nd Meeting Action Group – In progress - 6-month checkpoint (Action Group)- August 2025 - Pending - 12-month checkpoint (Action Group) February 2026 - Pending Key Actions & Accountability - Incorporate the action plan into the Care Group's Operational. - Integrate updates into accountability frameworks & business meetings. - Add as a standing agenda item in all team meetings. - Regular 4 weekly check-ins as a Working Group. - Compile a list of all line managers and track their attendance at the MDP programme - every 4 weeks (action group) - Collect feedback from attendees on three key areas 6 months. - Keep a tracer to track improvement on flexible working (already in place under operational plan) - Plan site visits and attend meetings by EEM (in progress) - Present progress reports to the working group every 4 weeks by the EEM.
YOUR PERSONAL DEVELOPMENT	- q24b There are opportunities for me to develop my career in this organisation - q23b Appraisal helped me improve how I do my job	Mandatory attendance for line managers at MDP Programme: - Make a list of all line managers and making sure all managers attend MDP (Focus on Appraisal, Career Development, and Flexible Working modules.) and track attendance and progress capture qualitative data through feedback. (Assess post programme outcomes - knowledge gain, confidence improvement).	- Manager Participation in MDP Programme - target of 95% attendance by the next staff survey. - NSS Survey Improvement. - ESR to track the number of completed appraisals within the care group.	
YOUR JOB	- q6b Organisation is committed to helping balance work and home life	- Identify the number of staff on Flexible Working arrangements using ESR data. - Collect Qualitative data and evaluate effectiveness and satisfaction through site visits and attendance at business and team meetings by EEM.	- Improved % of staff on Flexible Working arrangements (tracked via ESR) with progress monitored at 6 months and 12 months. - Qualitative feedback on effectiveness gathered through regular site visits and staff engagement by EEM. - NSS Score improvement	

Care Unit Name: Business Development & Contracting

Experience Lead: Kimberley Morley

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Business Development & Contracting
We are compassionate and inclusive	7.5	8.4
We are recognised and rewarded score	6.3	7.7
We each have a voice that counts score	6.9	7.9
We are safe and healthy score	6.3	7.4
We are always learning score	6.0	5.6
We work flexibly score	6.8	8.3
We are a team score	7.1	7.8
Staff Engagement score	7.0	8.1
Morale score	6.1	7.4

Respondents: 11

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Personal development including appraisals	We are safe and healthy (q12c) We are always learning (q24a, q24b, q24c, q24d, q24e, q23b, q23c, q23d)	1. Create a training and development plan for all staff, with a focus on career progression.	Staff book onto relevant training opportunities. Interest shown in other job areas of the trust.	First initial meeting held on the 22nd January and actions agreed. A further breakdown of the survey results were sent to the leads. Second meeting originally scheduled for the 12th February (postponed by leads). Re-arranged for the 19th February (postponed by leads). Meeting took place on the 6th March – updates on the actions: 1) Arrange virtual session with OD team on training opportunities. 2) LB speaking with Paul Taylor about the Brockfield sexual safety pilot. Going to invite him to the next team meeting. 3) Appraisals/1:1's – internal objectives are being planned.
Staff working additional unpaid hours over and above contracted hours	No people promise alignment (q10c)	2. Ensure all staff have 1:1's and appraisals booked, with appropriate objectives discussed including work capacity.	100% completion rate recorded for appraisals and supervision. Flexible working options promoted.	
Sexual safety of staff	No people promise alignment (q17b)	3. Ensure all staff have completed their sexual safety training and arrange a meeting with the Colleague Safety Consultant.	100% completion rate for sexual safety training. All or as many as possible staff to attend meeting with Elliott Judge.	

Care Unit Name: Inpatient Services

Experience Lead: Shayna Pearson

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Inpatient Services
We are compassionate and inclusive	7.5	7.0
We are recognised and rewarded	6.3	5.8
We each have a voice that counts	6.9	6.7
We are safe and healthy score	6.3	5.9
We are always learning score	6.0	5.8
We work flexibly score	6.8	6.2
We are a team score	7.1	6.7
Staff Engagement score	7.0	6.9
Morale score	6.1	5.8

Respondents: 346

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Low staff survey participation, low staff engagement	We each have a voice that counts	1. Regular visits from the EEM's, check on staff wellbeing and morale. EEMs to provide a written report on staff morale and wellbeing to director of OD and culture on a regular basis.	Action plan monitored. Feedback from visits recorded. **Improved response rate for the 2025 Annual Staff Survey.**	EEMs to visit each site at least every other month. EEMs to collaborate with director of OD and culture to develop a format for reporting feedback. *Adhoc action: Microwave and washing machine issues sorted at Hadleigh Unit (Basildon) following escalation **from the consultant psychiatrist** to operations management.
Burnt out and coming into work when unwell	We are safe and healthy: 11d, 12b, 12d, 12g	2. Time to Care – new staffing model. **Aim to have to all staff in post by July 2025.** EEMs to routinely get feedback from staff and managers, meet with HRBPs on a monthly basis in regards to impact of the new staffing model and promote staff wellbeing initiatives.	**Improved scores in relation to the theme 'We are safe and healthy' in the 2025 Annual Staff Survey.** **Reduced mental-health related sickness absence by March 2026 (ESR).** **Reduced voluntary resignations over a 12 month period**	**New staffing model: Currently - 184.82 WTE recruited and have 147.99 outstanding with 34.65 in the pipeline (offer, awaiting start date and booked start date). 11.49 WTE, 19.17 WTE, 58.21 WTE are in advertising, shortlisting and interview stage**
Relationships at work are strained	Morale: 5c	3. Time to care – new staffing model. Regular visits from the EEMs. Re-introducing Schwartz rounds and cup of coffee conversations training.	**Attendance and f**eedback from Schwartz Round attendees. **Improved scores in relation to the theme 'Morale' in the 2025 Annual Staff Survey.**	

Care Unit Name: Specialist Services

Experience Lead: Lorraine Ganney

Staff Survey People Promise Comparator		
People Promise Element	Comparator (Organisation Overall)	Specialist
We are compassionate and inclusive	7.5	7.6
We are recognised and rewarded	6.3	6.4
We each have a voice that counts	6.9	7.2
We are safe and healthy score	6.3	6.5
We are always learning score	6.0	6.1
We work flexibly score	6.8	7.0
We are a team score	7.1	7.3
Staff Engagement score	7.0	7.3
Morale score	6.1	6.4

Respondents: 238

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Diversity, equality & inclusion Experiencing discrimination from patients and public	Compassionate and inclusive	1. Increase equality, diversity and inclusion across Specialist services, away days, site visits and ad-hoc sessions when requested. Workshops for teams, EDI unconscious bias sessions/work with OD team to offer additional training and awareness, embed the values behaviours across the service. EEM to be involved with the Specialist service EDI sub meetings to hold learning and provide awareness sessions. Promote the EDI networks as a safe space for colleagues to join.	NQPS/Staff feedback and engagement/datix/freedom to speak up data Mandatory training checked to ensure all staff are up to date. Full attendance of F2SU follow up session	Spoke at SMT meeting and gave overview. Service lead aware of the plan and this is being picked up in February. Meeting held with HRBP and DDQS, slide to be sent to the senior team to review and agree, then present to the wider SMT end of February.
Staff working additional unpaid hours over and above contracted hours Staff feeling burnt out	No people promise alignment (q10c)	2. EEM drop in sessions to promote staff survey and offer further support, EEM to be visual and to be the link between the wider trust and the wards. Increase SLT visits to build visibility and reassurance staff voices are being heard. Ensure all staff have supervision and appraisals booked, with a focus on workload/capacity and individual objectives. Promote flexible working – look at the options for staff, time of in lieu, overtime (bank) and empower managers to have the local agreements with staff on flexible working within team.	NQS/Staff feedback and engagement/staff survey free text Flexible working requests.	
Experiencing physical violence, bullying, harassment or abuse from patients, public	A voice that counts	3. EMM support the service, attend drop in sessions, attend planned Specialist evening session to tackle inequalities and staff support sessions on wards, to engage and listen providing an opportunity for staff to express concerns within the area, provide an opportunity to discuss concerns regarding B& H within the service. Promote the EDI networks	NQPS/Staff feedback and engagement/datix/freedom to speak up data Mandatory training	

Care Unit Name: Quality & Safety (Nursing)

Experience Lead: Lorraine Ganney

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Quality & Safety**
We are compassionate and inclusive	7.5	7.3
We are recognised and rewarded	6.3	6.6
We each have a voice that counts	6.9	6.8
We are safe and healthy score	6.3	6.1
We are always learning score	6.0	6.1
We work flexibly score	6.8	6.8
We are a team score	7.1	7.2
Staff Engagement score	7.0	6.8
Morale score	6.1	5.8

Respondents: 53

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Health & safety at work		1. EEM and the SLT for the unit to promote health and wellbeing, provide staff with awareness and resources on wellbeing. Provide a reminder of well-being in the work place and hold wellbeing workshops for the unit.	NQPS/Staff feedback and engagement	Results have been presented to SMT for Quality and Safety.
Staff feeling their role makes a difference to patients		2. Promote the benefits of recognising and awarding staff. Arrange local/site recognition and awards, promote staff recognition awards and share experiences of winners and nominations via comms.	NQS/Staff feedback and engagement	
Morale		3. EEM drop in sessions to promote staff survey, NQPS and offer further support and a discussion on morale and to raise concerns, EEM to be visual and to be the link between the wider trust and the wards. Increase SLT visits to build visibility and reassurance staff voices are being heard.	NQS/Staff feedback and engagement	

Care Unit Name: Digital Strategy & Transformation

Experience Lead: Sonia Lollia

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Digital, Strategy & Transformation**
We are compassionate and inclusive	7.5	7.4
We are recognised and rewarded	6.3	6.3
We each have a voice that counts	6.9	6.7
We are safe and healthy score	6.3	6.6
We are always learning score	6.0	5.2
We work flexibly score	6.8	6.8
We are a team score	7.1	7.1
Staff Engagement score	7.0	6.6
Morale score	6.1	6.1

Respondents: 143

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Appraisals & development	**Q23a/b Q24b to Q24f**	1. Appraisals to be conducted and received in a timely manner - This should improve communication and provide an opportunity raise any concerns or feedback 2. Create more career coaching opportunities to respond to staff survey. 3. Inform staff of any opportunities and actions to respond to staff survey 4. Regular review at monthly face to face team meetings	1. 100% completion rate recorded on tracker. 2. Number of staff booked on training courses.	1. Review staff annual staff survey and pulse survey 2. Monitored through our continuous improvement process 3. Reviewed at monthly face to face team meetings
Health and Wellbeing Burnout and working long and extra hours	**Q2C, Q3B, Q10c, Q11b, Q12c**	1. Reviewed in monthly 1-1 supervision meetings with line manager - This should improve communication and provide an opportunity raise any concerns or feedback 2. Leadership review of resource requirements and allocation to ensure equal balance of work 3. Regular review at monthly face to face team meetings 4. Demand and capacity monitoring with Executive Team and adjusted where appropriate	1. Staff booking regular annual leave 2. Working hours review captured on 1-1 supervision record	

Care Unit Name: Medical

Experience Lead: Shayna Pearson

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Medical**
We are compassionate and inclusive	7.5	7.3
We are recognised and rewarded	6.3	6.3
We each have a voice that counts	6.9	6.6
We are safe and healthy score	6.3	6.3
We are always learning score	6.0	5.9
We work flexibly score	6.8	6.4
We are a team score	7.1	6.9
Staff Engagement score	7.0	7.0
Morale score	6.1	6.2

Respondents: 174

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Burnt out and exhaustion	We are safe and healthy: 12a, 12b, 12c, 12e, 12g	**EEMs to regularly visit wards, medical secretaries, doctors' training sessions and resident doctor inductions to check on staff wellbeing and morale. EEMs to involve Directors as and when needed to help address any complex issues that might need their attention.** **EEMs to provide regular reports to director of OD and culture.** **Re-introducing Schwartz Rounds (commenced January 2025)**	TBC – Finalising in February **Improved scores in relation to the theme 'We are safe and healthy' in the 2025 Annual Staff Survey.** **Reduced mental-health related sickness absence by March 2026 (ESR).** **Reduced voluntary resignations over a 12 month period**	Scheduled to present to the medical directors in the MMT meeting on 13th February 2pm *Adhoc action: Hawthorn Centre – equipment order has been signed off for trust site. This is to help support hybrid meetings/events and training.
Staff Recognition	We are recognised and rewarded: Q4 b	**TBC**	**Improved scores in relation to the theme "We are recognised and rewarded"**	

Care Unit Name: Major Projects & Programmes

Experience Lead: Shayna Pearson

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Major Projects & Programmes**
We are compassionate and inclusive	7.5	8.4
We are recognised and rewarded	6.3	7.9
We each have a voice that counts	6.9	7.7
We are safe and healthy score	6.3	7.2
We are always learning score	6.0	7.5
We work flexibly score	6.8	7.9
We are a team score	7.1	8.4
Staff Engagement score	7.0	7.5
Morale score	6.1	7.3

Respondents: 13

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Staff burnout and exhaustion	We are safe and healthy: 5a, 10b, 10c, 12a, 12b, 12c, 12e	1. Discuss additional wellbeing support for Inquiry Team, in addition to support from Here For You team.	TBC – finalising in February. Improved scores in relation to the theme 'We are safe and healthy' in the 2025 Annual Staff Survey. Reduced mental-health related sickness absence by March 2026 (ESR). Reduced voluntary resignations over a 12 month period	Met with service leads to discuss the results. Discussion on additional support to be provided to the team. Meeting TBC in February to discuss further progress.

Care Unit Name: Corporate Governance

Experience Lead: Hannah Beckwith

Staff Survey People Promise Comparator		
People Promise Element	**Comparator (Organisation Overall)**	**Corporate Governance**
We are compassionate and inclusive	7.5	7.2
We are recognised and rewarded	6.3	6.2
We each have a voice that counts	6.9	6.5
We are safe and healthy score	6.3	6.3
We are always learning score	6.0	5.8
We work flexibly score	6.8	6.7
We are a team score	7.1	6.8
Staff Engagement score	7.0	6.6
Morale score	6.1	6.0

Area of Focus	NSS Question/People Promise	Action agreed (SMART)	Measure of success (metric)	Progress
Compassionate culture	We are compassionate and inclusive (q6a, q25a, q25b, q25c, q25d)	1. Hold away day	Feedback evaluation of the day. Follow up session TBC.	Meeting request has gone out to leads to organise a meeting for after their away day to discuss what actions staff would like to see. Away day including team building will take place on the 7th Feb, staff survey results will be shared and "what is unprofessional behaviour" session held. All Heads of Service to ensure all staff have considered a reasonable adjustment passport and explore with staff any undisclosed disabilities. Emailed staff survey lead for an update on any established actions and updates from their away day held on the 07.02.25.
Autonomy & control	We each have a voice that counts (q3a, q3b, q3c, q3d, q3e, q3f, q5b)	2. Ensure all staff have 1:1's and appraisals booked, with appropriate objectives discussed.	100% completion rate on tracker. Staff have clarity of their role.	
Team working & motivation	We are a team (q7a, q7b, q7c, q7d, q7e, q7f, q7g, q8a)	3. Link with OD team for behaviours and team development.	NQPS results on motivation monitored.	
Motivation				

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 5

REFERENCES

Only PDFs are attached

Board Assurance Framework April 2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 April 2024

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

Risk Assessment of Report		
Summary of risks highlighted in this report	All high-level risks included in the Strategic and Corporate Risk Registers.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital and Data	✓
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

2 Note the increase in risk scores for:

- SR5 Lampard Inquiry
- SR6 Cyber Security

3 Note new controls assurance provided through the internal audit function.

4 Request any further information or action

Summary of Key Issues

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

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

The Board is asked to note:

- Board Assurance Framework dashboard providing an oversight, noting:

  A number of IA reviews providing controls assurance within the reporting period:

  - **SR6 Cyber Security** - IA opinion of reasonable assurance for the cyber security has been added to the controls assurance.
  - **SR8 Use of Resources** - IA opinion of reasonable assurance for the temporary staffing processes has been added to the controls assurance for enhanced controls for approval of temporary staffing use; and

    IA opinion of limited assurance for E-rostering non-medical rostering has been added to the controls assurance (negative) for Scheme of Delegation.
  - **SR13 Quality Governance** - IA opinion of reasonable assurance for the mortality review process has been added to the controls assurance for Quality Assurance Framework.

  Associated management actions are being taken to address identified gaps in control.

- Risks that have changed in risk score:

  SR5 Lampard Inquiry – a critical period of time with a significant number of Rule 9 requests from the Inquiry within short timeframe with timelines for submission mid-February 2025. As these are large in scope and complex the cumulative effect has necessitated additional capacity to be prioritised internally. We continue to hold open dialogue with the Inquiry team. As a consequence the risk score has been increased to 16 and continues to be under review.

  SR6 Cyber Security - Revised risk stratification approach discussed and approved at IGSSC - Revised risk score to 15 in response to cyber-attacks identified within other NHS organisations and wider supply chain, DSPT-CAF assessment adopted as additional measure of control.

- There were no risks de-escalated in this reporting period.

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

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

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓

SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

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

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

2 April 2025

Denver Greenhalgh,
Senior Director of Corporate Governance

EPUT

Risk Dashboard

February 2024

EPUT

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	0	2	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
2	0	9	7

% Risks with Controls Identified	% Risks with Assurance Identified	Actions Overdue	Risk Reviewed by Risk Owner
100%	100%	8	11

Overdue actions also include those with agreed timeline changed (11).

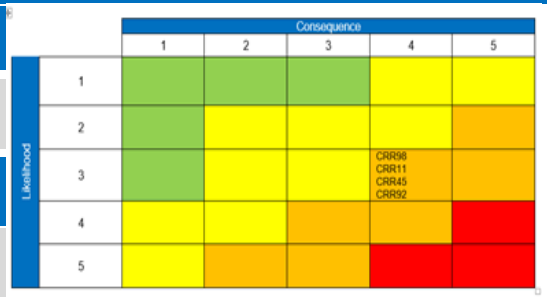
ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	4x2=8	8 8 16	Government led public inquiry in to Mental Health services in Essex	Critical period of time with a significant number of Rule 9 requests from the Inquiry within short timeframe with timelines for submission, with clarifications end of March 2025 . As these are large in scope and complex the cumulative effect will necessitate additional capacity to be prioritised internally. We continue to hold open dialogue with the Inquiry team. The Oversight Committee increased the risk score to reflect this current complexity and would review again post the April 2025 hearings.
SR7	All	Capital	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 20 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	Capital Plan for financial year 2025/26 plan set. Bid submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care, as part of 2025/26 capital plan.
SR8	All	Use of Resources	TS	Safety, Compliance, Service Delivery, Experience, Reputation	5x4=20	20 20 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Non- recurrent and unfound CIPs incorporated into new year plan. IA opinion of reasonable assurance for the temporary staffing processes has been added to the controls assurance for enhanced controls for approval of temporary staffing use. IA opinion of limited assurance for E-rostering non-medical rostering has been added to the controls assurance (negative) for Scheme of Delegation.
SR4	All	Demand and Capacity	AG	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The Demand and Capacity module (which provides predictive modelling and inpatient dashboard enabling visibility of patient level data and longest waits) is on track for the end of March 2025. The new Operational Model for Inpatient Services commenced implementation, including final recruitment to posts. Starting to see the implementation of outputs from the long stay review and system MADE events. New Governance and oversight of system delays and escalations put in place in January 2025 continues to function well. Implementing the shift trust-wide bed allocation to locality based model to ensure local MDT full involvement in discharge planning from the point of admission.
SR3	All	Infrastructure	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	A dedicated ERIC and PAM group has been established to review the national data submission and informs the strategy and Operating Plan. Capital Programme – a 10 year plan has been prepared and submitted to MSE and national team. Annual plan agreed within Capital programme 2025/26. Note extensions to actions to ensure alignment with business planning 2025/26.
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 8 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Revised risk stratification approach discussed and approved at IGSSC - Revised risk score L3 x C5 in response to cyber attacks identified within other NHS organisations and wider supply chain, DSPT-CAF assessment adopted as additional measure of control. IA opinion of reasonable assurance for the cyber security has been added to the controls assurance and associated new action to deliver management actions and cyber action plan.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR9	1	Digital and Data Strategy	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation.	Digital target operating model phase 1 staff consultation complete for senior team. Phase 2 will commence in April '25 following which the review and outcome will inform Phase 3. Care Unit digital prioritisation completed as part of operational planning cycle, capacity alignment to UEPR and key strategic / operational priorities defined. Action to close when operational plan is approved and submitted. Electronic Patient Record programme continues and contract awarded and signed.
SR10	ALL	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of Strategy and accompanying implementation plan commenced and has been updated to represent the additional activities on People Promise (retention). It is expected that the wider review of the strategy will take place between January and July 2025. Note: the further extension to enable work to be concluded (link same action SR11 and SR12). Training for the workforce modelling team and associated stakeholders in finance and care unit management teams established and controls are being monitored through the Operational Planning and Internal Workforce Planning meetings. Establish workforce modelling frameworks that link with operational plan and support the Trust and Care Units to have credible 1-5 year plans
SR11	ALL	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of strategy and accompanying implementation plan commenced. The new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority. Note: As a consequence of the level of transformation needed a further extension to enable work to be concluded (July 2025) - noting the co-dependency of the same action on risk SR10 and SR12.
SR12	ALL	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16 16 16	The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Review of Strategy and accompanying implementation plan commenced. The implementation plan has been updated to represent the additional activities on OD. It is expected that the wider review of the strategy will take place between January and July 2025. Note: extension to enable work to be concluded. Gap analysis of OD skills has been concluded and restructure consultation is underway.
SR13	1	Quality Governance	AS	Safety Effectiveness Experience Regulatory	5x3=15	15 15 15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	IA opinion of reasonable assurance for the mortality review process has been added to the controls assurance for Quality Assurance Framework. Focus on key metrics for each of the three quality areas including Time to Care is to be presented to Quality Committee (April 2025) with the view of triangulating different metrics and gaining insight to influence practice and provide assurance. SOPHIA platform is now live with a total of 33 published standard operating procedures, with a further 56 in draft. Staff are engaging with the platform with 5,309 confirmed users accessing to date. All policies and clinical guidelines have now been uploaded onto the platform. We will make the complete transition once the BCP database is fully validated and confirmed.

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
4	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	0	0	4



% Risks with Controls Identified	% Risks with Assurance Identified	Extended Actions	Risk Reviewed by Risk Owner
100%	100%	1	100%

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR98	Pharmacy Resource	FB	Safety	4x3=12	12 12 12	Continuous state of business continuity plan	Current vacancy factor is 10.2 wte. Of this, eight offers are in place with four commencing in post at the beginning of April and remaining four joining over the next three months; leaving a vacancy factor of 2.2wte. Reassessment of the risk will take place with the potential for de-escalation from the CRR.
CRR11	Suicide Prevention	MK	Safety	4x3=12	12 12 12	Implementation of suicide prevention strategy	The Effectiveness Group has been monitoring the progress against year 1 priorities and has agreed the priorities for year 2 (reported to the Quality Committee). Emphasis on a) self harm reduction; b) STORM training; c) Safety Plans; and d) Safe Discharges. As the priorities are developed into a delivery plan this action will be separated into the component parts for future reporting.
CRR45	Mandatory Training	MR	Safety Regulatory	4x3=12	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Bank staff training is at risk of not meeting compliance by the end of March. This is following the loss of 2 trainers within the team in the same time period. All active bank staff have been contacted for compulsory booking on to TASI courses to ensure high risk areas and active bank staff receive appropriate training. The reduction in bank staffing across inpatient and specialist services will support increased compliance by Summer 2025
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 12 12	Staff Experience	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. Utilising staff survey data and other relevant data points (Freedom to Speak Up, DATIX), a reset of EPUT specific EDI objectives aligned to this national framework will be agreed in April 2025. These objectives will address the deteriorating scores on the staff survey principally associated with racial discrimination and sexual safety (relates to questions 16b, 17b). The procurement of a Trust-wide culture review and senior leadership development programme will have professional behaviours and accountability as a key line of enquiry and delivery.

Strategic Risk Register

February 2024

EPUT

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previous reported completed actions 1- 4 and have been removed from the report. **Note 2:** Re-assessment of risk on completion of Estates Strategy as part of planning processes with timeline of end of March '25. **Note 3**: Extension to actions 5 and 6 to align with business planning for 25/26.

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
5	Review ERIC data submission against Peer groups and determine efficiencies	Extended April '25	MM	Control	A dedicated ERIC and PAM group has been established to review the national data submission and informs the strategy and Operating Plan.
6	Develop action plan for Premises Assurance Model (PAM) outstanding tasks	Extended April '25	MM	Control	A dedicated ERIC and PAM group has been established to review the national data submission and informs the strategy and Operating Plan.
7	New Action: Capital programme to be established for Estates	Mar-25	MM/JD	Roadmap	Capital Programme – a 10 year plan has been prepared and submitted to MSE and national team. Annual plan agreed within Capital programme 2025/26.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1-5, 8 and 9 have been removed from the report.
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Operating Officer Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff (including skilled flexible workforce via Trust Bank) Discharge Co-ordinator Teams	Establishment and Fill Rate Director of Operational Performance Agency Framework in place New roles: Activity Coordinators Clinical Flow Lead (Dr Bogdan) Jan '25	Performance Reporting Accountability Framework Meetings	
Care Unit Leadership	Establishment Integrated Director posts		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy	Dedicated discharge coordinators CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Yr2 Report to Board (Mar '23)	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitReps/ Performance Reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2023/24	Developed including out of area plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System Escalation in place
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

Actions (to modify risks)		By When	By Who	Gap	Update
6	Demand and Capacity module to be procured and fully implement	Extended March '25	JL	Control	The Demand and Capacity module (which provides predictive modelling and inpatient dashboard enabling visibility of patient level data and longest waits) is on track for the end of March 2025.
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Extended March '25	AG	Control	The system has appointed external consultant to support the risk share review and conclusion. PID complete and data collection requested, timeline on track.
8	Implementation of new operating model	Mar '25	LW	Control	The new Operational Model for Inpatient Services has been agreed and the launch events and training have concluded. Now commencing implementation, including final recruitment to posts. There is progress being seen with a reduction in temporary staffing use (month 11 reporting).
10	Implementation of recommendations following long stay review and system MADE events across the trust and system.	Jun '25	SG	Control	Starting to see the implementation of outputs from the long stay review and system MADE events. New Governance and oversight of system delays and escalations put in place in January 2025 continues to function well.
11	**New Action**: Implementation of a clinical and operational prioritisation matrix for bed allocation at locality.	April '25	NB	Control	Implementing the shift trust-wide bed allocation to locality based model to ensure local MDT full involvement in discharge planning from the point of admission. This shift to local accountability will improve the management of flow and improve our patient access to inpatient services where needed.

SR5 - Lampard Inquiry (At a Glance)

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

Likelihood based on: The Trust not effectively meeting the Rule 9 requests due to information not being found, unavailable or due to incomplete records

Consequence based on: Failure to respond resulting in the risk of a section 21 notice being issued to the Trust and the loss of confidence by the population of Essex.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C4 x L4 =16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1,2,3 and 5 have been removed from the Board report. **Note2:** Critical period of time with a significant number of Rule 9 requests from the Inquiry within short timeframe with timelines for submission, with clarifications end of March 2025 . As these are large in scope and complex the cumulative effect will necessitate additional capacity to be prioritised internally. We continue to hold open dialogue with the Inquiry team. The Oversight Committee increased the risk score to reflect this current complexity and would review again post the April 2025 hearings.

Executive Responsible Office: Executive Director Major Projects Board Committee: Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment and reporting in place.		
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Nigel Leonard) Project Director Browne Jacobson Essex Chambers	Trust Board of Directors	Internal audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry.
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Resources from GW. Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Support for families	Report from HPT to Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee, BOD	Internal audit.
Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Schedule meetings for Care Units and Wards in place	Ongoing	GW	Control	Ongoing schedule in place to attend Care Unit Meetings and completing staff visits.
6	Reviewing resources to ensure (C2) Best value for money; Right skills and resources in place; Operational planning	Extended Mar '25	GW/GB	Control	Rule 9 requests, clarifications and additional information requests continued to be received requiring additional staffing resource to be mobilised. It is anticipated that will reduce April 2025 to be in line with the Project Team's capacity. Constant review of prospective resources being undertaken. An increase in legal support required to finalise statements, and will continue in preparation for the scheduled April hearings.
7	Information system procured and in place (C3).	Complete	GW/GB	Control	System is in place and staff to receive training following conclusion of Rule 9 submissions by the end of March '25.
8	Rule 9 progress (C1 and 4) R9 (1) Draft Statement R9 (4) Draft Statement Other Rule 9s received (2-6) submitted in draft to the Inquiry.	Ongoing	GB	Assurance	Eight statements have been finalised and to be provided to the Inquiry in March 2025. Further Rule 9 requests allocated to Executive Directors and work underway facilitated by project leads.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C4 x L3= 12*	**Note 1:** Previous reported completed actions 1 - 6 have been removed from the report**.** **Note 2:** New action regarding delivery of management actions and cyber action plan. **Note 3:** Revised risk stratification approach discussed and approved at IGSSC - Revised risk score L3 x C5 in response to cyber attacks identified within other NHS organisations and wider supply chain, DSPT-CAF assessment adopted as additional measure of control. **Note 4:** IA opinion of reasonable assurance for the cyber security has been added to the controls assurance.

Executive Responsible Office: Executive Director Strategy Transformation and Digital
Board Committee: Finance and Performance Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC TIAA IA Reasonable Assurance (2025)	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; TIAA internal audit 2025 – overall reasonable assurance opinion	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming Audit
Business Continuity Plans and National Cyber Team processes	BCPs for critical systems in place. Cyber Incident Response Procedure (CIRP) approved.	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	TIAA Internal Audit 2025 DSPT -CAF underway in readiness for June submission of toolkit.

	Actions (to modify risks)	By When	By Who	Gap	Update
7	Implementation of revised cyber security stratification approach taking into account national NHS cyber risk profile.	Complete	AW	Control	New cyber risk assessment criteria has been developed, additional measures implemented to inform the cyber assurance report to Finance and Performance Committee. Implementation of the new framework was approved by the Information Governance steering sub-committee on the 10 Feb '25.
8	Assessment and development of action plan of the outcomes of the November 24 cyber penetration test and cyber security internal audit	Complete	AW	Control	Assessment of outcome is complete and addressed through the cyber risk action plan, with assurance oversight through Finance and Performance Committee. Internal audit report received a reasonable assurance assessment b the auditors and reported to the Audit Committee. Management actions will be tracked though IGSSC.

Actions (to modify risks)		By When	By Who	Gap	Update
9	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Jun-25	AW	Assurance/Control	Preliminary baseline assessments complete - an action plan is in development to address gaps and will be presented at the next Information Governance steering sub-committee on the 10 Feb '25 for onward reporting to the Finance and Performance Committee.
10	New Action: Delivery of IA management actions and associated cyber action plan in response to the 2025 internal audit on Cyber and 2024 Pen test	Jul '25	AW	Assurance/Control	Seven Actions identified from Audit: six in progress and one completed - on track to complete. Penetration test findings mitigation plan on track.

SR7- Capital (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previously completed action 2 has been removed from the report.
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources 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;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2023/24 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	OBC Agreed

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Bid submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care, as part of 2025/26 capital plan.
3	Track key strategic investments i.e. EPR to be monitored for impact on Capital Programme	Complete	JD	Control	Electronic Patient Record programme continues and contract awarded and signed. Tracking of EPR investments will now be part of business as usual monitoring and action closed.
4	Capital Plan for financial year 2025/26	Complete	JD	Control	Action complete - plan agreed.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	**Note 1:** Previous reported completed actions 1,3 - 5 has been removed from the report. **Note 2:** Note extension to management actions as part of action 2 (over delivery of efficiency targets in care units / Directorates to offset the off plan position). **Note 3**: Note new actions 12 and 13 to put in place enhanced controls on committing expenditure. **Note 4:** IA opinion of reasonable assurance for the temproary staffing processes has been added to the controls assurance for enhanced controls for approval of temporary staffing use. Note 5: IA opinion of limited assurance for E-rostering non-medical rostering has been added to the controls assurance (negative) for Scheme of Delegation.

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023). IA E-rostering - Limited Assurance opinion.
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	NOF Rating
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2024/25			
Forecast Outturn and risk/ opportunities assessments 23/24			
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team		IA Temporary Staffing Processes - Reasonable assurance.

	Actions (to modify risks)	By When	By Who	Gap	Update
2	Deliver Financial Efficiency Target	Mar '25	TS	Control	Non- recurrent and unfound CIPs incorporated into new year plan.
6	Deliver Financial plan for 24/25	Mar '25	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Forecast outturn agreed with region and national team.
7	Investigate & Intervention Programme Activity: Rostering and scheduling with Total Mobile and Health Trust Europe.	Mar '25	AM	Control	Progressing Workforce roster management progressing through weekly executive escalation with in-patient mental health services. Additional Accountability Escalation Framework meetings for focus on temporary staffing put in place.

Actions (to modify risks)		By When	By Who	Gap	Update
8	Investigate & Intervention Programme Activity: Estates commercials review i.e. leases, PFI, PropCo and Valuation options.	Mar '25	TS	Control	New valuation officer agreed. ProCo dispute ongoing.
10	Investigate & Intervention Programme Activity: VAT advice relating to a single contract (details provided to PwC)	Complete	TS	Control	Complete
11	Investigate & Intervention Programme Activity: Property Top-Up Insurance (details provided to PwC).	Mar '25	DG	Control	Linked to corporate services running cost reductions this is being progressed.
12	New: Enhanced approval controls for the use of temporary staffing	March '25	AMc	Control	Enhanced controls around temporary staffing with an emphasis on bookings not exceeding budgeted establishment unless exceptional circumstances where patient safety may be impacted to remain in place. Continuing and expanding this into 2025/26.
13	New: Enhanced recruitment controls for Corporate Services	March '25	AMc	Control	Enhanced controls on the recruitment to substantive roles in corporate services and also across administrative and clerical staff group unless exceptional cases where patient safety and business critical requirements support the role being recruited to remain in place. Continuing into 2025/26.

SR9- Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*	**Note 1:** Previously reported complete action 1-3 and 5-9 have been removed from the report. **Note 2:** Note new action 11 and 12 moving to next stages in the Digital Target Operating Model and UEPR.

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Resources			
IT/Digital team Resource and skill set is appropriate and sustainable	Education and training in specific technology Target operating model - modernise digital services	Digital strategy resource management (RAID Log)	
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.	CCIO/CNIO oversight		
Strategies & Policies			
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures	Information governance controls processes	Information Governance Steering Sub-Committee reporting and assurance	Data Security and Protection toolkit assessment (Standards Met) 2024
Data quality is of a standard that assures national standards.	Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT “standards met” can be achieved		Internal Audit	DSPT submission and Cyber assurance framework
Investment			
Capital allocation to digital and data initiatives secured	Approved Digital capital plan 2024/25		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes	Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation			
The space and governance exists to support innovation	CIO discover opportunities from national forums and partners (incl. Academic)	Innovation strategy governance - Strategy Steering Group	
Academic partnerships promote innovation	CIO engagement with academic partners on digital innovation opportunities		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
4	Digital target operating model implementation (Phase 1)	Complete	AW	Control	Digital target operating model phase 1 staff consultation complete for senior team. See new action 11 for Phase 2.
10	Prioritisation of capacity alignment to the UEPR programme whilst protecting the delivery of the trusts wider strategic objectives.	Mar-25	AW/RP	Control	Care Unit digital prioritisation completed as part of operational planning cycle, capacity alignment to UEPR and key strategic / operational priorities defined. Action to close when operational plan is approved and submitted.
11	New Action: Digital target operating model implementation (Phase 2)	Sep-25	AW	Control	Phase 2 will commence in April '25 following which the review and outcome will inform Phase 3.

Actions (to modify risks)		By When	By Who	Gap	Update
12	New Action: Implementation of new UEPR	Apr '27	ZT	Control	Electronic Patient Record programme continues and contract awarded and signed.

SR10: Workforce Sustainability

Risk Description: If EPUT does not have workforce plans that support recruitment and development, then staff may not choose to remain at EPUT, resulting in associated skills deficit, reliance on temporary staffing, staff morale and our ability to provide high quality of care to our services users.

Likelihood based on: Staff turnover, temporary staff usage and EPUT ability to provide career pathways
Consequence based on: Staff morale (staff survey results), skills gaps and identified quality of care risks associated with workforce sustainability.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3= 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 2 and 3 have been removed from the report. **Note 2**: The further extension of action 1 to July 2025.

Executive Responsible Office: Executive Director People and Culture
Director Lead: Paul Taylor
Board Committee: People Equality and Culture

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People and Education Strategy	People Strategy Implementation Plan	Strategy approved by Board of Directors 2024. Bi-annual Strategy Progress Reports to Board	
Recruitment and Retention Strategy	Recruitment & Retention Strategy	Recruitment Assurance Report & People Promise (Retention) Report	System People Board oversight of recruitment, retention and temporary staffing performance
Operational Plans	Accountability Framework meetings monitoring of plan delivery	PECC oversight reporting - month 6 actuals against the plan (noting the revised trajectory presented at the October '24 meeting).	
Workforce Planning and Modelling Team	Care Unit and Corporate workforce plans Operational Planning Meeting Workforce Planning Meeting	PECC oversight of workforce modelling plans at Trust level.	Submission to system plans

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review the People & Education Strategy and associated implementation plan with emphasis in staff retention.	Extended July 2025	Chief People Officer	Road Map	Review of Strategy and accompanying implementation plan commenced and has been updated to represent the additional activities on People Promise (retention). It is expected that the wider review of the strategy will take place between January and July 2025. **Note:** the further extension to enable work to be concluded (link same action SR11 and SR12).
4	To establish training for the workforce modelling team and associated stakeholders in finance and care unit management teams.	Complete	Associate Director of People - Operational HR	Control	Training established and controls are being monitored through the Operational Planning and Internal Workforce Planning meetings.
5	To establish workforce modelling frameworks that link with operational plan and support the Trust and Care Units to have credible 1-5 year plans.	Complete	Associate Director of People - Operational HR	Control	Frameworks established and controls are being monitored through the Operational Planning and Internal Workforce Planning meetings.

SR11: Staff Retention

Risk Description: If EPUT does not effectively and efficiently manage a coherent staff retention strategy, then will continue to effect staff and skills shortages in certain professions resulting in associated skills deficit, impact on staff morale and our ability to provide high quality of care to our services users.

Likelihood based on: Staff turnover, temporary staff usage and EPUT ability to provide career pathways
Consequence based on: Staff morale (staff survey results), skills gaps and identified quality of care risks associated with workforce sustainability.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3= 12*	*C4 x L3 = 12*	**Note1:** Previously reported completed actions 2 - 5 have been removed from the report. **Note 2**:The further extension of action 1 to July 2025.

Executive Responsible Office: Chief People Officer **Director Lead**: Director of OD and Culture **Board Committee**: People Equality and Culture	**Controls Assurance**

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Staff Experience Team (aligned with Retention Strategy and priority areas)	The new Director of OD & Culture to oversee alignment and development of strategy.	Operational Workforce Group and oversight and assurance at PECC	
People and Education Strategy	People Strategy Implementation Plan	Approved by Board of Directors January 2024	
People Promise investment by NHS England	People Promise Manager in post	People & Culture Indicators in IPR with oversight at PECC with emphasis on turnover rates and trends.	Workforce Key Performance Indicators oversight at System People Board

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review People Strategy and associated implementation plan with emphasis on staff retention.	Extended July 2025	Chief People Officer	Control	Review of strategy and accompanying implementation plan commenced. The new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority. **Note:** As a consequence of the level of transformation needed a further extension to enable work to be concluded (July 2025) - noting the co-dependency of the same action on risk SR10 and SR12.

SR12: Organisational Development

Risk Description: If EPUT does not have in place effective OD support to address cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.

Likelihood based on: limitations of workforce plans that support recruitment and development leading to workforce sustainability
Consequence based on: Staff Survey (culture indicators) and identified quality of care risks associated with workforce sustainability.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L4= 16*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 2, 3 and 6 have been removed from the report. **Note 2:** The further extension of action 1 to July 2025. **Note 3**: new action to deliver the OD and Development Programme.

Executive Responsible Office: Chief People Officer
Director Lead: Director of OD and Culture
Board Committee: People Equality and Culture

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
OD Team	The new Director of OD & Culture	Oversight will be provided and sought by PECC by Director of OD & Culture.	
People and Education Strategy	Oversight by Learning & Education Group	Oversight by PECC and approved by Board of Directors January 2024	
Key performance indicators.	Workforce Efficiency Group	Oversight by PECC and Board within the Integrated Performance Report	Oversight by system People Board.

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review People Strategy and associated implementation plan with emphasis on staff retention	Extended July 2025	Chief People Officer	Control	Review of Strategy and accompanying implementation plan commenced. The implementation plan has been updated to represent the additional activities on OD. It is expected that the wider review of the strategy will take place between January and July 2025. **Note:** extension to enable work to be concluded.
4	To undertake a gap analysis of OD skills to determine what is required to be effective	Complete	Director of OD & Culture	Control	Analysis complete, with job descriptions aligned to bridge the gaps. Commenced OD and Development Team restructure.
5	To source partnership arrangements with effective and established OD practitioners alongside an effective development plan that supports OD skills at the Trust	Complete	Director of OD & Culture	Assurance	OD Practitioners sourced externally to support with three main areas of senior leadership development programme and cultural review.
7	New Action: To deliver OD and Development programme		Director of OD & Culture	Control	Following conclusion of the gap analysis (action 4) restructure consultation underway.

SR13 - Quality Governance (At a Glance)

Risk Description: If EPUT does not have in place effective floor to Board quality governance and is not able to provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting (including triangulating a range of quality and performance information), then this may result in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.

Likelihood based on: Incidence of repeat incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions from the Care Quality Commission.

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** IA opinion of reasonable assurance for the mortality review process has been added to the controls assurance for Quality Assurance Framework.
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Nurse
Board Committee: Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (outcome detail to be added)
Patient Safety Incident Management Team	Team Established		IA PSIRF (outcome detail to be added)
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		
Learning Collaborative Partnership	Forum attendance and effectiveness review.		
Learning information communications plan			
Patient Safety Dashboard			
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports (pull forward details)
ESLMS			
Patient Incident Response Plan			
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA (outcome detail to be added)
Clinical Audit Programme	Annual Plan and Outputs	Quality Committee Oversight	National Audits / Confidential Inquiries Reports and Organisational reports
Quality Assurance Framework: Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits Compliance Reviews (Clinical Audit Plan / Compliance Team Reviews)	Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits		IA Mortality Review Processes 2025 - Reasonable assurance opinion.

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Develop and implement Quality Dashboard	April '25	RT / AW	Control	Focus on key metrics for each of the three quality areas including Time to Care is to be presented to Quality Committee (April 2025) with the view of triangulating different metrics and gaining insight to influence practice and provide assurance.

	Actions (to modify risks)	By When	By Who	Gap	Update
2	Raise the visibility of senior quality leaders within the Trust (through Back to Practice Visits) and embed.	May '25	AS	Assurance	Back to practice visits (Quality visits) are continuing with one of the Directors of Nursing having a focus on physical health services.
3	Refresh awareness of raising patient safety incidents and reporting.	July '25	MA	Control	Director of Patient Safety has met with Datix Manager who has organised drop in sessions and videos to support staff learning.
4	Continue to full implementation of the eSOP programme (ensuring that all SOPs are reviewed and uploaded to the new SOPHIA system)	Sep '25	RB/RJ	Control	SOPHIA platform is now live with a total of 33 published standard operating procedures, with a further 56 in draft. Staff are engaging with the platform with 5,309 confirmed users accessing to date. All policies and clinical guidelines have now been uploaded onto the platform. We will make the complete transition once the BCP database is fully validated and confirmed.
5	Deliver Safety Improvement Plans and embedding the learning.	Jun '25	NA	Control	Learning events to be held in April 2025 which will include a presentation on SIPs and a focus on improvements and learning. Communications plan in development for all staff to support continuous engagement and dissemination of learning.
6	Review the Quality forums from Care Unit to Board and reporting.	Sept '25	AS/DG	Control	A template has been provided to each Care Unit to support local Quality and Safety meetings that reflects experience, effectiveness and safety of care. An evaluation review and monitoring will be undertaken to confirm impact and sustainability.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Jul '25	RP	Assurance	Review will commence at the end of this month March 2025 - initial findings highlight some areas of non-adherence to plan. This will be explored further as part of the review to understand the causative factors.
8	To incorporate actions arising from PSII / Homicide Reviews and MHA inspections into the Action Leads Meeting for tracking and evidence assurance.	May '25	NJ/MA/ TM	Control / Assurance	PFD actions added November '24, following a period of embedding other areas will be added.

Corporate Risk Register February 2024

EPUT

CRR11 - Suicide Prevention

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1 - 4 have removed from the report for CRR11.
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*	

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	The Effectiveness Group has been monitoring the progress against year 1 priorities and has agreed the priorities for year 2 (reported to the Quality Committee). Emphasis on a) self harm reduction; b) STORM training; c) Safety Plans; and d) Safe Discharges. As the priorities are developed into a delivery plan this action will be separated into the component parts for future reporting.

CRR45: Mandatory Training

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L5= 20	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note 1:** Previously reported completed actions 1- 4 have been removed from the report. **Note 2**: The further extension of the action to achieve full compliance of 90% of bank staff having received TASI training.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Extended June '25	PT	Control	Bank staff training is at risk of not meeting compliance by the end of March. This is following the loss of 2 trainers within the team in the same time period. All active bank staff have been contacted for compulsory booking on to TASI courses to ensure high risk areas and active bank staff receive appropriate training. The reduction in bank staffing across inpatient and specialist services will support increased compliance by Summer 2025

CRR92: Addressing Inequalities

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	**Note 1:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report. **Note 2:** A review of the controls assurance is being undertaken to refresh the assurances from the recent staff survey results.

Executive Responsible Office: Executive Director People and Culture Director Lead: Paul Taylor Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	HIA4: Addressing Inequalities Staff Survey Results Increase of 0.86% for "My organisation takes positive action on health and well-being." (Staff Survey Q11a) Decrease of 4.16% for "How often, if at all, do you feel burnt out because of your work?" (Staff Survey Q12b) Decrease of 1.79% for "In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?" (Staff Survey Q11b) Decrease of 0.86% for "During the last 12 months have you felt unwell as a result of work related stress?" (Staff Survey Q11c) Decrease of 2.87% for "In the last three months have you ever come to work despite not feeling well enough to perform your duties? (Staff Survey Q11d)
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (inc. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place HIA2: Evaluation RISE 28.95% of participants achieved their goals completely, 89.47% of participants reported that the programme had a significant personal impact 27% have been promoted	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES / Gender Pay Gap	WRES and WDES plans in place Executive Sponsorship of plans		HIA3: For Pay Gap below the national average of 14.9% and has shown improvement from 2017 to 2023
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		HAI6: Eliminate Violence, Bullying and Harassment Staff Survey: Decrease of 0.75% for "In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers?" (Staff Survey Q14b) Decrease of 2.07% for In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? (Staff Survey Q14c) "On what grounds have you experienced discrimination?" Staff Survey Q16c
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	A three part organisational development plan commences in April with clinical staff across Specialist Services, focussed on unprofessional behaviours and a focus on sexual safety. This will be scaled up across the Trust following the learning and aims to bring to life the behaviour framework, enhance inclusion and safety for our staff.
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	LH	Control	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. Utilising staff survey data and other relevant data points (Freedom to Speak Up, DATIX), a reset of EPUT specific EDI objectives aligned to this national framework will be agreed in April 2025. These objectives will address the deteriorating scores on the staff survey principally associated with racial discrimination and sexual safety (relates to questions 16b, 17b). The procurement of a Trust-wide culture review and senior leadership development programme will have professional behaviours and accountability as a key line of enquiry and delivery.

CRR98: Pharmacy Resource

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L2 = 8*	

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	
1	Continue with recruitment campaign	Ongoing	HS	Control	Current vacancy factor is 10.2 wte. Of this, eight offers are in place with four commencing in post at the beginning of April and remaining four joining over the next three months; leaving a vacancy factor of 2.2wte. Reassessment of the risk will take place with the potential for de-escalation from the CRR.

Risk Movement and Milestones

Strategic Risk Movement – two year period (Feb 23 – Feb 25)

Risk ID	Initial Score	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
SR1	20	20	20	20	20	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	Closed			
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15
SR4	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**	15	15
SR5	20	15	15	15	15	15	15	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	16
SR6	12	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15
SR7	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20
SR8	15	15	15	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20
SR9	20												New	20	15	15	15	15	15	15	15	15	15	**15**	15	15
SR10	16																					New	16	**12**	12	12
SR11	16																					New	16	**12**	12	12
SR12	16																					New	16	**16**	16	16
SR13	20																						New	**15**	15	16

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two year period (Feb 23– Feb 25)

Risk ID	Initial Score	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**
CRR45	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	12	16	**12**
CRR77	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	8	**D**		
CRR81	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	**D**		
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**
CRR93	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10	**D**		
CRR94	16	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	10	**D**		
CRR98	20	20	20	20	20	20	20	20	20	20	20	20	20	20	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**

8.2 LEARNING FROM DEATHS Q3 REPORT

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Learning from Deaths Q3 2024-25 Report (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	02 April 2025

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data Report Q3 2024/25**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, (Learning from Deaths Co-ordinator)					
Report discussed previously at:	Learning from Deaths Oversight Group (18/02/25) Learning Oversight Sub-Committee (26/02/25) Safety of Care Group (27/02/25) Quality Committee (13/03/25)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	On-going risk relating to the resourcing capacity within the learning from deaths workstream being addressed Data processes currently in place continue to be reviewed to further strengthen the Trust's ability to undertake mortality surveillance		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand / Capacity		
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		✓
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		✓
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report

This report presents to the Board of Directors the *Learning from Deaths – Quarterly Overview of Learning (Q3 2024/25)* report, which includes the following: • Mortality context and data relating to Q3 2024/25; and • An overview of key learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report; and

2. Request any further information or action

Summary of Key Points

1. The Trust implemented the current Learning from Deaths Policy and Procedural Guidelines from 1 April 2022. Prior to that, the Trust had a Mortality Review Policy in place.

2. The Learning from Deaths – Quarterly Overview of Learning and Data report for Q3 2024/25 is attached. This presents data that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. The Q3 2024/25 data was extracted and analysed as at 04/02/25. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q3 data, which is broadly in line with that of previous quarters.

3. It also presents an overview of key learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. Detailed learning is presented on a monthly basis to the Trust's Learning from Deaths Oversight Group, Learning Collaborative Partnership and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

4. The processes by which mortality data is collated and analysed have been developed and refined over the past two years. However there continues to be scope to further refine and strengthen those processes, utilising improving technologies available to the Trust. Page 4 of the report details some of the work being undertaken to strengthen processes.

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

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

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

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

Acronyms/Terms Used in the Report			
LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	EDAP	Essex Drug and Alcohol Partnership

Supporting Reports and/or Appendices

Attached:

- Report: Learning from Deaths – Quarterly Overview of Learning and Data (Q3 2024/25)

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

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

Executive/ Non-Executive Lead / Committee Lead:

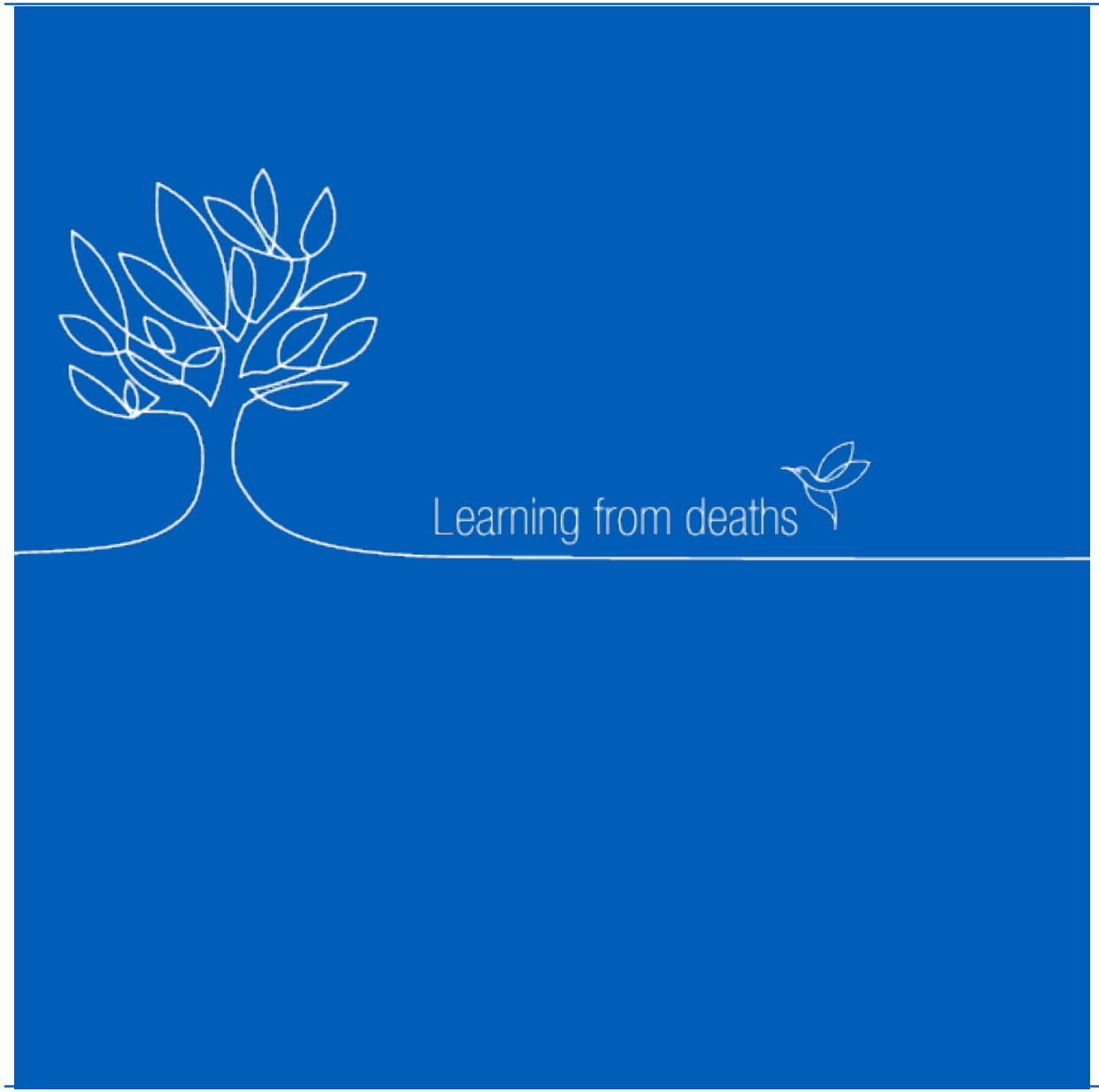
Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 3 - 2024/25

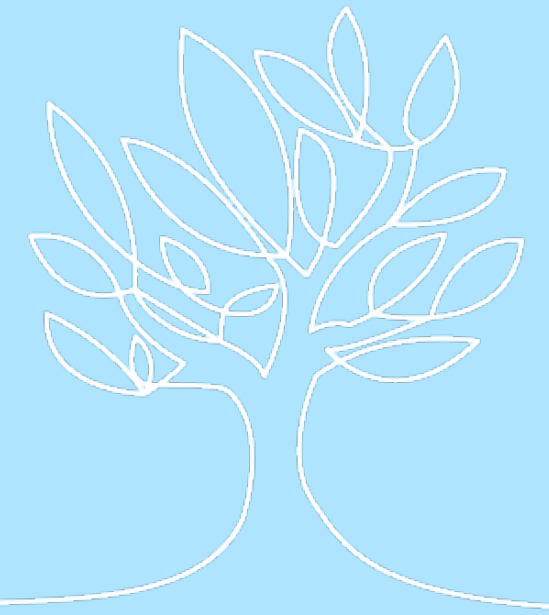


PURPOSE OF REPORT

This report sets out:

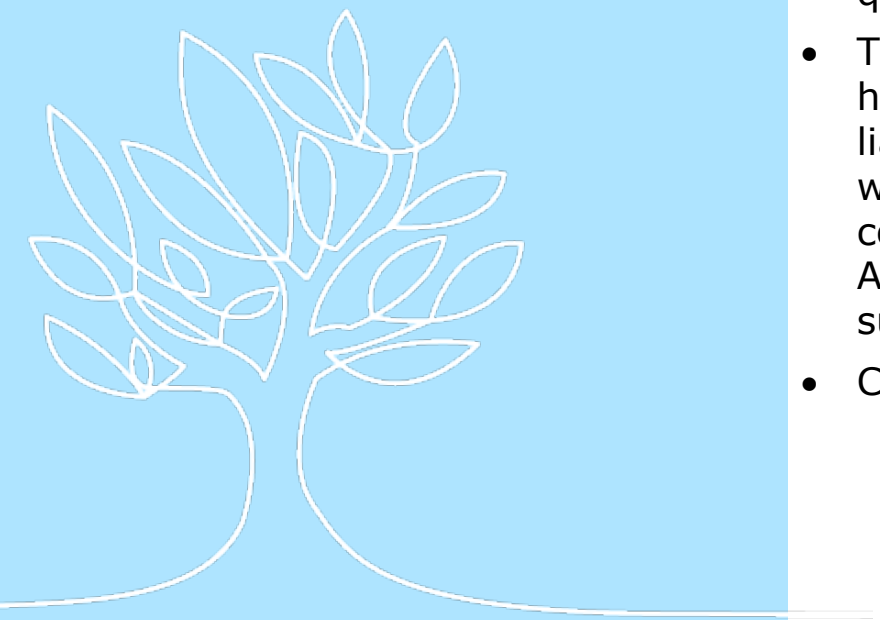
- Data relating to deaths recorded on Datix for Q3 2024/25 (1st October – 31st December 2024) (page 3);
- An update on developments being made to mortality reporting and review processes (page 4);
- Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board of Directors (pages 5-7);
- An example of specific learning and action from the review of a death under the Patient Safety Incident Response Framework (PSIRF) (page 8 - 10);
- Outcomes of mortality surveillance using statistical process control methodology (Appendix 1 – page 12); and
- Updated summary of mortality data – key points (Appendix 2 – pages 13).

Summary of Quarter 3 2024/25 mortality data (as at 04/02/25)



- **Total number of deaths reported:** There were a total of 127 reports of deaths made on Datix, relating to 125 deaths for Q3 2024/25 (including those not falling within the scope for mandatory reporting). To date, a total of 24 of those reported deaths have been deemed in scope for mandated reporting under the policy. Deaths reported on Datix over and above the deaths in mandated scope of the policy provide additional opportunities for the Trust to learn.
- **Inpatient / Nursing Homes deaths:** Of the 125 deaths reported in Q3, 4 were EPUT inpatient deaths and 4 were EPUT nursing home deaths. Two of the four inpatient deaths and all of the nursing homes deaths have been confirmed as due to natural causes. 2 of the inpatient deaths were sadly unexpected unnatural deaths and investigations are underway under PSIRF.
- **LeDeR reporting validation:** All 6 reported Learning Disability deaths have been confirmed as reported to the national LeDeR programme.
- **Stage 1 (Datix) reviews:** To date, a total of 79 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of these deaths. Stage 1 reviews are still actively awaited for 38 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 1 death in Q3 has been identified to date for Stage 2 mortality clinical case note review / thematic review.
- **Stage 3 (PSIRF) reviews:** A total of 4 deaths in Q3 have been identified to date for PSIRF review.
- **Problems in care assessment:** There are 0 deaths for Q3 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The approach to making this determination for deaths reviewed under PSIRF arrangements is under consideration as there is no national methodology for this. The determination will be made for death reviews already completed under the PSIRF arrangements once the Trust approach is agreed.

Mortality Data – Update on future developments



- The Trust continues to work on system enhancements whereby all patient deaths will be identified from the "National Spine", a central record fed by GP clinical systems, and included on a dashboard built in-house for Care Units to access on a daily basis for timely notifications of deaths.
- A new initial deceased patient review tool is being built onto all the Trust's Electronic Patient Records systems. This will be completed by service leads for all deaths to provide a record of review of all deaths (including learning) and to determine whether the death falls within the scope of the Trust's policy for report onto Datix.
- The technical system enhancement works are now almost complete and a period of testing / piloting will start shortly. It is hoped to start to launch the new arrangements in April 2025, with reporting being included in the Q1 2025/26 quarterly report onwards.
- There are no standard national, regional or local arrangements in place for trusts to have direct access to confirmed causes of death. The Trust is therefore continuing liaison with local Medical Examiners Offices and intends to commence discussions with Local Authority Registrars about establishing data flows to the Trust on confirmed causes of deaths for all deaths, not just those referred to HM Coroner. Appropriate information sharing agreements will be put in place in respect of any such information sharing.
- Consideration is also being given to:
    - how further automation could be introduced into the process for producing the quarterly mortality data; and
    - the agreement of some Key Performance Indicators to monitor the progress and timeliness of reporting and mortality reviews.

Key learning themes emerging from Stage 1 reviews

December 2024 – February 2025

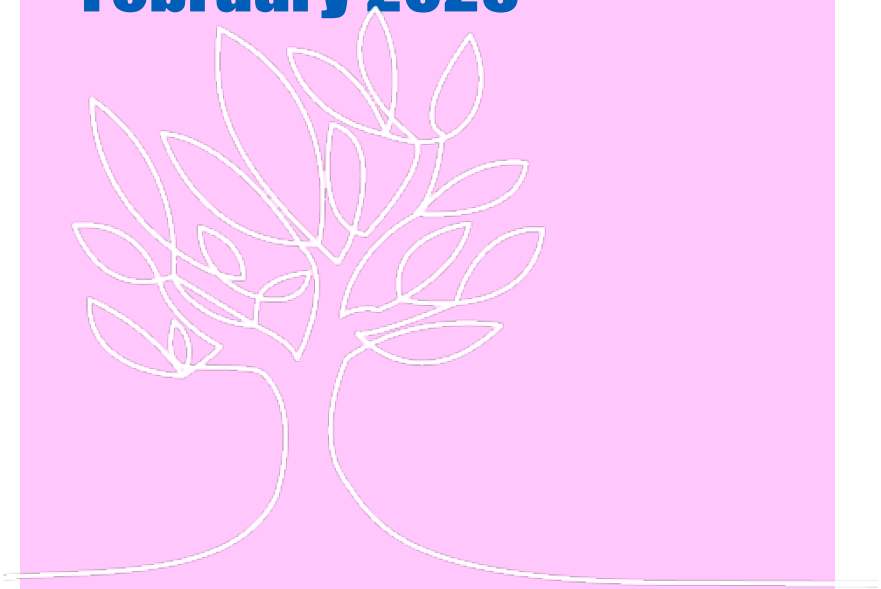
The three most common themes emerging from Stage 1 reviews of deaths in the period were as follows:

- **Theme 1:** Many of the deaths of patients are **expected deaths of patients often receiving end of life care** (cited in 18 reviews)**.** The Trust has a specific workstream in place designed to monitor the quality of end of life care provided by the Trust and to ensure this is strengthened, including quality audits reported via the Trust's governance structures.
- **Theme 2:** The majority of the deaths reviewed are from **physical health causes** (eg long term conditions, terminal illness, expected deaths of patients receiving end of life care, physical health crisis, deaths in Acute Trust hospitals) (cited in 16 reviews). Again, the Trust has a specific workstream in place to strengthen physical health monitoring and care of patients. The workstream has identified specific quality priorities and monitors / oversees achievement of these.
- **Theme 3:** For many deaths of patients, the Trust **does not have information on confirmed cause of death** which limits the Trust's ability to draw learning conclusions relating to the deaths (cited in 7 reviews). As outlined on page 4, work is being undertaken to establish data flows to the Trust to achieve routine receipt of timely information on confirmed causes of death for all patients to strengthen learning outcomes.

Other themes emerging from Stage 1 reviews during this period included clinical care, medication issues, transfers of care, nutrition, substance issues, records and declining services.

Key learning themes emerging from Stage 2 Clinical Case Note Reviews

December 2024 – February 2025



STAGE 2 CLINICAL CASE NOTE REVIEWS:

Since the last report to the Board of Directors, there have been two Stage 2 reviews approved. Learning was as follows:

Review 1:

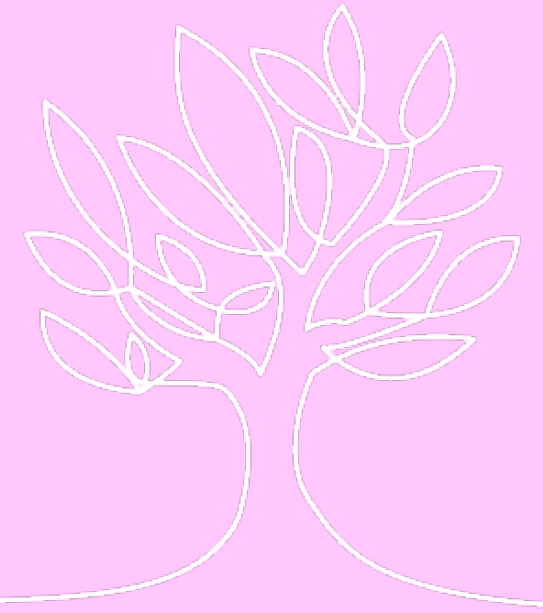
It was concluded that the patient had received excellent, consistent care from the mental health service and there was no learning identified.

Review 2:

It was concluded that there were no learning points relating to the care provided to the patient. However, learning was identified in terms of there being no standard process for notifying the Trust of deaths occurring in acute hospital settings meaning that mental health teams involved are informed much later which can be very distressing for the staff and family (e.g. if contact is made not knowing that the patient is deceased). The work underway to introduce a locally built dashboard of patient deaths (detailed on page 4 of this report) will significantly improve Trust services' awareness of patient deaths on a timely basis.

Key learning themes emerging from Stage 3 (PSIRF) reviews

December 2024 – February 2025



Since the last report to the Board of Directors, 24 deaths reviewed and closed under PSIRF since June 2024 have been added into the themed analysis of PSIRF learning emerging.

The three most common themes that learning identified was associated with were:

Theme 1: Clinical care (including for example care planning, risk assessment, multi-disciplinary team (MDT) discussions, observations)

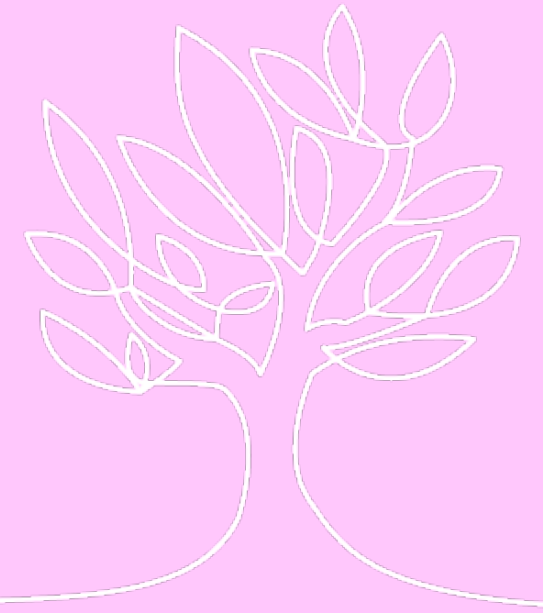
Theme 2: Record keeping (including for example content of clinical notes, timeliness of record keeping, location on Electronic Patient Records for storing information)

Theme 3: Communication (including for example between EPUT teams and with partner agencies)

Other themes identified regularly included training, policies and processes, medication, physical health and systems issues.

Action plans are developed for all PSIRF reviews and their delivery is monitored to completion. Learning is also used to inform the Trust's Safety Improvement Plans.

Example of specific learning and actions from a review undertaken under Stage 3 (PSIRF)



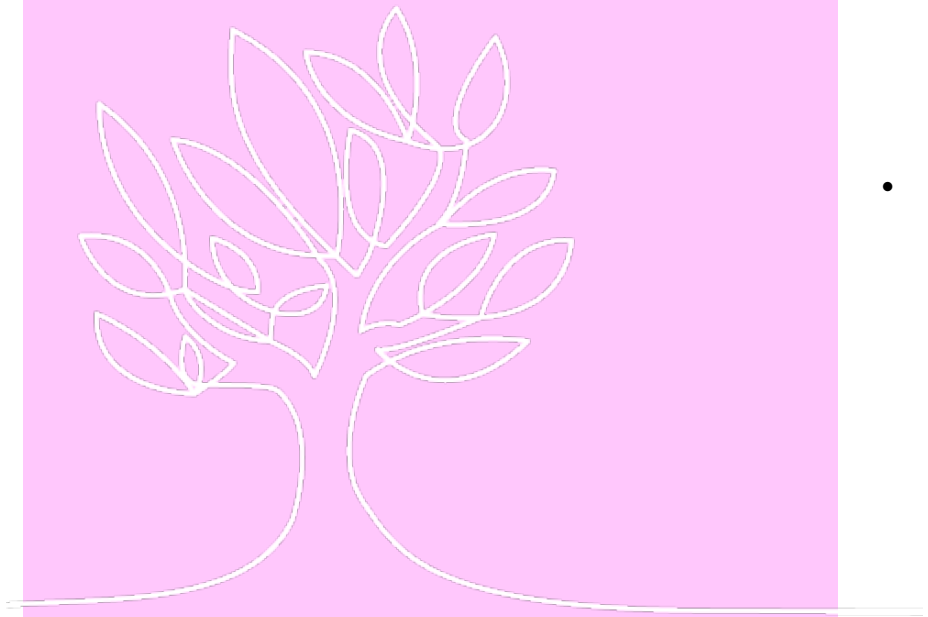
Description of incident:

The patient, who was being cared for by a Community Mental Health Team with an allocated Care Co-ordinator, sadly died at home from a multiple drug toxicity. The patient had previously experienced many admissions to hospital in crisis with behaviour that would put themselves at risk, including repeated attempts to overdose.

Summary of findings:

- No direct contributory factors were identified through this review. However, the Trust constantly seeks to improve the care it provides and key findings and recommendations for improvement have been identified.
- Prior to this event, the patient was seen within Urgent Care Services and referred to the Trust's Home First Team. However, the referral was handed over to the Care Co-ordinator by the Home First Team to carry out the assessment.
- The care plan did not specify the frequency of contact. Visits were organised on a fortnightly basis, and phone support was available if required. The team responded when the patient reached out. If face to face contact was required, this was provided by the care coordinator and weekend support within the Specialist Mental Health Team.

Example of specific learning and actions from a review undertaken under Stage 3 (PSIRF)

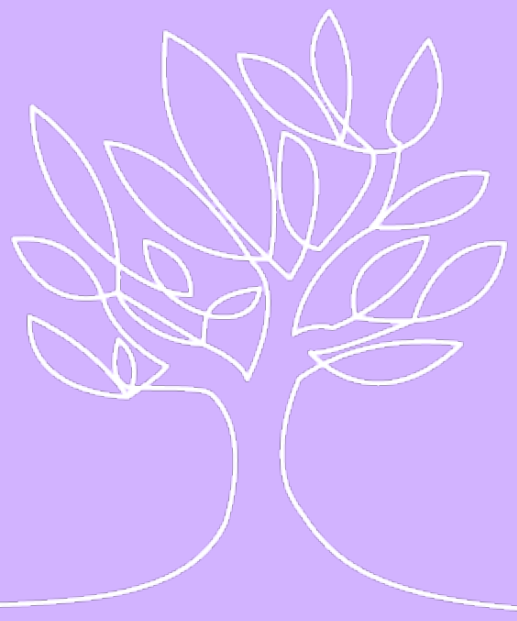


Learning identified

- Need to consider how assessment, referrals and discharges are managed within patient pathways so that patient safety is not compromised.
- Care planning should be specific and indicative of a person-centred approach, frequency of visits with rationale and contingencies for crisis planning and patient 'no shows'. With quality assurance where managers or supervisors have oversight to identify shortfalls.
- There can be limitations as to the extent a practitioner can safeguard someone from obtaining, keeping and taking prescribed, non-prescribed and illicit substances. They cannot be removed from a person without their consent and illicit substances cannot be removed at all by EPUT staff unless they are in a ward environment.
- There is an opportunity to explore greater collaboration between GP services and CMHT with medication management.

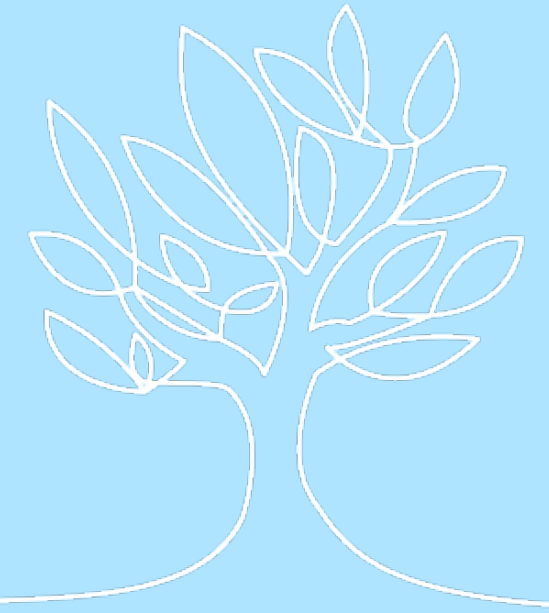
Recommendations	Safety actions to be taken
• Support forum to be set up for reflective practice for cross services delivery.	• Workshop to be held to bring representation from Crisis Home Treatment Teams and Community Mental Health Teams together to discuss ways of working better together. • Review of key policies, pathways and SOPS.
• Explore any possible workaround solutions to strengthen notes access whilst the Trust is operating with two mental health Electronic Patient Record (EPR) systems (until the new unified EPR comes into place).	• Training to be provided on archiving of notes for patients open and on the other EPR systems that can be accessed.
• Entries in the patient notes, for visits involving more than one clinician, should reflect this and reference be made to both record entries if on separate records. • Care Plan and Multi-Disciplinary Team (MDT) notes should demonstrate the use of Situation Background Action and Review (SBAR)and training to be available. • There should be a person-centred approach to crisis (safety) plans.	• Review of record keeping through clinical supervision. • Review of clinical record audit results. • Ensure new starters and agency workers have SBAR training. • Clinical record keeping training to be provided.
• EPUT have a clear process where urgent changes are emailed to the GP; however this needs always to be to the GP practice not a specific individual GP. • GP surgeries need to be responsive and aware of the risks involved in supporting the complex medication needs of those who mismanage their medications on a regular basis. • The policy for removal of patient medications should detail what a staff member should do if the patient does not consent to removal and is deemed to have capacity.	• Remind staff about the need to email to the GP Practice rather than a specific GP; and ensure staff have the correct email addresses. • Explore how to work with GPs on supporting the complex medication needs of those who mismanage their medications on a regular basis. • Encourage use of form already in Policy to support decision making in terms of medication removal and review Policy wording in relation to this.

CONCLUSIONS AND ACTIONS REQUIRED



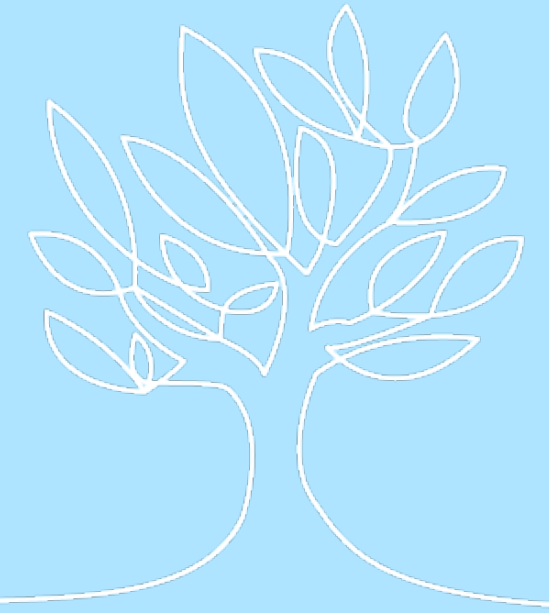
- This report provides:
  - Mortality data mandated for report to the Board of Directors in support of mortality surveillance. Statistical process control analysis of the data indicates that there are no matters of concern relating to the data for Q3 2024/25.
  - An overview of work being undertaken to strengthen the Trust's mortality reporting and review processes.
  - Examples of learning emerging from reviews of deaths being undertaken and actions being taken in response.
- The Board of Directors is asked to:
  - Note the information presented;
  - Note the assurance provided by the content of this report that there are robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high quality services; and
  - Request any further information or action.

APPENDIX 1 – Statistical process control analysis for Datix reported deaths / deaths in scope (for mortality surveillance)



- The current data collection and analysis arrangements have been in place since the implementation of the current Learning from Deaths arrangements (01/04/22). In previous quarterly reports up to and including the Q3 2023/24 data, a comparison of deaths in scope was made against the previous data arrangements' scope categories whilst a sufficient time period of data was built up under the new arrangements.
- As there is now over 20 months of data for the new arrangements, it is possible to produce Statistical Process Control charts, with control limits based on the first 20 months of data.
- Statistical Process Control charts are produced for:
  - Deaths reported on Datix
  - Deaths reported on Datix within scope of the Learning from Deaths Policy
- "Control limits" are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2022 – November 2023). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated.
- These Statistical Process Control charts are reviewed within the Trust's internal governance structure on a quarterly basis. For Q3 2024/25 there are no monthly levels of reported deaths or deaths in scope that fall outside of the control limits.

APPENDIX 2 - Summary of mortality data – key points of note



Key points of note:

- Targeted work has been commenced by Deputy Directors of Quality and Safety to pursue completion of all outstanding Stage 1 reviews; and to continue timely completion of these reviews on an on-going basis.
- There has been a reduction in the number of Stage 2 reviews to be commissioned since the last report to the Board of Directors. This is a result of the agreement at the Learning from Deaths Oversight Group and Trust Learning Oversight Sub-Committee in November 2024 to pause thematic reviews of non-patient safety incident physical health deaths on inpatient wards or of patients with Severe Mental Illness, to enable focus of resource on action implementation from the findings of these thematic reviews previously undertaken.
- Since the last report to the Board of Directors, the following progress has been made with completing / closing reviews for previous periods:
  - 45 more Stage 1 reviews have been completed
  - 115 more deaths have been closed at Stage 1 following consideration of the Stage 1 reviews by Care Unit leadership teams
  - 3 more Stage 2 (Case Note Reviews) have been approved
  - 22 more Stage 3 (PSIRF) reviews have been approved
  - 11 Learning Disability patient deaths open on the dashboard awaiting confirmation of LEDER outcomes have been closed, with 6 of these deaths having been subject to LEDER initial review and 5 deaths to full LEDER Quality Panel

9. REGULATION AND COMPLIANCE

9.1 ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST CONSTITUTION

Decision Item DG

REFERENCES

Only PDFs are attached

EPUT Constitution Report 02.04.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 April 2025

Report Title:	**Essex Partnership University NHS Foundation Trust Constitution**						
Report Lead:	Denver Greenhalgh, Senior Director of Corporate Governance						
Report Author(s):	Chris Jennings, Assistant Trust Secretary						
Report discussed previously at:	Task & Finish Group 12 February 2025 Council of Governors Governance Committee 26 February 2025 Council of Governors 19 March 2025						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**		

Risk Assessment of Report			
Summary of risks highlighted in this report	None – review of a key Trust governance document.		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the output of the annual review of the EPUT Constitution.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note that the annual review of the EPUT Constitution has been completed and received agreement from the Council of Governors at their meeting on 19 March 2025

2. Approve EPUT Constitution as amended

Summary of Key Issues

The Trust is required to undertake a review of its Constitution on an annual basis. The last review of the Constitution took place in May 2024. Noting that the review has been brought forward to enact proposed amendments to the Trust constituencies in advance of Governor elections 2025.

As the EPUT Constitution requires approval from the Council of Governors and the Board of Directors, the Board is asked to note:

- Reviewed by a Task and Finish Group on the 12 February 2025
- Council of Governors Governance Committee on the 26 February 2025
- The Council of Governors on the 19 March 2025

with the following amendments proposed and endorsed by the Council of Governors:

Reference	Proposed Change
Annex 1: The Public Constituencies Annex 4: The Composition of the Council of Governors	Removal of the Milton Keynes, Bedfordshire, Luton and Rest of England constituency. The addition of Rest of England to the West Essex & Hertfordshire constituency, incorporating councils included in the above removed constituency. The increase of Governors from 5 to 7 for this constituency to ensure there is no reduction in the Council size.
	The addition of "Lived Experience Ambassador" to the Appointed Governor for the Third Sector / Voluntary Sector *(noting the persistent difficulty in achieving representation from the third sector / voluntary sector)*
Annex 9: Section 2: Termination of Membership	The addition of a clause at 2.1.7 to allow the termination of membership where no response has been received to communications for a period of time.

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/Health watch			
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
EPUT Constitution

Lead
 **Denver Greenhalgh** **Senior Director of Governance**

20250404

Essex Partnership University NHS Foundation Trust

Constitution

Approved by Council of Governors 19 March 2025 and
Board of Directors 2 April 2025
Next Review Date: 30 April 2026

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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 are 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 referenced 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 most recent 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 regarding 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 Health watch 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 behavior 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 and Rest of England	• Bedford Borough Council • Borough of Broxbourne Council • Central Bedfordshire Council • East Herts District Council • Epping Forest District Council • Harlow Council • Luton Borough Council • Milton Keynes Council • North Herts District Council • Stevenage Borough Council • Uttlesford District Council • Welwyn Hatfield Borough Council • Any other Council in England unless named in Annex 1 to the Trust's Constitution	7	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, Hertfordshire and Rest of England	7	
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 / Lived Experience Ambassador	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/resources/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 their 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 another NHS Body 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 vision, objectives and / or values of the Trust

5.1.11. they are incapable by reason of mental disorder, illness or injury of managing and administering their 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 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, 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 another NHS Body and /or demonstrably hold views / act in ways that are inconsistent with Trust vision, objectives and values.

2.1.7 after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish they wish to continue to be a member of the Trust.

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.

10. OTHER

10.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item HLD 1

Verbal

10.2 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item | ALL | 1

Verbal

10.3 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL 5

Verbal

10.4 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

Information Item ALL 1

11. ANY OTHER BUSINESS

Information Item | ALL | 5

Verbal

12. QUESTION THE DIRECTORS SESSION

10

13. DATE AND TIME OF NEXT MEETING

Wednesday 4 June 2025 at 10.00, The Lodge Training room 1