Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

5 February 2025

10:00 GMT Europe/London

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

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

Part 1 BoD Agenda Feb 2025 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 5 February 2025 at 10:00

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION **Complex Housing** **James Lakey, Principal Psychologist and Mamade Auckburally, Interim Associate Director**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 4 December 2024	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	No actions	Noting
5	Chairs Report (including Governance Update)	SS	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	Code of Conduct for Members of the Board of Directors	DG	Attached	Approval
7.5	Gender & Race Pay Gap Report	AM	Attached	Approval
7.6	Equality Delivery System (2024)	AM	Attached	Approval
7.7	Public Sector Equality Duty (PSED)	AM	Attached	Approval

8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	End of Life Annual Report	AS	Attached	Approval
8.3	Learning from Deaths Q2 Report	AS	Attached	Noting
9	**OTHER**			
9.1	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
9.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
9.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
9.4	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
10	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
11	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
12	**DATE AND TIME OF NEXT MEETING** Wednesday 2 April 2025 at 10:00, The Lodge Training room 1			
13	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 4 June 2025 at 10.00, The Lodge Training room 1 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			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Standing item | SS | 1

2. DECLARATIONS OF INTEREST

Standing item | SS | 1

PRESENTATION - COMPLEX HOUSING WITH JAMES LAKEY, PRINCIPAL PSYCHOLOGIST AND MAMADE AUCKBURALLY, INTERIM ASSOCIATE DIRECTOR

Information Item | JL & MA | 10

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 4 DECEMBER 2024

Decision Item | SS | 2

REFERENCES

Only PDFs are attached

Board of Director Part 1 Minutes 04.12.2024 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 4 December 2024
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 Milind Karale	MK	Executive Medical Director
Nigel Leonard	NL	Executive Director of Major Projects and Programmes
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
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director
Diane Leacock	DL	Non-Executive Director (Joining virtually)
Loy Lobo	LL	Non-Executive Director
Elena Lokteva	EL	Non-Executive Director

IN ATTENDANCE:

Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Caroline Bogle	CB	Service Manager Trust Wide Specialist Community
John Jones	JJ	Lead Governor
Maxine Sadza		Governor
Stuart Scrivenor		Governor
Martine Munby		Director of Communications
Kim Russell		Head of Communications
Clare Sumner		Trust Secretary Administrator

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

The meeting commenced at 10:01am

125/24 APOLOGIES FOR ABSENCE
Jenny Raine, Associate Non-Executive Director

126/24 DECLARATIONS OF INTEREST
There were no declarations of interest.

127/24 PRESENTATION – PERINATAL SERVICE
CB delivered a presentation on the EPUT Perinatal Service, highlighting the following:

- The service has been developed through a complex piece of work over the last seven years, to deliver specialist perinatal health in the community.

- The service is covers a large geographical area and has helped inform national thinking by its approach. The service team received a nomination for the HSJ Awards around integrated collaborative working with partners across Essex.
- The service works with mothers who are at risk of a serious mental health episode through pregnancy until their baby is one year old. The aim of the service is to prevent the negative impact of the mother's mental health on their relationship with the baby.
- The Service was developed from scratch, balancing a uniform model with clear pathways with the bespoke needs of the individual.
- The services is a leader in the development of perinatal services nationally and uses evidence and recommendations to inform procedures and protocols.
- There is a clear focus on safeguarding, which benefits from having expertise in the Trust through the Safeguarding Team.
- The partnership working element includes training system partners (including GPs, health visitors etc.) which aims to bring together system partners to ensure individuals do not fall through any gaps in service provision.
- There was also a focus on equality and inclusion, such as understanding how individuals from different backgrounds have poorer outcomes during pregnancy and childbirth. The Service works with maternity colleagues to remove barriers to allow charities that work with people from more vulnerable backgrounds to directly refer to the service.

The presentation ended with a video of a Peer Support Worker who had previously accessed the service, providing details of their own experience.

Questions & Discussions

- EL asked how new fathers were supported as part of the service. CB advised that the service incorporates the support of family members as part of the care provided. The NHS Long Term Plan includes the aim of providing support to fathers / partners and a peer support worker has been subcontracted to develop a new pathway.
- LL asked whether the service was promoted to create greater awareness, to ensure individuals could access the service promptly. CB advised of work to raise the profile of the service with maternity colleagues. The service was also working with communities to break down the stigma of mental health in some areas by sharing knowledge and awareness.
- ZT highlighted the transformation work being undertaken by the service, which was demonstrated through Accountability Framework meetings. ZT also commented on the video sharing the experiences of the Peer Support Worker, which helped provide a valuable insight into the experiences of people accessing the service. AS agreed and highlighted the positive work being undertaken in terms of equality and inclusion.
- AM asked what support the service needed to assist with any workforce challenges. CB advised recruitment had improved considerably over the years, but the service had similar challenges as the wider NHS in having a pool of talent to be able to recruit.
- RJ asked whether there was any information on the impact on individuals that have accessed the service once they have been discharged. RJ advised that local universities have experience and suggested linking with them to see if there could be any support provided in this area.

SS thanked CB for the presentation and congratulated the team on its HSJ Award nomination.

128/24 MINUTES OF THE PREVIOUS MEETING HELD ON 2 October 2024

The Board of Directors reviewed the minutes of the meeting held on 2 October 2024 and agreed these as an accurate record, noting the record of questions and responses from Governors and members of the public.

129/24 ACTION LOG AND MATTERS ARISING

The Board of Directors reviewed the action log from the meeting held on 2 October 2024 and noted one action closed as covered by the CQC report on the agenda. There were no further actions to carry forward.

130/24 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 sad passing of Mark Dale. The Trust was currently working to support his family and the funeral would be held next week. SS advised she would be attending to represent the Trust and an internal memorial event would be held early next year. SS extended deepest sympathy to Mark's family and friends.
- SS had attended two conferences (on co-production and spirituality, faith and mental health). The events were inspiring, providing a multi-faith perspective.

The Board received and noted the report.

131/24 CEO REPORT

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

- Further Lampard Inquiry hearings had taken place online in November. PS reiterated the Trust commitment to servicing the Inquiry and reflect / learn from the hearings. PS highlighted the support available for patients and staff.
- There were a number of new MPs in Essex following the recent election. PS had spent time meeting with newly elected MPs, providing a recognition of the need to improve services, the progress made and the plans in place to continue the improvement.
- PS highlighted the Trust's shortlisting in three categories at this year's Nursing Times awards and congratulated the two individuals (Prince Adoe and Moriam Adekunle) and those involved in the development of the RISE Programme, which led to the Trust being shortlisted the Best Employer for Diversity and Inclusion Award

The Board received and noted the report.

132/24 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 in within their remits.

Operations (AG)

- There were some challenges relating to flow which is impacting on finances and the ambitions of Time to Care. Average length of stay has increased due to patient complexity, which has led to an increase in out of area placements and pressure on community team caseloads.

- The changes have been caused by multiple factors including the availability of supported accommodation for people with complex conditions
- There are a range of activities underway to address the issue, including holding multi-agency discharge (MADE) system events to review patients who are medically fit for discharge and how the system can help expedite their discharge. There is also a focus on system partners and the implementation of the target operating model to allow an increase in therapeutic input to patients and support them to stay well.

Questions & Discussions

- LL commented on the delayed discharges and suggested the consideration of having a long term plan to manage discharge / wrap-around services differently going forward, including linking with the estates strategy.
- PS advised this needed to be taken into consideration with the medium term system planning process and the changing population and how beds are configured going forward.
- NL advised he was currently undertaking work, with MK and AS, to look at community services at the beginning and end of the inpatient pathway to improve the flow and capacity.

Strategy, Transformation and Digital (ZT)

- ZT noted a correction to the published report regarding Sickness Absence data. This was caused by a data loading issue which had now been corrected. The correct figures for sickness absence were September (5.29%) and October (5.91%). ZT advised an update would be provided to the Finance & Performance Committee with assurance that issues have been addressed.

Executive Nurse (AS)

- The cardio metabolic inpatient indicator had shown an improved position in October. Whilst the target was not being achieved, the October figure represents the highest performance for 18 months. There was work underway with medical colleagues to improve the position and will be included as part of the Safety Improvement Plan which will be overseen by the Quality Committee.
- AS highlighted other KPIs, including no harm / low harm incidents and the work regarding the incident reporting system and the achievement of the Physical Health reporting target.

PS thanked colleagues for the updates and noted the significant challenges that were being worked through. PS advised on the risks highlighted by the updates and the connection between the Board, Standing Committees and Board Assurance Framework.

The Board of Directors received and noted the report.

133/24 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.

Audit Committee (EL)

- There had been improvement in risk management culture and the link between the work of the Committee and Board Assurance Framework. The next step was to test completed action plans.
- The Committee had approved key governance documents for onward approval by the Board of Directors.
- The Terms of Reference had been amended to allow an Associate NED to count towards the quorum and this was presented to the Board for approval.
- The annual report for the Committee was included in the pack for formal receipt by the Board.

Questions and Discussions

- TS noted the Core Financial System Internal Audit receipt of Substantial Assurance, congratulating Simon Covill, Director of Finance and the work of the Finance Team for the achievement. The result evidenced the internal control systems for Strategic Risk 5 - Use of Resources.

Finance and Performance Committee (LL)

- The Trust had received cash support from NHS England and SS congratulated TS and team for work with care units to ensure the Trust remained on track to break even at year end.
- The Committee had undertaken deep dives, including for capital and flow and capacity. The exercises provided solid assurance regarding what the organisation is doing to manage resources effectively.
- The Board Assurance Framework had matured well and allowed an improved flow from care units to Board.

Questions & Discussions

- TS commented that the capital deep dive was timely as it was able to strip away technical matters to provide a clearer view on local programme spend. This related to Strategic Risk 7 - Capital Resources, which was a high rated risk as there was aspiration to spend more in this area.
- AG commented on the time spent reviewing capacity, discharge and delays and had agreed to provide an Executive flow report to the Committee, to specifically look at data on discharge by ward level.
- PS highlighted the work of the Accountability Framework to allow Executive Directors and the Leadership Team to work together and have aligned objectives.

People, Equality and Culture Committee (RJ)

- There had been progress made with Time to Care within the difficult environment as mentioned earlier. It was positive to see posts filled and the impact this would have on the quality of care for patients.
- The nominations for awards for equality and inclusion, underpinned by the events noted in the Chairs report, showed the progress made in this area and linked to the metrics discussed at the Committee.
- The Committee had looked at research and innovation, including putting forward bids to the University of Essex regarding workforce challenges.

Questions & Discussions

- EL asked whether age discrimination with patients and staff was considered as part of the equality and inclusion work. AM advised there

were a number of papers being presented to the next Committee regarding EDI which would breakdown key information, including age.

Quality Committee (MJ)

- The Committee had received a number of assurance reports, which were triangulated with the quality performance dashboard and aligned locally and nationally. It is anticipated that this will allow the Committee to measure against national benchmarks in the next 12 months.
- MJ highlighted the co-production conference and research and innovation work to support learning.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**
2. **Received the Audit Committee annual report and effectiveness review.**
3. **Received and approved the Terms of Reference for the Audit Committee.**

134/24 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 were currently undertaking an unannounced inspection to adult and intensive care wards. The report for the CQC inspection completed earlier in the year was awaited and no timescale had been provided for when this would be received.
- The CQC Improvement Plan continued to be implemented, with the majority of actions (91%) reported as completed, with 32% receiving assurance of implementation through the evidence assurance group. As noted in previous Board meetings, partners will meet twice monthly to review and close actions faster from January 2025. The trajectories in the report for action completion were based on meeting once per month and would be amended as the twice-monthly meetings are underway.
- Details were provided of some actions that were off track, relating to the PARIS sytem upgrade, CCTV access and care plans. Assurance was provided of the action being taken to ensure these areas were back on track for completion.
- The action regarding sleeping on duty was reported as open. There had been no reports of staff sleeping on duty in October, but the action would remain open until there was assurance this was being sustained.

<u>Questions & Discussions</u>

- MJ provided assurance that this was regularly monitored by the Quality Committee and commented positively on the involvement of other organisations to ensure learning is shared.
- EL highlighted the Quality Assurance Visits completed by NEDs and Integrated Care Board colleagues, which provided evidence of action implementation. It was important to ensure Governors and people with lived experience were able to attend these visits to be provided with the same level of assurance.
- LL highlighted the work undertaken in developing quality dashboards and encouraged the development of early warning signs to have a proactive approach to identifying issues. AS advised that the Trust was now part of

NHS England's early warning system, which provided the opportunity to work with care units to develop metrics that can help influence clinical practice.

- EL asked whether the metrics would include ensuring there was no discrimination against protected characteristics. ZT noted it was important to prioritise health inequality data, as not all statistics were easily accessible with current systems. MJ suggested considering this as part of the Quality of Care priorities and research activity.
- PS thanked AS / DG for developing a robust system for utilising the CQC Improvement Plan to drive improvement and the Quality Committee testing the impact on services. This created a good vehicle for learning and improvement.

The Board of Directors:

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

135/24 BOARD ASSURANCE FRAMEWORK

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

- SR2 had been closed and broken down into constituent parts, (SR10: Organisational Development, SR11: Staff Retention, SR12: Workforce Sustainability).
- SR1 would be closed and reshaped to align with the Quality of Care Strategy.
- There were a number of risk scores noted in the report which were recommended for reduction following positive internal audit feedback.
- The Board meeting discussions had covered each of the strategic risks at different points.

<u>Questions & Discussions</u>

- MK noted the previous discussion regarding the development of metrics / quality indicators and how this could be linked to the BAF risks.
- MJ queried the risk score for cyber security and asked for assurance given the spotlight on the NHS regarding cyber attacks. LL advised that the Finance & Performance Committee had completed a deep dive which had provided assurance, but noted the rapid changes regarding cyber risk. The risk score was based on the assurance that there are mitigations and protections in place to manage and recover from any cyber attack, but the score would be closely monitored given the rapidly changing landscape. ZT advised there was also discussion with national colleagues to ensure there was learning from any cyber attack incidents.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the reduction in risk scores for**
   - **SR5 Lampard Inquiry**
   - **CRR94 Engagement and Supportive Observation**
   - **CRR77 Medical Devices**
   - **CRR81 Ligature (Fixed)**
   - **CRR93 Continuous Learning**
3. **Did not request any further information or action.**

136/24 LEARNING FROM DEATHS – QUARTERLY OVERVIEW OF LEARNING AND DATA REPORT Q1

AS presented the report which included an overview of learning resulting from the reviews undertaken, the Trust's learning from deaths arrangements and actions being taken as a result, as well as information relating to the content of mortality data and surveillance under the Trust's Learning from Deaths Arrangement.

Questions & Discussions

- EL asked whether patient disengagement was monitored. AS advised there was more area to do in this area, but work had been undertaken to speak with patients and families to understand the reasons behind disengagement, and discuss with partners what more can be done to support these individuals. The Trust was also looking at a digital platform which would help identify those most likely to disengage from services. MK advised there was also now a disengagement policy in place, which will be monitored to ensure it is followed.

The Board of Directors:

1. **Received and noted the contents of the report and did not request any further information.**

137/24 STRATEGIC IMPACT REPORT

ZT presented a report which provided an update on the implementation of the Trust's Strategic Plan at month 6 of the second of five years. It also provided updates on the Transformation portfolio and summarised a proposed approach to Operational Planning for 2025/26. ZT highlighted the following:

- The Trust was in the second year of its strategic plan and the update report had been scrutinised at Standing Committee level.
- ZT highlighted a number of developments, including creating a zero tolerance approach to inappropriate sexual behaviour, an approved Estates Strategy and the completion of all enabling strategies.
- The Trust also continued to work with partners as part of the SET strategic delivery and had published a Social Impact Charter to demonstrate the commitment to helping communities to thrive.

Questions & Discussions

- LL noted the positivity of having a multi-faceted strategy in place and the report demonstrating systematic implementation.

The Board of Directors:

1. **Noted and took assurance from the report.**

138/24 ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS

DG presented a report which provided the revised Standing Orders for the Board of Directors, the Scheme of Reservation and Delegation, Standing Financial Instructions and Detailed Scheme of Delegation for approval by the Board of Directors. DG advised that a new procurement act would be published in February 2025 and therefore requested approval to amend the documents as required without needing further Board approval.

Questions & Discussions

- LL queried whether the Lampard Inquiry Oversight Committee and EPR Joint Oversight Committee should be listed as part of the governance sections. DG advised this would not be required as the Committees were

not Board Committees, but delegated functions. DG agreed to discuss outside the meeting and add to the documentation if required.

The Board of Directors:

1. **Noted the annual review of the Trust governance documents.**
2. **Approved the Standing Orders, the Scheme of Reservation and Delegation, the Standing Financial Instructions and Detailed Scheme of Delegation and approved further amendments to be made in relation to the new procurement act.**

139/24 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) NATIONAL CORE STANDARDS RETURN 2024.

NL presented a report which provided information around the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment for 2024-25, completion of which is a requirement for all NHS organisations. NL highlighted the following:

- The annual self-assessment had been submitted to NHS England, following a process of internal and external review. The Trust had received a substantially compliant rating, with three areas of partial compliance.
- NL provided further details of the three areas of partial compliance and the action being taken to reach full compliance.

The Board of Directors:

1. **Noted the final Emergency Preparedness, Resilience and Response national core standards 2024-25 assurance level for EPUT.**

140/24 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

MK presented a report providing assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract. MK highlighted the following:

- There had been pressure on the on-call system, particularly in North East Essex. This was not uncommon in other settings, but is new for the Trust. The on-call arrangements are now being reviewed and amended to ensure there are no further breaches.
- There had been two breaches in the timeframe of the report, with the reasons and actions taken detailed.

The Board of Directors:

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

141/24 USE OF CORPORATE SEAL

PS presented a report providing a summary of use of the corporate seal. PS highlighted the Corporate Seal had been used on one occasion:

- 05.11.24 Lease Renewal – Ground floor and second floor rear, Western House, 2 Cambridge Road, Stansted, CM24 8AG.

The Board of Directors:

1. **Noted the contents of the document.**

142/24 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

143/24 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.

144/24 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

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

- The presentation regarding the Perinatal Service had demonstrated the work to eliminate systemic barriers and working with the community to support those individual backgrounds with poorer outcomes.
- The national award nominations recognised the work for equality and inclusion, including the success of the RISE programme.
- There had been discussions regarding protected characteristics and agreement that there would be focus on age discrimination.
- There had been discussions on the development of data to monitor people with protected characteristics.

145/24 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.

146/24 ANY OTHER BUSINESS

There was no other business.

147/24 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.

148/24 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 05 February 2025.

The meeting closed at 12:10pm

Appendix 1: Governors / Public / Members Query Tracker (Item 147/24)

Governor / Member of the Public	Query	Response
John Jones, Lead Governor	No queries assured by what heard. Presentation, struck have successful family intervention group programme, yet have recognition of certain cultural groups that may have difficulty in recognising they have mental health issues and potential for involvement of wider family involvement could help.	Helpful feedback to hear have found discussion analytical and robust.

4. ACTION LOG AND MATTERS ARISING

Standing item | SS | 2

No actions

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | SS | 5

REFERENCES

Only PDFs are attached

Chair Board Report 05.02.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 February 2025

Report Title:	Chair's Report					
Executive/ Non-Executive Lead / Committee Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, EA to Chair, Chief Executive and Non-Executive Directors					
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 07779212507	
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.

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

CHAIR REPORT

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 Lived experience/ service user voice progression across the Trust

As I draw near to the conclusion of my final term of office as Chair of EPUT, I am delighted to report that we continue to see steady growth in our lived experience team which is now close to 300 ambassadors, and in our volunteer team which numbers over 250. We are thus seeing much more collaboration with those who have lived experience in decision making, whether it is designing or improving services. This is most evident in the delivery of the quality of care strategy which has a whole team of lived experience leads working across all the key priorities. Further, we continue to see a greater number of I Want Great Care responses (IWGC), now having nearly 11000 reviews left on our services with an average rating of 4.8 stars out of 5.

We have also made significant strides in prioritising health inequalities, particularly the patient and carer race equality framework. Working with our lived experience team, and system partners to identify and address health equity issues in our services. This is just the start to the journey but it is truly exciting to think about where we are going and where we will get to with this.

Something we are particularly proud of, is the development and growth in our peer workforce, with close to 50 WTE allocated to support the new inpatient staffing model, including peer workers for patients, families, and peer leads to support clinical and operation leadership differently. The next developmental step in this new and exciting discipline is community services.

2.2 Family and Carer Ambassadors in our Adult Mental Health Wards

Building on the developments noted above, EPUT is one of the first NHS Trusts to introduce a new team who will use their personal experiences to support families and carers of people being cared for on adult mental inpatient wards. Our Family and Carer Ambassadors will build strong relationships with families and carers so they can advocate for their needs, make sure their views are heard and work with the clinical team to act on any concerns as early as possible. Most importantly, they all have personal experience of mental health services either as a patient, carer or relative or they may have extensive experience of working with relatives and services. These important roles show the continued efforts to ensure that the patient voice is heard to offer the best possible care to our patients.

It is without doubt that the voice of our patients and their families have never been so present, and that we hear you loud and clear.

2.3 Schwartz Rounds

I am delighted that Schwartz Rounds have returned to EPUT with the first session taking place on 28 January. Schwartz Rounds are a chance for staff from all areas of the Trust, both clinical and non-clinical to come together to reflect on the challenges and rewards of working in healthcare. Three Schwartz Rounds have been planned so far. Colleagues open each session by telling their stories before others are invited to share their personal reflections. I was honoured to join the first session as one of the story tellers and shared a reflection from my time spent in clinical practice, focussing on why I come to work and what learning have I been able to build into my practice over some four decades spent serving in the NHS.

2.4 Queen's Nurse

Jenny Dean, an EPUT employee in the Night Nursing Services team and also the Health Outreach team in Bury St Edmunds has been awarded the prestigious title of Queen's Nurse, for her commitment to patient care. This is a wonderful achievement. Many congratulations Jenny.

2.5 NHS Round Table discussion on the role of the Chair

I was recently invited to participate in an NHS Round Table discussion, hosted by Sir Andrew Morris, Deputy Chair of NHS England, and Jane Ellison, Non-Executive Director of NHS England. The session focused on identifying strategies to attract, support, and develop individuals from diverse backgrounds and experiences to step into their first chair role. During the meeting, I, along with other invited Chairs, shared insights on the realities and expectations of the chair position, as well as ways to better support aspiring chairs in developing the necessary knowledge, skills, and confidence for such roles. The discussion highlighted the increasing complexity and challenges of the NHS Trust Chair role, and explored the various factors that influence individuals' decisions to apply for or be appointed to these positions.

3.0 LEGAL AND POLICY UPDATE

3.1 The Procedure for Determining Mental Capacity in Civil Proceedings.

Please see below a copy of the report dated November 2024 but published in December 2024 that covers whether an adult party to court proceedings has the mental capacity to conduct the proceedings ("litigation capacity") is one of fundamental importance. Under the Civil Procedure Rules (CPR) a person who lacks litigation capacity is a 'protected party' and must have a 'litigation friend' appointed to conduct the litigation on their behalf.

For Information CJC Procedure for Determining Mental Capacity in Civil Proceedings - Nov 2024

3.2 The Cost of Delays in Disciplinary Actions – Thorpe v Cumbria Northumberland Tyne and Wear NHS Foundation Trust.

Please see the link below for a copy of the report published on 20 December 2024 that provides important lessons for employers in regard to disciplinary investigations and suspensions.

For Information: Thorpe v Cumbria, Northumberland, Tyne & Wear NHS FT - Hempsons - Hempsons

3.3 The Big Mental Health Report 2024

Please see the link below for a copy of the report that addresses that we are in the middle of a mental health crisis and the scale and severity of mental health need is spiralling.

For Information: Big Mental Health Report 2024

3.4 Northampton General Hospital NHS Trust v Mercer [2024] EWHC 2515 (KB)

Please see the link below for a copy of the report published December 2024 where the court gave legal and practical guidance in the form of a checklist for hospitals seeking possession in relation to patients whose refusal to leave hospital might be affected by a mental health or mental capacity issues. In the instant case, it was proportionate to grant a possession order where the patient, who had diagnoses of autistic spectrum disorder and emotionally unstable personality disorder, had been medically fit for discharge from hospital, but had refused to leave for 18 months due to anxiety about her proposed placement.

For Information: Northampton General Hospital NHS Trust v Mercer [2024] EWHC 2515 (KB) (Hearing 4 October 2024)

3.5 Bed Blocking, Possession Orders and Discharge Planning: Guidance from the Court

Please see the first link below for a copy of the report published on 13 January 2025 following the recent case of Northampton General Hospital NHS Trust v Mercer [2024] EWHC 2515 spotlights the pressing issue of bed blocking. The second is a copy of the publication.

For Information: Bed Blocking, Possession Orders and Discharge Planning | Bevan Brittan LLP
Northampton General Hospital NHS Trust v Mercer | 39 Essex Chambers

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 5

REFERENCES

Only PDFs are attached

CEO Board Report 05.02.2025 FINAL 1.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 February 2025

Report Title:	Chief Executive Officer (CEO) Report					
Executive/ Non-Executive Lead / Committee Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, EA to Chair, Chief Executive and Non-Executive Directors					
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
CEO Report

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

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Lampard Inquiry

The Lampard Inquiry have issued information via their public website outlining areas that would be covered at the April hearings, as well as subsequent planned hearings over the course of 2025 and 2026. The next scheduled public hearings will be held in London from 28 April to 15 May 2025. I know that this will be a difficult time for colleagues, patients and families, and continue to promote support services that are available. It is important that we engage openly with the Lampard Inquiry and encourage anyone who feels they have experiences of information they want to share (whether positive and negative) to do so. By being open and transparent we can support Baroness Lampard and her team to deliver meaningful conclusions that will improve mental health care nationally.

1.2 Health and Social Care Select Committee Inquiry into Community Health Services

The Health and Social Care Select Committee is one of the UK Parliament's cross-party parliamentary committees, which scrutinises organisations and services and holds more in-depth inquiries into specific areas of health and care provision. In December 2024, it launched an inquiry into adult community mental health services.

The inquiry will consider:

- What constitutes good practice from the perspective of service users and their families/carers
- How service users' wider health and social needs can be addressed, including in employment and housing

The Committee also wants to:

- Understand what policy interventions are required to improve how these needs are met
- Assess to what extent the Community Mental Health Framework is driving improvements in the delivery of more integrated, person-centred care

The Committee is calling for individuals, groups of individuals and organisations to submit evidence as part of its fact finding work by answering a number of specific questions related to community mental health service provision. This is a key opportunity for the Trust to share its perspective and to cite examples of its own services and innovations. The patient experience team is also encouraging and supporting involved patients to submit their own evidence as individuals with experience of using adult community mental health services.

1.3 Progress update for Community Inpatient Beds and Community Services Consultation

During 2024, the Mid and South Essex Integrated Care System (ICB) ran a public consultation on proposals to change how some community physical health services are provided and how community inpatient beds are used, including EPUT's beds at the Cumberlege Intermediate Care Centre (CICC) in Rochford. Following feedback from members of the public and staff in services involved, the ICB took the decision to delay any decisions about services and work more closely with people to look at future options. A working group has been established and has just published a three month report, which is available via the ICB's board papers. Key highlights from the report include the need for more work to review community inpatient beds in the context of trying to care for people at home wherever possible. The ICB is aiming for the review group's findings to be presented in April and final decisions to be made in the summer.

1.4 Time To Care / New Staffing Model

More than 150 new staff have joined our inpatient teams as part of the new staffing model we have created under the Time To Care programme, with more set to join us in coming months. The programme is focussed on releasing more time for frontline clinical teams to spend time caring for patient – at the centre of this is the expansion of our multi-disciplinary teams on our inpatient wards.

The new teams include a range of health professionals from AHPs, Activity Coordinators, Pharmacy Staff, Mental Health Nurses, Family and Carer Ambassadors, Peer Works and man more who will work together to support our patients.

1.5 Autism Specialist Consultant

I am delighted to report that Dr Catherine Dakin has taken on the advisory role of Autism Specialist Consultant, alongside her existing role as a psychiatrist within our Child and Adolescent Mental Health inpatient service in Colchester. Dr Dakin will use her clinical, academic and personal experience of neuro-divergence to support senior clinicians caring for complex patients, who are autistic or suspected of being so.

1.6 Importance of The Patient Voice in Mental Health Transformation

EPUT is leading the way in the transformation of mental health care, empowering patients and their families to have a voice in the future of its services. We now have more than 250 patients and former patients employed to ensure the patient experience remains at the heart of transformation of mental health, physical health and learning disability services provided by the Trust. This includes family and carer ambassadors who use their personal experiences of mental health services to support families and ensure they are fully involved in the care of their loved ones.

2. UPDATES

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

- Response time for Crisis calls improved for the second consecutive month. 87% were answered within 60 seconds against the 90% target. On-going monitoring of call volumes and handover challenges continues.
- Mental health inpatient capacity reports outside of target threshold for the Trust; Adult, Older Adult and PICU all report outside of target. Adult length of stay has reduced.
- Rates of patients clinically ready for discharge remains outside of the 5% target, reporting 6.9% in December. December is a reduction on recent months reporting the fewest numbers of patients delayed.
- Inappropriate out of area (OOA) placements remains outside of target threshold. There has been an increase in the number of placements in December, there were 58 remaining OOA at the end of the month. A clinical lead for flow has been appointed and MPACS are focusing on OOA discharge and repatriation.
- There has been an increase in Mental Health Act admissions in North East and West compared to November, however the Trust continues to report in line with the average for the last 18 months.
- There were 10 days at OPEL 4 in December reflecting pressure across the systems
- There has been a t access rate reduction for talking therapies across all areas in line with seasonal variation.
- Virtual Ward Occupancy for West Essex CHS remains below target. EPUT are engaging with NHS England to explore ways to maintain the improved occupancy rates following system MADE event.

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

- Income and Expenditure year to date deficit £7.7m, due to high levels of patient demand and acuity within Inpatient Mental Health services (total overspend including medical costs £12.5m). These costs include overspends in staffing and out of area placements. A range of measures and actions are being taken across the organisation and with system colleagues in order to deliver the planned deficit for the year.
- Capital expenditure totals £8.1m year to date.
- Cash balances total £24.5m with diminishing balances due to the operating deficit and costs of the Inquiry.
- Detailed planning activity is underway for next year's Operating Plan and Budget.

These matters are subject to in-depth discussion and challenge at the Finance & Performance Committee.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Engaging with patients and family (PSIRF)
The Trust is improving its process on patient and family engagement. This includes the launch of a refreshed leaflet **''***Patient Safety Incident Reviews – A Guide for Patients, Families, and Carers"* and will sit alongside our Patient Safety Incident Response Plan**.** This guide helps ensure that everyone affected by an incident; patients, families, carers and our staff, are treated with compassion and are engaged meaningfully in the learning response review process. Our Family Liaison Officers and Patient Safety Partners have been key in supporting the development of the leaflet, ensuring that families and patients feel heard, respected, and involved every step of the way.

An engagement survey have also been developed to ensure we receive feedback in real time. This will enable us to acknowledge areas of intervention that are effective and those areas that present opportunity for us to learn. The survey is currently in a testing phase with a plan to launch in early 2025.

Community Transformation
The Trust is undertaking a review and remodelling of secondary care community teams to meet the needs of the Essex population through the provision of a revised consistent, safe and therapeutic service model. This programme will redesign the current secondary mental health community and outpatients models as a result of many changes across Essex, including investment in primary care mental health, the Care Act and recent reviews and changes in Section 75 agreements. The new community model will also be required to reflect other changes in the provision and pathways for mental health services across Essex. The programme intends to provide safe and sustainable care through right sizing the capacity of existing services and reviewing the scope of the service offered to meet the needs of people in Essex with severe and enduring mental health needs. This likely change in capacity and scope will enable all clinicians in community health teams to have sufficient time and capacity to provide safe and effective care and treatment for patients and families, enabling an improved patient experience.

RISE
The Trust was awarded the Best Employer for Diversity and Inclusion – winner for its innovative RISE (Resilience, Intelligence, Strength, and Excellence) Talent Programme, which provides tailored support and development for Black and Ethnic minority colleagues, helping to create an inclusive and empowering workplace. This demonstrates the Trust's commitment and positive action towards the development of staff from Global Majority background. The quality improvement initiatives delivered on this programme contributes to the achievement of the Trust quality of care priorities.

Diversity and Inclusion Champion of the Year Award
Moriam Adekunle has been awarded the 2024 winner – Diversity and Inclusion Champion of the Year (Nursing Times Workforce Summit Awards).

EOE Regional Greener Allied Health Professional
Our Chief Allied Health Professional, Mobolaji Lewis has since taken up the role of EOE Regional Greener Allied Health Professional working in collaboration with colleagues across the region on net zero sustainability plans as part of AHP national priorities to reduce waste, consider sustainable low carbon alternatives, reducing carbon emissions, saving costs and improving health and wellbeing.

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

Workforce Performance

Substantive Staffing – The Trust has seen continued increase in recruitment based on Time to Care initiatives alongside continued focus on qualified nursing and HCA roles. The plan for substantive staff as at December 2024 was to have 6257.44 wte staff in post. The actual staff in post for December 2024 was 6220.16 wte, therefore being under target by 37 wte.

Temporary Staffing – The use of agency staff has continued to decline with approximately 40 wte reduction between November and December 2024. The plan for agency staff use at December was 101.57 wte with actual use at 134.72 wte.

The use of bank staff continues to be consistently high with only a modest decrease between November and December 2024. The plan for bank use in December 2024 was 824.25 wte with actual use at 1228.76 wte.

Additional controls have been agreed with Care Unit Management teams and the Executive to support a 25% reduction of bank use with immediate effect. In addition there will be additional measures to control corporate use of temporary staff as well as substantive recruitment until the end of March 2025.

Absence Management – The absence rate at the Trust has fallen in December 2024 to 5.2% from 5.8% in November 2024. We are expecting an increase in January absence rates. However the rate demonstrated in December should have a positive impact on the demand for temporary staff alongside the increase in the substantive workforce.

Staff Turnover – The turnover rate has continued to improve with the rate as at December 2024 at 9% from 9.5%. This is a positive position when taken into consideration alongside the improvements in absence rate and the increase in substantive staffing.

Staff Appraisals – The engagement with staff appraisals has not had the focus that it deserves and therefore the rate of compliance has been below the expected standard of 90%. We have seen recent improvements from 74% to 83% in December 2024. The new Director of Education will be developing a new framework for staff appraisal that will focus on staff development and some consistency in objective settings.

Mandatory Training Compliance – There has been a modest increase in mandatory training compliance with the December rate at 86.2%. There are now new reports available at Care Unit level as well as Trust level that provides clarity and detail of compliance based on staff groups and by subject matter to determine areas of risk and where mitigations can be applied.

Organisational Development & Culture

Sexual Safety & Unprofessional Behaviours

In the last few months, the Trust has been warmly supported by colleagues in the NMC and GMC to deliver a series of workshops on unprofessional behaviours, using the 'Vanderbilt model' to highlight how early 'cup of coffee' conversations can reduce workplace incivility and escalations of unprofessional practice. These workshops have developed our thinking further across the Trust to ensure colleagues feel safe to raise issues with their peers and can escalate issues appropriately through the right channels. Working with operational and lived experience colleagues, a set of OD interventions will complement the existing work being undertaken to address issues of sexual safety and incivility, starting with Brockfield House and Specialist Services.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item | PS | 15

REFERENCES

Only PDFs are attached

Quality Performance Scorecard 05.02.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 February 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	All inadequate and requiring improvement indicators			
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 & 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 Issues

This report to Board provides an interactive and detailed summary of performance across the Trust. It incorporates items from the NHS System Oversight Framework, Safer Staffing, and CQC. Each Key Performance Indicator (KPI) can be selected and viewed alongside trend analysis and informative narrative.

Crisis Call Response Times:
The 111 crisis line saw 4192 calls received, with 87% answered within 60 seconds in December (target 95%). This is a second month of improvement after a performance low was reported in October. The service continues to meet regularly with the Crisis Teams to discuss the challenges of call handovers and crisis call supervisors constantly monitor call volume.

Mental Health Inpatient Capacity:
December reports an all time high of 99% for Adult occupancy against the 93% target, Specialist occupancy is at 71% which is on par with the average for the past 18 months with little variation against their 95% target. Older Adults reports in line with target at 86% in December for second month in a row.
The average length of stay for Adult inpatients reduced in December to 69 days, this remains above the national benchmark of 35 days. The length of stay reduces to 52 days when including the assessment units. There were 67 discharges in December (40 from Assessment units), 17 of these had stays over 60 days, with an additional 3 discharged with stays over 200 days.
Older Adult length of stay reports an average of 110 days in December against the target of 74 days. Although this is in line with average for past 12 months, this has been gently increasing and is projected to continue. There were 33 discharges of which 23 were long stays.
Bed modelling is to progress from the manual collection, so that the bed management tool can be implemented for SMART. Accountability Framework noted the value of focusing on Older Adult activity and occupancy at year end for seasonal variation to contribute to bed modelling, which is expected to yield useable information from early Q1 2025/26.
PICU average length of stay reports outside of the 50 day target at 73 days. 2 of the 5 patients discharged were long stays (193 and 150 days).
(the average length of stay calculation includes the long stay patients, 60 days+)

Rates of Patients Clinically Ready for Discharge:
Adult mental health wards remain outside the 5% target at 6.9%. December is a reduction on recent months reporting the fewest numbers of patients delayed (25). 23 Inpatient and Urgent care patients and 2 on Specialist wards. The wards with the most patients delayed were Chelmer with 5 and Cedar with 4. PICU and Older Adults both continue to report in their respective targets.

Inappropriate Out of Area Placements:
During December seven patients were repatriated to an out of area placement closer to Essex, two patients stepped down from a PICU placement and one patient stepped up to a PICU placement, these ten patients are represented in both the number of discharges and number of new placements in December.
There has been an increase in the number of placements in December (36 Adult and two PICU). Following the repatriation of 32 (29 Adult, one Older Adult and two PICU), there were 58 remaining (52 Adult and six PICU) OOA at the end of the month. This is an increase compared to 52 reported at the end of November, however there were 1,642 OBDs in December, this is a positive reduction on the number of OOA placement bed days reported in November.
There is an increased focus on front door reviews and gate keeping and EPUT have been working with police to reduce the number of 136's and Mid and South Essex Partners to ensure that EPUT are embedded in their flow & recovery plan. Weekly mini MADE events are also taking place with LA's to work through the current delays.

Admissions Under MHA:
The Trust continues to see higher than threshold (44%) admissions to Acute wards under the Mental Health Act. Whilst December reports 80%, which is in line with the average for past 18 months, an increase was seen in the number of MHA admissions in North East and West compared to November.

OPEL Status:
There were 10 days at OPEL 4 status in December, with OPEL 4 being declared through the 1st to 9th December due to the demand and high risk for Adult beds. There was one additional day on 28th December where OPEL 4 was declared.

NHS Talking Therapies:
North East Essex has reported a decline in performance, falling below target with 555 referrals, compared to 684 last month. Similarly, Castle Point and Rochford experienced a decrease, dropping just below the target of 306 to 247. Although Southend-on-Sea remained above target, it also saw a decrease.
This decline in referrals across all areas appears to follow a seasonal trend, as indicated by the comparison with data from the past two years. It is expected that referrals will increase again in January, aligning with the typical seasonal patterns observed in previous years

Virtual Ward Occupancy CHS:
West Essex has consistently remained at around 60%, which is below the target of 80%. However, following a mini MADE held with Princess Alexandra Hospital (PAH), occupancy briefly rose above 85%. EPUT is engaging with NHS England to explore ways to maintain improved occupancy rates.
Mid and South Essex reported 88% occupancy in December, which reports above target.

Temporary Staffing:
December reports a further reduction in the number of booked shifts for Agency to 2124, which is the fewest reported yet, with all care units booking less in December than in November. West Essex care unit booked the highest number of shifts which is being contributed to by long term sickness.
The booking of Bank shifts in December was also a reduction on the past seven months, West Essex reported the highest increase of Bank use which is driven by funded bank use on Plane ward.
Time To Care continues to focus on reducing temporary staffing, with Agency request requiring senior authorisation. There are 271 roles in the recruitment pipeline with half of these either at offer stage or starting.

Training:
Mandatory training with a target of 90% showed a 86.2% compliance rate in December. The two care units below were Corporate (84.6%) and Medical (75.7%).
Information Governance remains below the target of 95%, reporting 85% in December. All care units are reporting below target.
Mandatory training with a target of 85% and Essential training were within target in December

1 to 1 Support:
Supervision compliance reports little variation month to month, reporting 70% in December against 90% target. Assurance in Accountability Frameworks was such that this performance is not reflective of support activity but of the administration associated with recording it.

Appraisals:
December performance reports at 75% against 90% target. Half of the Care Units are reporting improved positions at the end of Q3 compared to end of Q2.

Trust Financial Position:
Income & Expenditure

In month deficit £1m, YTD £7.7m due to high demand on Mental Health Inpatient services, including Out of Area Placements and Temporary Staffing. Grip and control actions in other Care Units and Corporate Directorates are offsetting Inpatient overspends.

Capital & Cash:

YTD capital spend £8.1m, cash balance £24.5m.

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

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

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

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

Supporting 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 Part 1 05.02.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 February 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. Finance & Performance Committee (Diane Leacock)
2. People, Equality & Culture Committee (Ruth Jackson)
3. 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
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors Part 1

February 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

NHS
Essex Partnership University
NHS Foundation Trust

1. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 24 January 2025

Assurance

Performance Report
- The Committee received assurance on the Trust's performance during December 2024.
- Areas of performance discussed included:
  - Crisis Call Response times
  - Mental Health Inpatient Capacity
  - Rates of Patients Clinically Ready for Discharge
  - Inappropriate Out of Area Placements
  - Admissions Under MHA
  - NHS Talking Therapies
  - Virtual Ward Occupancy

Financial Report
- The Committee received an update on the Trust's Revenue, Capital and Cash position.
- In month deficit £1m, reflecting high demand on mental health inpatient services, partly offset by Grip & Control actions in other Care Units and corporate directorates. The Trust's year end target remains breakeven.
- Cash balances are slightly behind plan. The cash position is impacted by the revenue deficit and Lampard Inquiry costs.

Time to Care Benefits Realisation Plan
- The Committee received a report providing a high level benefits realisation plan for the Time To Care Programme.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Estates & Facilities Quarterly Report
  - Board Assurance Framework Report

Information

Planning 2025/26
- Planning guidance is still awaited.
- Indicative deadlines include:
  - 27 February 2025: Headline Submission.
  - 27 March 2025: Final Submission.

Action

No Actions for the Board.

Alert

Chair of the Finance & Performance Committee
- Diane Leacock has commenced as Chair of the Finance & Performance Committee.

Trust Cash Position
- The Committee noted a new risk relating to the Trust's future cash position.

2025/26 Planning
- The Committee noted challenges relating to the 2025/26 Planning process; with the likelihood of decreased funding levels at a time of increased operational demand.

NHS
Essex Partnership University
NHS Foundation Trust

2. PEOPLE, EQUALITY & CULTURE COMMITTEE

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

Committee meeting held: 18 December 2024

Assurance

Time to Care
- The Programme is on track to achieve the overall target by the end of the financial year.
- There have been a range of staff communications, including ward visits and roadshows.
- Safety Improvement Plans have been launched on the Sophia platform.
- Funding has been identified by ICBs, for approval at public Board meetings in early 2025.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Annual Workforce Plan Progress Report.
  - Workforce Key Performance Indicators Report.
  - Workforce Efficiencies Programme Report.
  - Recruitment Strategy Assurance Report.
  - People Promise Exemplar Programme Assurance Report.
  - Employee Relations Case Management Assurance Report.
  - Independent Review Action Plan Report.
  - Board Assurance Framework Report.

Information

People & Culture Senior Leadership Consultation
- The People & Culture Senior Leadership Consultation is now complete, and the new structure commenced on 1 January 2025.
- Stage 2 of the consultation was expected to commence in late January 2025.

Leadership Development Programme
- A review of the Trust's Leadership Development Programme is underway, with an ambition to commence with the first cohort in Autumn 2025.

National Staff Survey 2024
- Take-up of the 2024 Staff Survey was 3% lower than 2023.
- The team are working on plans to improve take-up in future years.

Mid & South Essex Anchor Charter 2024-2027
- The Committee gave its approval for the Trust to become a signatory of the Mid & South Essex Anchor Charter 2024-2027.

Consultant Vacancies
- A deep dive into Consultant vacancies will be carried out in early 2025.

Action

Reports for the Board
- The Committee gave their approval for the following reports to be presented to the Board:
  - Public Sector Equality Duty Annual Report 2023/24
  - Gender & Race Pay Gap Annual Report 2023/24
  - Equality Delivery System (EDS2022)
- These will be presented in separate Agenda items.

Alert

Chair of the People, Equality & Culture Committee
- Ruth Jackson has commenced as Chair of the People, Equality & Culture Committee.

3. QUALITY COMMITTEE

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

Committee meeting held: 12 December 2024 & 9 January 2025

Assurance

Safety Improvement Plans (SIPs)
- Updates were received on Safety Improvement Plans for: Improving Physical Healthcare on Inpatient Wards; and Ligature Risk Reduction.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Mental Health Act Report
  - Safeguarding Report
  - Infection Prevention & Control Report
  - Learning From Deaths Report
  - Health Inequalities Report
  - Physical Health Annual Work Plan & Progress Report
  - Suicide Prevention Annual Work Plan & Progress Report
  - Quality of Care Groups Update
  - CQC Assurance Report
  - Board Assurance Framework Report
  - Reducing Restrictive Practice Report
  - Sexual Safety Report
  - Prevention of Future Deaths Report
  - Learning Disability Improvement Standard Update
  - Neurodivergent Quarterly Report

Alert

No Alerts for the Board.

Information

Body-Worn Cameras
- Following a review of equipment, some items have been replaced.

Flow and Capacity
- There continue to be concerns around inpatient flow and capacity. This is being monitored by operational leads.

Patient/Family Story
- A service user's experience with acute care during a period of psychosis was received by the Committee.
- The Executive Medical Director is investigating the potential to develop a joint programme with acute trusts for exchanging mental and physical healthcare knowledge and expertise.

Seclusion & Long Term Segregation
- A project has been commissioned by NHS East of England, which aims to reduce mental health inpatient stays for patients with Autism and learning disabilities by increasing community provision.

Action

Reports for the Board
- The Committee gave their approval for the following reports to be presented to the Board:
  - Learning from Deaths Quarter 2 Report
  - End of Life Annual Report 2023/24
- These will be presented in separate Agenda items.

7.3 CQC ASSURANCE REPORT

Discussion Item AS 10

REFERENCES

Only PDFs are attached

CQC Assurance Report FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 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 09 January 2025					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

✓ **please use this tick on the below**

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:	**Approval**	
	Discussion	✓

1. An update on CQC related activities that are being undertaken within the Trust. 2. An update and escalations as required on progress made against the Trust CQC improvement plan. 3. Internal Assurance against the CQC Quality Statements	**Information**	✓

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 CQC unannounced focused inspection process for the Safe and Well Led domains continues on our Adult Acute and PICU services.
- The CQC undertook an unannounced inspection of Clifton Lodge 09 January 2025. The inspection is complete and the report is awaited.
- 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 38% having been agreed for closure through the Evidence Assurance Group.
- The Trust awaits the CQC inspection report of our Forensic / Secure Services at Brockfield House in March 2024.
- There were three 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 Update January 2025

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

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 is expecting to receive 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 and work has commenced in preparation.

3. CQC Inspections and Improvement Plans

3.1. Unannounced CQC Inspection

3.1.1. Brockfield House

The CQC report following the unannounced inspection of our Forensic / Secure Services at Brockfield House in March 2024, is awaited.

3.1.2. Adult Acute and PICU services

The unannounced focused CQC inspection process for the Safe and Well Led domains continues on our Adult Acute and PICU services. Between the 18 November and the 5 December 2024, the CQC team visited sample wards across the Derwent Centre, Kingswood Centre, The Lakes, The Linden Centre and Basildon Mental Health Unit.

Following the visits an information request was received from the CQC. The Trust responded to the information request from the CQC in a timely manner and the CQC have confirmed that review of this information is underway.

Over a week in January the CQC undertook leadership interviews to conclude the well led component of the inspection.

During the site visits there were no immediate escalations made. Initial feedback from the CQC has been received highlighting areas for improvement and areas of good practice.

3.1.3. Clifton Lodge

The CQC undertook an unannounced inspection of Clifton Lodge 09 January 2025. Initial verbal feedback was received at the end of the day which highlighted some areas for

improvement and areas of good practice. There were no immediate escalations made. The inspection is complete and the report is awaited

.

3.2. CQC Improvement Plan

The Trust has continued to focus on implementation of the CQC improvement plan. As at 23 January 25:

- 74 (95%) of the Must do / Should do actions have been reported as completed by action owners. Of these, 30 (38%) have been closed following review at the Evidence Assurance Group.
- 341 sub-actions complete
- 5 sub-actions past timescale (Nb. Associated with 4 overall actions) weekly monitoring is in place.

The EAG meeting held on the 15 January 2025 was chaired by EPUT Executive Nurse with ICB representatives, EPUT operational and corporate staff in attendance. 2 actions and their relevant evidence, were discussed and approved for closure. The next EAG is scheduled for 29 January 2025 with a further 3 actions to be presented.

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

3.3. CQC Enquiries

During the period the CQC raised three (3) enquiries:

- The CQC raised a concern within Learning Disability Inpatient Service relating to quality and safety of the service. An initial response was provided followed by a comprehensive response after investigations into all elements of the concern.

- The CQC raised a concern within CAMHS relating to safety. Response was submitted to the CQC, who have requested additional information from the Executive Chief Nurse.

- The CQC raised a further concern within the CAMHS relating to service safety following a reported ligature incident. A response was collated and returned to the CQC.

3.4. CQC Notifications

During the reporting period the Trust has made eight (8) notification submissions to the CQC including:

- Death of a detained MH patient (1),
- Allegations of abuse (1),
- Serious injury to a person using the service (6).

4. Annual Programme 2024-25

4.1. Internal Assurance

At the end of December 2024, the Trust is reporting ‘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.

The Executive team continues to have monthly oversight of the assurance scoring for the Trust and each core service based on the 5 domain quality statements following internal Compliance visits.

4.2. Quality Assurance Visits

The re-developed Quality Assurance Visits have continued during the reporting period. Work continues to implement learning from the pilot.

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:

Amanda Webb
Emergency Planning and Compliance Manager

On behalf of

Ann Sheridan
Executive Chief Nurse

Appendix 1:

CQC Improvement Plan Update 23 January 25

CONTENTS

Introduction

Essex Partnership University NHS Foundation Trust

The purpose of this report is to provide an update on implementation and assurance status against the trust CQC action plan.

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)
- CQC Inspection Forensic and Secure Services (March '24 report pending)

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 23 January '25) associated with CQC activity.

Overview as of the 23 January '25:

- 74 (95%) of the Must do / Should do actions have been completed.
- 30 (38%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 341 sub-actions complete

5 sub-actions past timescale as at 23 January '25 (Nb. Associated with 4 overall actions status) 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 and Executive Chief Operating Officer.

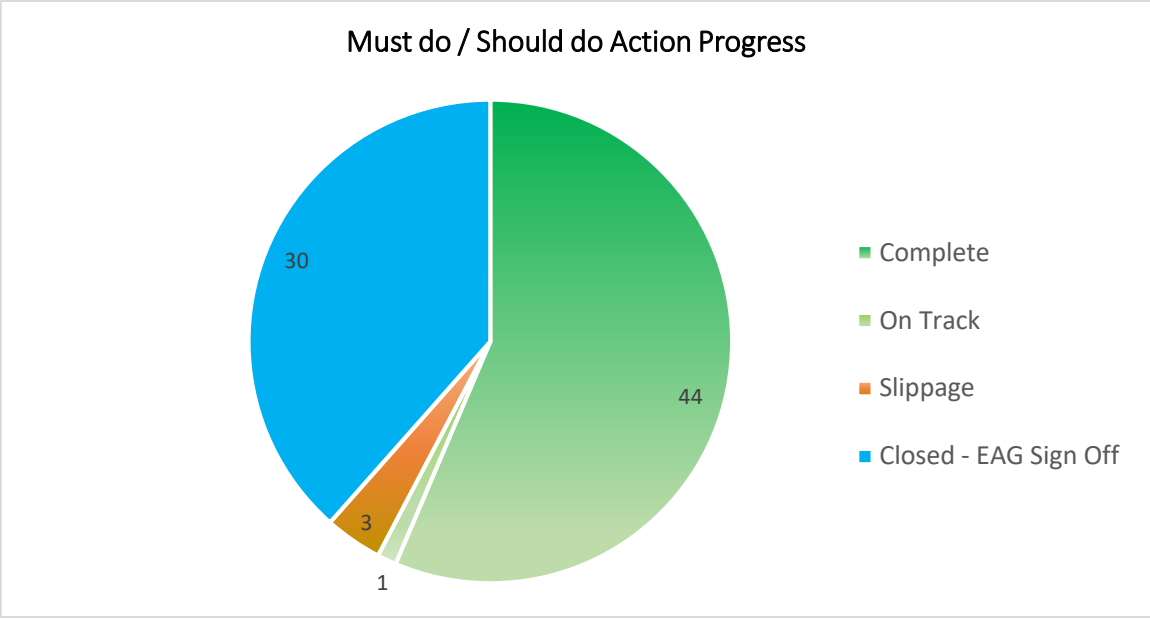
Next EAG arranged for 29 January '25.

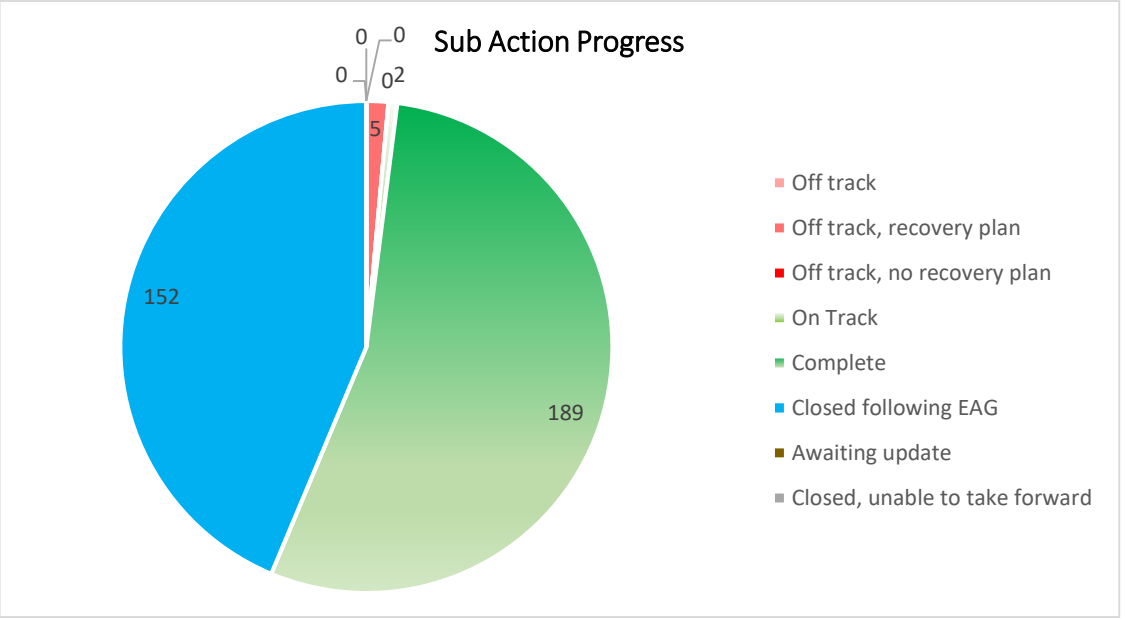
Action Progress Update

NHS
Essex Partnership University
NHS Foundation Trust

Summary of implementation status

- 78 Must do / Should do actions as at 23 January '24 and 348 Sub-Actions identified as at 23 January '24
- 30 (38%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 74 (95%) of the Must do / Should do actions have been completed. (next step is for the evidence to be presented to the CQC Leads Meeting and Evidence Assurance Group)
- 341 sub-actions complete
- 5 sub-actions past timescale as at 23 January '24 (Nb. Associated with 4 overall actions) recovery plans are in place





Summary of activities and highlights

NHS
Essex Partnership University
NHS Foundation Trust

Summary of key activities completed in the last month:

- M3 (Trust side) – Resolution of bug, with Paris upgrade now complete. Next steps are to enable Paris connect on each site with a timeline for full roll out set.
- M32 (MH Community) – Action closed and being prepared for EAG

Actions Closed

5 Actions closed by EAG in the reporting period (30 closed in total)

46 must do/should do actions complete and ready for closure. These are being prepared to be taken through the evidence assurance processes

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (5 Sub-actions are past timescale)				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M3: The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. M5: The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (4/11 actions complete / 2 on track)	M3.4.1 Complete Paris upgrade which will include waiting list management	Work on training videos and guides continues Application upgrade complete Oracle Upgrade planned for 25th & 26th Jan. Proceeding as planned	Paris Upgrade completed on the weekend of: 11th-12th January. New functions going live. **Timeline: Revised to January 2025.**	Jan Leonard
	M3.5.1 Enhancement of the Shared Care Record (SCR)	Work continue towards the dependency project of improving HIE functionality. SSO options are still being collated and finalised with timelines and prices.	Orion health/ Cerner (Suppliers) negotiations for resolution to share care record access between ICS's. See update above. **Weekly touchpoint to review**	Jan Leonard
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

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (5 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	Lead
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
M8: The trust must ensure that staff do not fall asleep when undertaking patient observations. (Regulation 12 (2).	M8.6 Address Sleeping on duty action plan following further review	New action incorporated following concerns identified during the evidencing of the embedding and sustainability of the original action. Formulation of risk register completed. Action Plan to address audit findings to be presented to Safety of Care.	Continuing to monitor as still no sustainability. Reviewing improvement implementations and benefit: Breaks / Welfare Checks / Supporting induction Criteria for closure to be identified (Exit Plan) to move to BAU **Weekly touchpoint to review**	Angela Wade

CQC Evidence Assurance Sign off Timeline

Actions with EAG sign off to date	Actions Awaiting Evidence Assurance	Actions On track	Actions In Recovery
30	44*	1 (March 26)	5 (1 due to complete Jan and 4 TBC)

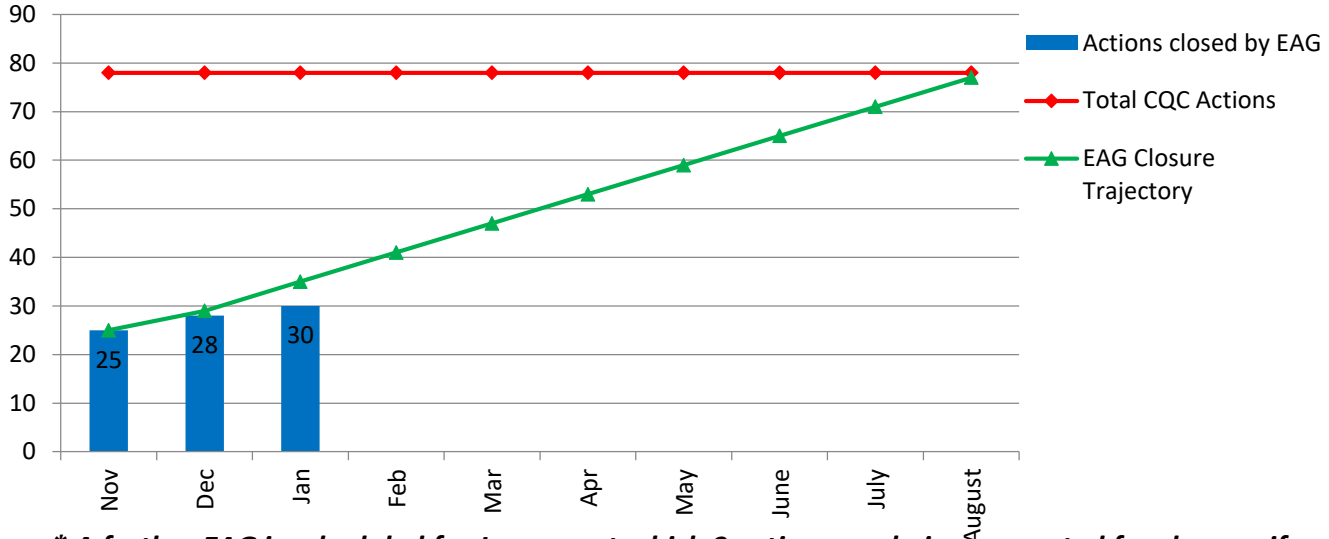
**** 3 previously presented to EAG with request for more evidence and 19 previously presented to CQC leads with request for more evidence***

A trajectory has been set to monitor actions being taken forward for EAG sign off. EAG has moved to fortnightly from January 2025 with an aim to sign off a minimum of 3 actions per meeting.

At the target rate all actions will have been through EAG by September 2025. We are working with our ICB colleagues to enhance capacity further.

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 is currently underway within 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 January at which 3 actions are being presented for closure, if all are successfully closed the January trajectory will be met***

Next steps

NHS
Essex Partnership University
NHS Foundation Trust

Areas of focus for the next month

- Continued focus on delivery of last actions
- CQC Leads with support from Compliance Team to build evidence assurance presentations for completed actions to undertake internal check and challenge and submission to the Evidence Assurance Group with ICBs (preparation for increasing EAG sessions)
- Ongoing implementation of the practice assurance toolkit for wards/services to provide assurance of delivery and change at local level

7.4 CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS

Decision Item | DG | 5

REFERENCES

Only PDFs are attached

Code of Conduct for Members 05.02.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2025

Report Title:	**Code of Conduct for Members of the Board of Directors**					
Executive/ Non-Executive Lead / Committee Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	NA					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	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 Code of Conduct for the Board of Directors for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the reviewed Code of Conduct for the Board of Directors

Summary of Key Points
The Trust is governed by the 2006 National Health Service Act, the 2012 Health and Social Care Act, the Health and Care Act 2022 and its constitution (i.e. regulatory framework). Members of the Board of Directors are required to act at all times in accordance with the regulatory framework and this Code. High standards of corporate and personal conduct are an essential component of public service. The Code of Conduct for the Board of Directors provides clear guidance on the standards of conduct and behavior expected of Directors. The Code of Conduct has been reviewed and transferred onto the new Trust policy template. Minor amendments have been made, regarding reference to guidance / legislation, including reference to the Health & Care Act 2022.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Code of Conduct for Members of the Board of Directors

Executive/ Non-Executive Lead / Committee Lead:
 **Denver Greenhalgh** **Senior Director of Corporate Governance**

Essex Partnership University
NHS Foundation Trust

Document title:	**CODE OF CONDUCT FOR MEMBERS OF THE BOARD OF DIRECTORS**		
Document reference number:	CP15	**Version number:**	3
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	Board of Directors
Author:	Assistant Trust Secretary		
Approval group/ committee(s):	Policy Oversight and Ratification Group (PORG)		
Professionally approved by: (Director)	Assistant Trust Secretary		
Executive Director:	Chief Executive Officer		
Ratification group(s):	Policy Oversight and Ratification Group (PORG)		
CQC Quality Statement	Compliance Team to provide relevant statement		
Key word(s) to search for document on Intranet / TAGs:	Conduct, Behaviour, Values, Board	**Distribution method:**	☒Intranet

Initial issue date:	02 October 2017	**Last Review date:**	05 February 2025	**Next Review date:**	31 January 2028	**Expiry Date:**	01 February 2028

What we do together matters

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Related Trust documents (to be read in conjunction with)
Fit and Proper Persons Test Policy & Procedure

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1	Trust Secretary		23 November 2017
1.1	Trust Secretary	6 month extension (Covid 19) Feb 21	01 February 2021
1.2	Trust Secretary	Further 1 month extension Apr 21 F&P	01 February 2021
2	Interim Trust Secretary	Additions to Appendix 1	01 April 2021
2.1	Interim Trust Secretary	s4.7 Amended	01 April 2021
2.2	Policy Team	Transferred to New Template	20 December 2024
3	Assistant Trust Secretary	Reviewed and minor changes to updated guidance / legislation included	05 February 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1 Introduction

1.1 The Trust is governed by the 2006 National Health Service Act, the 2012 Health and Social Care Act, the Health and Care Act 2022 and its constitution (i.e. regulatory framework). Members of the Board of Directors are required to act at all times in accordance with the regulatory framework and this Code

1.2 High standards of corporate and personal conduct are an essential component of public service.

1.3 The Code of Conduct is built upon and demonstrates the Trust's Corporate values:

- We care
- We learn
- We empower

Demonstrating these values will support the achievement of the Trust's strategic objectives:

- We will deliver safe, high quality integrated care services.
- We will enable each other to be the best that we can.
- We will work together with our partners to make our services better.
- We will help our communities to thrive.

2 Principles

2.1 The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of Directors

3 Scope

3.1 The Code of Conduct applies to all members of the Board of Directors, including Associate Non-Executive Directors.

3.2 It applies at all times when members of the Board are carrying out the business of the Trust or representing the Trust

3.3 The Code of Conduct for the Board of Directors together with the Code of Conduct for the Council of Governors and the constitution forms part of the governance framework designed to promote the highest possible standards of personal conduct and behaviour and high standards of business integrity at all times within the Trust

3.4 The constitution details the way in which the Trust operates. It outlines the qualification and disqualification criteria for Directors together with detailing their statutory roles and responsibilities. The constitution also includes the Standing Orders for the Board of Directors. Directors should familiarise themselves with the content of both the constitution and Standing Orders

3.5 This Code should be read in conjunction with, but not limited to, the Trust's Provider Licence, Standing Orders, Standing Financial Instructions, and Scheme of Reservation & Delegation as well as Code of Governance for NHS Provider Trusts.

3.6 This Code should also be considered alongside other organisational policies as listed under section 15 below.

4 Definitions / Glossary

Term	Definition / Meaning
2006 Act	means the National Health Service Act 2006
2012 Act	means the Health and Social Care Act 2012
2022 Act	Means the Health and Care Act 2022
Board/Board of Directors	means the Board of Directors as constituted in accordance with the Trust's constitution
Code/Code of Conduct	means this Code of Conduct for the Board of Directors and any associated appendices
Conflict of interest	is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. A conflict of interest may be: Actual: there is a material conflict between one or more interests Potential: there is the possibility of a material conflict between one or more interests in the future
Council/Council of Governors	is the Council of Governors of the Trust as constituted in accordance with the Trust's constitution
Director(s)	means the member(s) of the Board of Directors including the Chair, Chief Executive, Executive Directors and Non-Executive Directors
NHS FT	means NHS Foundation Trust
Governor	means a member of the Council of Governors

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Nolan Principles	means the seven principles of public life published by the Committee on Standards in Public Life
SFIs	means the Standing Financial Instructions of the Trust
SoRD	means the Scheme of Reservation & Delegation of the Board of Directors
SOs	means the Standing Orders of the Board of Directors
Trust	means Essex Partnership University NHS Foundation Trust (EPUT)

3.1 Unless otherwise stated, words and expressions contained in this Code of Conduct shall bear the same meaning as in the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and Health and Care Act 2022) and the Trust's constitution

5 Duties

5.1 The Board of Directors of an FT has a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct

5.2 As described in the Trust's constitution, the general duty of the Board and of each Director individually is to act with a view to promoting the success of the Trust and the wider system in which it operates so as to maximise the benefits for the members of the Trust as a whole and for the wider public

5.3 The Board undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. It will lead in ensuring that the provisions of the Trust's constitution, the NHS Constitution, SOs, SFIs and SoRD conform to best practice and serve to enhance standards of conduct

5.4 Directors are required to act with discretion and care in the performance of their role and to maintain confidentiality at all times with regard to any information gained via their involvement in the Trust

5.5 Ideally any penalties for non-compliance would never need to be applied. However, the Trust reserves the right to impose such penalties and regards non-compliance with the Code as a serious matter. This Code is considered an essential guide for Directors

5.6 The principles underpinning the Code are drawn from the Seven Principles of Public Life[1] (adapted from the Nolan Report). All members of the Board are expected to abide by them:

- **Selflessness:** Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends

- **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties

- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

- **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office

- **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands

- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

[1] HMSO 2013 Committee on Standards in Public Life 14th Report – *Standards Matter: a review of best practice in promoting good behaviour in public life*

5.7 All Directors are expected to demonstrate the Trust's values:

- We Care
- We Learn
- We Empower

6 Expected Standards of Behaviour

6.1 The Code will inform and govern the decisions and conduct for all Directors

6.2 Directors have a responsibility to be honest and act with integrity and probity at all times. Directors will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to Directors' own duties or the functions of the Trust

6.3 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute

6.4 Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code
- Respect others and treat them with dignity and fairness
- Seek to ensure that no one is unlawfully or otherwise discriminated against and promote equal opportunities and social inclusion
- Be honest and act with integrity and probity
- Recognise that the Board is collectively responsible for the exercise of its powers and the performance of the Trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors
- Make every effort to attend Board meetings, and those committees, sub-committees and joint working groups of which they are members
- Adhere to the good practice requirements in respect of the conduct of meetings as set out in appendix 1 to this Code and the Board's SOs
- Take and consider advice on issues where appropriate and respect the views of others
- Acknowledge the responsibility of the Council to hold the Non-Executive Directors individually and collectively to account for the performance of the Board, and represent the interests of the Trust's members, public and partner organisations in the governance and performance of the Trust, and to have regard to the views of the Council
- Not use their position for personal advantage or seek to gain preferential treatment, nor seek improperly to confer an advantage or disadvantage on any other person
- Accept responsibility for their performance, learning and development.
- Training and development are essential for Directors in respect of effect performance in their current role. Directors will therefore attend any training/development session as is reasonably required by the Trust in order to assist their role and functions.

7 Fit & Proper Person Requirement & Candour of Duty

7.1 Directors will need to be aware of the statutory duties imposed on the Trust under the 2012 Act in respect of NHS bodies meeting the 'fit and proper person' requirement for Directors and the duty of candour. The Trust acting through the Board will be legally responsible for compliance with its duties under the regulations. It is also a condition of the Trust's Provider Licence that every Director serving on the Board is a 'fit and proper person' as defined in the Licence and as revised by NHS England following the Kark Review.

7.2 As detailed in the Trust's Fit & Proper Person Policy, Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person or it comes to light that a Director is not a fit and proper person, they will be suspended from being a Director with immediate effect pending confirmation and any

appeal. Where it is confirmed that a Director is no longer a fit and proper person their Board membership is terminated

7.3 Directors must conduct themselves in a manner which ensures the Trust's compliance with the requirements set out in the Regulations in respect of the duty of candour and comply with the Trust's Policy on Being Open & Duty of Candour. The Directors must make sure that all staff are aware of the legal obligations that may apply in respect of the duty of candour when patients are harmed after a safety incident.

8 Training requirements

8.1 No specific training requirements.

9 Monitoring and audit

9.1 The Code of Conduct will be monitored through annual review requirements relating to Fit and Proper Persons and the Provider Licence, and through regular review of key governance documents (including the constitution).

10 Preliminary equality analysis

10.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

(Refer to appendix 3)

11 References

NHS Act 2006
Health & Social Care Act 2012
Health & Care Act 2022
Fit and Proper Persons Test Framework (NHS England – 2023)
Fit and Proper Persons Test Policy & Procedure
Nolan Principles

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 1: Etiquette for Board and Committee Meetings

All members of the Board of Directors shall comply with the requirements set out below when attending or preparing for Board meetings or meetings of the Committees of the Board.

1 The number of decisions required at Board meetings will be limited and the business will be conducted in a timely and focused manner

2 Meeting papers will be succinct and avoid too much detail, and written to an appropriate standard clearly detailing the purpose of the report, issues, risks and recommendations/actions to be taken

3 Every Director will have access to key information prior, at or after the meeting. This will include items discussed outside of Board/Committee meetings

4 The Chair will work to a timed agenda and all questions will go through the Chair

5 Clarity on feedback requirements and timescales will be agreed for all items requiring further action at the meeting

6 Messages to staff from Board/Committee meetings will be agreed at the end of each meeting

7 If any item on the agenda requires a vote to be taken, the most simple and effective process for implementing this will be adopted in line with the Standing Orders

8 In exceptional circumstances, the Chair will invoke Standing Orders

9 Directors will be expected to:

- Read all papers prior to attending the meeting to maximise effectiveness and clarify points of detail with the author beforehand
- Demonstrate mutual trust, courtesy, respect, honesty and openness
- Arrive or sign-in to meetings on time
- Contribute effectively and wholeheartedly to discussions at the meeting
- Be honest, open and constructive

- Show determination, tolerance and sensitivity
- Be rigorous, informed, challenging and constructive, employing questioning tempered by respect
- Be demanding and persistent but not attacking, crushing or dismissive
- Focus on material issues
- Be tolerant and understanding of diverse points of view, treating all ideas with respect and be ready to apologise
- Avoid giving or taking offence and stay open to discussion
- Show group support and loyalty to each other and the organization
- Be sensitive to the needs of colleagues when challenging or being challenged and ensure no-one becomes isolated when expressing their view
- Maintain confidentiality
- Act in a positive manner, expressing own point of view without being aggressive or overbearing and listen to what others say, respecting their viewpoint
- Challenge the issues not the individuals and raise issues concerns or conflicts appropriately
- Highlight or raise their issues or concerns if they experience conflict or disagreement during an agenda item discussion at that meeting and not revisit the issue once agreement has been reached
- Encourage and enable contribution from their peers
- Support the Chair of the meeting in maintaining focus on the relevant issues by stopping or refocusing discussions if this is lacking or not addressing the original issue including supporting colleagues and guests in making the best use of time and to maximise the scope and variety of viewpoints shared; Individual points should be relevant and made succinctly

10 Directors will not entertain irrelevant interruptions and will not read/respond to emails or otherwise use their communication devices during meetings.

11 At the end of each meeting, review performance against the above standards and to ask:

- Did we use our resources well?
- Who else should have been there, (or not)?
- What helped it go as well as it did?
- What could be done in future to help it run better?

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 2: The NHS Constitution for England

The *NHS Constitution for England* sets out a whole range of principles, values, rights, pledges and responsibilities for NHS organisations and employees as well as for patients and the public. The Trust is committed to abiding by these requirements in guiding its own actions and expects that directors, managers and staff will abide by these principles, values, rights, pledges and responsibilities when undertaking their own duties.

The NHS values which guide the NHS are:

- respect and dignity
- commitment to the quality of care
- compassion
- improving lives
- working together for patients
- everyone counting.

Under the *NHS Constitution* all Directors, managers and staff have the following duties:

- to accept professional accountability and maintain standards of professional practice
- to take reasonable care of health and safety at work for you, your team and others, and to co-operate with the organisation to ensure compliance with health and safety requirements
- to act in accordance with the express and implied terms of your contract of employment
- not to discriminate against patients and staff and to adhere to equal opportunities and equality and human rights legislation
- to protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of harm
- to be honest and truthful in applying for a job and in carrying out that job.

In accordance with the *NHS Constitution*, the Trust expects that its Directors, managers and staff should aim to:

- maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of
- your team, the organisation and the NHS as a whole
- take up training and development opportunities provided over and above those legally required for your post
- play your part in sustainably improving services by working in partnership with patients, the public and communities
- raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality),
- which may affect patients, the public, other staff or the organisation itself, at the

- earliest opportunity
- be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in the spirit of co-operation. You should contribute to a climate where the trust can be heard and the reporting of, and learning from, errors is encouraged
- view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 3: Initial Equality Impact Assessment analysis

This assessment relates to: CP15 Code of Conduct for Members of the Board of Directors
(Please tick all that apply)
Link to Full Equality Impact Assessment can be found in InPut Here:

Does this Policy/Service/Function affect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	No	
Sex (Based on Biological Sex; Male, Female or Intersex)	No	
Age	No	
Sexual Orientation Including the LGBTQ+ Community	No	
People who are Married or are in a Civil Partnership	No	
People who are Pregnant or are on Maternity / Paternity Leave	No	
People who are Transgender / who have had gender reassignment treatments As well as gender minority groups	No	
Religion, Belief or Culture Including an absence of belief	No	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Does this Policy/Service/Function affect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	No	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	No	

Guidance on Completing this Document

This screening tool asks for evidence to ensure that these considerations are done in collaboration with groups that may be affected. Listed below are the ways that this evidence can be gathered to support this decision:

- Reviews with Staff who may be impacted by these changes
- Service User / Carer feedback or focus groups
- Guidance from national organisations (CQC / NHS Employers)
- The Equality and Inclusion Hub (on the Staff Intranet)
- Input from Staff Equality Networks or the Equality Advisor
- Reviewing this against good practice in other NHS Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Initial Screening Question	Response
If you have identified no negative impacts, then please explain how you reached that decision. please provide / attach reference to any reasoning or evidence that supports this: (Nature of policy, service or function, reviews, surveys, feedback, service user or staff data)	The Code of Conduct provides for expected behaviours and requirements of the Board of directors as set-out in primary legislation and is applied equally.
Is there a need for additional consultation? (Such as with external organisations, operational leads, patients, carers or voluntary sector)	No
Can we reduce any negative impacts by taking different actions or by making accommodations to this proposed Policy / Service / Function?	N/A
Is there any way any positive impacts to certain communities could be built upon or improved to benefit all protected characteristic groups?	No
If you have identified any negative impacts, are there reasons why these are valid, legal and/or justifiable?	N/A

Please complete this document and send a copy to EPUT's Compliance, Assurance & Risk Assistant / Trust Policy Controller) at epunft.risk@nhs.net as part of the Approval Process, if this proposal / policy etc. has no positive or negative impacts on protected characteristic groups, a Full Equality Impact Assessment will not need to be completed

To be completed by the Trust Policy Controller				
Is a Full Equality Impact Assessment Required for this Policy, Service or Function?	**Yes**		**No**	
Name:				
Date:				

7.5 GENDER & RACE PAY GAP REPORT

Decision Item | AM | 5

REFERENCES

Only PDFs are attached

Gender and Race Pay Gap Report 05.02.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2025

Report Title:	**Gender and Race Pay Gap Report**					
Executive/ Non-Executive Lead / Committee Lead:	Andrew McMenemy – Executive Chief People Officer					
Report Author(s):	Lisa Fricker – Workforce, ESR & Payroll Manager. Sonia Lollia - Employee Experience Manager.					
Report discussed previously at:	Executive Team (December 2024), People Equality and Culture Committee (January 2025)					
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.			
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 Board of Directors with information about the Gender Pay Gap report.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve for publication on the Trust's website.

Summary of Key Points
Legislation requires organisations with 250 or more employees to report annually on their gender pay gap. NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into effect on 31 March 2017. These regulations underpin the Public Sector Equality Duty, which requires organisations to publish their gender pay gap data annually, including mean and median gender pay gaps; mean and median gender bonus gaps; proportion of men and women receiving bonuses; and the proportions of male and female employees in each pay quartile. The report will: • Provide equality data to aid development and implementation of the NHSE Equality, Diversity and Inclusion Improvement Plan and forms part of the NHS People Promise. • Provide an important strategic focus for change and help to drive systematic and demonstrable. Improvements in equality, diversity and inclusion framed by the Equality Act 2010. • Demonstrates the difference in average pay between men and women in a workforce. • Provide an overview of the organisation's most recent data which has been disaggregated by protected characteristics, as defined by the Equality Act 2010.

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**	

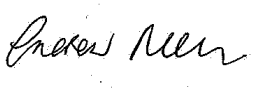
Acronyms/Terms Used in the Report			
WDES	Workforce Disability and Inclusion	EPUT	Essex Partnership University NHS FT
WRES	Workforce Race Equality Standard	BME	Black, Asian and Minority Ethnicity
ESR	Equality Staff Record	PSED	Public Sector Equality Duty
AFC	Agenda for change	HR	Human Resources
NHS	National Health Service	VSMs	Very Senior Managers
TCS	Terms and Conditions of Service	CEA	Clinical Excellence Awards
GPG	Gender Pay Gap	NED's	Chairs and Non-Executive directors

MSEFT	Mid and South Essex NHS Foundation Trust	HPFT	Hertfordshire Partnership University NHS Foundation Trust
ICS	Integrated Care System	NELFT	North East London NHS Foundation Trust
EDI	Equality Diversity and Inclusion	ELFT	East London NHS Foundation Trust

Supporting Reports and/or Appendices

Appendix 1 - 2024/2025 Action Update

Executive/ Non-Executive Lead / Committee Lead:



Andrew McMenemy
Executive Chief People Officer

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

GENDER PAY GAP REPORT 2024-2025

EPUT

Background to the Trust

Essex Partnership University NHS Foundation Trust (EPUT) was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust (SEPT). EPUT provide community health, mental health and learning disability services for a large population of people throughout Bedfordshire, Essex, Suffolk and Luton. We employ approximately 7,000 staff excluding bank across multiple sites.

EPUT is committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does.

Gender pay gap reporting

Legislation requires organisations with 250 or more employees to report annually on their gender pay gap. NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into effect on 31 March 2017. These regulations underpin the Public Sector Equality Duty, which requires organisations to publish their gender pay gap data annually, including mean and median gender pay gaps; mean and median gender bonus gaps; proportion of men and women receiving bonuses; and the proportions of male and female employees in each pay quartile.

Gender pay gap reporting demonstrates the difference in average pay between men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate issues to deal address, and further analysis may help identify the cause of those issues.

It is important to stress that the gender pay gap is different to equal pay. Equal pay considers pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally on the grounds of their gender.

In June 2023, NHS England launched the EDI Improvement Plan which sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The independent review Mend the gap (2020) describes actions that the NHS should take to address the gender pay gaps in medicine. Many of its recommendations can also be applied to non-medical senior leaders. By 31 March 2024, organisations are required to analyse data to understand relationships between pay, sex, and race.

This report includes:

- Data and analysis relating to the gender pay gap
- Data and analysis relating to the race pay gap, based on pay grades
- An action plan to address the pay gap (see appendix 2).

Definitions and scope

The gender pay gap is defined as the difference between the mean or median hourly rate of pay that male and female colleagues receive. The mean pay gap is the difference between average hourly earnings of men and women. This is commonly known as the average and is calculated when you add up the wages of all employees and divide the figure by the number of employees (see appendix 1).

What is the gender bonus gap?

Within the gender pay gap regulations, ‘bonus pay’ means any remuneration that is the form of money relating to profit sharing, productivity, performance, incentive or commission (see appendix 1).

EPUT's gender pay gap

The following gender pay gap report data is taken as the snapshot date of 31 March 2024.

1.	The mean gender pay gap for EPUT	**12.41%**
2.	The median gender pay gap for EPUT	**3.90%**
3.	The mean gender bonus* gap for EPUT	**55.31%**
4.	The median gender bonus* gap for EPUT	**0%**

* Please see comments later in this report explaining what constitutes a bonus.

Pay quartiles by gender

Quartile	Female	Male	Female %	Male %	Description
1	1520.00	373.00	80.30	19.70	Includes all employees whose standard hourly rate places them at or below the lower quartile
2	1415.00	485.00	74.47	25.53	Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	1483.00	417.00	78.05	21.95	Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4	1364.00	536.00	71.79	28.21	Includes all employees whose standard hourly rate places them above the upper quartile

What do we do to ensure equal pay?

As noted earlier in this report, it is important to stress that the gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender.

Legislation requires that men and women must receive equal pay for

- the same or broadly similar work
- work rated as equivalent under a job evaluation scheme; or work of equal value.

We are committed to providing equal opportunities and equal treatment for all employees, regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy/ maternity, sexual orientation, gender reassignment or disability. We pay employees equally for the same or equivalent work, regardless of their sex or race (or any other characteristic set out above).

We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce (see AfC, TCS, VSMs, NEDs appendix 1)

What is the data telling us?

The Gender Pay Gap (GPG) report looks at the average and median rates of two key indicators:

- The GPG hourly rate pay gap for EPUT is **12.41%**, with **males receiving an average of £21.64ph** and **females receiving £18.02ph**. When comparing the median hourly rate this reduces to 3.9%. This is a reduction of 0.52% in the average percentage and the median has decreased by 3.41% compared to 2023.

  This result means that **men on average are being paid 3.9% higher in the organisation than females.**

- The GPG **bonus pay gap for EPUT is 55.31%**, with **males receiving an average bonus pay of £6,204.85** compared to **£2,773.00 for females**. When comparing the median rate this has decreased to 0% due to the CEA scheme ceasing. The average percentage has reduced by 0.70% and the median has reduced by 66.84% compared to 2023.

  This result means that **men are on average receiving a 0% increase on bonus pay than females** within the organisation.

- A total of **2.76% of males received a bonus compared to 0.34% of females** during the reporting period.

Bonus payments include elements of doctors pay, this staff group have a higher number of male employees, therefore increasing the bonus pay gap in comparison to other staff groups within the trust. The bonus pay elements are as follows:

- Clinical Excellence Awards
- Discretionary Points
- Performance Related Pay.

Positively, over the past fifteen years there has been significant growth in the percentage of women in medical roles, which should see the gender bonus pay gap diminish with time:

- **Female medical workforce** – **17.7% growth** from 31.2% in 2008 to 48.5% in 2024, although this is a reduction on the 2023 figure of 48.9%. Currently 164 females employed.
- **Female medical consultants** – **10.4% growth** from 22.7% in 2008 to 33.0% in 2024, although this is a reduction on the 2023 figure of 35.6%.

Whilst there has been a growth in the female consultant medical workforce, the legacy of the CEA scheme means that there will continue to be a gender bonus pay gap because there are more male consultants than female consultants. The Trusts current medical consultant gender breakdown is detailed in the table below.

Reporting Year	Female Consultant Headcount	% of Total	Male Consultant Headcount	% of Total	% Difference between Female/Male
2022/23	36	35.60%	65	64.40%	28.80%
2023/24	36	33.00%	73	67.00%	34.00%

EPUT's staff pay profile by Ethnicity

The table below is a new breakdown for 2024 as outlined in the NHS EDI Improvement Plan (High Impact Action 3) and shows the breakdown of staff in scope by gender and race for the reporting period 1 April 2023 - 31st March 2024.

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	20.24	17.71	2,595
White	19.19	16.84	4,838
Not Known	21.46	18.47	160
% Diff White - BME	-5.48	-5.17	46
% Diff White - Not Known	-11.85	-9.67	97

The table below is a breakdown of pay quartile by Ethnicity:

Quartile	Asian	Black	Mixed	Other	White British	White Other	Not Stated
1	104	256	37	20	**1,328**	119	29
2	149	**651**	35	13	899	115	38
3	117	551	**49**	25	996	127	35
4	**225**	286	35	**42**	1,071	**183**	58

Looking at the above table the largest representation for each Ethnic Group by quartile is as follows:

- 32.68% of our BME workforce are in the 2nd quartile, followed by 28.59% in the 3rd quartile
- 29.91% of our White workforce are in the 1st quartile, followed by 25.92% in the 4th quartile

The table below shows the bonus payments broken down by race as of 31st March 2024.

Ethnic Origin Grouping Summary	Employees Paid Bonus	Total Relevant Employees	Total Full Pay Relevant Employees
BME	28.00	3251.00	0.86%
White	12.00	5455.00	0.22%
Not Known	2.00	205.00	0.98%

The national picture

The gender pay gap for workers is in favour of men for the majority of occupations; however, occupational crowding has an effect since those occupations with the smallest gender pay gap have almost equal employment shares between men and women.

It is also important to note that men and women have different personal and job characteristics, which ultimately impact their respective pay.

Across the UK, men earned on average 14.3% more than women in 2023, according to the Office of National Statistics, meaning that EPUT's gender pay gap is below the national average.

Below is a comparison table of how EPUT's gender pay gap sits in comparison to local neighbouring NHS organisations.

The mean gender pay gap for EPUT	Mean hourly rate 2023/24	Median hourly rate 2023/24
Hertfordshire Partnership University NHS Foundation Trust (HPFT)	7.9% lower than men	-2% lower than men
East London NHS Foundation Trust (ELFT)	7.2% lower than men	1.2% lower than men
EPUT	13.1% lower than men	6.2% lower than men
Norfolk And Suffolk NHS Foundation Trust	13.5% lower than men	7.4% lower than men
North East London NHS Foundation Trust (NELFT)	23% lower than men	5% lower than men
Mid and South Essex NHS Foundation Trust (MSEFT)	26% lower than men	11.3% lower than men
The Princess Alexandra Hospital NHS Trust	24% lower than men	13% lower than men
PROVIDE	20.3% lower than men	2.6% lower than men

Sample comparison data with neighbouring Trusts tells us:

- EPUT is performing well in comparison with neighbouring providers
- EPUT is a top performing NHS Provider in Mid & South Essex ICS (EPUT, MSEFT, NELFT, and Provide).

As part of our action plan, we will be working with HPFT and ELFT to share best practice and to learn what steps they have taken to reduce their gender pay gap.

EPUT's progress

On comparison to EPUT's gender pay gap for the year 2017, we have seen a **reduction of 4.49% over the seven years to 2024**.

The mean gender pay gap for EPUT	2017	2018	2019	2020	2021	2022	2023	2024
The mean gender pay gap for EPUT	16.90%	15.90%	15.90%	14.30%	11.90%	13%	12.93%	12.41%
The median gender pay gap for EPUT	7.50%	7.40%	8.90%	8.10%	6.50%	6.20%	7.31%	3.90%
The mean gender bonus gap for EPUT	34.40%	31.20%	25.20%	33.60%	47%	59.50%	56.01%	55.31%
The median gender bonus* gap for EPUT	50.30%	51.70%	45%	30.80%	75%	79.60%	66.84%	0.00%

When comparing EPUT's gender pay gap nationally, EPUT is **below the national average of 14.3%.**

Lisa Fricker
Workforce/ESR and Payroll Manager

Sonia Lollia
Employee Experience Manager

On behalf of:

Andrew McMenemy
Chief People Officer

Essex Partnership University NHS Foundation Trust

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

Tel: 0300 123 0808

APPENDIX 1: GENDER PAY GAP ACTION PLAN 2025

This action plan is built upon our ED&I Strategy, the NHS EDI Improvement Plan and the Mend the Gap review. Each action will be developed into a delivery plan and monitored throughout the year, with outcomes and delivery metrics.

EPUT's Executive Team have made a commitment to prioritising Equality Diversity and Inclusion through driving transformational work through their directorates, policies and work streams. This approach will make positive changes to the culture of EPUT and lead to greater equity for all staff. Progress against these actions will be driven through the Equality and Inclusion Sub Committee, the Gender Equality Network, and the Ethnic Minority and Race Equality Network and assurance provided to the People Equality and Culture Committee (PECC).

Roles and responsibilities: Executive

Directors

- Executive Team accountable for the delivery of the Action Plan
- Sponsor and drive the implementation of these actions and provide support to ensure their delivery
- Allocate appropriate resources to ensure that responsible teams are able to deliver effectively
- Sponsor the staff networks and attend meetings regularly to increase engagement with staff across the Trust.
- Ensure that ED&I is at the heart of executive decision making for staff and patients.

Appendix 1

Definitions and scope

The gender pay gap is defined as the difference between the mean or median hourly rate of pay that male and female colleagues receive. The mean pay gap is the difference between average hourly earnings of men and women. This is commonly known as the average and is calculated when you add up the wages of all employees and divide the figure by the number of employees.

The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle-most salary.

It is important to note that although this report includes the breakdown of pay grades by race, the scope is different to that of the Workforce Race Equality Standard (WRES). While the WRES is based on a snapshot of one day (31 March), the data extracted for this report is based on the financial year (1 April – 31 March). Therefore, as it includes paid substantive assignments and bonuses within that period, the total number of staff in this report will be different to that in the WRES.

What is the gender bonus gap?

Within the gender pay gap regulations, 'bonus pay' means any remuneration that is the form of money relating to profit sharing, productivity, performance, incentive or commission.

It is clear within the regulations that bonus pay does not include ordinary pay, overtime pay and redundancy pay or termination payments.

For the purpose of gender pay reporting, 'Clinical Excellence Awards' payments are regarded as 'bonus pay'. The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those consultants who perform 'over and above' the standard expected for their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services.

There are 12 Levels of award with monetary value. Levels 1-9 are awarded locally (employer-based awards) and Levels 10-12 (silver, gold and platinum hereafter) are awarded nationally in accordance with assessment criteria and application.

Consultants with an existing distinction award or discretionary points retain them, subject to existing review provisions, and are eligible to apply for awards under the new scheme in the normal way.

Accordingly, the legacy of the CEA scheme means that there will continue to be a gender pay gap because there are more male consultants than female consultants and the gender balance is only likely to improve over time (see above, and medical workforce and CEA breakdown below). CEA has now ceased.

What do we do to ensure equal pay?

As noted earlier in this report, it is important to stress that the **gender pay gap is different to equal pay**. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender.

Legislation requires that men and women must receive equal pay for:

- the same or broadly similar work
- work rated as equivalent under a job evaluation scheme; or work of equal value.

We are committed to providing equal opportunities and equal treatment for all employees, regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy/ maternity, sexual orientation, gender reassignment or disability. We pay employees equally for the same or equivalent work, regardless of their sex or race (or any other characteristic set out above).

We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce:

National NHS Agenda for Change Terms and Conditions of Service (AfC)

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at EPUT.

Typically, AfC terms and conditions apply to nursing, allied health professionals and administration and clerical staff, which are the majority of the workforce.

Where appropriate, locally agreed policies may supplement AfC arrangements, such as:

- family friendly policies
- evaluating job roles and pay grades as necessary to ensure a fair structure
- starting salaries policy.

Medical and dental staff are employed on national Terms and Conditions of Service (TCS) and pay arrangements

These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all consultants, medical and dental staff and doctors and dentists in training

Very senior managers (VSMs), Chairs and non-executive directors (NEDs)

As an NHS Foundation Trust, EPUT is free to determine its own rates of pay for its VSMs, Chairs and NEDs. VSMs include chief executives, executive directors and other senior managers with board level responsibility who report directly to the chief executive.

* Negative figures in the column ‘gender pay gap by pay band’ indicate a gender pay gap in favour of females.

Appendix 2

High Impact Action	Progress to date	Next Steps	Timescale
Promoting a flexible working culture	Implemented a policy that ensures all staff have a right to request flexible working. Regularly promoted flexible working to all staff in the Trust – these include promotion through: • internal communications • recruitment campaigns • Employee Experience Managers • Engagement Champion events • international recruitment on boarding sessions Reviewed and reported grievances including concerns relating to flexible working requests, broken down by gender and race, with appropriate action taken.	Include flexible working awareness sessions in Health and wellbeing events to address cultural barriers associated with flexible working to help with reducing the pay gap. Work with managers understand what additional guidance would help them to support their staff in seeking and securing flexible working arrangements New data collected on flexible working. Development of handbook for staff and Line Managers on flexible guidance - toolkit. Work with Rostering on flexible working solutions.	March 2025
Embedding fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity	Successfully launched a recruitment de-bias toolkit and an inclusion ambassadors scheme to ensure a fair and inclusive recruitment process. Ensured that wherever practicable, all applicants who meet the essential criteria were shortlisted for interview	Work in collaboration with Staff Networks to revise the process and start to actively recruit new trust inclusion ambassadors.	November 2024
		Report the gender and race balance of candidates	March 2025

	Minimised the use of local pay agreements by increasing the recruitment of senior managers on the Agenda for Change (AfC) Band 9 scale, instead of appointing managers where pay is agreed at a local level. Separated medical staffing data from other groups in the gender pay gap report, to better understand pay gaps specific to doctors and consultants.	shortlisted following a job application. Data to also include a breakdown down by disability.	
		Promote career development programmes to medical staff, with the aim of increasing the appointment of a senior workforce which is diverse, representative of the workforce, including those with protected characteristics.	March 2025
		Through the all Staff Network, utilise data from a range of listening tools to inform key stakeholders of barriers staff face, and how these may contribute towards pay gaps based on gender, race and disability.	June 2024

	□ Reported, monitored and published the gender balance of those who have been appointed to work at the Trust. □ Facilitated, promoted and monitored career development programmes: • Management Development Programme • Leadership Development Programme • RISE Programme • Edward Jenner Programme • Mary Seacole Programme • Elizabeth Garett Anderson Programme. □ Facilitated career development conversations with staff, informing them of relevant opportunities to develop within the Trust.	Establish a Gender Equality Network, working in partnership with the Ethnic Minority and Race Network and staff to: • address the gender and race pay gap • explore opportunities to support equity between men and women being represented in leadership roles • connect staff and promote gender and race equality across the Trust. • Menopause training sessions for Managers and staff members embedding as a response to staff requests. It helps informal discussions and	March 2024

		understanding around the menopause, women's or those who identify as women needs, including shaping the supportive measures in place such as Menopause policy and encourage reasonable adjustments.	
	Promote career development programmes to medical staff, with the aim of increasing the appointment of a senior workforce which is diverse, representative of the workforce, including those with protected characteristics. The group courses held of SAS Doctors: ▪ Introduction to Medical Ethics ▪ Preparing for CESR ▪ Managing Complaints ▪ ISTDP Training ▪ SAS Doctors Development Day ▪ Medical Update for Mental Health.	In the south of the Trust, weekly teaching sessions for all grades of doctors, both face to face and online, which counts towards their CPD record. Our core trainees also attend the MRCPsych sessions on a weekly basis. Group training sessions for the SAS Doctors/IMG Fellows. Funding from HEE for the use of Group Activities.	January 2024

	90 day Challenge project. Promotion of career development for Midwives and Nurses from minority background – Inclusive recruitment process and talent Management project. Explore opportunity to reduce race inequalities.	EDI project led by selected system wide members of staff from Provide, MSEFT, NELFT, EPUT, including Senior Leaders. Team has facilitated and supported a number of sessions with Senior Leaders within the Trust and system wide, attending online and face-to-face career development sessions. Regional presentation of 90-day-Challenge project. Rise and Thrive cohort and career conversations in progress.	October 2024

Promoting behaviour and cultural change	Reviewed and updated the whistleblowing policy to comply with the mandate for all NHS organisations to implement the NHS England National Freedom to Speak Up Policy. Conducted in-person and virtual focus sessions to promote the Trust's zero-tolerance approach to poor and/or abusive behaviour. In addition, promoted channels available to staff for reporting incidents, and how to do so anonymously. Embedded the 'no space for abuse' campaign, alongside sexual safety training. Reviewed and updated the Equality, Diversity and Inclusion (ED&I) training, which now includes an 'active bystander module'. Implemented a 'fair and just culture' which is reflected in all policies and procedures, ensuring best practice in supporting staff experience.	Promote wellbeing at work and related initiatives through health and wellbeing events, including underrepresented roles such as medical staff and senior managers. Facilitate health and wellbeing initiatives which promote behaviour and cultural change. These initiatives will align to the NHS Health and Wellbeing Framework. Roadshows provided by Safeguarding Team	January 2024

Clinical Excellence Awards (CEA) and performance payments	□ Monitored applications and ensured that both men and women had equal opportunity to apply for local and national awards. □ Reported on those in receipt of CEA in the gender pay gap report.	Report on the numbers of men and women eligible for awards, as defined by the Advisory Committee on Clinical Excellence Awards (ACCEA).	No longer required after year 2023

Priorities:

We aim to continuously reduce the gender and ethnicity gap year after year, fostering greater equality within our pay frameworks. Achieving this requires a multifaceted approach that encompasses attraction, recruitment, development and retention initiatives. To enhance our outreach, we will engage even more with local schools with career fairs, work experience opportunities, apprenticeship and buddy schemes. We aim to refine our recruitment practices to increase our workforce diversity and eliminate bias. This includes more development programmes, promotions of our leadership programmes, develop our new HCA Academy with an EDI focus and continue to develop comprehensive training courses for our Managers, including cultural awareness, civility and behaviour frameworks. Collaboration with all staff networks will be crucial as we take an intersectional approach to identify actions that support pay equality. We will design and conduct focus groups to uncover barriers to career progression, continue developing our Inclusion Ambassador and Lived Experience programs, and work closely with multicultural colleagues.

We will also create opportunities for women to share their experiences through events and activities, such as World Menopause Day, and encourage all staff networks to embrace and celebrate diversity and inclusion.

Conclusions:

While it is essential to acknowledge the progress made during this reporting period, we must recognise that substantial work remains to fully realise the Trust's strategic goals and effectively integrate Equality, Diversity, and Inclusion (EDI) across the organisation.

Advancing the initiatives outlined in our people strategy and enhancing values-based recruitment and HR practices are crucial steps toward achieving the cultural transformation necessary for the Trust to become a genuinely inclusive and supportive workplace.

Moreover, to achieve meaningful reductions in both gender and ethnicity pay gaps, we must give serious attention to developing and implementing positive action programs. These initiatives should focus on empowering underrepresented colleagues to assume senior roles and establishing talent pipelines to identify internal candidates before seeking external recruitment.

Recommendation

The Board is asked to receive this report for information and approve this report for publication on the Trust website in line with legal requirements.

7.6 EQUALITY DELIVERY SYSTEM (2024)

Decision Item | AM | 5

REFERENCES

Only PDFs are attached

EDS Report 05.02.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2024

Report Title:	**Equality Delivery System (2024)**					
Executive/ Non-Executive Lead / Committee Lead:	Andrew McMenemy – Chief People Officer					
Report Author(s):	Gary Brisco – Equality Advisor Paul Taylor - Director of Organisational Development and Culture					
Report discussed previously at:	Executive Team (December 2024), PECC (December 2024)					
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.		
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 Board with an overview of the Equality Delivery System (EDS2022).	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Points
• The Equality Delivery System or EDS is part of the Public Sector Equality Duty under the Equality Act (2010), helping NHS organisations improve the services they provide and working environments in the areas of improving wellbeing and reducing discrimination. • The Trust have collated evidence to show progress in each "Domain" (Appendix A) and have worked with stakeholders and independent adjudicators to provide an average grade for "*Commissioned or Provided Services", "Workforce Health and Wellbeing"* and *"Inclusive Leadership".* The Trust has completed its actions from of last year's EDS and listed this progress. • The Trust grade has declined from "achieving" to "developing" since the previous EDS and these grades as well as qualitative feedback from participants have been used to draft actions for the Trust in 2025 with the goal of improving future grading as well as equality, inclusion and wellbeing in EPUT.

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**	N/A

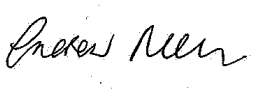
Acronyms/Terms Used in the Report			
EDS	Equality Delivery System	ICB	Integrated Care Board
MSE	Mid and South Essex	VCSE	Voluntary, Community and Social Enterprises
PSED	Public Sector Equality Duty	BAF	Board Assurance Framework
WRES	Workforce Race Equality Standard	WDES	Workforce Disability Equality Standard
PG	(Gender) Pay Gap Report	EDI	Equality, Diversity and Inclusion
BAF	Board Assurance Framework	PECC	People, Equality and Culture Committee
iWGC	"I want great care" patient feedback system.	PAM	People Asset Management (EPUT Occupational Health provider)
HWE	Herts and West Essex	SNEE	Suffolk and North – East Essex.
VAPR	Violence and Abuse Prevention and Reduction Team.	PCREF	Patient and Carer Race Equality Framework
XPERT / CIM	Diabetes Education Programs	DM	Diabetes (Type 2)

Acronyms/Terms Used in the Report			
DAFNE	Dose Adjustment for Normal Eating (educational program for type one diabetes)	EPR	Electronic Patient Record software (such as SystmOne and PARIS)
HCP	Healthcare Practitioner	DSN	District Nursing
DATIX	Online Incident Reporting software.	F2SU	Freedom to Speak Up.
BME	Black and Minority Ethnicity	VSM	Very Senior Managers

Supporting Reports and/or Appendices

Equality Delivery System 2024 Report
Appendix A – Equality Delivery System (EDS) Reporting Template
Appendix B – Grading Breakdown and Demographics of Stakeholders

Executive/ Non-Executive Lead / Committee Lead:



Andrew McMenemy
Chief People Officer

EQUALITY DELIVERY SYSTEM (2024)

1 EXECUTIVE SUMMARY

This report provides the Board of Directors:

- A summary of actions from the previous Equality Delivery System (2023)
- Oversight of the EDS Report for 2024
- Actions for 2025, which have been developed using stakeholder feedback.

This report evidences EPUT's implementation of equality, inclusion and wellbeing throughout the year. Patient and staff stakeholders grade this, with feedback informing the actions proposed as part of the action plan in **Appendix A** and in line with the Public Sector Equality Duty or PSED (2010). We as a Trust have seen a decrease in EDS overall grade for EPUT, from developing to achieving. Feedback from our stakeholders **(Appendix B)** has been developed into proposed actions for the Trust **(Appendix A)**, and guides our actions alongside the NHS EDI Improvement Plan in 2025. Whilst this has been drafted based on EPUT data, following approval, this will be submitted to Mid and South Essex (MSE) Integrated Care Board (ICB). This data will be used to develop a collaborative system score and wider system plan before April 2025.

2 BACKGROUND

The Equality Delivery System (EDS) is a tool to support the NHS in equality, inclusion and wellbeing. Whilst this framework is referred to as "EDS2022" based on the last date of revision, this will be referred to as 'EDS' or 'EDS2024' to show this report is for our current progress. The EDS is included in the NHS standard contract and we use the report template **(Appendix A)** to share our performance. This involves the collection of evidence, which is then presented to stakeholder volunteers for grading:

- **Domain One: Commissioned or Provided Services** Led by the Patient Experience Team and graded by patient, carers and volunteers.
- **Domain Two: Workforce Health and Wellbeing** Led by the Equality Advisor and graded by staff volunteers acting as stakeholders.
- **Domain Three: Inclusive Leadership** Led by the Equality Advisor and graded by an independent evaluator, peer reviewer and Trade Union representative.

A breakdown of grading from stakeholders and comparison to previous years is available in **Appendix B**.

3 UPDATE FROM EDS 2023 Action Plan

EPUT successfully completed all actions from the previous EDS report (2023) across the three domains. A full breakdown of each action, activity and data are available in **Appendix A**:

Domain One: Commissioned or Provided Services

- Increased scope and utilisation of Patient Safety Partner role across organisation; The Patient Safety Partner role has now been fully operationalised with regular ward visits happening across the Trust and the team has increased by 50% since 2023.
- Services using "I Want Great Care" (iWGC) feedback system has increased from 1% to 49%. iWGC is included in staff induction as a module.
- Virtual drop in sessions to improve staff knowledge and confidence of using iWGC are routinely held.
- iWGC data is used in a new Safety Dashboard. Monthly iWGC Reports are sent to all Deputy Director of Quality and Safety.

Domain Two: Workforce Health and Wellbeing

- Health and Wellbeing sessions taking place across the year with the Employee Experience Team and Voluntary, Community and Social Enterprises (VCSE's).
- Pilot of Discrimination and Violence interventions on five wards with a focus on reducing incidents, upskilling staff and better supporting those affected. Reviewing existing processes with peer support workers and working in collaboration with Essex police and the Crown Prosecution Service.
- 1.91% improvement in staff responses to *"I would recommend my organisation as a place to work."* (NHS Staff Survey Q25c).
- 2.63% improvement in staff responses to *"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."* (NHS Staff Survey Q25d).

Domain Three: Inclusive Leadership

- Board Members have EDI objectives, attend events in the EDI calendar and act as Executive Sponsors for EPUT staff Networks.
- Equality Impact Assessments are required for papers submitted to Board, and approved via EPUT's Equality and Inclusion Committee.
- EDI metrics included as part of EPUT's Accountability Framework and Trust People and Education Strategy, with bi-monthly reporting into the Board Assurance Framework (BAF).

4 EPUT EDS PERFORMANCE 2024

Stakeholders grade each domain's outcome as either "undeveloped", "developing", "achieving" or "excelling" based on technical guidance and criteria provided by NHS England. The average score is used to calculate a final grade for each outcome and the overall EDS. Following the submission of evidence **(Appendix A)** to the three stakeholder cohorts, each group was encouraged to provide their grading as well as any potential improvements they would like to see within the organisation:

Domain One *(Commissioned or Provided Services)*

- In line with EDS technical guidance, EPUT's Patient Experience Manager conducted this collaboratively with Mid and South Essex ICB, with services nominated each year. EPUT's diabetes services were chosen for grading this year.
- The Patient Experience Team contacted stakeholders and provided them with a summary of progress in Domain One and an online survey.
- Grades were provided by anonymous online survey (MS Forms), which also collected demographic information. **(Appendix B)**

Domain Two (*Workforce Health and Wellbeing*)

- EPUT staff members acting as stakeholders completed this, promoted across the Trust via Communications, engagement with Staff Networks and Engagement Champions.
- Participants were provided with a summary of EPUT progress in Domain Two, this evidence was shared alongside the criteria for an Excelling Trust to help give context.
- Grades were provided by anonymous online survey (MS Forms), which also collected demographic information. **(Appendix B)**

Domain Three (*Inclusive Leadership*) was graded independently by two stakeholders;

- Paul Curry *(Equality and Diversity Lead for Hertfordshire and West Essex Integrated Care Board)* and Oladipo Ogdenbe (EPUT Staffside Chair) provided peer review as independent evaluators.
- These two stakeholders were provided with a summary and additional evidence on request, including a snapshot of EPUT Board Papers, Public reports (WRES, WDES, PG) and Domain Three **(Appendix A).**

- Stakeholders provided their individual grading, feedback and suggested next steps for improvement, used in developing the recommendations in this report. **(Appendix B)**,

6 CONCLUSION AND NEXT STEPS

In conclusion, whilst we previously graded as "achieving" with a score of 22 out of a possible 33, we have seen a slight decline in grading from "achieving" to "developing" with a final score of 20.21 out of a possible 33 **(Appendix B)**. Potential reasons for this based on qualitative feedback include dissatisfaction from staff participants negatively skewing their grading for Domain 2 as well as a stringent review of Domain 3 by an experienced ICB lead.

Whilst our evidence shows we are achieving in these areas as a Trust, with predicted grading showing a higher score for Domain 2 and 3, more work needs to be done to raise awareness and improve perceptions of the support available for wellbeing, equality and inclusion.

The EDS Action Plan has been developed based on these scores, the criteria required to be seen as an "Excelling" Trust and stakeholder feedback (**Appendix A**). These will also influence our wider EDI, Health Inequalities and Wellbeing work within the Trust in 2024-25. A short summary of collected feedback and recommendations from our independent adjudicators to improve in Domain 3.

9 ACTION REQUIRED

Trust Board are required to:

1. Approve the report and appendices.
2. Approve the proposed actions in response to stakeholder feedback.
3. Approve the submission of the report and appendices to Mid and South Essex Integrated Care Board (MSE ICB) for submission by February 2024.

Report prepared by:

Gary Brisco
Equality Advisor

Paul Taylor
Director of Organisational Development and Culture

Amy Poole
Patient Experience Manager

On behalf of:
Andrew McMenemy
Chief People Officer

Appendix A – Equality Delivery System Reporting Template

NHS Equality Delivery System (EDS)

Name of Organisation	**Essex Partnership University NHS Foundation Trust (EPUT)**	**Organisation Board Sponsor/Lead**	
		Andrew McMenemy – Chief People Officer	
Name of ICB	**Mid and South Essex ICB**		

EDS Lead	**Amy Poole** (Patient Experience Team) **Domain 1** **Gary Brisco** (Equality Advisor) **Domain 2 and 3**	**At what level has this been completed?**	
			***List organisations**
EDS engagement date(s)	**Domain 1** 11/10/24 – Lived Experience Experts 4/12/24 – Collaborative with MSE ICB **Domains 2 and 3** 18/11/24 – 6/12/24 – Engaging with Staff Stakeholders and Independent Adjudicators	**Individual organisation**	**Domain 2 and 3** EPUT and submission to MSE ICB on February 2024
		Integrated Care System-wide*	**Domain 1** Graded collaboratively with Mid and South Essex ICB

Date completed	Monday 9th December 2024	**Month and year published**	**TBC**
Date authorised	**TBC**	**Revision date**	January 2026

Domain 1: Commissioned or provided services actions from EDS 2023	Equality Objectives
1A - Increase scope and utilisation of Patient Safety Partner role across organisation. • The Patient Safety Partner (PSP) role has now been fully operationalised with regular ward visits happening across the Trust • A Patient safety Partner handbook has been coproduced and acts as the standard operating procedure for the PSP role • EPUT's adoption of PSPs was nominated for a HSJ award • The Patient Safety Partner team has increased by 50% since 2023 • The PSP's have also redesigned the patient safety question set to be utilised on patient walkabouts which allows patients to select which group of questions they would like to answer under the headings of safe, effective, caring, responsive and well-led. • Due the positive interactions and receptiveness of patients, Patient Safety Partners are now due to take part in the trust wide audit of Therapeutic observation and will also be involved in a Quality Improvement project for Reducing Restrictive Practice.	**Trust Strategic Objective SO1** "We will delivery safe, high quality integrated care services."
1B - Ensure every service within EPUT is using iWGC as the recognised patient feedback service. • Services using "I want great care" (iWGC) patient feedback collection system has increased from 1% to 49% • Provided every service with unique four digit code increasing accessibility of providing feedback • iWGC is included in staff induction as a module, Dec 2023 • Service specific posters have been provided all services • Virtual drop in session to improve staff knowledge and confidence of using iWGC are routinely diarised • Incorporated data from iWGC into Safety Dashboard • Feedback challenge incentives set for staff • Increased scope of iWGC volunteer role; continuing to visit inpatients wards with plan to roll out to the community in 2025 • Monthly iWGC Reports are sent to all deputy director of quality and safety.	**Trust Strategic Objective SO2** "We will enable each other to be the best we can"
1C - Increase scope and utilisation of Patient Safety Partner role across organisation. • The Patient Safety Partner (PSP) role has now been fully operationalised with regular ward visits happening across the Trust • A Patient safety Partner handbook has been coproduced and acts as the standard operating procedure for the PSP role • EPUT's adoption of PSPs was nominated for a Health Service Journal award • The Patient Safety Partner team has increased by 50% since 2023	**Trust Strategic Objective SO1** "We will delivery safe, high quality integrated care services."

1D - Ensure every service within EPUT is using iWGC as the recognised patient feedback service. • Services using iWGC has increased from 1% to 49% • Provided every service with unique four digit code increasing accessibility of providing feedback • iWGC is included in staff induction as a module, Dec 2023 • Service specific posters have been provided all services • Virtual drop in session to improve staff knowledge and confidence of using iWGC are routinely diarised • Incorporated data from iWGC into Safety Dashboard • Feedback challenge incentives set for staff • Increased scope of iWGC volunteer role; continuing to visit inpatients wards with plan to roll out to the community in 2025 • Monthly iWGC Reports are sent to all Deputy Director of Quality and Safety	**Trust Strategic Objective SO2** "We will enable each other to be the best we can"
Domain 2: Workforce health and well-being actions from EDS 2023	**Equality Objectives**
2A - Improve wellbeing and health support to EPUT staff members, promoting a healthy workforce in collaboration with Voluntary, Community and Social Enterprise services. • Staff health and wellbeing reviewed as part of appraisal process, with options to refer to occupational health or counselling and therapy service "Here for You". • Managers are equipped with toolkit and resources to implement Access to Work requests or informal reasonable adjustments for staff with disabilities, long-term conditions or who are struggling in their role. • Equality Advisor / Disability and Mental Health Staff Network can provide guidance and support. • EPUT Intranet promotes initiatives, which improve work-life balance, healthy lifestyles and exercise. For example, Cycle-to-Work scheme. • VCSE offers regularly promoted via staff intranet pages, and available on request to staff. • New Occupational Health Provider (*People Asset Management or PAM*) provide support with health and wellbeing issues, and can provide assessments for reasonable adjustments in the workplace. • Health and Wellbeing sessions provided throughout the year covering key topics including menopause café and men's health awareness. . • Launched a new Reasonable Adjustments Toolkit as well as training tools and sessions for managers.	**NHS EDI Improvement Plan HIA 4** **Trust Strategic Objective SO3** "We will work together with our partners to make our services better. **Trust Strategic Objective SO2** "We will enable each other to be the best we can"
2B - Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. • Reduction of bullying and harassment within the Trust has been an objective of the Executive Team and Employee Experience Team based on WRES / WDES / Staff Survey Data. • EPUT Behavioural Framework clearly states that discriminatory or anti-social behaviour is against Trust values, and has been widely promoted throughout the Trust.	**NHS EDI Improvement Plan: HIA 2** **NHS EDI Improvement Plan: HIA 5**

• EPUT is an Anti-Racist Trust and works closely with multiple ICB groups as part of their anti-racism strategies (HWE, MSE, SNEE) • EPUT's Disciplinary and Conduct policies and procedure have been updated in line with EPUT Behavioural Framework. • Equality, Inclusion and Human Rights Policy and procedure has been updated to reflect how managers can support those experiencing discrimination, with specific guidance aimed at how managers should support marginalised communities (such as racism, transphobia, reasonable adjustments for employees) • Employee Experience Team works collaboratively with the Peer Support Team and Patient Lived Experience Ambassadors to identify opportunities to reduce incidents of abuse as part of a wider pilot project. • Pilot of Bullying and Harassment interventions on five wards across the organisation led by Employee Safety Programme Lead, with successes implemented wider in 2025. • Active Bystander Training provided to all staff, encouraging staff to challenge discriminatory behaviour when they witness it, to report incidents and to support those affected. • International Recruits receive pastoral care upon entering the Trust, supported in joining the organisation as well as with accommodation and on-boarding. • Inclusion Ambassadors program and De-Bias Toolkit are both used in our recruitment process to mitigate potential discrimination in our services.	**NHS EDI Improvement Plan: HIA 6** **Trust Strategic Objective SO2** "We will enable each other to be the best we can"

2C - Review support available for addressing poor staff wellbeing, anti-social or discriminatory behaviour. With clear access to independent support
• As our WRES and WDES data showed a need to address discriminatory behaviour in the Trust, we developed a pilot program across five "hot spot" wards to improve the support available for those affected.
  ○ We are currently trialling the use of body worn cameras for repair meetings between patients and staff
  ○ Improved response to staff who experience these from our Here for You and Violence and Aggression Prevention and Reduction (VAPR) teams.
  ○ Behaviour pledges to reinforce the Trust Behavioural Framework as part of our People and Education strategy.
• We have updated our Equality and Inclusion policies and procedures to clearly state how managers can better support those affected by discrimination, as well as how to prevent it and lead inclusively.
• We as a Trust regularly promote our Here for You, Freedom to Speak up and Employee Experience services within the Trust, staff are able to request support, guidance or advice.
	NHS EDI Improvement Plan: HIA 6
	
	Trust Strategic Objective SO2
	"We will enable each other to be the best we can"

2D - Improve on previous survey scores of staff recommending EPUT services and recommending the organisation as a place to work. • *"I would recommend my organisation as a place to work. (Q25c) "*= 1.91% increase from previous year (62.53% to 64.44%). • *"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d)"* = 2.63% higher than the previous year (57.55% to 60.18%).	**NHS People Promise** We are Compassionate and Inclusive **Trust Strategic Objective SO2** "We will enable each other to be the best we can" **Trust Strategic Objective SO1** "We will delivery safe, high quality integrated care services."
Domain 3: Inclusive leadership actions from EDS 2023	**Equality Objectives**
3A - Embed equality and health inequalities into Board and Committee Meetings. • Board members have SMART EDI objectives, and are accountable for these. • EDI is a standing item at Executive Team meetings and overseeing the delivery of EPUT's EDI strategy, including WRES, WDES, PCREF and the NHS EDI Improvement Plan.	**NHS EDI Improvement Plan HIA 1** **Trust Strategic Objective SO2** "We will enable each other to be the best we can"
3B - Ensure EIA's are completed for all projects and polities (where appropriate). • Equality Impact assessments are completed by staff as part of Equality and Inclusion Policy, encouraging staff to consider all marginalised communities under the Equality Act 2010. Included as part of a project, policy or procedure when submitted to Trust Board. • Equality Impact Assessments are approved by the Chief People Officer and Director for Employee Experience as part of the Equality and Inclusion Committee. • Ongoing work taking place to develop and implement digital Equality Impact Assessment System within ICB.	**NHS EDI Improvement Plan HIA 1**

3C - EPUT to show improvements in comparison to previous year's EDI, Staff Experience and Health Inequalities data. Monitoring the implementation and impact of actions.

EDI metrics included as part of EPUT's Accountability Framework and People and Education Strategy, with bi-monthly reporting into the Board Assurance Framework (BAF)

EPUT saw improvements in six out of the nine WRES indicators and nine out of the ten WDES Metrics, including:

- A higher percentage of staff declaring themselves as having a disability in the Trust in comparison to previous years (via ESR). (WDES 1)
- A reduction in the percentage of disabled staff saying that they have felt pressure from their manager to come to work. Now lower than the national average. (WDES 6)
- An increase in disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work. Higher than the national average. (WDES 8)
- Improvements in the likelihood of BME staff accessing non-mandatory training and career progression. (WRES 2)
- Reduction in BME staff members reporting bullying, harassment and abuse from colleagues, which was lower than the national average and near equal to the experiences of white counterparts. (WRES 6)
- Evidence from the NHS Staff Survey (2023):
- EPUT's highest scoring People Promise element was "*We are Compassionate and Inclusive*" scoring 7.55 out of 10.
    - Of the four sub-scores within this People Promise, *"Diversity and Equality"* is the highest, scoring 8.25 out of 10.
    - The Trust saw slight improvements to question 15, "*Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?*" 60.86% (above the national average) answered "yes" in comparison to 59.65% in 2022.
    - Q21 "I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc.)", 75.63% (above the National Average) of respondents answered "Yes" in comparison to 75.02% in 2022.
    - Q31b, "Has your employer made reasonable adjustment(s) to enable you to carry out your work?" 81.03% (above the national average) of respondents answered "Yes", in comparison to 78.68% in 2022).

NHS EDI Improvement Plan HIA 1

NHS EDI Improvement Plan HIA 1

NHS EDI Improvement Plan HIA 6

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Service users with diabetes are referred to the community dietetics and diabetes services according to an agreed referral pathway and triaged accordingly. • Referral for those under Mid & West Essex mental health in-patient service are able to be seen face to face during their admission with a team member who covers this particular speciality purely for those with diabetes. There is also a specialist dietitian who covers in & out-patient mental health services where those with diabetes would also be reviewed. • The Diabetes Specialist Practitioners (community diabetes) are able to access the local secondary care Consultant Specialist for advice & support for those with diabetes with complex health needs who would otherwise face lengthy waiting times to be seen in secondary care. This promotes timely action and treatment for the individual. • Within primary care, there is support for those managing diabetes within the GP practice during dietetic diabetes consultations. • For those accessing diabetes structured education for X-PERT/CIM (Type 2 DM) or DAFNE (Type 1 DM) courses are delivered face to face as close to home as possible as well as on-line (virtual) with additional virtual self-directed learning for those completing the DAFNE course • Timings of course delivery aim to support patient needs i.e. morning & afternoon & X-PERT evening • For those unable to attend face-to-face or complete virtual course education programmes, this can be offered on a one to one basis. • Patient and healthcare leaflets for diabetes structured education programmes are freely available and provided. For those planning to complete DAFNE education, pre-assessment for support prior to attendance is offered • Promotional videos covering structured education programmes are available and accessible via EPUT/ICB websites for those managing Type 1 & 2 diabetes • Referrals are accepted from all health care professionals, including our peers within the mental health care, social care, emergency services and pharmacies. • Service users are able self-refer on to our Type 2 structured diabetes education course, SWEET. SWEET is network of paediatric diabetes centres known for their expertise in treatment and education and connected through common objectives, SWEET will help to improve the quality of life of children and adolescents with diabetes.	2.4	Patient Experience Team – Amy Poole

	1B: Individual patients (service users) health needs are met	• An in-depth initial assessment is completed at first meetings with the client to enable development of concise awareness of their individual needs and identify support mechanisms that may require. The aim is to support agreed care planning and goal setting, to empower the client with managing their diabetes. • Following a referral, a one-to-one consultation, ideally f2f, will be made whereby a plan of care is agreed and patients are advised that the expectation is for them to communicate their blood glucose levels within an agreed period, either via telephone or via email. . • The teams are able to direct/signpost to other services that may be required during contact among these include, VitaMinds, Community Nursing teams, social services, podiatry, social prescribers, clinical pharmacists, weight management programmes, diabetes remission service, and local voluntary services where need is required as well as national diabetes support services such as Diabetes UK. • All adults referred are assessed at the point of contact and reviewed with an agreed care plan. Assessment will incorporate medical history, medications, investigation results with the aim to support the health needs identified by the patient/carer or HCP. • As specialist practitioners, we work in a professional and patient centred way using communication skills, to facilitate empowerment and self-management. • For those patients unable to engage in this process, we work with their carers appropriately **For at risk groups the service has implemented the following:** • Daily advice line 9-12.30 mon- Friday, • Patient email, • SMS messages so patients can have these dictated in their chosen language. • Language empire for face to face appointments, • Monthly visits to HARP and will attend some of the soup kitchens if unable to see the person living with diabetes at HARP • Transition and younger people specific nurse (looking after 19-24) • Designated home visit DSN who will visit the housebound. • Engaged with staff engagement team to support the diabetes team with delivering education for festivities – i.e. Ramadan where a person may fast for prolonged periods of time • Engaging with community nurses to change practice • Currently engaging with ICB re changes to insulin pump processes and availability in line with NICE TA	2.2	Patient Experience Team – Amy Poole

	1C: When patients (service users) use the service, they are free from harm	• Patient Safety Partners are working within EPUT to support and contribute to EPUT's governance and management processes for patient safety. It is the role of Patient Safety Partners to communicate rational and objective feedback focused on ensuring that Patient Safety is maintained and improved with EPUT as part of the Safety First, Safety Always initiative. • Serious Incidents and reports of harm are routinely monitored by Essex STaRS data analyst, the diabetes service manager and Essex County Council commissioners to identify any themes or trends that relate to Equality and Diversity. • Safety measures when attending face to face DAFNE: hypo treatments and ketone testing readily available. Assessment and advice on different tech to monitor BGs and ketones and advice on how to interpret levels • Venues are risk assessed • Patients referred into the services who meet service criteria are triaged and offered within an agreed wait time. For those who do not fit the criteria the referrer would be advised accordingly. Where required, an advisory is also put into place to support the patient concerned to ensure they can have access to and receive the appropriate care. The teams formulate and maintain close working relationships with GP's, Practice Nurses, Integrated nursing teams as well as many other HCP's. • The teams liaise with family, friends, and carers, who are also involved in support to maintain safety and free from risk of harm • All clinicians are registered with relevant Professional body and subjected to audit as required. • All practitioners learning needs are identified within supervision, one to one, and appraisal to ensure practice remains safe and up to date. • Staff engagement team are engaging with the team for MH first aid and support • Regular MDTs and complex case discussions which involves engagement from Therapy for you services	2.4	Patient Experience Team – Amy Poole
	1D: Patients (service users) report positive experiences of the service	• Patients are encouraged to complete IWGC (I Want Great Care) forms. This is the trusts contracted provider of PREMS (Patient Recorded Experience Measure). The platform is accessible in different languages and is presented through varying methods depending on what may be most suitable to the patient demographic. • Family and friends-DAFNE comments book. • Post course patients are given the opportunity to feedback via questionnaire on whether the course met their needs to allow the team to reflect. • EPUT outcome global questionnaire where possible to consent for those on caseload • Those attending courses can offer verbal feedback and are invited to complete the 'I want great care' paperwork	2.4	Patient Experience Team – Amy Poole

		• Every individual with connection/interest in EPUT can attend the EPUT forum, which is held once a quarter by the Patient Experience and Volunteers team as an opportunity to ask people and communities what matters most to them and where “citizens” feel EPUT should be targeting their energy. This gives all patients the opportunity to provide feedback on their experiences of care. • On average, the diabetes service scores 4.86 out of 5 for patient experience according to iWGC feedback. • Positive patient experiences are evidence by thank you cards and emails that we receive.		
Domain 1: Commissioned or provided services overall rating			9.4	

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Wellbeing, health and any issues currently affecting a staff member are embedded into staff appraisals and supervision process to monitor staff health and wellbeing.
		• Health and Wellbeing Toolkit available to all staff, aligns to NHS England Health and Wellbeing Framework and provides advice on physical, financial and mental wellbeing. Subjects include addiction, work-life balance and flexible working.
		• Provision of flexible working as well as special leave policy to ensure staff are able to request time for their health and wellbeing, especially for those wishing for maternal or paternal leave and those seeking leave for treatment of long term conditions of carer's leave.
		• New Occupational Health Provider PAM (People Asset Management) provide support with health and wellbeing issues, and can provide assessments for reasonable adjustments in the workplace. The service offers free and confidential support, guidance and counselling 24/7, with an option for referral to specialised support (debt, legal, bereavement, relationship support and trauma).
		  ○ Accessible via live hub app available to EPUT staff and access to live counsellors and support.
		  ○ Breakdown of Occupational Health access available to Employee Experience Team, Wellbeing Lead can access this data (appointments, access time, health surveillance, vaccinations, service usage) and used to drive initiatives and identify hot-spot areas.
		• Health and Wellbeing sessions provided throughout the year by the Employee Experience Team, covering key topics including menopause, men's health awareness and support during difficult events.
		• EPUT staff intranet pages have many health and wellbeing pages with links and resources. These include physical activity, sleep, healthy eating, staying hydrated, stopping smoking, substance misuse, resilience, mindfulness, finance and our Cycle-to-Work scheme.
		• EDI pages available support staff on the autism spectrum and with neurodiversity, guidance for supporting those with dyslexia, ADHD and other long-term conditions that may affect health in the workplace.
		• "ACT for You" workshops teach staff Acceptance and Commitment Therapy training techniques. This teaches participants skills to support psychological flexibility and resilience.
		• There are several trained Mental Health First Aiders across the Trust.
		• Access-to-Work support available to individuals with depression, anxiety, stress and/or other mental health conditions. With trained professionals able to support employees in resuming their role.
			1.42	Equality Advisor - Gary Brisco

		• Reasonable Adjustments passport available for all staff in EPUT. Managers equipped with toolkit and resources to implement Access to Work requests or adjustments for staff with disabilities or long-term conditions, as well as supporting their wellbeing in the workplace.
		• Our Workforce Disability Equality Standard (WDES) data has shown
		  ○ An increase in disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work.
		  ○ A reduction of staff reporting pressure from their manager to come into work when unwell.
		• NHS Staff Survey data has been used to implement health and wellbeing initiatives including EPUT Health and Wellbeing roadshows across the Trust available to all staff, as well as menopause awareness workshops.
		• Signposting to external organisations available from Equality Advisor, Employee Experience and Staff Engagement Teams when engaging with staff and resolving issues or providing support.
		• Service leads hold sickness task and finish groups across the Trust, reviewing sickness and absence data on a monthly basis.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• EPUT is an Anti-Racist Trust and works closely with multiple ICB groups as part of their anti-racism strategies (HWE, MSE, and SNEE). • EPUT has a Zero Tolerance approach to discrimination of all kinds, and discriminatory bullying, harassment and abuse is penalised as part of our Conduct and Equality, Inclusion and Human Rights policies. • Pilot of Bullying and Harassment interventions on five wards across the organisation led by Employee Safety Programme Lead, with successes implemented wider in 2025. • Staff from marginalised groups are encouraged to report incidents of discrimination and EPUT's Bullying and Harassment pilot investigated the reasons staff may choose not to do this and how to encourage reporting. • Implementation of new DATIX systems to capture incidents of racial abuse or discrimination, which triggers a debriefing process from the manager to ensure employee wellbeing. Each incident reviewed to establish what has occurred, what support has been provided and whether there are any opportunities identified to reduce the likelihood of incidents occurring in the future. • Equality Advisor can provide guidance and signposting to third party support organisations (such as Switchboard LGBT+, EASS and Stop Hate UK) Employee Relations or Patient Experience if staff members raise concerns of discriminatory behaviour in their teams (or if they would like help in improving the inclusion in their services).	1.28	Equality Advisor - Gary Brisco

		• EPUT staff engagement champions in the organisation trained to challenge bullying and harassment behaviours as well as share lived experiences with our Staff Engagement Team and Employee Experience Managers. • "No Space for Abuse" program in collaboration with Essex Police, encouraging everyone's responsibility to challenge racism and discriminatory behaviour, as well as better engage with Essex Police in reporting and prosecuting negative behaviour from service users. • Reduction of bullying and harassment within the Trust has been an objective of the Executive Team and Employee Experience Team based on WRES / WDES / Staff Survey Data. • Newly developed EPUT Behavioural Framework clearly states that discriminatory or anti-social behaviour are against Trust values, and has been widely promoted throughout the Trust. • Partnerships with Next Chapter, supporting our Safeguarding team and providing resources and seminars for patients, carers or staff members experiencing domestic abuse and stalking. • EPUT Equality, Inclusion and Human Rights policy and Induction training supports staff to challenge patients and carers who verbally or physically abuse them, as well as encouraging others to support them as part of Active Bystander training. Updated to reflect how managers can support those experiencing discrimination, with specific guidance aimed at how managers should support marginalised communities (such as racism, transphobia, reasonable adjustments for employees). • Active Bystander Training provided to all staff, encouraging staff to challenge discriminatory behaviour when they witness it, to report incidents and to support those affected. Training recognises the link between staff wellbeing and inclusion and the positive effect on patient experience.		
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical	• EPUT staff intranet provides options for staff to access multiple unions, and regularly involves Staffside and Union Representatives in key projects and Board functions. • EPUT collaborates with multiple ICB groups to share learning and good practice, and this is used to influence other system partners. • F2SU Guardian and process explained to staff as part of their initial induction when joining the Trust. Chief People Officer oversees this as part of Whistleblowing Policy and Procedure. Guardian is embedded into the organisation and works closely with Staff Networks within the organisation. Freedom to Speak Up guardian and service can be accessed anonymously via a web-form to protect identity of someone disclosing an incident or concern. • EPUT has five Staff Networks, each one with support from members of the Employee Experience Team as well as Sponsors from the Executive team who attends meetings and	2	Equality Advisor - Gary Brisco

	violence from any source	key events in their calendar. Networks discuss key issues and support staff members who attend or contact with enquiries or concerns (*with support from EPUT's Equality Advisor*). ○ LGBTQ+ ○ Gender Equality ○ Faith and Spirituality ○ Ethnic Minority and Race Equality ○ Disability and Mental Health (*Inc. Neurodiversity and Long Term Conditions*) • Equality Impact assessments are completed by staff as part of Equality and Inclusion Policy, encouraging staff to consider all marginalised communities under the Equality Act 2010. Included as part of a project, policy or procedure when submitted to Trust Board. • The Chief People Officer and Director for Employee Experience approve equality Impact Assessments as part of EPUT's Equality and Inclusion Committee. • Ongoing work taking place to develop and implement digital Equality Impact Assessment System within ICB. • All staff have access to People Asset Management (PAM), our Occupational Health provider. The service offers free and confidential support, guidance and counselling 24/7, with an option for referral to specialised support (debt, legal, bereavement, relationship support and trauma). • Reflective sessions held throughout the year to offer support during difficult events or issues that may affect staff members. Including allyship, reporting and challenging discrimination, reasonable adjustments, gender identity, sexuality, and incidents of discriminatory abuse and harassment, death and spiritual support. Guest speakers or volunteer staff members hold these sessions. • HSBC provide financial advice resources and "Always On" webinars, available to all staff, as well as 30-minute financial health checks. • Diaspora group alternatives offered for staff who wish to request additional support *(for example, the British Indian Nurses Association)* • EPUT Safeguarding Roadshow sessions held across the Trust for staff to access information and guidance for incidents of sexual misconduct, stalking and domestic abuse against patients or staff. • Racial Abuse Scrutiny Panel, including staff from EPUT, Essex Police and the Crown Prosecution Service, recently convened to understand how the police could better support EPUT colleagues when they report incidents of violence or discrimination. Colleagues from the Basildon Mental Health Unit met with Police Commander Regional Hate Crime Lead for the Crown Prosecution Service.		

		• EPUT's Director of Employee Experience and Employee Safety Programme Lead regularly meet with Essex Police leads to review how incidents of discriminatory behaviour on inpatient wards have been supported and to identify hot spots.		

	2D: Staff recommend the organisation as a place to work and receive treatment	• EPUT uses Staff Survey Data 2023 to gauge staff opinion on working conditions, morale and wellbeing.
		• *"I would recommend my organisation as a place to work. (Q25c) "*= 1.91% increase from previous year (62.53% to 64.44%). 1.15% below national average (65.59%).
		• *"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d)"* = 2.63% higher than the previous year (57.55% to 60.18%). 5% lower than national average (65.18%)
		• EPUT uses WRES and WDES Data to compare the experiences of marginalised staff groups to their non-marginalised counterparts,
		  ○ Whilst rates of BME and White staff reporting belief of career progression and promotion has increased (WRES Ind. 7), there is still a disparity in favour of White staff. EPUT works to mitigate this via our inclusion ambassador (*BME volunteers on senior interview panels to ensure inclusive recruitment*) and RISE (*career development created specifically for and by BME staff members*) programs, providing bespoke, and equitable support.
		  ○ On the WDES, this is near-equal (WDES Met. 5), and EPUT has provided bespoke Career lounges to support employees in career progression and development, as well as offering reasonable adjustments from interview to recruitment for all staff.
		• The Retention Team at EPUT has completed a comprehensive retention report for the previous financial year, analysing staff turnover across care groups at EPUT. This report provided valuable insights into the reasons behind staff departures. This data was used to implement exit interviews, leaver questionnaires, and new starter surveys to identify and address any issues that may arise during an employee's career journey within the Trust. These initiatives allow us to gather valuable data on why staff leave and why they stay, helping us understand the factors that affect retention.
		  ○ Current improvements include updates to the on-boarding process, refining the new starter lifecycle, expanding training opportunities, focusing on areas with higher turnover (such as AHPs), flexible working options, and linking this data to our NHS People Promise targets.
		• Retention data shows that staff highly recommend EPUT as both a place to work and a provider of treatment due to its strong commitment to professional development, a supportive
			1.14	Equality Advisor - Gary Brisco

		and inclusive work environment, and a focus on patient-centred care. The most common known leaving reasons captured for staff voluntarily leaving include *retirement (16%), work life balance (11%) and promotion (9%).* • A Retention Strategy is in development based on this reporting, detailing the Trust's approach to improving staff turnover and experience. This will be produced in Q4, and include activity resulting from the People Promise Exemplar Programme. • We as a Trust work alongside multiple ICB groups, implementing strategies to promote inclusion, wellbeing and retention of staff (Herts and West Essex, Mid and South Essex, Suffolk and North East Essex).		
Domain 2: Workforce health and well-being overall rating			5.84	

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Staff Networks have sponsors from the Executive Team, as well as additional support from members of the Employee Experience Team and Equality Advisor. • Senior Leaders regularly attend EPUT Staff Networks and events in Network Calendars, such as Black History Month, Pride Month and other cultural or spiritual events across the organisation. Chief People Officer and Director of Employee Experience have attended where available. Chief Executive Officer currently acting as sponsor for Ethnic Minority and Race Equality Network. • Board members including Chief Executive Officer work with communications team to regularly update staff on EDI events and initiatives throughout the year via Trust Today email and live video. • Staff Equality and Inclusion is discussed at EPUT Equality and Inclusion Committee, chaired by Chief People Officer as well as Director of Employee Experience. Network Chairs and key managers discuss EDI updates and initiative as well as review Equality Impact Assessments. Learning and actions feed into PECC. • People, Equality and Culture Committee (PECC) comprised of VSM Directors and Non-Executive Directors for assurance and review, yearly discussions of WRES, WDES, EDS, PCREF and PSED data.	2	Equality Advisor - Gary Brisco

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Equality, Diversity and Inclusion for staff and service users (as well as the measures above) discussed at each Trust Public Board and evidenced in all sets of minutes. Board members and Non-Executive directors are able to challenge and request additional data (for example, a deep-dive into career progression and development for BME staff in Q1 2024).
		• Equality and Inclusion part of People, Equality and Culture Committee standing agenda.
		• Equality Impact assessments are completed by staff as part of Equality, Inclusion and Human Rights Policy, encouraging staff to consider all marginalised communities under the Equality Act 2010. Included as part of a project, policy or procedure when submitted to Trust Board.
		• Equality Impact Assessments are approved by the Chief People Officer and Director for Employee Experience after submission and review by Equality and Inclusion Committee.
		  ○ Ongoing work taking place to develop and implement digital Equality Impact Assessment System within Mid and South Essex ICB. EPUT are currently reviewing the use of this in our services.
		• Risk assessments are available on request for staff who feel at-risk in the workplace due to COVID-19, disabilities or long-term conditions.
		• Board Assurance Framework (BAF) contains section on People and Culture, addressing EDI concerns (for example bullying highlighted on the WRES) and steps being taken to mitigate these as well as controls, measures and outcomes. Director of Employee Experience updates BAF on a regular basis.
		• WRES, WDES, EDS2022, PCREF, Pay Gap and PSED reporting are part of overarching People and Education strategy (2024-2028)
		  ○ WDES and WRES targets set, with the goal of improvement towards this each year.
		  ○ Yearly WDES and WRES progress (completed actions, improvements) are listed to board, and are used to develop approaches and priorities for the ongoing action plan.
		• Equality and Inclusion is also part of EPUT's wider Strategic Plan (2023-2028): *"At the core of our strategy is our ambition to ensure that staff not only have a great experience but feel happy and valued at work. We will also tackle equality, diversity, and inclusion issues within our Trust to collectively improve civility and respect and ensure that staff from underrepresented backgrounds have equal opportunities."*
			1.5	Equality Advisor - Gary Brisco

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Trust Board and BAF report the actions developed within the Trust and their efficacy in the WRES, PSED workforce report, WDES, Impact Assessments, EDS2022, Pay Gap reporting, retention reporting and PCREF.
		• WRES Data shows that at present we have a 9.2% difference between the overall percentages of BME staff (29.2%) and Board Membership (20%).
		• WDES Data shows we have a 2.4% difference between the percentage of staff with disabilities in the Trust (7.6%) and Board Membership (2.4%)
		• A breakdown of year on year progress for the WRES has shown year-on-year improvement in the following areas:
		  ○ Overall BME population in EPUT.
		  ○ BME staff likelihood accessing career progression and development opportunities (near-equal likelihood to white counterparts)
		  ○ BME staff believing that EPUT provides equal opportunities for career progression or promotion. (48.92% to 53.29%)
		• A breakdown of year on year progress for the WDES has shown year-on-year improvement in the following areas:
		  ○ Overall population in EPUT with disabilities (from 3.7% to 7.56%)
		  ○ Percentage of staff with disabilities experiencing harassment, bullying or abuse from patients/service users, their relatives or the public (37.85% to 28.76%)
		  ○ Staff with disabilities saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (56.51% to 62.35%).
		  ○ Percentage of staff with disabilities saying their employer has made reasonable adjustment(s) to enable them to carry out their work (78.76% to 81.29%)
		• Pay Gap Data:
		  ○ Differences in male and female wages at EPUT are at an average of 7.31%, meaning that men at EPUT are paid 7.31% more than females.
		  ○ EPUT's pay gap is better than the national average (14.3%) This is also a marked improvement compared with the previous year (13%).
		  ○ EPUT is performing well in comparison with neighbouring providers.
		• NHS EDI Improvement Plan High Impact Actions are aligned to the EPUT People and Education Strategy. A programme of delivery has been developed to ensure that activity is monitored and delivered on time.
		• Executive Director Sponsors have joined Staff Equality Networks, providing support to Network Chairs and acting as champion for the Network.
			1.5	Equality Advisor - Gary Brisco

		• Employee Experience Managers will be working closely with EPUT's Peer Support Group, staff members with lived experience of receiving treatment on a mental health unit who provide one-to-one and group support to patients at the Linden centre) to strengthen the relationship in our services between staff and patients, • EPUT's Director of Employee Experience and Employee Safety Programme Lead regularly meet with Essex Police leads to review how incidents of discriminatory behaviour on inpatient wards have been supported and to identify areas for improvement.		
Domain 3: Inclusive leadership overall rating			5	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): **Oladipo Ogdenbe** (Trade Union / Staffside Rep)	**Independent Evaluator(s)/Peer Reviewer(s):** **Paul Curry** (EDI Manager, Herts and West Essex)

EDS Organisation Rating (overall rating): 20.21 / 33 (Developing)

Organisation name(s): Essex Partnership University NHS Foundation Trust (EPUT)

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Gary Brisco – Equality Advisor	2019 - Present
EDS Sponsor	**Authorisation date**
Andrew McMenemy	December 19th 2024 TBC

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Use patient data to ensure that those from marginalised communities have equal access to services.	• Improve data quality and visibility so that evidence is made available which shows how services accommodate patients with higher risks due to a protected characteristic or at risk of health inequalities to have adequate access to the service.	**April 2025**
	1B: Individual patients (service users) health needs are met	Ensure patients are empowered to access VCSE organisations as part of their health and wellbeing.	• Document routine signposting to VSCE organisations and use of social prescribing. • Ensure details of how personalised care is embedded into the care for those with higher risks due to a protected characteristic is clearly evidenced. • Increase scope of working in partnership with community groups, and VCSE organisations to support service delivery for those with protected characteristics.	**February 2025**
	1C: When patients (service users) use the service, they are free from harm	Continue to develop the Patient Safety Partner (PSP) role in EPUT to ensure patients are free from harm.	• Actively include equality and health inequality themes in safety incidents and near misses. • Continue and increase scope of Patient Safety visits to include community services • Agree reporting method for Patient Safety Partner interviews; ensure actions, themes, and trends from patient interviews are captured and incorporated into learning from complaints and PALS with assigned accountability.	**April 2025**

	1D: Patients (service users) report positive experiences of the service	Improve on patient feedback scores and evidence use of iWGC results in future service developments.	• Improve protected characteristic listing with iWGC • Improve access to collate data from patients with protected characteristics about their experience of the service with iWGC • Continue campaign to ensure every service within EPUT is using iWGC as the contracted provider of PREMS • Patient Experience team to work with services to engage with patients specifically with protected characteristics and other groups at risk of health inequalities about their experience of the service. • Document existing and future work with the VCSE to ensure all patient voices are heard; from this create data driven/evidence-based action plans to monitor progress. Governance structure to follow PCREF; EoC and Quality committee	**April 2025**

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	**2A:** When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**NHS EDI Improvement Plan HIA4:** Develop and implement an improvement plan to address health inequalities within the workforce.	• Continue to monitor health, inclusion and wellbeing of staff via appraisal process. • Use sickness and absence data in the Trust to help guide wellbeing interventions, use this learning to reduce negative impacts in working environment. • Promote initiatives for work-life balance in the Trust, including access to VCSE organisations.	**October 2025**
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**NHS EDI Improvement Plan HIA6** Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	• Develop effective interventions against bullying, discrimination and harassment from service users against staff members, as well as improved support for those affected. • Collaboratively develop new guidance with Ethnic Minority and Race Equality Network for staff to promote EPUT's Anti-Racist and Zero-Tolerance approach to discrimination.	**September 2025**
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	**NHS EDI Improvement Plan HIA6** Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	• Promote and distribute Reasonable Adjustments / Health, and Wellbeing Toolkit across EPUT. • Continue to promote and raise awareness of Freedom to Speak up Guardians. • Improve access to workforce support resources for those unable to access them online.	**March 2025**
	2D: Staff recommend the organisation as a place to work and receive treatment	**NHS People Promise** "We are Recognised and Rewarded."	• PSED / General Workforce / Staff Survey data will be used gauge the experience of marginalised staff (BME, LGBTQ+) within EPUT, and develop interventions for retention. • Implement EPUT retention strategy, with actions to improve staff turnover and experience. • Creation of a Recruitment and Retention Task and Finish Group to continue development of retention actions within the Trust.	**August 2025**

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	**3A:** Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**High impact action 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	• Senior Leaders to continue to demonstrate a commitment to health inequalities, wellbeing and EDI by attendance of relevant events. • Ensure evidence for board members actively communicating messages for inclusion, wellbeing and health are collected throughout the year.	**October 2025**
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**High impact action 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	• Equality and Inclusion as well as Health Inequalities of Patients and Staff to be standing agenda items in all board and committee meetings, even those outside of People and Culture Directorate (such as Estates or Finance.) • Review Equality Impact Assessment process in EPUT to ensure this is a mandatory item in project development and approval / discussion takes place at a senior level. • Ensure equality and health inequalities are reflected in the organisational business plans to help shape work to address needs	**October 2025**
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**High impact action 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	• Review Trust staffing to ensure those at Band 7+ are reflective of the population served and Trust demographics to ensure representation. • Ensure Accessible Information Standard (AIS) is present in EPUT and part of the contracts and services provided by the Trust. • Board EDI objectives should be dictated by existing data from PSED, Staff Survey and WRES / WDES data, with interventions at a senior level to address negative trends or lack of progress.	**October 2025**

Appendix B – Grading Breakdown and Demographics of Stakeholders.

	Outcome	2022 EDS Grading	2023 EDS Grading	2024 EDS Grading
Domain 1	**1A:** Patients (service users) have required levels of access to the service.	Developing	Achieving	**Achieving (2.4)**
	1B: Individual patients (service users) health needs are met.	Achieving	Achieving	**Achieving (2.2)**
	1C: When patients (service users) use the service, they are free from harm.	Achieving	Achieving	**Achieving (2.4)**
	1D: Patients (service users) report positive experiences of the service.	Achieving	Achieving	**Achieving (2.4)**
Domain 2	**2A:** When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.	Achieving	Achieving	**Developing (1.42)**
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.	Achieving	Achieving	**Developing (1.28)**
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.	Achieving	Achieving	**Achieving (2)**
	2D: Staff recommend the organisation as a place to work and receive treatment.	Achieving	Achieving	**Developing (1.14)**
Domain 3	**3A:** Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	Developing	Achieving	**Achieving (2)**
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.	Underdeveloped	Achieving	**Developing (1.5)**
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.	Underdeveloped	Achieving	**Developing (1.5)**
	Overall Grade	Developing	Achieving	**Developing 20.21**

Each Domain:	**Overall**
Undeveloped (Score 0)	Score under 8: **Undeveloped**
Developing (Score 1)	Score between 8 and 21: **Developing**
Achieving (Score 2)	Score between 22 and 32, **Achieving**
Excelling (Score 3)	Score of 33: **Excelling**

Domain One: Commissioned or Provided Services.
Data collected via anonymous online survey, all grades collected and averaged by number of participants (five anonymous lived experience stakeholders).

	Average grade of Lived Experience Experts
1A	Achieving (2.4)
1B	Achieving (2.2)
1C	Achieving (2.4)
1D	Achieving (2.4)

- 100% of all participants identified as White English / British.
- Three expressed that they had a disability or long-term condition, with effects on Mental Health, Mobility, Learning and Behaviour declared by participants.
- 60% of participants were Male and 40% female, with all declaring that they are the same gender they were assigned at birth.
- 60% of stakeholders identified as heterosexual, with one choosing not to disclose this information.
- 80% of patient stakeholders identified as Christian, with 20% identifying as not having any religion or faith.

Following a review of this data with the Equality Advisor and as part of the collaborative discussion with Herts and West Essex ICB at a grading event on Wednesday 4th December 2024, it was agreed that the sample size (5 volunteers) and a lack of diversity in this cohort present an immediate action for improvement in 2025.

Domain One – EPUT Service User feedback:

- Patient feedback should be easy to give to the Trust at point of service and through a range of difference mechanisms (SMS message, WhatsApp, Online).
- Improve the ways we collect and record data on ethnicity, sexuality, gender identity and all protected characteristics (improvements to iWGC / PARIS.)
- Patients need better access to their care plans and support in understanding how this will be used in their care.

Domain Two: Workforce Health and Wellbeing
Data collected via anonymous online survey, all grades collected and averaged by number of participants (37 anonymous staff volunteer stakeholders)

	Average grade of EPUT Staff Stakeholders
2A	Developing (1.42)
2B	Developing (1.28)
2C	Achieving (2)
2D	Developing (1.14)

- 54% of participants identified as White British (with 11% identifying as other White ethnicities). 35% of participants identified as being from a Black, Asian or Minority Ethnicity (BME) group.
- 41% of participants identified as having a disability, neurodiversity or long-term condition.
- 57% of participants identified as female, with 30% identifying as male and 23% identifying as transgender, non-binary or “other”.
- 73% of participants identified as heterosexual with 27% identifying as either Lesbian, Gay, Bisexual, Pansexual or “Other”.

- Whilst there was a diverse group of participants with Sikh, Muslim, Buddhist and Humanist representation, the largest groups were 30% “No Religion” and 38% Christian.

Domain Two – EPUT Staff Stakeholder feedback:

- Improve resources for neurodiversity, providing guidance for managers to better support those with conditions such as Autism Spectrum Disorders, ADHD, Dyslexia or Dyspraxia.
- Provide better support for staff experiencing bullying, discrimination and harassment within the Trust from service users.
- Improve access to information and resources to frontline staff unable to access these on the intranet in their working day.

Domain Three: Inclusive Leadership

Data collected by liaison with Equality Advisor:

	Paul Curry EDI Lead for H&WE ICB	Oladipo Ogdenbe Staffside Chair / EPUT Unison Representative	Average Grade
3A	Achieving (2)	Achieving (2)	Achieving (2)
3B	Developing (1)	Achieving (2)	Developing (1.5)
3C	Developing (1)	Achieving (2)	Developing (1.5)

Domain Three – Independent Adjudicator / Trade Union Representative feedback

- EDI and health inequalities were hard to evidence in committees that did not focus on EDI or culture.
- Whilst the Executive Team engage with staff Networks and events, more evidence of wider Board involvement in this area would improve this domain. With consideration on equality impacts needing to be more evident in patient services.
- Equality Impact Assessments should be a mandatory requirement for Board approval, with process in place to show these are completed for all new projects, reviewed and approved at a senior level.
- Senior leaders should be active in supporting the implementation and monitoring of EDI reporting, with evidence that they are developing direct interventions where actions are unachieved or metrics do not show signs of improvement.

7.7 PUBLIC SECTOR EQUALITY DUTY (PSED

Decision Item AM 5

REFERENCES

Only PDFs are attached

PSED Report 05.02.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2024

Report Title:	**Public Sector Equality Duty (PSED) Report 2023 - 2024**					
Executive/ Non-Executive Lead / Committee Lead:	Andrew McMenemy – Chief People Officer					
Report Author(s):	Paul Taylor – Director of OD and Culture Lorraine Ganney – Employee Experience Manager					
Report discussed previously at:	PECC – December 2024					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
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*	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 Board of Directors with • Oversight of Trust performance relative to the workforce and the local demographics	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Points

Public Sector Equality Duty (PSED) is a legal requirement for all listed public authorities. PSED is a mandatory requirement in addressing disparities which affect people from different protected characteristics as defined under the Equality Act 2010.

This report demonstrates EPUT's continued compliance with the PSED to publish equality information annually. This report will:

- Provide equality data to aid development and implementation of the NHSE Equality, Diversity and Inclusion Improvement Plan and Forms part of the NHS People Promise.
- Provide key employment statistics for April 2023 to March 2024 regarding protected characteristic of employment data gathered from NHS electronic staff record (ESR), recruitment records and Employee Relations.
- Provide an important strategic focus for change and help to drive systematic and demonstrable improvements in equality, diversity and inclusion framed by the Equality Act 2010.
- Provide an overview of the organisation's most recent data which has been disaggregated by protected characteristics, as defined by the Equality Act 2010.

The report demonstrates how the Trust is meeting its Public Sector Equality Duty by gathering data required under the three areas of the legislation.

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	✓

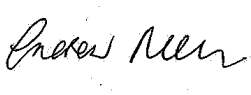
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
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			
WRES	Workforce Race Equality Standard	PSED	Public Sector Equality Duty
WDES	Workforce Disability Equality Standard	EDI	Equality Diversity and Inclusion
ESR	Electronic Staff Record	HR /ER	Human Resources / Employee Relations
BME	Black, Asian and Minority Ethnicity	NHSE	National Health Service England
EDS	Equality Delivery System	EPUT	Essex Partnership University Trust
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, plus	VSM	Very Senior Management
TRAC	Online Recruitment System	AFC	Agenda for Change

Supporting Reports and/or Appendices

Appendix 1 – Local Demographics – Census 2021
Appendix 2 - EPUT Workforce data March 2023-April 2024

Executive/ Non-Executive Lead / Committee Lead:



Andrew McMenemy
Chief People Officer

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT 2023-2024

PUBLIC SECTOR EQUALITY DUTY 2023/2024

1. INTRODUCTION

Implementation of the Public Sector Equality Duty (PSED) is a legal requirement for all listed public authorities. Organisations are required to follow the implementation of PSED in accordance with PSED guidance documents.

The report provides staff and leaders with tools to improve, review and develop their approach in identifying and addressing disparities which affect people from 9 protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage or civil partnership). The PSED has two parts – the General Duty and the Specific Duty:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act 2010.
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

The report presents data that represents EPUT's workforce, which has been collected from employee records, recruitment, and employee relations data.

Each year we are required to publish this information on our public website from data provided from 1 April 2023 to 31 March 2024.

2. EDI MONITORING

EDI Strategy

We are committed to challenging discrimination, both within our workforce and within the care we provide. We're proud of the diversity of our staff and want EPUT to be a great place to work and for all staff to feel they belong and are equally valued.

This Equality Diversity and Inclusion (EDI) Strategy is aligned with the Trust's strategic vision, values and objectives. It is about everyone actively reducing inequalities, respecting one another, and building an open and equitable culture within our organisation that celebrates diversity. This strategy will enable us to fulfil the Trust's purpose, "We care for people every day. What we do together, matters"

Staff Diversity Networks

The staff networks work with the Trust to improve staff experience and develop and deliver the Trust's priorities by creating an inclusive environment. The Networks provide a psychologically secure environment for staff to share lived experiences, feel empowered, be heard and drive change.
EPUT currently have the following diversity networks:

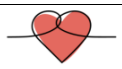
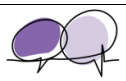
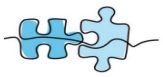
- Spiritual and Faith
- Disability and mental Health
- LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, +)
- Gender Equality
- EMREN (Ethnic Minority Race Equality)

To drive the agenda forward each network has appointed a chair and an executive sponsor and developed the terms of reference. The networks meet regularly, enabling them to grow, develop staff-related activities, explore opportunities for cross-network collaboration, and establish the priorities and objectives that support their members and colleagues within the Trust.

Staff Survey

In 2023, the Trust achieved a response rate of 44%, with 2,795 questionnaires returned; this was a 1.5% increase from 2022. Analysing our respondents, we have seen an increase in respondents across all minority groups, while this is a positive step, we need to continue to engage with staff to extend future participation and representation. Moreover, we have also seen an increase of respondents with a long-lasting health condition or disability.

The table below summaries our ranking of the People Promise scores for the Trust;

People Promise Year	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team
2022	7.49	6.22	6.90	6.23	5.74	6.77	7.09
2023	7.55	6.37	6.98	6.45	5.96	6.84	7.20

3. WORKFORCE DATA

The workforce data contained within this report has been obtained from various sources:

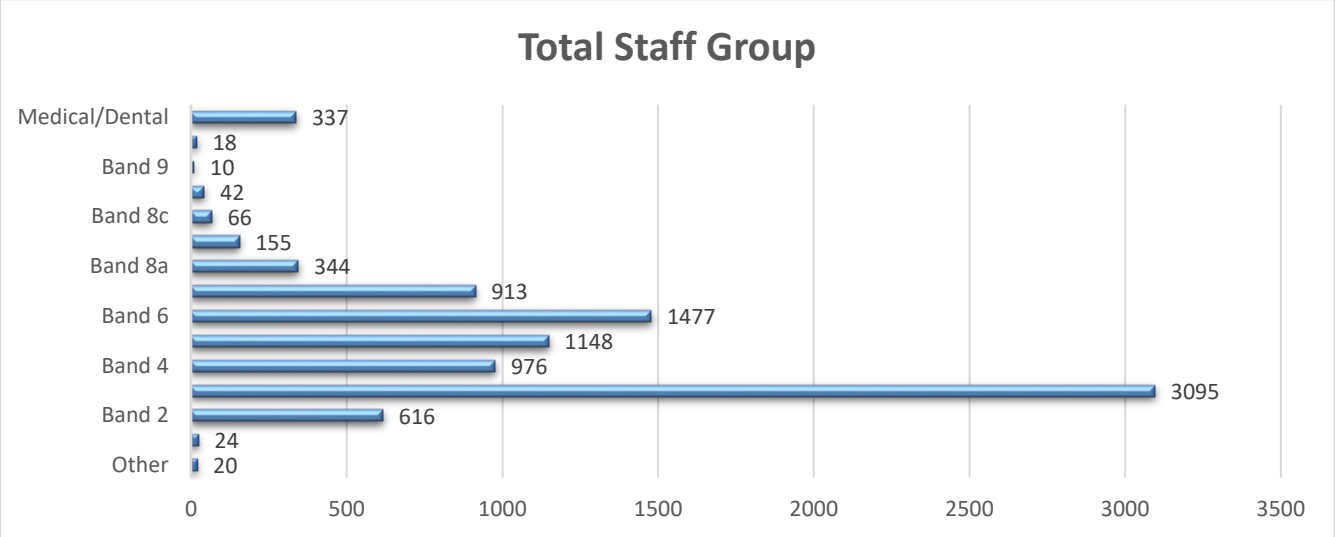
- Electronic Staff Record (ESR)
- TRAC (recruitment records)
- Employee Relations.
- NHS Staff Survey
- WRES (Workforce Race Equality Standard)
- WDES (Workforce Disability Equality Standard)

It is important to note that within ESR, there may be gaps in data relating to certain protected characteristics where colleagues have been given the option not to disclose information in relation to those protected characteristics. This is a common dynamic across most NHS organisations.

4. STAFF PROFILE IN POST

For the 2023/2024 reporting period, the total headcount for EPUT was 9241, which is an increase of 796 staff from the last reporting period. This figure includes all permanent, fixed-term, bank workers, and leavers during this period.

Table 1 – Total Staff Group



Staff Profile by Ethnicity

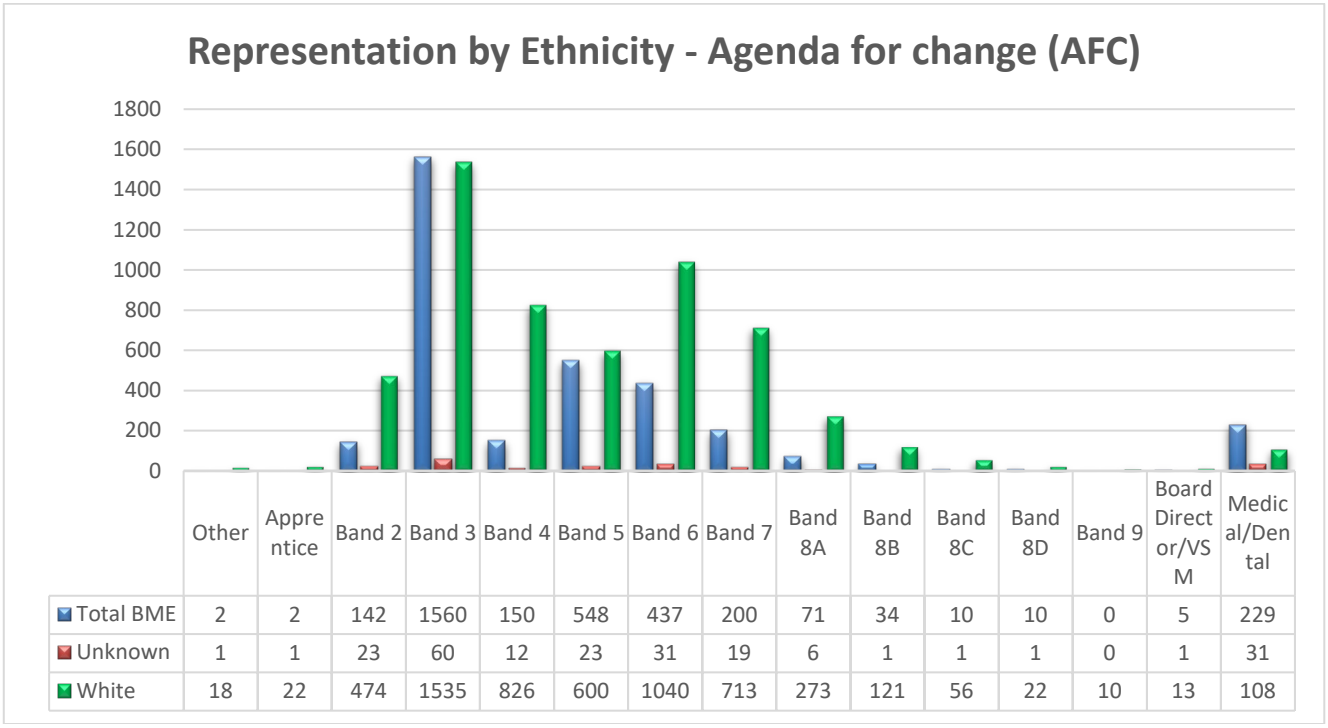
Our records show **37%** of our workforce is from a BME background, which is an increase of 5% compared to the previous year's PSED report. This indicates that our workforce demographic aligns to our local population, which has a BME representation of 5.72% (Census 2021). This is positive and shows that EPUT employs a diverse workforce for the community it serves. ,

The Trust composition of ethnicities are as follows:

Table 2 – Ethnicity Breakdown

Code	Ethnic Origin	EPUT Workforce - 2023	Code	Ethnic Origin	EPUT Workforce - 2023
A	White - British	5010	K	Asian or Asian British - Bangladeshi	76
B	White - Irish	84	L	Asian or Asian British – Any other Asian background	175
C	White-Any other White background	536	M	Black or Black British – Caribbean	98
D	Mixed – White & Black Caribbean	38	N	Black or Black British – African	1935
E	Mixed – White & Black African	55	P	Black or Black British – Any other Black background	352
F	Mixed – White & Asian	33	R	Chinese	17
G	Mixed – Any other mixed background	56	S	Any other ethnic group	129
H	Asian or Asian British-Indian	361	U	Unknown / Not Stated	98
J	Asian or Asian British - Pakistani	75	Z	Unknown / Not Stated	113

The table below is a breakdown of ethnicity by banding. :



	Other	Apprentice	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Board Director/VSM	Medical/Dental
Total BME	2	2	142	1560	150	548	437	200	71	34	10	10	0	5	229
Unknown	1	1	23	60	12	23	31	19	6	1	1	1	0	1	31
White	18	22	474	1535	826	600	1040	713	273	121	56	22	10	13	108

Slight changes were identified in comparison with the previous reporting period;

- Medical & Dental (68%), an increase of 4% from previous year reporting period.
- Band 3 (50%), an increase of 5% from previous reporting period.
- Band 5 (48%), an increase of 12% from the previous reporting period.

Whilst overall BME representation across the Trust is increasing, this is not proportional in all bandings, particularly in roles Band 6 and above which represents 8% of EPUT workforce.

Workforce Race Equality Standard (WRES) Metrics for 2023/2024

EPUT saw improvements in six out of the nine WRES indicators, a full breakdown and analysis of these are available in the WRES report.

Notable positives include:

- Trust's BME workforce increased by 2.9% from the previous year.
- The percentage of BME staff as part of the Executive Board increased by 8.9%.
- The percentage of BME staff believing EPUT offered equal continued professional development opportunities improved by 0.6%, this was 3.5% lower than the national average.
- Improvements in the likelihood of BME staff accessing non-mandatory training and career progression.
- BME staff experiencing discrimination by 0.1% which was lower than the national average and near-equal to the experiences of white counterparts.

Whilst we have worked hard to improve the experiences of BME staff, the WRES 2024 report highlights areas for development. We will continue to work in collaboration with our Ethnic Race Equality Network and Employee Experience Team in order to drive improvement in creating an inclusive and supportive environment for our BME staff.

Staff Profile by Disability of Staff in Post and Banding

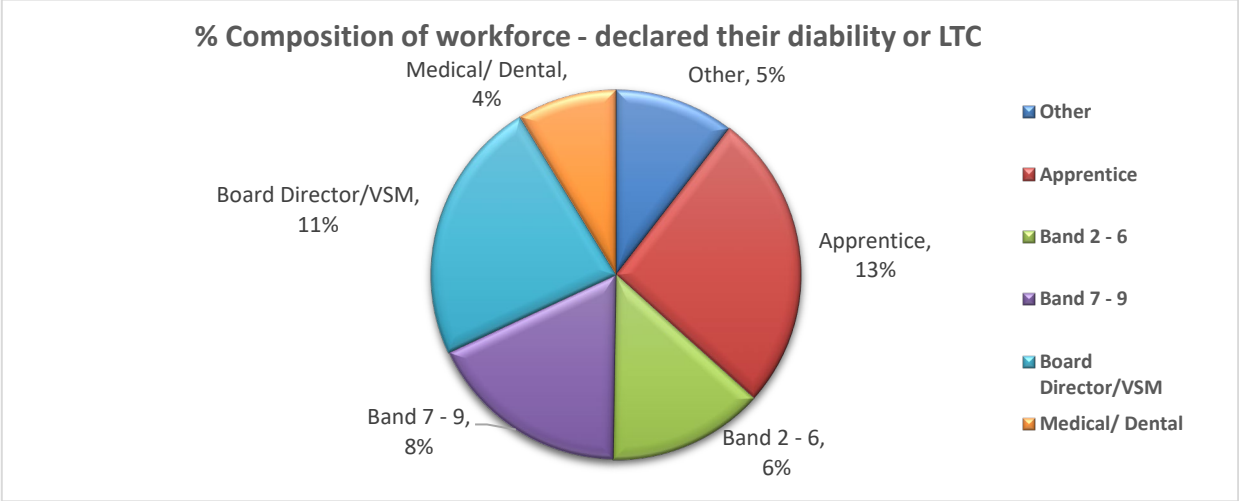
EPUT have **625 (7%)** staff who declared themselves as having a disability or long term health condition (LTC) during this reporting period. With a **3% increase** from the previous year' report, it is encouraging to see staff with a LTC or disability declaring a declaring their condition. This reflects that EPUT is a disability

confident leader and promotes an inclusive environment.

The Trust will continue to encourage all colleagues to declare their status and reassure colleagues the benefits of doing so. This will help the Trust in providing a psychologically safe environment for its staff, as well as, improving the quality of data for this protected group. To further support achieving this we are:

- Promoting communication and encouraging staff to share their personal experience relating to their disability/LTC;
- Encouraging wellbeing discussions and updates at appraisal and 1:1 support
- Promoting the use of the ESR self-service function in which staff have the opportunity to update information relating to their protected characteristics.
- Reviewing and updating the Trust's reasonable adjustment passport tool.

AFC Bands 2-6 have the highest number of staff who have disclosed a disability or LTC, however, the highest percentages of staff who declared a disability or LTC lie within the apprentice (13%) group. In addition, the percentages of colleagues sharing their disability is higher within senior roles, which is contrary to the pattern seen across the local system.



There are particularly low numbers of Medics who declared themselves as having a disability or LTC. This is not unsurprising as the majority of doctors rotate through different Trusts, meaning that demographic data needs to be re-shared each time they join a new organisation.

In addition, there were 2,197 new starters in EPUT during this reporting period, which was lower than the previous year (2,435). All new starters are given the opportunity to share their information relating to a disability, LTC and required workplace adjustments. For this period, 7% of new starters stated that they have a disability, an increase of 1% since the previous report. This demonstrates that the Trust is in alignment with the NHSE EDI Improvement plan and the WDES by continuing to improve the experiences of our workforce who have a disability or LTC. Further information about the Improvement Plan is detailed at the end of this report.

WDES – Workforce Disability Equality Standard

Notable positives were seen across the following indicators:

- An area of notable improvement is disabled representation on the board. In this metric, we are in the top 10% of mental health and community trusts nationally
- Indicator 1: year on year improvement (+ 1.21%) in the number of colleagues sharing their disability status;
- Indicator 2: 22% of disabled staff being appointed from shortlisting which is an improvement in the overall likelihood score.

- Indicator 4b: The percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers, colleagues and patients or members of public has decreased in all areas. With 7.9% of staff reporting that these incidents were reported when they occurred.
- Indicator 5 – 4.5% increase for disabled or LTC staff reporting that the Trust provided equal opportunities for career progression or promotion.
- Indicator 7 – 4.9% increase of disabled staff compared to non-disabled staff stating that they are satisfied with the extent to which their organisation values their work.
- Indicator 8- 2.5% increase of disabled staff stating that EPUT has made adequate adjustment(s) to enable them to carry out their work.

The full report can be accessed via WDES Report 2024 and Appendix A [intranet].pdf (eput.nhs.uk)

Health and wellbeing

A comprehensive occupational health service is available to staff, to support their wellbeing within their working environment. Services include:

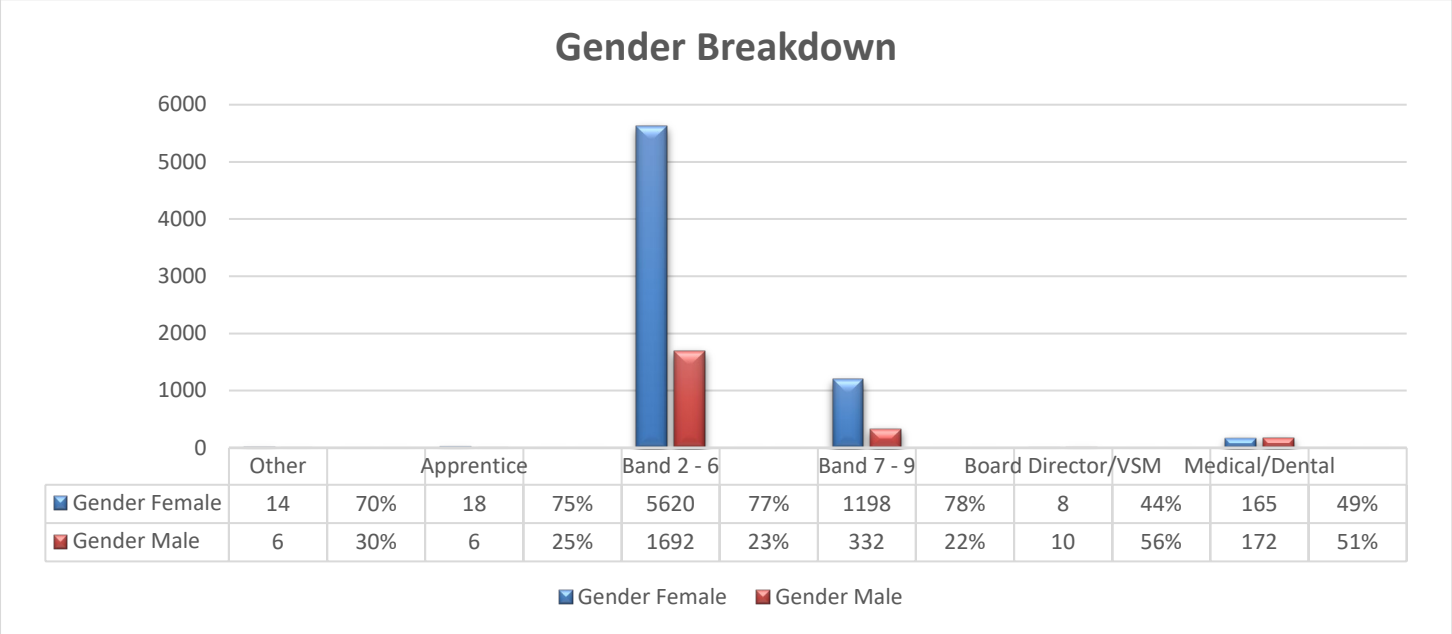
- Health assessments
- Fitness to work/practice
- Permanent/temporary injury applications
- Detailed recommendations for work related rehabilitation (for example, phased return to work, re-deployment, adjustments to duties/post)
- Ill health retirement, providing advice in line with national guidelines
- Immediate response and follow-up service for staff with sharps injuries
- Pre-employment health assessments (including for international recruitment)
- Fast track physiotherapy referral
- Workplace adjustments for neurodivergent colleagues

The wellbeing of our colleagues is our priority; there are several aspects in place to help, manage and support individuals, such as:

- Here for you - provides therapeutic support where difficulties are linked to the workplace. This could be stress, distress and/or trauma, which is impacting on a person's ability to be at work or carry out their duties. Continued support via the various EDI network meetings.
- Promoting wellbeing local and national wellbeing initiatives/programmes relating to mental and physical wellbeing.
- Utilising the Occupational Health service for advice/support on the health of staff in the workplace.
- Promoting the services of the Trust's EAP, which provides a range of counselling services, self-help programmes, as well as, a fast-track physiotherapy service.

Staff Profile by Gender

76% of the workforce are female, which is a decrease of **1%** in comparison to the previous year's report, The Trust saw an increase of **1%** in our male workforce from last year's report. These figures are similar to the wider NHS, which is predominantly female.



	Other		Apprentice		Band 2 - 6		Band 7 - 9		Board Director/VSM		Medical/Dental	
Gender Female	14	70%	18	75%	5620	77%	1198	78%	8	44%	165	49%
Gender Male	6	30%	6	25%	1692	23%	332	22%	10	56%	172	51%

The largest proportion of staff lie within AFC Bands 2-6, with a female workforce of **77%.** In comparison to last year, the percentage of female staff in senior management roles has remained the same at 44%.

A key part in enabling female colleagues to progress into senior roles is ensuring they are proportionally represented in talent management and leadership development programmes, as well as, identifying dedicated and bespoke development programmes.

Pay Gap

The Trust adheres to the Government Equalities Office's Gender Pay Gap (GPG) reporting requirements and has a GPG action plan, in which it sets out its remedial objectives to address any gender pay inequality.

The GPG is defined as the difference between the mean or median hourly rate of pay that male and female colleagues receive. The mean pay gap is the difference between average hourly earnings of men and women. This is commonly known as the average and is calculated when you add up the wages of all employees and divide the figure by the number of employees.

It is important to stress that the gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender.

We are committed to providing equal opportunities and equal treatment for all employees, regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy/ maternity, sexual orientation, gender reassignment or disability. We pay employees equally for the same or equivalent work, regardless of their sex or race (or any other characteristic set out above).

We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce:

- National NHS AFC Terms and Conditions of Service
- Medical and dental staff are employed on national Terms and Conditions of Service (TCS) and pay arrangements

The full report can be accessed via gender-pay-gap-report-2024-final.docx (live.com)

Flexible working

EPUT are aware from over the last 2 years the significance increase of flexible working requests, which appears to be a key priority for EPUT staff.

The implementation of the flexible working policy can often influence individuals in feeling supported and fulfilled in undertaking their role. Flexible working increases diversity and equality of opportunities for those with disabilities, caring responsibilities and provides further support during pregnancy or older colleagues who no longer wish to work full time.

Table of flexible working request:

Category	2022/2023	2023/2024
Flexible Working	**249**	**301**

Table flexible working requests age:

Age - Row Labels	Flexible Working
< 20	0
20's	42
30's	93
40's	65
50's	65
60's	33
> 70	3
TOTAL	**301**

The flexible working request for our female workforce is significantly higher (251) than for our male (50) workforce.

The Trust recognises more needs to be done to increase the equity of access and to demonstrate to line managers the extensive benefits in support flexible working requests, increasing productivity, retention and wellbeing. The Trust appointed the NHS People Promise Manager to develop strategies ensuring the benefits within these areas are developed and encourage.

Pregnancy & Maternity

The data for this section breaks down active assignments which shows breaks or changes in staff employment. The Trust workforce data shows 8444 members of staff are in active assignments, of these active assignment the data show us **135 (1%) of staff have taken maternity or adoption leave which is a slight decrease** from the previous year report. A further breakdown from the data reported within this period shows that the highest number of those who have taken maternity or adoption are paid AFC band 3.

Menopause

The majority of EPUT staff are likely to experience the menopause and therefore it is vital that we are providing a supportive working environment.

EPUT offer the following resources to support colleagues:

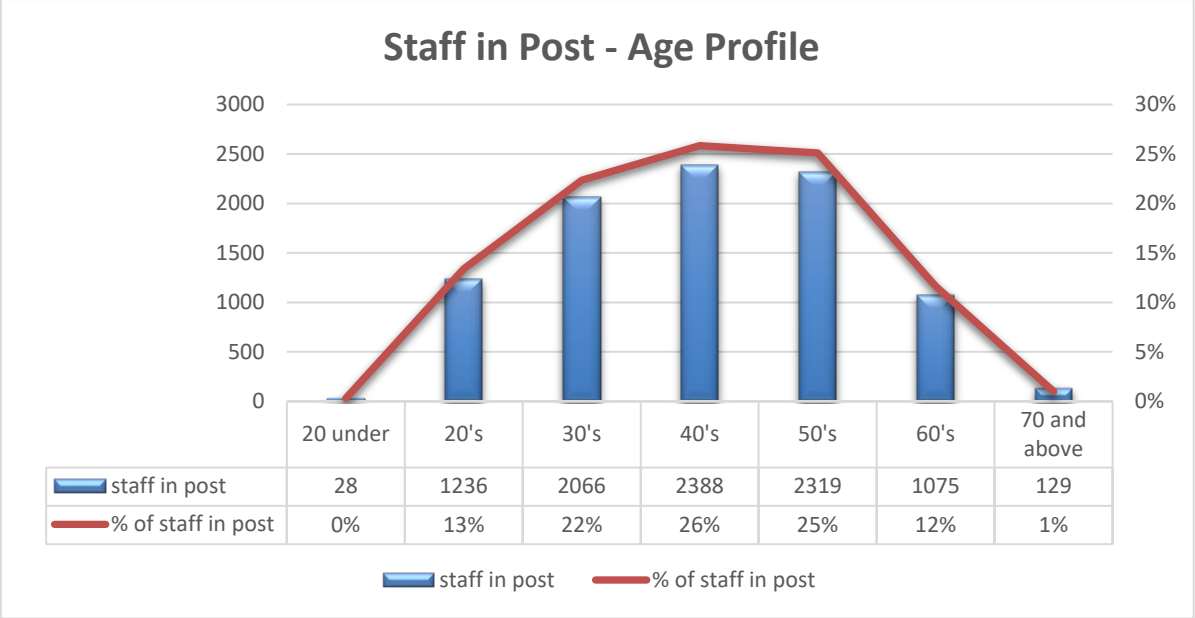
- The Menopause Café – provides support and hosts events for all colleagues in relation to the menopause.
- Wellbeing hub – accessed via EPUT intranet
- Menopause guidance and information on the staff internet website.
- Menopause advocates who provide awareness sessions for colleagues and managers.
- Employee experience managers who provide wellbeing support and guidance to staff

Managers also are able to record menopause related absence for their staff via the health roster system. This enables the Trust record reasons behind absence and gain a better understanding of the impact of the menopause on its staff and put in place appropriate support.

Age profiles

EPUT consider all ages when it comes to filling vacancy rates. We know that hiring across a broad age range contributes to diversity and inclusivity. There has been a slight decrease in staff whose ages are within their 20's, a slight increase by 1% for staff in their 40's, and a slight decrease by 1% for staff in their 50's. All other age groups have remained the same. In comparison, the age demographic within the Trust is slightly below to that of the local area in which there large population aged 50 and above.

Workforce breakdown by Age:



	20 under	20's	30's	40's	50's	60's	70 and above
staff in post	28	1236	2066	2388	2319	1075	129
% of staff in post	0%	13%	22%	26%	25%	12%	1%

As a large portion of staff are entering retirement age between the age group 60-70 (13%), there is a need to offer support and build sustainable career pathways to help attract and retain the younger workforce to ensure that our service users continue to receive high-quality care. The Trust is actively engaging with young people in local communities by:

- Hosting recruitment drives
- Working with local schools, colleges and universities, encouraging young adults to consider a career within the NHS.
- Promoting the benefits of the NHS apprenticeship schemes available at the Trust.

Flexible Retirement

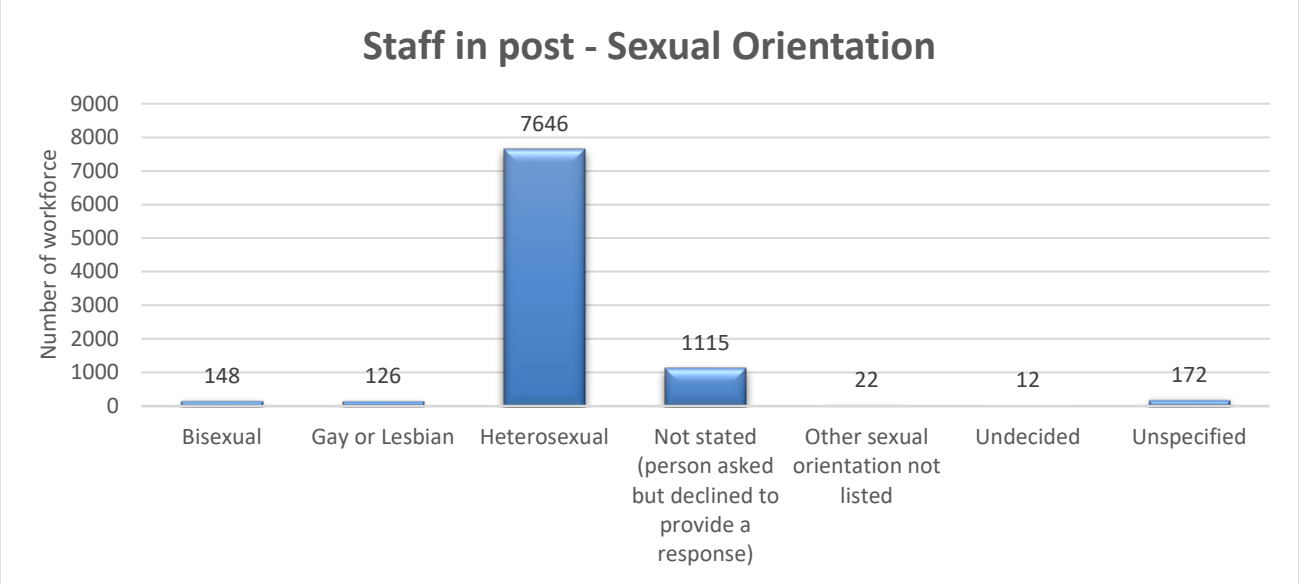
Within the reporting period EPUT saw 116 members of staff leave due to retirement. EPUT appreciates the benefits of retaining the knowledge, skills and experience of its older employees and, therefore, offers a range of flexible retirement options to support the health and wellbeing of staff. Options include:

- Step Down;
- Retire and Return;

- Partial Retirement;
- Early Retirement Reduced Buy Out.

Staff Profile Sexual Orientation

The majority of staff declared their sexual orientation as heterosexual (83%) which is a 2% increase from the previous year's report.3% of the workforce declared their sexual orientation as lesbian, gay, bisexual, transgender, queer/questioning and any other gender identified (LGBTQ+), which has remained the same from the previous year's report. There was a 10% reduction of staff choosing to not declare their sexual orientation.

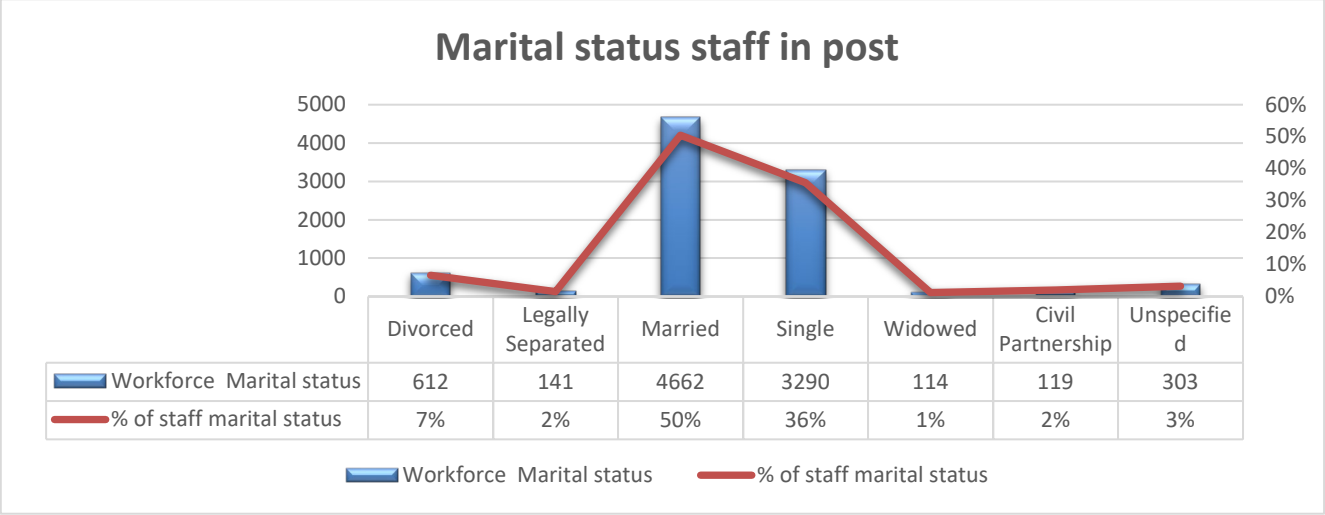


The Trust is conscious that the percentage of staff who shared their sexual orientation as LGBTQ+ is extremely low; this could be a result of anticipated discrimination, bullying and harassment, hate crimes and fear of being undermined.

EPUT updated the Equality, Inclusion and Human Rights policy and procedure with additional guidance for managers to support transgender staff members and patients, this was developed in collaboration with the LGBTQ+ Network in EPUT as well as contribution from the East of England Rainbow Network. EPUT recognises there is more that can be done to support its LGBTQ+ colleagues in terms of offering reassurance, physiological safe spaces, further LGBTQ+ training and resources. The Trust provides resources and guidance for colleagues on the EDI hub, embedded the LGBTQ+ diversity network and develop a Transgender guidelines.

Staff Profile Marriage & Civil Partnership

The marital status with the highest percentage reported was married, with single following closely after. Since our previous report, there has been an increase for those selecting unspecified by 4%; this could be due to the fact that staff no longer had the option to select 'unknown'. We have seen a slight decrease in the following statuses: married, single, divorced, legally separated, widowed, and civil partnership.



The Trust ensures all colleagues have equal opportunities and recognition, regardless of marital status, by keeping HR policies are current and up to date in line with employment law. The Trust also encourages colleagues to update their status on ESR.

Staff profile Religious Belief

When reviewing the religious beliefs declared by EPUT's workforce, we can see the most highly represented religious belief is **Christianity (51%**) and **Atheism (15%)**. **17%** of staff did not disclose their religious belief this year; this also reflects the current Census as more people across the UK selected the option, 'No Religion' as their belief.

Table below workforce breakdown religious Belief:

	Religious Belief										
AFC Band	**I do not wish to disclose my religion/belief**	**Atheism**	**Christianity**	**Buddhism**	**Hinduism**	**Islam**	**Jainism**	**Judaism**	**Other**	**Sikhism**	**Unspecified**
Other	3	5	10	0	0	0	0	1	1	0	0
Apprentice	3	12	9	0	0	0	0	0	0	0	0
Band 2	142	81	286	8	6	26	0	2	49	1	15
Band 3	405	326	1855	12	44	174	1	5	223	15	35
Band 4	191	188	442	2	9	26	0	2	83	0	33
Band 5	154	146	684	3	24	40	0	2	77	5	13
Band 6	245	257	708	9	33	38	0	6	143	5	33
Band 7	204	173	381	6	19	15	0	4	89	1	21
Band 8a	60	82	138	5	8	12	0	1	23	2	13
Band 8b	28	29	73	1	4	4	1	0	12	1	2
Band 8c	16	13	24	0	3	1	0	0	4	1	4
Band 8d	12	2	19	0	1	1	0	1	2	1	3
Band 9	2	2	6	0	0	0	0	0	0	0	0
Board Director/VSM	2	4	7	0	1	1	0	0	3	0	0
Medical/Dental	92	21	85	7	49	65	1	2	6	2	7
Total	**1559**	**1341**	**4727**	**53**	**201**	**403**	**3**	**26**	**715**	**34**	**179**
%	**17%**	**15%**	**51%**	**1%**	**2%**	**4%**	**0.03%**	**0.3%**	**8%**	**0.4%**	**2%**

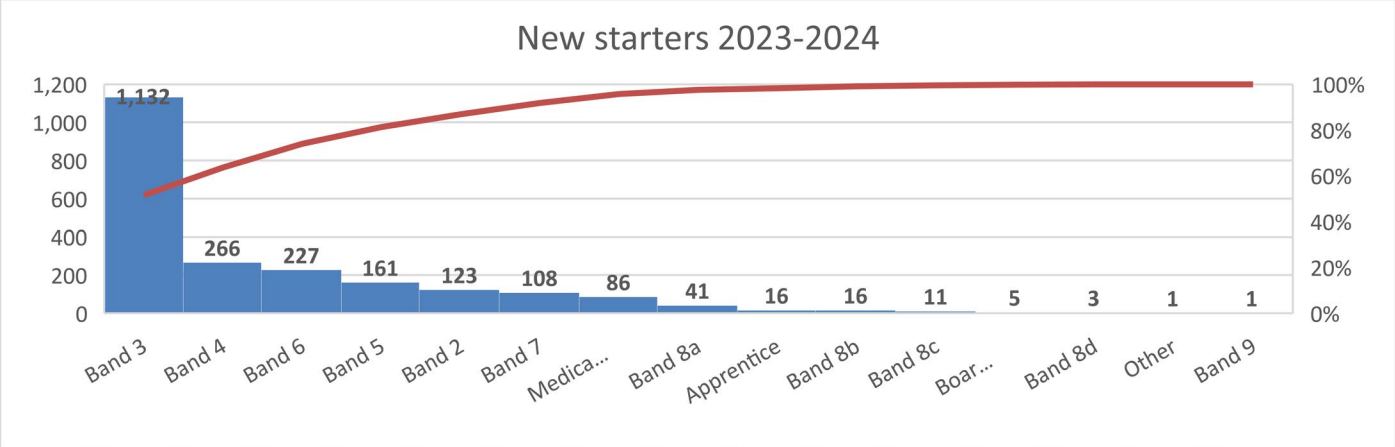
EPUT pays due regard to religious beliefs by promoting the Faith and Spirituality Diversity Network, and celebrating religious festivals and events. The Trust encourages staff to update their religious status on

ESR to support the Trust in providing equal opportunities for all faiths and non-faiths. The Interfaith and Spirituality Diversity Network works in collaboration with the Trust chaplaincy services, offering emotional, spiritual and religious guidance to all colleagues. Newly embedded prayer rooms have been provided, to enable staff to have space for prayer and reflection.

5. NEW STARTERS & LEAVER PROFILE

The Trust has taken action to promote a more diverse workforce by embedding a fairer recruitment process, facilitating a large recruitment drive and introducing the international recruitment programme.

There were **2197** new starters in EPUT during this reporting period, a reduction of 9% from the previous year **(2435)**. The majority of new starters were employed in Band 3 or Band 4 posts.



The demographic composition of new starters within the Trust:

Ethnicity: The total percentage of all new starters from ethnic minority backgrounds during this reporting period was 53%. This is an increase from the previous year's report by 47%.

Age: The highest percentage of new starters are those aged in their 20's (24%), 30's (24%) and 40's (26%)

Gender: The workforce is predominately female which reflects in the new starters data - 71% new starters were female and 29% were male. In comparison from last year's report, we saw a 4% decrease of female new starters, but saw an increase of 4% of male new starters

Disability: Overall **7%** of new starters stated that they have a disability, an increase of **1%** since the previous year report.

Sexual Orientation: The highest representation for sexual orientation was heterosexual (86%), followed by 10% of new starters declining to provide a response. 4% of our new starters were from an LGBTQ+ background, a 1% increase from the previous year. As a Trust we recognise that the current ESR data collected on a national level falls short on the recording of gender identity for our transgender and non-binary staff members.

Religious Belief: The highest representation of religious belief within new starters was Christianity (57%), followed by Atheism 16%, which reflects the figures of the local demographics. However, there were a large number of new starters who chose not to disclose this information (11%).

Marital Status: The highest declared marital status was married with 1004, which is a decrease of from the previous year. This was followed closely by Single 963, a decrease from the previous year.

These figures reflect the dedication and work in appointing and retaining a diverse workforce. To align with the NHS EDI High Impact Action Plan, as well as the WRES/WDES action plans, EPUT continues to strive:

- To improve the recruitment process by developing and embedding the De-Bias toolkit for hiring managers to ensure the process is fair for all.
- To promote and build awareness of the Disability Confident Scheme.
- To promote its status as a Disability Confident Leader on all job advertisements

Leavers

Turnover is calculated by dividing the number of employees who left by the average number of employees, then multiplying by 100. Our overall turnover rate was 10%, which remains the same as previous year's report. The highest proportion of leaver's falls within AFC bands 2-6.

Out of the 1,347 leavers, 45% of were planned (end of fixed term contracts, retirements and employee transfers) and 55%were unplanned exits (death in service, dismissal and voluntary resignation). 48% of unplanned leavers were recorded as 'other' or 'unknown'. ..

Planned/Unplanned Workforce Turnover:

Planned/Unplanned Turnover	Leaving Reason	TOTAL
Planned	End of Fixed Term Contract	13
	End of Fixed Term Contract - Completion of Training Scheme	15
	End of Fixed Term Contract - End of Work Requirement	14
	End of Fixed Term Contract - External Rotation	2
	End of Fixed Term Contract - Other	11
	Flexi Retirement	0
	Merged Organisation - Duplicate Record	1
	Mutually Agreed Resignation - Local Scheme with Repayment	0
	Retirement - Ill Health	10
	Retirement Age	116
	Redundancy - Compulsory	3
	Voluntary Early Retirement - no Actuarial Reduction	4
	Voluntary Early Retirement - with Actuarial Reduction	6
	Bank Staff not fulfilled minimum work requirement	415
	Planned Total	**610**

Planned/Unplanned Turnover	Leaving Reason	TOTAL
Unplanned	Dismissal - Capability	13
	Dismissal - Conduct	27
	Dismissal - Some Other Substantial Reason	6
	Dismissal - Statutory Reason	1
	Voluntary Resignation - Adult Dependants	4
	Voluntary Resignation - Better Reward Package	31
	Voluntary Resignation - Child Dependants	14
	Voluntary Resignation - Health	39
	Voluntary Resignation - Incompatible Working Relationships	10
	Voluntary Resignation - Lack of Opportunities	13
	Voluntary Resignation - Other/Not Known	354
	Voluntary Resignation - Promotion	60
	Voluntary Resignation - Relocation	56
	Voluntary Resignation - To undertake further education or training	30
	Voluntary Resignation - Work Life Balance	74
	Unplanned Total	**737**

The demographic composition of leavers for the Trust:

Ethnicity: 42% of leavers were from ethnic minority groups, which is an increase of 16% in comparison to the previous year's report.

Disability: 6% of all leavers identified themselves as having a disability, an increase of 5% in comparison to the previous year.

Gender; 74% of leavers were female and 26% were male, which is proportionate to the overall workforce. We can see a slight decrease in female leavers (2%) and an increase of male leavers (5%) from the previous reporting period.

Religion; The highest percentage of leavers declared themselves as Christian (54%), which is proportionate to the overall workforce.

Sexual Orientation: 5% of leavers were LGBTQ+, an increase of 2% compared to last year. This increase may be partially due to improvements in the quality of data as staff feel more confident in disclosing their sexuality on ESR.

Age: The average percentage of leavers remains equal across the 20-60 year age groups, however leavers which fall within the age group of 70 remains at 2% the same as the previous year's report.

It is encouraging to see there hasn't been an overall increase in leavers within the Trust. This is due to a combination of the Trust's initiatives to improve staff retention, improved access to career development opportunities, and fewer dismissals.

6. PROMOTIONS

There were **510** promotions during this reporting period, which is a 9% decrease from the previous year **(559)** and a 62% decrease from the 2021-2022 reporting period **(1,338)**., This could be as a result of no promotional vacancies or appropriate candidates for the role.
The demographic composition of staff who have been promoted within the Trust:

Ethnicity: 30% of staff who were promoted were from a BME background. This is a **23% increase** in comparison to last year's report.

Disability: 8% of the staff that were promoted declared that they had a disability, which is a **1%** decrease in comparison to last year's report.

Gender Breakdown: 78% of the promotions were female, while **22%** were male (an increase of **1%** in comparison to last year's data).

Religious Belief: The highest number of promotions came from those who declared themselves as Christian, which is representative of the underlying workforce.

Sexual Orientation: The highest proportion of staff who were promoted declared themselves as heterosexual (**87%**), which aligns to the overall workforce of the Trust. The percentage of LGBTQ+ staff who received a promotion remains unchanged at **4%** in comparison to last year.

Age: The data shows EPUT's staff promotions falls within the younger and older adults appearing more frequently within the workforce aged group 26 – 55.

Please note there is no marital status breakdown for promotions.

The Trust recognises the importance supporting staff throughout their career within EPUT and encourage career progression and development by providing the following initiatives:

- Management Development Programme
- Ward Manager Programme
- Leadership Development Programme
- RISE Programme
- Career Lounge for BME colleagues.

7. EMPLOYEE RELATIONS (ER)

Data in this category includes the following:

- The number of staff undergoing a disciplinary hearing
- The number of staff submitting formal grievances,

- The number of staff who have been the subject of investigation and capability procedures the number of allegations made in relation to bullying and harassment (Dignity at Work)
- The number of staff whose level of sickness absence prompted formal action as detailed in the Trust's Management of Sickness & Ill Health Procedure.

The data includes all staff (permanent and bank workers) across all pay bands.

Type / Category (reporting only)	Number of cases - 2022/23	Number of cases - 2023/24
Capability	22	22
Conduct	67	96
Temporary Worker Conduct	82	149
Flexible Working	249	301
Grievance	59	84
Temporary Worker Complaint	17	18
Sickness	14	10
TOTAL	**510**	**680**

The table above shows the majority of formal capability process has remained the same from the previous reporting period, with the exception of cases relating to sickness absence which has seen a slight decrease. We can see an increase across other areas particularly in cases relating to flexible working. The increase in cases relating to flexible working requests may be a result of the implementation of The Employment Relations (Flexible Working) Act 2023, which enables employees to submit two flexible working requests per year (rather than one), as well as, no longer requiring them to explain the effect of their requested change.

The demographic composition of staff who were involved in ER cases within the Trust:

Ethnic: In comparison to the previous year's report we have seen an increase in formal cases overall, including **an increase in cases involving our BME staff**. Most staff who are involved in ER cases are white British (55%), with just under half of cases (45%) being attributed to workers from a BME background which in comparison is high due to the 37% of EPUT workforce is BME. 79 flexible working applications were submitted from BME employees, with a further 221 from non-ethnic employees. **Of the 96 conduct cases 53 were from BME staff**;

Disability: 10% of ER cases involved staff who identified as having a disability or long term health condition, an increase of 3% since the previous reporting period. In comparison, 79% of cases involved staff who declared that they did not have a disability an increase of 2% from the previous year.

Gender: The gender breakdown of staff involved in ER cases is (102) for men and (143) for women. This figure is particularly high for male staff as nearly a quarter of the workforce are men.

Religious: Christianity (55%) is the highest declared religion followed by "I do not wish to disclose my religion or belief" (15%).

Sexual Orientation: 11% of staff who have been involved in ER cases have chosen not to disclose their sexual orientation, which is a decrease of 3% in comparison to the previous year. It should be noted the ER team have included reporting on 'other sexual orientation, not listed' and 0.1% of staff selected this option.

Age: The majority of staff who were involved in ER cases were aged group 30 – 50, this is aligned with the Trust's overall workforce as this is the largest age group within the Trust. The main areas for ER procedures falls within conduct, flexible working and grievance.

8. EQUALITY DELIVERY SYSTEM

The Equality Delivery System (EDS) designed by NHS England to support the NHS in making improvements on equality, diversity, wellbeing and inclusion for the benefit of patients and staff.

- Domain One: Commissioned or provided services led by the Patient Experience Team and graded by patient, carers and volunteers.
- Domain Two: Workforce Health and Wellbeing led by the Employee Experience Team and graded by staff volunteers.
- Domain Three: Inclusive Leadership led by the Employee Experience Team and graded by an independent evaluator, peer reviewer and trade union representatives

EPUT has seen an improvement in both Domain 1 and Domain 3 whilst Domain 2 remains consistent. It is encouraging to have improvements as it shows a positive perception of our services from both an internal perspective within our workforce and an external perspective from our patients and independent adjudicators. Under the EDS rating EPUT was rated as 'achieving'.

To achieve and monitor progress we will:

- Align action plans for each domain with the WDES, WRES, and EDI Improvement Plan
- Track and monitor actions via the EDI committee, Employee Experience Team and patient feedback.

9. CONCLUSION

Whilst we acknowledge the improvements in declarations rates for many protected characteristics within 2023/2024, the Trust are aware that extensive efforts are required to reach its objectives and to fully embed EDI across the organisation.

We are committed to challenging discrimination, both within our workforce and the care we provide. Our new People and Education Strategy and Trust Behavioural Framework is aligned with the Trust's values and objectives, on the basis that everyone takes an active role to reduce inequalities, respects one another and builds an open and equitable culture within our organisation. We believe that EDI is everyone's responsibility, not the function of a single team.

We are working to meet targets set by the NHSE EDI Improvement Plan. Launched on June 2023, the Plan outlines a strategic approach to enhance EDI within the NHS workforce. It aims to dismantle prejudice and discrimination through behaviour, policies, practices, and culture. Developed collaboratively with staff networks and leaders, the Plan emphasises intersectionality, recognising the complex identities of individuals.

Improvements will be made, through a number of approaches led by the Trust's Executive Board and The People and Culture and The People and Culture Team. Our approaches to improve EDI will be aligned with NHSE EDI Improvement Plan and will incorporate the WRES, WDES, staff survey in order to create a diverse and inclusive culture at work and ensure there is fair representation at all levels of the Trust.

Key focusses for 2024/2025 will be:

- EDI Networks - ensuring each Executive Sponsor is actively participating in their allocated EDI network.
- Recruitment - Improving proportional representation of ethnicity, gender, disability and sexual orientation in all band and roles by:
    - Implementing the De-bias Recruitment Toolkit

  - Encouraging the use of NHS values-based questions
  - Embedding Inclusion Ambassadors to drive actions to mitigate potential bias within recruitment
  - Delivering targeted workshops and career development lounges for minority staff, such as the Trust's leadership and management programs, as well as, the RISE program.

- Training - promoting the refreshed EDI training to EPUT staff, embedding this within the management development and leadership programmes, and b promoting inclusive behaviours and influencing cultural change within the organisation.
- Reasonable Adjustments - improving the working experience of staff with a disability or long term health condition by ensuring staff are provided with reasonable adjustments and promoting disability passport.
- ER Cases – Reducing the number of incidents of staff with a disability or long term health condition entering formal capability process in comparison to their non-disabled counterparts by changing the culture around how complaints and investigations are completed, ensuring decisions are informed and based on evidence, which will reduce the number of incidents specially relating to staff with disabilities or long term health conditions.
- Behavioural Framework - utilising the Framework to improve patient and employee experience in order to reassure patients and staff that the Trust takes a zero tolerance approach to violence and abuse.
- Continuous Improvement - To continuously learn, lead and improve policies and procedures in relation to EDI by listening and responding to feedback provided by our staff, service users, volunteers and networks.

Report prepared by:
Lorraine Ganney
Employee Experience Manager

Lorraine Di Rosa-Hammond
Director of Employee Experience

Paul Taylor
Director of OD and Culture

On Behalf of:
Andrew McMenemy
Chief People Office

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Information Item | PS | 5

REFERENCES

Only PDFs are attached

Board Assurance Framework Feb 2025 05.02.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 February 2024

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive					
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 – *mandatory section*		
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:	SR1 Safety	✓
	SR2 People (workforce)	✓
	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	✓
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 reduction in risk scores for:

- SR10 Workforce Sustainability
- SR11 Staff Retention

3 Note 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

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:

  SR1Safety has been superseded by SR13 as reframed to align with the Quality of Care Strategy.

  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 continues to be under review.

- Risks that have changed in risk score:

  SR10 - **Workforce Sustainability** – The risk score has been reviewed and demonstrates a reduction in score from 16 to the designated target of 12. The reduction is risk score is based on a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target). This is supported also by a reduction in Trust vacancy rate from 15% in August 2024 to 13.3% in December 2024 demonstrating the continued emphasis on recruitment initiatives. The number of staff in post has also increased from 6029.29 wte (April 2024) to 6220.16 wte (December 2024). This takes into consideration the planned recruitment to support Time to Care as well as initiatives to eradicate HCA vacancies. Therefore due to the positive trend the risk has been reviewed and the risk score reduced to 12.

  SR11 – Staff Retention - The risk score has been reviewed and demonstrates a reduction in score from 16 to the designated target of 12. The reduction in risk score is based on a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target). This has been supported by other initiatives within the People Promise Exemplar remit that was assigned to the Trust in 2024 for 12 months from NHS England. This has included funding to support a People Promise Manager with focus on new staff experience and enhancing flexible working opportunities to support better staff retention. Therefore the risk score has been reviewed and reduced to 12.

- Risks that have been formally de-escalated:

  CRR94 Engagement and Supportive Observation - Risk assessment has been reviewed and following the review of latest Tendable audit data and IA review (Recording and monitoring of therapeutic observations) it is assessed that the risk score be reduced to 10. And, consistently achieving training compliance of 97% for substantive staff and 84% for bank staff.

  CRR77 Medical Devices - Following a significant programme of work there is now a robust asset register for medical devices, a procured medical devices management contract and revised and implemented medical devices policies and SOPs. Reassessment of the risk is that the risk score is reduced to target of 8

CRR81 Ligature (Fixed) - This risk is associated with 'fixed' ligature and following review of data it is proposed that the risk has reached its target risk score. Awaiting confirmation through LRRG to enact de-escalated from the CRR. Note that a new risk associated with 'unsecured' ligatures is has been incorporated into CR11 as a priority area under reducing self-harm.

CRR93 Continuous Learning - Risk rating reviewed following discussion with Executive Nurse. Agreed risk rating target score has been achieved. Continuous learning mechanisms / structure within EPUT, developed through the Culture of Learning Programme is noted as controls with the new SR13 Quality Governance.

- 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

- Further to this through various meeting forums in the reporting period the following risks are being developed for inclusion on the CRR:

  a) Cash Balance
  b) EPR Benefits Realisation
  c) Time to Care Benefits Realisation

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

5 February 2025

Denver Greenhalgh,
Senior Director of Corporate Governance

EPUT

Risk Dashboard

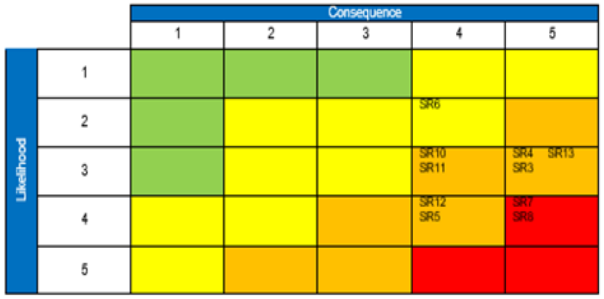
December 2024

EPUT

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	1	2	1-SR1

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



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

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

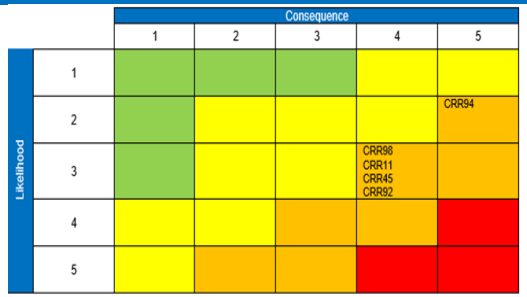
ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	4x2=8	15 8 8	Government led public inquiry in to Mental Health services in Essex	The internal governance is now well established and functioning as an oversight Committee, on behalf of the Board. 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 will necessitate additional capacity to be prioritised internally. We continue to hold open dialogue with the Inquiry team. As a consequence we are keeping the risk score under review).
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	We have been successful in securing an additional £0.5m from the National Energy Efficiency - Building Management Programme. Electronic Patient Record Full Business Case approved. We have signed the contract and finalising the governance and finance to manage the contract accordingly. A CRR entry is being developed to track the benefits realisation of the new EPR. Reviewing and developing the 2025/26 Capital requirements as part of budget setting 2025/26.
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. Deficit funding received (£11.1m), revised plan is breakeven. And, progressing with the Investigate & Intervention Programme activity. Enhanced controls have been established for the use of temporary staffing and recruitment into Corporate Services and administrative and clerical roles (unless exceptional cases where patient safety and business critical requirements outweigh).
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 new Operational Model for Inpatient Services has been agreed and the launch events commenced in October 2024, with the roadshows now having been completed. Now commencing implementation, including final recruitment to posts. Consultant with responsibility for flow and capacity has been appointed to commence Jan 2025. Following system MaDE events, themes and recommendations for application across the Trust and Essex wide system to support transfer of care of patients clinically ready for discharge presented to SET SIG. SET SIG to oversee progress against recommendations. Governance and oversight of system delays and escalations reviewed and strengthened with new arrangements commenced in January 2025
SR1	1	Safety	AS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	SR1 formally closed and replaced by SR13 Quality Governance.
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.	Estate Strategy approved by Board October 2024, and discussed at the November '24 Joint Council of Governors and Board meeting. Premises Assurance (PAM) data submitted Sept '24 and ERIC data to be published in December '24. A dedicated ERIC and PAM group has been established to undertake a benchmark review of the national data and develop and improvement plan. A 10-year capital plan for estates is being developed for submission in February '25.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	New cyber risk assessment criteria has been developed. The two reports (Pen test and cyber audit) have been received, action plan in draft. 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.
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 on plan for Phase 1. Timing for Phase 2 will be set on completion of Phase1. Criteria for prioritisation has been developed to support assessment of new and existing projects to ensure resource and capacity is aligned to the highest priority projects to support our strategic objectives and maintain safe and secure services.
SR10	ALL	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	16 16 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.	The People Promise Manager has developed a 1 year strategy. However, this will be developed further with potential for changes throughout the next 12 months. This is now embedded with clear actions and expected outcomes aligned to impact on staff retention rates. Consultation paper completed for workforce leadership team and approved by the Executive Team has been completed and implemented. This risk is associated with the recruitment of staff into posts at EPUT - data shows a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target); a reduction in Trust vacancy rate from 15% in August 2024 to 13.3% in December 2024 demonstrating the continued emphasis on recruitment initiatives; and the number of staff in post has increased from 6029.29 wte (April 2024) to 6220.16 wte (December 2024). This takes into consideration the planned recruitment to support Time to Care as well as initiatives to eradicate HCA vacancies. Due to the positive trend the risk has been reviewed and the risk score reduced to 12.
SR11	ALL	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	16 16 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.	The review of workforce KPIs has been completed and provided to the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs. Data shows a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target) - therefore the risk score has been reviewed and reduced to 12.
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 March 2025. Consultation paper completed for workforce leadership team and approved by the Executive Team has been completed and implemented. The review of workforce KPIs has been completed and provided to the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs.
SR13	1	Quality Governance	AS	Safety Effectiveness Experience Regulatory	5x3=15	15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	New risk superseding SR1 Safety and encompasses the three facets of quality governance and outcomes (Safety, Effectiveness and Experience).

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
4	0	0	1

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%	2	100%

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement & Supportive Observation	AS	Safety Regulatory	5x2=10	20 → 10 → 10	CQC found observation learning not embedded	Risk assessment has been reviewed and following the review of latest Tendable audit / IA review (Recording and monitoring of therapeutic observations) it is assessed that the risk score be reduced to 10. De-escalation of the risk from the CRR with ongoing review through the Reducing Restructive Practice Group and Nursing and Quality Risk Register. Will be removed from future reports to the Board. Safeward is part of our reducing restrictive practice priorities over the next 3 years. In year one we have rolled out across inpatient and specialist services and this was supported by two learning events that occurred in October 2024 and January 2025 and we are now working on the embedding and learning. Note amendment of timeline to reflect a six month monitoring period to provide assurance that Safe Ward Interventions have been embedded fully.
CRR98	Pharmacy Resource	FB	Safety	4x3=12	12 → 12 → 12	Continuous state of business continuity plan	Recruitment campaign will continue on an ongoing basis. 1Pharmacist and 1 Technician will join the Trust in January; 2 Technicians in February; and 3 Pharmacists offered and due to commence March / April. This will mean that the service is fully established for MH Pharmacy Service when all the individuals commence in post. BC plan reviewed 16 December 2024 with just one action remaining on the 'stop list'. Ward rounds have been reinstated (with the exception of MDT in West Essex Community Health Services). Next review February 2025.
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 TASI training 88% This supports a projected trajectory of 90% compliance by end of March 2025.
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 → 12 → 12	Staff Experience	Designing a OD and Engagement Strategy which will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evaluation and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)

Strategic Risk Register

December 2024

EPUT

SR1- Safety (At a Glance)

Risk Description: If EPUT does not invest in safety or effectively learn lessons from the past, then we may not meet our safety ambitions, resulting in a possibility of experiencing avoidable harm, loss of confidence and not meeting regulatory requirements.

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previous reported completed actions 2-6 have been removed from the reporting. **Note 2:** As reported to the Board in December 2024 - this risk will now be superseded by SR13 Quality Governance, with carry forward of the incomplete actions.

Executive Responsible Office: Interim Chief Nurse
Board Committee: BSOG and Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Patient Safety Incident Management Team	Team Established (note vacancies and some team members undertaking skills development).	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	PSIRF Yr1 early adopter review
EPUT Lessons Team	Team Established	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	
Learning Collaborative Partnership	Forum - live		
Quality and Safety Champions Network	Network - live		
Information sharing communication strategy (lessons learned)	Lessons identified Newsletter Induction Videos Mandatory Training (name)		
Capital Investment	Delivery of essential safety improvements		CQC CAMHS inspection report (safety improvements)
Patient Incident Response Plan	Incident Response Plan - live and being used	Refreshed Incident Response Plan (2023-25)- approved and published on the Website	Refreshed Incident Response Plan (2023-25)- approved by ICB
Culture of Learning Programme		SoC (Safety of Care)	
Patient Safety Dashboard	Safety Dashboard - live (Note: additional development see actions)		

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. The undertaking of thematic analysis of the key areas to inform Safety Improvement Plans is in progress. With a Safety Improvement Plan Oversight Group has bee established and reports monthly into safety of care committee. by the Executive Nurse to oversee their development and programmes of work. Reporting monthly into the Safety of Care Group.
7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	Extended Jan 25	NJ	Assurance	All actions are complete with the exception of completing the change control process for the reporting and oversight of Duty of Candour, which will be achieved in January 2025.

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*	**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 24/25.
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	

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	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. T
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 in readiness of March 2025. And a further 10 year capital plan for estates is now anticipated to be submitted February 2025.

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, 2, 3, 4, 4.1,4.3, 4.4, 4.5, 4.8 and 5 have been removed from the report. **Note:** New actions 9 and 10.
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 (TTC) and CD Flow	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 launch of the Demand and Capacity module is reliant on the completion of co-dependent works, with the required data ingestion being a prioritised project. These development works to on-board the necessary data for the module is on track. Minor delays as a result of establishing cyber assurance but not expected to impact the March timeline.
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 commenced in October 2024, with the roadshows now having been completed. Now commencing implementation, including final recruitment to posts.
9	Appointment of clinical lead for flow and capacity	Complete	AG	Control	Consultant has been appointed to commence Jan 2025.
10	Implementation of recommendations following long stay review and system made events across the trust and system.	Jun-25	SG	Control	Themes and recommendations for application across the Trust and Essex wide system to support transfer of care of patients clinically ready for discharge presented to SET SIG. SET SIG to oversee progress against recommendations. Governance and oversight of system delays and escalations reviewed and strengthened with new arrangements commenced in January 2025

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 L2 =8*	*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 mid February 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. As a consequence we are keeping the risk score under review).

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	None	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 Feb '25	GW/GB	Awaiting potential additional Rule 9 Request	No evidence schedule received from the Inquiry. A number of Rule 9 requests and a S21 have been received with dates for completion through to mid-Feb 2025. This has a significant impact on capacity and resources due to defined time to respond and the breadth of the request being over the 24-year period covered by the Inquiry. To mitigate, prioritising staff resources (including bank staff) from other departments to temporarily redeploy to support the Trust response.
7	Information system procured and in place (C3).	Extended Jan '25	GW/GB		Lampard inquiry have now made the decision to purchase the relativity system but will not fund licences for other core participants. Meetings scheduled to start internal implementation and training.
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	Awaiting decision on whether Assessment criteria will be expanded by the Inquiry. Awaiting response to concerns raised over personal identifiable information.	Rule 9 (1) original deadline of 28.05.24 met and two extensions provided by the Inquiry to allow for assessment information to be extracted also met (11.06.24 and 11.07.24). Finalise the data set for Rule 9 (1). Further Rule 9 requests to allocated to Executive Directors. Work underway overseen by project leads. Note: There is a current impact on capacity of the Inquiry Team and wider teams within the Trust. Where required reasonable extensions have been requested - the Trust is awaiting response from the Inquiry.

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	*C4 x L3 =12*	*C4 x L3= 12*	**Note 1:** Previous reported completed actions 1 - 6 have been removed from the report**.** **Note 2:** New actions 7,8 and 9. **Note 3**: Awaiting final report for IA Cyber Security

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	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) 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 BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP development plans in progress – due date Dec 23	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DPST BDO audit completed, recommendations accepted and in plan

	Actions (to modify risks)	By When	By Who	Gap	Update
7	**New Action** : Implementation of revised cyber security stratification approach taking into account national NHS cyber risk profile.	Mar-25	AW	Control	New cyber risk assessment criteria has been developed, additional measures will be implemented to inform the cyber assurance report to Finance and Performance Committee. Approval for implementation of the new framework will be presented to the Information Governance steering sub-committee on the 10 Feb '25.
8	**New Action** : Assessment and development of action plan of the outcomes of the November 24 cyber penetration test and cyber security internal audit	Feb-25	AW	Control	The two reports (Pen test and cyber audit) have been received, further dialogue with the auditors is ongoing to define some of the recommendations, action plan in draft.

Actions (to modify risks)		By When	By Who	Gap	Update
9	**New Action** : 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.

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

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	£0.5m from the National Energy Efficiency - Building Management Programme.
3	Track key strategic investments i.e. EPR to be monitored for impact on Capital Programme	Mar '25	JD	Control	Electronic Patient Record Full Business Case approved. We have signed the contract and finalising the governance and finance to manage the contract accordingly.
4	**New Action**: Capital Plan for financial year 2025/26	Apr '25	JD	Control	Reviewing and developing the 2025/26 Capital requirements as part of budget setting 2025/26.

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.

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).
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		

Actions (to modify risks)		By When	By Who	Gap	Update
2	Deliver Financial Efficiency Target	Mar '25	TS	Control	£28.6m (5.2%) by 31 March 2025 - schemes identified but with high risk of full delivery. YTD delivery £16.2 million. Reviewing over delivery of efficiency targets in Care Units / Directorates to offset the off plan position.
6	Deliver Financial plan for 24/25	Mar '25	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Deficit funding received (£11.1m), revised plan is breakeven. YTD deficit is £7.7m
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. Discussions commencing with Litmus, re: potential further external support.

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	Contract dispute under escalation. New value being instructed with IFRS16 expertise.
10	Investigate & Intervention Programme Activity: VAT advice relating to a single contract (details provided to PwC)	Mar '25	TS	Control	Progressing. PwC have reviewed contract and will be producing advice note.
11	Investigate & Intervention Programme Activity: Property Top-Up Insurance (details provided to PwC).	Mar '25	DG	Control	Action subject to Estates Specialist being identified to be 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. To be reviewed in March 2025.
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. To be reviewed in March 2025.

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 10 regarding IT capacity prioritisation.

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 assesment (Standards Met)
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		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 (inl. 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	Mar '25	AW	Control	Digital target on plan for Phase 1. Timing for Phase 2 will be set on completion of Phase1.
10	Prioritisation of capacity allignment to the UEPR programme whilst protecting the delivery of the trusts wider strategic objectives.	Mar-25	AW/RP	Control	Criteria for prioritisation has been developed to support assessment of new and existing projects to ensure resource and capacity is aligned to the highest priority projects to support our strategic objectives and maintain safe and secure services.

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:** This risk is associated with the recruitment of staff into posts at EPUT - data shows a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target); a reduction in Trust vacancy rate from 15% in August 2024 to 13.3% in December 2024 demonstrating the continued emphasis on recruitment initiatives; and the number of staff in post has increased from 6029.29 wte (April 2024) to 6220.16 wte (December 2024). This takes into consideration the planned recruitment to support Time to Care as well as initiatives to eradicate HCA vacancies. Due to the positive trend the risk has been reviewed and the risk score reduced to 12. **Note 2**: The extension of action 4 to April 2025. **Note 3**: In recognition of the financial impact of use of temporary staffing, a risk is being established for the oversight of rostering and use of temporary staffing, with associated controls and will be included within the next reporting cycle.

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	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 April 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 March 2025.
2	To develop a supporting Staff retention strategy alongside relevant internal and external stakeholders.	Complete	Director of OD & Culture	Road Map	The People Promise Manager has developed a 1 year strategy. However, this will be developed further with potential for changes throughout the next 12 months. This is now embedded with clear actions and expected outcomes aligned to impact on staff retention rates.
3	To review the leadership and wider workforce structure with clear objectives that align to supporting the staff retention strategy.	Complete	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team has been completed and implemented.

4	To establish training for the workforce modelling team and associated stakeholders in finance and care unit management teams.	Extended April 2025	Associate Director of People - Operational HR	Control	This will be sourced following the implementation of the new team. The new leadership team have commenced considering the objectives and structure of the wider People & Culture teams going forward to meet expectations. Therefore consultation is expected to be commenced in January 2025, with new draft structure developed with clear identification of workforce modelling skill requirement.
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.	Mar '25 (Implementation from Apr '25)	Associate Director of People - Operational HR	Control	These will be developed alongside the introduction of the new team. The new Associate Director has been appointed with plans in place to create a defined workforce modelling team for the Trust.

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:** Data shows a consistent reduction in turnover from 11% in 2023 to 9% (3% under the designated target) - therefore the risk score has been reviewed and reduced to 12. **Note 2**: Note the extension of action 1 to April 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 April 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.
2	To develop a supporting Staff retention strategy alongside relevant internal and external stakeholders	Complete	Director of OD & Culture	Control	The newly appointed People Promise Manager has developed a 1 year strategy. However, this will be developed further with potential for changes throughout the next 12 months. The new People Promise Manager has been working with colleagues in the region and nationally to enhance the strategy and operational actions to support staff retention. This will be reviewed by PECC and also by the NHS England team associated to People Promise.
3	To review the leadership and wider workforce structure with clear objectives that align to supporting the staff retention strategy.	Complete	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team (being implemented). Since November the new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority.
4	To implement the investment of People Promise exemplar status with new People Promise Manager.	Complete	Director of OD & Culture	Assurance	People Promise exemplar status has been implemented and completed.

5	To review workforce core and extended key performance indicators with emphasis on turnover related analysis	Complete	Associate Director of People – Resourcing	Assurance	The review of workforce KPIs has been completed and provided to the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs.

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:** Note the extension of action 1 to April 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)
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 April 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 March 2025.
2	To review the leadership and wider workforce structure with clear objectives that align to supporting the staff retention strategy.	Completed	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team has been completed and implemented.
3	To review workforce core and extended key performance indicators with emphasis on staff experience and OD interventions	Completed	Director of OD & Culture	Assurance	The review of workforce KPIs has been completed and provided to the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs.
4	To undertake a gap analysis of OD skills to determine what is required to be effective	Jan '25	Director of OD & Culture	Control	To be undertaken prior to finalising the revised OD team in conjunction with wider workforce team changes. The new objectives have been published for the Director of OD & Culture in order that this can inform the review of the service and advise the nature of the new structure, skills required and the consultation process.
5	To source partnership arrangements with effective and established OD practitioners alongside an effective development plan that supports OD skills at the Trust	Jan-25	Director of OD & Culture	Assurance	To be undertaken prior to finalising the revised OD team in conjunction with wider workforce team changes. The new Director of OD & Culture has developed partnership arrangements with system partners and regional partners on OD best practice.

6	To review workforce core and extended key performance indicators with emphasis on turnover related analysis	Complete	Associate Director of People – Resourcing	Assurance	The review of workforce KPIs has been completed and provided to the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs.

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:** New risk superseding SR1 Safety and encompasses the three facets of quality governance and outcomes (Safety, Effectiveness and Experience)
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Nurse Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1**	**Level 2**	**Level 3**
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		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Develop and implement Quality Dashboard	April '25	RT / AW	Control	In development
2	Raise the visibility of senior quality leaders within the Trust (through Back to Practice Visits) and embed.	May '25	AS	Assurance	Back practice visits have commenced and will be monitored for effectiveness over the next three months.

Actions (to modify risks)		By When	By Who	Gap	Update
3	Refresh awareness of raising patient safety incidents and reporting.	July '25	MA	Control	Datix systems amendments been made and now working up programme of engagement.
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	eSOP SOPHIA system planned to go live in February '25 with all current documents.
5	Deliver Safety Improvement Plans and embedding the learning.	Jun '25	NA	Control	SIP plans in progress.
6	Review the Quality forums from Care Unit to Board and reporting.	Sept '25	AS/DG	Control	Not started
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Jul '25	RP	Assurance	Not started
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 December 2024

EPUT

CRR94 - Observation and Engagement

Risk Description: If EPUT does not manage supportive observation and engagement then patients may not receive the prescribed levels resulting in undermining our Safety First Safety Always Strategy.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L2 = 10*	*C5 x L2= 10*	**Note 1**: Previous reported completed actions 1-12 have been removed from the report. **Note 2:** Risk assessment has been reviewed and following the review of latest Tendable audit / IA review (Recording and monitoring of therapeutic observations) it is assessed that the risk score be reduced to 10. De-escalation of the risk from the CRR with ongoing review through the Reducing Restructive Practice Group and Nursing and Quality Risk Register. Will be removed from future reports to the Board.

Executive Responsible Office: Executive Nurse Director Lead: Director of Nursing and IPC Leads: Deputy Directors of Quality & Safety (Inpatients and Specialist Services) 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		IA Recording and Monitoring of Therapeutic Observation (Reasonable Assurance Opinion received 2024)
Weekly Ward Huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks		
Electronic observations recording tool	e-observations in wards (with exception of 7 wards)		IA Recording and Monitoring of Therapeutic Observation (Reasonable Assurance Opinion received 2024)
Tendable Audits (quality control)	Audit results reviewed at weekly huddles		
Observation and Engagement e-learning and training videos			
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		
Deep dive into unexpected deaths in inpatient services or within 3 months of inpatient admission between 2000 - 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise and assurance report to ET Apr '23	
Ward Improvements	Planning supported by patients Grab Therapy Resources available		

Actions (to modify risks)		By When	By Who	Gap	Update
13	Monitor Safe Wards Interventions	July '25	LJ	Assurance	Safeward is part of our reducing restrictive practice priorities over the next 3 years. In year one we have rolled out across inpatient and specialist services and this was supported by two learning events that occurred in October 2024 and January 2025 and we are now working on the embedding and learning. Note amendment of timeline to reflect a six month monitoring period to provide assurance that Safe Ward Interventions have been embedded fully.

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

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*	**Note:** Previously reported completed actions 1- 4 have been removed from the report.
C4 x L5= 20	*C4 x L3 = 12*	*C4 x L2 = 8*	

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 March '25	PT	Control	Bank staff training 88% This supports a projected trajectory of 90% compliance by end of March 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:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report. **Note: Current risk is under review and reassessment**

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	Designing a OD and Engagement Strategy which will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evaluation and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)
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. The Leadership Behaviour Toolkit continues to be socialised and will be further strengthened through the OD and Engagement Strategy. With a plan to include a targeted approach for leaders and a timeline with monthly activity to engage all staff around behaviours including discrimination, code of conduct, policies, and behaviours in meetings.

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	1Pharmacist and 1 Technician will join the Trust in January; 2 Technicians in February; and 3 Pharmacists offered and due to commence March / April. This will mean that the service is fully established for MH Pharmacy Service when all the individuals commence in post. BC plan reviewed 16 December 2024 with just one action remaining on the 'stop list'. Ward rounds have been reinstated (with the exception of MDT in West Essex Community Health Services). Next review February 2025.

Risk Movement and Milestones

Strategic Risk Movement – two year period (Nov 22 – Dec 24)

Risk ID	Initial Score	Nov 22	Dec 22	Jan 23	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
SR1	20	20	20	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	**15**
SR4	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**
SR5	20	15	15	15	15	15	15	15	15	15	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**
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	**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	**20**
SR8	15	15	15	15	15	15	15	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**
SR10	16																								New	16	**12**
SR11	16																								New	16	**12**
SR12	16																								New	16	**16**
SR13																										New	**15**

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two year period (Nov 22– Dec 24)

Risk ID	Initial Score	Nov 22	Dec 22	Jan 23	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
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	**12**
CRR45	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	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	16	16	16	8	**D**
CRR81	12	16	16	16	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	**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	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	20	20	20	10	**D**
CRR98	20			New	20	20	20	20	20	20	20	20	20	20	20	20	20	12	12	12	12	12	12	12	12	12	12	**12**

8.2 END OF LIFE ANNUAL REPORT

Decision Item | AS | 5

REFERENCES

Only PDFs are attached

End of Life Annual Report 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2025

Report Title:	**End of Life Annual Report**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Tracy Reed, Clinical Lead End of Life Care					
Report discussed previously at:	End of Life Sub-Committee, Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	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.	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 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.	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Points
Details of the End of Life Care provided by Essex Partnership NHS Foundation Trust (EPUT) in line with the EPUT Framework and national documents related to End of Life Care. In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission (CQC). The services continue to strive to maintain and support 'outstanding' care to all those recognised as end of life irrespective of which service within EPUT they are receiving their care. The new review process of all deaths by a Medical Examiner's Office supports the Coroner's services and the process of releasing a Death Certificate. It means that all care leading up to death is reviewed by a Medical Examiner who then supports discussions with the loved ones and the process of the production of the Death Certificate. People are no longer required to be seen twenty-eight days prior to death by a doctor. During 2023 into 2024, we have continued to see service adaptions to ensure the best outcomes for people at end of life irrespective of diagnosis, the service delivering care or care setting. The Community Health services have continued to see an increase in the number of people dying at home as more people are presenting later within services following on from the Covid-19 Pandemic.

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			
CHS	Community Health Services	CQC	Care Quality Commission
Datix	Electronic risk management incident reporting system	DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
EoLC	End of Life Care	EPaCCs	Electronic Palliative Care Co-ordination system
ESNEFT	East Suffolk and North Essex NHS Foundation Trust	GP	General Practitioner

GSF	Gold Standards Framework	HPAL	Digital electronic platform for palliative care information
ICB	Integrated Care Board	ICS	Integrated Care System
LPA	Lasting Power of Attorney for health and welfare	MDT	Multi-disciplinary Team
MEO	Medical Examiner's Office	NACEL	National Audit of Care at End of Life
NHSI	NHS Improvement National collaborative	NICE	National Institute for Health and Care Excellence
PEACE	Proactive Enhanced Advance Care Plan	PCN	Primary Care Network
PPC	Preferred Priorities for Care	PPD	Preferred Place of Death
STaRS	Specialist Treatment and Recovery Service	TEP	Treatment Escalation Plan
VOED	Verification of expected death		

Supporting Reports and/or Appendices

End of Life Annual Report
End of Life Framework

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan
Executive Nurse

Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

END OF LIFE ANNUAL REPORT 2023-24

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

END OF LIFE ANNUAL REPORT

Oct 2023 – Oct 2024

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

Dr Fiona McDowall
Old Age Psychiatrist

Prepared: November 2024

CONTENTS

Table of Contents

INTRODUCTION

There were 581,363 deaths registered in England and Wales in 2023, this was an increase of 0.07% from the previous year. With Dementia and Alzheimer's disease continuing to be the top leading cause of death these were registered as 66,876 of deaths (11.6% of all deaths).

High quality end of life care is an indicator of how we care for sick and vulnerable people across health and social care services. End of life care seeks to enhance quality of life in the face of death by addressing physical, psychological, social and spiritual needs of patients with life limiting diseases and their families. Good end of life care encompasses recognising the dying phase, high quality coordinated care, carer support and advice. It must be delivered in a personalised, dignified and respectful manner to the person and their families.

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

The new review process of all deaths by a medical examiner's office supports the coroner's services and the process of releasing a death certificate. It means that all care leading up to death is reviewed by a medical examiner who then supports discussions with the loved ones and the process of the production of the death certificate. People are no longer required to be seen twenty-eight days prior to death by a doctor.

There are a number of national documents which support recommendations for high quality end of life care. These include the Ambitions for Palliative and End of Life Care (2021-2026), NICE guidance for end of life care (2019) that built on the Strategy for End of Life Care (2008). They identify six ambitions and the actions required to achieve each one.

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

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

This report provides a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life. In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission (CQC). The services continue to strive to maintain and support 'outstanding' care to all

those recognised as end of life irrespective of which service within EPUT they are receiving their care.

During 2023 into 2024 we have continued to see service adaptions to ensure the best outcomes for people at end of life irrespective of diagnosis, the service delivering care or care setting. The community health services have continued to see an increase in the number of people dying at home as more people are presenting later within services following on from the Covid 19 pandemic.

END OF LIFE SUBCOMMITTEE

The End of Life Subcommittee continues to report into the Quality Committee with Leadership overview from the Director of nursing, and Chief Nursing and AHP information officer. For the Quality Governance structure end of life sits with the Experience of care and has recruited two lived experience ambassadors. The subcommittee meets monthly with representation from:

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

The subcommittee is responsible for overseeing and monitoring the implementation of the End of Life Care Framework and work plan by making

recommendations to the Trust in relation to the planning and provision of end of life and last days of life care. End of life care is a standing agenda item at locality Quality group meetings and the Clinical Governance and Quality sub-committee to ensure updates and lesson's learned are shared at a local level across the organisation. These are also shared and reviewed with the Learning from Death oversight group.

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

CLINICAL LEAD FOR END OF LIFE CARE AND SPECIALTY DOCTOR

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

COMPETENCIES

The clinical lead has developed a competency framework for end of life care to support the enhancement of knowledge, development of skills and promotion of positive attitudes and behaviors in care delivery. The objective of the framework is to ensure staff develop professionally through reflection, supervision, informal and formal training. The aim is to ensure staff confidently provide the highest quality of care by early identification and response to patients who are recognised as end of life in all settings. The past year has seen the use of digital training and blended approaches to supporting learning and competency training. Adapting a blended approach to the need of teams as caseload capacity issues within the teams has reduced the number of staff who can attend face to face training. Bespoke training to support new staff and new teams has been created to ensure staff are confident in end of life care delivery. Staff also have the opportunities to attend external training to support their roles as identified during their supervision and appraisals.

POLICIES AND PROCEDURAL GUIDELINES

All procedural guidance and policies are due for review during 2025. There is support to develop standard operating procedures for staff to have easier access to guidance.

Procedural Guideline for the care of the Deceased Patient

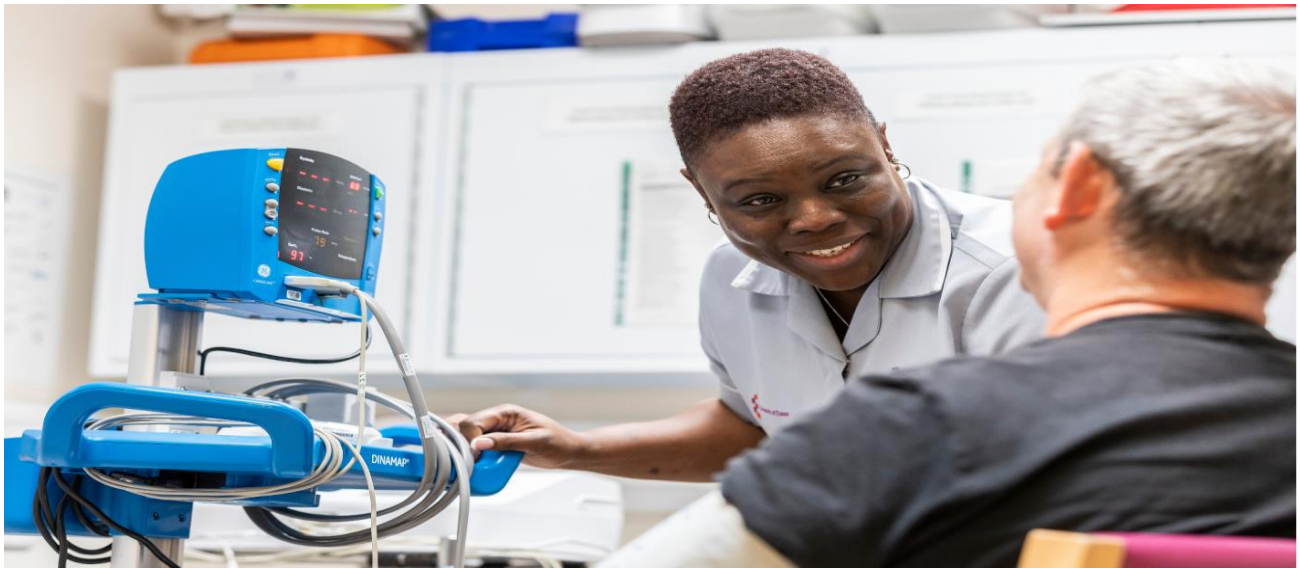
The guideline was revised in 2022 and due for update in 2025, it sets the standard for sensitive and compassionate communication with family members/significant others. Providing guidance on cultural and spiritual elements of care throughout end of life services. Sensitive care and support after death can be one of the most difficult and challenging aspects for clinical staff but, equally, the most rewarding. The aim of the guideline is to ensure that there is timely confirmation and notification of death by medical staff and that there is correct preparation of the deceased person's body for viewing by family members / significant others and dignified removal to the appropriate mortuary.

Advance Decisions and Advance Statements

The guideline was introduced to provide clarity to staff in relation to the process for advance decision making and advance statements and choice for adults within the care of EPUT. It supports safeguarding, mental capacity issues and person centred choices though the provision of guidance on the process and legislative requirements. This guideline updated in 2022 is due for update in 2025 includes updates related to changes in national guidance with the introduction of The Universal Principles of Advance Care Planning 2022.

Verification of Expected Death (VOED)

The existing guideline is under review to support the changes to the Medical Examiners process and the



governance process to support are in place. The training and competency for staff has already been updated to support the changes that were introduced in September 2024. It is accompanied by a competency framework and a register of competent staff is maintained within each locality and service.

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

This was developed to support areas without 24 hour domiciliary services and rural localities. The operational guidance provides the legal and management information to support patients/carers/relatives to administer subcutaneous medication in the community in a timely way to manage symptoms. The guideline is robust in ensuring safe and effective practice and provides clear information and practical steps to ensure robust risk assessment whilst ensuring a person centred approach to patients, carers, relatives who wish to take on this element of care. This is currently being updated in line with local integrated care boards - ICB guidance. A new care plan and information to the end of life template has been added to support audit across all systems.

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

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

The standard operating procedure, training programme and competency framework has been developed in partnership with hospices across Essex and the clinical lead for end of life care supports all elements of education, training and the competency framework. This has resulted in us now having forty-eight senior clinical staff who have successfully completed their competencies and supporting this element of care across our community services in West and South East Essex.

At the last deteriorating patient meeting it was discussed that at the next update in 2025 DNACPR should become a stand-alone guidance.

End of Life Care Guidelines

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

It sets out the guidance from recognition of death through to last days of life. Within dementia and Learning disability services this was adapted into a poster as a visual aid to support process and ensure staff were familiar with guidance. These are due to be updated in 2025.

Operational Guideline for Deactivation of Implantable Cardioverter Defibrillators

The need for development of this document as an independent

guideline was the increase during the Covid 19 pandemic and with the increase of patients being treated with an implantable cardioverter defibrillator device.

In 2021 education and training were developed with the heart failure teams to support best practice and guidance for deactivation of this element of a pacemaker when someone is recognised as end of life and unable to return to hospital to have the procedure for deactivation carried out. This training is ongoing within community teams. The increase in deaths at home has seen this element of care is used more frequently. Training has also included system partners in the ICB to ensure best practice across services. It has supported advance care planning information for patients at insertion of a pacemaker to support discussion and understanding.

END OF LIFE CARE CHAMPIONS

End of Life Care Champions have been identified in all areas across the Trust to share learning and continuously develop the approaches to care at end of life. The aim of the champion is to share best practice and ensure, staff, patients and their loved ones have a positive experience of end of life, delivered to the very highest standard. There are currently sixty champions across the Trust. Forums are held four times a year where reflective learning and shared practice are encouraged. The forums provides the opportunity to update champions on the latest national and local guidance and for them to share experiences within their clinical settings. Champions have the opportunity to complete end of life care training to support this role. The forums have guest speakers and those areas relevant to the whole trust are recorded and available to all staff on the end of life care intranet page for wider sharing.

The Clinical Lead for End of Life Care supports this role within the teams and works with each individual to support partnership working with their local specialist palliative care teams ensuring that, irrespective of a patient's environment they receive fair access to palliative and end of life care services, this is irrespective of the clinical setting. The clinical lead for end of life care is also supporting the role of the practice development team to support this role and enhance patient experiences within our mental health settings in terms of physical care in last days of life. It is hoped this will support future practice.

END OF LIFE CARE FRAMEWORK

The Trust End of Life Care Framework sets out clear guidance in accordance with the ambitions for palliative and end of life care (2021-2026) and the National End of Life Care Strategy (2008). These, together with NICE guidelines are the quality standards to support end of life care practices. The Framework was reviewed in accordance with the guidance issued in 2021 and the Trust End of Life Care Framework second edition 2022 includes the new guidance.

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

1. Each person is seen as an individual	
Key Achievements	The systems capturing incidents, compliments and complaints have continued to be strengthened during 2024. The clinical lead is copied into any Datix or complaints in any EPUT's service related to end of life care or expected deaths so these can support lessons learned. There have been five complaints this year that have been resolved and shared for learning. The focus on quality improvement and wider organisational lessons learned have seen a wider sharing of learning and outcomes across all teams and the wider integrated care systems – (ICS). The use of Datix to record compliments to the teams has enhanced sharing of compliments that are sent to individual teams by a variety of other sources enabling a collation of evaluation of care. The IWANTGREATCARE has been revised and the survey is now being used within our inpatient, nursing homes and specialist services. Feedback is given directly to the teams. The Electronic Palliative Care coordination systems have seen growth within both areas and the shared data to coordinate patients recognised as end of life has proved invaluable in increasing the numbers of people dying in their preferred place of death. The data indicates we are achieving between 82-95% monthly. The national average is 70%. The palliative systems have been showcased within the East of England and as part of end of life best practice and we are supporting other ICB areas with system partners to support their implementation plans. The formation of review of expected deaths via a medical examiner's office – (MEO) across all our localities means a doctor from the MEO office speaks to relatives prior to issuing a death certificate. This

	gives bereaved families the opportunity to share concerns and systems to learn together from bereaved experiences. We sent out an evaluation questionnaire to system partners this year and received some positive feedback although the response rates were low. The responses were extremely positive to support system working and integration to support end of life care and peoples choices, with some high praise for our teams evident.
Areas to be progressed	Continue to strengthen processes to gain feedback within all EPUT services. Ensure IWANTGREATCARE continue to be utilise widely for end of life care elements. Work with system partners to share locality learning and integration of services as a collaborative approach and continue to seek system partner's feedback. Integrating services as part of coproduction and seamless care. Work with local MEO's to support best practice for death certification and bereavement support, including any concerns or issues raised Escalate to lessons learned with EPUT inclusive of our system partners for quality improvement as services progress. Ensure that all praise and compliments is cascaded to teams involved as these are very positive support to staff morale.

2. Each person gets fair access to care	
Key Achievements	The Clinical lead and Specialty Doctor for end of life care continue to have strong links with partner organisations. The growth of integrated collaboration of services within Integrated Care Systems (ICS) have seen joint working continuing to develop services and provide fair access for all. These include local acute services, hospices and voluntary services in all locations across EPUT. The collaboration has seen joined up policy and procedural guidance which EPUT have supported. This has also seen redesign of some ICS services with system partners introducing elements of EPUT approaches as best practice. The development and roll out of guidance for STaRS teams to support integration of services and understanding of end of life care in North and West Essex has seen care delivery with positive outcomes for care. The integration of services within the localities and partnership working has resulted in some very positive outcomes for patient care. This approach has been developed and quality of care improvements as best practice. It supports voluntary sector organisations, health and social care to integrate wrapping around patient need to enhance end of life care experiences. The dashboard, capturing quality and performance indicators measured against national data it has seen further developments and growth especially in recognition of dementia and frailty through the FReDA template. Receiving recognition both Nationally and through the East of England, the templates developed to support the processes won an HSJ award in November 2023.

	The development of shared care records which includes an Electronic Palliative Care Co-ordination (EPaCCs) System has seen a growth in integrated approaches and sharing of patient choice. EPUT are leading across the ICS systems and used as best practice examples.
Areas to be progressed	The implementation of guidance for end of life within the STARS service in North and West Essex which is working well needs to be developed within Mid and South East Essex with system partners. To continue to support future growth of shared care records supporting EPaCCs and recognition of death across EPUT and the wider systems within local communities. To stop duplication and people having to retell their story to all those involved in care delivery.

3. Maximising comfort and wellbeing	
Key Achievements	The development of an updated formulary and Medicine Management Guidance in partnership and approved across the HWE and MSE ICS in 2024 to support common symptoms at end of life. This includes knowledge of community pharmacists whom stock the end of life care medications out of hours. The development of HPAL – a digital electronic platform for palliative care information for all patients and clinical staff to support information about treatment and services in MSE. The do not attempt cardiopulmonary resuscitation – DNACPR competency training for senior clinical staff. The clinical lead continues to support this training for senior clinical staff. Since 2022 we have a total of 50 senior clinician's with competencies who are able to support this element of care. Resulting in partnership training and timely conversations to support best practice. To provide training and sharing of all end of life learning opportunities across all areas in EPUT to maximise care for those recognised as end of life care. The use of digital training and collaborative learning across ICS.
Areas to be progressed	Continue to cascade end of life care competencies to all grades of staff in community services to ensure maximum skills. Ensuring staff have skills to support clinical practice within the community. Work with practice development team to upskill them to enhance training support within mental health services with physical health and end of life care. Continue working in partnership with external stakeholders as part of co-production. This includes access to external training and development shared with all staff across EPUT.

4. Care is co-ordinated	
Key Achievements	The Clinical Lead and Specialty Doctor for end of life care continue to have strong links with systems partners and attend the ICS meetings both locally and within the East of England. This has seen a rise in identification of end of life care across systems. The dashboard recognises diagnosis for referrals and there has been a significant rise

	in referrals especially within frailty and dementia from primary care. Monthly multi-disciplinary meetings with primary, secondary care and hospices is now well established in all areas. To ensure an integrated approach and co-ordination of care. These include an integrated approach from any team or organization relevant to specific patient's needs. (Specialist teams in EPUT, mental health, paramedics, GP, social care and voluntary services). Guidance has been developed to support people with multiple organ failure and long term conditions who are on the caseload of the STaRS Team in North and West Essex. This is to support early recognition of end of life care needs and coordinate personalization to supporting their choice and needs. The EPACCs continues to grow with caseloads increasing there is more recognition of frailty and dementia prognosis for end of life which is now higher than cancer and other long term conditions. These support allowing sharing of patient choice wider across the ICS footprints and ensuring services are personalized wrapped around the person.
Areas to be progressed	To continue with enhanced partnership working across systems to create best approaches, co-production and ensuring advance care planning, individualised care plans and shared data happen with a timely robust approach.
5. All staff prepared to care	
Key Achievements	End of Life Care Champions are supporting staff at a local level. There are currently sixty champions across services to support best practices and provide updates on end of life care. The ICS's are supporting training needs across localities. The Clinical lead is supporting sharing training and development of standard approaches to delivery of training and care. EPUT continue to have in-house training and support to teams. A quarterly training report shows training delivered by clinical lead with the number of staff and service that have attended. Bespoke training for teams related to patient care is also delivered to support staff understanding and care delivery.
Areas to be progressed	Continue to support the roll out of end of life care competencies for all grades of staff. Continue to expand the number of End of Life Care Champions across all areas of the organization. Ensure champions are engaging in updates and scope the areas they are working in line with support for the new physical health practitioners. Continue to partnership work to support accessibility of end of life care training as an integrated approach to include specialist services delivered by the hospices.

6. Each community is prepared to help	
Key Achievements	Community staff are involved in supporting work within the Primary Care Networks – PCN to ensure local communities are supported and seamless care and approaches to care are supported. They are involved in working with all elements of the community including care homes and other settings. There is ongoing work with EPUT learning disability services to support equitable care for all. This has included using national care planning approaches, Victoria and Stuart with early recognition of end of life. The Oliver McGowan mandatory training also supports best practice. The Trust participates in Dying Matters events on an annual basis. In 2023 this was undertaken via social media and virtually. The second Death Café was held in EPUT with the Chaplaincy and Psychological services providing staff time to share their own experiences. It was attended by over sixty members of staff some sharing their experiences both personally and professionally, prompting positive discussions. The Clinical Lead and Specialty Doctor for end of life are active members of all the ICS alliances across Essex, supporting NHS England nationally and within the east of England. This has supported partnership collaboration and service redesign within Essex end of life care services. It also supports EPUT to have national and local updates and share more widely best practices.
Areas to be progressed	To continue to provide public information relating to end of life care to be posted on the Trust Website and through social media to include blogs and sharing stories with staff and patient experiences. The Clinical and Specialty Doctor with the Chaplaincy service are also now holding Death Café's four times a year to support staff.

CLINICAL AUDIT

National Audit of Care at End of Life (NACEL)

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

There are several components consisting of an organisational level audit for the period 1st January 2024 - 31st December 2024 and a case note review of all deaths within the same period.

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

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

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

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

EPUT to date have submitted eight patient records within the criteria for review, this may increase as the closing date is 31st December 2024. The audit is still ongoing this year and the results will not be available until 2025.

In 2025 NACEL will be holding a separate audit for mental health in-patients as well as the current audit. EPUT will be participating in both the physical and mental health audits in 2025.

The Specialty Doctor and Clinical lead for end of life have been part of a team developing the audit with NACEL for use nationally.

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

An audit of 30 records from expected patient deaths were reviewed as a case note review, using an end of life care audit tool in line with the questions of the NACEL audit. The aim was to establish that the services within EPUT delivering end of life care are supporting the requirements in line with best practice and national averages. Within the findings overall EPUT services are providing above the national averages which are between 70-76% for end of life care services. The majority scored 100% for symptom management and coordination of care delivery. The end of life care templates within EPUT electronic databases are supporting record keeping and the trends are evident on the end of life care dashboard which is reviewed monthly. The template has made it easy to find relevant information within the data required to complete the audit and it shares information across services. There were 8 other patient records reviewed as part of the audit but they didn't meet the criteria for inclusion for the following reasons West Essex Team had not seen three patients until the referral was received on the day they died as not previously referred or known to the caseload. In South East Essex there were three patient referred to the palliative care team to be added to the register but they were still in hospital awaiting discharge, all had not been seen when they died so not known by the team.

The findings from the main audit were pleasing as there was clear evidence we are supporting high standards of care across services.

Audit of Do Not Attempt Cardiopulmonary Resuscitation Documents

An audit of DNACPR for those at end of life was completed in 2024. The purpose of the audit was to ensure the correct processes were in place to ensure a person centered approach to all decision making and support the

recommendations from the Care Quality Commissioning review in 2020 of DNACPR implementations.

The audit reviewed thirty eight documents across inpatient, community health and mental health services and included reviewing the following elements:

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

Findings

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

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

The results are very positive highlight support from the senior clinical staff who have completed training and competencies to support DNACPR discussions. The conversations and recognition of end of life care are happening in a timely approach to support inclusion of those important to the patient and their loved ones. Irrespective of the care setting these discussions are supporting the implementation of the DNACPR document in a robust and timely way.

The National Confidential Enquiry into Patient Outcome and Death Audit (NCEPOD)

The NCEPOD audit review healthcare practice by undertaking confidential studies, and make recommendations to improve the quality of the delivery of care, for healthcare professionals and policymakers to implement. Data to inform the studies are collected from NHS hospitals and Independent sector hospitals across England, Wales, Northern Ireland and the Offshore Islands. NCEPOD are supported by a wide range of bodies and the Steering Group consists of members from the Medical Royal Colleges and Specialist Associations, as well as observers from The Coroners Society of England and Wales, and the Healthcare Quality Improvement Partnership (HQIP). Although this audit was completed in March 2024 it was looking at deaths in 2022.

The quality of care provided towards the end of life for adults with a diagnosis of dementia, heart failure, lung cancer or liver disease were reviewed. The sampling period of death or final admission (for

community deaths) was between 1st April 2022 and 30th September 2022. Data included 701 clinician questionnaires and the assessment of 350 sets of case notes.

EPUT provided case note review of 4 patients discharged from dementia wards to a care home where they died.

National Findings and Recommendations

- Palliative care is not just about end of life care.
- Normalise conversations about death and dying.
- Have a named care co-ordinator.
- Provide specialist palliative care services in hospitals and in the community.
- Palliative and end of life care should be a core competency for all healthcare staff.

All these national recommendations are mentioned within the EPUT End of Life Care work plan. EPUT's End of Life audit (23015) and DNACPR audit (23016) findings from 2023/24 covers most of these national actions. Project leads will compare the NACEL audit (23001) findings with these recommendations when they are published in 2025.

PATIENT STORY / LIVED EXPERIENCE

A 58 year old gentleman who lived with his wife in a top floor flat receiving care from the Specialist Treatment and Recovery Service - (STaRS) team. The team were concerned as he refused to access healthcare and they could see he was deteriorating in his physical health. He was unable to leave his flat due to reduced mobility and general deterioration. The team recognised using prognostic indicators he was at end of life. STaRS contacted the Clinical Lead for end of life Care.

He previously would not access the GP or community district nursing team, despite a number of attempts for them to visit. But he trusted the STaRS nurse. It was important to build trust and recognise his human rights and ensure he was safeguarded. Working together a process started where the STaRS team built totally trust as both him and his wife used drugs they brought themselves. They started to share with STaRS team there concerned they would be judged and would not have control over their own situation if they accessed other healthcare.

The STaRS team were supported to give them confidence to recognise they did need support and other services could help them. After building trust they agreed for an MDT meeting to be held and STaRS team would support them but they needed to make a plan to support their wishes and that could only happen together. The STaRS Team, GP, integrated care team nurse, occupational therapist and the hospice team together worked to support them and their family. A PEACE treatment escalation plan was written identifying his priorities. He wanted to die at home but did agreed to go into the hospice to be symptom managed while he was rehoused by the council to support his needs. The team

supported him to be rehoused in a council bungalow that would support his care needs. Respecting his human rights was very important to the teams and ensuring he got the equitable care he deserved.

Over a couple of months he was supported at home with a number of challenges and safeguarding issues related to the families lifestyle choices and addictions but the teams involved supported his end of life needs and worked together to provide safe approaches and solutions to his care.

In the last days of his life he still wanted to stay at home and a local agreement with the pharmacy and nursing team enabled them to take the necessary drugs in daily and the plan of his care was clear around identified needs. He died peacefully at home with his wife at his side. This was only achieved by working together with system partners and looking for solutions to wrap all services around his needs and ensure his wishes and priorities were personalised to support the way he chose to live and wanted to die. All the teams worked together to support this and looked for solutions to ensure his safety and wishes were met. This has enhanced relationships between the local services in primary care, community teams and the hospice. Staff together went over and above to support his wishes.

NHSI AND EOE END OF LIFE CARE COLLABORATIVE

The Clinical and Medical Leads for End of Life Care are members of the NHSI PEoLC collaborative which supports shared best practice across a variety of settings across England, Scotland and Wales. The work undertaken by the Trust in accordance with the Ambitions for End of Life Care has been presented both nationally and at the East of England. The end of life care dashboards have been recognised locally within the ICS localities and there is ongoing work across ICB's for other providers to align to this model. The integration of the mental health and physical health services is starting to show that the dashboard has more representation of dementia and frailty than any other long term condition or diagnosis. Nationally it has been recognised as best practice for the growth of identification of dementia and frailty through the FReDA template as best practice and this has won an HSJ award.

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

DEVELOPMENTS IN MENTAL HEALTH

The Gold Standard Framework process is now well established on Tower ward in Clacton who have achieved re-accreditation. There is strong integration with the specialist teams and patients receive person centered approaches to their end of life care. Feedback from carers and relatives has been positive. The clinical lead continues to support

patients whom are identified as end of life by supporting staff on mental health wards and supports confidence to care.

A clinical guidance for patients under the care of Specialist Treatment and Recovery Service – (STaRS) is established in the North and West Essex to work to support end of life care patients and ensure local services work together to support. Including local acute trusts. These have been developed jointly with acute trusts, community services, local voluntary organisations, primary care, social care and Hospices.

The end of life lead and medical lead have worked with the NE Alliance to restart Advance Care Planning meetings for patients with a dementia diagnosis while they still have capacity to take part in these discussions. Supporting training on difficult conversations and approaches to starting conversations to support.

DEVELOPMENTS WITHIN NURSING HOMES

The two nursing homes Clifton Lodge and Rawreth Court continue to have strong links with the specialist palliative care team and primary care within the South East Essex area. They are on the same electronic data bases so can share records and information across the community services. The two homes are managed by two different managers. Patients are identified using the prognostic indicators and are added to the electronic EPaCCs Register. They use the Gold Standards Framework prognostic indicators to identify patients at end of life and manage their symptoms accordingly. This incorporates all elements of advance care planning and patient choice is recorded inclusive of their loved ones. The shared data sharing has further strengthened joint working and coordinated care between Primary Care, the integrated teams and the care home staff. The homes have received a number of compliments and high praise from bereaved relatives for the approaches of personalised care their loved ones received with compassion and dignity and felt extremely supported by all members of the teams. Rawreth Court Nursing Home this year have started to undertake the Gold Standards Training and this will be ongoing during the next year.

CONTINUED SUPPORT WORKING WITHIN PARTNERSHIPS

The Clinical Lead and Specialty Doctor have continued to support the development and implementation of a wide range of initiatives including

enhanced skills and guidance around early recognition of end of life and symptom management. These include:

- Working with the integrated care systems in each of the localities across EPUT. This includes the Mid and South Essex (MSE), West Essex and Herts and the North Alliance. This supports a number of initiatives supporting integrated partnership working. Including competencies and training for end of life care, Electronic palliative care co-ordination and end of life dashboard – EPaCCs, Procedural guidance documents and aligning services to system partners including hospices. Learning from current services across the end of life care services in each of area.
- Care home project in West Essex to ensure all residence with long term conditions have advance care plan choices documented whether in a residential or nursing home and are added to EPaCCs in a more timely way.
- Implementation of the Dependency guidance at end of life for the STaRS Team in North and West Essex to support best practice. Working with St Helena and St Clare Hospice to deliver training to all the multi-professional agencies involved. There are plans to support future developments across South East Essex so all STaRS teams have a guidance tool.
- Continue to work with Learning disability _ LD lead to support training and conversations with people with LD and their families. Support for LD training on advance care planning and difficult conversations. Using Victoria and Stuart tool kit and working to provide collaboration for sharing

and education across the whole community.

- Person centred approaches to care: complete roll out of Treatment Escalation Plans and new DNACPR documents which include capacity as there is some variation in our localities (PEACE documents across Essex and ReSPECT document in all other areas) to record discussions and choices including PPC/PPD/DNACPR/Requesting treatment.

- Training delivered in a bespoke way and relating to a variety of aspects of end of life care with blended approaches to delivery including, virtually and face 2 face to ensure end of life competencies for staff are met.

- Training podcasts to support training and provides accessibility to all staff. There is a large amount of digital podcasts and information platforms across ICB's to support staff which EPUT are involved in supporting.

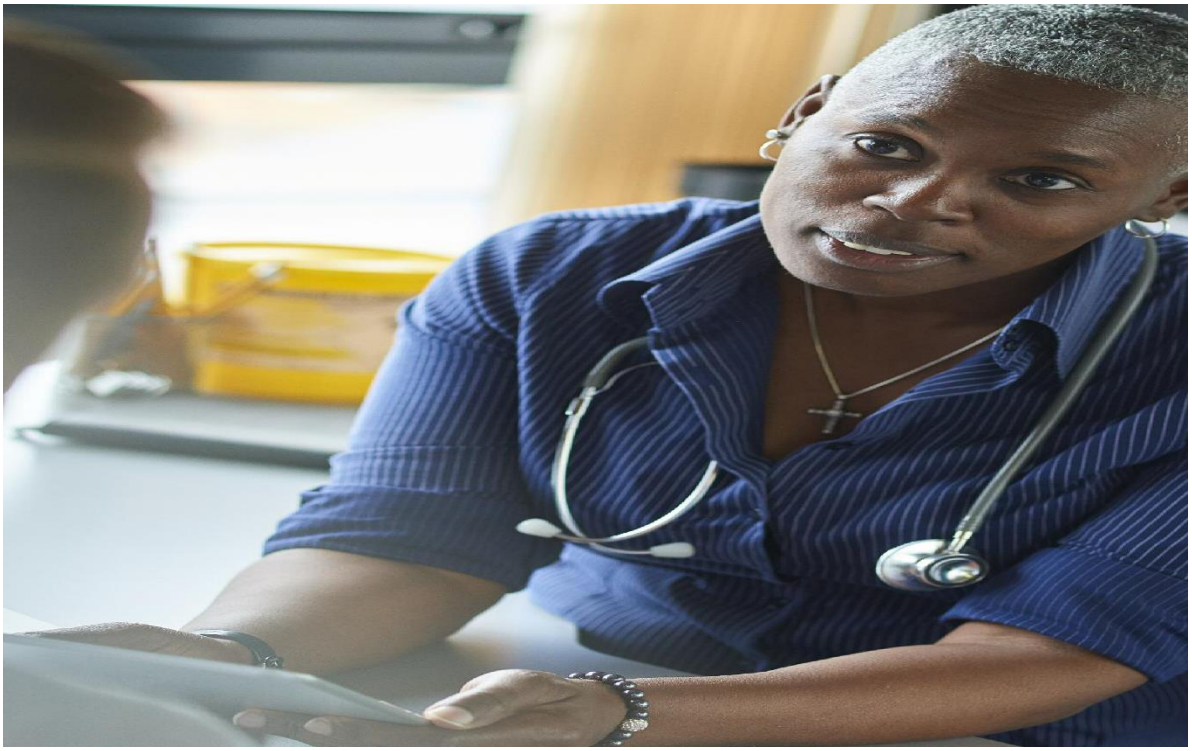
- Collaborative redesign of services working with system partners as locality growth of end of life care is double in previous years. The EPaCC's service for end of life is showing growth as earlier identification is becoming more apparent. The numbers of people on caseloads have doubled in some areas for end of life care. It is important that together we work to support best practices and person centred accessible care for all irrespective of care setting.

- Expert support/advice provided on a daily basis to clinical teams and staff members working outside of their usual area of expertise. The complexities of care of people being cared for in their own home has seen growth in the number of patients with complex needs.

ABBREVIATIONS

CHS	Community Health Services
CQC	Care Quality Commission
Datix	Electronic risk management incident reporting system
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
EoLC	End of Life Care
EPaCCs	Electronic Palliative Care Co-ordination system
EPUT	Essex Partnership University NHS Foundation Trust
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
GP	General Practitioner
GSF	Gold Standards Framework

HPAL	Digital electronic platform for palliative care information
ICB	Integrated Care Boards
ICS	Integrated Care Services
LPA	Lasting Power of Attorney for health and welfare
MEO	Medical Examiner's Office
MDT	Multi-disciplinary Team
NACEL	National Audit of Care at End of Life
NHSI	NHS Improvement National collaborative
NICE	National Institute for Health and Care Excellence
PCN	Primary Care Network
PEACE	Proactive Enhanced Advance Care Plan
PPC	Preferred Priorities for Care
PPD	Preferred Place of Death
STaRS	Specialist Treatment and Recovery Service
TEP	Treatment Escalation Plan
VOED	Verification of expected death



Essex Partnership University NHS Foundation Trust

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

Tel: 0300 123 0808

@EPUTNHS

NHS
Essex Partnership University
NHS Foundation Trust

END OF LIFE CARE FRAMEWORK.

2022-2024

"HOW WE CARE FOR THE DYING IS AN INDICATOR OF HOW WE CARE FOR ALL SICK AND VULNERABLE PEOPLE" (NATIONAL END OF LIFE CARE STRATEGY 2008)

Natalie Hammond
Executive Nurse

Amanda Sherlock
Non-Executive Director

NATIONAL AMBITIONS

1. **Each person is seen as an individual**
2. **Each person gets fair access to care**
3. **Maximising comfort and wellbeing**
4. **Care is co-ordinated**
5. **All staff are prepared to care**
6. **Each community is prepared to help**

INTRODUCTION

Essex Partnership University NHS Foundation Trust (EPUT) provides health and social care services across Essex, Suffolk, Bedfordshire and Luton.

Our Services Include:

Mental health services

We provide treatment and support to adults and older people experiencing mental illness. We also provide treatment to adults and young people in secure and specialised settings.

Community health services

Community health services provide a wide range of care, from supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions within a persons' own home, in community hospitals and clinic settings.

Learning disabilities services

We provide treatment and support to people with a learning disability in the community and within a specialist learning disability unit.

END OF LIFE CARE

End of life care encompasses all care given to patients who are approaching the end of their life and following death. Care is delivered either on our wards or within integrated community health services in people's own homes by a range of healthcare professionals including nurses, therapists and doctors.

The trust is committed to providing the highest quality care for patients, their families and carers. Therefore, we are pleased to present our End of Life Care Framework that sets out how, as a trust, we will continue to strive to provide the best end of life care. To achieve our objectives, we have been guided by the work presented in the Ambitions for Palliative and End of Life Care: A National Framework for End of Life Care 2021 – 2026 which is a refresh of the initial framework published in 2015.

The End of Life Subcommittee oversees delivery of this framework, reporting to the Trust Board through the Quality Committee. Individual service leads are responsible for embedding the framework at a local level. Service leads are also responsible for delivering the strategic goals with support from the End of Life Subcommittee.

BACKGROUND

All people, irrespective of diagnosis, who are recognised as approaching the last year of their life, should have an integrated approach to their end of life care, aligned to external organisations and services. Every person identified at end of life should be offered the opportunity to discuss, plan and record their preferences for care, inclusive of where they would like to die.

We believe that every person identified at end of life must be treated with dignity, respect and compassion as an individual. Our aim is to ensure symptoms are managed and that suffering is kept to a minimum with access to skilful symptom management for optimum quality of life.

People at the end of their life and those who are important to them, will be communicated with respectfully and involved in decision making. The principles under which care is provided will include respect for every individual's views and beliefs and recognition of the importance of providing privacy and dignity in care.

The pandemic has highlighted the absolute necessity of ensuring that people at end of life and those they love have information and access to person centred care and resources to enable a dignified death with the appropriate symptom management in the place of their choosing.

In 2014 the Leadership Alliance for Care of Dying People published One Chance to get it Right which set out the five priorities for care for nurses and other health professionals. This, together with Priorities for Care of the Dying Person (Leadership Alliance for the Care of Dying People, 2014b) set out the approach to the care that people who are dying should receive.

THE FIVE PRIORITIES FOR CARE

1. Recognising that someone is dying

2. Communicating sensitively with them and others important to them

3. Involving them and others important to them in their decisions

4. Providing support

5. Creating an individualised plan of care and delivering it with compassion

Ambitions for Palliative and End of Life Care: A National Framework for End of Life Care (2021) continues to recognise the important role of the communities within end of life care. This is why, as a Trust, the guidance included in Ambitions for Palliative and End of Life Care: A National Framework for End of Life Care is so important in our everyday work.

Building on the information previously available to us to achieve the best end of life care, our Framework will outline how, over the next two years, we will achieve the Ambitions (2021) and the **nine foundations** that are required to attain this:

1. **Timely and early identification of all adults with Palliative and End of life care (PEOLC) need, regardless of the nature of their underlying condition(s), background and circumstance -** So that we can reduce inequalities and ensure everyone who is likely to be in their last year of life gets fair access to PEOLC support, equal opportunity to focus on their personalised goals and respecting their choices.

2. **Personalised Care Planning -** Everyone approaching the end of life should be offered the chance to create a personalised care plan so that you have an opportunity to record their preferences and goals so they can focus on the outcomes that matter most to them.

3. **Shared records -** To ensure the care plan can guide a person-centred approach, it has to be available to that person, so that they can review, change and update it themselves. Subject to that person's consent, or, if they lack mental capacity, in their best interests, the plan should also be shared with all those who may be involved in their care.

4. **Evidence and information -** Involving, supporting and caring for those important to the dying person.

5. **Education and training** - Every professional must be competent and up to date in the knowledge and practice that enable them. It is vital that every locality and every profession has a framework for their education, training and continuing professional development, to achieve and maintain this competence to play their part in good end of life care.

6. **Involving, supporting and caring for those important to the dying person –** Ensuring we listen to feedback and build upon this to improve our services.

7. **24/7 access -** Every person at the end of their life should have access to 24/7 services as needed as a matter of course.

8. **Co-design -** The people who know the most about what services should look like are those that are using them. Therefore, all health and social care systems should involve people who have personal experience of death, dying and bereavement.

9. **Leadership –** Strong leadership that works with local partners and commissioners to provide care that is suited to the needs of the population.

HOW WE WILL ALIGN WITH THE NATIONAL AMBITIONS

AMBITION 1

Each person is seen as an individual.

"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."

EPUT Ambition

We pledge that all of your personal needs and wishes will be explored through honest conversations about dying, death and bereavement at a time when you feel ready to have them; this will include you and the people that are important to you.

Our staff will deliver care that is person centred and will ensure that choices about your care are recorded, supporting you to retain as much control as you wish to have. We will provide you and those important to you with information, advice and support to enable you to make timely decisions about your care.

We will achieve this through:

Strengthening our skills in honest and well informed conversations regarding dying, death and bereavement by cascading our Competency Framework.

Continuing to develop and implement individualised care plans for everyone receiving end of life care in our services.

Building on our relationships with our local partners to ensure access to the best clinical assessment and care delivery in an environment that meets your needs and choice.

Working with you and those important to you in preparation for bereavement and signposting to appropriate services.

AMBITION 2

Each person gets fair access to care.

"I live in a society where I get good access to care, regardless of who I am, where I live or the circumstances of my life."

EPUT Ambition

Dying, death and bereavement affects everyone; we will ensure that you get the care that works for you personally. You and those important to you have the right to expect services at the end of your life that are coordinated and provide you with all.

We recognise that there are vulnerable groups and individuals who may find it more challenging to access end of life services. Achieving equity, access and responsiveness will be at the centre of the day to day care we provide.

We are committed to understanding what outcomes are important to you in relation to your care, recognising that these are key in helping us to make continuous improvements.

We will achieve this through:

Using all available data sources to better understand the reach of our services and identify any gaps in the provision of end of life care. We will generate and use this data to inform us how we may need to improve care. We commit to using national, regional and local data to further guide and develop services that will improve care for you.
Continuing to strengthen relationships with our acute, local authority and hospice providers to maintain clear and open communication to facilitate an ease of transition of your care between services, where this is required. We will continue to work with primary care to support you in your local area.

Working with you and those important to you to develop a set of measurable, person centred outcomes so that we can continue to improve services in the future.
Ensuring you know how to access services 24 hours a day, 7 days a week, 365 days per year.

AMBITION 3

Maximising comfort and wellbeing.

“My care is regularly reviewed and every effort if made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.”

EPUT Ambition

We know that many people approaching death may be fearful of being in pain or distress. We will recognise and respond your concerns, assess the cause and identify what might help you 24 hours per day, 7 days per week, 365 days of the year.

We know that access to early, good quality palliative care can improve outcomes. We will maintain and develop the existing palliative care service that we provide. Where this is not present, we will utilise the skills of external Specialist Palliative Care services to ensure that all your needs are supported.

We will achieve this through:

Continued rollout of the competency framework for all clinical staff to ensure skilled assessment and symptom management.

Working with you and supporting you to achieve your personal goals whilst maximising your independence and embedding the use of an individualised care plan both in an inpatient and community setting.

Equipping our staff with the knowledge of how to access expert advice, medicines and equipment so they can respond rapidly to your changing needs.

AMBITION 4

Care is coordinated.

“I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time, day or night.”

EPUT Ambition

We understand that fragmented care can be a source of anxiety and frustration. We are committed as a partner in Integrated Care Systems to develop a more coordinated response that is proactive to your needs and uses a full range of services.

We commit to providing services that sustain excellent care outside of inpatient services. We will continue to work with our local partners.

We will achieve this through:

The continued roll out of the Proactive Elderly Advance Care Plan and patient held information.

Active participation in multi-disciplinary meetings and care reviews.

Implementation of the Electronic Palliative Care Coordination System in west Essex.

Continued recruitment and support of End of Life Care Champions.

Signposting to relevant services available to you locally and nationally.

AMBITION 5

All staff are prepared to care.

"Wherever I am, health and care staff bring empathy, skills and expertise to give me competent, confident and compassionate care."

EPUT Ambition

We will adhere to values-based recruitment at all levels of our organisation. We remain open to new ways of learning and interacting with the people we support. We are committed to providing our staff with the correct education and skills to help them to best meet your needs.

We will listen to your voice and ensure that any themes or trends identified are reported through governance and reporting structures to enable shared learning across the organisation.

We will undertake regular audits to establish adherence to best practice and make changes to practice where these are required.

We will achieve this through:

Providing opportunities for clinical supervision and peer support in all clinical teams to allow for reflection and learning.

Continued participation in the National Audit of Care at End of Life and will undertake local audits to enable us to review the quality of care that we provide to you and make improvements where issues are identified.

The provision of bespoke and blended learning opportunities for all staff.

Clinical leadership and executive support for excellent end of life care.

AMBITION 6

Each community is prepared to help

"I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways."

EPUT Ambition

We believe that it is important to work with partner organisations to help support you and those close to you.

We are committed to increasing public awareness of the difficulties faced by those who are dying.

We will continue to promote openness around end of life issues in our communities.

We will achieve this through:

Continuing to develop signposting systems through the Trust website and easy read leaflets.

Raising awareness around the importance of early discussions relating to end of life and supporting staff so that they have the competence and confidence to undertake difficult conversations.

Accountabilities and Responsibilities

Delivery of this Framework is overseen by the End Of Life Sub-Committee which reports to the Trust Board via the Quality Committee. Individual service leads are responsible for embedding this Framework at local level. Service leads are also responsible for delivering the strategic goals at an operational level, with support from the End of Life Care Sub-Committee.

8.3 LEARNING FROM DEATHS Q2 REPORT

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Learning from Deaths Q2 Report 2024-25.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	05 February 2025

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data Report Q2 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 (19/11/24 & 17/12/24) Learning Oversight Sub-Committee (27/11/24) Safety of Care Group (28/11/24) Quality Committee (12/12/24)					
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 (Q2 2024/25)* report, which includes the following:	**Approval**	
	Discussion	
	Information	✓

• 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 • An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result		

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report
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 report 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 Q2 2024/25 data was extracted and analysed as at 14/11/24. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q2 data, which is broadly in line with that of previous quarters.

   Key points of note for Q2 data are (as at 14/11/24):

   - There were a total of 145 deaths reported on Datix for Q2 2024/25 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 148 Datix reports made in respect of the 145 deaths.
   - A total of 37 of these deaths had, as at 14/11/24, been deemed in scope.
   - Of these deaths 4 were inpatient deaths and 5 were EPUT nursing homes deaths. Three of the four inpatient deaths and all of the nursing homes deaths have been confirmed as due to natural causes. The cause of death for the remaining inpatient death is under determination and a Patient Safety Incident Investigation is underway under PSIRF.
   - 17 deaths in Q2 had been closed at Stage 1 via Care Unit scrutiny and assurance processes as requiring no further level of review. 4 deaths had been identified as requiring a Stage 3 PSIRF review via Care Unit Patient Safety Oversight Groups and 6 had been identified as requiring a Stage 2 clinical case note / thematic review in line with the Trust's mandated criteria for Stage 2 reviews.
   - A total of 48 deaths were awaiting completion of a Stage 1 review.
   - All deaths requiring report to LeDeR, the national review programme for LD deaths, have been confirmed as reported to the programme.

   At the point of extracting the data for Q2, a total of 75 Stage 1 reviews had been undertaken by local service managers in relation to deaths occurring between 01/07/24 – 30/09/24 to ascertain learning and identify those for further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally.

   The processes by which mortality data is collated and analysed have been developed and refined over the past year. There continues to be scope to further refine and strengthen those processes, utilising improving technologies available to the Trust. Work is to be undertaken with the Trust's systems teams to strengthen the Trust's death notification and initial screening processes and this work is being progressed as a priority for the Trust.

3. The Learning from Deaths – This provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being

taken as a result. This 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 actions taken that form part of the Trust's Safety Improvement Plans.

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 (Q2 2024/25)

Further Reading:

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

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

"Using the Care Review Tool for mortality reviews in Mental Health Trusts" Royal College of Psychiatrists November 2017:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.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

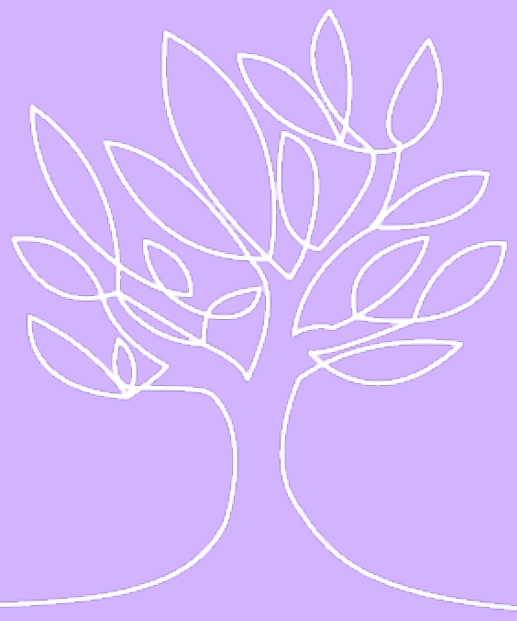
QUARTER 2 - 2024/25

PURPOSE OF REPORT

This report sets out:

- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1st April 2022;
- An update on changes to reporting and review processes in progress;
- Data relating to deaths recorded on Datix for Q2 2024/25 (1st July – 30th September 2024);
- Updated data for deaths relating to 2023/24 and 2022/23; and for previous years under the previous mortality review arrangements; and
- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (December 2024) – i.e. learning identified between September 2024 – November 2024).

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT



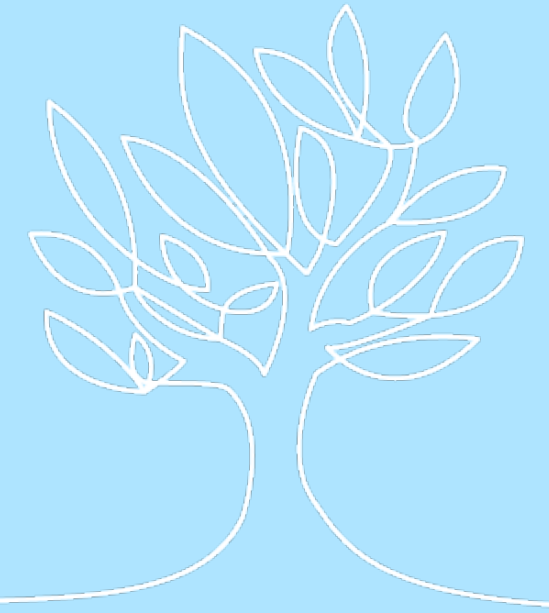
The aims of the Trust's Learning from Deaths Policy are to provide a robust governance framework for undertaking mortality review in order to:

- improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it;
- further develop systems of care to continually improve their quality and efficiency;
- improve the experience for patients, their families and carers wherever a learning issue from the review of deaths is identified;
- improve the use of valuable healthcare resources; and
- improve the working environment for staff in relation to their experiences of reviewing deaths and associated reviews / investigations.

The Trust sets out to achieve these aims by:

- ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice, or conversely problems in care, to be identified on an individual basis;
- ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;
- ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; and
- ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action.

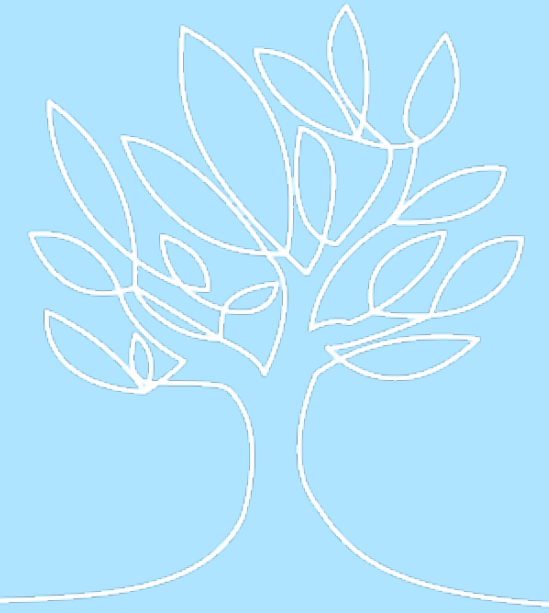
Mortality Data – Context



- From 1st April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust and thus report on Datix. This definition was based on the categories defined in the National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf and Royal College of Psychiatrists mortality review guidance https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf and is outlined on the following page.

- Services are encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data from Q1 2022/23 onwards.
- It should be noted that data in this report was extracted as at 14/11/24 and updates will be included in future reports.
- Mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee monthly and quarterly for review and approval.
- Summary mortality data for Q2 2024/25 is detailed in the following section.
- For Q2 2024/25 there are no monthly levels of reported deaths or deaths in scope that fall outside of the control limits.

Summary of Quarter 2 2024/25 mortality data (as at 14/11/24)



- **Total number of deaths reported:** There were a total of 145 deaths reported on Datix for Q2 2024/25 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 148 Datix reports made in respect of the 145 deaths. This is broadly in line with previous quarters. The number of deaths reported for Q1 has also increased to levels in line with previous quarters – the increase is due to deaths occurring in Q1 being reported post-quarter end. This includes deaths identified as a result of the end of quarter audit.

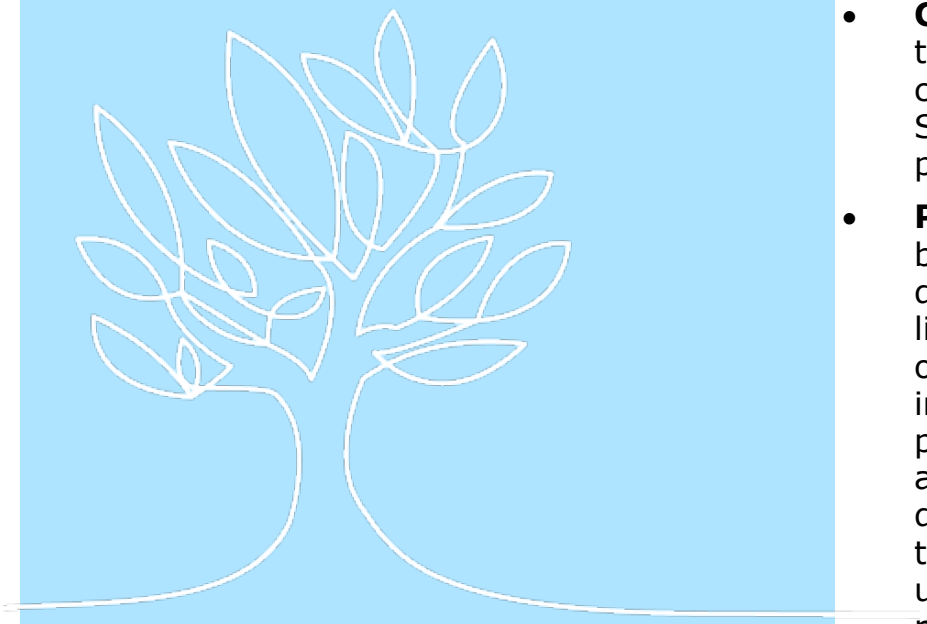
- **Total number of deaths in scope for mandated reporting:** To date, a total of 37 deaths in Q2 2024/25 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 48 deaths which is required to determine whether they are in scope for mandated reporting and this total is therefore expected to increase). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 (Q1 – 65 Q2 – 63 Q3 – 60 Q4 – 61); in 2023/24 (Q1 - 68 Q2 - 62 Q3 - 60 Q4 - 58) and Q1 2024/25 (40). The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

- **Inpatient / Nursing Homes deaths:** Of the 145 deaths reported in Q2, 4 were inpatient deaths and 5 were nursing home deaths. This is broadly in line with previous quarters. Three of the four inpatient deaths and all of the nursing homes deaths have been confirmed as due to natural causes. The cause of death for the remaining inpatient death is under determination and a Patient Safety Incident Investigation is underway under PSIRF.

- **LeDeR reporting validation:** All 7 reported Learning Disability deaths in Q2 2024/25 have been confirmed as reported to the national LeDeR programme.

- **Level of review:** Thus far, 11% of deaths in Q2 2024/25 have been closed at Stage 1; 4% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 3% have been referred for Stage 3 full PSIRF review. Obviously, these figures are expected to increase as deaths are progressed through the review consideration processes.

Summary of Quarter 2 2024/25 mortality data (2) [as at 14/11/24]



- **Stage 1 reviews:** A total of 75 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the 148 Datix death reports in Q2. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 48 outstanding Stage 1 reviews for Q2 deaths. This is at the higher end of the range usually reported for outstanding Stage 1 reviews at this point.
- **Stage 2 (clinical case note) reviews:** A total of 6 deaths in Q2 have been identified to date for Stage 2 mortality clinical case note review / thematic review, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 4 deaths in Q2 have been identified to date for PSIRF review.
- **Completion of Stage 2 (Clinical Case Note Review) and Stage 3 (PSIRF) reviews:** Given the point of reporting, no Stage 2 and Stage 3 reviews for deaths occurring in Q2 have yet been completed. However, since the data in the last quarterly report to the Board of Directors, 1 x Stage 2 reviews and 8 x Stage 3 reviews have been approved for deaths occurring in previous periods.
- **Problems in care assessment –** There are 0 deaths for Q2 thus far that have been assessed as being more likely than not due to problems in care by EPUT; and the assessment is still to be determined for 116 deaths. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 80 out of the total of 520 deaths for that year and for 253 out of 716 total deaths for 2023/24. This includes deaths closed following PSIRF review as the assessment of problems in care has been paused whilst further research continues to be undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination given that the PSIRF methodology has not been designed for this purpose. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will be reassessed. This data will be updated in future reports as reviews are completed and the likelihood is determined.

Summary of previous years' mortality data (2017/18 – 2023/24)

- Mortality data for previous years (2017/18 – 2023/24) as at 14/11/24 has also been updated and presented to relevant Trust committees for monitoring.
- In summary, since the last report to the Board of Directors the following progress has been made:
  - **2023/24**
    - 25 x Stage 1 reviews have been completed
    - 24 x deaths have been closed at Stage 1
    - 1 x Stage 2 review has been approved
    - 7 x Stage 3 (PSIRF) reviews have been approved
  - **2022/23:**
    - 1 x Stage 3 (PSIRF) review has been approved
  - **2021/22:**
    - 1 review remains open (1 x external PSIRF review). This continues to be actively progressed.

Examples of good practice emerging from Stage 1 reviews

September – November 2024

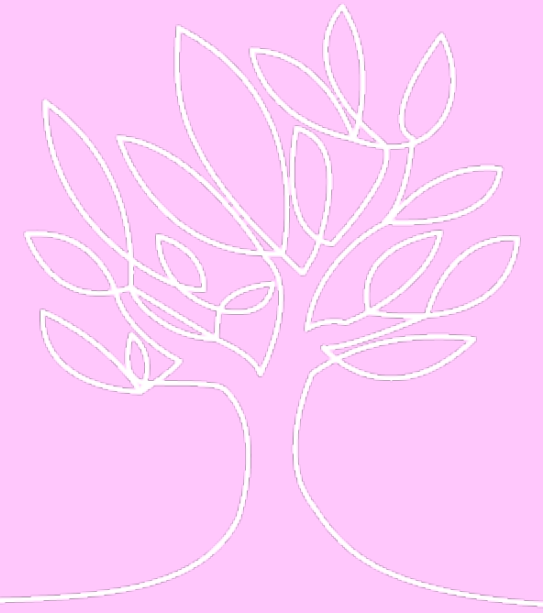
The following pages outline examples of some of the learning and themes emerging from reviews of deaths, as well as some examples of the actions being taken in response to learning.

EXAMPLES OF GOOD PRACTICE:

- We have noted appropriate referrals made, patient's wishes were adhered to. All documentation completed appropriately.
- Patients' families were complimentary of care received on wards.
- All reasonable and practical steps were taken by staff to ensure safety. Patient had engaged with services, no concerns raised.
- Timely discharge.
- No new learning identified. Patient had a diagnosis of psychosis but remained on their depot and had not suffered any relapses since 2005 when they were first registered with the Trust.
- Reviewer reviewed the case against the relevant policies and procedures for secondary care services and, without any objective evidence of an underlying mood disorder being available to staff at the time, believed that the decision to treat in primary care was the correct one.

Learning themes emerging from Stage 1 reviews – continuing themes

September – November 2024



- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues for timing of Stage 3 PSIRF / Stage 2 reviews).
- Majority of the deaths reviewed are from **physical health causes** (e.g. long term conditions, terminal illness, expected deaths of patients receiving end of life care, physical health crisis, deaths in Acute Trust hospitals) – importance of considering capacity to comply with physical health medication regimes and provision in assistance to comply; management of physical health decline.
- **Clients not open to services at time of death –** e.g. Coroner Do You Know? enquiries
- **Communication and information sharing (**between Trust teams and with external partners such as GPs, acute trust, local authorities, care homes) – e.g. liaising in relation to physical health decline; notifying of admissions to Acute Trusts; ensuring access to other forms of support; making other NHS agencies aware; communicating in terms of physical health to avoid inappropriate transfers between acute and mental health trust inpatient facilities.
- **Internal reporting and review processes** – e.g. team responsibility for reporting, commissioning investigations.
- **Medications** – e.g. monitoring impact of antipsychotic medications on physical health; conditions being well controlled by medications.
- **Family and carer involvement –** e.g. involvement of families / carers in care planning; soliciting feedback from all involved parties to continually refine and enhance care practices; providing on-going support to patient and family.
- **Importance of Multi-Disciplinary Team (MDT) meetings –** e.g. regular and timely MDT meetings allow for diverse perspectives, ensuring that all aspects of a patient's needs are considered.
- **Importance of robust risk assessment and safety planning –** e.g. updating care plans following discharge from inpatient wards, ensuring risk assessment are up to date.
- **Hydration and nutrition** – e.g. continued importance of raising awareness.
- **Appropriateness of mental health care provision when in receipt of end of life care –** e.g. elderly patients still open to Community Mental Health Teams when in receipt of recognised end of life care for expected deaths.

Learning themes emerging from Stage 2 Clinical Case Note Reviews

September – November 2024

Since the last report to the Board of Directors, there has been one Stage 2 review approved.

There was no new learning identified and care was in line with standards expected.

However, local actions were agreed by the relevant Care Unit to be clear on responsibility for physical health monitoring and intervention when EPUT is commissioned to undertake only an annual care package review.

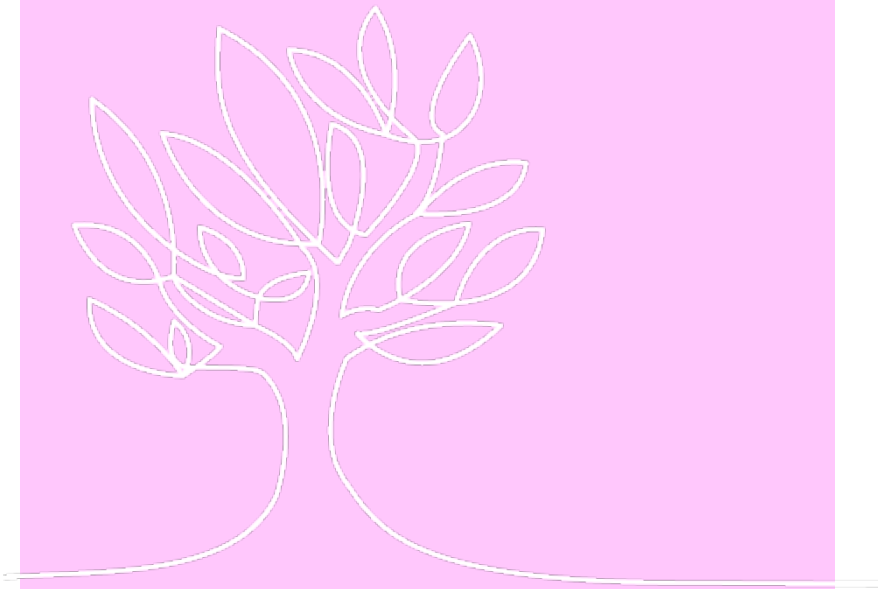
Example actions being taken in response to learning from deaths – Stage 1 and 2 reviews

Examples of local immediate actions taken by services:

- EPUT autism lead to be involved in future LEDER Quality Panels where reviews of deaths of individuals with autism but not learning disability are to be considered. They are also to become a member of the Southend, Essex and Thurrock (SET) LEDER steering group to raise more awareness of autism issues.
- Revised hospital policies and procedures to incorporate new practices and improve patient care based on the identified learning.
- Discussions with Clinical Managers to emphasise the necessity of holding group multi-disciplinary team (MDT) meetings on a regular basis. These conversations focused on the importance of consistent communication and collaboration amongst the team to ensure comprehensive patient care. By reinforcing this expectation, the aim is to establish a routine that prioritises timely MDT meetings, thereby minimising gaps in care and improving overall patient outcomes.
- The service reviewed the way in which risk was stratified in terms of the service risk management policy - this was a service wide review and included updating of the policy involving the input of all clinical staff. This was shared with the team via email and at the team meeting.

Learning themes emerging and example actions from End of Life care reviews

September – November 2024

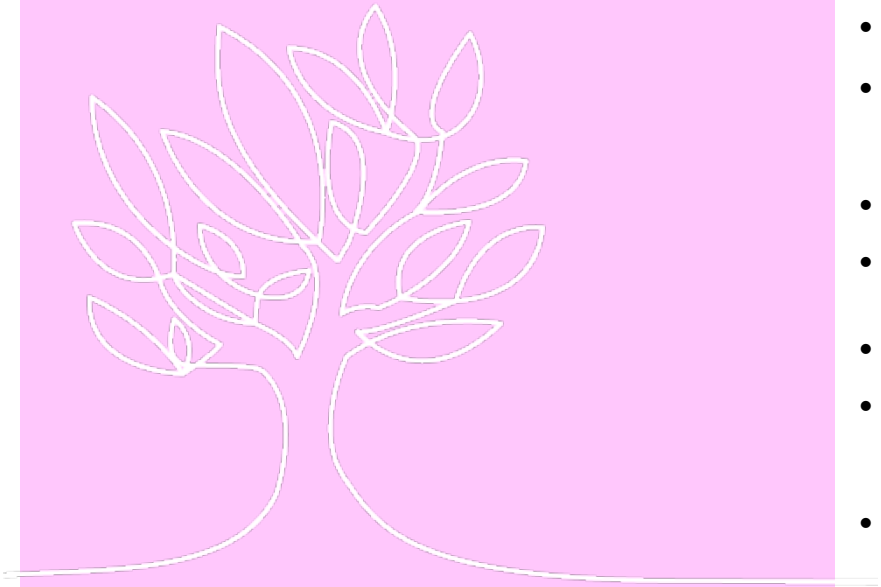


Examples of learning identified via reviews of end of life care in the period include:

- A relative of a patient who had been under the care of Dementia services commented on a bereavement evaluation about her experience - the End of Life Care lead and patient experience team have therefore met with the relative to identify learning to help inform future practice.
- Revising guidance in collaboration with the ICB in relation to home oxygen therapy for palliative care patients to reflect learning from an incident in the community.
- Challenges in obtaining Continuing Healthcare (CHC) funding which is potentially impacting on achieving patients' "preferred place of death" and hospice at home capacity. A system wide meeting of all partners involved is being held to consider the way forward. This is being monitored by the Integrated Care Board. The Trust's End of Life Care Lead as shared training opportunities for staff on the new processes and documentation.

Learning themes emerging and example actions from EDAP multi-agency collaborative reviews

September – November 2024



Examples of good practice include:

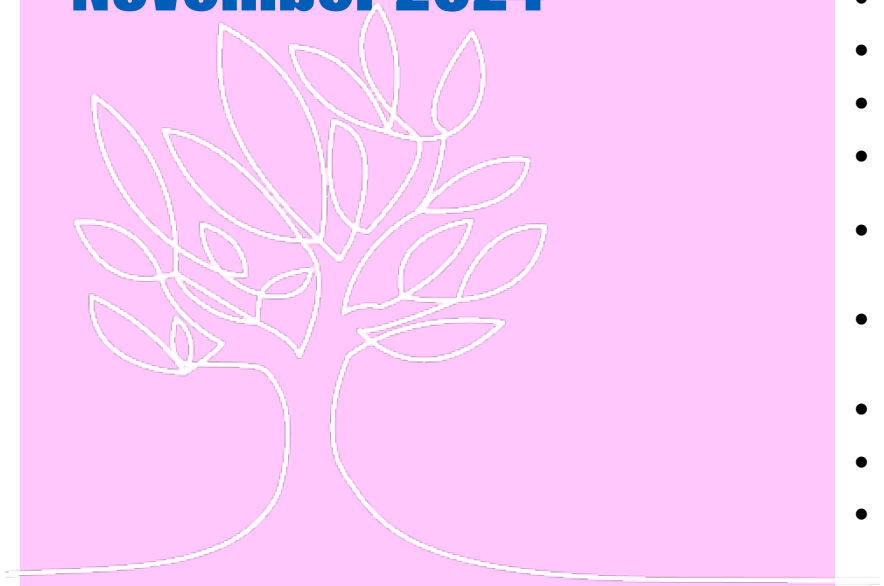
- Very good liaison between doctors in general hospital and in EDAP regarding pain relief and management.
- Good joined up working in relation to a patient at end of life – team now has contact point within end of life team within Trust.
- Examples of strong partnership working between mental health services and EDAP agencies relating to a particular death.

Examples of learning and actions being taken include:

- Consideration of support and awareness raising/education for family members caring for individuals in receipt of drug and alcohol services.
- Importance of ensuring that the safeguarding elements of clients with substance use issues are followed up.
- Exploring how relationships between the Trust MH Services / EDAP and Whipps Cross Hospital can be strengthened.
- Continue strengthening communication and collaboration between Trust MH Services / EDAP services.
- It would be valuable to add more content into the dual diagnosis training around physical health monitoring and interventions – this is being explored by the Clinical Leads for Dual Diagnosis with the lead Deputy Director of Quality and Safety for physical health.
- Strengthen clarity on care packages when patients / clients are discharged from the acute Trust
- Importance of consistency of support from designated staff members (try and maintain continuity of the staff member providing the care)
- Ensure involvement of family members in situations of disengagement
- Ensure collaborative working together across mental health services and EDAP in situations of disengagement (e.g. where client is engaging with one service but not the other) – again work is on-going to strengthen this and dedicated Dual Diagnosis workers have been introduced since this death
- Challenges in relation to being able to identify when vulnerable clients are potentially struggling during COVID when not able to enter homes

Learning themes emerging and example actions from local LeDeR reviews (national Learning Disability review programme)

September – November 2024



Examples of good practice include:

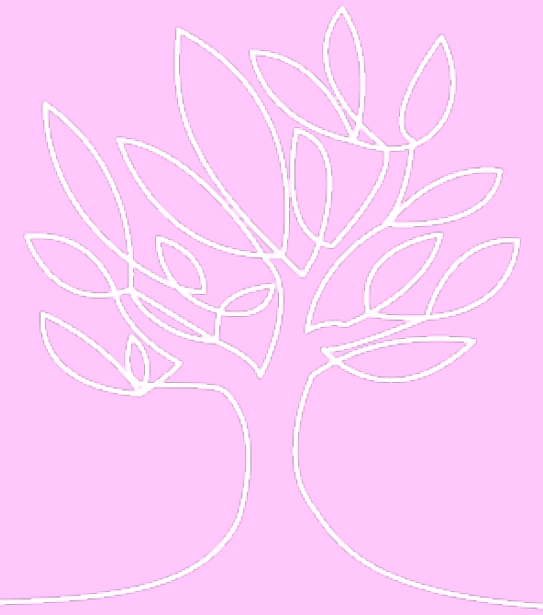
- Good support from Children with Disability team
- Children and Young People's inpatient services

Examples of learning and actions being taken include:

- Transitions from Children and Young People's services to Adult services (a toolkit is being considered, learning to be mapped into Essex County Council's existing transitions mapping work)
- Importance of face to face assessments
- Familiarity with patients condition (e.g. medication history) is essential to ensure safe practice
- Recording of medications in patient notes is essential
- Handwritten guidance not appropriate
- Importance of updating community nurses of any changes to medications
- Communication – answering patient and carer queries in timely manner
- Reasonable adjustments need to be considered – particularly for vulnerable patients
- Staff resourcing issues addressed
- Commissioners to work with young adults who have autism to understand what provision would support them
- Providers require support to understand autistic people's needs and should appropriately record needs and triggers
- Requirement for user led family voices in the care of autistic people
- Requirement for lived experience on consistency of support and information for autistic people
- Reasonable adjustments need to be considered – particularly in services not tailored for people with LD/autism

Learning themes emerging from PSIRF reviews

September – November 2024



Similar themes continue to emerge from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Medications
- Documentation / Record keeping
- Clinical care – e.g. personalised care planning, risk assessments, referrals, safety planning
- Communication / collaborative working – Inc. multi-disciplinary team meetings
- Staffing
- Staff training
- Family and carer involvement
- Physical health
- Safeguarding
- Disengagement

Example actions being taken in response to learning from deaths – PSIRF [1]

- Record keeping for Multidisciplinary Team (MDT) discussions was identified as a theme. There is currently a Safety Improvement Plan to standardise the structure and content of MDT discussions, ensuring there is appropriate communication to all those involved in the care of the patients.
- Another theme identified was appropriate record keeping which is also being addressed through the Record Keeping Safety Improvement Plan.
- Care planning was identified as a theme in some of the investigations completed. To immediately address this with the respective teams there was communication to remind staff on value of the content within care plans and process for regularly updating them, as well as supportive training for staff. The Trust has a programme of work for implementing nationally approved Goal Attainment Score (GAS) care plan. This will include involving patients and carers in the development and review of care plans.
- Use of Oxehealth featured in one of the PSII's with key learning relating to training and adherence to Standard Operating Procedure. The OxeHealth Project Board have oversight and assurance for embedding; and monitoring of the actions is through the local quality of care meetings chaired by the Deputy Directors of Quality and Safety.

Example learning themes and actions in response to Prevention of Future Deaths (PFD) Reports from HM Coroner [1]

A thematic review of learning from Prevention of Future Deaths (PFD) reports was undertaken in 2024 and identified the following key themes:

- Communication
- Training & Supervision
- Record keeping
- Discharge Planning
- Care Planning
- Risk Assessment

These themes are consistent with themes also identified from Stage 1, Stage 2 and Stage 3 (PSIRF reviews) as outlined in this report.

All themes emerging from the learning are being addressed via action plans including the Trust's Safety Improvement Plans, detailed on the following page.

Safety Improvement Plans informed by identified learning from incidents

The Trust is developing and implementing 10 Safety Improvement Plans (SIPs) covering key areas informed by learning from incidents including themes from patient safety incident responses, learning from deaths reviews, Prevention of Future Death reports from the Coroner and a variety of other sources.

Actions taken in response to the Coroners' concerns are reviewed and mapped against the ongoing Safety Improvement Plans developed in the trust to promote continuous improvement.

The Trust's 10 Safety Improvement Plans are as follows:

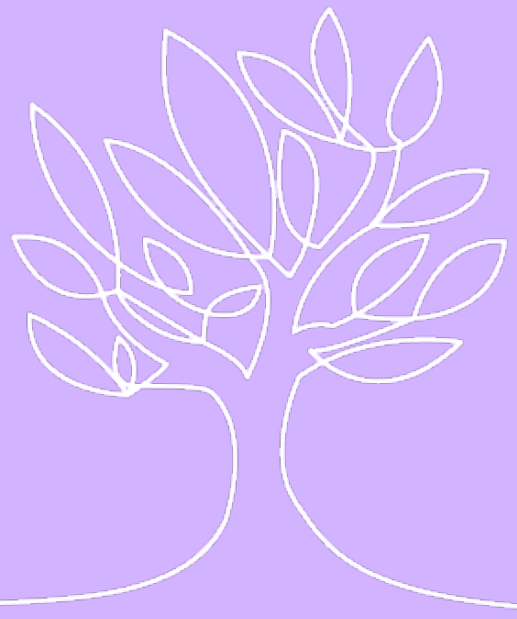
- Ligature risk reduction
- Falls risk reduction
- Transition from children and young people's services to adult services
- Multi-disciplinary team (MDT) communication gap
- Record keeping
- Clinical handovers
- Policies and Standard Operating Procedures (SOPs)
- Patient disengagement
- Medication incident risk reduction
- Discharge and transfers

Examples of Trust-wide actions being taken in response to learning from deaths (all review mechanisms)

Examples of Trust-wide actions taken:

- Learning presented to and considered monthly by the Trust's Learning Collaborative Partnership and included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate (e.g. timeliness of completion of Stage 1 reviews, being specific in terms of physical health issues contributing to deaths of patients to further inform the Trust's work in relation to physical health monitoring and intervention).
- Learning used to inform topic areas for "Learning Matters" MST development sessions – e.g. lessons learned from specific deaths.
- Thematic learning being used to inform the Trust's Safety Improvement Plans.
- Sharing of local learning (e.g. from Stage 2 reviews) is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change.
- Learning from deaths is also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.
- Learning is also now being shared in system wide learning from deaths forums, facilitated by the respective Integrated Care Boards (Herts and West Essex; Mid and South Essex; and Suffolk and North East Essex).

CONCLUSIONS AND ACTIONS REQUIRED



- This report provides mortality data mandated for report to support mortality surveillance; and information in relation to the learning emerging from reviews of deaths being undertaken under the learning from deaths arrangements.
- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q2 2024/25.
- The report also provides assurance that the learning is being acted upon, with examples provided of actions taken in response to learning identified.
- Given the outcomes outlined, it provides the Trust Board of Directors with assurance that there are robust processes in place in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing and ensuring that patients are receiving safe, high quality care. It also highlights the work that has been undertaken, and continues, to strengthen mortality data reporting processes and implement refined processes.
- The Board of Directors is asked to note the information presented; and request any further information or action.

9. OTHER

9.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item SS 1

Verbal

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

Decision Item | ALL | 1

Verbal

9.3 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item | ALL | 5

Verbal

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

Information Item ALL 1

10. ANY OTHER BUSINESS

Information Item | ALL | 5

Verbal

11. QUESTION THE DIRECTORS SESSION

10

12. DATE AND TIME OF NEXT MEETING

Wednesday 2 April 2025 at 10:00, The Lodge Training room 1