Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

5 June 2024

10:00 GMT+1 Europe/London

MS Teams

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda June 2024 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 5 June 2024 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 Via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 27 March 2024	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Approval
7.3	Freedom to Speak-Up Annual Report	NL	Attached	Noting
7.4	PLACE 2023 Report	ZT	Attached	Noting
7.5	Safe Working of Junior Doctors Annual Report	MK	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Complaints & Compliments Annual Report	ZT	Attached	Approval
8.2	Patient Experience and Volunteers Annual Report	ZT	Attached	Noting
8.3	End of Year Governance Reviews	DG	Attached	Approval
9	**STRATEGIC INITIATIVES**			
9.1	Strategic Impact Report M12	ZT	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
10.1	Trust Constitution Review	DG	Attached	Approval
11	**OTHER**			

11.1	Use of Corporate Seal	PS	Attached	Approval
11.2	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
11.3	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.4	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.5	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 7 August at 10.00, virtual using Microsoft Teams			
15	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 2 October 2024 at 10:00, The Lodge Training room 1 Wednesday 4 December 2024, 10.00, The Lodge Training room 1 Wednesday 5 February 2025 10:00, The Lodge Training room 1			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Information Item SS 1

2. DECLARATIONS OF INTEREST

Information Item SS 1

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 27 MARCH 2024

Decision Item | SS | 2

REFERENCES

Only PDFs are attached

#0 BOD Part 1 - DRAFT Board Minutes - March 2024 (V003) FINAL (1).pdf

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 27 March 2024
Held at Colchester Football Stadium, Colchester

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Director of Finance and Resources / Deputy CEO
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Alex Green (AG)	Executive Chief Operating Officer / Deputy CEO
Milind Karale (MK)	Executive Medical Director
Ann Sheridan (AS)	Executive Chief Nursing Officer
Marcus Riddell (MR)	Interim Chief People Officer
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Diane Leacock (DL)	Non-Executive Director
Jenny Raine (JR)	Non-Executive Director
Ruth Jackson (RJ)	Associate Non-Executive Director

In Attendance:

Angela Laverick	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
John Jones	Lead Governor
Gill Brice	Director of Major Projects (for Nigel Leonard)
Matthew Goddard (MG)	Head of Community Occupational Therapy, Adult Speech and Language Therapy, Equipment and Southend Wheelchair Service
Stuart Scrivener	Governor
Teresa Bradford	Council of Governors and Membership Administrator
Kim Russell	Head of Communications
Dr Ray Lashley	Member of the Public

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

The meeting commenced at 10:00

025/24 APOLOGIES FOR ABSENCE

Apologies were received from:
- Nigel Leonard, Executive Director of Major Projects and Programmes
- Loy Lobo, Non-Executive Director

026/24 DECLARATIONS OF INTEREST

There were no declarations of interest.

027/24 PRESENTATION – WHEELCHAIR SERVICE

AG introduced Matthew Goddard. MG shared a video of a service user in the South Essex area who had been known to the service for 5 years. The service user had previously purchased his own wheelchair before accessing EPUT services. The service user in the video shared that:

- The Wheelchair service had allowed him independence.
- He now led a more active lifestyle and work life.
- He had taken up a lived experience ambassador role with EPUT, which he found rewarding and highlighted the amazing work the service does. He enjoyed the opportunity to feed in and share his perspective as service user to help improve not only his experience, but that of others.

MG commented that this was an inspiring, powerful story. Interaction and intervention from the Wheelchair Service has meant that this service user was able to live an active lifestyle and continue with employment. The service user was an active member of the community and felt able to work and contribute, due to the improvements made by having suitable equipment. The service user had joined the Trust in an ambassador role eight months previously, providing experience and a powerful perspective. The team try to listen to service users' journeys, but having them there and engaging in conversations was very important and impactful.

Questions & Discussion

ZT queried at what point the conversation for service user involvement take place and how did the service user take on the role in the Trust. MG responded that the service recognised the need for the patient voice at the forefront and had asked service users who would like to be involved. This particular service user had been involved with the team for around 5 years and as such had a well-rounded experience of the service.

JR noted the seriousness the Trust took service user involvement in service management and design. JR asked if there was an example of the impact and change this involvement had. MG shared that the meeting the team, the service user had stated that they were the first people that had listened to what he believed he needed as well as sharing their professional experience with him. The service user's chair was custom made to fit ergonomics of the service user's body; this took a lot of adjusting and work together to get right. MG advised the service had worked hard to improve communications and listening to what patients want and need.

EL queried how well the "I Want Great Care" (IWGC) feedback system was embedded in services led by MG. MG confirmed that he and the teams were trying to promote this and give everyone access to get a fair perception of services. IWGC was promoted at every visit to get feedback, recognising the importance of hearing from as many people who have contact with the service to hear their perspective.

AS asked whether there was support from the Board and Senior Managers in the work of the service. MG felt that there was support from the Board and senior colleagues, and would be happy to approach and request support should it be necessary. MG advised the service felt supported to address issues and were empowered to take any action needed.

AG commented the story was an example that demonstrated disability was not the barrier, and the video provided evidence of the effect of breaking barriers through changes to the environment / equipment. AG felt this linked with the Social Impact Strategy as showed the impact the right level of service provided, with the individual able to become involved in the wider community.

SS took a question from a member of the public, who asked if there was a set budget for each person. MG advised that every case was reviewed individually and the service looked across the health economy to utilise stock and have better buying power to ensure the best value for service

users. SS welcomed the approach and suggested it demonstrated working together collaboratively to achieve the best value.

028/24 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on the 31 January 2023 were reviewed. It was noted that the attendance of the meeting needed to be amended to provide for the attendance of Jenny Raine, Diane Leacock and Marcus Riddell. The attendance also should be amended to remove Susan Young, who was not in attendance.

With the above amendments, the Board of Directors agreed the minutes as an accurate record.

029/24 ACTION LOG AND MATTERS ARISING

The action log was reviewed and discussed, noting that there were no items currently due.

- **09/23 Update to Board regarding relevant recommendations from the Rapid Review into Data on Mental Health Inpatient Settings:** To be discussed on today's agenda – action closed.

030/24 CHAIRS REPORT

SS presented the report highlighting the following points to note:

- Manny Lewis, Non-Executive, term of office ended after completing a six year term of office. SS extended her thanks to Manny for his contribution over this period, as both NED and Vice Chair, and wished him well for the future.
- The Council of Governors has supported a Board recommendation to appoint Loy Lobo as Vice Chair. SS congratulated LL.
- SS welcomed AS as the Executive Chief Nurse.
- SS advised the recruitment process to appoint a substantive Executive Chief People Officer had now concluded, with the appointment of Andrew McMenemy. SS thanked MR for his continued support and commitment as Interim Executive Chief People Officer.
- SS formally welcomed Dr Ruth Jackson who had joined the Trust and Board in the role of Associate NED. RJ brings expertise from both an academic and workforce perspective.
- SS advised that with regret, resignation had been received from Professor Stephen Heppell, NED. Due to personal circumstances he would be stepping back from the role, Professor Heppell sends best wishes and thanks to all for the support received during his time with us as part of the EPUT Board.
- A joint Council of Governors meeting was held with Mid and South Essex Foundation Trust. This was a useful session sharing updates from each organisation. EPUT had the opportunity to share some of the work around lived experience ambassadors, co-production and service user involvement magnifying that patient voice.

The Board received and noted the Chair's Report.

031/24 CEO REPORT

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

PS welcomed AS to the Executive Team and thanked MR for his leadership during the recruitment process for the substance Executive Chief People Officer.

PS highlighted the following from the report

- The Electronic Patient Record (EPR) business case had received approval from both EPUT and MSEFT Boards and would now be submitted alongside the preferred supplier for national approval. There had been significant work to get to this point, PS thanked ZT for his leadership.
- The NHS staff survey results had been received with some good positive feedback, despite a difficult period with scrutiny and pressure over winter.
- PS was pleased to open the Trust's recent Sexual Safety conference where the Trust had confirmed the sign-up to NHSE Sexual Safety Charter and committed to the 10 pledges associated with that.
- Engagement continues across the system, with attendance at local authority Health and Oversight Scrutiny Panels to update elected members on the Trust's CQC action plan. PS had also welcomed the NHSE CEO and Regional Director to the Linden Centre to see progress and development of the team alongside patient involvement in the service, following which positive feedback was received.

Questions & Discussion

EL commented there had been a promise from the government to provide significant funding to the NHS in digital development. EL asked if there was a view on what can be secured in terms of the unified EPR. PS advised the Trust focus for digital development was around EPR which had existing national funding allocated and the investment referred to by EL was expected to be for prospective bids. ZT welcomed any additional national investment over and above had already been committed for EPR programmes. ZT advised work had been undertaken to identify funding for the EPR programme and would continue to review any new sources as the programme progressed.

The Board received and noted the CEO Report.

032/24 QUALITY AND PERFORMANCE SCORECARD

PS presented the Quality and Performance Scorecard as part of the CEO Report, with Executive Directors highlighting the following key areas.

Operations – Alex Green

- There had been improvement in delays in inpatient mental health services and older adults. The data was at the lowest point since July 2022 and the aim was to ensure this improvement continues, with a focus on patients ready for discharge.
- There were 25 Out of Area placements reported at the end of the month, which continued the trajectory of reduction.
- There was a focus on mental health follow up for people discharged and followed up with 72 hours. There had been breaches seen, a validation exercise showed there was a delay in data entry and as such focussed work was being undertaken to ensure this was resolved.
- There was a challenge in second appointment waiting times for speech and language therapy. However, there continues to be an improvement.
- Wheelchair service had seen 100% achievement of people with an urgent need being seen in 5 days.
- Essex STaRS had recovered performance for medical review and physical health review, now achieving 98% and 91% - the highest rate since reporting had commenced.

Nursing and Quality – Ann Sheridan

- CQC action plan compliance was making good progress
- Work was underway around incident reporting, particularly around physical and mental health, working with care units to make sure this was triangulated into wider intelligence.

Finance – Trevor Smith

- At month 11 the Trust had a strong cash balance at £50m.
- The team were working on closure of accounts for this year.
- Financial results were overseen at Finance and Performance Committee.

Questions and Discussions

MJ noted there was a good level of upward trajectories in the data reported, but noted there was still an issue with following-up patients quickly after discharge. MJ asked how many individuals had re-entered the system and if there was any potential harm or determination for individuals not followed-up quickly. AG advised this would require a review of re-admission rates and would review this outside of the meeting with MJ.

PS confirmed that the detail within the Quality and Performance report had been addressed through board standing committees.

The Board of Directors received and noted the report.

1. **Review re-admission rates for patients to determine if there a correlation between follow-up and individuals re-entering the system. (AG)**

033/24 COMMITTEE CHAIR'S REPORT

This report summarised assurance reports from the Board of Directors Standing Committees which were crucial for governance and for the Board to be able to discharge responsibility appropriately.

- **Quality Committee:** RH noted the reduction in risk in two risks, with significant reduction in fixed ligature. With regards to pharmacy resource, there had been successful recruitment and a good stream of pharmacy graduates coming into the service.
- **Finance and Performance:** There were no issues to raise or escalate.
- **People, Equality and Culture (PECC) Committee:** DL noted that the Committee continued to focus and recognise the hard work around staffing issues in the Trust to reduce temporary staff usage. This was overseen in conjunction with the Finance and Performance Committee and was a big priority for the Trust.
- **Charitable Funds Committee:** MJ thanked to team who were working hard on building a new strategy of bolstering charitable funds and shared learning with colleagues in the region.
- **Audit Committee:** EL reported there had been a strong start with external auditors and confidence in the progress according to the time line. The Committee had discussed and provided support for the internal auditors to deliver the 2023/24 annual plan by the end of June 2024 following concerns being discussed. TS advised he had met with the internal auditors regarding how to work collectively to improve the time of audits. There was a clear programme and timeline, with TS and team working with them to make sure this was delivered. The Board were asked to approve the revised Audit Committee Terms of Reference.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**
2. **Approved the Terms of Reference for the Audit Committee.**

034/24 CQC COMPLIANCE UPDATE

AS presented the report which outlined updates on CQC registration requirements and other activity since the last Board of Directors meeting. AS highlighted the following areas:

- A request for provider information for the care home sector had been received and completed satisfactorily using the usual process of executive sign off.
- There was an overarching plan with scrutiny at weekly meetings for the CQC Action Plan with designated CQC leads. There were currently 51 must do / should do actions completed (74%), with a further 9 agreed for closure which would take completion of the plan to over 80%. 16 actions had gone past time scale, however AS assured Board members that work was focused on these actions, although taking longer than first through. There was good traction and fortnightly executive oversight.
- An evidence assurance group with partners and ICB colleagues, chaired by the ICB nursing director was also in place. This was a positive meeting with positive feedback to support trajectory.
- A recent unannounced CQC visit to the forensic secure unit took place in line with the Trust's work around sexual safety. This two day visit received positive feedback regarding senior managers. The full report following the visit is awaited.
- Five MHA assessments were received since the last Board meeting; this was part of the annual CQC inspection regime. Some issues that had been raised were around blanket restrictions and use of advocacy services, and were being followed-up.
- Work was underway on the CQC compliance annual plan, working to meet the single assessment framework. Lots of work had taken place internally to meet the quality standards and how we use our quality assurance framework.
- The CQC were interested to hear feedback as they progress with their new single assessment approach and so there were opportunities to feedback from the Trust's perspective.

Questions & Discussion

SS noted the significant activity outlined in the report. It was important to note that the Trust continue to make steady progress against the improvement plan and were evidencing through the evidence assurance process with ICB colleagues. The Board noted slippage for 16 items, acknowledged the rationale to work through thoroughly and were clear that there was executive oversight.

The Board of Directors:

1. **Noted the content of the report.**
2. **Noted the progress update on the Improvement Plan.**
3. **Did not request any further information.**

035/24 EQUALITY DIVERSITY AND INCLUSION

MR presented the Equality, Diversity and Inclusion reports highlighting changes from the previous year. Overall the Trust had improved its rating on equality delivery system, achieving a grade of 'achieving' from stakeholders on the evidence published for this year. This was an improvement from the previous year grading of 'developing'.

The most recent general workforce report showed improvements in declaration rates for many protected groups, as well as a decrease in members of marginalised groups leaving the organisation and in increase in BME staff joining the Trust in comparison to the previous year.

The most recent Pay Gap report showed that men on average were being paid 7.31% higher than women. EPUT were performing well in comparison with neighbouring providers and was a top performing NHS provider in the MSE Integrated Care System when it comes to pay gap reporting.

A recent Board Seminar session took place to discuss and agree priorities to progress EDI, including:

- Sponsorship of staff networks from Executive Directors.
- Introduced EDI metrics to the Accountability Framework, this would be submitted to the Executive Team for approval.
- Review content of leadership development and management development.
- Introduce a line management module on the RISE programme.
- Draft EDI objectives for each Executive Director and joint EDI objectives for the NEDs.
- Update on actions and progress to come through PECC and Board.

Questions & Discussion

PS commented that it was good to celebrate where there were improvements, recognising there were clearly areas where continued focus was required. There was some difficult reading on some of those areas, with Board support to drive to make improvements and impact with plans in place. Acknowledging the complexity, PS queried whether there was a view on how quickly there could be an impact and what the Board could expect going forward. MR advised work was taking place to identify themes earlier in the process, rather than awaiting annual reports, which will provide live responses providing a greater understanding of the impact.

ZT agreed that it was right to acknowledge progress in terms of the strength of the report and plan. This was a much stronger plan than that of a year ago and demonstrated good improvements. ZT picked up that the table showed that in 2021 the percentage of staff leaving due to equal opportunities for career progression was 20% between white and BAME; this had reduced to 10%. This progress was meaningful and needed to be acknowledged.

The Board had discussed and been challenged at a Board Seminar Session regarding the approach to EDI and had allowed a reflection to drive more focused work in this area.

RJ noted the data was a high level Trust overview and asked whether there was underlying data which could identify areas making better progress, to allow for learning to be shared. RJ also asked if there was any learning from other organisations which could be utilised. MR advised there was further data available and could be used to identify further learning. MR advised there were exploratory conversations with partner organisations taking place, thinking about how we could collaborate and share learning.

EL agreed that there were a lot of things to celebrate and thanked the team for their hard work. EL suggested reviewing exit interview data to determine how often bullying and harassment or racial discrimination was mentioned during exit interviews for colleagues leaving the Trust.

MR advised following discussions at the Board Seminar, all Board members would have EDI objectives. Discussions had been held with NHS England around the different approach to Executive / NED roles. It was agreed that Executive Directors would have individual EDI objectives and NEDs having joint EDI objectives.

Equality Diversity and Inclusion Report
The Board of Directors:

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

Public Sector Equality Duty (PSED)
The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the publication of the PSED Report for 2022 – 2023.**

Signed: …… Date: ……

Gender Pay Gap Report
The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the publication of our Gender Pay Gap Report for 2024.**

Equality Delivery System
The Board of Directors:

1. **Received the Equality Delivery System Template for 2023-224. Noting that this paper had already been approved by the Chair through delegated authority as part of the Mid and South Essex Integrated Care System overall Equality System submission and was published on 29 February.**

036/24 STAFF SURVEY RESULTS

MR presented the staff survey results advising that there were some missing tables within the results. This was due to an issue with the survey provider and was a national issue that was being followed through. A small increase in the response rate had been seen, with a number of areas with positive progress compared to last year. Five of the people promise elements and themes were significantly higher compared to last year, and there was positive progress on responses to questions around line management, appraisal, autonomy and control. There had also been a notable improvement around morale.

In terms of areas for improvement, race discrimination from service users and patients as well as colleagues and management was below benchmark, as was people recommending services for relatives and friends. In terms of raising concerns, there had been no real shift, this remains and issue nationally that people feel unable to raise concerns and so work around Freedom to Speak-Up remains relevant.

MR advised work took place around communications, including focus on communications from the senior leadership team to try to improve response rates. Communications had also included staff stories and emphasising that the survey had an impact on changes and improvements made - a big increase in uptake of survey responses had been seen following that.

Questions & Discussion

EL noted that when looking at breakdowns for divisions, it appeared that the medical directorate had the lowest average across the organisation in all domains, and queried whether there were any risks or negative trends related to this. MR agreed that there were notable results for the medical directorate as well as a small number of corporate areas where performance was below the benchmark. An immediate reflection around engagement. MK added that there was a very strong medical staff committee who felt united. Recent consultant panels had also seen motivated new consultants joining the organisation which is important to invigorate the medical workforce.

GB was pleased to see improvements listed and the level of engagement, querying how this would be measured to see improvement going forward. MR advised the Pulse survey was a useful resource, however it was acknowledged that there was not currently a 24/7 live engagement survey programme. The Pulse survey was useful but was a point in time, and the benefits of a live system could not be underestimated.

There were some questions that were also asked as part of other feedback surveys, for example, MK noted that the question around recommending services to family and friends was asked as part of the Friends and Family Test and IWGC, it may be helpful to compare against patient feedback to see if there were any discrepancies or common themes.

Reflecting on speaking up and the data showing this was an area to focus on, RJ stated this often related to mechanisms and ease that a person could speak up, and questioned whether there was any further work that could be undertaken to help staff to understand mechanisms available to speak up. MR agreed, referring to the substantial piece of work with the F2SU guardian taking place and a full campaign in the autumn. Identifying those different routes was important. The F2SU principal guardian had found issues that overlap into other areas i.e. HR or safeguarding. Work is ongoing to triangulate and pull out to ensure they follow the most appropriate route.

DL welcomed the report which showed significant improvement and work still to be done. It was disappointing that one area that had increased was discrimination experienced by staff and there needed to be a focus on improving in this area.

The Board of Directors:

1. **Noted the contents of the report.**

037/24	**SUMMARY OF THE RAPID REVIEW INTO DATA ON MENTAL HEALTH INPATIENT SETTINGS**

GB presented the report, reminding colleagues that this had previously been presented in July 2023 following a review commissioned in response to concerns that the right data was not available and a key driver around appropriate use of data at national and system level. There were 13 recommendations set out for mental health. GB noted a number were at national level for NHSE and ICB. Good progress on recommendations was seen at provider level, with some slippage noted at national level. EPUT were working with ICB colleagues to take forward recommendations.

GB sought delegated authority to the People, Equality & Culture Committee to take forward oversight of the action plan implementation.

Questions & Discussion

PS commented the review and action plan aligned with work already taking place across the Trust. The Executive Team were also reviewing other recently published reports, such as Greater Manchester, that would provide additional learning.

The Board of Directors:

1. **Considered and noted the Rapid Review into Data on Mental Health Inpatient Settings.**
2. **Approved delegated oversight of the ongoing implementation of national progress and Trust actions to the People, Equality and Culture Committee (PECC).**

038/24	**BOARD ASSURANCE FRAMEWORK**

DG presented the Board Assurance Framework, which was the last for 2023/24 as the risks were re-aligned for the new financial year.

DG highlighted the following:

- SR1 safety of services. The Safety First Safety Always three year strategy comes to an end, with a new Quality of Care Strategy launched in April 2024.

- SR2 transition to new people and education strategy. To assess the new People and Education Strategy and its implementation plan.
- CRR81 Fixed Ligature – reduction in score. The likelihood of high impact had reduced, with interventions taken both environmental and therapeutic this had brought down that risk significantly and reduction of harm.
- SR5 Lampard Inquiry. All actions were near completion, however any further review was delayed pending the publication of the Lampard Inquiry Terms of Reference.

DG confirmed that a demo version of the new electronic Risk Register in the Datix system was currently being trialled with an ambition for this to be fully implemented by the June Board of Directors meeting.

Questions and Discussion

AG advised the Ligature Risk Reduction group had focussed on reduction of environmental factors and had seen a shift to other forms of self-harm. The new risk would be scoping the clinical management of ligature risks and risks associated with that, alongside a slight change of focus for the Ligature Risk Reduction Group. SS commented this was a national issue, with all learning together nationally to draw through and feed in locally.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the reduction in risk scores for CRR81 Ligature.**
3. **Did not request any further information or action.**

039/24 SOCIAL IMPACT CHARTER

GB presented the Social Impact Charter which had been developed following the approval of EPUT's Social Impact Strategy by the Board of Directors in 2023. The charter sets out EPUTs commitments to delivering positive social impact through its actions as an employer, a purchaser, a land owner and civic partner. The commitments had been structured to align as far as possible with the Anchor Charters that had been signed off or were in development through Integrated Care Partnerships.

Questions and Discussion

PS welcome this charter, explaining that the relationship between social health of the people served and the health needs of the population was an area that had been explored before as a Board. There were possibilities with engaging differently with community services and the voluntary sector, and building relationships. It was important to get feedback on how we are progressing and to measure and showcase what had been achieved.

MK added that this went beyond EPUT being a mental health and community care provider, stating that every member of the clinical and corporate team could play a role and it was about how it was cascaded to help people understand their role.

AG commented the charter linked with the service user story earlier in the meeting, particular in the Trust role as purchasers.

SS welcomed the report and the proposal to approve the Social Impact Charter.

The Board of Directors:

1. **Considered and approved the Social Impact Charter.**

040/24 USE OF CORPORATE SEAL

The Board of Directors noted that the Corporate Seal had been used on the following occasions:

- 24 October 2023 Lease Agreement RCS Lettings LTD, Tylers House, Southend.
- 24 October 2023 Lease Renewal 3 years Oakley Court, Luton.
- 05 March 2024 Appointment of Fire Safety Engineer for Forensic and Low Secure Services at Runwell Hospital / Brockfield House.

The Board of Directors:

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

041/24 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

042/24 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.

043/24 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SS reflected that Equality and Inclusion had been an important theme of discussions held today. MJ agreed that it had been a golden thread throughout the Board discussions. What was important was trust, respect and common values; that comes through from a united board and we should capitalise that, not just in objectives for assurance but how we take away as personal social objectives to embed in the organisation.

MJ continued that discussion had been honest, with Board members able to challenge. For example, reflecting on discussions around the staff survey, it was acknowledged that there had been some amazing work, but there were areas where we can go back and challenge to see what further work was needed. As a benchmark, during conversations we must think about region but look further nationally and beyond to look at what makes us a leader during this time of intense scrutiny.

Case studies within the presented papers reflect that individual experience was very different, so to bring equality and equity, we need to look at behaviours and strategies. “You said we did” was reactive, what can we do as a preventative organisation that takes us away from reactiveness to true clinical pathway. Thinking of some things that may be difficult to measure, social values would only be fed back when people continuously engage and involve with us, that is what we measure. Equality is about how we behave around people, there were some real examples of improvement but we must think about what we need to do to improve further.

044/24 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

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

Signed: …… Date: ……

In the Chair

045/24 ANY OTHER BUSINESS

There was no other business.

046/24 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.

047/24 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 05 June 2024.

The meeting closed at 12:12

Signed: …… Date: ……

In the Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 046/24)

Governor / Member of the Public	Query	Response
Dr Ray Lashley, Member of the Public	Dr Lashley advised that they were autistic and victim of abuse by the Trust. They had listened closely to discussions held today, noting connections with their own experience and welcoming positive progress. Dr Lashley queried why the Trust did not have a procedure to investigate and deal with complaints of abuse of patients by the Trust and its staff. This was dealt with by the complaints department under a complaints process that should be resolved within six months, but in their personal experience this had been longer. Dr Lashley did not see anywhere online or from speaking to staff in the Trust, where was the policy on dealing with complaints of abuse that have ongoing harm on patients. Dr Lashley had seen an interesting piece on p95 of the board pack regarding matters relating to EDI would be thoroughly and independently investigated, however this was not their personal experience. There was a potential gap allowing abuse of patients by staff and causing reactions and breakdowns. Why does the Trust not have such a policy to deal with those situations?	The Trust wants to ensure people receive are with dignity and respect. There are multiple policies in place, including safeguarding, with the expectation that anyone experience abuse has a quick response and quick action taken. The Executive Chief Nurse offered to meet with Dr Lashley outside of the meeting to discuss their specific experiences and concerns.
John Jones, Lead Governor	JJ referred to P44 of the Board pack around efficiencies. This showed a shortfall of £3.3m against planned efficiency saving of £6.6. The required policy is that shortfall is carried forward – JJ queried how much if any of that shortfall was caused by carry forward from previous year.	The shortfall was driven by two aspects, expectations of lower levels of demand on serves (in particular out of area placements) and the expectations in reduction in temporary staff and the impact of international recruitment. This remains part of plans to resolve going forward and there was a minimal carry-forward from the previous year.

Signed: …… Date: ……

In the Chair

4. ACTION LOG AND MATTERS ARISING

Information Item | SS | 1

REFERENCES

Only PDFs are attached

BoD Part 1 Action Log June 2024 draft.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 27 March 2024

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG				

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

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 032/24	Review re-admission rates for patients to determine if there a correlation between follow-up and individuals re-entering the system.	AG	June 2024	A review of readmissions did not identify this was an issue. In terms of follow ups, these are validated each month to ascertain the reason for any breaches	Closed	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | SS | 5

REFERENCES

Only PDFs are attached

Chairs Report June 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Chairs Report (including Governance Update)**					
Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & 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		
	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*	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 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

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
Chairs Report (Including Governance Update)

Non-Executive Lead:
Professor Sheila Salmon, Chair

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Reflection on Recent Changes to the Board of Directors

The past year has seen significant changes to the non-executive directors, with two longstanding NEDs leaving the Trust after serving full terms in office. A third NED suffered a long period of unexpected absence through the year due to acute ill health and resigned in March 2024. With the support of governors, the Trust was able to recruit four high quality individuals at specific points during the year to enable transition to happen as seamlessly as possible. Alongside significant change within the Executive Team with the appointment of a new Executive Chief People Officer and Executive Nurse, a refreshed Unitary Board is now in place and continuing to function strongly and dynamically. I believe that the appointments made are strong and bring a wealth of knowledge, experience and approach that will complement the existing Board members to lead the organisation successfully into the future.

2.2 General Election Considerations from NHS Providers

NHS providers have published a briefing which sets out considerations for NHS foundation trusts and trusts in the period of time leading up to the 2024 general election on 04 July. It highlights practical implications around providers' activities and communications during the pre-election period. It also covers requirements on central and local government, the civil service and arm's length bodies during the pre-election period. This is to maintain political impartiality in carrying out public duties and ensuring public resources are not used for the purposes of political parties or campaign groups.

2.3 Governor Elections

Governor elections will take place in June 2024, with vacancies for two staff governors, one clinical and one non-clinical, as well as vacancies for public governors in north east Essex and Suffolk, and west Essex and Hertfordshire. Workshops were held during April for any members wishing to find out more about the role with nominations to become an EPUT Governor open from 17 April to the 17 May 2024. Further information will now be provided to members on how to vote.

2.4 Education and Research:

The Trust will launch its first Learner's Council in June 2024 which will be chaired by Dr Ruth Jackson, Associate Non-Executive Director. This is an exciting step to expand the opportunities to hear the student voice in our journey of excellence in education.

The Research Strategy Group chaired by Dr Milind Karale, Chief Medical Officer is a key part of the Trust's aspiration to encourage research within the Nursing, Psychology, Allied Health Professional (AHP) and our administration workforce. On the 21 May 2024, a Forum for all those Trust staff undertaking a Master's Degree programme was held, chaired by Rebecca Pulford (DON/CNIO) to support the research aspect of their programme and link these to our Trust strategies.

The Trust is part of the exciting International Fundamentals of Care which aims to transform care globally by valuing and prioritising person-centred care. We are one of the first providers of mental health the UK to join the Learning Collaborative, allowing us to access good practice globally. Divisional Director, Lizzy Wells and Rebecca Pulford, Director of Nursing are leading this work and aims for all staff to apply its principles by embedding person centred care in their practice, and this work supports the recently published Culture of Care Standards for Mental Health and also compliments other Trust initiatives, such as the Time to Care and Patient Safety Improvement projects.

2.5 International Nurses Day

We held a live event on 13 May 2024 to celebrate International Nurses Day (12 May) for all our nurses and to hear their inspiring nursing journeys and experiences. We also announced the 6 Trust-wide nurse winners who were nominated by their colleagues as our 'Nurses of the Year'. We took this opportunity to thank all our nurses who work tirelessly with other members of the team. Our Director of Nursing will be visiting all those nominated in the clinical areas over the next month to personalising thank them and present them with their award.

2.6 Allied Health Professional (AHP) International Recruitment Programme

The Trust has successfully recruited 24 AHPs; 21 Occupational Therapists and 3 Podiatrists, of which all 21 Occupational Therapists and 1 Podiatrist have since arrived and are working in various teams and services in mental health and community health services. We are awaiting the arrival of the remaining 2 Podiatrists in June. Overseas trained AHPs were recruited from India, Nigeria, Ghana, South Africa and Qatar.

The Trust held its first ever AHP International Recruitment Conference on 21 May 2024. The conference was well attended and had representation from NHSE, Regional NHSE and Mid and South Essex ICB, with focus discussions on exploring valuable support to enable AHPs to stay and thrive at EPUT, lived experiences, development opportunities, leadership, cultural awareness, equality, diversity and inclusion, AHP Anti-racism Strategy and the NHS Workforce Long Term Plan. Both Alex Green, Chief Operating Officer and Ann Sheridan, Executive Nurse opened the conference and shared their journeys and talked about the values, skills and the expertise that AHPs bring to patient care, and in supporting multidisciplinary teams to improve health outcomes of patients and their families. Lessons and feedback from the workshop sessions are being collated to be shared as part of improvement plans to support AHP recruitment and retention going forward.

3.0 LEGAL AND POLICY UPDATE

3.1 National Partnership Agreement: Right Care, Right Person (RCRP)

The Policy is a country wide policy which sets out what is needed to ensure that people experiencing a mental health crisis receive an appropriate, health based response. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. The threshold for a police response to a mental health incident is:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subjected to or at risk of serious harm

For Information: National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)

3.2 DHSC sets out plans for NHS Constitution update

The government has proposed a raft of changes to the NHS Constitution for England in an update that ministers have said 'is about putting patients first.' The NHS Constitution was last updated in 2015. The government has launched a consultation as the first stage of a review of the Constitution, which will run for eight weeks. **For Information:** NHS Constitution: 10 year review - GOV.UK (www.gov.uk)

3.3 New rules for holiday pay

Every independent healthcare provider who has employees or workers must be aware of the change to how holiday pay is calculated. New regulations relating to holiday pay, and setting out changes to the Working Time Regulations, came into force on 1 January 2024. They contain some significant changes and aim to simplify or consolidate some of the processes for certain categories of workers. The Government has chosen to maintain many of the EU rules on holiday already in force, with a few changes and additions. It is important that all employers are aware of the changes so that they can identify whether any of their employees or workers are likely to be affected. **For Information:** New rules for holiday pay - Hempsons - Hempsons

3.4 The Procurement Act 2023 – "Go-Live" date announced

On 22 April 2024 Cabinet Office announced an intended "go-live" of Monday 28 October 2024 for the new Procurement Act 2023. What does this mean for procurement practitioners and suppliers? The Procurement Act 2023 received Royal Assent on 26 October 2023 but is not yet "in force" "Working towards" a "go-live" of 28 October 2024 (this will be formalised in Commencement Regulations - which we understand will be passed in May) Secondary legislation containing extensive detail about transparency (the Central Digital Platform and the content of notices) has already been laid before Parliament and are expected any day now (to be the Procurement Regulations 2024) Technical Guidance being published from March through to June. **For Information:** The Procurement Act 2023 - "Go-live" date announced | Bevan Brittan LLP

3.5 Culture of care standards for mental health inpatient services

The following co-produced guidance sets out the culture of care everyone, including people who use services, families, carers and staff, want to experience in mental health inpatient settings, and supports providers to realise this. The standards apply to all NHS-funded mental health inpatient service types, including those for people with a learning disability and autistic people, as well as specialised mental health inpatient services such as mother and baby units, secure services, and children and young people's mental health inpatient services. **For information:** NHS England » Culture of care standards for mental health inpatient services

3.6 Psychological therapies for severe mental health problems – implementation guidance 2024

This guidance is for NHS commissioned mental health provider organisation, integrated care boards (ICBs), regional NHS England offices and chief psychological professions officers in mental health trust. It aims to support mental health providers to deliver the NHS long term plan objective to increase access to psychological therapies for people with severe mental health problems, as part of a wider transformation of adult and older adult community mental health services. **For Information:** NHS England » Developing a local strategy for psychological therapies for severe mental health problems – implementation guidance 2024

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 5

REFERENCES

Only PDFs are attached

CEO Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Chief Executive Officer (CEO) Report**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & 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		✓
	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*	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 a summary of key activities and information to be shared with the Board.	**Approval**	
	Discussion	
	Information	✓

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

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

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

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

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

Acronyms/Terms Used in the Report			

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

Non-Executive Lead:
Paul Scott, **Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Changes to Executive Team

I am pleased to report that Andrew McMenemy has now joined EPUT as Executive Director of People and Culture. Andrew brings a wealth of experience to EPUT with a health care career spanning over 28 years. He has worked in an Executive role on four trust boards and joins us from West Essex Hertfordshire teaching Hospitals NHS Trust where he held the role of Chief People Officer.

Andrew is passionate about inclusion, wellbeing and staff development so I know he will be keen to meet with as many colleagues as possible in the coming months. We are delighted to have Andrew with us and I am sure you will all join me in welcoming him.

I would like to take this opportunity to thank Marcus Riddell for his support and leadership of People and Culture over the last few months. Sadly, Marcus will be leaving us in June to take on the role of Chief People Officer at Hertfordshire NHS Trust. The rest of the Executive team and I wish Marcus every success for the future in his new role.

1.2 Engagement with Local MPs

As part of our continued commitment to engage proactively with local Members of Parliament with constituencies serviced by EPUT services, we continue to provide regular updates on Trust news and hold regular briefings either face to face or online. Members of the Executive Team recently attended a joint MP briefing with system partners from the Mid and South Essex ICB and MSEFT which was well attended and well received. . With the announcement of a general election and the dissolution of parliament we will of course be following the Cabinet Office guidance during the pre-election period.

1.3 Positive Practice in Mental Health Awards

Colleagues from the Trust were recognised for their outstanding work at the recent Positive Practice in Mental Health Awards. The Personality Disorder and Complex Needs Service User Network (SUN) were named winner of the Complex Mental Health Needs Award for their work in supporting people with personality disorders and complex needs, and their families and carers. Our Lived Experience Ambassador, Martine Jeremiah and Colleagues from the Urgent Care and Inpatients Care Unit were highlight commended on their work to update our therapeutic engagement and supportive observations policy for all inpatient wards across the Trust. We have a huge amount to be proud of within the Trust and it is fantastic for colleagues to be recognised for their hard work and dedication to providing effective services for our service users.

1.4 Lampard Inquiry

The Terms of Reference for the Lampard Inquiry were confirmed by the Secretary of State for Health and Social Care on 10 April. Investigations have been extended to the end of 2023 and the internal Inquiry Team have taken time to go through the Terms of Reference to understand the implications for the Trust and our partners. Dedicated intranet pages are in place to ensure information and support continues to be available for our staff.

To ensure managers across EPUT are equipped with the most accurate information about the Inquiry to effectively support their staff, management development programme sessions have been scheduled. These sessions will cover the Terms of Reference and Scope of the Inquiry, how EPUT is affected by the Inquiry and the role of staff members throughout. They will also include the expectations of staff in the completion of witness statements, attending public hearings, and what support is available to staff who are affected by the Inquiry.

I recently met with the Chair of the Inquiry, Baroness Lampard, where I emphasised our commitment to do all we can to support the Inquiry to deliver on its terms of reference. As a Trust

we welcome the progress of the Inquiry and will be doing all we can to support the Lampard Inquiry Team so that they can deliver the answers that patients, families and carers deserve.

1.5 NHS Mid and South Essex ICB Chief Executive Appointment

I was pleased to be part of the recent interview panel to appoint a new Chief Executive for NHS Mid and South Essex ICB. Tom Abell was the successful candidate following a competitive recruitment process. Tom has a wealth of leadership experience across the local health and care system, most recently as Chief Executive of the East of England Ambulance Service Trust. Tom has held senior leadership roles within the MSE system previously, and will be warmly welcomed back to the MSE health and care system.

2. UPDATES

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

- Significant number of long stay (60day+ patients were discharged across adult and older adult and PICU).
- Demand for admissions remains pressured, reflected in our occupancy rates. Mental health adult occupancy rose to 97.4% from 95.7% (target <93); older adult occupancy remained consistent with previous months at 90% (target <86); PICU occupancy remains within the 88% target at 54% whilst working with reduced bed numbers.
- Out of area (OoA) placement numbers increased in April and at month end there were 30 patients in an OOA bed. 21 patients were successfully transferred back to EPUT wards.
- Following successful recruitment, the wait from first to second appointment within the Children's Speech & Language service improved for the first time since 2023. Performance increased to 61% of patients waiting no longer than 4 months for a second appointment.
- Inpatient follow ups continue to improve and in April. 94.2% of 7 day post discharge follow ups were carried out within timescale (95% target), improving for the second month in a row and the highest since July 2023. Performance against 72hr follow ups remains above target at 86% (80% target), the highest since June 2023
- NHS Talking Therapy (IAPT) services meeting targets and key performance indicators in 2 of our 3 areas of provision, with NE Essex access rates falling short of the target, despite an improved position.

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

The Trust has submitted its 24/25 operating plan with a £11.1m revenue deficit plan. The plan has been agreed by NHSE and is underpinned by an annual efficiency programme of £28.6m (5.2%). The plan includes a £25m capital investment programme.

M1 revenue results are £0.5m behind plan although improvements in temporary staffing expenditure are being made. Financial controls and monitoring remain in place to support the delivery of the plan.

The Trust has submitted its 23/24 annual accounts in accordance with National deadlines. The audit of the accounts is underway with final accounts submissions required by 28 June.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

<u>Patient Safety Incident Response</u>

A number of improvement actions have been identified to strengthen the process for reviewing patient safety incidents in the Trust at a care unit level. This work will ensure that there are clear processes, systems and the development of an infrastructure in place to support the local triumvirate leadership. Work has commenced to align some of the corporate staff from the Patient Safety Incident Management, Inquest and Safeguarding teams into the care units to strengthen clinical governance in the operational delivery of services. This will ensure that subject matter experts work with care units to drive improvement and oversight of Patient Safety Incidents leading to timely reviews, development of robust safety action planning, and shared learning.

The new model is being co-produced with the Care Unit Leadership who are reporting that this is a welcomed approach and much needed support. The effectiveness of this new way of working will be tested and further updates provided in due course.

Launch of the Quality of Care

To support the continued focus on improving care and services, the Trust has recently launched a Trust-wide approach to delivering Quality of Care which was enabled by our co-produced Quality of Care Strategy. The focus will create a foundation of safety, effectiveness and experience for delivering consistent and reliable care. We have adopted new guideline principles, a quality governance framework and quality tools to empower and enable delivery of great care by bringing people together; the people we care for, their loved ones and supporters with our staff.

As part of this holistic approach to care, we also launched our new Quality Senate, with the inaugural meeting held on 07 May which reviewed evidence presented by clinical experts, people with lived experience, and the review of available published evidence - the first topic was Trauma Informed Care. The Quality Senate brings together a panel of professional and service leads and people with lived and learnt experience, and provides recommendations to the Trust through our Executive Sponsor for Effectiveness of Care, to ensure our care is evidence based and using best practice guidance.

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

Workforce Planning

Earlier this month we submitted our Trust-wide workforce plan to NHSE, which was developed alongside finance and operational care unit colleagues. At the centre of the workforce modelling is the Trust's commitment to continue our track record on quality improvement, recruiting more substantive staffing into the Trust and reducing agency spending - including off-framework agency use by the end of June 2024. We will be monitoring the delivery of the workforce plan throughout the year through in our relevant governance meetings.

Education & Learning

The Trust has been working closely with our Higher Education Institute partners including the University of Essex (UoE) and Anglia Ruskin University (ARU) to further strengthen our partnership arrangements and create safe and effective clinical learning environments. To give our students more of a voice in matters of safety, quality and learning, we have our first 'Learners Council' commencing on 17th June. EPUT colleagues across education and quality are collaborating with ICB and NHSE colleagues on how best to develop this Council and ensure that it is inclusive and drives positive experiences for all our learners.

Temporary staffing

In April the Trust is reporting a continued downward trend for bank and agency use, although WTE use is tracking above the planned trajectory for bank. NHS agency rule breaches have continued to decline in April. Current targeted actions are in delivery to end all off framework use by 1st July 2024. Good process has been made in May and the Trust will start to report a significant reduction in off framework use from the 20th May onwards with actions in delivery to have zero use by 1st July 2024 in line with the NHS planning guidance. The Direct Engagement Model for admin and clerical agency placements has been implemented in April and released a £6.3k saving for April.

Recruitment & Retention

The Trust has a current vacancy rate of 9.5% against our target of 12%. Further consideration by staff group shows a vacancy rate for nursing at 15.9%, HCS at 17% and AHPs at 11.2%. Going forward we will be looking more closely at our time to hire which has seen improvements. However there continue to be areas of further improvement that will support better outcomes for substantive recruitment that can assist with reductions in agency and bank use. The other area of priority will be supporting better levels of retention by focusing on career opportunities, learning and education and staff wellbeing.

Consultant Contract (2023)

A agreed new pay deal effective from **1 March 2024**, the new deal will modernise the consultant pay structure by reducing the number of pay points and the time it takes to reach the top. The shortened pay scale will improve inequalities by helping to reduce the gender pay gap in medicine. The deal also reflects modern ways of working by offering enhanced shared parental leave, in line with other NHS staff. The pay increase is to be paid in May salaries backdated to 1 March 2024.

In addition, the government will enact changes to the operation of the Review Body on Doctors' and Dentists' Remuneration (DDRB) to provide greater confidence in its operation.

The deal builds on a headline pay uplift of 6 per cent for 2023/24 which was settled through the pay review body process. Headline pay for 2024/25 will be determined through the DDRB process as usual, with government expected to announce details before the end of July 2024.

Specialty and specialist (SAS Offer)

After further negotiations between government and the British Medical Association (BMA), a revised and final offer has been made. BMA members will vote on this between 31 May to 14 June. Strike action will continue to be paused during this time. The offer has been designed to address the imbalance between old and new contracts, speed up the delivery of some of the key objectives of the 2021 deal and encourage more existing SAS doctors to take up the new contracts. If accepted, this deal will prevent industrial action by BMA SAS members.

Junior Doctors

On 15 May 2024 the British Medical Association (BMA) junior doctor committee and government announced that they have entered a new intensive phase of talks and have mutually agreed to explore mediation, facilitated by an external mediator. Further information will be released by NHS Employers as and when it becomes available.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item | PS | 15

REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 05.06.2024 (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

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			✓
	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 & Data Strategy			
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.

Mental Health Inpatient Capacity -
In April a significant number of long stay patients (60+ days) were discharged, and whilst this is a positive example of flow, it does cause average length of stay performance to fluctuate.

In April the average length of stay for adult patients rose to 83 days, against a target of <35. When monitoring this performance with assessment units included; we see an average length of stay positon of 58 days. There were 135 discharges, 32 of whom were long stays.
Older adult average length of stay also rose in the month to 134 days, against a target of <74. There were 21 discharges, 13 of whom were long stays.
In contrast, PICU average length of stay reduced back to target at 39 days (target <50).

Adult and Older Adult bed occupancy rates continue to be higher than their respective targets, whilst PICU occupancy is comfortably within target. In April, adult occupancy rose to 97.4% from 95.7% (target <93%), and this marks the highest rate since October 2023.
Older adult occupancy remained consistent with previous months at 90% (target <86). PICU occupancy remains within the 88% target at 54% whilst working with reduced bed numbers.

Rates of patients who are clinically ready for discharge remains within targets across all ward types.

Inappropriate Out of Area Placements –
At the end of April there were 30 patients in an out of area bed, which represents an increase from 26 in March. There were 25 patients newly placed in an OOA bed during the month, 19 of whom were to adult beds, 2 to older adult beds, and 4 to PICU beds.
Efforts were made in the month to repatriate and a total of 21 clients were successfully brought back to EPUT wards.

The developing integrated flow team and the introduction of the Clinical Director for Flow role have proven valuable, leading regular Inpatient and Urgent Care Consultant meeting focused on patient flow and alongside the dedicated discharge coordinators, supporting the oversight of the care and treatment pathway and resolution of barriers to discharge with EPUT and for those people placed in inappropriate out of area placements.
The Time to Care staffing model will enable an increase in registered discharge coordinators, lifting the current provision to 1 per site (2 adult wards) and 1 for each assessment unit. In addition, the introduction of registered discharge coordination for Older Adults will support the current provision of unregistered ward discharge coordinators.

The Flow team have worked collaboratively with local Essex out of area providers to develop join working agreements, identifying quality and continuity of care principles. Providing a dedicated discharge coordination lead has supported to ensure EPUT oversight of the care and treatment pathways and timely progression to discharge for the people placed with these providers. Joint quality assurance visits with the ICB quality leads have been completed.

MH Inpatients Follow Ups –
Performance against both the 7 day and 72hr KPIs continues to be validated each month, and updated once any changes to the patient record are made following that validation.

The performance for 7 day follow ups has improved to 94.2% (target 95%) in April, the highest performance since July 2023. This marks a second month of improvement. There were six discharges not followed up within 7 days in April.

In addition, whilst performance against 72 hour follow ups reduced to 86.4% (target 80%), this still remains higher than performance witnessed June 2023 and above target. There were 14 discharges not followed up within 72 hrs, of these; two were out of area, one was discharged to police custody, two could not be contacted (attempts made), four were due to communication errors, and reasons could not be identified for five and are being investigated by the Operational Productivity team.

Care unit leads continue to ensure MDT is involved in discharge planning and delivery, including representation from the different points in the patient care pathway, as per the recommendations outlined in the 'Discharge from mental health care: making it safe and patient-centred', Feb 2024, Parliamentary and Health Service Ombudsman report.

NHS Talking Therapies (IAPT) –
Access rates within North East Essex continue to be the most challenged area, and whilst performance rose to 709 in April, this does not attain the 844 target. The target against this KPI has not been achieved since March 2023.

Castle Point and Rochford, and Southend both continue to achieve their respective targets for access rates. Across other Talking Therapies KPIs; all areas consistently meet 100% for clients beginning treatment both within 6 weeks and 18 weeks. The percentage of clients moving to recovery also maintains consistent target attainment.

Performance continues to be monitored through the Psychological Services Accountability Framework.

Finance –
Efficiency: The month 1 delivery is a £0.7m shortfall against the efficiency programme with £0.9m delivered against the plan of £1.6m. Adverse variances have been partially mitigated by vacancies in Locality, Specialist and Psychology services.

Temporary Staff: The total temporary staffing spend in month 1 was £6.3m (bank £4.1m, agency £1.9m). Vacancy control panels are continuing to operate within Care units and corporate services. Workforce trajectory plans are being assessed for future substantive recruitment and temporary staffing reductions.

Capital: A spend of £1.1m was incurred at the end of M1. The Trust is ahead of plan by £0.6m due to acceleration of planned schemes.

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

Decision Item | Chairs | 10

REFERENCES

Only PDFs are attached

Committee Chairs Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

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

Risk Assessment of Report				
Summary of risks highlighted in this report	N/A			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 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)?	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. • Approve the People & Culture Committee Terms of Reference 2024/25 (Attached - Appendix A). • Approve the Quality Committee Terms of Reference 2024/25 (Attached – Appendix B). • Approve the Quality Committee Priorities 2024/25, as outlined in the report.

Summary of Key Points

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

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

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

- Assurance – any key assurances to be provided to the Board.
- Information – any issues previously identified which have now been resolved, including lessons learned.
- Alert – any issues / hotspots for escalation to the Board.
- Action – any issues where the Standing Committee is requesting action from the Board.

The attached report provides updates in relation to the following Standing Committees:

1. Audit Committee (Elena Lokteva)
2. Finance & Performance Committee (Loy Lobo)
3. People, Equality & Culture Committee (Diane Leacock)
4. Quality Committee (Dr Rufus Helm)

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:			
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	WDES	Workforce Disability Equality Standard

Supporting Reports and/or Appendices

Committee Chairs Report
Appendix A: People & Culture Committee Terms of Reference 2024/25.
Appendix B: Quality Committee Annual Report 2023/24 & Terms of Reference 2024/25
Appendix C: Finance & Performance Committee Annual Report 2023/24 & Terms of Reference 2024/25

Non-Executive Lead:

Chairs of Board of Director Standing Committees.

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Committee Chairs Report

Board of Directors Part 1

5 June 2024

EPUT

INTRODUCTION

Purpose of the report

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

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

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

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

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1. AUDIT COMMITTEE

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

Committee meeting held: 16 May 2024

Assurance

Internal Audit Progress Report & Follow Ups
- The following reports with limited assurance were challenged:
  - Compliance with Policies and Review of Recruitment Processes.
- Based on the TIIA report and discussion at the meeting, the Committee provides the Board with:
  - Partial level of assurance correct pace over the 2023/24 financial year IA plan progress (three reports are at the field work stage). The Committee has been reassured that the 2024/25 financial year will proceed at the .
  - Acceptable level of assurance over Recommendations implementation during the period (there were no P1 recommendations with a revised due date).

External Audit Progress Report
- A verbal update provided assurance that the Trust's external audit activity was progressing well, and there were no concerns for the Committee to note.

Draft Internal Audit Annual Report
- The draft Internal Audit Annual Report was presented to the Committee for information.

Conflict of Interest Report
- The Committee received a report providing assurance that the appropriate systems and processes were in place to manage conflicts of interest within the Trust.

Counter Fraud Annual Report & Functional Standards 2023/24
- The Committee received a report providing assurance that the Counter Fraud Functional Standard Return highlighted an overall Green rating for the Trust.
- There were seven Amber ratings, which are outlined in the Alerts section, below.

Directors' Expenses
- The Committee received a report providing details of Board of Directors expenses paid during the 2023/24 financial year.

Information

Anti Crime Progress Report
- The Committee received an update on Counter Fraud activity.
- An E-Learning module would be rolled out to increase staff understanding of fraud, and what to do if they suspected fraudulent activity.

Waiver of Standing Orders Monthly and Annual Reports
- An update on Standing Orders waived during March 2024 was presented for information.
- Further details are outlined in the Alerts section, below.

Write Offs Annual Report 2023/24
- The Committee received the Write Offs Annual Report 2023/24.
- Write offs for the period April 2023 to March 2024 totalled £16,350.

Losses & Special Payments Annual Report 2023/24
- The Committee received the Losses & Special Payments Annual Report 2023/24.
- The Trust reported loses and special payments of £90,627 during this period.

EPUT Draft Annual Report 2023/24
- Committee members received the draft Annual Report for review.

Salary Overpayments
- The Committee received a report providing analysis of salary overpayments over the last three financial years.

AUDIT COMMITTEE

Assurance (cont'd)

Waiver of Standing Orders Monthly and Annual Reports

- 14 Waivers were submitted during March 2024, with a total value of £1,398,344.
- The number of Waivers submitted during 2023/24 had reduced to 77 with a value of £3,849,878, compared to 127 with a value of £5,577,996 in the previous financial year.
- The Committee ensures waivers are kept under review, applying additional scrutiny to the top beneficiaries for waivers over the financial year.

Alert

Counter Fraud Annual Report & Functional Standards 2023/24

- The Counter Fraud Functional Standard Return highlighted seven Amber ratings where additional evidence was needed to support a green rating. These were in the following categories:
  - Fraud, Bribery & Corruption Risk Assessment
  - Policy & Response Plan
  - Annual Action Plan
  - Reporting Routes for Staff, Contractors and Members of the Public
  - Undertake Detection Activity
  - Access to and Completion of Training
  - Policies and Registers for Gifts and Hospitality and COI
- These would be addressed in the 2024/25 work plan.

Action

There are no Actions for the Board.

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2. FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo, Non-Executive Director

Committee meetings held: 18 April & 23 May 2024

Assurance

Provisional 2023/24 Outturn

- The Committee received an update on the revenue outturn, Lampard Inquiry, capital and cash outturn, and the 24/25 Operating Plan.
- The revenue outturn for 2023/24 reported a deficit of £9.88m as a result of continual operational pressures throughout the year, whilst maintaining a safe and quality service to patients.
- The capital and cash outturn delivered on its projected outturn.
- The Operating Plan was due to be submitted during May 2024.

Quality & Performance

- Children's Speech & Language Therapy wait times have decreased following successful recruitment.
- Average length of stay for mental health inpatient services has reduced, thanks to concerted efforts to discharge patients with extended lengths of stay.
- Out of Area Placements have increased as a result of continued demand, high levels of acuity and the Easter break.
- Mental Health inpatient 7-day follow up performance improved in April 2024. 72-hour follow up performance reduced in this period, but remained above target.
- NHS Talking Therapies performance remains largely positive, however challenges remain within North East Essex.

Month 1 Financial Position

- The Trust's annual plan is an £11.1m deficit. Month 1 was £0.5m adverse to plan. This is largely due to temporary staffing costs and demand for out of area placements.
- The Trust's annual capital plan is £25m.
- The YTD plan is £0.4m with actual spend totalling £1.1m.
- Variances relate to the acceleration of the timing of capital schemes.

Information

No items this month.

FINANCE & PERFORMANCE COMMITTEE

Assurance (cont'd)

Strategic Impact Report

- A high level year end summary of delivery was presented to the Committee. This noted the progress against some of the Trust's headline projects and programmes including the Quality of Care Strategy, Time to Care, the new Operating Model, and the forward view focus which will be adopted by the Transformation Team for efficiency programmes.

Cyber & Information Governance Assurance

- The Committee received a presentation which outlined the Cyber Team's core function, the Trust's compliance with anti-virus software and how governance is assured and controlled.
- The presentation also outlined how the MSE ICS Cyber Steering Group, for which EPUT is the host, is working as a system.
- Members noted that acute colleagues have been working with EPUT to learn from the Trust's robust Cyber processes, and that the Trust's performance in this context continues to be good.

Provider Licence Review

- The Trust is required to review its Provider Licence on an annual basis.
- There were some recommendations for improvements, but these relate to ongoing improvement plans already in motion.
- The review recommended that the Trust is compliant, and Committee members endorsed this recommendation to the Board.

F&P Committee Effectiveness Review

- The Committee achieved an overall score of 85%.
- Key areas of consideration were the setting of objectives, assessing the performance of third party contracts, incorporating meeting reflections, and the Committee's role as an assurance framework.
- Members agreed to revisit the Committee Effectiveness Review mid-year to assess how effectively feedback has been taken forward.

Alert

There are no issues or hotspots for escalation to the Board.

Action

No items this month.

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3. PEOPLE, EQUALITY & CULTURE COMMITTEE

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

Committee meeting held: 29 April 2024

Assurance

Workforce
- Bank, agency and Framework rates have reduced, but work to reduce these further continues.
- The 'time to hire' position has improved, down to 68.3 days from 79.7 in October 2023
- The team is finalising the 2024/25 Workforce Plan.
- Apprenticeships were being built into the strategy to help improve staff retention.

Equality, Diversity & Inclusion Plan
- All five of the Trust's Staff Equality Networks have been allocated an Executive Sponsor, and are receiving support from the Employee Experience and Transformation teams to drive equitable changes within the organisation.
- The team has been working in collaboration with staff and patient stakeholders to co-produce resources and tools for preventing discriminatory behaviour.
- The Trust continues to resource the RISE programme.
- The Trust's WRES, WDES and NHS People Promise scores showed improvements, and demonstrated that EPUT was delivering against key driver metrics as part of the People & Education Strategy.
- The team has been working with Essex Police on methods for preventing and de-escalating violent and aggressive incidents on wards.

Board Assurance Framework
- Committee members received an update on the Board Assurance Framework.
- Risk SR2 People would be split into separate risks, enabling them to be tracked in more detail.

Information

Freedom to Speak Up
- The Trust's Freedom to Speak Up (FTSU) Guardian provided an update on the FTSU service, noting:
  - Year on year, more people were using the service.
  - Detailed information had been added to reports to enable analysis of the themes.
  - A range of initiatives would be implemented to enable more issues to be resolved within business as usual.
- Training rolled out across the Trust had been well attended.
- Additional resources have been allocated for FTSU initiatives in 2024/25.

Time to Care
- The Ward Manager Development Programme is progressing well, and has received positive feedback from participants.
- Good progress has been made with rolling out the staffing model within inpatient and urgent care units.
- A range of short term initiatives is underway, including:
  - Improvements to the SITREP process.
  - Trialling of a Smart Bed Management Programme.
  - Digital System Optimisation and Compliance Assessment.
- A recruitment event held in April attracted a large number of attendees.

Education
- The Committee received a presentation on the Mid & South Essex Virtual Reality Project, noting the team was exploring a variety of opportunities for this tool, including:
  - 2D scenarios of long term conditions such as diabetes.
  - 360º immersive simulations, such as the common symptoms of mental health issues.
  - Restrictive practice.

PEOPLE, EQUALITY & CULTURE COMMITTEE

Assurance (cont'd)

Committee Effectiveness

- Committee members received the results of a self-assessment on committee effectiveness.

Committee Work Plan 2024/25

- Committee members approved a Committee Work Plan for 2024/25, noting that the new Chief People Officer may wish to make slight changes as they come into post.

Alert

There are no issues or hotspots for escalation to the Board

Action

- The Board of Directors is asked to approve the attached People, Equality & Culture Committee Terms of Reference 2024/25.

4. QUALITY COMMITTEE

Chair of the Committee: Dr Rufus Helm, Non-Executive Director

Committee meetings held: 11 April & 9 May 2024

Assurance

Quality Performance Report
- Use of restraints on wards have reduced month on month.
- Reduction in inpatient ligatures is a safety improvement priority area for the Trust. Initiatives include therapeutic engagement safety huddles and staff training.
- Incidents of violence and aggression on wards have decreased. There have been lots of work in this area, including de-escalation training, safety huddles and safety pods.
- Absence Without Leave incidents have increased. A review of observation processes has been carried out, Estates works have been planned, and additional support will be provided to patients prior to commencing planned leave.

Reducing Restrictive Practice
- The Trust's new Framework for Reducing Restrictive Practice was discussed
- The Framework has been developed following consultation with a range of stakeholders, including people with lived experience.
- The aim of the Framework is to *"reduce restrictive practices by 75% by the end of 2025".*
- A range of staff events and training initiatives have been held with the Trust's adult inpatient, specialist, CAMHS and learning difficulty teams. These included the sharing of patient stories and examples of good practice.
- The Committee will receive regular assurance updates on the Framework's progress.

Rawreth Court CQC Update
- An update on actions following CQC activity at Rawreth Court provided assurance to Committee members that the Action Plan was progressing well.

CQC Compliance Update
- Committee members received an update on progress. This is presented to the Board as a full agenda item.

Information

Neurodiversity Services
- An update on improvements made to neurodiversity services at the Lighthouse Child Development Centre was received. The improvements have led to a reduction in waiting times and a decrease in negative feedback received via complaints and PALS.

Tendable – Ward Audit Process
- A new ward audit process has been developed, consisting of four levels of internal audits: Walk-Round; Clear to Care; Ward Manager; and Specialist Audits.
- A pilot is currently underway, and will be rolled out across the Trust later this year.

Safety Improvement Plan
- A thematic review of patient deaths over the past 23 years has been carried out, resulting in the development of a number of Safety Improvement Plans (SIPs).
- Subject leads have been identified to coordinate each SIP, reporting to a SIP Oversight Group which is accountable to the Learning Oversight Sub Committee.
- The Trust has adopted digital patient safety quality improvement software programme LifeQI to manage the recording and governance of QI activity.

Clinical Audit Annual Priority Programme
- The Annual Priority Programme of Clinical Audits for 2024/25 was received.
- This includes the Priority 3 Audits generated from Care Groups; current Tendable audits, and triangulation against safety improvement priorities.

Sexual Safety Gap Analysis & Deep Dive
- A Sexual Safety Framework commits the Trust to seven key sexual safety domains.
- Regional colleagues commented that the sexual safety training programme developed by the team was very unique, and may be of interest to other NHS organisations.

QUALITY COMMITTEE

Assurance (cont'd)

Board Assurance Framework
- Non-Executive Directors have been encouraged to ask staff about the impact of the Safe Wards programme during site visits.
- The Executive Team had implemented a forward plan for CRR11 (Suicide Prevention).
- All items in CRR93 (Continuous Learning) had been completed, and the risk level would be reviewed.
- CRR96 (Loggists) had progressed well, with an increase in new Loggists.
- CRR77 (Medical Devices) will be reviewed following the implementation of a new process.
- A new system for generating reports from Datix will be implemented shortly.
- CRR99 (Safeguarding) had been closed following the implementation of a new team structure.

Infection Prevention & Control
- The Committee received a report providing assurance that the Trust's Infection, Prevention & Control service delivery was in line with national recommendations.
- The Group G Strep incident was stood down in March 2024.
- Resolution of water safety concerns at St Margaret's Hospital continue to be proactively managed whilst a longer term solution is achieved.
- There has been a national increase in Measles cases, which is being monitored.

Annual Reports
- The following annual assurance reports were received:
  - Strategic Impact Report
  - Patient Safety Incidence Response Framework (PSIRF)
  - Patient-Led Assessment of the Care Environment (PLACE)
  - Quality Committee Annual Report

Information (cont'd)

Quality Committee Work Plan 2024/25
- Committee members approved a Committee Work Plan for 2024/25.

Committee Effectiveness Review
- Committee members received the results of a self-assessment on committee effectiveness.

Action

Quality Committee Terms of Reference 2024/25
- The Board of Directors is asked to approve updated Terms of Reference for 2024/25.

Quality Committee Priorities 2024/25
- The Board of Directors is asked to receive the Committee's annual report (inclusive of priorities for 2024/25):
  - To improve our oversight of physical health service provision;
  - To improve our oversight of quality issues arising from sub-contracted services;
  - To receive all internal audit reports pertaining to clinical governance, irrespective of the auditors opinion;
  - To provide active leadership to the new Quality of Care Strategy and the nine priority areas through reporting from the new executive governance (Safety of Care, Experience of Care and Effectiveness of Care Groups);
  - To maintain focus on the delivery of the CQC improvement plan.

Alert

There are no issues or hotspots for escalation to the Board

PEOPLE EQUALITY AND CULTURE COMMITTEE

CHAIRED BY:	Diane Leacock, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Committee Secretary	**FREQUENCY:**	Bi-monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee.
AUTHORITY:	The People Equality and Culture Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's people, equality and culture. In particular, that adequate workforce resourcing governance processes and controls are in place throughout the Trust to: a) identify, prioritise and manage risk arising from our status as an employer; b) ensure effective and efficient use of resources through evidence based people and leadership development and c) protect the health and wellbeing of employees. To ensure the organisation is working within the legal requirements of a foundation trust, and with reference to guiding principles as set out in the NHS People Plan.		
PURPOSE- The duties of the Committee shall include the following:	**Workforce** 1 To recommend to the Board for approval and oversee delivery of the Trust's strategy and plan relating to people and organisational development. 2 To approve the Trust's strategic workforce plan, taking into account local, regional and national policies and /or directions and receive assurance on its implementation. 3 To receive assurance and relevant reports detailing compliance with key national and local workforce indicators including progress against local workforce metrics and the NHS People **Culture** 5 To maintain oversight of the Trust's systems and process by which staff are able to raise concerns and ensure that these are fit for purpose and the outcomes are monitored. 6 Receive the annual staff survey results and ensure appropriate actions are taken to address any issues. **Equality, Diversity and Inclusion** 8 Receive assurance that the Trust is meetings its statutory and regulatory obligations in relation to equality, diversity and inc lusion and delivers improvements as required. 9 Receive annual reports on the Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality Delivery S tan dards and the NHS EDI Improvement Plan 10 Oversee the Trust's programme of work on EDI for both staff and patients **Leadership** 12 Receive assurance on the quality and effectiveness of leadership and management development in the Trust 13 Receive assurance on the approach to talent management and succession planning (for roles other than very senior managers) **Education and Learning** 15 Receive assurance on the implementation of appraisals and mandatory training 16 Receive assurance on the development of career pathways for all roles, linked to learning opportunities and apprenticeships 17 Receive assurance on the provision of high quality professional under and post graduate education **Governance and Risk Management** 19 Review those entries on the Trust's Board Assurance Framework (BAF) and corporate risk registers which are to be overseen by the Committee and identify any new or emerging risk areas which may need to be added to the BAF. 20 Receive and review the findings of relevant Internal and External Audit reports covering workforce, education and training an d s taff engagement and to assure itself that recommendations are appropriately responded to and implemented in a timely and effective way.		

ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair. And includes Associate Non-Executive Director Chief People Officer Executive Chief Finance Officer Executive Chief Operating Officer Executive Chief Nurse	**IN ATTENDANCE:** NED (Chair of Audit Committee) as required Senior Director of Corporate Governance Other Directors / Officers as required
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Date Approved:** TBC	**Date of Last Review:** 2021 **Next Review:** March 2025

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Quality Committee Annual Report 2023/24

Quality Committee

Annual Report 2023/24

1. Background

The purpose of this report is to review the work undertaken by the Quality Committee (a standing committee of the Board of Directors) for the period covering 01 April 2023 to 31 March 2024.

The Committee oversees all aspects of quality performance and provides assurance to the Board of Directors on meeting national standards and quality objectives, informing the Audit Committee of any significant issues.

2. Committee Membership

Dr Rufus Helm, Non-Executive Director, chaired the Committee during the year.

Included within the current membership are two other Non-Executive Directors, the Executive Nurse, Executive Medical Director. The Committee has a number of subject matter leads who attend to provide additional probity for the subject matter. Other member of the executive team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Executive Assistant to the Executive Chief Nurse (until August 2023) and then by the Board Committee Secretary (from September 2023). In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting, they are made available to Board members for information.

Table 1: Attendance at meetings held 2023/24:

		Attended	Total No. Meetings
Dr Rufus Helm	Chair	11	11
Janet Wood (until Sep '23)	Non-Executive Director	5	5
Elena Lockteva (from Sep '23)	Non-Director	6	7

Mateen Jiwani (from Dec ’23)	Non-Executive Director	4	4
Natalie Hammond	Executive Nurse	3	4
Frances Bolger (from Sept ’23 to Feb ’24)	Interim Executive Nurse (from Sept. ’23)	5	6
Ann Sheridan (from Mar ’24)	Executive Nurse (from Mar ’24)	1	1
Zephan Trent (from Jun ’23)	Executive Director Strategy Transformation and Digital	8	9
Denver Greenhalgh (from Jul ’23)	Senior Director of Corporate Governance	8	8

ICB quality lead colleague also attended the meeting in the year, and one of our Governors observed the Committee.

3. Meetings

Meetings were held monthly, with the exception of August 2023, with eleven meetings taking place during the year.

The eleven meetings held met the obligations regarding membership, attendance and quoracy (with the appropriate use of deputies at times of absence).

4. Terms of Reference

As an integral part of the annual effectiveness review, the Committee has reviewed its terms of reference and are reflected in appendix 1 of this report.

5. Arrangements

The Committee provides internal assurance by reviewing the establishment and maintenance of effective systems of clinical governance, clinical risk management, quality assurance and clinical effectiveness in all areas excluding those managed by the Audit Committee.

The Quality Committee receives reports from the management forums for patient experience, patient safety, clinical effectiveness and the Health & Safety Committee. It received a chairs escalation report throughout the year.

The minutes of the Quality Committee are made available to the Board of Directors. The Committee also reports to the Board via a Chairs Key

Issues report, which highlights for the Board's attention whether an issue is for approval, alert, action or assurance.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. Together, the minutes and the action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule, and is amended as necessary through the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with its schedule of business.

The Committee received reports on the following within the year:

- Patient Story
- Quality Performance Report
- Reducing Restrictive Practice Framework
- Power BI Progress Update
- CQC Assurance Report & CQC Exception Report
- Workforce Presentation (staffing)
- Research Programme and Governance Framework
- Patient Safety Incident Response Framework Progress Report
- Patient Safety Incidents Assurance Report
- Collaborating for Care Strategy Annual Review
- IPC Board Assurance Framework
- Sub Committee Combined Assurance Report (covers all committees e.g. MHA and Safeguarding)
- Draft Quality Account
- System Partnership and Engagement Project
- Mental Health Act Activity Deep Dive
- Emergency Preparedness Resilience & Response Annual Report and Quarterly Reports
- CMH Survey (CQC) Action Plan
- Patient Experience Annual Report
- Complaints / Compliments Annual Report
- Board Assurance Framework Risks
- Clinical Audit Annual Report
- Information Governance Framework and DSPT
- Annual SIRO Report
- LD Improvement Standards Progress Report
- Falls Reduction Mid-Year Report
- Ligature Risk Management Quarterly Report
- Pharmacy and Medicines Optimisation Annual Report 2022/23
- Experience of People with Personality Disorders and Complex Needs
- Learning from Deaths Quarterly Report

- End of Life Care Annual Report
- Quality of Care Strategy
- Patient Experience and Compliance Quarterly Report
- Complaints Process Redesign Evaluation
- Deep Dive NHS Sexual Safety Charter
- Suicide Prevention Strategy & Plan Annual Report
- Deep Dive Restrictive Practice
- Clinical Audit Programme

The Committee received details of all clinical governance audits carried out by the internal auditors where there was a 'limited assurance' outcome and the results of each audit discussed.

6. Duties of the Quality Committee

Committee members carry out a self-assessment of the effectiveness of the Committee. The Trust Secretaries Office manages this on an annual basis. The results enable the Committee to draw up a plan for improvement, which, for 2023/24 evaluation was considered at their meeting held in April 2024 and alongside review of terms of reference.

The Committee administrator monitors attendance at the Committee and compliance to reporting arrangements. Where an executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2023/24 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from committees of the Board of Directors. The following represent laps in control, such that they are required to be considered for inclusion within the annual governance statement as significant issues (criteria applies):

- The CQC enforcement action arising from inspection of Rawreth Court Nursing Home is consider a significant internal control issue for EPUT. We consider that the Trust's governance structure enabled a prompt response to the Section 29A warning notices received and the four 'must do' recommendations made by the CQC in their report published November 2023. The Trust initiated an internal Intensive Support Group and has made significant progress against the actions arising from the CQC action. There has been and will continue to be substantial oversight by the Executive team to ensure improvements are sustained over time.

- The CQC rating of our acute wards for adults and PICU (published April '23 and July '23) is considered a significant internal control issue for EPUT. Progress to deliver our improvement plan has been

made and working with our system partners, we are quality assuring for both impact and sustainability.

The Committee believes the areas of risk, patient experience, patient safety, clinical effectiveness and all other areas covered by the terms of reference (with the exception of those items highlighted above) remain compliant with the risk management and assurance requirements to support the annual governance statement.

The Committee has reviewed its terms of reference in response to the new Quality of Care Strategy, its effectiveness review, and feedback from external regulators e.g. Care Quality Commission.

See appendix 1 for revised terms of reference.

8. Priorities for 2024/25 (to be agreed by the Committee)

The Quality Committee has agreed the following priorities for 2024/25:

- To improve our oversight of physical health service provision;
- To improve our oversight of quality issues arising from sub-contracted services;
- To receive all internal audit reports pertaining to clinical governance, irrespective of the auditors opinion;
- To provide active leadership to the new Quality of Care Strategy and the nine priority areas through reporting from the new executive governance (Safety of Care, Experience of Care and Effectiveness of Care Groups);
- To maintain focus on the delivery of the CQC improvement plan.

9. Recommendation

The Committee received and approved the annual report and recommend it to the Board of Directors, along with its revised terms of reference for 2024/25.

QUALITY COMMITTEE

CHAIRED BY:	Rufus Helm, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Committee Secretary	**FREQUENCY:**	Monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee.
AUTHORITY:	The Quality Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's quality of care provision (meaning Safety, Effectiveness and Experience of care and services). In particular, that adequate clinical governance processes and controls are in place throughout the Trust to: a) identify, prioritise and manage risk arising from clinical care; b) ensure effective and efficient use of resources through evidence based clinical practice; and c) protect the health and safety of employees and service users. To ensure the organisation is working within the legal requirements of the Mental Health Act, and with reference to guiding principles as set out in the Code of Practice and all relevant Deprivation of Liberty Safeguards. To ensure children and adults are safeguarded from abuse.		

PURPOSE- The duties of the Committee shall include the following:

Clinical Governance and Strategy

1 To monitor quality of operational performance trends against targets and ensure all statutory and regulatory elements are adhered to.

2 To recommend to the Board of Directors the Trust-wide quality and clinical governance priorities.

3 To recommend the Trust's annual Quality Accounts to the Board of Directors for approval.

4 To review implementation and monitor progress against the Quality of Care Strategy and other improvement initiatives through the use of the Trusts Quality Improvement Model.

5 To receive assurance reports from executive led quality groups (namely Safety of Care; Effectiveness of Care and Experience of Care) and subject matter forums (e.g. Safeguarding and MHA Committee).

6 To consider clinical governance matters referred to the Committee by the Board of Directors, its standing committees or other forums within the Trust.

7 To receive and approve Quality of Care Strategy and annual work plan, and receive assurance reports from all priority steering groups.

8 To receive and review the annual clinical audit programme and progress reporting thereafter.

9 To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.

10 To agree the Health and Safety Work plan and monitor progress.

11 To ensure registration criteria of the Care Quality Commission continue to be met and to monitor compliance with the Quality Statements.

12 To ensure processes are in place to oversee, review and analyse mortality trends across the Trust.

13 To assure that the Trust has reliable and up-to-date information about what it is like being a patient experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected.

14 To oversee processes to ensure the review of patient safety incidents (including near-misses, complaints, claims and coroners reports) from within the Trust and wider healthcare community to identify areas of focus and learning in response to trends where appropriate.

15 To monitor the development of quality indicators throughout the Trust and their use through the Quality Assurance Framework.

16 To ensure the research programme and governance framework is implemented and monitored.

17 To oversee the Trust's application of policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines, Data Security and Protection Toolkit (DSPT) and the Data Protection Act and to approve the submissions required under the DSPT.

18 To receive assurance that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines including but not limited to NICE guidance and radiation use and protection regulations (IR(ME)R).

19 To receive assurance on the Trusts implementation of and compliance with all current legislation and codes of practice relating to mental health and physical health applicable to our services.

20 To receive assurance on the implementation of the Trusts procedures for the management of safeguarding.

21 To ensure that risks to patients are minimised through effective risk horizon scanning: responding to recommendations from external bodies e.g. National Confidential Inquiries into Patient Outcomes and Death; Care Quality Commission surveys and reports; independent reviews and inquiries; National Patient Safety Alerts and other internal learning in connection with PSIRF, safe staffing reports and other quality intelligence.

22 To identify areas of significant risk to be included in the Corporate Risk Register and gain assurance that appropriate priorities and actions to mitigate such risks are in place.

ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair. And includes Associate Non-Executive Director Executive Chief Nurse Executive Medical Director Executive Director of Strategy, Transformation and Digital	**IN ATTENDANCE:** NED (Chair of Audit Committee) as required Executive Chief Operating Officer (when items require) Director of Nursing and Director of Infection Prevention and Control Director of Patient Experience and Participation Director of Patient Safety Director of Risk and Compliance Deputy Director of Nursing for Safeguarding and Mental Health Act Senior Director of Corporate Governance Other Directors / Officers as required
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on quality performance and assurance. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Date Approved:**	**Date of Last Review:** 2023 **Next Review:** March 2025

Appendix 2: Quality Committee Effectiveness Review 2023/24

Background

In the terms of reference for the Committee, there is a requirement for the Committee to complete a self-assessment of effectiveness at least annually in order to support the continuous improvement of governance standards and to inform any future iterations of its terms of reference.

Process

The evaluation took the form of an online survey of 38 statements. Seven people responded to the survey. The results were reported in full to the meeting of the Quality Committee in April 2024 and is attached for information.

Summary of Findings and Areas for Action

An overall score of 71% was achieves, providing a reasonable assurance that the Committee is being effective, with areas of improvement identified. It is worth noting that the feedback was positive about the improvements the Committee had been making in the latter part of 2023/24 and it is therefore recommended that the Committee continue with these into 2024/25.

A further number of the reflections have been addressed through the 2024/25 schedule of business planning, with the Committee reviewing its terms of reference and forward plan at its meeting in April 2024. This ensures that we keep an awareness of topical, legal and regulatory issues; areas of its work which may cross over with other Board committees and continue to progress with the Board Assurance Framework, Clinical Audit Programme and other key work streams.

There were also some questions where there was a level of 'cannot say' responses which could also indicate areas for potential improvement, though accompanying narrative and information would seem to suggest that these were due to inconsistent attendance at the Committee. The Committee will need to keep this under review.

This summary report shows total scores, total percentage scores and a breakdown of responses by category and by individual statement.

Key and Scoring

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

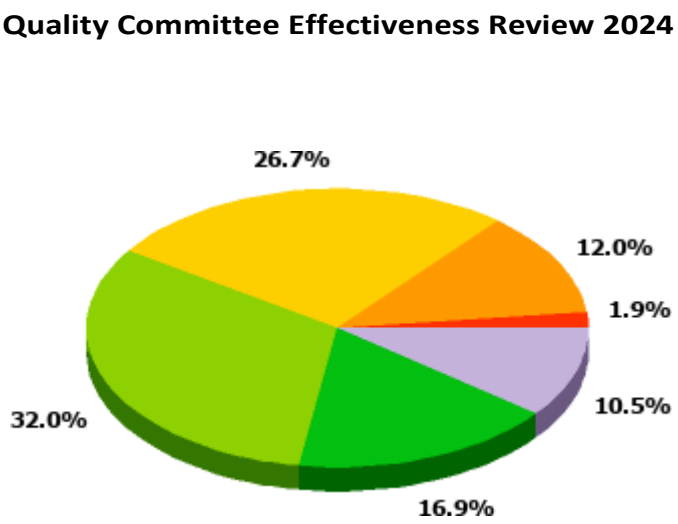
Quality Committee Effectiveness Review 2024

Number of respondents: 7
Number of statements: 38

Table 1: Spread of scores

							Score	%age
Quality Committee Effectiveness Review 2024	5 [1.9%]	32 [12%]	71 [26.7%]	85 [32%]	45 [16.9%]	28 [10.5%]	847/1190	71%

Display 1



Breakdown of report by category

Table 2

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

Quality Committee Effectiveness Review 2024							Score	%age
General Questions	0	11	25	36	7	5	276/395	70%
Committee Focus	1	7	10	10	6	1	115/170	68%
Committee Team Working	3	6	14	17	16	0	205/280	73%
Committee Effectiveness	0	5	14	16	12	2	176/235	75%
Committee Engagement	1	3	8	6	3	0	70/105	67%
Strengths & Weaknesses	0	0	0	0	1	20	5/5	100%

Breakdown of report by individual statements

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

	Quality Committee Effectiveness Review 2024							Score	%age
	General Questions								
1	The terms of reference for the Committee are clear	0	0	4	2	1	0	25/35	71%
	Comment: I joined this Committee after its terms of reference were reviewed and approved. Committee's terms of reference were not provided to me as part of my induction. Maybe we should consider sending Committee terms of reference to new members. **Comment:** There was an assumed understanding of the Committee. ***Response 1**: Executive Directors should ensure anyone attending this Committee on their behalf are fully briefed on the purpose of the Committee and its Terms of Reference.* ***Response 2**: The Committee should consider how all members are made aware of the terms of reference.*								
2	There is a set and agreed forward plan	0	0	2	4	1	0	27/35	77%
	Comment: I joined the Committee in Sep '23 as an ex-officio and have not seen FY23/24 annual plan. I attend infrequently but would welcome a set and agreed forward plan with all members of the Quality Committee. ***Response 3**: The Committee should consider adding the forward plan to the agenda for each meeting for information, to ensure that all attendees have it as a reference point.*								
3	The committee meets frequently enough and with enough time to discharge its duties	0	0	0	6	1	0	29/35	83%
	Comment: The meeting covers a wide range of topics but always finishes on time.								
4	The committee has a mechanism to keep it aware of topical, legal and regulatory issues	0	1	3	2	1	0	24/35	69%
	Comment: There was no evidence of this being formally agreed. **Comment**: There is planning to consider what is covered within the meeting. ***Response 4**: The Committee through its forward planner for 2024/25, ensure that this is picked up through the new 'emergent issues' which is a standing item.*								
5	The committee understands how it integrates with other committees	0	1	2	4	0	0	24/35	69%
	Comment: There was an emerging reference to other committees and this was improving, however clear boundaries of governance were not obvious.								

Comment: There are assurance reports from other committees but I am not aware of integrated between committee mapped out I am clearer on vertical integration rather than horizontal integration with other committees.

***Response 5**: The Committee (with other Board Committees) should continue to check the correct alignment of assurance work across the Board Committees. Using the mechanism (via the Chairs Key Issues Report) to make requests of other Committees to gain both a performance and a quality viewpoint for the Board of Directors.*

6	There is no duplication or overlap with other committees	0	3	3	0	0	1	15/30	50%

Comment: There has been an element of overlap with the Finance and Performance Committee (which has been resolved now). Also, patient experience is now reporting into the Committee.
Comment: Occasionally there may be a discussion about a workforce or performance issue that is impacting on quality of care but generally not.
Comment: Quality Committee and BSOG work mapping would be helpful.
Comment: I cannot comment on this.

***Response 6**: See response 5 above.*

***Response 7**: It is recognised that BSOG was set up to address concerns at a given point in time. BSOG has now been absorbed back in to the Quality Committee for 2024/25 year. The Executive Safety Oversight Committee (ESOG) has been absorbed into the Executive Operational Committee Structure for 2024/25 year and is Executive Quality and Safety Oversight (Week 2).*

7	The committee has reviewed the robustness and effectiveness of the content of the Board Assurance Framework relevant to its area	0	1	3	1	1	1	20/30	67%

Comment: I did not see evidence of this.
Comment: The Committee receives the report, for 2024/25; there is a need to systematically plan to complete deep doves into these risks.
Comment: Not during meetings, I have attended.

***Response 8**: The Committee should continue to receive on a bi-monthly basis the BAF. As part of the BAF maturity process the deep dive into controls assurance as well as reviewing action status.*

8	The committee considers the internal auditor's recommendations for those key controls within its assurance framework	0	1	2	3	0	1	20/30	67%

Comment: I did not see evidence of this.
Comment: Not sure as only at the Trust a short time.
Comment: I joined this Committee in Sep '23 as an ex-officio and haven't seen IA reports coming to the QC yet.
Comment: I am unable to answer this question.

***Response 9**: The Audit Committee oversees management actions in response to IA assurance reviews. IA reports are passed to the Committee (via the Audit Committee Chairs Key Issues Report) where the report receives a negative assurance opinion from the auditors. The Committee should consider the benefit of receiving all relevant internal audit reports for information.*

9	If the committee receives reports from programmes of work e.g. clinical audit , CIP and Transformation, the Committee: • Reviewed an annual plan, which is clearly linked to clinical risks and assurance needs • Received regular progress reports • Monitored the implementation of management actions	0	2	3	2	0	0	21/35	60%
	Comment: I did not see evidence of this. **Comment**: The Committee receives reports (annual or per schedule). The review of up front plans for the year need to be included within the forward plan. **Comment**: I think the Committee would benefit from a more robust approach as this question eludes to. ***Response 10**: This has been programmed into 2024/25 forward plan for the Committee.*								
10	The committee ensures it receives explanations for variation in performance / achievement of objectives	0	0	1	6	0	0	27/35	77%
	Comment: However, these were not formally agreed and I experienced an ad hoc and anecdotal approach to this. ***Response 11**: The Committee should continue to support the narrative explanations of variation in performance / achievement of objectives through the improved Power BI reporting.*								
11	The committee receives and reviews the evidence required to demonstrate compliance with regulatory requirements	0	2	1	3	1	0	24/35	69%
	Comment: It is not immediately clear what regulatory requirements the committee was interested in. ***Response 12**: Executive Directors should ensure reference to regulatory requirements are clearly stated within the front covers of their reports to the Quality Committee.*								
12	The committee provides a meaningful summary report of its meetings to the next available Board meeting	0	0	1	3	1	2	20/25	80%
	Comment: The Chair of the Committee provides a 'Chairs Key Issues Report' to each public meeting of the Board. **Comment**: I did not see the detail of this. **Comment**: I am not able to answer this.								

Quality Committee Effectiveness Review 2024								Score	%age
Committee Focus									
13	The committee has set itself a series of objectives it wants to achieve this year.	0	2	3	1	1	0	22/35	63%
	Comment: I did not see the detail of this. **Comment**: I joined this Committee is Sep '23 as an ex-officio and have missed the FY23/24 objective setting. ***Response 13**: The Committee should consider what objectives it would like to set itself and include these within its annual report (May meeting).*								
14	The committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.	0	1	4	1	1	0	23/35	66%
	Comment: I experienced an ad hoc and anecdotal approach to this. ***Response 14**: Executive directors should continue to work with the chair to ensure good level of information is provided.*								
15	Committee members contribute regularly across the range of issues discussed.	0	0	0	5	2	0	30/35	86%
	Comment: There was good discussion and sharing of experiences at the meeting.								
16	The committee is fully aware of the key sources of assurance and who provides them in support if the controls mitigating the key risks to the organisation.	1	1	2	2	1	0	22/35	63%
	Comment: I did not see evidence of this. ***Response 15:** see response 14 above.*								
17	The committee clearly understands and receives assurances from third parties the Trust uses to manage/operate key functions – for example, shared services, other NHS bodies or private contractors	0	3	1	1	1	1	18/30	60%
	Comment: To some extent, the Committee considered external party information. ***Response 16:** The Committee should consider what information to receive in terms of having oversight of contracts for services with third party providers.*								

Committee Team Working									
18	The committee has the right balance of experience, knowledge and skills to fulfil its role as designed in the terms of reference.	0	1	2	3	1	0	25/35	71%
	Comment: Skills and experience.								
19	The committee has structured its agenda to cover its main duties in its terms of reference.	0	0	3	1	3	0	28/35	80%
	Comment: This has improved greatly in the latter part of year.								
20	The committee ensures that the relevant executive director/manager attends meetings to enable it to secure required level of understanding of the reports and information it receives (i.e. the right executive lead is there to discuss risk and internal matters in their area of responsibility rather than the committee having to rely on a single director to act as conduit to the executive).	1	1	1	3	1	0	23/35	66%
	Comment: Although this was improving. **Comment**: As a Board Committee there is a need to ensure that Executive Directors are taking the lead and limit attendance of others to be aligned to specific items on the agenda. ***Response 17**: This has been addressed through the review of membership and detailed within the terms of reference for 2024/25.*								
21	Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'.	0	3	2	1	1	0	21/35	60%
	No comment added ***Response 18**: The Board Assurance Framework continues to mature, and through the 'emergent issues' agenda item management will brief the Committee of any additional key risks / issues.*								
22	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	0	0	0	2	5	0	33/35	94%

	No comment added

Quality Committee Effectiveness Review 2024								Score	%age
23	I understand the messages being given	0	0	0	4	3	0	31/35	89%
	No comment added								
24	Members hold the reporting members to account for late or missing assurances.	1	0	4	1	1	0	22/35	63%
	No comment added								
25	When action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.	1	1	2	2	1	0	22/35	63%
	Comment: This has improved greatly in the latter part of the year. **Comment**: The Committee within year had some items on the action tracker for a considerable time. These are now resolved and the Committee membership needs to ensure this is a sustained position going forward. ***Response19**: This has been addressed in year.*								
Committee Effectiveness									
26	The quality of the committee papers received allows me to perform my role effectively.	0	1	2	3	1	0	25/35	71%
	Comment: Papers need to demonstrate a stronger link to regulatory requirements and progress against work plans. They also need to identify risks / issues for the Committee to be aware of. **Comment**: The assurance reports from the committees required further refinement to enable me to do this. ***Response20**: Within the new governance structure, underpinning Quality Committee business, the assurance reports from clinical governance and subject matter expert forums will be via the new Executive Led Groups.*								
27	Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	0	1	3	1	2	0	25/35	71%
	Comment: I am not sure if it is always formalised what the action required as a result of a challenge. **Comment**: This is not consistent.								
28	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.	0	0	3	2	2	0	27/35	77%

	Comment: Within year there have been occasions where the tail end of the agenda has been rushed. This could be improved on by focusing on time allocation for each item. ***Response 21**: Improved agenda planning has addressed this in year.*								
29	Each agenda item is 'closed off' appropriately, so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.	0	1	2	3	1	0	25/35	71%
	Comment: This has improved greatly in the latter part of the year. **Comment**: The Chair could close the agenda item with clear summary of what has been agreed. **Comment**: This has improved. ***Response 22**: The Chair should reflect on and continue the improvement seen in year.*								
30	At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.	0	2	0	3	2	0	26/35	74%
	Comment: I didn't see evidence of this. **Comment**: Towards the end of the year we have seen good constructive feedback given – which has been taken forward. ***Response 23**: This has always been in place and contribution has improved as noted above.*								
31	The committee provides a written summary report of its Board	0	0	1	3	3	0	30/35	86%
	Comment: I cannot answer this.								
32	The Board challenges and understands the reporting from this committee	0	0	3	1	1	2	18/25	72%
	Comment: I was not witness to board conversations on this matter in my role.								
Committee Engagement									
33	The committee actively challenges management during the year to gain a clear understanding of their findings.	0	2	3	1	1	0	22/35	63%
	Comment: I did not see evidence of this.								
34	The committee is clear about the complementary relationship it has with other Board assurance committees.	0	1	2	3	1	0	25/35	71%
	Comment: I did not see evidence of this.								

35	I can provide two examples of where we as a committee have focused on improvements as a result of assurance gaps identified.	1	0	3	2	1	0	23/35	66%

Comment: I cannot.
Comment: The redesign of the complaints handling process and then assessment of the success of the change to process.
Comment: Complaints process.
Comment: LD and MHA
Comment: Complaints and restrictive practice.

***Response 24**: The Committee should reflect and note where improvements are achieved in response to gaps in assurance. The Committee to consider including this in the end of meeting reflections section.*

Quality Committee Effectiveness Review 2024								Score	%age
Strengths & Weaknesses									
36	This is what the committee should do more of (Free Text - please select N/A before adding comment)	0	0	0	0	1	6	5/5	100%

Comment: Collective planning and development

Comment: Focus on ensuring management reports include link to regulatory requirement / give a clear picture of EPUT and any benchmark information available. Do more on monitoring workplans under the banner of quality e.g. clinical audit programme (what audits have been completed / the outcomes / management actions as a result). Quality priorities progress in year.

Comment: Have a clear articulation of the route to Quality Committee with papers having been discussed prior to coming to Quality Committee.

Comment: Roles and responsibilities (and agreement of membership) of members with an understanding of the function of the Committees and attendees responsibilities in relation to this design and received a schedule of deep dives relating to Quality matters link back to the BAF.

Comment: Launch and implement the quality of care agenda to support quality outcome assurance and evaluation supported by the new governance structure.

Comment: More time to focus on the key issues (within the same timeframe)

37	This is what the committee should do less of (Free Text - please select N/A before adding comment)	0	0	0	0	0	7	0/0	0%

Comment: Doing work within the committee.
Comment: Deviate from the agenda and share long presentations.
Comment: Use data poorly.
Comment: Lower-priority issues should be managed before they come to the Quality Committee.

38	Any other comments / observations: (Free Text - please select N/A before adding comment)	0	0	0	0	0	7	0/0	0%

Comment: No further comment.
Comment: In Q4 of the year there has been significant improvement on the structure and reports in QC, the agenda and NED challenge for assurance has been improved as Power BI and the IPR matures.
Comment: The scope of the TOR has been broad and on occasions disconnected, and due to the lack of robust governance structures has historically resulted to discussion rather than assurance. The use of patient stories has been welcomed however reflection is more anecdotal than what next. Finally enabling pan Essex ICS quality present is a positive step forward for system assurance and efficiency so that other meetings can be stepped down. However, noting that the specialist commissioned services are not as well established in the Pan Essex approach.
Comment: N/A

General comments for the Quality Committee Effectiveness Review 2024 appraisal.
Comment: Looking forward to the new governance arrangements that will come in with the launch of the Quality of Care strategy.

Comment: The Quality Committee has felt improved in the last few months and the direction felt positive. As a member, I was gaining confidence in the remit of the committee and my purpose as an attendee at the meeting.

Essex Partnership University
NHS Foundation Trust

Finance & Performance Committee Annual Report 2023/24

Finance & Performance Committee

Annual Report 2023/24

1. Background

The purpose of this report is to review the work undertaken by the Finance & Performance Committee (a standing committee of the Board of Directors) for the period covering 01 April 2023 to 31 March 2024.

The Committee oversees all aspects of finance and performance, and provides assurance to the Board of Directors on meeting national standards and quality objectives, informing the Audit Committee of any significant issues.

2. Committee Membership

Loy Lobo, Non-Executive Director, chaired the Committee during the year.

Included within the membership was one other Non-Executive Directors, the Executive Chief Finance Officer, Executive Chief Operations Officer and Executive Director of Strategy, Transformation & Digital. The Committee has a number of subject matter leads who attend to provide additional probity for the subject matter. Other members of the Executive Team may attend on an ad hoc basis. A Trust Governor observes the Committee.

Administration relating to the Committee business was undertaken by the Executive Assistant to the Executive Chief Operations Officer (until December 2023) and then by the Board Committee Secretary (from January 2024). In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting, they are made available to Board members for information.

Table 1: Attendance at meetings held 2023/24:

		Attended	Total No. Meetings
Loy Lobo	Chair	10	10
Manny Lewis (until February 2024)	Non-Executive Director	7	9
Janet Wood (until July 2023)	Non-Executive Director	4	4

Elena Lokteva (From September 2023)	Non-Executive Director	4	6
Alexandra Green	Executive Chief Operations Officer	10	10
Denver Greenhalgh (From January 2024)	Senior Director of Corporate Governance	2	3
Diane Leacock (From February 2024)	Non-Executive Director	2	2
Jenny Raine (From February 2024)	Non-Executive Director	1	2
Trevor Smith	Executive Chief Finance Officer	10	10
Zephan Trent	Executive Director of Strategy, Transformation & Digital	8	10

3. Meetings

Meetings were held monthly, with the exception of August and December 2023, with 10 meetings taking place during the year.

The 10 meetings held met the obligations regarding membership, attendance and quoracy (with the appropriate use of deputies at times of absence).

4. Terms of Reference

As an integral part of the annual effectiveness review, the Committee has reviewed its Terms of Reference and are reflected in Appendix 1 of this report.

5. Arrangements

The Committee has responsibility for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance and best practice.

The minutes of the Committee are made available to the Board members. The Committee also reports to the Board via a Chairs Key Issues report, which highlights for the Board's attention whether an issue is for approval, alert, action or assurance.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. Together, the minutes and the action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule, and is amended as necessary through the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with its schedule of business.

The Committee received reports on the following within the year:

Part 1 Meetings

- Performance Report
- Finance Report (Revenue, Capital, Cash, Efficiency, FOT)
- Accountability Framework Reports
- BAF Risk Summaries
- Analysis of Ligature Risk Programme's Impact
- Code of Governance Review
- Cyber & Information Governance Report
- Cyber Security Monitoring & Assurance
- Demonstration of Demand & Capacity Software
- Digital Strategy Refresh
- Estates & Facility Updates
- International Recruitment Benefits Realisation
- MSE ICS Medium & Long Term Plan
- National Cost Collection Pre-Submission Report
- NHS England Self-Assessment Report
- Strategic Impact Report
- Strategy Impact Report & Transformation Delivery Framework
- Strategy Risk Assessment
- Transformation Updates
- Update on MHED Unit
- Electronic Patient Record Business Case

The Committee held a private session (when required) for confidential and commercially sensitive items (i.e. contracts), and for this reason not detailed within this report.

6. Duties of the Finance & Performance Committee

Committee members carry out a self-assessment of the effectiveness of the Committee. The Trust Secretary's Office manages this on an annual basis. The results enable the Committee to draw up a plan for improvement, which, for 2023/24 evaluation was considered at their meeting held in March 2024 and alongside the review of the Committee's Terms of Reference.

The Committee Secretary monitors attendance at the Committee and compliance to reporting arrangements. Where an Executive member is

unable to attend a meeting, a deputy is required wherever possible. The attendance during 2023/24 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from committees of the Board of Directors. The following represent key control issues, such that they are required to be considered for inclusion within the annual governance statement as significant issues (criteria applies):

- The Lampard Inquiry is considered a significant matter for EPUT both in regards to its resource requirements and implications. The Trust has therefore used its best knowledge, information and external advice to provide for the estimated financial resources as part of its final accounts process (this remains subject to audit)

- The Mid and South Essex Integrated Care System financial deficit is considered a significant matter for EPUT with the potential for it to prejudice the achievement of Trust priorities to sustain and improve services. For example, impact on achievability of our Time to Care Programme and for the capital investment for a new Electronic Patient Record.

The Committee believes the areas of risk, financial and operational performance and all other areas covered by the Terms of Reference (with the exception of those items highlighted above) remain compliant with the risk management and assurance requirements to support the Annual Governance Statement.

See Appendix 1 for revised Terms of Reference.

8. Priorities for 2024/25 (to be agreed by the Committee)

The Finance and Performance Committee has agreed the following priorities for 2024/25:

- To continue to oversee the development of the new Electronic Patient Record system;

- To receive all internal audit reports pertaining to finance and performance, where a limited or moderate assurance rating is received;

- To provide active leadership within the System finance;

- To maintain focus on the delivery, and oversee the medium term planning and financial forecasts.

- To contribute to improved triangulation of workforce, activity and financial plans (whilst maintaining the primary monitoring of workforce trajectories is undertaken at People & Culture Committee.

- To continue to receive benefits realisation reports associated with key business cases and initiatives e.g. Time To Care.

9. Recommendation

The Committee received and approved the Annual Report and recommend it to the Board of Directors, along with its revised Terms of Reference for 2024/25.

FINANCE AND PERFORMANCE COMMITTEE

CHAIRED BY:	Loy Lobo, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Committee Secretary	**FREQUENCY:**	Meetings shall be held not less than six times a year and in exceptional circumstances, as determined by the Chair or three members of the Committee

AUTHORITY:

The Finance and Performance Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance and best practice. The Committee is responsible for ensuring the appropriate investment of funds, and to oversee the amalgamation and disaggregation of funds arising from potential mergers, acquisitions or organisational reconfigurations.

PURPOSE- The duties of the Committee shall include the following:

Performance

1 To consider in detail as necessary reports prepared on a monthly basis by the Executive Operational Committee detailing the performance against identified local and national targets/ indicators that contribute to the delivery of quality services and ensuring that the Trust meets its contractual requirements. To monitor agreed plans to mitigate underperformance, where necessary reporting these to the Board.

2 To scrutinise the risks (hotspots) to organisational performance, seeking assurance that the risks are clearly articulated and mitigating action has or is being taken by Executive Directors. To monitor progress made with implementing actions to address identified risk.

3 To ensure the Trust's compliance with the terms of its Licence, and its Constitution. To oversee self assessment of compliance with annual corporate governance statements.

4 To scrutinise financial performance, seeking assurance that variation and risk are clearly articulated and mitigating action has or is being taken by Executive Directors. To monitor progress made with implementating actions to address identified variation or risk.

5 To receive assurance in relation to the use of resources (including people, estates & facilities, digital, capital / revenue and assets).

6 To monitor the implementation of the corporate and Care Unit objectives in the Annual Plan. And provide oversight to key major projects as instructed by the Board of Directors.

7 To provide oversight of the relevant Trust Strategies including Digital and Estates.

8 To ensure appropriate links with the Audit Committee, PEC Committee and Quality Committee.

9 To receive assurance on management of the Trust's strategic capital programme approved by the Board of Directors.

10 To receive BAF risk action plans appropriate to the scope and role of the committee.

11 To consider reports on the performance of any Joint Committees where they are transacting business on behalf of the Trust.

12 To ensure the Trust's compliance with the Data Security and Protection Toolkit and that cyber security risks are being clearly articulated and mitigating action has or is being taken by Executive Directors.

	Investment: 13 To establish and monitor compliance with a written Investment Policy (which is periodically reviewed by independent professional advisors) to establish the overall methodology, processes and controls which govern selection of Trust investments. 14 To monitor investments where total revenue resulting from the investment or capital value is within the delegated limits outlined in the Trust's Investment Policy for the Committee. 15 To consider investments or marketing initiatives/opportunities: • Where a change to the Trust's corporate structure is required (for example establishment of a subsidiary vehicle) • To approve development of ITT that are reportable transactions to NHS England • To review all potential new transactions in the light of potential risks • To review investment properties and vacant properties plans. 16 Ensure that the underlying liquidity of the Trust is maintained where surpluses are used to finance investments. 17 The committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and setting the terms of reference for any external investment consultants. 18 To approve external funding within limits delegated by the Board of Directors.	
ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair. Executive Chief Finance Officer Executive Chief Operations Officer Executive Director of Strategy, Transformation and Digital	**IN ATTENDANCE:** NED (Chair of Audit Committee) as required Executive Medical Director Executive Nurse Executive Director of People and Culture Director of Finance Senior Director of Corporate Governance Other Directors / Officers as required
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on performance (contractual, operational and financial) They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Date Approved:** (TBC) March 2024	**Date of Last Review:** June 2023 **Next Review:** March 2025

Appendix 2:
Finance & Performance Committee Effectiveness Review 2023/24

Background

In the terms of reference for the Committee, there is a requirement for the Committee to complete a self-assessment of effectiveness at least annually in order to support the continuous improvement of governance standards and to inform any future iterations of its terms of reference.

Process

The evaluation took the form of an online survey of 38 statements. The results were reported in full to the meeting of the Finance & Performance Committee in April 2024 and is attached for information.

Summary of Findings and Areas for Action

An overall score of 85% was achieves, providing a reasonable assurance that the Committee is being effective, with areas of improvement identified.

A number of the reflections have been addressed through the 2024/25 schedule of business planning, with the Committee reviewing its terms of reference and forward plan at its meeting in March 2024. This ensures that we keep an awareness of topical, legal and regulatory issues; areas of its work which may cross over with other Board committees and continue to progress with the Board Assurance Framework, and other key work streams.

There were some changes in Non-Executive Directors for the Committee in 2023/24 and the Committee should ensure that the new members are supported in their orientation to the Committee business.

This summary report shows total scores, total percentage scores and a breakdown of responses by category and by individual statement.

Key and Scoring

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

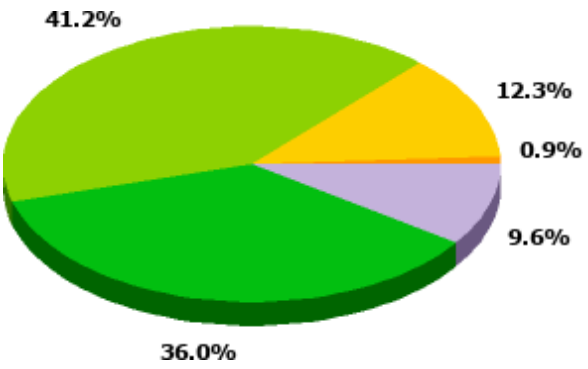
Finance & Performance Committee Effectiveness Review 2024

Number of respondents: 3
Number of statements: 38

							Score	%age
Finance & Performance Committee Effectiveness Review 2024	0 [0%]	1 [0.9%]	14 [12.3%]	47 [41.2%]	41 [36%]	11 [9.6%]	437/515	85%

Display 1

Finance & Performance Committee Effectiveness Review 2024



Breakdown of report by category

Table 2

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

Finance & Performance Committee Effectiveness Review 2024							Score	%age
General Questions	0	0	6	19	11	0	149/180	83%
Committee Focus	0	0	3	7	3	2	52/65	80%
Committee Team Working	0	0	3	6	15	0	108/120	90%
Committee Effectiveness	0	1	2	10	8	0	88/105	84%
Committee Engagement	0	0	0	5	4	0	40/45	89%
Strengths & Weaknesses	0	0	0	0	0	9	0/0	0%

Breakdown of report by individual statements

Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	N/A (0)

	Finance & Performance Committee Effectiveness Review 2024							Score	%age
General Questions									
1	The terms of reference for the Committee are clear	0	0	0	2	1	0	13/15	87%
	Comment: Currently subject to review and adaptation to TOR on a page. ***Response**: Note the terms of reference have been reviewed and approved by the Committee in March 2024.*								
2	There is a set and agreed forward plan	0	0	0	1	2	0	14/15	93%
	Comment: Recently revised and refreshed. ***Response**: Note the forward plan was reviewed and agreed by the Committee in March 2024.*								
3	The committee meets frequently enough and with enough time to discharge its duties	0	0	0	2	1	0	13/15	87%
	Comment: The committee might be meeting too often. There are meetings where there are no items for approval other than the minutes of previous meeting. **Comment**: Reviewed as part of the forward plan refresh. ***Response**: The Committee has agreed to move to a bi-monthly schedule from June 2024, whilst holding a slot in the interim month for any urgent business.*								
4	The committee has a mechanism to keep it aware of topical, legal and regulatory issues	0	0	0	2	1	0	13/15	87%
	No comments.								
5	The committee understands how it integrates with other committees	0	0	1	1	1	0	12/15	80%
	Comment: I think we could do better here as there is still some ambiguity. **Comment**: Some cross over with Quality Committee and PECC when reviewing the performance scorecard – this should be rectified from April 2024. ***Response**: The Committee will continue to keep a focus on this with the other committees.*								

6	There is no duplication or overlap with other committees	0	0	1	2	0	0	11/15	73%
	Comment: Items of duplication have been identified, particularly in relation to performance metrics. The resolution is in progress at the time of this evaluation. **Comment**: The Committee works to avoid overlap and duplication with PECC, Q&S and BSOG etc. ***Response**: The Committee will continue to keep a focus on this with the other committees.*								
7	The committee has reviewed the robustness and effectiveness of the content of the Board Assurance Framework relevant to its area	0	0	1	1	1	0	12/15	80%
	Comment: The Committee received a report on risks but should consider scheduling deep dives into specific risks to triangulate management actions and be able to provide an assurance statement to the Board. **Comment**: Clear focused reports to Committee ***Response**: The Committee will continue to keep a focus on its risks and as the risk management framework matures, deep dives will assess the controls assurance more effectively.*								
8	The committee considers the internal auditor's recommendations for those key controls within its assurance framework	0	0	1	2	0	0	11/15	73%
	Comment: Committee receives relevant referrals from IA and the Audit Committee.								
9	If the **committee** receives reports from programmes of work e.g. clinical audit , CIP and Transformation, the Committee: • Reviewed an annual plan, which is clearly linked to clinical risks and assurance needs • Received regular progress reports • Monitored the implementation of management actions	0	0	1	2	0	0	11/15	73%
	Comment: The Committee receives many such reports. It would be helpful to the committee to have a birds eye view, perhaps integrated through the BAF. ***Response**: The Committee should discuss how this should be strengthened.*								
10	The committee ensures it receives explanations for variation in performance / achievement of objectives	0	0	0	1	2	0	14/15	93%

	No comments.								
11	The committee receives and reviews the evidence required to demonstrate compliance with regulatory requirements	0	0	1	1	1	0	12/15	80%
	No comments								
12	The committee provides a meaningful summary report of its meetings to the next available Board meeting	0	0	0	2	1	0	13/15	87%
	Comment: Chairs Key Issues Report to the Board.								

Committee Focus

	Finance & Performance Committee Effectiveness Review 2024							Score	%age
13	The committee has set itself a series of objectives it wants to achieve this year.	0	0	2	1	0	0	10/15	67%
	Comment: While the committee has a set of objectives to monitor performance and receive assurance, it has not taken a step back to review whether these remain relevant or need to be refreshed. **Comment**: I am not sighted on the objectives at this stage. ***Response**: The Committee should consider setting three objectives for the year to be stated within its annual report to the Board.*								
14	The committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.	0	0	0	3	0	0	12/15	80%
	No comment.								
15	Committee members contribute regularly across the range of issues discussed.	0	0	0	1	2	0	14/15	93%
	No comment.								
16	The committee is fully aware of the key sources of assurance and who provides them in support if the controls mitigating the key risks to the organisation.	0	0	0	2	1	0	13/15	87%
	No comment.								
17	The committee clearly understands and receives assurances from third parties the Trust uses to manage/operate key functions – for example, shared services, other NHS bodies or private contractors	0	0	1	0	0	2	3/5	60%
	Comment: not aware of any such assurances. ***Response**: The Committee should consider how it receives assurance that contracts are performing and there are no contractual concerns.*								

Committee Team Working									
18	The committee has the right balance of experience, knowledge and skills to fulfil its role as designed in the terms of reference.	0	0	0	1	2	0	14/15	93%
	Comment:								
19	The committee has structured its agenda to cover its main duties in its terms of reference.	0	0	0	1	2	0	14/15	93%
	Comment:								
20	The committee ensures that the relevant executive director/manager attends meetings to enable it to secure required level of understanding of the reports and information it receives (i.e. the right executive lead is there to discuss risk and internal matters in their area of responsibility rather than the committee having to rely on a single director to act as conduit to the executive).	0	0	0	1	2	0	14/15	93%
	Comment:								
21	Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'.	0	0	1	0	2	0	13/15	87%
	Comment:								
22	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	0	0	0	1	2	0	14/15	93%
	Comment:								

23	I understand the messages being given	0	0	0	1	2	0	14/15	93%
	Comment:								

Finance & Performance Committee Effectiveness Review 2024								Score	%age
24	Members hold the reporting members to account for late or missing assurances.	0	0	1	0	2	0	13/15	87%
	Comment:								
25	When action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.	0	0	1	1	1	0	12/15	80%
	Comment:								
Committee Effectiveness									
26	The quality of the committee papers received allows me to perform my role effectively.	0	0	0	3	0	0	12/15	80%
	Comment: The papers are usually on time. On occasion, some parts have been late. ***Response**: Note this has improved and executive management to keep a keen focus. Any late paper should be agreed with the Chair of the Committee.*								
27	Members provide real and genuine challenge—they do not just seek clarification and/or reassurance.	0	0	0	1	2	0	14/15	93%
	Comment:								
28	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.	0	0	0	1	2	0	14/15	93%
	Comment:								
29	Each agenda item is 'closed off' appropriately, so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.	0	0	1	0	2	0	13/15	87%

	Comment:								
30	At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.	0	1	0	2	0	0	10/15	67%
	Comment: ***Response**: The Committee should consider adding this to the meeting reflection section at the end of the agenda.*								
31	The committee provides a written summary report of its Board	0	0	0	2	1	0	13/15	87%
	Comment: ***Response**: The Committee provides a key controls report to the Board every meeting.*								
32	The Board challenges and understands the reporting from this committee	0	0	1	1	1	0	12/15	80%
	Comment:								
Committee Engagement									
33	The committee actively challenges management during the year to gain a clear understanding of their findings.	0	0	0	1	2	0	14/15	93%
	Comment:								
34	The committee is clear about the complementary relationship it has with other Board assurance committees.	0	0	0	3	0	0	12/15	80%
	Comment:								
35	I can provide two examples of where we as a committee have focused on improvements as a result of assurance gaps identified.	0	0	0	1	2	0	14/15	93%
	Comment: The committee has called for evidence on benefits realization from the international recruitment programme. This is an ongoing action. Service waiting times, length of stay and out of areas placements receive close scrutiny on an ongoing basis as we are not yet where we need to be.								
Strengths & Weaknesses									

Finance & Performance Committee Effectiveness Review 2024								Score	%age
36	This is what the committee should do more of (Free Text – please select N/A before adding comment)	0	0	0	0	0	3	0/0	0%

Comment: Deep dive into risks on the BAF within its scope of work. Identification of risks.

Comment: Deep dive on key performance issues. Ask for greater visibility of the progress of transformation plans. Allocate time for reflection on committee performance.

Comment: Further enhance its complementary work with other board sub-committees.

***Response**: The Committee forward plan is inclusive of deep dives of performance areas and risk register entries.*

37	This is what the committee should do less of (Free Text - please select N/A before adding comment)	0	0	0	0	0	3	0/0	0%

Comment: Operational detail.

Comment: Spend time on items received for information / noting. Each of these items should be submitted with a cogent 1-2 page summary.

***Response**: The Chair to reflect on how to boundary contributions to the right level of detail within the committee. In addition, to address the time spent on items for information to include timing for each agenda item to manage expectations of presenters.*

38	Any other comments / observations: (Free Text – please select N/A before adding comment)	0	0	0	0	0	3	0/0	0%

Comment: The cadence of the committee meetings needs to be reviewed. It is likely it only needs to meet about two weeks prior to a Board meeting.

Comment: Well run and well attended committee with good focus and participation. Membership is relevant, focused and delivers to the agenda.

***Response**: The Committee will move to a bi-monthly meeting from June 2024.*

7.3 FREEDOM TO SPEAK-UP ANNUAL REPORT

Information Item NL 5

REFERENCES

Only PDFs are attached

Freedom to Speak-Up Annual Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Freedom to Speak Up Service: Annual report**					
Executive Lead:	Nigel Leonard – Executive Director of Major Projects and Programmes					
Report Author(s):	Bernie Rochford MBE – Principal Freedom to Speak Up Guardian					
Report discussed previously at:	People, Equality & Culture Committee - 29 April 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)?	No but FTSU provides insight into		
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*	Currently on the Directorate Risk Register		
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 a review of the activity and progress of the Trusts Freedom to Speak Up Service since introduction with focus on 2023/24 as well as next steps for 2024/2025	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the contents of the report
2. Support greater collaborative work around Speaking Up across disciplines / the trust
3. Review and use in conjunction with the Board Reflection Self-Assessment tool and TIAA audit findings when available to inform the Freedom to Speak Up Strategy and priorities for 2024 / 2025

Summary of Key Points

The report provides the following key points:

- Pg4. The number of cases raised through FTSU has increased. The majority are around inappropriate behaviour, bullying and worker safety more than patient safety. The national picture reflects this trend.
- Pg6. Emerging themes underpinning issues raised are lack of confidence and hesitancy around having difficult direct conversations, disempowerment and futility.
- Pg6. The majority of cases are raised openly or 'in confidence' and some anonymous callers have progressed to speaking up in confidence
- Pg7. The expanding broad remit of FTSU may impact on other Speak Up routes
- Pg7. The introduction of more local data collection points rather than reliance on national categories should improve quality of responses to cases, turnaround times and evidence cultural change
- Pg8. Coaching and upskilling colleagues to Speak Up compassionately and navigate through difficult conversations should increase confidence levels and empower the management pipeline
- Pg8. Recruitment for more Guardian resource is in progress (awaiting internal audit recommendations) and in the interim FTSU has been placed on the Directorate Risk Register as a precautionary measure
- Pg9. Good progress has been made over the last year in understanding the levers and barriers to Speaking Up within the trust and additional resources for the service will aid this further
- Pg10. The extended three month Speak Up, Listen Up, Follow Up campaign, Managers Listening Sessions and roll out of FTSU e-learning modules has provided valuable insight into EPUT culture
- Pg11. Collaborative work with other Trusts is underway to share resources / learning

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			
FTSU	Freedom to Speak Up	NGO	National Guardians Office
BAU	Business As Usual	EMREN	Ethnic Minority & Race Equality Network
SU, LU, FU	Speak Up, Listen Up, Follow Up	IRN's	International Recruited Nurses

Supporting Reports and/or Appendices
Freedom to Speak-Up Service Report Appendix 1: Quality & Quantity of Concerns Raised

Lead:

Bernie Rochford MBE
Principal Freedom to Speak-Up Guardian

Nigel Leonard
Executive Director of Major Projects and Programmes

Board of Directors Part 1
5 June 2024

FREEDOM TO SPEAK UP SERVICE

1. PURPOSE OF REPORT

To provide a summary review of inherited activity and progress of the Trusts Freedom to Speak Up Service with focus on 2023/24 as well as next steps for 2024/2025

2. DATA AND ANALYSIS OF FREEDOM TO SPEAK UP (FTSU) SERVICE

Since the Freedom to Speak Up Guardian Service was introduced in late 2016 / early 2017, the number of cases raised through the service has increased. This indicates the key message to Speak Up is working and colleagues are aware of the service. And colleagues who have spoken up previously but believe their issue has not been fully addressed, are giving EPUT another opportunity to resolve their concern. Being able to speak up is important to the trust and colleagues are encouraged and thanked for doing so. Members of the Board will note that not all cases raised by colleagues involve concerns.

Number of cases and types of issues raised through EPUT FTSU service

Number of cases and types of issues raised through the FTSU service

Guardians	AP	? AP / YM	? AP / YM	YM	YM	YM Q1 EJ Q2 EJ / CB Q3 & 4	EJ / CB Q1 CB / BR Q2 BR Q3 & 4
		Not sure when AP / YM changed over					
	2017 - 2018	**2018 - 2019**	**2019 - 2020**	**2020 - 2021**	**2021 - 2022**	**2022 - 2023**	**2023 - 2024**
	Total	**Total**	**Total***	**Total**	**Total**	**Total**	**Total**
# cases raised in quarter (See Note 2)	**16**	**30**	**43**	**235**	**199**	**232****	**254**
# cases raised Anonymously	6	17	34	90	57	32+	42
# cases with an element of patient safety / quality	3	7	8	18	22	54	48
# cases with an element of bullying or harassment	7	8	14	109	125	129	60
# cases where people indicate that they are suffering detriment as a result of speaking up	0	1	1	15	9	7+	20
# cases with an element of worker safety or wellbeing					12	71	69
# cases with an element of inappropriate attitude or behavours						87	140

Note:

1 * NGO report No Data Received for Qtr 1 & 2 Data, so likely higher than # stated
** includes Q4 data missing from NGO / Model Hospital data; Anonymous and Detriment data may be higher
2 Slight changes & more classifications for data capture over time
2017 - 18 asked for # cases raised in quarter
2018 - 19 asked for # cases raised to Guardians, Champions, Ambassadors
2019 - onwards asked for # cases brought to FTSU Guardians

Figures as published on the National Guardians Office Speaking Up Data - National Guardian's Office

2020 – 2023 figures may reflect number of issues raised via FTSU rather than number of people speaking up i.e. some people raise multiple issues within one case. The NGO state one person equates to one case regardless of number of issues raised.

A total of 254 cases were raised via FTSU over the last year. The majority of cases were raised individually rather than colleagues jointly raising concerns over one issue. Many cases involve elements of 'double dipping', citing worker safety *and* bullying *and* inappropriate behaviour / attitude with some cases independently citing the same alleged perpetrators.

Methods used to raise concerns

Anonymous cases account for 14% of cases raised over the last year.The majority of cases (86%) were raised openly (46 %) or in confidence (40%).

Initial methods used to raise concerns	2023 - 2024				
	Q1	Q2	Q3	Q4	Total
Open	24	18	57	17	**116**
In Confidence	66	14	13	9	**102**
Anonymous	9*	4	15	8	**36**
Total number of concerns raised	**99**	**36**	**85**	**34**	**254**

**The NGO / Model Hospital sites should read 9 not 15 as previously submitted*

Number of cases raised by professional / worker group

Number of cases raised by professional / worker group	2023 - 2024
Allied Health Professionals	6
Medical and Dental	3
Ambulance	0
Nurses & Midwifery	**55**
Admin & Clerical	**41**
Additional Professional Scientific and Technical	3
Additional Clinical Service	**40**
Estates and Ancillary	7
Healthcare Scientists	0
Students	30
Not Known	56
Other	13
Total number of colleagues Speaking Up	**254**

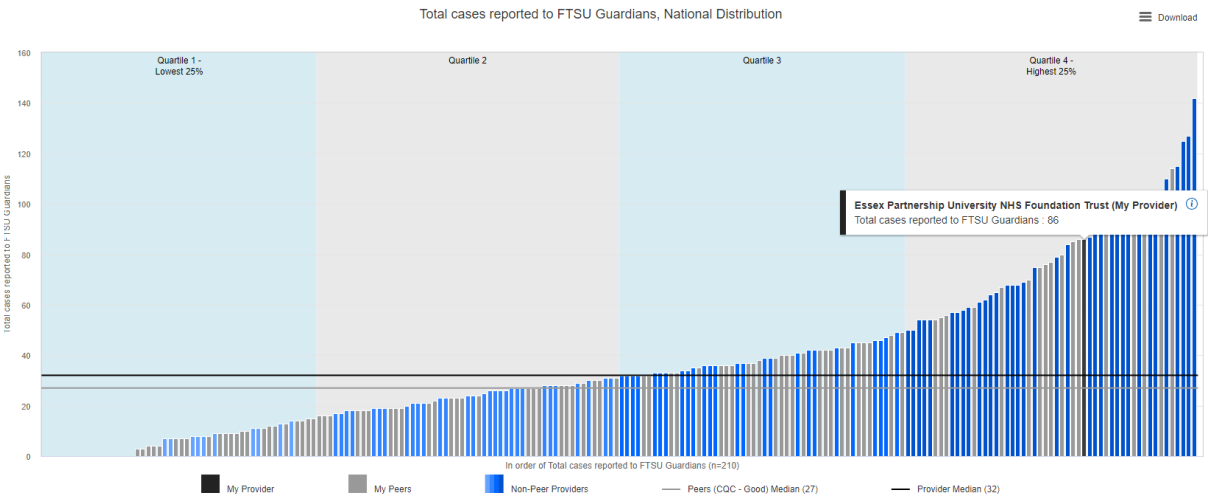
The majority of cases were raised by nurses, HCAs and clerical workers. The latter largely reported impact of previous decision making around changes in service delivery and inappropriate behaviours and bullying from colleagues. The nurses and HCAs report a mix of patient safety and inappropriate behaviours.

The Model Hospital

Model Hospital data indicates EPUT is in quartile 4 nationally for number of cases raised through the FTSU service. Being able to Speak Up and the majority openly or In confidence is encouraging.

Benchmark comparisons with other trusts is useful but limited given the number of variables i.e. experience and number of FTSU Guardians / Champions, the number of sites each operate out of as well as internal models used etc. Surges on cases raised can be for reasons beyond actual concerns or issues i.e. change in manager, policy, annual leave, weather etc.

But on the whole, it is encouraging colleagues are speaking up and we are made aware of any issues they may be experiencing or getting in the way of them fulfilling their role. Without minimising cases of reported bullying, inappropriate behaviours / attitudes they are subjective interpretations of events by individuals who need to be supported through the processes; once collated it becomes objective data. How we manage the juxtaposition of individuals reporting the same event through different lenses is work in progress.



Published Figures up to Q3 2023 [View FTSU Guardian Cases - Culture & Engagement - Model Mental Health]

Total cases reported to FTSU Guardians 12 month rolling average (Q3 2022 – Q3 2023)	EPUT average	Peer Average*	National value
Total Cases reported to FTSU Guardians	216	79	79
Bullying or Harassment cases	58	14	14
Patient safety and quality cases	35	17	13
Detriment as a result of Speaking Up	21	1	1
Anonymous cases	33	4	4
Worker Safety and well being	50	27	21
Inappropriate Attitudes and behaviours	123	32	24

**Published data. Peer value based on Trust Type (ERIC)*

3. AREAS / ISSUES

The number of anonymous cases are relatively low in comparison to the numbers speaking up openly or in confidence. Where possible I provide a reference number to anonymous callers they can quote, if they want to contact FTSU again for an update, thus keeping dialogue open to build confidence. Some anonymous callers have converted to 'in confidence' as a result and some speaking up 'In confidence', have gone on to speak up openly. Understanding hesitancies, lack of confidence and developing colleagues to work through conflict to resolution and have difficult conversations should lead to a more open, transparent culture.

Early indicators from the Letby case suggest the need for greater consideration of dynamics and power of the group – Truth to Power conversations within the team as much as floor to board.

Recurring issues would benefit from closer scrutiny by the Responsible Directors (issues / cases and learnings should be owned in each area), but some underpinning themes to the presenting issues may be better addressed more centrally / strategically i.e.

1. Some people speaking up lack the confidence in addressing issues directly with the people concerned / managing conflict / having difficult conversations *(taking over and doing this for them, will not build up their ability, confidence or resilience)*
2. Managers cite FTSU and grievances are being used as a threat or retaliatory measure against them should they try to performance manage individuals *(without address, this disempowers managers, impacts on patient safety, undermines FTSU and HR processes and weakens confidence in both)*

3. Managers uncertainty in knowing how to approach concerns or cherry picking the easier bits and not addressing all elements within the concern raised *(supports the belief nothing changes as a result of speaking up)*

These would need to be addressed in addition to the two main barriers to Speaking Up

4. Fear of detriment / retaliation. (A follow up longitudinal case study to identify if individuals citing *fear of detriment,* went on to receive it, would be useful)
5. Futility of Speaking Up as nothing changes. (Useful to communicate wider, findings, positive outcomes and numbers of actual v fear of detriment and how dealt with)

As well as operational case handling, much of the work since I joined in July 2023 has been exploratory in trying to ascertain how Speaking Up fits within the trust, the need, flow and surges; what / where barriers and bottlenecks are and identifying any training / upskilling needs. Given the number of cases raised though FTSU a more strategic approach to streamline emerging themes, pulling them together under existing pieces of work rather than requiring more random, labour intensive resource would be of benefit.

Not all 'cases' are concerns, many include signposting / other issues not recorded under NGO data collection. Refinement of local data collection points (See Appendix 1) should improve evidencing cultural change, the quality of casework handling, identification of tipping points, failure demand (i.e. demand created by not getting it right first time) and how to more efficiently signpost within / outside FTSU. Otherwise we are promoting FTSU whilst underpinning many cases is lack of understanding the individual / team fit into the bigger picture, escalation and reporting structures or how a trust / NHS works beyond the immediate team.

The FTSU remit broadened from initial focus on reporting concerns around patient safety to now "*anything that gets in the way of doing your job.*" Thus greater likelihood the remit could move further into other existing avenues for reporting concerns i.e. University students* and HR in particular; and / or FTSU is at risk of becoming a surge valve rather than safety valve with safety concerns overlooked within the noise of other 'cases' raised via this route. All issues need to be raised and addressed but we need to revisit how, when, who by, for what reason.

**Following feedback, work with university students has temporarily been put on hold to stabilise and strengthen where possible their existing reporting structures, so issues can be addressed quicker at source.*

Individual cases re relationship issues, behaviours and attitudes may benefit from earlier signposting to HR / other avenues, pastoral care or training. If / as the numbers of cases routed through FTSU keeps growing, the need to empower, coach and upskill colleagues to Speak Up at source, may be a safer, effective and more efficient way of addressing issues rather than initiate several hundred reviews, lines of enquiry or investigations each year. Adding additional resource to improve quality and turnaround is needed in the short-term but not sustainable in the long-term, and likely to pull Speaking Up out of business as usual / line reporting structures.

Individual cases directly linked to patient safety may indicate a need to do more team training around Wilful Blindness and Active Bystanders (i.e. with patient safety concerns, why does only one person see / report it?). Concern should be, not all direct or indirect patient safety issues were identified by some individuals when raising cases to FTSU. In addition, several patient safety cases involve allegations of colleagues making false entries in records, documenting appointments that didn't take place or not seeing patients when they should.

These are the type of concerns FTSU was originally intended to field and provide an additional safety net for individuals and the organisation. In order to protect the integrity of FTSU and prioritisation of patient concerns, we need to explore and monitor the uptake of the service more closely; which will require either more resourcing or a radical shift in approach / routing of cases.

With more resource, adopting an empowering coaching style approach to Speaking Up would be of benefit. Empowering colleagues to Speak Up directly and more assertively for themselves (rather than passively handing over) is necessary for building the pipeline of future EPUT managers.

FTSU Guardians should be amplifying the message and push through the system, rather than replacing the voice of those who can with support, speak for themselves.

Aligning FTSU to the trust values would strengthen this approach.

We are in the process of recruiting further Guardians as I have been managing the FTSU Guardian service solo since October 2023. The volume and complexity of cases impacts on turnaround times and visibility across sites which impacts on momentum and compromises the quality / integrity of the service. This could reduce confidence in Speaking Up and increase the sense of futility or likelihood of individuals personalising the delay rather than recognising it as a system delay. In acknowledgement of the stretch on FTSU capacity, it has been placed on the Directorate Risk Register as a precautionary measure. In addition to mitigations in place (reviewing funding & recruitment / TIAA audit), others have generously stepped in to pick up adhoc elements.

Current priority focus is managing open cases in the system, following up with Directors and feeding back to colleagues; and establishing a rhythm and flow to meet capacity, demand and expectations. Case trackers are being introduced so each Director responsible will have greater oversight of FTSU cases assigned to them which should improve turnaround and resolution times. Once stabilised, focus will be on re-educating what FTSU is / isn't to prevent drift, disempowering or handing over responsibility outside of appropriate routes.

Exploring managers understanding of what is needed to fulfil a concern raised (directly or via FTSU), how to approach them, what to consider, what is needed for resolution, who is accountable for sign off and closure etc. is planned. FTSU sessions for managers via the Management Development Programme are temporarily on hold due to Guardian capacity and will be re-opened as soon as possible (see section 4).

Complexity of cases

Expectations as well as remit and requirements of FTSU have evolved over time. Greater sophistication around documentation is needed to house contemporaneous record keeping, future proof for reference and evidence changes made as a result of Speaking Up. FTSU requires the use of a more robust case management system and meetings with Information Governance will be scheduled shortly to discuss asset management further.

FTSU relies more on quantitative data, yet qualitative data can be more persuasive in moving positions, reaching resolution and effecting change. This impacts resolution approach, impressions of and resources. Umbrella terms i.e. *inappropriate behaviour*, *worker safety* or *patient safety* can mask the complexity of underpinning issues, and the time and resources needed to address them, especially when they span several disciplines, divisions or groups

'Patient safety'	
Example cases raised about …	**Require exploring underpinning issues of**
Calibration of blood glucose monitoring machines	Training / upskilling
Delay in receiving ipad / IT equipment	Distribution issue
Poor / no Datix reporting on issues	Reminding / communications
Lack of managers presence on the ward	Behavioural / HR
Doors / ligature points	Estates
Stimulation / ward activities	Staffing Levels / capacity / motivation / ability

'racism'
Colleagues on ward racially abused by service user and visiting family
BAME colleague citing not getting bank shifts
Experiencing racist comments but being told *"you're white, so it's not classed as racism"*
Cross cultural hostility and bickering between International Recruited Nurses
Organising a Christmas party but no whites allowed, only BAME colleagues

On first reading, it may be disappointing to read such allegations of perceived racism and discrimination. But it is a sign of progress these important issues are now being aired and voiced. And an indicator we are currently working through really uncomfortable territory to create a fairer, more open environment for service users and everyone to work within. This work also highlights the continued importance of the work led by the People and Culture directorate and the Trust's focus on Equality, Diversity and Inclusion.

It is well documented some colleagues may experience greater difficulty when speaking up than others; but we can't assume NHS Speaking Up processes work for everyone else. I have joined various networks (EMREN, Gender, LGBTQ, Disability and MH, Faith and Spirituality) to extend the reach of promoting the FTSU message and pick up any emerging key themes. Developing a FTSU champion network will aid this further. Work is also needed to ascertain cross-generational influences and communication styles as well as cross-cultural work. We (EPUT and nationally) are still at the stage we need to create a timely, supportive, responsive environment with the Freedom *to* Speak Up before we can assure ourselves of any equity or Freedom *of* Speech.

4. ACHIEVEMENTS AND AREAS OF GOOD PRACTICE / SUCCESSES

At EPUT, the October 2023 FTSU national campaign was extended to a three month campaign with a monthly focus from October – December on Speak Up, Listen Up, Follow Up respectively. Visits to the Freedom to Speak Up intranet page rose from 282 in September to 664 in October, a 135% increase. We saw a 216% increase in colleagues speaking up in October, compared with September. Numbers of colleagues speaking up remained higher than usual throughout the campaign.

Following manager's feedback of their experience of FTSU, during the three month campaign a series of eleven manager Listening Exercise events was held over Teams. Thus affording managers a safe space to Speak Up themselves. All line managers were asked to attend at

least one session and provide feedback on Speak Up, Listen Up and Follow Up, what it means to them in practice and any barriers they had identified. The timings of the line manager listening sessions were designed around shift patterns and included early morning sessions as well as late evening and night. This ensured we captured experiences from as many colleagues as possible, including those who only work night shifts. More than 445 line managers attended and gave their feedback during the eleven listening sessions.

Collation and dissemination of feedback and learnings from these managers listening sessions is in progress (awaiting and use in connection with TIAA audit outcome). A further series of Manager Follow Up events is planned to share the learnings, which will then inform the FTSU and communication strategies, Manager Development Programme (MDP) sessions and key themes to thread into the overarching Speak Up strategy and objectives.

One of the juxtaposition themes emerging from manager's feedback was speculation FTSU may inadvertently pull Speaking Up out of business as usual line management structures. Whilst the numbers / types of concerns raised by reportees to them is not routinely recorded, managers felt sometimes they were blindsided by cases / concerns coming left field from FTSU without the opportunity to respond in the first place. A counter argument colleagues report is a sense of futility and little point in speaking up as nothing happens or that they have tried but nothing changed. On occasion FTSU have been cc'd or bcc'd into email exchanges between reportees and managers but without a clear request to intervene. This is not in-line with the correct utilisation of the FTSU process and re-clarification of the role is a clear action for next year. In all cases, I contacted those involved to educate FTSU cannot be used as an enforcer / take sides but act more as facilitator to work through appropriate processes. With good grace so far, this is well-received. Achieving balance and creating a fair supportive approach for all parties is in progress.

The FTSU e-learning module training was launched in October and 7460 colleagues (including bank) have since completed training on Speaking Up.

- 6813 staff members have completed 000 Speak Up - Core training for all workers
- 439 staff members have completed 000 Listen Up - Training for all Managers
- 154 staff members have completed 000 Follow Up - For Senior Managers

Analysis of the manager listening exercises, reflections on the Letby case, FTSU data and on the basis *"What we do together matters"*, indicates a greater need for wider listening up and following up at an individual, team and senior level. As a result, we have recently opened up and rolled out the ask for all colleagues to complete all three FTSU modules. There has been some challenge to this, especially as the modules are generated by NHSE and we cannot modify the language or modules but it is also creating other opportunities and for group work and team discussion to complete the Follow Up module in particular.

Several colleagues expressed further interest and commitment to the FTSU agenda and asked how they could become more involved. I am enlisting their support in creating a FTSU Champion network. In collaboration with the FTSU Guardian at Hertfordshire Partnership University NHS FT, we are joining forces / resources in training and developing FTSU champions. Before the joint meeting in July 2024, we will be developing interest from existing / potential champions to build a wider network and learning opportunity across both trusts.

Whilst more work / re-education is needed to stream line FTSU processes and timelines, acknowledgement should be given to the swift response times from Directors when a FTSU concern is first raised to them. This is encouraging. With few exceptions, the response rate is impressive with an update on assignment of a delegated person to follow up also. Where potential patient safety transactional issues are more clearly evident, these are generally addressed faster. Further work is needed on turnaround times, assigned reviewer updates to Directors who then update FTSU (otherwise Directors lose oversight). The introduction of case trackers should help. Early indicators are we may soon be able to predict the type of cases /

concerns that get resolved quicker, the reasons why and adjust responses / resources / expectations accordingly.

I have attended the Quality Senate and arrangements are being made to join visits with the Executive Nurse and NEDs across the trust. But the volume of case work, emerging issues and patterns around speaking up and working as a sole Guardian has limited the ability to have a physical presence across trust sites during this period. The communications team have been invaluable in promoting the FTSU message with me during this time. For example, in developing the following communication channels:

- Intranet page and 15 articles
- 3 x intranet banners
- 3 x screensavers
- 2 x tickers
- 12 x articles in Wednesday Weekly
- 2 x appearances at all staff updates
- 4 x mentions in managers' briefs
- 1 x mention in a senior leadership update
- 11 x line manager listening feedback sessions
- 1 x all staff email
- 1 x email sent to bank colleagues
- 1 x email sent to volunteers
- 19 x staff Facebook posts
- 1 x mention in EPUT News

I am in collaboration with Mersey Care NHS FT Guardians to look at developing quality controls and consistency around case management and categorisation; with Derby and Burton NHS FT around best practice responses to sexual safety, enlisting Elliott Judge's lead on this; and liaising with NHSE / NGO re impact and consistency of messaging around the terms 'Speak Up' and 'Call It Out / Name It' - the latter being viewed as more combative and leading to increased inappropriate behaviour.

I attend ICS, regional and national networks with fellow FTSU Guardians to learn and share themes and best practice and assist on the NHS Nye Bevan programme. I am part of a 'buddy' network and a national mentor for new FTSU Guardians. I am also liaising with NHSE on support for international recruited nurses and have been shortlisted for a Churchill Scholarship to explore Speaking Up / Whistleblowing cross-culturally.

5. IMMEDIATE NEEDS / AREAS TO DEVELOP

In order to realise the potential of FTSU, the service would benefit from additional recruitment to strengthen operational and strategic elements. The Trust has allocated funding for the service to meet the Trust's ambition and will prepare a business case to support recruitment once we have received the internal audit review of the FTSU function.

Immediate focus is on processing casework, developing a case management system and case trackers for Responsible Owners and work towards triangulating data and intelligence to create a more informed picture of what is emerging across the trust, where and why. Developing more local data parameters should inform the process and improve the quality of responses (See Appendix 1).

Several other initiatives are already in the pipeline including developing a FTSU Champion network to provide greater visibility and coverage across multiple sites, case trackers, a re-education piece on what FTSU is / isn't, manager training in how to manage concerns and work around wilful blindness / bystander effect and the FTSU & Communications Strategy. As FTSU should be only one element of the wider trust approach to Speaking Up, then some of these initiatives may be quicker and better served through other work streams.

Report prepared by:

Bernie Rochford MBE
Principal Freedom to Speak Up Guardian

On behalf of:

Nigel Leonard
Executive Director of Major Projects & Programmes

Appendix 1

Quality and Quantity of concerns raised

To improve culture and the quality of responses to concerns raised, the introduction of more local measures will aid our understanding of the flow and journey of concerns raised through EPUT. This then lends itself to greater triangulation and capture of learnings to evidence change over time, improve efficiency, service offerings, increase accountability and reduce the time taken to resolve cases. Recognising timing does not necessarily equate to quality, it's a start and sends a message as well as informs practice and process. For example, capture –

- Time lapse between incident / issue and reporting it to someone
- How many people / disciplines was the concern raised to before approaching FTSU
- Over what time period
- Time taken for FTSU to respond to the colleague speaking up
- Ascertain rational / tipping points for approaching FTSU if not first point of call
  How the individual categorises the presenting issues (? differ from Guardians)
  Do they present / report any patient safety issue as the priority?
  Is it secondary or embedded within personal impact?
- How many report going off sick or intention to leave due to issues raised / futility
- Expectations and desired outcomes
- Turnaround time to clarify notes with the individual before referring to Director
- Time from referral to Director to acknowledgement / initial update
- Time to next update from Director (what has happened in between)
- Time to provide an update to the colleague speaking up
- Time to resolve and close a case
- Drop-out rates
- Number of people / resources needed to resolve a case
- How many cases are open at any point in time
- How many cases involve signposting / system or policy issues / seeking support / pastoral requests
- How many people speaking up identify as having protected characteristics and believe these are impacted due to the issues raised
- Ascertain if any futility precedes FTSU intervention or after
  Feedback rates on any actual detriment v fear of
- Feedback, reflections and learnings from all parties including individual speaking up
- Perform random quality checks and audits to identify sustainable change as a result of Speaking Up
- How many have used the service before or would use it again

We may want / expect faster response rates for patient / worker safety issues and longer response rates for relationship / behavioural issues so they have time to address and respond rather than react. This should then move Speaking Up into more useful quality insight information than a numbers collation. Issues raised will be more manageable if tied into (if possible) strategic pieces of work rather than continual adhoc symptomatic reactionary work.

7.4 PLACE 2023 REPORT

Information Item ZT 3

REFERENCES

Only PDFs are attached

PLACE Audit Results 2023 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**PLACE 2023 Report**					
Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital					
Report Author(s):	Matthew Sisto, Director of Patient Experience and Participation					
Report discussed previously at:	Experience of Care Group (02/05/2024) Quality Committee (09/05/2024) Council of Governors (23/05/2024)					
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/		
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 the analysis of the PLACE 2023 report	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the contents

Summary of Key Points

The EPUT supplementary report for PLACE 2023 provides a detailed breakdown for the organisational scores, with some comparative analysis pulled out from the national report, and recommendations detailed within.

General themes

- Patient assessors were impressed with the attractiveness and availability of recreational activities for patients, with many wards having games rooms, gyms and well-kept outdoor spaces.
- A key area for improvement is accessibility for those with disabilities and for those with visual impairments in particular.
- By using colour effectively, the Trust can aid patient's orientation around sites. E.g. doors and toilet seats are not the same colour as the walls and surrounding systems.
- It was also noted, on the majority of sites that signs leading to the centre and car parking availability could be improved to make it easier for people to find the sites.
- Last year, COVID-19 outbreaks on some sites meant that visits to those sites were no possible. This year, all sites were successfully visited. EPUT PLACE results were therefore included in national publication.

General Recommendations

Due to the success of the 2023 PLACE visits and planning recommendations for the planning and implementation of the PLACE 2024 assessments remain:

1. Each visit will need two patient assessors to be included in the National Publication
2. Each visit will need to allow for a food assessment to be included in the National Publication
3. Every effort is made by services to facilitate assessments in 2024

Experience of Care Group Recommendations:

- Map the PLACE scores to the estates improvement programme to see if the low scoring areas are awaiting improvement work
- Ensure that findings from PLACE a included in the incoming Estates Strategy
- Refine the sites and locations with NHS England to ensure a clearer breakdown of services, and divide between mental and physical health for PLACE 2024

Site specific results have been presented at Standing Committee level.

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

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

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

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

1. PLACE 2023 Supplementary Report
2. NHS England PLACE 2023 Report (Hyperlink to NHS England website)

Executive Lead:

Zephan Trent
Executive Director, Strategy, Transformation, and Digital

NHS
Essex Partnership University
NHS Foundation Trust

PLACE 2023
Supplementary Report

Patient Led Assessments of the Care Environment

Contents

PLACE Introduction

Introduction

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. ***Patient Led Assessments of Care Environments*** (PLACE) provide the motivation for improvement by giving a clear message, directly from patients, about how the environment or services might be enhanced. PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision (quality and safety, or ligature risk) or how well staff are doing their job. Having said that, any concerns on safety, quality, and ligature risk are highlighted on the day of assessment and picked up by the teams for immediate action.

The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. The PLACE collection underwent a major national review between 2018 – 2019, significantly revising the question set and guidance documentation. Annual review continues before each programme to ensure this collection remains relevant and delivers its aims.
The assessments involve local people (known as patient assessors) going into hospital 'sites' as part of teams to assess how the environment supports the provision of clinical care. Assessors rate each site out of 1-5 (1 being poor, and 5 being good) based on the following 6 domains:

1. 'Food & Hydration',
2. 'Disability',
3. 'Condition, Appearance and Maintenance'
4. 'Privacy, Dignity and Wellbeing'
5. 'Cleanliness'
6. 'Dementia Friendly'

Each patient assessor is provided with training as per the national guidance, which the patient experience team have adapted for EPUT. They also have an on-the-day orientation of the site, approach, and timings. At this point, each assessor can raise questions, and concerns if there are any. Each visit is facilitated by a member of the Patient Experience team and supported by the Estates and Facilities Team. A key learning remains that PLACE is a great opportunity for corporate services to get out and visit our care environment.

Purpose and Background

The purpose of this report is to provide an update to the Board of Directors regarding PLACE following the 2023 assessments and any recommendations for improvements. PLACE visits in 2023 took place between September and November.

PLACE aims to focus on areas that matter to patients, families and carers. PLACE encourages the involvement of patients, the public, and both national and local organisations that have an interest in healthcare in assessing providers. On the day(s) of assessment, the assessing team visit the various areas of the hospital and unit (e.g. wards, communal areas) filling out the relevant scorecards (paper or digital) based on observed conditions. Results are sent to NHS England for analysis and benchmarking.

This report contains the organisational overview (themes and trends) and a breakdown for each site visited in order for quality improvement actions to be devised as an organisation and ownership of actions to be taken for specific sites.

National Publication

NHS England published the PLACE scores into the public domain on the 22nd February 2024. This includes EPUTs 2023 scores.

In line with the 2019 national review, learning from 2022 was taken into account and successfully applied for the 2023 visits. This ensured that EPUT visits and subsequent scores were included within the national publication. Scores are therefore comparable with other published NHS sites.

The Patient Experience team ensured that in order to go ahead at least 2 patient assessors were present at each site visit and the only sites who did not engage in a food assessment were those where daily meals are not routinely served to all patients (self catering). This is an improvement from last year and demonstrates learning

Scoring

- On the day(s) of assessment, the teams visit the various areas of the hospital and unit (e.g. wards, communal areas) filling out the relevant scorecards (paper or digital) based on observed conditions

- Results are sent to NHS England by hospital staff using the Estates and Facilities Management (EFM) online portal

- Marks awarded for each question count towards one or more domains. Domain totals are then calculated on EFM and expressed as a percentage of the maximum marks available for each domain for each organisation and site.

- National averages are calculated to take into account the variation in hospital size (and that not all areas are assessed in larger sites):

What is your immediate impression upon arriving at the hospital / health care site? How happy/confident are you that a good level of patient care and experience will be delivered within the environment?	Very Confident
	Confident
	Not Very Confident
	Not At All Confident

Table 1- overall rating score

Same question is asked upon leaving

	Please Tick
Overall, how would you rate the patient meal service observed?	Good
	Acceptable
	Poor

Table 2 – overall food rating score

P	Pass = all aspects of all items must meet the definition/guidance.
Where a Pass is not appropriate, the team must decide to apply a Qualified Pass or Fail score.	
Q	Qualified Pass = a small number of items (no more than 20%) do not meet the definition/guidance.
F	Fail = more than a small number of items do not meet the definition/guidance or where blood or body fluids are present (these always result in a fail score)

Table 3- Individual domain scoring key

Summary Insights

General Themes

- Patient assessors were impressed with the attractiveness and availability of recreational activities for patients, with many wards having games rooms, gyms and well kept outdoor spaces.
- A key area for improvement is accessibility for those with disabilities and for those with visual impairments in particular.
- By using colour effectively, we can aid patients orientation around our sites. e.g. doors and toilet seats are not the same colour as the walls and surrounding systems.
- It was also noted, on the majority of sites that signs leading to the centre and car parking availability could be improved to make it easier for people to find our sites.
- Last year, not all sites were visited due to covid breakouts and reluctance from staff. This year, all sites were successfully visited. EPUT PLACE results were therefore included in national publication.

National and Local Comparisons

240 organisations took part in PLACE assessments 2023. For comparison, the national average and 2 local and similar trusts have been selected below to demonstrate how EPUT scores compare. ELFT has also been included as they are currently rated as outstanding by the CQC and therefore should be contacted before PLACE 24/25 to understand any learning opportunities relevant for PLACE that EPUT can adopt.

Organisation Name	Commissioning Region	Organisation Type	NHS or Independent	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National Average				0.981	0.909	0.912	0.910	0.875	0.959	0.825	0.843
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.965	0.8882	0.889	0.8879	**0.9671**	0.9384	0.8501	0.8772
NORTH EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.9785	0.9239	0.9282	0.9184	0.9686	0.8067	0.9197	0.9427
EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.9572	0.8501	0.8971	0.789	0.9457	0.9341	0.8692	0.8513

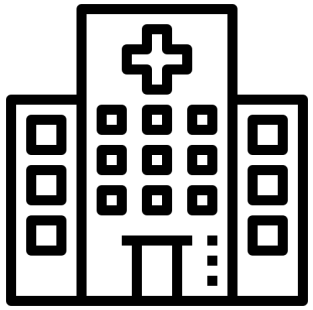
Organisational overview

Site Name	Organisation Type	NHS or Independent	PLACE Site Type	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
LANDERMERE CENTRE MENTAL HEALTH WARDS, CLACTON-ON-SEA	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.8761	0.9279	0.906	0.9524	0.8605	0.7083	0.5	0.5455
COLCHESTER - THE LAKES	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9304	0.8422	0.8848	0.7895	0.9672	0.9457	0.75	0.8205
THE CRYSTAL CENTRE	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9871	0.9335	0.8848	0.9881	0.9831	0.9511	0.9516	0.9483
EDWARD HOUSE	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9794	0.9127	0.8848	0.9474	1	0.9457	0.8621	0.9111
BASILDON MENTAL HEALTH UNIT, BASILDON	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	0.9357	0.8848	0.9889	1	0.9947	0.975	0.9857
BROOMFIELD HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9021	0.838	0.8848	0.7857	0.9508	0.8315	0.5536	0.7143
BROCKFIELD HOUSE	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	0.8736	0.8848	0.8667	1	0.996	0.9762	0.9885
BYRON COURT - 5 HEATH CLOSE	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9402	0.937	0.8848	1	0.9048	0.8917	0.5441	0.6512
CHRISTOPHER UNIT (LINDEN)	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9231	0.8324	0.8848	0.7692	0.9302	0.8833	0.625	0.7179
CLIFTON LODGE	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Other inpatient	0.9784	0.8447	0.8986	0.7857	0.9767	0.9333	0.9015	0.8846

Organisational overview continued

THE ST. AUBYN'S CENTRE, COLCHESTER	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	0.9271	0.9273	0.9268	0.9844	0.9891	0.9688	0.9524
THE BRAMBLES - COLCHESTER	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9744	N/A	N/A	N/A	0.9318	0.9167	0.6786	0.7143
THURROCK COMMUNITY HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9923	0.9448	0.906	0.9881	0.9655	0.9837	0.9842	0.9565
WOOD LEA CLINIC, BEDFORD	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	N/A	N/A	N/A	0.975	0.9833	0.9231	0.8947
ROCHFORD COMMUNITY HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9317	0.8268	0.8848	0.7619	0.9231	0.9355	0.7823	0.8
SAFFRON WALDEN COMMUNITY HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	0.883	0.906	0.8571	0.8864	0.95	0.8509	0.8125
ST MARGARET'S HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9776	0.9054	0.8848	0.9286	1	0.9709	0.9769	0.9806
RAWRETH COURT	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9915	0.9391	0.8848	1	0.9211	0.9167	0.8667	0.86
ROBIN PINTO UNIT	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.953	0.9335	0.8848	0.9881	0.9756	0.9333	0.8	0.8286
KING'S WOOD CENTRE - COLCHESTER	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	0.9253	0.8998	0.8848	0.9189	0.9839	0.8315	0.8103	0.8444
PRINCESS ALEXANDRA HOSPITAL	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	Mental Health Only	1	0.9312	0.8848	0.9872	1	0.9946	0.9355	0.9333

Recommended Targeted Interventions



Improvement across all domains at the Broomfield sites would have the biggest impact on the collective average

Focused improvement effort on domains of ‘Disability’ and ‘Dementia Friendly’ at Landermere

General Recommendations

Due to the success of the 2023 PLACE visits and planning recommendations for the planning and implementation of the PLACE 2024 assessments remain:

1. Each visit will need 2 patient assessors to be included in the National Publication
2. Each visit will need to allow for a food assessment to be included in the National Publication
3. At times some wards were quite resistant to PLACE assessments, preventing them from going ahead, which impacted the overall process. Because of this, it is our recommendation that every effort is made by services to facilitate assessments in 2023.

Notable improvements:

1. Signage is generally more visible and clear
2. Flooring improved to matt and non reflective across a number of sites
3. Sites being more accommodating of PLACE visits going ahead with less refusal of assessments upon arrival

Recommendations for improvements based on findings from the PLACE 2023 assessments:

1. Making the accessibility of our sites for those with disabilities a priority area in the incoming Estates Development Strategy (i.e. effective use of colours, and clearly marking uneven surfaces)
2. Increasing the available parking where possible, markings, access, and disabled spots too
3. Ensuring high visibility markers are placed on all entrance doors
4. Refine the sites and locations with NHS England to ensure a clearer breakdown of services, and divide between mental and physical health for PLACE 2024

DOCUMENT END

7.5 SAFE WORKING OF JUNIOR DOCTORS ANNUAL REPORT

Information Item | MK | 3

REFERENCES

Only PDFs are attached

Safe Working of Junior Doctors Annual Report FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Safe Working of Junior Doctors Annual Report**					
Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr P Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 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)?	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	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to the Medical Director. Medical Staffing ensures that the Junior doctors working hours are in line with the Junior Doctors contract 2016.	
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 Safe Working of Junior Doctors Annual Report.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Points

1. The National recruitment of trainees is an ongoing issue.

2. The Board to note that there are no specific concerns related to recruitment within the Trust. There has been a significant improvement in the intake of trainees in the last year.

3. Trust has employed international Doctors, LAS and MTI and this helps to cover the service provision.

4. The Trust does not use agency locums.

5. The Junior Doctors participated in the industrial action. There were 9 episodes from April 2023 until February 2024. The Trust were supportive of Doctors. The gaps in the rota, ward cover and emergency cover were all filled in by internal locum doctors so that safety of patients are not compromised. The Trust spent £313,909.50 to cover gaps during this period.

6. Room refurbishments for junior doctors' room and on-call rooms across all 5 sites of the Trust is now complete.

7. Trainees have raised 19 Exception reports between April 2023 and March 2024. All the issues have been resolved.

8. The Trust was fined on one occasion where a higher trainee raised an Exception report for stepping down during an on-call.

9. Bi-monthly junior doctors' forum (JDF) is well attended by Junior Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved timely and escalated to Clinical Tutors/DME/Senior Managers where necessary

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			
JDF	Junior Doctors Forum	DME	Director of Medical Education
MTI	Medical Training Initiative	LAS	Locum Appointed Service

Supporting Reports and/or Appendices

Appendix 1: Details of Exception reports raised by trainees from 1 April 2023 until 31 March 2024.

Executive/ Non-Executive Lead / Committee Lead:

Dr Milind Karale
Executive Medical Director

Appendix Exception Apr 2023 to March 2024

Quarter	Exception	Outcome
Apr to June	Core trainee worked 1 hour 45 minutes overtime to complete tasks to manage a patient who was in crisis	Time off in lieu given.
Apr to June	Core trainee worked overtime for 2 hours to complete admin tasks and paper works.	Time off in lieu was given and adjustments made on supervision for the trainee by their clinical supervisor.
Apr to June	Core trainee worked 1 hour 45 minutes overtime on the ward	Time off in lieu was given.
Apr to June	Core trainee worked 1 hour extra during their on call,	Time off in lieu was given.
Apr to June	FY2 trainee worked extra 1 hour 30 minutes to complete documentations following ward review. The task could not be left till next day.	Time off in lieu was given.
Jul to Sept	Senior trainee worked an extra 1 hour 30 minutes on the ward due to work load	Time off in lieu was given.
Jul to Sept	GP trainee raised an exception report for working an extra 1 hour on the ward due to excess workload.	Time off in lieu was given.
Jul to Sept	A senior trainee had to step down and do a resident on-call during a weekend for 12 hours, as the junior doctor rostered was sick	The Trust was fined. Doctor was paid £670.25 as per the stepping down guidance. Guardian received £1116.95 (as per the 2023 Pay and Conditions circular (M&D) 4/2023 guidance). The money is under the training budget, the junior doctors will decide in the forum on how to use this money for their welfare.
Jul to Sept	FY1 trainee raised an exception report for working extra 1 hour 45 minutes on the ward due to excess workload.	Time off in lieu was given.
Oct to Dec	Trainee raised an exception report on immediate safety concern, highlighting areas on increased workload, time taken to travel between sites, lack of rest period and lack of support during on-call.	Time off in lieu was given.
Oct to Dec	Trainee raised **4 exception reports** for working a total of extra 7 hours (Liaison Psychiatry), as being the only doctor on site.	Time off in lieu was given.
Jan to March	A Trainee worked extra 30 minutes on the ward and also raised an issue of excessive workload during on call hours covering different sites	Time off in lieu was given.
Jan to March	A trainee raised an exception report on behalf of 8 trainees on delay in getting psychotherapy cases allocated to them and lack of availability of supervisors.	The matter was escalated to senior managers, Clinical Tutor and Psychotherapy team. The trainees who are in the 3rd year of core training have been given high priority and the matter has now been resolved.
Jan to March	A trainee worked extra hours on the ward	Time off in lieu was given.
Jan to March	A higher trainee worked extra hours on the ward	Time off in lieu was given.
Jan to March	Lack of adequate rest periods due to increased workload during on call.	Time off in lieu was given.

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 COMPLAINTS & COMPLIMENTS ANNUAL REPORT

Decision Item | ZT | 10

REFERENCES

Only PDFs are attached

Complaints & Compliments Annual Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Complaints and Compliments Annual Report 2023/2024**					
Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital					
Report Author(s):	Claire Lawrence, Head of Complaints and PALS Matthew Sisto, Director of Patient Experience					
Report discussed previously at:	Experience of Care Group (02/05/2024) Quality Committee (09/05/2024)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	Complaint volumes, themes, response times, service user satisfaction and trust in the integrity of our complaints service.		
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)?	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 the Complaints Annual Report for 2023-24. It includes: • Number of complaints/ PALS received and closed during the year. • Response timescales • Complaint themes • PHSO referrals • Learning from Complaints and Compliments	**Approval**	✓
	Discussion	
	Information	

• Feedback from Complaints Satisfaction Survey • Quality Assurance feedback from NEDs • Update on the priorities we identified last year • Sets out priorities for 2024-2025.		

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve the Annual Complaints & Compliments Report for 2023/24

Summary of Key Points

Introduction

The purpose of this report is to provide an overview of complaints, concerns and compliments that were received by the Trust throughout the year from 1 April 2023 to 31 March 2024 (this period is referred to as "2023/24" throughout the report). As well as data relating to volumes, response times and themes of complaints, it will review the impact of the new complaints process. The report also includes examples of lessons learned from complaints and compliments and provides an update on the priorities we identified last year and sets out our priorities for 2024-2025.

This report covers the discharging of the trust's duties under the NHS Complaints Regulations.

Key points

- There has been significant change in complaints processes following co-produced redesign of the service. This has led to significant improvements and greater opportunities to resolve issues more quickly and to identify lessons.
- There was a 5% decrease in overall complaints/ concerns compared to the previous year.
- The Trust resolved 14% more concerns via the PALS service compared to last year, which has helped to reduce the number of Formal Complaints by nearly a third.
- 94.8% of formal complaints were closed within agreed timescales
- More formal complaints were closed (332) than received (275) which led to the backlog of open investigations decreasing by over a third from the previous year.
- The top category for Formal Complaints was "Assessment & Treatment (Clinical Practice)", however the top theme of complaints received via MPs was "Lack of Community Support" for the third consecutive year.
- The response rate for Complaints Feedback Survey increased to 14% by including a QR code with a link to the survey on response letters – but the survey feedback demonstrates a mistrust in the Complaints Service
- Of the 19 Quality Assurance reviews completed so far by the Non-Executive Directors, 100% were rated positively for the 'quality of the response letter'
- There was a 2% increase in the number of compliments received directly to EPUT services this year.
- Complaints are recognised as a valuable source of feedback from which the Trust can learn and improve services. An integral part of the complaints investigation process is to consider if there are lessons that can be learnt and/or improvement actions.
- The Complaints Team follow up with the service to provide assurance that improvement actions have been taken forward and embedded into everyday practice.
- Lessons identified are presented monthly at the Learning Collaborative Partnership meeting and circulated Trust-wide in the Lessons Identified Newsletter. Learning from complaints is also discussed at monthly Quality & Safety meetings, and the Commissioners of EPUT's services receive a quarterly report containing the lessons learned from complaints for their specific geographical areas.

Next steps

- Priorities for 2024/25 include continued focus on improving the complaints process and building trust in the process; improving response times; strengthening the learning between complaints and PALS

and improving the capture and reporting of the demographic breakdown of complainants, so it may be better identified if there are certain groups who are not speaking up.

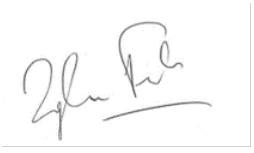
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			
PHSO	Parliamentary & Health Service Ombudsman	CLO	Complaints Liaison Officer
PALS	Patient Advice & Liaison Service		

Supporting Reports and/or Appendices
Complaints and Compliments Annual Report

Executive Lead:
 **Zephan Trent** Executive Director of Strategy, Transformation and Digital

NHS
Essex Partnership University
NHS Foundation Trust

Complaints & Compliments

Annual Report 2023/2024

May 2024

Contents

PURPOSE

The purpose of this report is to provide an overview of complaints, concerns and compliments that were received by the Trust throughout the year from 1 April 2023 to 31 March 2024 (this period is referred to as "2023/24" throughout the report). As well as data relating to volumes, response times and themes of complaints, it will review the impact of our new complaints process. The report also includes examples of lessons learned from complaints and compliments and provides an update on the priorities we identified last year and sets out our priorities for 2024-2025.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides services to more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. With more than 5,500 staff working across over 200 sites, we also provide services in people's home and community settings.

The Complaints Team is part of the Patient Experience portfolio, and provides a Complaints Service and Patient Advice and Liaison Service (PALS) for people who use the Trust services. This includes current and past service users or patients, carers, friends and relatives. We are there to help provide resolutions and rebuild relationships.

This year's annual report (2023/24) will be the first to look at a full 12 months of working with our new complaints process, which was launched in January 2023 after a co-produced re-design project. The changes to the process have had a positive impact on the service we deliver, and on the experience of our service users and staff.

We are taking a complainant-led approach to complaint resolution, by focussing on the desired outcome of the person raising the complaint, and agreeing together the best route to resolving the issues raised. This approach has allowed us to resolve a greater proportion of concerns informally through the PALS service. Our PALS officers have liaised with the clinical services to provide much faster and more direct responses to the less complex concerns. As a result, the number of formal complaint investigations has fallen by nearly a third.

The table below shows the volume of complaints and concerns logged by type, compared with the previous year. Please also note the increase in locally resolved complaints, which is a positive indicator that services are resolving more issues raised directly with them, thereby preventing the escalation of issues to a formal complaint. Overall, there has been a reduction of 5% in total complaints raised.

	2022/23	2023/24	+/-
Formal Complaints	397	275	**-31%**
PALS Concerns	470	537	**+14%**
MP Complaints	71	69	**-3%**
Locally resolved complaints	48	60	**+25%**
Grand Total	**986**	**941**	**-5%**

Report Highlights

- The trust received 941 complaints and concerns in 2023/24 which is a 5% decrease compared to the previous year (986).
- 275 were formal complaints investigated by the Complaints Team; 537 were concerns raised and resolved informally via the PALS service; 69 were complaints raised and resolved via a local MP, and 60 were raised directly to the relevant service and resolved locally by them.
- Only 96 formal complaints (29%) were resolved within the Trust's target of 60 working days.
- However, 94.8% of formal complaints were closed within agreed timescales (this includes keeping the complainant updated with extended timescales)
- We closed more formal complaints (332) than we received (275) which led to the total caseload of open investigations decreasing by over a third from 157 as at 31 March 2023 to 100 as at 31 March 2024.

- The top category for Formal Complaints was "Assessment & Treatment (Clinical Practice)", however the top theme of complaints received via MPs was "Lack of Community Support" for the third consecutive year.
- Lessons were identified from 172 (52%) of the 332 formal complaints closed during the year, and many were shared Trust-wide in our Learning Lessons Newsletter.
- We increased the response rate for our Complaints Feedback Survey to 14% by including a QR code with a link to the survey on our response letters.
- Of the 19 Quality Assurance reviews completed so far by the Non-Executive Directors, 100% were rated positively for the 'quality of the response letter'
- 9 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust.
- We resolved 14% more concerns via the PALS service compared to last year, which has helped to reduce the number of Formal Complaints by nearly a third.
- There was a 2% increase in the number of compliments received directly to EPUT services this year.

Although we have made substantial improvements to our complaints service, we do continue to have some challenges. Constrained resource, and limited capacity in the frontline teams to support the complaints liaison team provide an ongoing challenge to meeting targets for response times. We continuously review the way we work to improve efficiency, and we will continue to consider ways to do this in the coming year.

We are pleased to have improved the response rate for our Complaints Feedback Survey this year: however, the scores and comments received have given us a lot to think about. Despite receiving some very positive feedback directly from people that have used our complaints service this year, the clear message from people completing the complaints survey is that they do not have faith in our complaints service, with only one fifth of respondents saying they believe it is fair.

Our focus for the year ahead will be on building trust with our service users, by listening to their feedback and taking positive action to improve confidence in our service.

FORMAL COMPLAINTS

Complaints that are received directly into the Trust's Complaints Team are allocated to a Complaints Liaison Officer (CLO) within the Complaint Team. The CLO will attempt to contact the complainant to discuss their concerns and agree together how to proceed with resolving the issues raised.

A formal complaint investigation is likely to be the recommended route if:

- The concerns relate to a past event (rather than an ongoing situation which requires immediate/ urgent action).
- The complaint is complex, and cannot be reasonably addressed without a formal investigation into what happened.

The CLO carries out the formal investigation liaising with the complainant and a clinical advisor from the service as necessary. When their investigation is complete, a Formal Response Letter is sent to the complainant to explain how the complaint was considered and the outcome of the investigation.

Where we have found failings in our service we explain what happened, take accountability and set out what action we have taken to put matters right. We detail any lessons identified and improvement actions that were taken as a result of the complaint investigation, and we notify the complainant of their right to refer the complaint for an independent review by the Parliamentary and Health Service Ombudsman (PHSO).

Received and Closed

Carried forward from 2022/23	Received 2023/24	Closed 2023/24	Carried forward to 2024/25
157	275	332	100

275 formal complaints were received by the Trust during 2023/2024, which is a decrease of 31% on the previous year's figure (397). This reduction reflects our focus on resolving complaints informally via the PALS service wherever it is appropriate – i.e. if the concerns raised relate to an ongoing issue that requires prompt action and/or are low complexity and do not require a formal investigation to address them.

Received by Area

Our complaints reporting system (Datix) is now aligned to the Trust's Care Units, and the below table shows formal complaints received by Trust Care Unit in 2023/24.

	2023/24
Community Delivery Mid and South Essex	88
Community Delivery North Essex	30
Community Delivery West Essex	34
Inpatient and Urgent Care	89
Psychological Services	21
Specialist Services	10
Corporate / Business Units	3
Grand Total	**275**

Comparative data is not available for the previous year by Care Unit, as complaints were logged under the Trust's old organisational structure in 2022/23. Therefore, for comparative purposes the data is also presented below by area under the old structure.

Area	2022/23	2023/24	% change
Mid and South Essex STP	132	102	-23%
North East Essex STP	56	46	-18%
West Essex STP	29	22	-24%
Medical – Trust-wide	68	40	-41%
Specialist – Trust-wide	20	10	-50%
Psychology Services	21	16	-24%
Total Mental Health	**326**	**236**	**-28%**
Community - South East Essex	42	17	-60%
Community - West Essex	16	19	+19%
Total Community Health	**58**	**36**	**-38%**
Corporate Services	13	3	-77%
Grand Total Received	**397**	**275**	**-31%**

Received by Patient Contacts

Due to the different volume of services delivered within these localities, the number of patient contacts vary significantly. Data for patient contacts in 2023/24 are shown below:

Area (MH Services)	Total Formal Complaints	Total Patient Contacts	Complaints per 1000 patient contacts
Mid & South MH	102	361,511	0.28
North Essex MH	46	171,334	0.27
West Essex MH	22	124,719	0.18
TOTAL MH Services	**170**	**657,564**	**0.26 ***
Community - South East Essex	17	608,483	0.03
Community - West Essex	19	504,429	0.04
TOTAL Community Services	**36**	**1,112,912**	**0.03**
Grand Total	206	1,770,476	0.12

* In the previous year (2022/23) the number of complaints received per 1,000 patient contacts constituted between 0.5 and 0.6 complaints across all 3 localities for Mental Health Services.

Trend Analysis by Area

The comparative data demonstrates a reduction in formal complaints received in all areas, with the exception of West Essex Community services. The 19% uplift in that area represents a difference of 3 complaints. Two complaints were logged in 2023/24 for the Virtual Hospital service, which was a new service launched in December 2022.

The most significant decreases in formal complaints are seen in Corporate Services (-77%) and South East Essex Community (-60%).

Of the 13 complaints logged in 2022/23 for Corporate Services, 10 related to covid vaccinations. The Trust's covid vaccination programme has now been significantly scaled down, and we did not receive any complaints for this service in 2023/24.

The 60% reduction in formal complaints logged for SEE Community can be attributed to service improvements made at The Lighthouse Centre in Southend. EPUT took over the management of children's services at The Lighthouse Child Development Centre in Southend from Mid and South Essex NHS Foundation Trust in March 2022, and 22 formal complaints relating to this service were logged in that year relating to:

- Access to treatment
- Referrals / Appointments
- Medication
- Communication

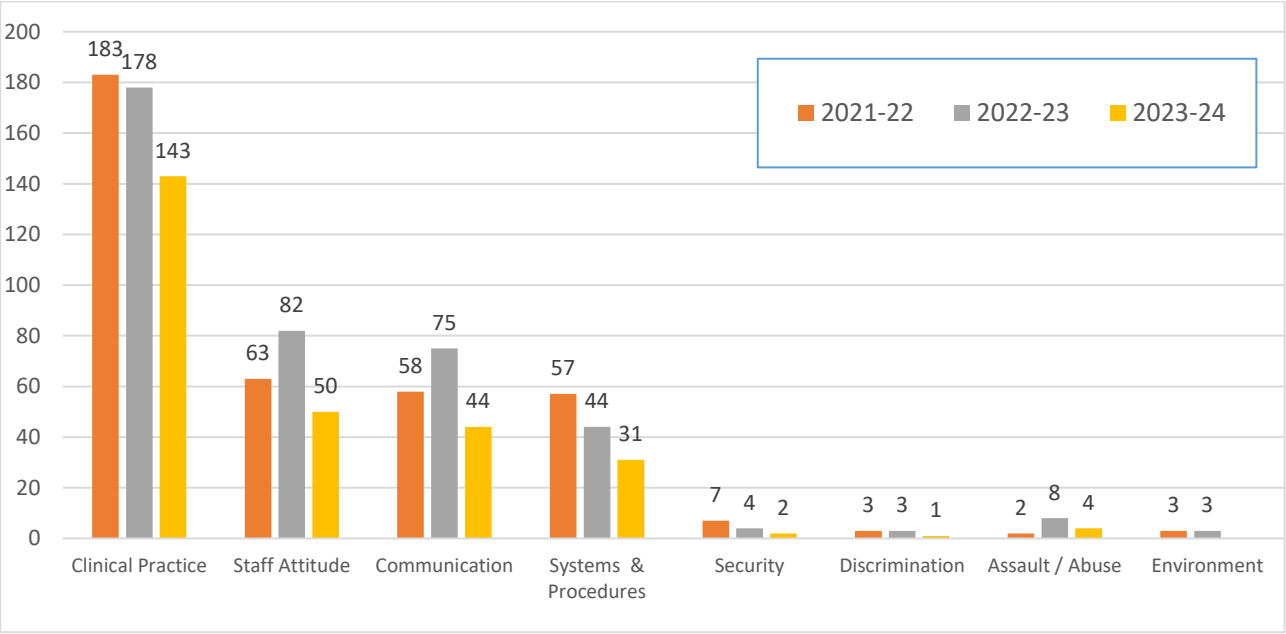
The service worked closely with the Patient Experience Team and local partners, including commissioners, councils, schools, GPs, parent carer forums, and families to improve services at The Lighthouse. This has been a great example of how we can use patient insight and information from PALS, Complaints, and I Want Great Care, to drive improvements.

We set up a new nurse-led ADHD service, which provides various diagnostic assessments for children with suspected ADHD, and treatment. We also now have more doctors working with us, and we have recruited additional administrative staff to answer phones more quickly, to support with referrals and booking appointments.

These changes are providing families with a better experience at The Lighthouse, and we didn't receive any formal complaints for The Lighthouse Centre in 2023/24.

Complaint Categories

Complaints are categorised according to the main theme of the issues raised. The chart below shows the 3-year trend of formal complaints received in these categories.



- Clinical Practice remained the highest category in 2023/24, although the number of complaints logged within this category fell by 35 (20%) from the previous year.
- Complaints about Staff Attitude and Communication both increased last year, but both decreased below the 2021/22 level in 2023/24.
- All complaint categories have decreased compared to last year.

Top ten sub-categories

Under each main category, there are a number of sub-categories, which drill down further the theme of the complaint. The top ten sub-categories made up 54% of the total formal complaints received in 2023/24 (149 out of 275), as follows:

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Assessment & Treatment	29	11%
Communication	Communication breakdown with patient	23	8%
Clinical Practice	Unhappy with Treatment	17	6%
Clinical Practice	Discharge / Follow Up	17	6%
Clinical Practice	Medication	14	5%
Clinical Practice	Poor care on ward	11	4%
Staff Attitude	Rude face to face	10	4%
Staff Attitude	Inappropriate behaviour	10	4%
Staff Attitude	Unhelpful	9	3%
Systems & Procedures	Waiting Lists/Times	9	3%
		149	**54%**

Common themes in the complaints that were categorised under 'Assessment & Treatment' were:

- Patients unhappy with their diagnosis, feeling that the assessment was not thorough/ correct
- Patients feeling unsupported and not knowing what is happening
- Appointments being cancelled, leading to delays in assessment/ treatment

Many of these complaints also link to communication. Complaints are regularly discussed in team meetings to reinforce how important it is to maintain good communication with patients and families.

Complaint Outcomes

When a formal complaint is investigated, a review is carried out to establish if something has gone wrong with the care or service provided. The investigation seeks to confirm what happened, and considers this against what *should have* happened according to relevant regulations, standards, and policies or published guidance.

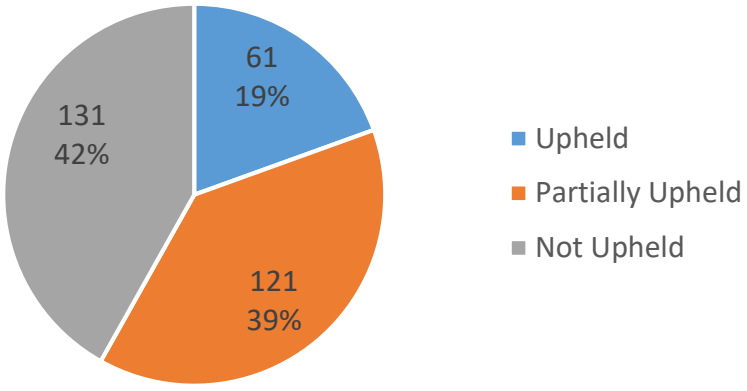
If the evidence demonstrates a difference between what happened and what should have happened, the complaint is recorded as 'upheld.' If the investigation finds that the care or service provided was in accordance with expected standards, the complaint is recorded as 'not upheld'.

If there are multiple points raised within one complaint, each point is considered separately and each one is either upheld or not upheld. Where there is any combination of upheld/ not upheld complaint points, the overall complaint outcome is logged as 'partially upheld'.

332 formal complaints were closed during 2023/24, but a formal investigation was not completed for 19 (6%) cases for the following reasons:

- 2 were withdrawn by the complainant after being logged.
- 6 were initially logged as formal complaints, but were subsequently resolved informally by the service (with the agreement of the person who raised it) to achieve a faster resolution.
- 11 were closed with no investigation for various other reasons, e.g. a Patient Safety Incident Investigation (PSII) was looking at the same issues so the complaint was closed in agreement with the complainant; a lack of patient engagement made it impossible to complete one investigation; another complaint was re-directed to a different Trust after discussion with the complainant.

Of the 313 formal complaint investigations that were completed by the Trust's Complaints Team in 2023/24, the outcomes were recorded as follows:



Re-opened Complaints

We encourage people to let us know if they remain dissatisfied after receiving our response to their complaint, so that we can continue to seek resolution on any outstanding concerns for the complainant.

Of the 332 formal complaints closed in the year, 7% (23) were subsequently reopened. The reasons given for requesting the complaint to be re-opened are categorised below, alongside the previous year's data for comparison.

Reason for Re-opened Complaint	2022/23	2023/24
New questions/ information	3	8
Disagrees with response	1	6
Dissatisfied with investigation	10	5
Unhappy with outcome	8	3
Complaint not fully addressed	5	1
Grand Total	**27/380 (7%)**	**23/332 (7%)**

A recurring theme is a mistrust of the information provided to the complaints investigator by the service. Comments from the file include:

- *"Complainant is accusing staff of submitting false statements and making up information on records"*
- *"Complainant is unhappy with outcome of complaint, feels the information given by the service was not correct"*
- *"Complainant unhappy with response and disagrees with much that has been said. States assessments were not completed, feels accusations have been made and would like to know where these have come from."*

Under our new complaints process, formal investigations are conducted by a Complaints Liaison Officer (CLO) within the Complaints Team, rather than by an investigator allocated from within the service that the complaint is about - a change that was made (in part) to improve the transparency and integrity of the investigation process.

The CLO's investigation necessarily involves reviewing records made by the service and taking statements from staff about their recollection of events, but it is crucial that we balance this by also speaking to the complainant, taking their recollection of events into account and providing them the opportunity to be heard and involved in the investigation process.

Since launching our new process we have taken further steps to increase the objectivity of the complaint response. Previously, the Complaints Liaison Officer would conduct their independent investigation and then draft a response letter to be approved and signed by the service director for the area the complaint was about. Following direct feedback from complainants we changed this approach, and now the CLO writes the response letter directly to the complainant, explaining the outcome of their investigation.

We know that fairness must be at the heart of any complaints process in order for people to use it with confidence. The challenge when delivering an internal complaints service is not only to ensure that the process is as impartial and fair as possible, but also to provide assurance of this to the service user. We are determined as a service to strengthen our service users' trust in our complaints process, and we will continue to focus on this challenge in 2024/25.

Non-Executive Director Complaint Quality Reviews

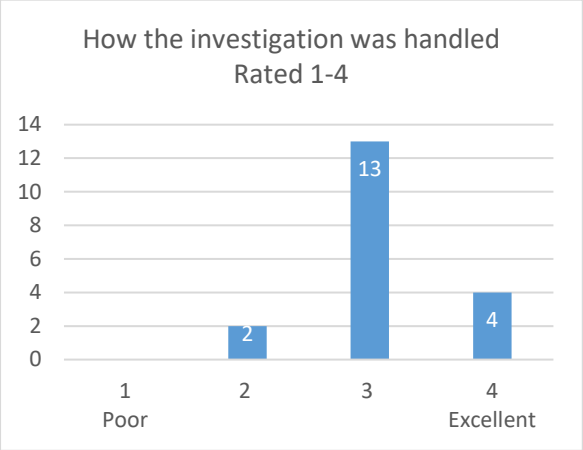
The Trust's Non-Executive Directors (NEDs) provide an important and valuable quality review of 10% of complaints that are closed each quarter.

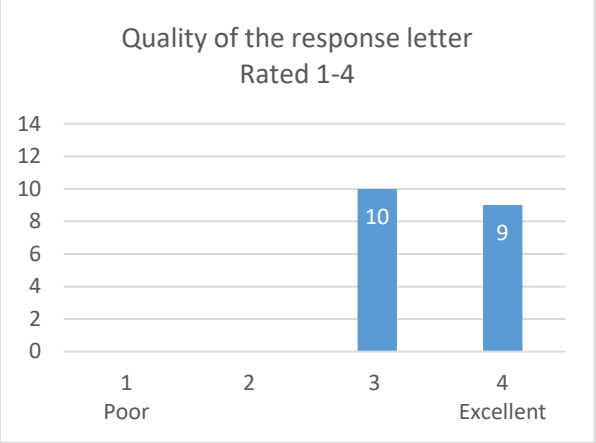
The reviewer rates the quality of the investigation and the response, and considers whether the Trust has done all it can to resolve the complaint and if appropriate lessons were identified and taken forward.

A total of 19 reviews have so far been completed for Q1-Q2 2023/24, which represents 6% of the total formal complaints closed in the whole year (332). A further 15 reviews will be completed, to ensure that a total of 10% are reviewed.

Of the 19 reviews that have been completed:

- 89% were rated positively for 'how the investigation was handled'
- 100% were rated positively for the 'quality of the response letter'





Along with scoring the quality of the complaint files, the Non-Executive Directors provide comments that are shared with the Complaints Team as feedback to take on board for future. Some examples from this year are below.

The language in the response letter could have been simpler. e.g. the term "in line with presenting needs" is not used in everyday language outside the NHS.

It was not clear despite the investigation how Mrs X would get the right incontinence pants that she needed. In addition, the Trust ends up blaming the ICB in the response letter…we should own the commissioning responsibility.

We should always aim to be replying sooner, but it was a reasonable turnaround. Clear and concise investigation.

MP COMPLAINTS

The Trust received 69 complaints from MPs on behalf of their constituents, down by 3% compared with the previous year (71). The top 4 topics for MP complaints were as follows:

- Lack of Community Support (12)
- Assessment & Treatment (8)
- Unhappy with Treatment (7)
- Access to Treatment (6)

LOCALLY RESOLVED COMPLAINTS

All EPUT staff are encouraged to resolve concerns or complaints directly at the point they are first raised wherever this is feasible, because it provides a much better patient experience. A sincere apology and prompt resolution by the service when something has gone wrong can prevent matters from escalating, and also save the person raising the concern a lot of time and worry.

It is important that we capture the details of complaints that are resolved locally, so that we are aware of emerging issues, and any lessons learned can be recorded and shared as appropriate. Until last year, staff were required to complete a manual form and pass it to the Complaints Team for logging if they resolved a complaint locally. We felt this manual process was deterring staff from reporting locally resolved issues, so we devised a more efficient process.

Following a systems development in 2023, complaints resolved locally by the services can now be logged directly on the complaints reporting system (Datix) by any member of staff – and this appears to have had a positive effect on the numbers that are being reported.

There were 60 locally resolved complaints recorded on Datix for 2023/24, which is an increase of 25% compared to the previous year's total (48). The numbers logged are shown below by area.

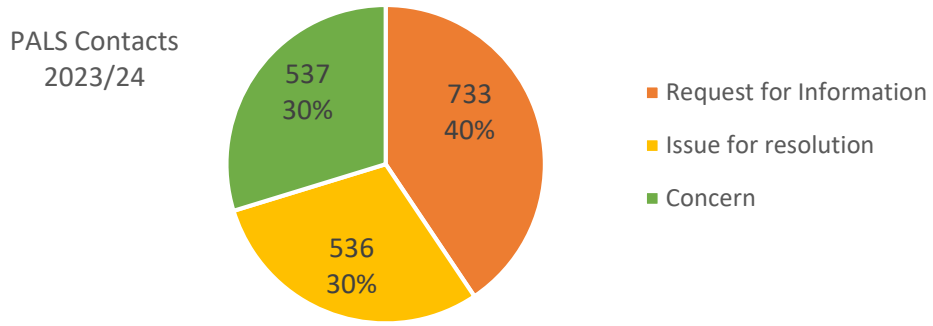
	2023/24
Community Delivery Mid and South Essex	37
Community Delivery North Essex	12
Community Delivery West Essex	4
Inpatient and Urgent Care	6
Corporate / Business Units	1
Grand Total	**60**

PATIENT ADVICE AND LIAISON SERVICE (PALS)

The PALS service sits within the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. Our PALS service supplies confidential advice, support and information about all aspects of EPUT services, primarily to patients, their families and their carers.

The majority of contacts to PALS are either resolved by a PALS Officer at the point of contact, or passed to the relevant service to contact the enquirer and resolve the issue raised.

PALS received 1,806 contacts during the year 2023/24, which was an increase of 35% on the previous year (1,337). A breakdown of the type of enquiries received is shown below.



In addition, PALS Officers signposted 1,686 enquirers for help to other services/ organisations.

Concerns

Concerns that the PALS service typically manage are where the issue relates to an ongoing or current patient situation which requires immediate action and/or the issues raised are not complex and can be resolved promptly by liaising with the relevant service without carrying out a formal investigation.

If the issues raised are complex and require a formal complaints investigation in order to provide a resolution, this would be discussed with the person raising the concerns and, with their agreement, passed to the Complaints Team to manage through the Trust's complaints process. In total, 37 concerns (2% of PALS contacts) were passed to the Complaints Team to be investigated as formal complaints in 2023/24.

We remain focussed on resolving issues informally via the PALS service wherever this is likely to provide the best outcome for the person raising the concerns, and we saw a 14% increase in the number of concerns resolved via PALS in 2023/24.

The top 10 sub-categories for PALS concerns in 2023/24 make up 78% (419) of the total for the year (536).

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Care	167	31%
Communication	Communication breakdown with patient	96	18%
Communication	Communication breakdown with relatives	35	7%
Clinical Practice	Unhappy with Treatment	26	5%
Clinical Practice	Referrals / Appointments	25	5%
Clinical Practice	Lack of Community Support	19	4%
Clinical Practice	Discharge / Follow Up	18	3%
Clinical Practice	Medication	12	2%
Communication	Sharing of Information/Record Keeping	11	2%
Staff Attitude	Inappropriate behaviour	10	2%
		419	**78%**

Some brief summaries of PALS concerns from last year are provided below:

Concern sub-category	Concern Raised	Outcome
Care	Daughter unhappy with her mother's treatment and lack of care on the wards. Mum now being told she will be discharged on Monday and daughter does not believe she should be. Would like it looked into.	Consultant has responded to enquirer regarding their concerns and invited them to attend the review on Monday to discuss discharge.
Communication breakdown with patient	Enquirer (service user) unhappy as received a telephone call on Friday from Brentwood Resource Centre to their home telephone number and have not given permission for this to be used. All calls should go to their mobile telephone number. Would like home telephone number removed from all records.	Email sent to service from PALS who responded to enquirer. PALS confirmed telephone number has been removed from system and patient summary record before closing.
Communication breakdown with relatives	Enquirer not happy that someone from Memory Monitoring came to see his wife (who has memory issues) and he was not aware of it so was not present. Wife then cannot remember what was said and gets upset.	PALS liaised with service who confirmed they would contact Enquirer when wife has appointment so that they can be present.

RESPONSE TIMES

Formal Complaints

Completed within agreed timescale (Target 95%)

In line with the NHS Complaints Regulations (2009), we investigate Formal Complaints as quickly and efficiently as possible, keeping the complainant updated with progress.

Every formal complaint is allocated to a Complaints Liaison Officer (CLO) who makes contact with the complainant as soon as possible to discuss the issues raised. The CLO explains how their investigation will be taken forward, and, based on the complexity of the case, provides a likely timescale for completion.

If we are unable to meet the original timescale provided, the CLO is responsible for keeping the complainant updated regarding the revised timeframe.

In 2023/24 we completed 94.8% within the agreed timescale, which was an increase compared to the previous year (91%).

Completed within internal service level (Target = 90% within 60 working days)

Although complaint response timescales inevitably vary based on the complexity of the case, we also measure our performance against a fixed internal service level of 60 working days (3months) for responding to formal complaints.

Out of the 332 formal complaints closed in 2023/24, 62 (19%) were legacy complaints that were investigated and responded to under the old process. There is a significant variation compared with the response times for the 270 complaints managed under the new process, as shown below:

Complaints Process	Number Closed in 2023/24	% Closed within 60 working days	Average Response Time (working days)
Old Process (received <2023)	62	0% (0)	197
New Process (received ≥01/01/23)	270	35% (96)	78
Total	**332**	**29% (96)**	**100**

The new complaints process has demonstrated an improvement of 16% (15 working days) compared with the previous year's average response time of 93 working days for formal complaints.

PALS Concerns

Completed within internal service level (Target =90% within 15 working days)

We work to a service level of 15 working days (3 weeks) for low level concerns raised through PALS. These concerns are sent via PALS to the service to address directly, or to respond to the patient via the PALS team.

In 2023/24:

- 74% of PALS concerns were closed within 15 working days.
- The average response time was 15.3 days

PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a person is dissatisfied with the response they receive and the Trust's complaints process has been exhausted, they can refer their complaint to the Parliamentary & Health Services Ombudsman (PHSO) to conduct an independent review. We inform complainants of this right within our response letter.

The PHSO conduct an initial assessment of the complaint to decide whether to investigate it. They consider several things, including whether there are signs that the Trust potentially got things wrong that have had a negative effect on the person, that haven't already been put right by the Trust's internal complaint process.

PHSO Referrals

During 2023/24, 9 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust. Of these 9 referrals:

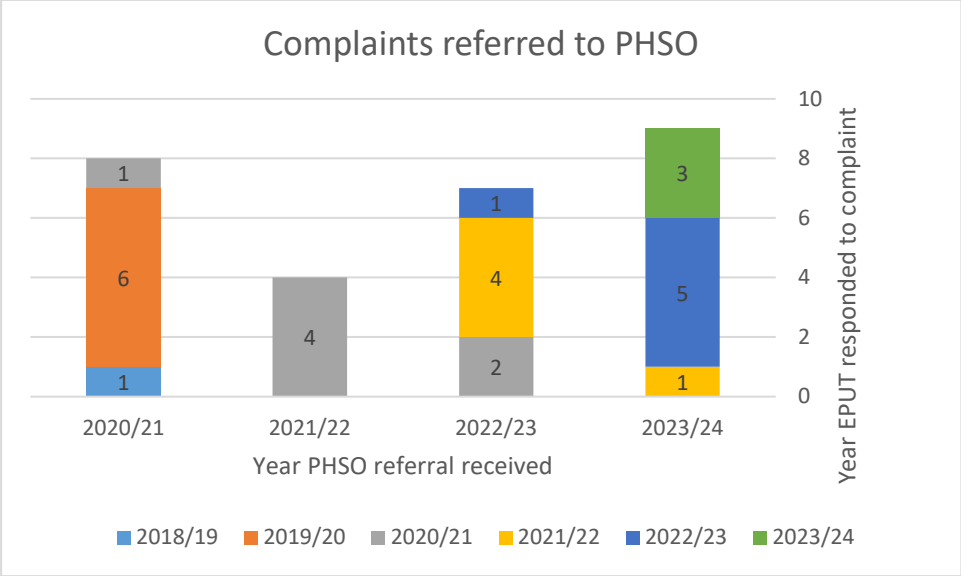
- 2 were closed without further investigation after an initial assessment by the PHSO.
- 7 referrals are still awaiting an initial assessment at the time of writing this report.

Only 3 of the 9 referrals were complaints that had been responded to by EPUT in 2023/24.

The other 6 were complaints we had responded to under the old complaints process in the previous 2 years: 5 in 2022/23 and 1 in 2021/22.

The PHSO has suffered from a backlog of cases since the start of the Covid pandemic, both due to the organisation briefly pausing the processing of complaints at the start of the pandemic and a reduced capacity in the NHS to deal with complaints when it resumed casework.

The below chart shows how 6 complaints that were closed by EPUT in 2020/21 and referred to the PHSO (indicated in grey), filtered through to us gradually across 3 years. The number of referrals received in 2023/24 is the highest since the pandemic, reflecting that the PHSO are catching up on their backlog.



PHSO Investigations

One PHSO investigation was completed during 2023/24, and the case was partially upheld by the Ombudsman. This case is summarised below.

The complainant (Mrs W) was unhappy that her mother had an unwitnessed fall during an inpatient stay on Meadowview Ward in 2020. Specifically, Mrs W's complaint was that EPUT failed to:

- complete the necessary risk assessments or put appropriate risk measures in place despite knowledge of her mother's falls and self-harming history
- ensure Level 3 observations were consistently provided to her mother
- involve her as her mother's representative and Legal Power of Attorney (LPA) during discussions with her mother about 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR)
- provide appropriate care to meet her mother's physical health needs throughout the admission.
- investigate her mother's unwitnessed fall as a Serious Incident

PHSO findings:

The first 4 points were not upheld, however the PHSO upheld the last complaint point, stating:

"*We think Essex Partnership should have identified what happened as a Serious Incident, completing a report in line with the CCG's directive, implemented in March 2020*".

The PHSO recommended that EPUT send a letter to Mrs W to acknowledge this failure and to apologise for the avoidable upset and distress this had caused her. The Trust wrote to Mrs W apologising for our failing to act in line with the Clinical Commissioning Group (CCG) directive in place at the time and to provide a 7-day report in place of a Serious Incident investigation.

We confirmed that we have since taken steps to improve our processes to reduce the likelihood of a similar situation occurring in the future by implementing the Patient Safety Incident Response Framework (PSIRF). We have also employed two Family Liaison Leads who support patients and families following patient safety incidents.

LEARNING FROM COMPLAINTS

The Trust has a strong culture of learning, and recognises complaints as a valuable source of feedback from which we can learn and improve our services. An integral part of the complaints investigation process is to consider if there are lessons we can learn and/or improvement actions we can take to minimize the risk of errors reoccurring. The Complaints Team follow up with the service to provide assurance that improvement actions have been taken forward and embedded into everyday practice.

Lessons identified are presented monthly at the Learning Collaborative Partnership meeting and circulated Trust-wide in the Lessons Identified Newsletter. Learning from complaints is also discussed at monthly Quality & Safety meetings, and the Commissioners of EPUT's services receive a quarterly report containing the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

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Examples of lessons learned

Lessons were identified from 172 (52%) of the 332 formal complaints closed during the year. Below are a few examples of learning from complaints.

1. Psychological Services, Therapy For You (South East):

A patient had to have surgery following a miscarriage. A few weeks later she received an invite from Therapy for You for a "Living well with your baby" 6-week programme and a breakdown of the topics covered, which was very distressing. The assessing clinician had incorrectly used the "perinatal" category with the intention of fast-tracking the patient. (The label is used for patients who are pregnant, expecting a child or have a child up to the age of 1 year old). The clinicians who run the "Living well with your baby" group had then sent letter invites out based only on the attached category, without screening them for suitability.

Learning identified:

Labels are no longer to be used for intervention allocation and the service policy has now been amended and shared with staff. Additionally, group clinicians have been made aware to read all referrals before invites to groups are sent out.

2. Specialist Mental Health Team, West Essex

A patient hand delivered a letter to Latton Bush regarding an appointment at the Derwent centre. The security guard started to open the letter and the patient advised him not too as it was confidential and for medical staff only. The security guard took the patient and her son through the ward to a nurse so the letter could be hand delivered. The letter was handed to a nurse, but it never reached the Derwent centre.

Learning identified:

This case was discussed at a wider management meeting (West Essex). A change of process was agreed for when forms are hand delivered. Self-addressed envelopes are to be included with forms and detail is now provided in the letter of where and when patients can hand deliver letters.

3. CAMHS, Longview Ward

Father unhappy that the transfer of ward was not discussed with him, as the patient has Autism and finds change difficult.

Learning identified:

Communication with the family could have been much better and a phone call should have been made on the morning the transfer took place, and then another call once the patient had left the Ward. Having to move a young person so quickly and at such short notice is something that the service should try to avoid. Especially a young person with ASD who needs time to process information. Discussed at Ward Meeting and Operational Meeting and shared via CAMHS Shared Learning System.

4. First Contact Practitioners Service, West Essex

Patient emailed with complaint regarding delayed diagnosis, treatment and physiotherapy causing more damage to their Achilles and tears of the tendons.

Learning identified:

On their first appointment the patient was advised of exercises and advice for footwear. At this point the patient should have been referred for urgent imaging and to the fracture clinic. On their second appointment the patient reported having a further injury. Conservative management was advised and a physiotherapy referral was made. However, the patient should have had an urgent referral to the fracture clinic or imaging. Investigation concluded that the appropriate referrals were not made when they should have been. The pathway for managing this clinical presentation has been updated and shared with all MSK (Musculoskeletal) teams.

5. Mid Essex Immunisation team (Children's Services)

A mother complained that her 12 year old son was given the HPV Vaccine with no consent at school. Her son was asked by the nurse if he had any allergies or medical conditions to which he replied no, when in fact he did have but was unaware of them.

Learning identified:

Investigation identified the consent form completed was for Year 9 cohort, which was the year group of the complainant's other son. As the signed consent form was over six weeks old, we should have sought confirmation that details were up to date and consent had not been withdrawn, this did not happen. Complaint discussed with staff. We now operate a guide of seeking consent a maximum of 4-6 weeks prior to a vaccination session, and a system development is being explored to email confirmation of consent and send text or email reminders.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints linked to Patient Safety Incidents

All complaints are logged onto the Datix reporting system and are cross-referenced with incidents that have been logged separately, to highlight any incidents that are connected to the complaint.

Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Liaison Officer works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2023/24 there were 58 complaints investigated that were linked to separate incidents that had been recorded on Datix. Of these, 7 were linked to a Patient Safety Incident.

Legal Claims related to Complaints

There were 10 claims opened in 2023/24 that related to complaints; 8 related to alleged clinical negligence, and 2 to alleged data breaches.

A total of 6 claims were closed that related to formal complaints (none of these were any of the above 10 claims, but were received prior to 2023/24).

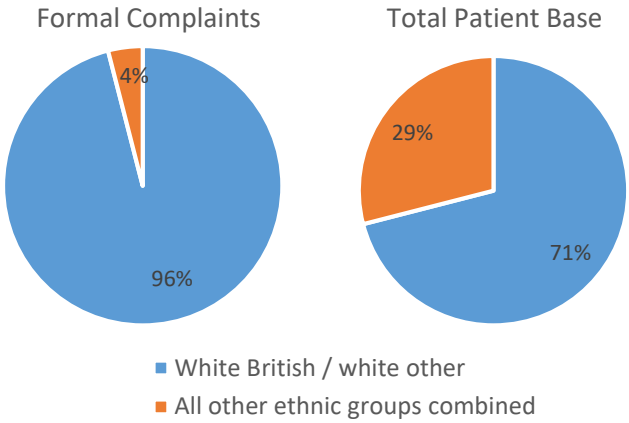
In two of the cases closed there were damages awarded, with a joint total of £67,500.

PATIENT DEMOGRAPHICS

Research published by the Care Quality Commission (CQC) in 2019 revealed that patients from ethnic minorities are less likely than those from a white British background to raise concerns about the standard of care they receive, particularly in relation to mental health. (*Ref: CQC Press Release, 12 June 2019*).

We record patient details on our complaint database (Datix) when logging a complaint, including their ethnicity where this is known. The patient ethnicity data recorded for formal complaints received in 2023/24 is presented below in a pie chart, alongside a pie chart showing ethnicity by our total patient base for comparison.

Ethnicity of patients 2023/24



Through the implementation of our Patient and Carer Race Equality Framework (PCREF), we aim to reduce inequalities in access, experience, and outcomes for racialised and ethnic minority communities.

Complaints are a vital source of knowledge for the Trust, from which we can learn and improve our services. Understanding who is complaining, and proactively seeking out feedback from those who do not, is key to ensuring that all patients have a voice.

In 2024/25 we will be improving how we collect and record demographic data for people who make complaints, so we can better understand which groups are not speaking up, and consider ways to improve access to our complaints service for these groups.

We also recognise that not everyone wants to make a formal complaint, so as a Trust we continue to develop our methods for engaging with the people and communities we serve. By encouraging and acting on informal feedback through patient surveys, NHS reviews, focus groups and workshops, we aim to provide everyone with opportunities to inform and shape our services.

FEEDBACK ON OUR COMPLAINTS SERVICE

Complaints Survey Results

In 2023 we redesigned our Complaints Feedback Survey and introduced a QR code at the end of every response letter that provided a digital link to the survey. We also send a follow-up email with a link to the survey, several weeks after the response is sent.

This approach has been successful in increasing responses, and in 2023/24 we received 48 survey responses (v. 24 the previous year) which represents a response rate of 14%.

Summary of results 2023/24:

- 28% were satisfied that all aspects of their complaint were addressed (v.42% 2022/23)
- 21% believed the complaints process was fair (v. 29% 2022/23)
- 28% were satisfied with the timescale of the response (v.8% 2022/23)
- 22% were satisfied with the overall handling of their complaint (v.33% 2022/23)

The survey is anonymous, and there is a free-text field for any additional comments. Some verbatim comments we received are shown below:

> Your complaint process is one of the worse possible ever, because basically it boils down to the NHS investigating themselves and of course anyone who investigates themselves when there are such high stakes involved, is going to promote their service.

> The resolution was satisfactory. The case handler was excellent and I really appreciated her professionalism especially the timely updates on the case

> This was not an investigation. This is an NHS department protecting other NHS departments and staff.

> Once the complaint is dealt with it would be nice to have received a personal phone call rather than a letter or email.

Based on the feedback received, we shall be considering what actions we can take in 2024/25 to improve satisfaction and confidence in the integrity of our complaints process. Whilst our Complaints and PALS team have some degree of independence from the clinical teams, ultimately they are part of the Trust and our complaints process is internal. The responses received to our survey have highlighted that we need to do more to build trust with people using our service.

Direct feedback to Complaints Team

We received lots of positive feedback directly to the team from people that had used the complaints service in 2023/24. Some examples are given below:

"Dear Lisa [*Complaints Investigation Manager*] Just a note to say thank you for your visit with Tracy [*End of Life Lead*] a few weeks ago and for your follow-up letter. It was helpful to explain my concerns and thank you both for listening and taking them seriously. I hope others in a similar situation will benefit."

(Email received following a Complaint Resolution Meeting)

"Thank you for your assistance in getting my medication rectified. I am very grateful and really appreciate your help, thank you." (

(Email sent to Complaints Liaison Officer)

"I am grateful for the comforting words and empathy shown in your report and the fact that you intend to make improvements regarding communication. Thank you for giving time to investigate. I needed to do this to prevent other families experiencing the same."

(Email sent to Complaints Liaison Officer)

"Thank you for your letter and attachments, I appreciate the steps taken in this investigation. You have answered the points raised…I am happy that the complaint is now resolved and the matter can now be brought to a close."

(Email sent to Complaints Liaison Officer)

"As a family we wanted to thank you all for your help in moving my father's care forwards. We are all quick to complain when things go wrong but not so quick to thank everyone when things go really well, thus the reason for us writing again to you today. We will be writing to the team as well to thank them personally. Thanks again for the lovely help and service you all provided for my father, it felt like the NHS truly paid him back for all the years he devoted to them as a GP for all those years."

(Email sent to PALS mailbox)

"Thank you so much for taking the time to investigate and for all you have done to help me with my complaints… you always listen to me and even speaking with you this morning made me feel so much happier, you made me feel heard and I trust that you actually take on board my concerns."

(Feedback given verbally to Complaints Liaison Officer)

COMPLAINANT STORIES

Reflecting on complainant stories is valuable, because they provide greater insight and context to the complaints data. Case studies are a powerful tool that we use in team meetings and coaching to bring real complaints 'to life' and prompt discussion, reflection and learning.

Note: All names and some other minor details have been changed in these case studies to protect patient and staff confidentiality.

Story 1:

A complaint was received from Mrs J, the mother of an adult patient, Kelly, who had been referred to the Mental Health Crisis Team by their GP after experiencing symptoms of a psychotic episode, including hearing voices, having visual hallucinations and becoming suddenly non-verbal.

After an initial assessment at home the patient was referred for an appointment with the Psychiatrist Team, and following that, the patient was referred to EIP Service (Early Intervention Psychosis).

At her initial appointment with the EIP service, Kelly was further assessed and Mrs J was given a date by which they would be informed if her daughter met the criteria for EIP services. The date passed with no contact, but Mrs J chased it up, and was advised the following day that Kelly did meet the criteria, and a meeting was arranged for the following week.

Mrs J was happy with the support that was offered at this first meeting. It was explained to her that the patient would be under the EIP service for 3 years, and Mrs J was also offered support. However, there were soon problems. A meeting was arranged for the patient to meet her Care Co-ordinator, but when the day arrived Mrs J had to cancel the appointment as Kelly was too unwell to attend it. When Mrs J called to cancel, the receptionist told her that the Care Coordinator was not even in work that day and nothing was in the diary for Kelly to attend an appointment.

Following this, there were more poor experiences. On one occasion the Care Coordinator turned up with another member of staff, who was not introduced to them until they asked who she was. Kelly felt anxious and unnerved by this. Mrs J was left frustrated when numerous appointments were cancelled. This didn't make Kelly feel valued or cared for.

Mrs J repeatedly requested for the Care Coordinator to set a regular time and day for his visits with Kelly, because uncertainty heightened her anxiety. These requests were not responded to.

Mrs J eventually made a complaint after Kelly attended a further psychiatry assessment, where it was decided that she would be discharged from the EIP service. Mrs J was left confused after this appointment, not knowing what would happen with Kelly's care. She emailed Kelly's Care Coordinator and the service to ask for clarification, but received no response.

In her complaint Mrs J said that the uncertainty of the situation had a negative impact on Kelly's mood, and had left her feeling disengaged. She expressed her disappointment with the lack of consistency in Kelly's care, and the support that had been promised and then not delivered. She felt that if the early support had been better then Kelly would have been further along with her recovery. Mrs J requested a second opinion on Kelly's case.

All aspects of Mrs J's complaint were upheld.

We apologised for the poor communication, and the fact that many of her emails to the service were not responded to. Our investigation found that miscommunication between staff had led to this. Some tasks had been delegated within the service, but not followed up.

We apologised for the service provided by the Care Coordinator, which fell short of the standards we expect. He had failed to follow through with plans for regular, weekly support for Kelly. And when he suddenly left the service, a proper handover did not take place.

Our complaint response explained that Kelly was referred to the Early Intervention Psychosis (EIP) team for further assessment, and although intervention with EIP can be up to 3 years, this depends on the outcome of assessments. This should have been explained to Mrs J from the beginning.

We explained that the reason Kelly had been discharged from EIP was because the Consultant had concluded that her symptoms were related to anxiety, and her presentation did not support a diagnosis of psychosis. Therefore, it was determined that EIP was not the most appropriate care team for Kelly. The service recognised that staff could have better explained this to Mrs J and Kelly, and we apologised for this lapse.

We acknowledged that a decision had been made to refer Kelly to a Specialist Community Mental Health team, and this had now been discussed with Mrs J. It was agreed that, in the meantime, Kelly would still be supported and continue with psychology intervention until the referral was complete.

In accordance with Mrs J's request, a second opinion was arranged regarding Kelly's diagnosis and care plan.

This complaint was discussed with the teams involved, to reflect on the errors that were made and the impact that these had on Mrs J and on the patient's care.

Story 2:

A complaint was raised by Mrs B, the daughter of a patient, Olive, who lived in a Care Home and was under the Trust's Dementia Memory Service.

A member of the Dementia Service team attended the Care Home to complete monitoring appointments for a number of residents. On arrival, the member of staff was advised by the Care Home staff that Olive had been made palliative 3 days previously, and that all medication had been stopped by her GP. The patient was in bed with her family by her side, and it would be inappropriate for the planned assessment to go ahead.

The member of staff insisted that he still needed to see Olive, and Mrs B reported that she could hear the Care Home staff outside trying to stop him from entering the room. In addition, there was a butterfly symbol on Olive's bedroom door to indicate that she was on end of life care. Despite this, he entered the room, and began by incorrectly addressing the patient as 'Enid'. He explained that he was there to complete an assessment. Mrs B asked him to leave, but he insisted on explaining that he would be writing to the next of kin (at which point Mrs B informed him that she was the next of kin) and he confirmed that he would be sending Mrs B a letter to say that he had attended to complete the medication monitoring assessment and that she had denied him access. He explained this was part of the Trust's policy and procedure.

Mrs B was upset at the intrusion, and was left feeling that she had been 'told off'. Her mother was unsettled by what happened, and it made what was already an extremely difficult time much worse.

Olive passed away a week afterwards, and Mrs B wrote to the service to complain about what had happened. She questioned if the member of staff had followed the correct procedure by insisting on seeing her mother, and suggested that, if so, the policy should be changed as she would not wish for any other families to go through this ordeal.

The complaint investigation quickly established that there was no policy in place to state that the visit needed to be made. At the time of the appointment, the service were unaware that the patient was now under palliative care and that the visit was not required, which highlighted an issue with communication between our services and those in the community.

As a result of this complaint, the admin staff that book monitoring appointments will now check if patients are on End of Life care before booking in the appointments.

The learning from this complaint included the retraining of the staff member involved, and enrolling all staff in the Dementia Memory Service on 'End of Life care' training. It was also highlighted that the team were not all aware that a butterfly symbol on a patient's door signifies they are on end of life care, so this was communicated in a team business meeting.

In addition, the experience of this family was raised in an external 'End of Life' forum to highlight the impact of the identified communications issues and share learning.

A face to face meeting was held with Mrs B to apologise for the failings and to explain the lessons that had been learned from her complaint.

COMPLIMENTS

1,344 compliments were received directly to the services in 2023/24, compared with 1320 for the previous year. (+ 2%)

A selection of compliments are published throughout the year in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

Received by Area

Area	Compliments Received
Mid & South Essex STP	516
North East Essex STP	151
West Essex STP	54
Specialist	265
Total Mental Health	**986**
South East Essex Community Health Services	189
West Essex Community Health Services	142
Total Community Health	**331**
Corporate Services	27
Total	**1344**

Learning from Compliments

Along with complaints, all compliments received by the Trust are analysed for potential learning that can be shared, as they can provide an excellent opportunity to highlight good practice.

Below are some examples of lessons learned from compliments that were shared Trust-wide in the monthly Lessons Identified Newsletter in 2023/2024:

1. **Basildon Mental Health Unit (MHU), Grangewaters:**

   "I have been a patient on the ward for almost 3 weeks. I would like to say how wonderful the staff have all been. I have been treated with respect, care and understanding. My risk assessment was done swiftly. The nurse (E) asked the sensitive questions in a hushed respectful manner. This made me feel less conscious... My care has been without doubt 100 % positive."

   Good practice shared: By demonstrating sensitivity in this moment we made the patient feel respected and cared for.

2. **rTMS, Brentwood Resource Centre**

   "The staff were kind, helpful, knowledgeable and supportive. They reduced fears and were very thorough. They showed interest in us as people. The treatment has been literally life changing, both for my husband and myself. It is a real joy to see him so able to cope with life. Thank you so much."

   Good practice shared: Taking a personal interest in our patients and their families helps build trust, engagement and shows that we care.

3. **St Margaret's Hospital, Admin**

   "I was enquiring about the progress of my referral yesterday and I was lucky enough to be put in contact with Karen. She listened attentively to my issue, unpicked all the confusion and even though I had been put through to her department by mistake, she spent a great deal of time explaining to me what information I needed to seek… she was patient, intelligent and gave up her time freely."

   Good practice shared: Effective listening skills are fundamental to providing a great service, and spending extra time to help provide clarity for someone can make a huge difference.

4. **Plane Ward, Older Adult Inpatient (Community Health Services)**

   Letter received to thank staff for the care given to their father in his final days, before he passed away on Plane Ward. The family wanted to thank staff for the care and attention given not only to the patient but also the whole family at such a difficult and sensitive time. The letter from the patient's son ended *"The calm atmosphere of the ward and being told we could visit at any time was so important and even being offered a cup of tea by the ward team was a small but greatly appreciated act of kindness. We will never forget the excellent care our father received at your hospital".*

   Good practice shared: In addition to delivering compassionate care and treatment to our patients, it is important to show kindness and understanding to their family/carers, recognising what a difficult time this can be for them.

5. **South East Essex, Occupational Therapy**

   Telephone call from patient complimenting Community Occupational Therapist, Beverly, on her professionalism and caring attitude. The patient said that by providing the appropriate equipment to support and enable her at home, her condition is improving. She also added that Beverly asked about her wellbeing regarding her chemo treatment, and asked how she was feeling which the patient found very caring.

   Good practice shared: Taking a whole person approach to treatment is understanding that health and wellness are not limited to physical health.

UPDATE ON PRIORITIES SET FOR 2023/2024

Please find an update on the priorities set in last year's annual complaints report in the table below.

Priority	Status	Action Taken
Embed new complaints process.	Complete	An evaluation of the re-designed Complaints Process was presented at Quality Committee in Dec-23.
Enhance PALS accessibility by creating a network of volunteer's onsite within our services to provide support and advice, and proactively seek feedback from our service users.	In progress	A trial of this is planned in West and North East. A role description was advertised for volunteers and we have some applicants. Meeting planned to agree details of the role and book in some shifts.
Implement self-logging facilities for staff and service to log informal complaints and compliments.	Partially Complete	This facility has been delivered for self-logging compliments. The feasibility of extending this to locally resolved complaints is being reviewed.
Establish an effective feedback process (service user survey, and quality feedback from NEDs and Patient & Carer Forum) for the complaints process	Complete	Service User survey is now digital, with a QR code on every response letter, and a follow-up email sent with a link to the survey. The NED review process has also been reviewed so it is aligned with the new complaints process and is completed through MS Forms to make it a more efficient process. Advice was sought from Information Governance regarding consent required for quality reviews through the Patient & Carer Forum, and it was agreed we would need to gain the explicit consent of complainants to do this. We shall consider this as part of a wider review of the way we obtain and use consent for complaints

Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective .	Carried Forward	Due to operational pressures we have not yet started this review.
Engagement with Deputy Directors of Quality and Safety to implement effective feedback and follow up on lessons/ actions	Complete	An effective feedback process is now in place, and DDQS have been engaged to provide monthly feedback on lessons identified.
Review the information on the Trust website, make it more accessible and clearer regarding the PALS and Complaints services.	Complete	Information has been updated on the Trust website to provide clear guidance regarding the PALS and Complaints services. A directory has been added to the PALS page to provide contact details for alternative Trusts and ICBs, to reduce the number of "signposting" calls we receive in PALS.

PRIORITIES FOR 2024/2025

- Focus on maximising the integrity of our internal complaints service by:
    - Providing PHSO training for the whole Complaints Team (NHS Complaints Standards accredited course), to increase skills and confidence in conducting evidence-based investigations that are balanced and fair.
    - Minimising the potential for bias (or the perception of bias) by removing the requirement for the service to approve the response letter that is sent to the complainant following the CLO's independent investigation. Replace this with a requirement for senior approval of the clinical information provided for the Complaints Investigation Report.
- Build trust with complainants and improve their faith in our service by:
    - Sharing our investigation plan with them at the beginning of the process so that (a) the complainant is clear on our intended approach and can provide input and feedback at an earlier stage, and (b) it provides better context for our estimated timescale for completion, which is based on the complexity of the investigation.
    - Where it would be helpful, providing our 'initial view' to the complainant and the service prior to sending our final response letter, so that both parties can raise any concerns and provide any further information to be taken into account.
- Improve response times by providing more effective early dispute resolution, including resolving a greater proportion of concerns via the PALS service.
- Implement a robust process for capturing and sharing lessons learned from PALS concerns, to ensure that we are not missing learning opportunities when we resolve complaints informally.
- Improve the capture and reporting of the demographic breakdown of our complainants, so we may better identify if there are certain groups who are not speaking up.
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective (carried forward from last year).

Report produced by:

Claire Lawrence, Head of Complaints and PALS
Matthew Sisto, Director of Patient Experience

On behalf of:
Zephan Trent, Executive Director of Strategy, Transformation and Digital

May 2024

8.2 PATIENT EXPERIENCE AND VOLUNTEERS ANNUAL REPORT

Information Item ZT 5

REFERENCES

Only PDFs are attached

Patient Experience & Volunteers Annual Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Patient Experience and Volunteers Annual Report 2023/24**					
Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital					
Report Author(s):	Amy Poole, Head of Patient Experience and Volunteers Matthew Sisto, Director of Patient Experience and Participation					
Report discussed previously at:	Experience of Care Group (02/05/2024) Quality Committee (09/05/2024)					
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		
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		
The purpose of the report is to provide an updated position on the Patient Experience portfolio, summarising key achievements, engagement methods and success measures of the last year.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

- Note the contents of the report.

Summary of Key Points

Introduction
Over the last year, the Trust Board has approved a new Quality Strategy (People Together Creating Safety, Effectiveness and Experience) and a new Working in Partnership with People and Communities Strategy. This annual report demonstrates early progress against these strategies and highlights areas for continued focus going forward in our work on patient experience and participation. The Trust's aspiration remains that people (patients, carers, and families included) are involved with key decisions and engaged in driving forward meaningful change; with learning from lived experience at the heart of everything the Trust does.

Key points

- Whilst challenges remain, there has been remarkable success from the portfolio this year with notable progress against the commitments in EPUT strategies
- Co-production practice continues to develop across the trust and has been supported by the success of EPUT's first coproduction conference. Our work on coproduction was nominated for a national care award.
- There has been significant growth in volumes of patient feedback through I Want Great Care, with feedback up 89% in Q4 23/24 compared to Q4 22/23.
- The Trust is using the Patient Carer Race Equality Framework as a new lens to view involvement activities and have recruited a co-production lead for the work in this area.
- The Trust now has over 50 peer support workers in the lived experience team.
- The Trust has seen significant year-on-year growth in numbers of volunteers (up 81%), lived experience ambassadors (up 64%) and hours of involvement (up 33%). Lived experience ambassadors are increasingly involved in important programmes of work across the trust and trust governance.
- New governance arrangements have been established to strengthen the voice of lived and living experience in the trust including the People Participation Committee and a new executive chaired Experience of Care Group.
- Key challenges include variability in uptake and adoption of I Want Great Care feedback tools and variability in utilisation of volunteers and the lived experience team across care units

Next steps
Over the next year, the Trust will continue to increase the impact and learning from patient experience and participation across the trust. To support this, the Director of Patient Experience and Participation will work with Care Unit leads to review how this work is embedded further into care groups.

The Board is asked to note this report.

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			
PLACE	Patient Led Assessments of the Care Environment	LEA	Lived Experience Ambassador
iWGC	iWantGreatCare	PSP	Patient Safety Partner

Supporting Reports and/or Appendices
Patient Experience Annual Report

Executive Lead:

Zephan Trent
Executive Director of Strategy, Transformation and Digital

NHS
Essex Partnership University
NHS Foundation Trust

Patient Experience and Volunteers

Annual Report 2023/2024

April 2024

Contents

Purpose

The purpose of this report is to provide an update on the current position of the Patient Experience portfolio at EPUT. This report will reflect on progress over the past year with frequent reference to the 'Working With People and Communities' enabling strategy (referenced in the Trusts Corporate Strategy 2023 – 2028) which aligns to the National Guidance from NHS for Working in Partnership with People and Communities and its 10 Principles (see figure 1);

Figure 1: 10 Principles for working In Partnership with People and Communities NHS England

The Aspiration

'Our people (patients, carers, and families included) are involved with key decisions and engaged in driving forward meaningful change; with learning from lived experience at the heart of everything we do.' To do this, we must learn from the experiences of the people that use our services, consistently involving the people we care for in shared decision-making, co-design, and co-delivery across all of our services.

Our Updated Position

The patient experience portfolio continues to evolve year on year. The portfolio includes:

- Patient Advice and Liaison Service (PALS)
- Complaints
- Patient Experience
- The Lived Experience Team / Lived Experience Ambassadors (inclusive of coproduction champions and coproduction leads)
- Volunteers
- iWantGreatCare
- Chaplaincy and Spiritual Care Team
- The Inpatient Peer Support Team

Each of the teams and functions within the portfolio share the common goal of developing our relationship with the people and communities we serve, supporting our clinical teams to collectively improve services. The capabilities of the portfolio can largely be grouped under three headers:

1. ***Lived Experience:*** listening, learning, improving the access, experience, and outcome for patients and carers
2. ***Participation:*** involving service users, carers, and volunteers, to co-design, develop, and deliver our services
3. ***Partnerships****:* partnering with our services users and carers, and working with partners across the system, including VCSE, to improve access, experience, and outcomes for patients and carers

The portfolio has now been aligned to the Strategy, Transformation and Digital Directorate for over a year. Since this move, the portfolio and its capabilities have become more strategically aligned, enhancing the strategic development and transformation of the Trust, putting he people that use our services at the heart of strategic design, delivery, and change. The portfolio teams have worked increasingly closer with the operations teams to deliver EPUT's operating model with the six clinical operational delivery units. Teams are frequently liaising with and involving Lived Experience Ambassadors (LEAs) in multi-disciplinary and multi professional work streams and core projects. This ensures the emphasis remains on the voice of people with lived experience, their families and carers, recognising this relationship as our most important partnership. The continued growth of the portfolio means that it now has increased influence over key decisions within the Trust. Whilst there is a way to go in ensuring all staff work with the people we care for in a way that fosters reciprocity, inclusivity, and mutuality, we continue to shift the balance of power through subtle and incremental developments.

Transformation

- There is an increased awareness of the trusts Reward and Recognition policy and, subsequent requests for involvement from teams within EPUT and wider system partners including Essex County Council and three integrated care systems.
- The Reward and Recognition policy has inspired national colleagues and has been used as an example of best practice on how to increase involvement and lived experience activity
- Lived experience is referenced throughout the corporate strategy 2023 -2025 as a golden thread.
- Ways to get involved and engage remain clear, with a supporting policy, processes, and systems.
- We are working with our Lived Experience Ambassadors to enhance our staff induction offer, complete the Lived Experience Practice framework and create a bespoke Lived Experience Ambassador introduction.
- The three different rates of involvement continue to work well with an increasing amount of Lived Experience Ambassadors becoming 'Coproduction leads' facilitating and monitoring the progress of their own involvement groups to feedback into strategic work streams and steering groups. This provides further assurance that people with lived experience have increasing influence in key decision making across the trust.
- Patient Led Assessments of the Care Environment have been facilitated by the Patient Experience team for the last 2 years. This year, we saw record participation from people with lived experience and the Trusts results were included in the national publication.
- The remit and utilisation of the PIPE (Patient Information in Plain English) group has grown significantly and is being increasingly included in the development and review of patient facing documents.
- The Lived Experience Team has continued to grow exponentially and now includes 50 fully qualified Peer Support Workers.
- The Patient Safety Partner role has been fully operationalised with regular ward visits happening across the Trust.
- The Lived Experience Ambassador (LEA) Role is even better established with LEA support weeks scheduled twice a year, inclusive of individual development goals, training needs, concerns and wellbeing.
- We have maintained an increase in the utilisation of the reward and recognition policy and increased number of involvement activities and hours contributed by LEA's.
- We have improved the uptake of IWGC ensuring that it is included in the accountability framework, and set targets for services to seek feedback from services users, families, and friends.
- Our iWantGreatCare feedback response rates have increased incrementally, quarter on quarter. Whilst we still strive to include data collection in business as usual processes, this provides assurance that our Patients, their families and carers have the opportunity to give feedback and increasingly do so. This feedback identifies best practice, acting as an early warning system for complaints, and is utilised with lessons learnt team.
- The role of our iWGC reporting and training manager has been extended for another year. The role is specifically designed to work on Patient Insight and Intel, frequently reporting to the care units, and key decision-making committees. This year, we have evidence that this role is having an impact in patient Insight and Intel driving forward meaningful change.
- The Patient Experience team have assumed the management of compliments in order to align the feedback with iWantGreatCare.

- The Patient Experience reporting co-ordinator has defined processes of working with Care opinion, NHS reviews and Healthwatch to manage service reviews and encourage local ownership, allowing us to respond to people in a timely and personalised manner.
- The co-designed inpatient welcome brochure has received excellent feedback from patients, families and staff.
- For the new Quality of Care Strategy we are actively recruiting lived experience leads to support our governance, which is in line with the guiding principles of the Working in Partnership Strategy.
- The Patient Carer and Family Collaborative has been redesigned to become the People Participation Committee. This is the trusts equivalent to a citizen's panel, and is led by the people we work with and will be a key contributor to decisions in the new Experience of Care Group set up to support the delivery of the Quality of Care Strategy.
- The Experience of Care Group is chaired by the Executive Director of Strategy, Transformation and Digital. This group is inclusive of representatives from our Lived Experience team and a variety of senior leaders across the trust whom are in a position to influence the development and implementation of the Trusts strategy.
- Increased involvement from our lived experience team across the majority of major programmes.
- Key policy update for recruitment, mandating that a person with lived experience is a panel member for interviews for roles band 8a and above.
- Increased the number of lived experience ambassadors whom identify as a minority, or with a protected characteristics as per the Equality Act 2010. (See Figures 1 and 2)

Figure 2: 2023 Volunteer Demography

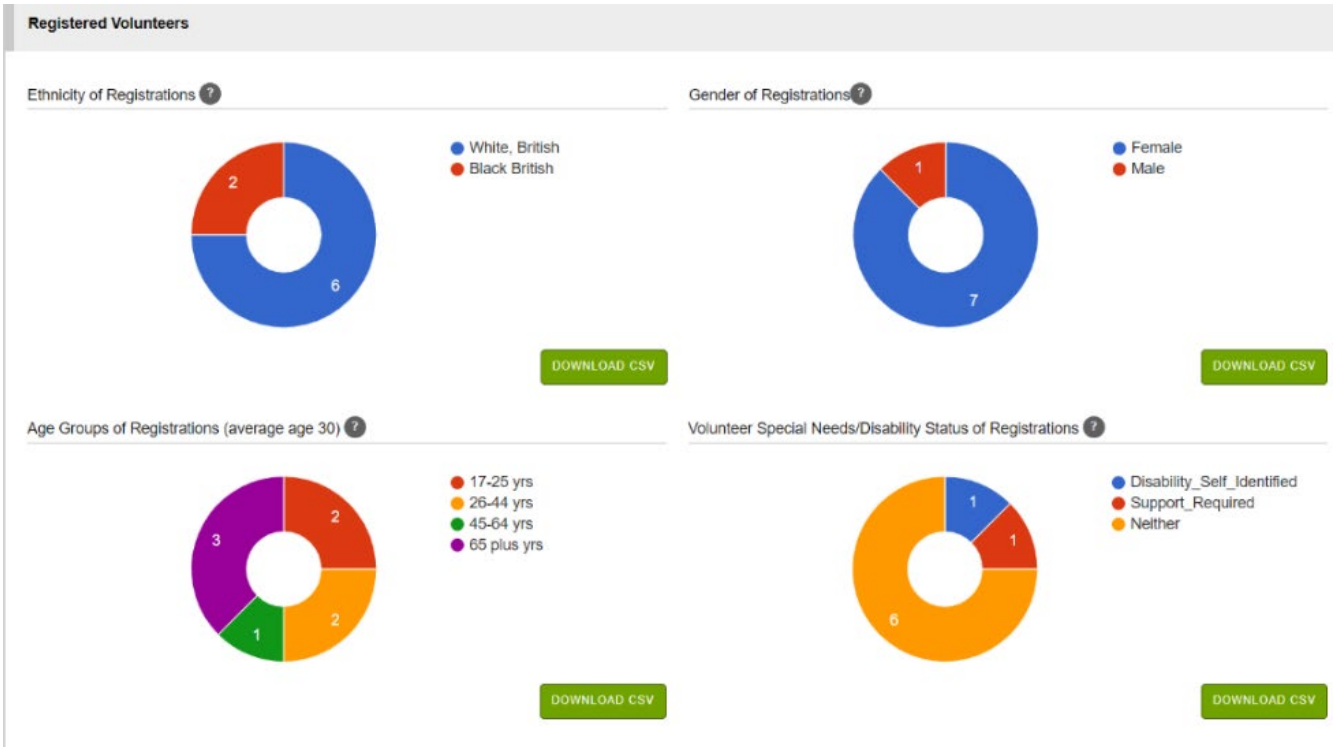
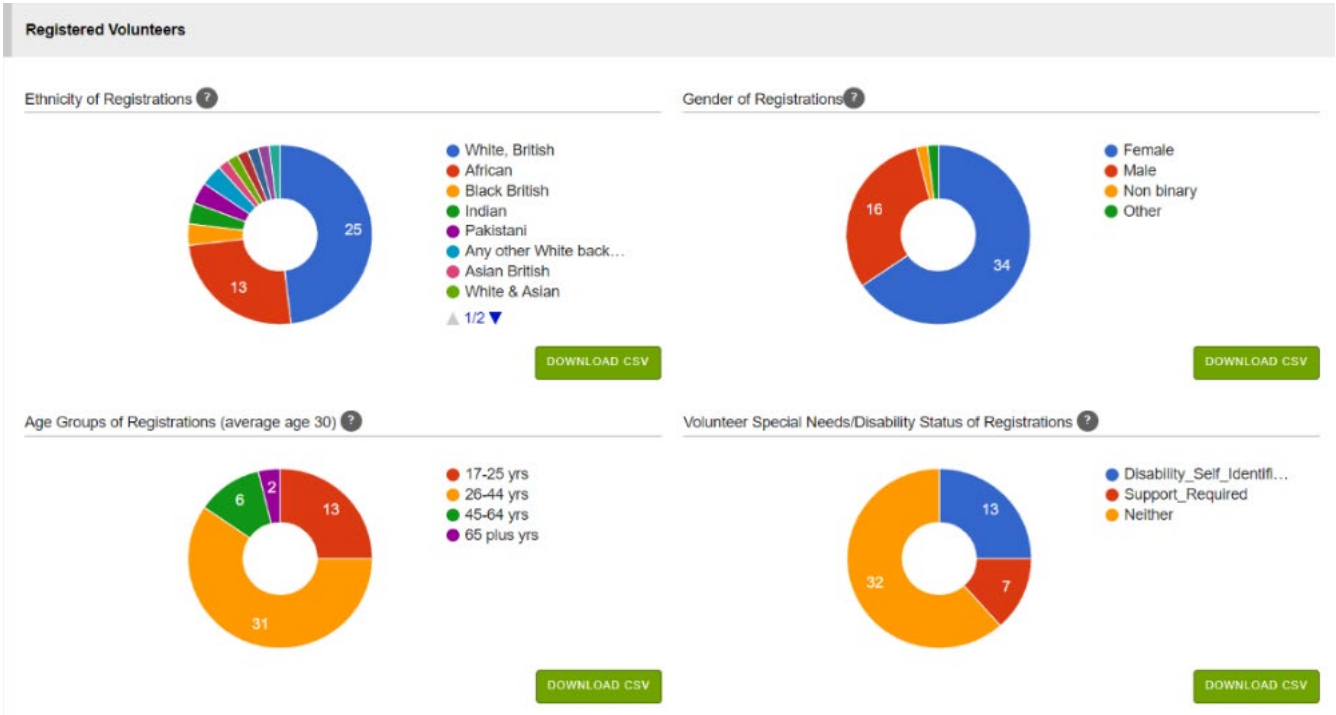


Figure 3: 2024 Volunteer Demography



In March 2023 we had people from 2 different ethnicities sign up as a Lived Experience Ambassador compared to 12 different ethnicities in March 2024 which equates to an increase of 500%.

Engagement methods

The People Participation Committee

Evolved according to need of those in attendance; formally known as the Patient Carer and Family Collaborative and now known as the People Participations Committee (PPC). This remains a key decision influencing group made up of staff, patients, carers, governors, volunteers and partners. The purpose of the PPC is to contribute and collaborate as a community. The PPC concerns itself with all EPUT services (community health services, mental health services, learning disability services and social care) and utilises the intersectionality of the committees' membership. The PPC is designed to amplify the patient and carers voice to the executive team and produce tangible, tracked actions that demonstrate the reciprocal value of the committee.

The EPUT forum

Aligned to The NHS Constitution recommendation of 'the NHS belongs to the people'; services shaped by people, (especially those with lived experience), are more likely to be needs-led and patient-centred, resulting in better outcomes' our open forum communicates key initiatives and updates from EPUT and acts as an effective listening channel for themes and trends of patient feedback to be established. The agenda is driven by the public, whom can raise items and queries via a Microsoft form ahead of the meetings, and the team work closely with the trust secretaries office to ensure that the forum compliments the your voice events.

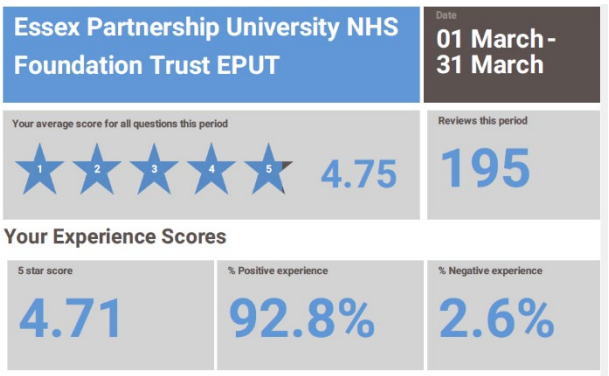
iWantGreatCare

We continue to maintain a slow and progressive growth in review responses and the uptake of iWantGreatCare. Figure 3 illustrates the consistent positive increase in reviews received since the formal launch of the iWantGreatCare contract in 2022.

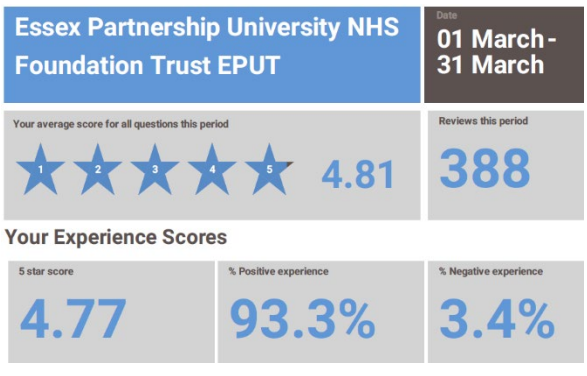
Figure 4: Growth of iWGC Response Rates

Figure 4 illustrates the increase in growth within the same calendar month over two consecutive years. From March 2023, March 2024 feedback has increased by 98%

Figure 5: Year on year IWGC Response rate comparison by Month



March 2023



March 2024

To help staff to learn about iWGC and the importance of seeking feedback, iWGC now has its own OLM training module, is included in the all staff induction and has regular 'all staff' question and answer sessions facilitated with iWGC.

All services have been provided with a bespoke content pack containing, posters with QR codes and business cards to encourage all services to display, request and utilise feedback. The iWGC reporting and training manager meets with the learning and development team to produce themed reports from reviews that reference staff behaviour each month. Some of these lessons have been used in the ward manager development programme to understand best practice, lessons learnt and opportunities to act differently.

To further support services to capture feedback from service users, the team have recruited and trained iWGC volunteers who can support patients, families and carers wishing to complete reviews. There is currently one iWGC volunteer assigned to each care unit.

Network of Networks

Our networks of networks have continued to grow and evolve according to the needs of those who attend them. Networks can be service specific, like The Lighthouse Parent and Carer Network, community-specific, i.e. The Coproduction champions network, or based on a group of shared characteristics such as the Neurodiversity network.

Patient Carer Race Equality Framework

Since 2022, EPUT has been working hard to be an early adopter of the Patient Carer Race Equality Framework (PCREF) and the Trust has made an active commitment to involve patients and carers from our black and minority ethnic communities in decisions of care, treatment and policy making based off of lived experiences. PCREF is designed to ensure racialized communities have fairer access to services, improved outcomes and better experiences of services. This year we have begun the implementation of PCREF by working with a Lived Experience Coproduction Lead. We are proud to currently be the only regional provider that has introduced a coproduction lead to the implementation of the framework.

"I am so excited to be working on such a monumental project. When I was asked to join this team it was too good an opportunity to turn down. I have spent almost 20 years in institutions, mainly prison, but I have also been sectioned, briefly. Through participating in various different types of therapy, I have found that it's been largely a case of being misunderstood. I welcome this opportunity to be a part of change"- Tola Coproduction Lead December 2023

To support the delivery of the PCREF an action plan under the following headings has been co-designed by Tola and the Patient Experience Team; Leadership and Governance, Organisational competencies and the Patient and Carers feedback mechanism.

Tola has been working with the employee safety programme lead, employee experience manager and SRO for inclusion to identify existing work streams in the trust that are already working towards identifying and preventing violence, abuse and racism. This has led to a PCREF lens being applied to the review of the leadership behavioural framework, PCREF being incorporated into the working with people and communities strategy and into the all staff induction.

Podcasts

In 2023 the Patient Experience team launched the "lived experience matters" podcast, with a series of co-designed podcasts recorded and hosted by two of our LEA's. The episodes are designed to address myths and challenge the stigma that those with particularly mental illness continually face. Each episode has a theme decided upon during show plan meetings held with LEA's and volunteers.

Available episodes online include Peer support, volunteers, and Personality Disorder and Complex Needs Service user network. 2024 episodes to be recorded include health inequalities through a PCREF lens, Coproduction week and dual diagnosis.

Newsletter

At the end of each calendar year the Patient Experience Team create a newsletter for LEA's and volunteers to summarise achievements of the year, thank LEA's, volunteers, patients, families and carers for continuing to work with us and ask for input into proposed plans for the next year.

The newsletter contains case studies of success, word searches and recipes and has been very well received by the people we serve as a small gesture of gratitude for working with us to continually improve services.

Patient Safety Partners

The Patient Safety Partner (PSP) role is one of our Lived Experience roles and this year we have achieved our aim of increasing the team by 50%, from 5 to 10 PSPs. PSP's aim to improve the safety of our services, through meaningful collaboration, co-production, and learning. This year, the team have designed an EPUT bespoke patient safety partner handbook including guidelines and regulations, the patient safety partner rights and responsibilities and the patient safety partner code of practice. 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 to the positive interactions and receptiveness of patients working with the PSPs, 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. The increase in involving PSP's in other key work streams and projects across the trust demonstrate the value and starting success of the role.

Inpatient focus groups and interviews

In 2023, the Patient Experience and Volunteers team have increasingly visited wards to gain insight from patients and feed back into key work stream projects. Not only does this increase assurance that quality improvements are patient driven, but this has been particularly useful in ongoing projects such as the PCREF and Time To Care. Having a physical presence on wards has increased positive working relationships with clinical staff.

Inpatient Peer Support Workers

We have 50 Peer Support Workers who completed specialist training between April 2023 and March 2024 as part of the Health Education England programme for increasing the use of peer support across mental health services. Operating within inpatient services, all of the team have lived or living experience of mental health challenges and many have received treatment on a mental health inpatient ward. Peer support workers are providing one-to-one and group support to patients on across many services and localities, drawing on their own lived experiences to offer hope through recovery. The project initially launched as a pilot in the Linden Centre and is currently being trialled on the wards in Colchester and Basildon.

"Peer support workers act as a light for patients who aren't as far along in their journey of recovery as you are. As people with lived experience we can be understanding, empathetic and very compassionate about what patients are going through. It can also act as a mirror helping us to continue our recovery – it feels very healing to give back in that way." Charlotte, Peer Support Worker

"I have been mindful over the years of the much needed and valuable resource peer support offers so I'm grateful for the opportunity to provide peer support, inspiring hope and helping others see the possibilities, so they too can move forward with their lives." Renee Conley, Inpatient Peer Support Team Lead.

Guiding Principles

As part of the new 'Working in Partnership with People and Communities' Strategy there are 3 guiding principles to help the Trust to navigate the next few years towards becoming the best in class in this area:

- **Equitable Partnerships at every level of the organisation:** with people using our services, relinquishing power and control whilst maintaining our responsibility to care for people.
- **Lived Experience Practice (LXP) is what we do, it's in our DNA:** Our Lived Experience is Invaluable, which we celebrate, and harness to drive meaningful change. In order to excel at LXP Our workforce and lived experience team have their training and support needs met.
- **Coproduction First:** Everything we do, we do in partnership with people using our services. Actively seeking and Encouraging feedback, good or bad.

Success Measures

Within the Working in partnership with People and Communities strategy six success measures are identified in order to assess the impact and successful implementation of the enabling strategy:

1. **10 Principles of Working with People and Communities:** We have demonstrable evidence of improvements against all 10 principles with a significant improvement in principles 1, 2, 3, 4, 7, and 8.
2. **The Lived Experience Team:** Significant growth in our lived experience team, and evidence of them being utilised at all levels.
3. **Lived Experience Practice (LXP):** at all levels, lived experience practice is adopted with a significant increase in Lived Experience roles and activity trust-wide. Where feasible, every governing body has at least 1 lived experience practitioner, and there is significant evidence of LXP being central to decision making, particularly within services.
4. **I Want Great Care:** every service is using IWGC, with demonstrable evidence of experience data driving improvement activity, which is feedback to the public.
5. **Coproduction:** As an organisation we have a coproduction first approach, and there is significant evidence to support this at all levels. We celebrate and reward good practice seeking national awards when we can.
6. **Peer Review:** Our peers, (staff, patients and their supporters, and system partners) publicly recognise our improvements in working with people and communities, utilisation of experience data, and our competency for coproduction.

The table below provides an overview of progress against each of these measures.

#	Success Measure	April 2024 Progress Update
1	**10 Principles of Working with People and Communities:** We have demonstrable evidence of improvements against all 10 principles with a significant improvement in principles 1, 2, 3, 4, 7, and 8	The working in Partnership with People and Communities enabling strategy is the launch pad for building working relations with the people and communities we serve based on equity, inclusivity, mutuality, and reciprocity. To support the delivery of the guiding principles the Quality of care strategy was coproduced with the people we serve, and, a key part of the delivery mechanism for the quality of care strategy sees our lived experience team as having key roles at every level of the governance. Further, we have a growing list of examples where we are working with people and communities in collaborative ways to support and enhance the services we provide.
2	**The Lived Experience Team:** Significant growth in our lived experience team, and evidence of them being utilised at all levels.	Since March 2023 Lived Experience Ambassador team has grown by 117% (100 to 217). Included within this, we have coproduction leads working on key programmes such as Time To Care and Mental Health Urgent Care Department; running their own involvement groups of LEA's to feed back into wider organisational steering groups.
3	**Lived Experience Practice (LXP):** at all levels, lived experience practice is adopted with a significant increase in Lived Experience roles and activity trust-wide. Where feasible, every governing body has at least 1 lived experience practitioner, and there is significant evidence of LXP being central to decision making, particularly within services.	In terms of growth in opportunities for Lived Experience roles, we have 89 opportunities compared to 46 in April 2023 (increase of 93%), and we are actively recruiting and have successfully filled 4 of the 9 lived experience lead roles for each of the subgroups of the QoC strategy implementation. With this growth we have seen the need for a more robust framework by which the Trust can operate from when using lived experience, and so the Lived Experience Practice (LXP) Framework is being developed in partnership with colleagues from Psychological services: The Personality Disorder and Complex Needs Service User Network group and Lived Experience Ambassadors. More than 115 people across EPUT attended the first scoping session for the network and an area of focus to increase the capability of staff in working with people with lived experience was uncovered as the most area where attention needs to be focused.
4	**I Want Great Care:** every service is using IWGC, with demonstrable evidence of experience data driving improvement activity, which is feedback to the public.	1322 responses in Q4 23/24 compared to 697 in the same quarter the previous year (increase of 89%). Although, less than 50% of services are using iWantGreatCare, and so the focus for the next year will be to engage all services who are not using iWGC to build feedback opportunities into business as usual processes, using technology where possible to ease the demand on frontline staff using things like SMS.

5	**Coproduction:** As an organisation we have a coproduction first approach, and there is significant evidence to support this at all levels. We celebrate and reward good practice seeking national awards when we can.	More than 100 people attended the first Co-Production Conference in October 2023. The conference was organised by the Co-Production Champions Network to showcase and celebrate how people with lived experience are contributing to our work and co-designing and shaping our services. The success of the conference quickly led to 2024 demand which is currently being designed by the growing team of coproduction champions. Furthermore, there continues to be lots of examples of collaboration, and coproduction from across the organisation, delivering value to service improvement.
6	**Peer Review:** Our peers, (staff, patients and their supporters, and system partners) publicly recognise our improvements in working with people and communities, utilisation of experience data, and our competency for coproduction.	We asked staff, patients and their supporters to complete a survey as part of the LXP Framework and year-end strategic impact report. The following statements were provided as part of that survey: *"I feel that the increase has positively impacted service users in multiple ways. With more lived experience ambassadors there has been an increase in facilities available for us to benefit from"* *"EPUT provides a broad range of services, and the increase in the number of LEAs has resulted in a more representative cross section of EPUT users participating in the LEA team's activities. It's a case of the more the merrier really as you need input across the board - from people who make intensive use of inpatient facilities to those who are outpatient only, from youth to old age. I find that this input of additional voices has resulted in EPUT taking people's views on board"* *"I feel that this increase has generated more value towards those with lived experience; that we are listened to and heard. That we have a voice and that our inpatient experiences are acknowledged."*

Evidence of impact

	September 2022	**% increase**	**April 2023**	**% difference**	**April 2024**
Volunteers	228	17%	267	81% increase	484
Lived Experience Ambassadors	60	120%	132	64% increase	217
Involvement activities	30	53%	46	43% decrease	26
Hours of Involvement	297	34%	717	33% increase	955.5

There has been a reduction in the amount of involvement activities available for LEA's and volunteers to engage with this year. This is likely due to the involvement activities that are on offer being on-going rolling groups and arguably more defined in their routine membership than last year. For example, PIPE, Time to Care and the Coproduction champion's network are each "one activity" however the hours contributed to these continue to increase.

Testimonials

'Involvement helps me stay in a good place, it makes me feel like I am doing something valuable' (LEA)

'Staff at EPUT aren't afraid to have the uncomfortable conversations that lead to change' (LEA)

'Now I am operating in a coproduction lead role, I have felt my confidence increase. When I visit the office, I am spoken to just like any other colleague. It just makes me feel really good' (LEA)

'I can go to the patient experience team with my ideas and contributions and feel listened to and understood' (LEA)

'To work with a team that are so open is rare and special' (LEA)

Key milestones

- Recruiting an additional People Participation Lead to support services in facilitating participation and collaboration with people who have lived experience of services
- Successfully designed and delivered the coproduction conference 2023
- Aligning iWGC reporting to the care unit structure and embedding this into the PowerBI data dashboard
- The team were nominated for the coproduction award at the Great British Care awards for the Reward and Recognition policy.
- Learning from lessons in 2022 to ensure EPUT PLACE results were included in national publication
- The communications approach to get people involved, and recruitment, is more effective due to having dedicated resource within the Patient Experience team who is actively working with our branding and marketing teams to ensure organisational alignment
- Director of Patient Experience and Participation and Head of Patient experience leading sessions on the RISE programme and ward management development programmes
- Recruiting and aligning one iWantGreatCare feedback volunteer to each care unit
- Publishing the co-designed and coproduced Lived Experience Matters podcasts online
- improved the development of the Lived Experience team and roles like 'Patient Safety Partners' and 'Inpatient Peer Support Workers' by making access to systems, training, and equipment easier
- Successfully making HR policy changes which mandate a person with lived experience being a panel member for interviews 8a and above
- Working with colleagues from Equality Diversity and Inclusion to collect inpatient data which has contributed to the leadership behaviour framework and Patient Carer Race Equality Framework data collection
- Successfully launching and developing the Inpatient Peer Support worker team.
- The successful launch of Patient Safety partners and commencement of ward visits in these roles, growing the team by 50% from 5 to 10 people.

- Having Lived Experience Leads for key national frameworks such as the Patient Carer Race Equality Framework and Accessible information standard.
- Created bespoke posters and printed materials for iWGC which have been sent out to all services for promotion
- Applying a PCREF lens to the review of the leadership behavioural framework, incorporated into the working with people and communities strategy and into the all staff induction.
- Held a 2023 Volunteers day celebration event
- Supported Ruby ward to have 2023 summer party

Having listed some of the successes we have had, we continue to experience challenges, particularly at a time of immense pressure in the NHS with constrained resources across the board. Although, nothing is insurmountable and we moved forward as an organisation significantly in the areas of involvement, participation, and coproduction. The following is a list of some of the key challenges we are still to overcome:

- The adoption of IWGC has been slower than we would like, and its use variable
- The utilisation of volunteers and the lived experience team is variable across care units and services, although is continually improving

In short, although we have progressed immensely to develop a strong capability for participation, with the systems and processes in place to support it, the majority of our workforce and those that use our services are unaware of this capability. Therefore, we will be focussing our energy on raising the profile of this service and its capabilities, and developing the lived experience team to support the implementation of the enabling strategy for 'Working with People and Communities'.

Recommendations

We know that we still have a long way to go to achieve the strategic ambition of being the best healthcare provider in this space, although our intent and ambition remains. Some recommendations to support the future delivery of the 'Working with People and Communities' strategy are as follows:

- Each service should has at least 1 lived experience role/activity to support the delivery and development of the service
- Improve our staff induction offer so that the availability of the Patient Experience team involvement is clear and understood by all
- Develop the people participation function, and adopt a business-partnering model with People Participation Leads (PPLs) assigned to each care unit. The Director of Patient Experience and Participation will work collaboratively with Care Unit Directors to review how Lived Experience is embedded into operations
- A review on the progress of embedding into care units to be included within the 2024/2025 annual report. This progress will be continually reviewed by Quality Committee throughout the following year
- Use technology to support the use of IWGC with things like text messaging (SMS)

Our Commitment

Our commitments as a portfolio to the Trusts services and people whom use them remains the same and based on following five key principles:

1. We will continue to strive to be the best in everything we do, through the amplification of the service user voice, by increasing and elevating involvement and engagement across all our services.
2. We will continue to innovate and lead across our system by increasing and elevating involvement and engagement across all areas of health and social care that EPUT is a deliver partner in.
3. We will enable our services to involve and collaborate in a meaningful way with service users which breeds a culture that values patient experience through involvement
4. We will strive to add value across all of ours services through our core capabilities, through the synthesis of patient insight and by increasing and elevating public involvement and engagement across EPUT.
5. We will continuously improve our offer through evolution, and organic growth to meet the needs of the organisation and our systems by increasing and elevating public involvement and engagement across EPUT

Report produced by:
Amy Poole
Head of Patient Experience and volunteers

Matthew Sisto
Director of Patient Experience and Participation

On behalf of:
Zephan Trent
Executive Director of Strategy, Transformation and Digital

May 2024

8.3 END OF YEAR GOVERNANCE REVIEWS

Decision Item | DG | 5

REFERENCES

Only PDFs are attached

End of Year Governance Reviews 05.06.2024 (1).pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**EPUT Provider Licence Review (Including Code of Governance)**					
Executive Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	CoG Governance Committee 1 May 2024 & Council of Governors 23 May 2024 (Code of Governance) Executive Team 20 May 2024 Finance & Performance Committee 23 May 2024					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A – Self-Certification	
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*	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 the end of year self-assessment reviews undertaken against the Provider License and Code of Governance for NHS Providers.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve the detailed review of Trust compliance against the Provider Licence (including the Code of Governance) for submission to NHS England (as required) and declaration in the annual report.

Summary of Key Points

Provider Licence Review

NHS Foundation Trusts are required to make annual self-certification under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual report submission. There is no requirement to submit these to NHS England, but these must be kept on file and submitted on request.

The Provider Licence was amended in 2023, however, the certificates have not been updated and do not match the new requirements. Therefore, it is proposed the attached licence review is filed and relevant forms completed once these become available.

Self-certification is required against Section 3 (previously G6) and CoS7 by 31 May 2024. Self-certification is required against NHS2 (previously FT4) and Governor Training by 30 June 2024. The Governor Training self-certification has been taken forward with the Council of Governors.

A detailed self-assessment review was undertaken against the requirements of Section 3: General Conditions (G6), CoS7 and NHS2 (FT4) by the Trust Secretary's Office and was considered by the Executive Team on 20 May 2024. The review indicates the Trust is fully compliant with the provisions of its licence and is attached to this report as Appendix 1.

The reviews have been attached to this report as appendices and a recommendation is made to declare compliance with all the requirements of G6, CoS7 and FT4.

Code of Governance Review

The purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and also confirm that the Trust 'complies' with the provisions, or if not, provide an explanation as to why it has departed from the Code. The review process to be followed is as follows:

- Self-assessment against the Code of Governance
- Internal independent assessment by the Council of Governors Governance Committee (Complete)
- Report to Council of Governors (23 May)
- Assurance report to Finance & Performance Committee (23 May)
- Draft annual report, including relevant statement to Board of Directors (5 June)
- Final annual report (24 June)

The self-assessment review of the Trust's position against the Code was undertaken by the Assistant Trust Secretary. The review indicates the Trust is fully compliant with all provisions, except E.2.2 where the Trust has deviated due to the Trust following the principles of the Chair and NED Remuneration Structure, whilst ensuring it considers extra time commitments and uplifts recommended by NHS England since the framework was published in 2019. There are some provisions where action is required to strengthen and this has been detailed in the review.

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
Appendix 1: Provider Licence Review 2024
Appendix 2: Code of Governance Review 2024

Non-Executive Lead:
Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

EPUT REVIEW OF COMPLIANCE AGAINST THE PROVIDER LICENCE 2023/24 AS AT APRIL 2024

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 1: INTEGRATED CARE			
IC1: PROVISION OF INTEGRATED CARE			
IC1.1	The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph 2.	Compliant	• EPUT utilises integrated care models to provide a range of healthcare services. • EPUT actively works with its partners through both formal and informal mechanisms to foster and enable integrated care • The Trust is actively involved with system working including Board members as members of Integrated Care Boards and the Mid & South Essex Community Collaborative, which is working together with providers of linked services to provide joined-up services. • EPUT has representation on local partnership boards feeding into system wide working and planning • Stakeholders are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership
IC1.2	The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	Compliant	• The Trust Strategic Objectives are in-line with the objectives in the provider licence, such as the delivery of safe, high quality integrated care services, working together with partners to make services better and helping our communities to thrive, which includes reducing health inequalities. • The Trust has developed a number of enabling strategies to support the delivery of strategic objectives; including the Quality of Care Strategy, Working with People & Communities, which specifically supports this condition. • The Trust has developed and published a Social

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			Impact Strategy and Charter, which aims to be the key driver behind the reducing health inequalities.
IC1.3	The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.	Compliant	• The Chairs Report to the Board of Directors includes a Governance Review which identifies new guidance issued by a range of organisations, including NHS England. This is highlighted to the responsible Executive Director for consideration and reflection in any future developments. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance.
IC1.4	Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests	N/A	
IC2: PERSONALISED CARE & PATIENT CHOICE			
IC2.1	The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	Compliant	• The Trust has internal processes to ensure patient care is as personalised as possible, including the development of personalised care plans. • The CQC Inspection completed in January 2023 (published July 2023) found the Trust provided personalised care across services. Where the CQC identified any areas of improvement for personalised care, this was developed into a CQC Improvement Plan, overseen by the Mid & South Essex Integrated Care Board.
IC2.2	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	Compliant	• The Trust has internal processes which ensure people who use the services are offered information, choice and control to manage their own health and wellbeing. • The Trust operates a principle of “no wrong door” to ensure individuals are provided with the right level of

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			information and receive the right choice of care wherever they access services. • The Trust operates a principle of purposeful admission for inpatient services to ensure there is a clear pathway for patients entering inpatient services from admission to discharge. • The Trust works with other providers and system partners to ensure the patient pathway is clear, including the Mid & South Essex Collaborative, where partners providing similar services can work together to ensure personalised, holistic care can be provided between organisations. • The Strategic Objective "The Trust will help our communities to thrive" includes ensuring the wellbeing of the local communities and to ensure people are able to manage their own care and wellbeing. The Social Impact Strategy and Charter is now taking this forward. **Area for Improvement** • **CQC Inspections have identified some areas for improvement in some clinical services for personalised care and will be addressed through the CQC Improvement Plan overseen by Mid & South Essex ICB.**
IC2.3	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.	Compliant	• All services have eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts and service specifications. The criteria is reviewed with commissioners as required. • The EPUT website provides details of service provision by geography and service type. The information includes eligibility criteria and contact details for the service or to find further information. • There are some limitations to choice for some Tier 4

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			and / or specialised services, where patients may require urgent intervention provided by a particular service provider.
IC2.4	Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	Compliant	• The information on the EPUT website is provided by the individual services and is accurate based upon the service specifications / commissioning contracts. • Commissioners monitor EPUT's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirement.
IC2.5	Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	Compliant	• The EPUT service directory on the website sets-out the services available. • The service information and eligibility criteria is clear on the function of the service and the eligible patients, which allows individuals to make an informed choice in accessing services.
IC2.6	In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	Compliant	• The Standing Orders for the Board of Directors provides a clear procedure for tendering and contracting services, which does not include the providing of gifts and / or benefits in kind for the tendering / contracting of services. **Proposed Action:** **1. Governance documentation could be strengthened to include specific instruction that gifts and / or benefits in kind must not be offered.**
SECTION 2: TRUSTS WORKING IN SYSTEMS			
WS1: COOPERATION			
WS1.1	This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	N/A - Statement
WS1.2	The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Compliant	• The Trust works with other NHS bodies as part of contractual arrangements and collaborative working. • EPUT has representation on local partnership boards feeding into system wide working and planning

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• Section 75 arrangements in place with local authorities and the Trust attends Health Oversight Scrutiny Committees (HOSC) with local authorities.
WS1.3	Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i. as necessary and appropriate for the purposes of developing and delivering system plan(s). ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans	Compliant	• As above. • The Financial / Operational Plan is developed alongside the Integrated Care Boards and other NHS bodies to ensure it supports system plans and financial plans.
	b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services. ii. as necessary and appropriate for the purposes of improving NHS services.	Compliant	• As above regarding collaborative working and working with local authorities.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
WS1.4	The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England.		• The Trust Secretary's Office receives any new guidance from the Secretary of State for Health and Social Care and / or NHS England and implements as required. • The Chairs Report to the Board of Directors includes a review of any new information / guidance to be shared with the Board of Directors. • The Trust Policy review process includes a requirement for policy authors to horizon scan for any new guidance issued which may impact any policies and procedures, including any relating to co-operation with partners.
WS2: THE TRIPLE AIM			
WS2.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS2.2	When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	Compliant	• The Trust Operational Plan has been developed to consider the quality of care provided, the optimising of resources and the tackling of inequalities. (Page 2-8) • The Trust Strategic Objectives helping communities to thrive, which includes promoting wellbeing and reducing health inequalities. • The Financial Plan has been developed to take into consideration the financial position of the NHS and local system. • The Trust has robust processes and systems in place to ensure it has the resources necessary to deliver services and support the wider system.
WS2.3	The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	Compliant	
WS2.4	In this condition, "the triple aim" refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.		
WS3: DIGITAL TRANSFORMATION			
WS3.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS3.2	The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Compliant	• The Trust Digital & Data Strategy 2023 consider the Health & Social Care Act 2022 and other guidance published by NHS England. (Page 10) • The Trust has an Information Governance Policy & Procedure in place, which is currently being reviewed, and takes into consideration any legislation as required. • The Trust has an Information Governance Team, responsible for overseeing governance processes within the organisation to ensure it is in line with relevant legislation, including where information is shared as part of cooperation and the triple aim. **Action:** **1. The Information Governance Policy & Procedure is currently under review and should include updated references to Section 250 of the Health & Social Care Act 2012.**
WS3.3	The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).		• The Trust Digital & Data Strategy 2022 sets-out a plan for data maturity over an 18-24 month period to ensure required levels of digital maturity are reached. • The plan includes consideration of suppliers and alliances to ensure data maturity allows for effective use and integration with the wider system and partners. (Page 15)
SECTION 3: GENERAL CONDITIONS			
G1: PROVISION OF INFORMATION			

Ref	Condition Summary	EPUT Position	Evidence/Assurance
G1.1	The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	Compliant	• The Trust has systems and processes in place to identify and respond to any routine and non-routine information requests. • The Trust submits all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time • Any submissions required are made by the Finance Directorate and retained • Copies of all documents to NHSE are retained
G1.2	Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.	Compliant	
G1.3	The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested.	Compliant	• The Trust has check and balance processes in place, to ensure any information supplied to NHS England is accurate, complete, not misleading and is a true copy of any documentation requested.
G1.4	This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A - Statement
G2: PUBLICATION OF INFORMATION			
G2.1	The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.	Compliant	• The Trust publishes information / documentation on its public website as required and would publish any additional information instructed by NHS England. • The Trust complies with all reporting guidance for annual documents, including the ARM, Quality Account and Constitution.
G2.2	For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals.	N/A	• N/A - Statement
G3: FIT AND PROPER PERSONS AS GOVERNORS AND DIRECTORS (ALSO APPLICABLE TO THOSE PERFORMING THE FUNCTION OF; OR FUNCTIONS EQUIVALENT OR SIMILAR TO THE FUNCTIONS OF, A DIRECTOR			
G3.1	The Licensee must ensure that a person may not become or	Compliant	• The Trust Constitution sets-out disqualifications for acting or continuing as a Director or Governor at

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.		EPUT, which includes the criteria provided by this condition. • The Trust has robust systems in place for completing Fit and Proper Persons Test (FPPT), in line with new guidance published in 2023. This includes the completion of self-attestations by members of the Board of Directors and a check on public registers to ensure no members of the Board of Directors meets any of the disqualification criteria. • The Trust Fit and Proper Persons Test Policy & Procedure sets-out the requirements for the Board of Directors and is currently being reviewed to ensure it is line with the new requirements published in 2023. • The Code of Conduct for Members of the Board of Directors references the Trust Constitution for any disqualification criteria. • The Council of Governors Code of Conduct includes disqualification criteria, in line with the Trust Constitution, and Governors are required to sign documentation to confirm they do not meet any of the disqualification criteria.
G3.2	The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.	Compliant	• The Fit and Proper Persons Test process described above, is completed as part of the pre-appointment checks prior to any appointment. Annual checks are completed to ensure this is maintained.
G3.3	For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or	Compliant	• As above, the FPPT checks include a review of relevant public registers, including Companies House.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986; iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.		
G3.4	In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	Compliant	• The Trust takes into consideration any guidance published by the CQC in relation to FPPT requirements, for example, DBS Checks.
G4: NHS ENGLAND GUIDANCE			
G4.1	Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	Compliant	• The Trust has systems and processes in place to ensure it responds to / meets guidance issued by NHS England. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance. • Full reviews of NHSE guidance is undertaken by relevant teams including Compliance Team, Trust Secretary's Office, Legal Team, Finance Team as
G4.2	In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			part of reviewing internal processes.
G5: SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS AND RELATED OBLIGATIONS			
G5.1	The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	Compliant	• The Trust has a Board Assurance Framework in place and processes, supportive of the identification and management of risk across the organisation. • Risks are identified and managed at all levels of the organisation, including Board, Standing Committees and local clinical business units. • The Trust undertakes an annual review of compliance with the terms of the provider licence, with actions to address any areas for improvement. • Compliance declarations made by the Board of Directors within required timeframe (note NHSE no longer require these to be submitted)
G5.2	Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness.	Compliant	
G6: REGISTRATION WITH THE CARE QUALITY COMMISSION			
G6.1	The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.	Compliant	• The Trust is fully registered with the CQC.
G6.2	The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	Compliant	• The Trust CQC Registration has not been cancelled by the CQC to date. • The Compliance Team manages the CQC Registration and any cancellation by the CQC would be notified to NHS England within the relevant timescales. **Potential Action:** **1. Develop process / procedure to make explicit the notification of NHS England of any cancellation to CQC Registration within the advised timescales.**
G6.3	A notification given by the Licensee for the purposes of paragraph 2 shall: a. be made within 7 days of: i. the making of an application in the case of paragraph		

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	(a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).		
G7. PATIENT ELIGIBILITY AND SELECTION CRITERIA			
G7.1	The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	Compliant	• Patients' eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts within individual service specifications: available on request • Commissioning contracts are subject to regular reviews. • EPUT website includes its service provision by geography and service type, and contact details. There is limited eligibility criteria included
G7.2	"Eligibility and selection criteria" means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b. if the person is selected, the manner in which the services are provided to the person.	N/A	• N/A - Statement
G8: APPLICATION OF SECTION 6 (CONTINUITY OF SERVICE) - N/A - Section required for Commissioner Requested Services – EPUT does not currently provide any Commissioner Requested Services.			
SECTION 4: TRUST CONDITIONS			
NHS1: INFORMATION TO UPDATE THE REGISTER			
NHS1.1	The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement

Ref	Condition Summary	EPUT Position	Evidence/Assurance
NHS1.2	The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution; b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.	Compliant	• Trust Constitution submitted to NHS England on an annual basis and following any in-year review. • Annual Report & Accounts sent to NHS England upon approval by the Board of Directors.
NHS1.3	Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	Compliant	• Copies documents listed above submitted to NHS England following approval at Board of Directors.
NHS1.4	The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person.	N/A	• N/A - Statement
NHS1.5	The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	Compliant	• Documents submitted to NHS England via email and would be submitted in any format instructed by NHS England.
NHS1.6	When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	Compliant	• The documentation is submitted via email with key information in the body of the email advising of the content of the documentation and reason for submitting.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
NHS 2: GOVERNANCE ARRANGEMENTS			
NHS2.1	This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement
NHS2.2	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	Compliant	• EPUT has sound corporate governance systems and processes in place, based upon NHS England guidance and other legislation. • The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically
NHS2.3	Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.	Compliant	• The EPUT Green Plan 2021-22 sets-out the Trust ambition for sustainability and the reduction of the Carbon Footprint. The Plan is set to be reviewed in 2024 and will incorporate any guidance issued by NHS England. • The Digital Strategic Plan 2023 – 2029 provides corporate governance systems and processes, developed in line with NHS England guidance, other digital guidance and legislation. The Strategy will be reviewed on a regular basis and incorporate any new NHS England guidance.
NHS2.4	The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Compliant	• The Trust has an effective Board and committee structure with appropriate terms of reference • The Terms of Reference provide clear areas of responsibility, reporting lines and accountabilities for each Standing Committee. • Effectiveness reviews of Board and its committees is

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	c. clear reporting lines and accountabilities throughout its organisation.		currently underway for 2023/24. • Scheme of Reservation and Delegation sets out the powers reserved to the Board and those that the Board has delegated, i.e. the schedule of matters reserved to the Board. This is reviewed annually and reflects delegation derived from the constitution, accounting officer memorandum, standing orders, SFIs, NHSE *Code of Governance* and Board *Code of Conduct* • Reviews of the corporate governance systems included in internal audit annual work programme. • The Trust operates an Accountability Framework, which provides clear accountability for Clinical Business Units.
NHS2.5	The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Compliant	• The minutes of Board of Director meetings and Standing Committees provide details of the effectiveness and scrutiny of all operations. • Regular reports to the Board of Directors cover quality, performance, finance, corporate and clinical governance. • The Board Assurance Framework provides details of any key risks to achieving objectives and is reported to Board on a regular basis. This is supported by a series of local corporate risk registers. • An annual review of the *Code of Governance for NHS Providers* is completed to ensure compliance with all governance requirements. • An annual review of the provider licence is completed and scrutinised by the Finance & Performance Committee, Executive Team and Board of Directors. • Regular monitoring of progress with objectives set out in the operational plan and enabling strategies, via a regular Strategic Impact Report. • Resources allocated to provision of internal legal services team and to secure appropriate legal advice

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.		when necessary.
NHS2.6	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Compliant	• The Board complete an annual appraisal process, including review of skills and meeting of objectives. This is monitored by the Board of Director Remunerating and Nomination Committee and Council of Governors respectively. • The Quality Committee as a standing committee of the Board oversees quality of care considerations for any planning and decision-making processes and reports to the Board of Directors. • The newly developed Quality of Care Strategy sets-out the Trust approach to quality and safety over the next few years. • Accurate, timely and up to date information on the quality of care provided by the Quality and Performance Scorecards and other reports to the Board of Directors. • Governors and members of the public attend Board meetings and can query any information provided to the Board of Directors, including any relating to the quality of care.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
NHS2.7	The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.		• Safe staffing reports to Finance and Performance Committee, Quality Committee and Board included in performance, quality and finance reports. • Action taken by the Trust has improved the position identified as a potential risk in last year's review in relation to staffing. However, this remains a risk monitored through the Board Assurance Framework. • Robust HR recruitment processes and selection criteria and information provided to the Board via the Quality and Performance scorecard. • Time to Care programme currently being implemented, which will ensure the right personnel are completing the right tasks, to ensure better overall staffing. • Fit and Proper Persons Requirements incorporated in employment contracts, contracts and appointing letters to ensure individuals are employed meet the fit and proper requirements. • Regular appraisals in place to ensure individuals are appropriately qualified. • Board skills and experience review undertaken when any changes to the Board are being made. The Trust is in the process of implementing the Board-level competency framework recently published by NHS England.
SECTION 5: NHS CONTROLLED PROVIDERS CONDITIONS – N/A – Does not apply to Foundation Trusts			
CP1: GOVERNANCE ARRANGEMENTS FOR NHS-CONTROLLED PROVIDERS			
SECTION 6: CONTINUITY OF SERVICES			
CoS1: CONTINUING PROVISION OF COMMISSIONER REQUESTED SERVICES – N/A – EPUT does not currently provide any Commissioner Requested Services.			
CoS2: RESTRICTION OF THE DISPOSAL OF ASSETS			
CoS2.1	The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	Compliant	• The Finance Directorate maintain an asset register of all capitalised assets in line with accounting and NHSE guidance. This is subject to external audit on

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			and would include both relevant and non-relevant assets that are owned (or have had tenant improvements where leasehold) • Estates retains an asset register for leasehold assets in line with the Asset Register and Disposal of Assets Guidance for Providers of Commissioner Requested Services guidance
CoS2.2	The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	N/A	• EPUT does not currently provide any Commissioner Requested Services
CoS2.3	The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	Compliant	• The register is maintained and updated by the Finance Directorate and is subject to external audit.
CoS2.4	The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.	Compliant	• EPUT is only required to seek NHSE's consent for disposal of assets if NHSE had a concern about its ability to continue as a going concern (currently does not apply). EPUT has a procedure on asset disposals which includes NHSE's requirement for relevant and non-relevant assets
CoS2.5	The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this Condition.	Compliant	
CoS2.6	The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	Compliant	
CoS2.7	Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	Compliant	
CoS2.10	The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which	Compliant	• The Finance Directorate would take into consideration any guidance issued by NHS England in the maintaining of the asset register. • N/A for Commissioner Requested Services

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.		
CoS3: STANDARDS OF CORPORATE GOVERNANCE, FINANCIAL MANAGEMENT AND QUALITY GOVERNANCE			
CoS3.1	The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	Compliant	• EPUT has comprehensive corporate and financial governance arrangements, systems and processes in place; these are updated according to changes in guidance/requirements • Compliance with the *Code of Governance* reviewed annually • Annual review of EPUT's constitution, SFIs, SoRD and DSoD against regulation and NHSE guidance • Annual review of Board standing committees' terms of reference against regulation, NHSE guidance and good practice. • Monthly monitoring of performance, quality and finance by Finance and Performance Committee with quarterly review of governance arrangements (Board Governance Framework) and considered at each Board meeting • Risk management programme in place monitored through Finance and Performance Committee and considered at each Board meeting. • Flow and Capacity meetings take place at clinical unit level to ensure services are delivered during periods of high demand or acuity. • N/A – re. Commissioner Requested Service
CoS3.2	In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies	Compliant	• As above re. consideration of any guidance published by NHS England.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology		
CoS4: UNDERTAKING FROM THE ULTIMATE CONTROLLER			
CoS4.1	The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	N/A	• Not applicable
CoS4.2	The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	N/A	• Not applicable
CoS4.3	The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;	N/A	• Not applicable

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.		
CoS4.4	For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.	N/A	• Not applicable
CoS4.5	A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity.	N/A	• Not applicable
CoS5: RISK POOL LEVY			
CoS5.1	The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under	Compliant	• No payment requests received from NHSE; any payment required would be made in accordance with licence conditions

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	section 143(10), by the dates by which they are required to be paid.		
CoS5.2	In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	Compliant	
CoS6: COOPERATION IN THE EVENT OF FINANCIAL OR QUALITY STRESS			
CoS6.1	The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	N/A	• N/A – NHS England has not given notice that it is concerned carry on as a going concern.
CoS6.2	When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	N/A	
CoS7: AVAILABILITY OF RESOURCES			
CoS7.1	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	Compliant	• Operational Plan and Financial Plan developed, setting out details of resource requirements and efficiencies. • EPUT has robust processes and systems in place to

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			ensure it has the resources necessary to deliver its services.
CoS7.2	The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	Compliant	• The Financial Plan developed setting out any plans for entering into agreements and undertaking any activity, with consideration for any material risk to the availability of resources. • The governance documents (SoRD, SFI's, DSoD) provide delegated spend limits for Executive Directors, after which approval would be required by the Board of Directors. Any request for approval by the Board of Directors to undertake a transaction would include consideration of any material risk to the availability of resources. • The Trust Constitution provides for the Council of Governors approval of any transaction defined as "significant" and a procedure is in place for the identification / approval should this occur.
CoS7.3	The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to	Compliant	• EPUT submits certificates/statements as required by NHSE

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".		
CoS7.4	The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	Compliant	
CoS7.5	The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	Compliant	
CoS7.6	The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3	Compliant	• This has not occurred, but the Trust would inform NHS England immediately if any circumstances were to occur.
CoS7.7	The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	Compliant	• The certificates are included in the Annual Report & Accounts, published on the Trust public website.
SECTION 7: COSTING CONDITIONS			
C1: SUBMISSION OF COSTING INFORMATION			
C1.1	Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	Compliant	• EPUT maintains a costing system that utilises information from the general ledger to calculate planned and fully absorbed costs of providing services. These costs are published on an annual basis • Information can be provided to NHSE as required
C1.2	Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.		
C1.3	If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner.	N/A	• The Trust does not sub-contract any services that has been required by NHS England.
C1.4	Records required to be maintained by this Condition shall be kept for not less than six years.	Compliant	• The Storage, Retention & Destruction of Records Procedure (Appendix 1) provides for any information relating to the ledger (as described above) to be retained for a period of six-years.
C2: PROVISION OF COSTING AND COSTING RELATED INFORMATION			
C2.1	Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	Compliant	• EPUT submits to NHSE all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time in respect of pricing • Copies of all documents are submitted to NHSE and retained by the Finance Directorate.
C2.2	In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate,	Compliant	• Information provided is approved through the relevant and appropriate authorisation processes to ensure information is accurate, complete and not misleading; and is a true copy of the document requested.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	complete and not misleading; b. in the case of a document, it is a true copy of the document requested;		
C2.3	This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A – Statement
C3: ASSURING THE ACCURACY OF PRICING AND COSTING INFORMATION			
C3.1	Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	Compliant	• The Trust operates an internal process for maintaining accurate and complete records in relation to costing. • Internal audit could review the costing and pricing processes within EPUT as part of the internal audit programme, and this assurance could be provided to NHSE as required • Data Quality checks are undertaken by the Information team.
C3.2	This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	Compliant	
SECTION 8: PRICING CONDITIONS			
P1: COMPLIANCE WITH THE NHS PAYMENT SCHEME			

Ref	Condition Summary	EPUT Position	Evidence/Assurance
P1.1	Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.	Compliant	• All NHS Foundation Trusts continued to operate under the financial regime during 2023/24. The Trust has been paid on the basis of block contract payments for 1st April 2023 to 31st March 2024.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF GOVERNANCE FOR NHS PROVIDERS END OF YEAR REVIEW

2023/24

Code	Provision	Comply	Narrative
Section A: BOARD LEADERSHIP & PURPOSE			
A.1. Principles			
A.1.1.	Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.		
A.1.2.	The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.		
A.1.3.	The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.		
A.1.4.	The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.		
A.1.5.	For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.		
A.1.6.	The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.		

Code	Provision	Comply	Narrative
A.2. Provisions			
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaborates. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	✓	• The Board of Directors undertakes a review of its effectiveness to ensure efficiency and economy. A review is undertaken annually as part of the Board sign-off of operational plans. These plans include both revenue and prioritised capital budgets with Operational Plans subject to NHS approval. • On an annual basis, the Trust External Auditors perform and Annual Audit Review which includes Value for Money (VFM) assessment. The assessment reviews the proper arrangements are in place to secure economy, efficiency and effective Use of Resources. The 2022/23 annual assessment concluded there were no matters to report by exception on VFM. • The Trust is currently undertaken a Well-Led Review facilitated by NHS England. • The Trust has performance, quality and finance management systems in place to measure and monitor the Trust effectiveness, efficiency, economy and quality of services on a day-to-day basis. The internal processes are monitored via an integrated performance dashboard and a series of audit processes, including External Audit, Internal Audit and Clinical Audit programmes. • The Target Operating Model provides for individual care units to make decisions on the delivery of services by clinical managers which ensures the quality and safety of services for patients. The Accountability Framework provides clarity on the level of responsibility and accountability for the decisions made within the clinical care units. • The Board receives a Quality & Performance Scorecard which provides detailed data to measure the effectiveness, efficiency, economy and quality of services on a regular basis. The scorecard is scrutinised by the Board standing committees and the new Power BI report allows for a more detailed review of all data, including any hotspots and mitigating actions.

Code	Provision	Comply	Narrative
			• The Board Assurance Framework (BAF) is presented at each Board meeting and relevant standing committees, reviewing any key strategic risks and providing updates on any mitigating actions or hotspots for escalation. • The Trust is inspected by the Care Quality Commission (CQC) and the outcomes of any inspection are reported to the Board of Directors to provide assurance on services provided or identifying any issues highlighted by the CQC. • The Trust has developed a CQC Improvement Plan, which incorporates all areas for improvement identified. The plan is monitored via a CQC Action Leads meeting, which is attended by Care Unit leaders for the identification and implementation of improvement actions. There is also an Evidence Assurance Group, which reviews evidence of action completion to provide additional assurance and ensure impact has led to sustainable change. The Evidence Assurance Group is comprised of our partners from all three ICBs and is chaired by a member of the MSEICB to provide challenge for any actions deemed to have been closed and provide any support for actions requiring input by the wider system. • The Compliance Team complete an internal review programme which provides additional assurance in relation to the quality of services and respond to any information requests / inquiries from the CQC. • The Trust works closely with system partners and is involved in collaborative working across the system. Examples include: The Mid & South Essex Community Collaborative partners (EPUT, NELFT & Provide); Mental Health Specialist Commissioning Collaborative detailed in the annual report; and joint working with MSEFT for the joint procurement of new Electronic Patient Record. • The Annual Report for 2022/23 provides a section Key Issues, Opportunities and Risk (Page 13) which includes information on opportunities and risks to future sustainability, lined to the strategic objectives for the organisation.

Code	Provision	Comply	Narrative
A.2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaborates. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	✓	• The vision and values of the organisation are underpinned by partnership working. The Vision and Values for the organisation were developed in September 2021 as part of the development of Strategic Objectives, which included consideration of the development of ICB's and the focus on place-based delivery of services. These were developed in consultation with a range of key system partners. • The Vision and Values are underpinned by an overall purpose, which articulates working together with patients, families and system partners as part of the ICB working to ensure there are joined-up services. • The Vision and Values led to the development of Strategic Objectives, which includes a focus on transformation to develop the culture within the organisation to deliver the vision and values. • The Strategic Impact report to the Board of Directors provides an update on key transformation work to develop and drive the culture and behaviours within the organisation to achieve the vision and values of the organisation.
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	✓	• The Quality & Performance Scorecard includes a Workforce & Culture section which provides a range of KPI's for monitoring culture, including staff turnover and sickness absence. • The Staff Survey results are discussed by the Board of Directors on an annual basis, which provides a key indicator in terms of the culture of the organisation. Where the results raise cultural issues, these are developed into action plans to identify and address the concerns. • The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) are additionally used as a measure of internal culture. The results from previous years as well as national comparisons are used to identify potential issues and actions identified to address the concerns. The Board of Directors focused on racial incidents at its meeting in March 2024, which demonstrated action being taken at board-level.

Code	Provision	Comply	Narrative
			• The Annual Report 2022/23 (Page 63), includes information on staff wellbeing, involvement and recognition, including staff networks, engagement champions and staff recognition scheme.
A.2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaborative.	✓	• The Quality & Performance Scorecard provides a range of operational and financial KPI's to regularly monitor the effectiveness, efficiency, economy and the quality of health services provided by the Trust. This is supported by narrative provided in the CEO Report, providing information on key success and hotspots in relation to operational and financial performance. • The KPI's are developed to take into consideration regulatory / contractual requirements and operational / strategic plans which take into consideration partnership and collaborative working. • The Finance & Performance Committee scrutinises the Scorecard and provides any challenge prior to presenting to the Board of Directors. The Quality Committee oversees elements of the quality of services, including the development of the new Quality of Care Strategy. • The Financial Plan for 2024/25 was presented to the Board of Directors in March 2024 and provides information in relation to the development of the Revenue and Capital Plan, which includes meetings at national, regional and local level to agree the financial allocations and plans.
A.2.5	In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed	✓	• Quality & Performance Scorecard at each Board of Directors meeting and at relevant Committee level (Finance & Performance, People Equality & Culture

Code	Provision	Comply	Narrative
	so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.		and Quality). The Power BI scorecard allows data to be reviewed in detail and broken down by relevant demographics. • Internal Audit function in place, with programme of work. Audit Committee oversees the programme and provides assurance to the Board of Directors via the Committee Chairs Report.
A.2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	✓	• The EPUT Strategic Plan 2023-2028 contains plans for each of the clinical care units, which provides information on the local approach to clinical governance. • The Quality of Care Strategy (January 2024) sets-out the Trust approach to clinical governance, including the replacement of the Clinical Governance & Quality Sub-Committee with a multi-professional quality senate. • The Trust has in place a clinical governance structure, which includes subject matter experts, forums and procedural documents. For 2024/25 the clinical governance structure has been redesigned to align with the Quality of Care Strategy with the development of Executive led groups for Safety of Care; Effectiveness of Care and Experience of Care. This is set out in the Quality of Care Strategy. • The Quality Committee focuses on the Trust approach to quality and outcomes. It oversees the establishment of appropriate systems for ensuring effective clinical governance and quality management arrangements are in place throughout the Trust.

Code	Provision	Comply	Narrative
			• The Trust employees key subject matters experts who lead of specific areas of clinical governance e.g. Director of Patient Experience and Participation; Director of Patient Safety; Director of Infection Prevention and Control; etc.
A.2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	✓	• The Trust has a continuing positive relationship with stakeholders and staff through the delivery of strategic plans and delivering performance against contracts. Any risks to public stakeholders are managed through formal review processes with NHS England and the ICBs through joint actions on specific issues. • Risks are also reviewed via scrutiny meetings with Local Authorities Health and Overview Scrutiny Committees (HOSC). • Members of the Board of Directors engage regularly with the ICB's, including membership of the individual Boards (ICB and ICP). • The Working In Partnership with People and Communities Strategy sets-out the movement towards co-production and co-design, which includes having service user representatives on various groups, quality improvement initiatives and service led programmes. • The Trust has in place a Membership Strategy, which aims to enhance the engagement with its members. • The papers for the Board of Directors are published and members of the public can review performance data using the Power BI system. Members of the public are invited to attend the meeting and submit any questions on any information contained within the Board reports. • The Council of Governors Engagement with the Board of Directors Policy and Procedures sets-out the processes in which the Board of Directors will engage with the Council of Governors, including information to be provided to allow

Code	Provision	Comply	Narrative
			Governors to represent the views of the members at all levels of the organisation. • The Board of Directors (Executive and Non-Executive) regularly attend the Council of Governors meetings. • Executive and Non-Executive Directors attend the Your Voice Meetings, where members of the public are invited to share their views on a particular subject and there is an open session for members of the public to share their views on any subject. • The Trust Annual Members Meeting was last held on the 6 November 2023. • Executive Directors, Non-Executive Directors and Governors undertake service visits to engage with staff, patients, service users and family members to understand the level and quality of services being provided and represent any views during relevant Board-level discussions.
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	✓	• Annual Report 2022/23 (Page 98) includes an Involvement of Stakeholders section. • The Annual Report 2022/23 (Page 114) includes details of the Mental Health Provider Collaborates in which the Trust is involved. • The Annual Report 2022/23 (Page 11) includes details of our Care Unit structure and that they are place-based, and describes our key partnerships across four integrated care systems, to maximise local delivery for the local community.
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and	✓	• The Trust appointed a new Freedom to Speak-Up Principal Guardian (Bernadette Rochford) in 2023/24 to complement existing systems for raising any concerns including line management, Employee Relations, Safeguarding and Student Facilitators.

Code	Provision	Comply	Narrative
	the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.		• The Trust has a Freedom to Speak-Up / Whistleblowing Policy, which supports existing arrangements. • The Principal Guardian completed a review of current processes and advised the Board of Directors in January 2024 that colleagues raising concerns via this method is encouraging. The Principal Guardian is completing a review of the use of the system to understand why people are raising issues through this method, to ensure the service is able to meet expectations and demand. • The Principal Guardian will produce thematic reports for the Board of Directors, summarising concerns raised and any investigations completed. • The Freedom to Speak-Up Principal Guarding has an open invitation to address the Board of Directors if there are any significant concerns identified.
A.2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case	✓	• The Board of Directors has in place a Conflict of Interest Policy and Procedure which clearly sets-out the process to be followed should a conflict of interest arise. • The Board of Directors has an item at each meeting for Board members to declare any conflict of interest for items on the agenda and action is taken by the Chair should a conflict arise. • The Conflict of Interest register is available on the Public Website.

Code	Provision	Comply	Narrative
	of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).		
A.2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	✓	• Board of Director meetings are comprehensively and accurately record in the minutes and include any concerns raised by Directors. • Evidence contained in the minutes that Directors seek assurance relating to concerns they may have and request assurance or action where it is not immediately available. • There have been no instances where a Non-Executive Director has resigned due to having concerns. However, concerns would be circulated to the Board of Directors if this situation were to arise.
Section B: Division of Responsibilities			
B.1. Principles			
B.1.1. The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information. **B.1.2**. Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision. **B.1.3.** Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account. **B.1.4**. The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically. **B.1.5.** The board is collectively responsible for the performance of the trust.			

Code	Provision	Comply	Narrative
B.1.6. The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies. **B.1.7.** All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.			
B.2. Provisions			
B.2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	✓	• The Board of Directors schedule of business provides items for all future meetings and is used to develop each agenda. The agenda is discussed with the Chair to ensure they are satisfied with the focus of the business and there is adequate time for discussion on all items. • The Chair is provided with an annotated agenda prior to any meeting, which provides information on each item to help ensure the right amount of time is dedicated to each item. • The Council of Governors schedule of business provides the items for all future meetings and is used to develop each agenda. The Lead / Deputy Lead Governor meets with the Chair prior to the Council of Governors to review and agree the agenda. • The Standing Orders for the Board of Directors and Standing Orders for the Council of Governors includes provisions for setting the agenda, including any additional items being added with written permission from the Chair.
B.2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary	✓	• Papers and information for Board meetings are shared with Directors via a Board Portal, which allows papers to be uploaded as they are made available. • The papers are circulated to the Council of Governors prior to the Board meetings and for public board meetings posted on our externally facing website.

Code	Provision	Comply	Narrative
	skills and knowledge to undertake their role.		• The Standing Orders for the Board of Directors provides the minimum time for papers to be circulated to Directors prior to any Board of Director meeting. • Governors receive a weekly Governor Update, which includes any additional information to enable them to perform their duties effectively. • The Learning and Development Plan for Governors provides topics to ensure Governors have the necessary skills and knowledge to undertake their role. The plan is developed and monitored by the Council of Governors Training & Development Committee. • The Governors receive a Governor Induction booklet upon election and annually, which provides detailed information on the Trust and the role of a Governor.
B.2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	✓	• The Trust operates an open and honest culture, which is underpinned by the Code of Conduct for the Board of Directors, which is based on the Nolan Principles. • The Chair promotes a culture of honesty, openness, trust and debate at each Board of Directors meeting, ensuring that Executive Directors / Non-Executive Directors are provided with the opportunity to constructively challenge each other in an open environment. • The Standing Committees of the Board are chaired by Non-Executive Directors, allowing a detailed scrutiny of items prior to the Board of Director meetings. • The Chief Executive Officer regularly meets with the Non-Executive Directors to share details of the operating of the Trust and any topical / emergent issues.

Code	Provision	Comply	Narrative
			• There is a programme of Board Seminar / Development sessions where Executive and Non-Executive Directors meet to discuss certain topics or upcoming strategies / services. For examples in 2023/24 a development session was held on what it meant to be a digitally enabled organisation.
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	✓	• The Council of Governors Relationship with the Board of Directors Policy & Procedure sets-out how the Board and Council will work together effectively, including in the event of any dispute. • The Board and Council hold joint seminar sessions twice per-year to discuss key topics of shared interest. • Executive and Non-Executive Directors regularly attend (by invitation) Council of Governor meetings. • Non-Executive Directors meet with Governors quarterly at a constituency level.
B.2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	✓	• The independence of the Chair is set-out in the recruitment criteria for any appointment. • The Trust operates an electronic declaration of interest system where individuals, including the Chair, are required to make annual declarations. • The role of Chair (Professor Sheila Salmon) and CEO (Paul Scott) are held by separate individuals. The current Chair has not been a CEO of the Trust. • The Trust has a Vice Chair (Manny Lewis until March 2024, Loy Lobo, from April 2024). The role and appointment of the Vice Chair is set-out in the Managing the Absence of the Chair Procedure. • The Trust has a Senior Independent Director (Dr Mateen Jiwani) • The Chair is not a member of the Audit Committee. The Chair of the Audit Committee is Elena Lokteva.

Code	Provision	Comply	Narrative
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date	✓	• The Annual Report 2022/23 (Pg78) provides a statement confirming the independence of the Non-Executive Directors following review of the Code of Governance. • The electronic declaration of interest system requires Non-Executive Directors to make an annual declaration. The Board of Directors agenda includes an item for Board members to declare any interest that may impact their independence for any items on the agenda. • As at 31 March 2024 there are no circumstances identified which are likely to impair the independence of the Non-Executive Directors as outlined in this provision. • The Chair of the Trust has served longer than six-years, however, this was due to an extension to their term of office of one-year, which was agreed through appropriate governance with NHS England.

Code	Provision	Comply	Narrative
	of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.		
B.2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	✓	• The Board of Directors in 2022/23 had seven Non-Executive Directors (excluding the Chair) and seven Executive Directors in a voting capacity. This requirement is set-out in the Trust Constitution. • The Trust is currently undertaking a recruitment process to replace a Non-Executive Director who stepped down due to ill health.
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	✓	• There are no Directors who are also Governors of the Trust.
B.2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into	✓	• The Trust reviews the roles of Non-Executive Directors, including membership / chairing of Standing Committees. This is reviewed and refreshed on appointment of new Non-Executive Directors. • The Council of Governors Nominations Committee reviews a skills matrix to ensure any gaps in skill sets, backgrounds and lived experience are

Code	Provision	Comply	Narrative
	account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.		considered as part of any appointment process. This includes ensuring at least one Non-Executive Director has a clinical background.
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	✓	• The Audit and Remuneration & Nominations Committee have clear Terms of Reference in place, setting-out the Chair and Membership. • Other individuals attend the Committees to present papers and discuss items within their portfolio or area of expertise. For the Remuneration & Nominations Committee this is usually only the CEO and Chief People Officer.
B.2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England	✓	• Dr Mateen Jiwani is the current Senior Independent Director. The appointment was undertaken as an expression of interest, approved by the Board of Directors and endorsed by the Council of Governors at respective meetings. • The Senior Independent Director appraises the Chair on an annual basis. The process includes receiving and considering views from the Board of Directors, Council of Governors and a range of external stakeholders / partners.

Code	Provision	Comply	Narrative
	as set out in the Chair appraisal framework.		
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	✓	• The Board of Directors Remuneration & Nominations Committee leads on any Executive Director recruitment, including final approval of candidates. This is evidenced from the appointment of an Executive Nurse and Executive Chief People Officer in 2023/24. • The Interview Panels and Stakeholder Groups included Non-Executive Directors. • The Board of Directors Remuneration & Nominations Committee receives the outcome of annual appraisals of Executive Directors, including achievement of objectives and the setting of future objectives. The Committee receives an update via a mid-year review of objectives from the CEO. • The Chair meets with Non-Executive Directors on a weekly basis, without the presence of Executive Directors.
B.2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	✓	• The Standing Orders for the Board of Directors sets-out the role of the Chair and Chief Executive. The appointment of the Senior Independent Director is included and the role outlined as part of descriptions of specific processes led by the SID. • The Scheme of Reservation & Delegation (SoRD) provides the responsibilities reserved for the Board of Directors and the delegated authority provided to the Standing Committees. • The Standing Committees of the Board of Directors each have a Terms of Reference setting-out the responsibilities of each Committee. • The Annual Report 2022/23 provides records of Board and Standing Committee attendance for individual Directors. • All documents are available on request.

Code	Provision	Comply	Narrative
B.2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chair ship of such an organisation.	✓	• The job descriptions (Executive Directors) and Terms & Conditions (Non-Executive Directors) sets-out the time commitment for the specific roles. • Directors are required to disclose any significant commitments prior to their appointment. • The Declaration of Interest system requires Directors to make annual declarations and identify any new commitments. Any significant commitments would require approval by the Board of Directors Remuneration & Nomination Committee. (Evidenced by CEO appointment as a non-executive director for Carradale Futures). • No current Executive Directors holds a non-executive directorship of another trust or organisation of comparable size and complexity to EPUT.
B.2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	✓	• The Senior Director of Corporate Governance (Denver Greenhalgh) acts as the company secretary (Trust Secretary) and is accessible for all directors. • The Senior Director of Corporate Governors is a member of the Board (non-voting) and provides any relevant governance advice as required.
B.2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values,	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions. • The Board of Directors receives a Quality & Performance Scorecard using Power BI, which allows directors to undertake deep dive reviews of financial

Code	Provision	Comply	Narrative
	standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.		and clinical quality data which allows for the scrutiny of performance and assessment of the integrity of internal controls. • The Board Assurance Framework provides relevant information on the risks and internal control mechanisms. • All Board Standing Committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes
B.2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees	✓	• The Board of Directors meets a minimum of six-times per year and holds Extra-Ordinary meetings to consider relevant items outside of this schedule of business. The Board of Directors met eight times in 2023/24. • The Scheme of Reservation & Delegation (SoRD) clearly provides the matters reserved specifically for its decisions. The Board of Directors Schedule of Business provides a list of items for consideration and / or decision for the financial year. • The Standing Orders for the Council of Governors provides the roles and responsibilities of the Council of Governors. The Standing Orders also includes a section setting-out the process for resolving any disagreement between the Board and Council. • The Council of Governors Relationship with the Board of Directors Policy & Procedure provides for the action to be taken should there be a disagreement. The Council of Governors also has a number of procedures in place detailing processes to be undertaken for any statutory function, including a section on the action to be taken should there be a disagreement.

Code	Provision	Comply	Narrative
	and the types of decisions that are delegated to the executive management of the board of directors.		• The Annual Report 2022/23 provides details of the governance arrangements for the Trust, including the Board of Directors, Standing Committees and the Council of Governors. The report provides information on any key decisions made, including appointment / re-appointment of Directors.
SECTION C: COMPOSITION, SUCCESSION AND EVALUATION			
C.1: Principles			
• **C.1.1** Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths (for more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES)). In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher. • **C.1.2** The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed. • **C.1.3** Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.			
C.2: Provisions for Foundation Trusts Board Appointments			
C.2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations	✓	• The Trust has two committees responsible for Executive Director appointments and Non-Executive Directors appointments / reappointments as set out in their terms of reference: - Board of Directors Remuneration and Nominations Committee reviews the structure, size and composition of the Board of Directors, considers succession planning and makes recommendations for changes as

Code	Provision	Comply	Narrative
	committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.		appropriate; it is responsible for the Executive Director appointment process. - Council of Governors Nominations Committee implements the procedure for the identification and nomination of suitable candidates for Chair and Non-Executive Director appointments / reappointments (for recommendation to the full Council) that fit the succession planning criteria recommended by the Board of Director Remuneration and Nominations Committee. • Recruitment processes for the Executive Nurse, Executive Chief People Officer and Non-Executive Directors included a representative from either NHS England or the ICB as part of the interview process.
C.2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	✓	• See C.2.1 • Composition of the Board of Directors considered as part of appointment process for Board members. • A regular review of skills and experience is undertaken to ensure that the Board has the right skill mix to discharge its duties, including when appointing new Non-Executive Directors. • The Trust is currently in the process of implementing the new competency framework published by NHS England, which will support the regular review of skills mix and capability of the Board of Directors.

Code	Provision	Comply	Narrative
C.2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	✓	• The Chair (Professor Sheila Salmon) chairs both the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee. The Lead Governor or the Vice Chair acts as Chair of the Council of Governors Nominations Committee where items are related to the Chair.
C.2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	✓	• The Council of Governors Nominations Committee leads on the appointment of the Chair and Non-Executive Directors. • The Council of Governors Appointment of the Chair and Non-Executive Directors Procedure provides the process.
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	✓	• The Trust engages Executive Search organisations for the recruitment of Directors. In 2023/24 the Trust engaged Alumni for Executive Directors and Hunter Healthcare for Non-Executive Directors to provide independent support. This will be included in the Annual Report for 2023/24.

Code	Provision	Comply	Narrative
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	✓	• The Council of Governors Nominations Committee membership has Governors in the majority, which is outlined in the Terms of Reference for the Committee. • The Interview Panel for the appointment of the Chair and Non-Executive Directors includes Governors as the majority in a voting capacity, as outlined in the Appointment of the Chair / Non-Executive Directors Procedure. • An independent external chair joins the interview panel to provide an objective view of suitability for post for Non-Executive Directors.
C.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	✓	• Arrangements in place between the Board of Directors Remuneration and Nominations Committee and Council of Governors Nominations Committee to ensure there is a dialogue between the two Committees (as detailed in terms of reference, for continuity Chair of the Trust is Chair of both committees • Appointment process took place in 2023/24 and a report was provided to the Council of Governors Nomination Committee by the Senior Director of Corporate Governance providing information to support discussions, including the views of the Chair / Board of Directors. • Members of the Board of Directors participate in Stakeholder Panels for the appointment of Non-Executive Directors. The views of the Stakeholder Panel are provided to the Interview Panel for consideration.
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-	✓	• The Annual Report 2022/23 (Page 80-81) provides details of appointment / re-appointment process undertaken during the financial year.

Code	Provision	Comply	Narrative
	executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.		• The Terms of Reference for the Council of Governors Nominations Committee is available on request.
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	✓	• The Trust Constitution process for Governors to hold terms of office of up-to three years before re-election. • The election process completed in 2023/24 were undertaken using CIVICA Election Services, which provided the names and biographical information for candidates. The Trust would include any performance related information as necessary.
C.2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and,	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference.

Code	Provision	Comply	Narrative
	except in the case of the appointment of a chief executive, the chief executive.		
C.2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference. • The Trust Constitution provides for the Chief Executive Officer to be appointed and removed by Non-Executive Directors, with the appointment being approved by the majority of members of Council of Governors present and voting at a general meeting. • The Appointment of the Chief Executive Officer Procedure in place sets-out the process for Governor involvement in the process and process for the Council to approve the appointment. The procedure sets-out the minimum requirement and the actual process may change in agreement with the Council.
C.2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	✓	• Procedure for the recruitment of Chair / Non-Executive Directors in place. • Council of Governors Nominations Committee has a clear terms of reference • Recommendations made to Council of Governors by Council of Governors Nominations Committee for appointment of Non-Executive Directors and are recorded in the minutes. • Re-appointment / appointment of Non-Executive Directors undertaken in 2023/24 managed by the Council of Governors Nomination Committee and approved by the Council of Governors.
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and	✓	• The Council of Governors appoint Non-Executive Directors for a specific term of office that does not exceed three-years. This is outlined in any reports to the Council and subsequent minutes. • The Trust Constitution provides clear criteria, in line with the 2006 Act, for the removal of a Director and this would be undertaken if required.

Code	Provision	Comply	Narrative
	subject to the 2006 Act provisions relating to removal of a director.		
C.2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	✓	• The Terms and Conditions for Non-Executive Directors are available to the Council of Governors on request. • The letters of appointment for Non-Executive Directors sets-out the expected time commitment. This is established as part of the recruitment process with Non-Executive Directors agreeing to the time commitment. • Any additional significant commitments are provided to the Council of Governors Nominations Committee as part of the recruitment process. • The publically available declaration of interest system provides for any new commitments and a process is undertaken to approve any NED who is appointed as a NED of another NHS Body. • The time commitment of Non-Executive Directors is informally monitored as part of regular NED team meetings. Any issues with time commitment would be reported to the Council of Governors as required. Governors can also raise concerns regarding the time commitment of NEDs if required.
C.3: Provisions for NHS Trust Board Appointments (N/A)			
C.4: Board Appointments: Provisions Applicable to both NHS Foundation Trusts and NHS Trusts			
C.4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence,	✓	• The Fit and Proper Persons Policy & Procedure sets-out the process for assessing if a person is fit and proper. • The Trust is implementing the new Fit & Proper Persons Test requirements issued by NHS England. The Trust Secretary's Office complete all relevant checks of Directors and identifies any concerns to the Chair / CEO for consideration in annual appraisals.

Code	Provision	Comply	Narrative
	skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.		• Following annual appraisals, the Chair is required to sign the Fit and Proper Persons Test form to confirm an individual Director is Fit and Proper. Action would be taken if there are any concerns raised as part of this process. • The Trust Constitution sets-out the criteria for disqualification as a Director and Governor, in line with the FPPT requirements. • Directors complete an annual Self-Attestation confirming they do not meet any of the disqualification criteria, as part of the overall FPPT test. • Governors complete a Self-Attestation on appointment, confirming they do not meet any of the disqualification criteria and sign-up to the Council of Governors Code of Conduct.
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	✓	• The Annual Report 2022/23 (Page 40 – 46) provides biographies of the Board of Directors, including skills, expertise and experience. • The Annual Report 2022/23 (Page 79) provides a statement of the balance, completeness and appropriateness of the membership of the Board of Directors. • The Annual Report is available on the Public Website.
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years	✓	• No current Non-Executive Director has exceeded nine-years in post. • The Chair has been in post for seven years following an extension of their term of office. This was agreed with the Council of Governors and NHS England, including clear rationale.

Code	Provision	Comply	Narrative
	can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.		
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	✓	• See section C.2.9 • The Trust Constitution provides for Governors to serve a maximum of three terms of office of up to three-years, before having a break of a year before seeking any further term of office.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a	✓	• The Annual Report 2022/23 (Page 101 – 103) provides details of the regular review of the performance of the Board / Organisation, including internal and external audit. • The Trust Well-Led Review was undertaken by Deloittes in 2019 and identified no areas of concern. The Trust has commissioned an independent

Code	Provision	Comply	Narrative
	process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.		Well-Led Review to be undertaken by NHS England in 2024/25, which is currently underway. • The Council of Governors complete an annual effectiveness review, including its own performance and that of its sub-committees. • The Board and standing committees undertake an annual effectiveness review. • The Chair and Chief Executive Officer complete annual appraisals of Non-Executive Directors and Executive Directors respectively, which includes a review of performance against objectives. • The appraisal of the Chair is undertaken by the Senior Independent Director. • The Council of Governors Remuneration Committee reviews Non-Executive Director appraisals and meets with each individual to discuss the content. The Committee considers the quality and accuracy of the appraisals and reports back to the Council of Governors.
C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	✓	• Any action plans from annual reviews are presented to the Board of Directors and monitored by the relevant Standing Committee. • The Chair / Senior Independent Director acts on the outcome of appraisals of Non-Executive Directors, recognising strengths and addressing any weaknesses. • The Chief Executive Officer shares the outcome of the Executive Director appraisals with the Board of Directors Remuneration & Nominations Committee to identify strengths and discusses addressing areas of weakness.
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years,	✓	• The last externally facilitated development review of leadership and governance using the Well-Led Review was undertaken by Deloittes in 2019 and a Well-Led Review is now underway by NHS England.

Code	Provision	Comply	Narrative
	according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.		
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS	✓	• The Council of Governors completes an annual effectiveness review of its own performance and its sub-committees. The results are presented to the Council of Governors for discussion and the identification of any actions to be taken forward.

Code	Provision	Comply	Narrative
	foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.		
C.4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	✓	• The Trust Constitution sets-out the criteria for the disqualification of a Governor, including failing to attend Council meetings and conflicts of interest. The Constitution also provides for the process to be followed for the removal of a Governor if the need arises, which is supported by the Council of Governors Code of Conduct. • The Monitoring of Council of Governors Attendance Procedure provides further context to the terms "consistently and unjustifiably fails to attend" and the process to be followed. The procedure was developed and approved by the Council of Governors.
C.4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed	✓	• The Trust Constitution includes criteria for the disqualification of a Governor and removal from office where their values and behaviours are not compatible with the Trust. • As above re. process for removal of a Governor. • The Council of Governors Code of Conduct is based on the Nolan Principles and is based on the Trust values. Governors are required to agree to the Code of Conduct on appointment and includes the process to be followed should a Governor breach the Code.

Code	Provision	Comply	Narrative
	removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.		
C.4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	✓	• See Section C.2.1
C.4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	✓	• To date no Executive Directors have left the Trust outside of the terms of their employment contract.

Code	Provision	Comply	Narrative
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the	✓	• The Annual Report 2022/23 (Page 80 – 81) provides details of the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee. • The Annual Report 2022/23 (Page 27) provides details of the Equality Monitoring policies in place. Page 33 provides information relating to the race equality of the workforce, linked with the WRES. • The Annual Report 2022/23 (Page 62) provides a workforce profile, which provides gender balance for senior management and their direct reports. • **Information on the diversity of the Board and Senior Managers in comparison with the workforce needs to be included in the annual report for 2023/24.**

Code	Provision	Comply	Narrative
	trust's workforce and communities served • the gender balance of senior management and their direct reports.		
C.5: Development, Information and Support			
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	✓	**Director induction** • NED induction is included in NED's objectives and is monitored and reviewed by Chair • NED and ED induction programme and information pack reviewed and updated in line with good practice; induction programme is tailored to the Director's requirements based on skills and experience • All Directors new to the NED role completed the NED induction programme • NEDs are encouraged to attend relevant briefings and conferences organised by NHS Providers and other national NHS-related organisations, and provide feedback at the NEDs Discussion Group meeting • Executive Directors undertake corporate induction training programme; additional induction and ongoing training requirements will be identified relevant to role. The Executive Director induction is managed through the Trust's Supervision and Appraisal Policy and Procedure. • Executive Directors are given a 6-month probationary period following commencement with the Trust. Objectives are set for achievement within this probationary period and these are formally reviewed at the end of the probationary period. The outcome of the review is provided to the BoD RemNom Committee.

Code	Provision	Comply	Narrative
			• Non-Executive Directors are given a one-year probationary period following appointment, which is reviewed by the Council of Governors at the end of the 12-month period. S **Governor induction** • Governor induction programme reviewed and included as part of the Governor Learning & Development Schedule and regularly updated taking account of good practice and relevance to the Trust • Governor Induction Handbook based on documents developed by NHS Providers provided to any new Governors. • Individual induction sessions held with new Governors joining the Trust throughout the year due to Governor resignations and Appointed Governors.
C.5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training,	✓	• Directors individual appraisal and performance evaluations undertaken annually with six monthly reviews • Directors have individual personal objectives and professional/personal development plans. The Trust is currently implementing the NHS England Competency Framework. • Directors have access to training courses/materials as identified in their individual personal development plan • Non-Executive Directors personal development objectives received by Council of Governors Remuneration Committee as part of review/assurance of Non-Executive Directors performance. • The Council of Governors have a Learning & Development Plan, monitored by the Council of Governors Training & Development Committee which identifies a wide range of topics for learning and development. The Plan is regularly reviewed and updated with any new learning requirements. • The Council of Governors Nominations Committee receives training in recruitment prior to any NED appointment process. In 2023/24, this was

Code	Provision	Comply	Narrative
	including on equality, diversity and inclusion, and unconscious bias.		provided by the Interim Chief People Officer and included areas such as equality, diversity, inclusion and unconscious bias.
C.5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	✓	• The induction programme includes details about the Trust, including operations and key issues, for both Board and Council members. • The Quality & Performance Scorecard presented to the Board of Directors incudes Key Performance Indicators developed to monitor the operational practices of the Trust. The Chairs Report and CEO Report to the Board of Directors / Council Governors provides regular updates on operational matters. • Directors and Governors complete service visits to understand the operations of the Trust. The Trust is currently implementing a Quality Visits Framework which will formalise the process and ensure a wider range of services are visited. • The Staff Governors meet with Non-Executive Directors as part of Staff Constituency meetings to share the views of staff members. • The summary reports for the Board of Directors and Council of Governors contain boxes providing the Trust Values and indicating if the report impacts any of the values of the Trust. The Board of Directors and Council of Governors were involved in the development of the values when first implemented. • Directors have access to the intranet which includes policies and procedures developed by the Trust. Governors can access policies and procedures through the publication scheme and procedures relevant to the Council are monitored via the Council of Governors Governance Committee and approved by the Council of Governors.
C.5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored	✓	• See Section C.5.1

Code	Provision	Comply	Narrative
	induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.		• Directors and Governors are invited to attend a wider range of stakeholder meetings and events to engage with stakeholders, this includes constituency meetings, patient forums, Your Voice meetings, ICB meetings, service visits etc. • Directors are able to claim expenses through the internal EASY expense system, with NEDs accessing this via the Chairs Office. Governors are able to submit expenses to the Trust Secretary's Office for any expense incurred whilst undertaking their role of a Governor.
C.5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	✓	• The appraisal process reviews and agrees training and development needs for each Director. This is undertaken by the Chair (NEDs) and CEO (Executive Directors). • The Trust is currently implementing the new competency framework published by NHS England which will strengthen this area.
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	✓	• See Section C.5.2 regarding the Learning & Development Plan.
C.5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect	✓	• Comprehensive reports and executive summaries (including detailed appendices) circulated prior to each Board of Directors and Council of Governors meetings, as well as Committee meetings. Standardised approach for all meetings. Information available on website/intranet. • Annual meeting business schedule in place for Board of Directors and Council of Governors.

Code	Provision	Comply	Narrative
	the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.		• All Board of Director standing committees and Council of Governors sub-committees have developed a work plan and progress against the plan is regularly monitored • Circulation of papers / uploading of papers to the Board Portal requirements detailed in Board of Director and Council of Governors standing orders • Directors and Governors able to request information as necessary. • Informal confidential briefings prior to each Council of Governors meeting by the Chief Executive Officer • Governor Updates distributed regularly to all Governors • Information on ICS plans, decisions and delivery that directly affect the organisation and its patients are included within reports as relevant to the subject matter.
C.5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	✓	• See section C.5.7
C.5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating	✓	• This is covered by Sections above relating to the sharing of information, the induction programmes, the relationship between Executive Directors and Non-Executive Directors and communication between the Board of Directors and Council of Governors.

Code	Provision	Comply	Narrative
	appropriate induction and assisting with professional development as required.		
C.5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	✓	• See Section C.5.7 • The Board of Directors Schedule of Business is developed in conjunction with Executive Directors. Standing Committees of the Board of Directors have clear Terms of Reference and clear work plans are currently being developed. • The Council of Governors Schedule of Business is discussed with the Chair and the Lead / Deputy Lead Governor when planning the agenda for each Council of Governors meeting. The Lead / Deputy Lead Governor can request any additional items to be added to the agenda following consultation with fellow Governors. • Board papers are developed and approved by relevant Board directors to ensure these are concise, accurate and timely. These are reviewed by the Trust Secretary's Office prior to uploading to the Board Portal.
C.5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Advice will be sought from relevant adviser if required as detailed in terms of reference • Any such challenges are recorded in the minutes

Code	Provision	Comply	Narrative
	informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.		
C.5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	✓	• Independent professional advice is made available at the Trust's expense to directors in respect of critical or significant activities, e.g. audit, Mental Health Act Managers, legal advisors, other specialist advisors • Appointment of advisers in relation to significant transactions is approved by the Board and the process scrutinised by the Audit Committee. • Board of Director Committees are provided with support as identified in their terms of reference • Board of Director Remuneration and Nominations Committee may, at the Trust's expense, appoint independent consultants or commission independent professional advice if considered necessary (included in terms of reference)
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	✓	• Board of Director Committees are provided with support as identified in their terms of reference. • All Council meetings and committee meetings are supported directly by the Trust Secretary's Office • Trust Secretary's Office also provides day to day support to Governors including regular communications and updates, advice, managing queries, etc.

Code	Provision	Comply	Narrative
C.5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge and/or to request 1:1 meetings with EDs to seek further clarification/assurance • Regular briefing with the CEO with NEDs. • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes • Non-Executive Director skills balance considered in succession planning
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	✓	• Public and members meetings (Your Voice) held virtually. • Governors invited to participate in discussions for the new EPUT Strategy. • The Trust has developed a Membership Strategy which sets-out the priorities to ensure Governors are able to canvass the opinion of Trust members and represent these to the Board of Directors. • Annual Report 2022/23 (Page 87) outlines how Governors have 'canvassed' members/public
C.5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views	✓	• Governors have been involved in the forward plans of the organisation, included being included in the development of key enabling strategies in the Trust. This has been undertaken as part of stakeholder engagement and Joint Board / Council Seminar Sessions.

Code	Provision	Comply	Narrative
	have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.		
	The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	✓	
C.1.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	✓	• The Trust Constitution (Section 50) includes information on liabilities for the Board of Directors and Council of Governors in-line with this provision.
SECTION D: AUDIT, RISK & INTERNAL CONTROL			
D.1. PRINCIPLES			
D.1.1. The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements. **D.1.2.** The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.			

Code	Provision	Comply	Narrative
D.1.3. The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives. **D.1.4.** Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners.			
D.2. PROVISIONS			
D.2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	✓	• The Trust has an established Audit Committee with the membership including three Non-Executive Directors. • The Chair of the Board of Directors is not a member of the Committee. • The Chair of the Audit Committee (Elena Lokteva) is not the Vice Chair or the Senior Independent Director. • The Terms of Reference provides for at least one member of the Committee to have recent and relevant financial experience. This is currently with the Chair of the Committee (Elena Lokteva). • The Terms of Reference provides for a regular attendance of key individuals to support the Committee to ensure competence relevant to the sector in which it operates, including the Executive Chief Finance Officer.
D.2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them	✓	• The Audit Committee Terms of Reference outlines the role and responsibilities of the Committee and covers each of the points included in this provision. Evidence of discussion is included in the minutes of the meeting. • The Audit Committee reports to the Board of Directors at each meeting via the Committee Chairs Report, summarising the work of the Committee in the preceding months.

Code	Provision	Comply	Narrative
	• providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements		

Code	Provision	Comply	Narrative
	• reporting to the board of directors on how it has discharged its responsibilities.		
D.2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	✓	• The Trust completed a market testing exercise of the External Auditors in 2021/22 and appointed Ernst & Young (EY). The contract is for five-years, with a review every year to confirm re-appointment by the Council of Governors.
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans	✓	• The Annual Report 2022/23 (Page 82) includes a section on the work of the Audit Committee, which includes significant issues relating to financial statements. • The Annual Report 2022/23 (Page 82) confirms the External Auditors did not complete any non-audit work. The section also includes the details of the market testing exercise completed in 2021/22 and identifies Ernst & Young as the External Auditors. The section also includes details of the length and value of the contract. • The Annual Report 2022/23 (Page 104) provides an independent report to the Council of Governors by the External Auditor into how the audit opinion was reached and the work undertaken by the External Auditors. • The Audit Committee completes an annual review of Audit Services and last completed the review in July 2023. The review supports the Council of Governors in reviewing and re-appointing the External Auditors on an annual basis. However, this needs to be included in the annual report.

Code	Provision	Comply	Narrative
	• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.		**Action: Annual Report for 2023/24 needs to include more detail on how the Audit Committee has assessed the independence and effectiveness of the audit process.**
D.2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	✓	• The Standing Financial Instructions (SFI's) include a section on the responsibilities of the External Auditors, which does not provide for any non-audit services to be undertaken. The External Auditors do not currently undertake any non-audit work for the Trust and this is not permitted. However, this could be strengthened by stating in a specific protocol. • The Standing Orders for the Council of Governors provide for the Council of Governors to appoint and remove the External Auditors. The Council of Governors Appointment of the External Auditors procedure sets-out the process to be followed. **Action: Consider amending the Detailed Scheme of Delegation (DSoD) to clarify the Trust's approach to engaging the External Auditor to supply non-audit services.**
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	✓	• The Annual Report 2022/23 (Page 46) provides a section outlining the director's responsibility for preparing the annual report and accounts. • The section includes a statement that the Directors consider the annual report taken as a whole as fair, balance and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.

Code	Provision	Comply	Narrative
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	✓	• The Board Assurance Framework has been developed to identify and assess emerging and principle risks to the Trust achieving its strategic objectives. The framework is regularly discussed by the Executive Team and presented to the Board of Directors, including any mitigation to emerging risks. • The Annual Report 2022/23 (Page 95 – 98) provides details of the assessments completed to identify and manage risk within the organisation. This includes the identification of significant risks to the achievement of its strategic objectives as at 31 March 2023.
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	✓	• As above regarding the Board Assurance Framework and annual report information, which also includes reviewing internal controls relating to quality governance. • The Annual Report (Page 95 – 97) provides the Annual Governance Statement and includes all material controls, including financial, operational and compliance controls.
D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be	✓	• The Annual Report 2022/23 (Page 113) provides a statement concluding the adoption of the going concern basis of accounting when preparing the annual accounts. The statement identifies any material uncertainties considered when making the statement.

Code	Provision	Comply	Narrative
	based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.		
SECTION E: REMUNERATION			
E.1. PRINCIPLES			
E.1.1. Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts and NHS trusts should also follow Guidance on senior appointments in NHS trusts. **E.1.2.** Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post. **E.1.3.** The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance. **E.1.4.** The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases. **E.1.5.** There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration. **E.1.6.** The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals (for further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations).			

Code	Provision	Comply	Narrative
E.1.7. The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration. **E.1.8.** Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest. **E.1.9.** NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.			
E.2. PROVISIONS			
E.2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to	✓	• The Chief Executive Officer has a contractual due payment in place (2.5k per quarter) which is based upon achievement of objectives related to the strategic objectives of the organisation. The strategic objectives were developed to align with the interests of service users, patients and use of public money. • The Board of Directors Remuneration & Nominations Committee receives a quarterly report outlining the key achievements of the CEO for that period, aligned to the strategic objectives. The Committee considers the report and approves (or not) the contractual due payment for the quarterly period. • The Terms and Conditions for the Non-Executive Directors are set by the Council of Governors Remuneration Committee and Council of Governors. The Terms and Conditions are standard and any changes are approved by the Remuneration Committee, in line with any adjustment to remuneration.

Code	Provision	Comply	Narrative
	criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. • For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.		
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	-	• The Council of Governors agreed to adopt the principles of the Chair and Non-Executive Director Remuneration Structure Framework when setting remuneration levels, whilst not being bound to any previous decision of the Council in the setting of future remuneration. • The Council of Governors Remuneration Committee considers the framework when agreeing any adjustment to Chair / NED Remuneration. However, it

Code	Provision	Comply	Narrative
			should be noted the framework has not been updated since 2019 and does not consider any recommended annual uplift from NHS England. • The remuneration of the Chair is set using the table included in the Framework considering the annual turnover of the Trust. • The remuneration of the Non-Executive Directors was originally set in line with the framework, with an adjustment to the uplift recommended to ensure it reflected the additional time commitment of the Vice Chair and Chair of the Audit Committee.
E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	✓	• Executive Directors are required to make annual declarations of interest which would identify any positions held such as a non-executive director role. • If an Executive Director is released to serve as a Non-Executive Director of another organisation, a statement would be included in the Annual Report as required.
E.2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	✓	• The responsibility for the approval of termination of employment arrangements and / or making of any extra contractual payments to Executive Directors is within the remit of the Board of Directors Remuneration & Nominations Committee and referenced in the Terms of Reference. • During the year, no extra contractual payments have been made to Executive Directors following termination of employment.

Code	Provision	Comply	Narrative
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	✓	• The secondment arrangement for the Executive Director of People & Culture was discussed with NHS England regional director.
E.2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	✓	• The Trust has an established Remuneration & Nominations Committee that includes all Non-Executive Directors as members. The Terms of Reference for the Committee sets-out the roles and responsibilities for the Committee. • The Executive Chief People Officer / Interim Chief People Officer attends the meeting from time-to-time as required to provide HR advice and is outlined in the Terms of Reference. • The Trust has not used remuneration consultants.
E.2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee	✓	• The Remuneration & Nomination Committee Terms of Reference provides the remit of the Committee, including setting remuneration for Executive Directors, including pension rights and any compensation payments.

Code	Provision	Comply	Narrative
	should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.		• The Terms of Reference includes for the remit of the Committee the level and structure of remuneration for very senior managers (VSM's).
E.2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	✓	• The Council of Governors Remuneration Committee is responsible for agreeing the remuneration for the Chair and Non-Executive Directors. Recommendations are made to the Council of Governors for approval.

9. STRATEGIC INITIATIVES

9.1 STRATEGIC IMPACT REPORT M12

Information Item | ZT | 10

REFERENCES

Only PDFs are attached

Strategic Impact Report 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Strategic Impact Report M12**					
Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy Richard James, Director of Transformation					
Report discussed previously at:	Strategy Steering Group Executive Committee 7 May Quality Committee 9 May People, Education & Culture Committee (virtual discussion with Committee chair) Finance & Performance Committee 23 May					
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)?	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 an update on the implementation of the Trust's Strategic Plan at the end of the first of five years.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1. Note and take assurance from the report.

Summary of Key Points

A strategic impact report is prepared and presented to the Board three times per year. Its purpose is to monitor and assess delivery of the Trust's Strategic Plan and identify further action where required.

Since the last iteration of this report presented to the Board in January, the report has been strengthened in two key ways:

- The process of developing the report has been strengthened this time by taking it through board committees to provide the opportunity for closer scrutiny of relevant content and to increase members' ownership of the content
- To supplement the wider narrative about EPUT's partnership working, the scorecard for strategic objective three (we will work together with our partner to make our services better) has been developed to include Research & Development performance metrics. These have been chosen on the basis that clinical research is a key way in which EPUT can drive improvements in care through collaboration with academic and commercial partners, and over time should show the impact of the Trust's Research strategy coming into effect.

At the end of Year 1 of its Strategic Plan, EPUT can evidence steady progress against each of its strategic objectives within each care unit.

- **We will deliver safe, high-quality integrated care:** Across all care units, place-based integration is progressing through a range of delivery models and there is evidence of quality improvements in each care unit. Safe, high quality and integrated care will progressively be underpinned by a modern and unified Electronic Patient Record (EPR), for which a preferred supplier has been selected and the name Nova been selected by stakeholders. The shared care record programme supports the ongoing integration of a single care record across EPUT and our system partners for existing EPRs. Trust oversight and governance processes have been amended in the last four months to support implementation of the new Quality of Care strategy with executive oversight groups now in place to focus on driving improvements in patient experience, effectiveness and safety of care.
- **We will enable each other to be the best we can be:** The Time to Care programme has progressed throughout the year with strong multi-professional leadership and buy-in. The co-design of the new therapeutic inpatient care model is now almost complete and management development programme has been comprehensively rolled out to inpatient matrons. EPUT's new People & Education strategy was approved in January 2024 and is now in the early stages of implementation with a particular focus on embedding the Behaviours Framework and supporting the Sexual Safety of all staff. Numbers of Lived Experience Ambassadors and Volunteers have grown steadily throughout the year as part of the new Partnering with People & Communities strategy. 2023 National Staff Survey results have improved from the prior year with above average scores for staff engagement and morale. Further work is underway to address lower than average scores on discrimination and raising concerns. National Quarterly Pulse Survey results in Q4 have highlighted concerns from staff that are being further analysed and plans developed accordingly.
- **We will work together with our partners to make our services better:** Relationships across four Integrated Care Systems (ICS) continue to strengthen with a particular focus in recent months on the maturation of local community collaboratives, both formal and informal. Implementation of the Southend, Essex and Thurrock All Age Mental Health Strategy has progressed well and priority programmes of work are now agreed, including metrics for oversight of impact. EPUT remains committed to the broadening and strengthening of all partnerships across and beyond the local ICSs. Partnership for service improvement is a key feature of EPUT's Research, Innovation and Commercial Strategies that were approved in November 2023 and are now in the early stages of implementation.
- **We will help our communities thrive:** The Board of Directors approved EPUT's new Social Impact charter in March 2024 which will now move to publish. The Social Impact Leadership Group has continued to grow in recent months with new Lived Experience Ambassadors and grass roots community leaders joining the group. In the last four months, Enable East has secured over £400k in Local Authority Grants to deliver Multiply, a numeracy skills programme that has already supported 330 adults since April who do not have a GCSE in mathematics. Care Unit teams continue to be heavily engaged with place based inclusive recruitment events and in exploring

ways to open pathways to employment for those that traditionally find it hard to access good quality work e.g. those with Learning Disabilities or Autism. The final phase of development of the new EPUT Estates strategy provides an opportunity to consolidate thinking about how buildings are used o best effect for local communities and maximise environmental sustainability. Similarly, the Pharmacy & Medicines Optimisation Strategy has been developed to reduce waste, maximise recycling of medicines-related items and provide pre-discharge counselling as standard to support people to thrive once they are home after an inpatient stay.

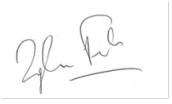
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
M12 Strategic Impact Report

Executive Lead:

Zephan Trent **Executive Director of Strategy, Transformation & Digital**

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT REPORT

M12 2023/24

EPUT

CONTENTS.

NHS
Essex Partnership University
NHS Foundation Trust

INTRODUCTION

EPUT

EPUT'S STRATEGIC PLAN 2023/24-2027/28

OUR VISION

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

OUR VALUES

Strategic objectives

We have four strategic objectives to achieve our vision:

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

Delivered through our target operating model

A balanced scorecard approach has been developed to support reporting of progress against delivery of the Trust's strategic plan

- In the Strategic Plan we committed to a series of outcomes, sub-outcomes and measures for each of our four Strategic Objectives
- For each of the four Trust strategic objectives, a small number of metrics have been selected
- Metrics have been selected on the basis that they are indicators of progress with the relevant strategic objective and that, if there is an adverse trend reported for that metric, delivery of the relevant strategic objective could be at risk and corrective action should be considered
- The dashboard provides a visual representation of in-year trends
- Supporting narrative has been triangulated with other reporting flows to the Board and sub-committees
- This approach compliments established Board assurance reporting with focus on the delivery of the Trust's strategic plan. This report is not exhaustive and does not replace or summarise other reporting to the Board.

Ongoing reporting development process

- This report is the third in a three times yearly reporting cycle and will continue to iterate and evolve based on new data workflows as well as constructive feedback from the Board
- In this third iteration, a more active scrutiny role for Board committees has been built into the process of developing the report. There has also been some focussed development of the metrics relating to strategic objective 3: we will work with our partners to make services better
- This report has been developed through a combination of:
    - Analysis of available performance data by the Business Information team aligned with the measures agreed for each of the Trust's four strategic objectives
    - Thematic review and distillation of Accountability Framework papers for M9-12 2023/24
    - Supplementing Accountability Framework discussions, informal meetings with care unit leadership teams to review progress against operational plans for 2023/24 and five-year care unit strategies as well as any risks to operational delivery. While mid-year reports focused on three out of six care units in more detail, this report provides a Trust-wide position at the end of Year 1 of the Strategic Plan
    - We continue to work towards further alignment of this report with established reporting to Board via the Accountability and the Integrated Performance Report.

NHS
Essex Partnership University
NHS Foundation Trust

DELIVERY AGAINST STRATEGIC OBJECTIVES

M12 2023/24

EPUT

SUMMARY OF EPUT'S COMMITMENTS FOR Y1 DELIVERY OF ITS STRATEGIC PLAN

We will deliver safe, high quality, integrated care services

- Finish implementation of current safety strategy and develop continuation plan
- Phased implementation of Time to Care models
- Continue to actively engage with the Lampard Inquiry and respond to recommendations once concluded
- Develop clinical quality strategy

We will enable each other to be the best we can be

- Develop people and culture strategy including development of behavioural framework
- Continue to collaborate with local and regional partners on long term workforce development plan
- Improve our staff development offer and extend this to lived experience and volunteer roles

We will work together with our partners to make our services better

- Build on recent successes in the way we partner with lived experience experts, families, carers and communities to drive cultural change within EPUT
- Deepen approach to partnerships with ICSs and Local Authorities to maximize influence
- Better define EPUT's role in Population Health Management across three ICSs

We will support our communities to thrive

- Develop social impact strategy with focus on parity for people with serious mental illness, learning disability or autism
- Form local commercial and innovation partnerships
- Consolidate local recruitment plans

Finalise digital strategy and progress towards streamlined EPR
Develop estates strategy
Develop research & innovation strategy
Become a Trauma-Informed and psychologically-informed organisation

At the end of Year 1 of its Strategic Plan, EPUT can evidence steady progress against each of its strategic objectives within each care unit.

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STRATEGIC OBJECTIVE 1: WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

Trust level highlights M9-12 by exception

- Patient Safety Incident Reporting rates have followed a positive, upward trend M1-12 with the implementation of PSIRF and the adoption of a learning culture
- The methodology for analysing harm rates in reported incidents has been updated since M8. The table below does not include incidents waiting to be reviewed. During 2023/24, we have seen a reducing trend in total incidents reported and slight reduction in the proportion of incidents reported with low or no harm. This issue is monitored via the Learning and Oversight Subcommittee with the lessons and datix teams completing further analysis to validate and monitor. Place based care unit teams will continue to use safety dashboards to monitor and report trends and benchmarked performance via local overview and scrutiny committees.
- Patient reported experience measures give a good indication of the quality of care EPUT provides. In the last four months of the year, the increased number of reviews received has driven the monthly average number of reviews up by 27 which provides increased opportunity for the Trust to act on the feedback received
- The proportion of patients and families reporting feeling safe in EPUT's care has been on an increasing trend throughout the year, achieving a high of 98.2% in M9 and an average of 95% over the course of the year
- In M9-12 2023/4, 91.8% reported a positive experience (therefore 0.6% increase on M1-8 average) and 3.1% negative (0.7% decrease from M1-8 average). We have seen an overall increase in positive responses 2023/24 compared with the prior year and corresponding dips in performance in M6 and M10 in both years.
- Community teams continue to iterate models of network integration with Primary Care across Greater Essex bringing together physical and mental health services. In South Essex, the focus has been on aligning community teams to primary care around cohorts of patients with frailty and plans are in place to pilot a mental health integration model with one PCN.

Metric		Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Patient Safety incident rates (PSIM)	Incident Reporting Rates (as at 08/05)	>44.33	64	75.3	76.8	63.6	68	69.8	69.6	67.3	70.3	73.2	58.8	75.2	
	Reduction in PSIs (as at 08/05)	<3	0	3	1	0	2.4	0	2	2	1	3	3	0	
Patient Safety Events rated by Harm *(not including incidents that have yet to be reviewed)*	No/low harm incident rates		90%	89%	89%	90%	90%	89%	88%	88%	88%	85%	85%	85%	
	Total incidents reported		1932	2193	2185	1923	1943	1755	1809	1848	1732	1794	1521	1344	
Live Integrated Network Teams	West Essex	6							6						
	MSE (SEE)	6							4						
	NEE	10							4						
Patient Reported Experience Measures (PREMS)	No. reviews		196	314	514	310	345	303	369	367	367	463	471	388	
	5 star score		4.77	4.76	4.76	4.6	4.73	4.69	4.71	4.72	4.84	4.7	4.75	4.77	
	% Positive experience		92.9%	91.1%	92.0%	89.0%	90.1%	91.7%	90.4%	92.6%	96.2%	93.3%	84.3%	93.30%	
	% Negative experience		2.6%	3.5%	1.8%	4.8%	4.6%	5.3%	4.5%	3.0%	2.2%	4.1%	2.8%	3.40%	

Note: Any data variance from the Integrated Performance Report is driven by live updates from Datix on incidents reported retrospectively

STRATEGIC OBJECTIVE 1:

WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

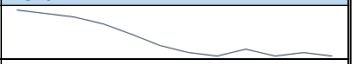
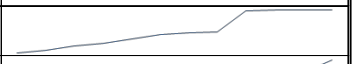
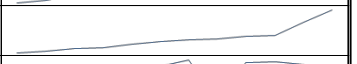
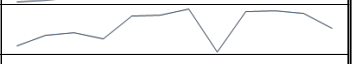
Care Unit	Successes M9-12
Urgent Care & Inpatients	• Reducing numbers of Out of Area Placements from 30 in M9 to 20 in M12 • Secured £2m investment for renovation of Psychiatric Intensive Care Unit (Hadleigh Unit) to improve safety and enhance therapeutic environment
North East Essex	• Adopted a "back to basics" approach to operational planning for 2024/25 with a clear focus on safe staffing and quality of care • Progressed implementation of Trauma Informed model of care
Specialist Services	• Implemented Dialectical Behaviour Therapy prescribing on CAMHS wards to reduce reliance on medication • Reduced negative intervention rates from staff during incidents of ligature using quality improvement methodology
West Essex	• Ran Quality & Safety workshop with care unit staff to drive engagement in and support for range of change programmes underway across the care unit, with positive feedback from commissioners • Maintained good level of occupancy in virtual wards at average 68% M9-11
Mid & South Essex	• Embedded mental health practitioner roles in GP surgeries as part of integrated network teams • Achieved target for reduced Referral to Treatment times for Lighthouse service, reduced waiting list and longest waiting times
Psychological Services	• Driven increased patient engagement with Talking Therapies through Limbic's Attend, Engagement and Discharge process • Developed Eating Disorders service specification to mandate treatment of secondary mental health difficulties comorbid with Eating Disorders e.g. trauma

STRATEGIC OBJECTIVE 2: WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Trust level highlights M9-12 by exception

- Trust-wide turnover rates have continued to reduce steadily all year and have been maintained at 9.1-9.3% in the last 6 months a target of 12%
- Vacancy rates have fallen consistently since the high of 13.2% in M4 and have been comfortably maintained below the 12% threshold since M6
- In Q4, we reported a 2.97% decrease in National Quarterly Pulse Survey response rates. All nine NQPS scores have shown statistically significant deterioration since the previous quarter. Notably, there has been a drop in staff enthusiasm about recommending EPUT as a workplace and in their confidence in the standard of care provided to our patients. This overall downturn is a concern and suggests a need for deeper analysis. Despite these declines, the organisation's involvement score still stands above the national average. Q4 results will be reviewed alongside Q1 24/25 results to identify any statistically significant trends in the areas highlighted for improvement by staff in Q4, together with management action plan
- EPUT achieved 2% higher response rate to the 2023 National Staff Survey than in 2022. EPUT performed better than peers in our benchmarking group for two 'People Promise' elements, and in line with the average for seven remaining measures. Areas of success include themes around Autonomy and Control, Work Pressure and Stressors, Morale, Staff Engagement, Line Management and Appraisals.
- Uptake of professional development opportunities remains high: in Q4 25 EPUT staff have undertaken leadership development training including three apprentices, 64 have completed the Management Development Programme and 23 Acceptance & Commitment Therapy (wellbeing) training
- Whilst our pool of Lived Experience Ambassadors has not grown in the last four months, the number of volunteers onboarded has more than doubled during that period. In addition, the average hours invested each month in LEA activities has been higher in Q4 (522 hours/month) than the average for the first three quarters of the year (372 hours/month). This shows progress in implementing our Working with People & Communities strategy.

STRATEGIC OBJECTIVE 2:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Metric		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Retention rate	Staff Turnover (Target 12%)	10.4%	10.3%	10.2%	10.0%	9.7%	9.4%	9.2%	9.1%	9.3%	9.1%	9.2%	9.1%	
Range and update of learning & development opportunities (inc. volunteers and lives exp. roles)s		Leadership Programme: 70 Management Development Programme: 112 Edward Jenner Programme: 14 STORM Training: 45 PSIRF (Systems Approach to Learning from Patient Incidents): 40 Time Management: 1 Minute Taking: 9 VDT MOCA Training: 2 ACT Training: 36 RISE: 45												
Number of PSE and Lived Experience role	Total No. LEAs	106	112	123	129	140	152	156	158	211	214	214	214	
	Total No. Volunteers inc LEA	251	258	270	277	292	304	311	317	330	332	394	455	
	Hours LEA (per month)	136.5	278	314.5	225.8	539	557	645	47	607	610	584	371.5	
Staff survey - Pulse results	Reported quarterly	**Reporting window July 2023** There has been a 92.5% increase in response rate when compared with Q1 2023/24, with 605 responses • Results from the survey are overall positive, with: • EPUT performing above national averages on engagement scores • Improvements in 3 of 9 questions • Worsening scores in 3 questions • 3 question scores remaining in line with Q1 2023/24				See narrative on slide 12							

STRATEGIC OBJECTIVE 2:

WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

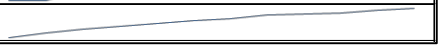
Care Unit	Successes M9-12
Urgent Care & Inpatients	• Completed pilot of Autism and Neurodiversity training for Linden Centre staff • Rolled out Dialectical Behaviour Therapy training to staff across five wards
North East Essex	• Restorative supervision framework used to review leadership of a challenged community team • Reduction of vacancies from 16% in M5 to 12% in M11 with a strong pipeline of prospective new joiners in place
Specialist Services	• Achieved National Staff Survey result of 6.37 against EPUT average of 5.96 for We Are Always Learning domain • Embedded new Lived Experience roles in CAMHS and EoE family ambassadors
West Essex	• Recruitment and retention strategies are delivering benefits as vacancy and turnover rates have continued to decrease and remain below the Trust target alongside reducing agency spend as a proportion of overall staff costs
Mid & South Essex	• Recruitment and retention strategies are delivering benefits as vacancy and turnover rates have continued to decrease and remain below the Trust target alongside reducing agency spend as a proportion of overall staff costs
Psychological Services	• Co-facilitated Living Well with Dementia group for carers and relatives • Individual self referrals to Here For You service averaged 29 per month compared to 21 per month in M1-8 showing strong uptake and EPUT staff representing 43% of all referrals to the service in 2023/24

STRATEGIC OBJECTIVE 3: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Trust level highlights M9-12 by exception

- EPUT is able to evidence numerous examples of how it is working with its system partners to improve the quality of care we provide to local people. The Quality Together governance structures in place with Essex Integrated Care Board leaders oversees delivery of EPUT's Quality Strategy with thematic deep dives as well as supporting delivery of EPUT's Quality Assurance Framework. Highlights include a downward trend in restrictive practice in the last six months and improved performance in time taken to resolve complaints with clear demonstration of embedded learning into practice.
- EPUT is a key partner in delivering the Southend, Essex and Thurrock all age mental health strategy, the implementation of which started during 2023. Priority programmes have now been agreed along with cross-cutting approaches to measuring impact on inequalities and outcomes. Key activities have been aligned to address the new way of working under the Right Care, Right Person framework with Essex Police, and to address the key lines of enquiry in the Lampard Inquiry.
- EPUT is a key partner in the County of Essex Crisis Care Concordat alongside local statutory NHS and social care providers and Essex Police who work together to improve urgent care pathways. In the last four months the partnership has focussed on transition to the Right Care Right Person framework and developing Memoranda of Understanding with police, ambulance and acute trusts
- In Q4, EPUT conducted its first lived experience survey. Of the 28 responses received, the majority described a positive experience of working as a lived experience ambassador with EPUT and six showing the need for further work in valuing lived experience and translating time invested into positive change
- Across all the places EPUT serves, the Trust is an active player in place-based integration of health and social care, working with Local Authority partners on a range of innovations like virtual wards and integrated network teams. The last three months have seen a renewed focus on developing relationships with University Partners with a view to collaborating on workforce development, quality of clinical training placements and shared innovation.
- Delivering clinical research is an important way in which EPUT can work with its partners to improve care for those that need it. Following the launch of EPUT's revised Research strategy in January 2024 and the appointment of experienced clinical leads, we are now able to baseline the Trust's clinical research output and monitor the impact of the delivery planned designed to drive up the amount and the complexity of the research EPUT delivers over the next three years. In 2023/24, EPUT delivered 34% of its target for weighted recruitment of patients into research studies. Re-balancing the research portfolio towards more highly weighted interventional studies and supporting the development of new clinical research leaders in 2024/5 will support better achievement next year.

STRATEGIC OBJECTIVE 3: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Metric	Target (if applicable)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Lived experience survey											28 responses received. Of the 28 received; overall 19 were positive, 3 were neutral and 6 were negative			
Number of open clinical research studies	22	19	19	20	20	20	19	19	19	18	18	18	19	
Large Scale Survey: Observational : Interventional	02:12:08	02:12:05	02:12:05	02:12:05	02:12:05	02:13:04	02:12:04	02:12:04	02:13:03	02:12:03	02:12:03	02:12:03	02:12:04	
Cumulative combined all commercial and NIHR non-commercial raw recruitment numbers across all study types		27	81	151	558	968	1388	1801	2242	2572	3048	3493	3530	
Cumulative combined study types weighted NIHR non-commercial research studies recruitment numbers	5500	107	408.5	610.5	777	939	1108.5	1249	1426.5	1495	1577	1734.5	1866.5	
		2%	7.40%	11.10%	14.10%	17.10%	20.20%	22.70%	25.90%	27.20%	28.70%	31.50%	33.90%	

STRATEGIC OBJECTIVE 3:

WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

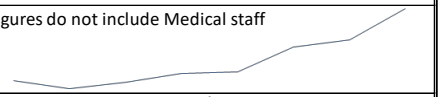
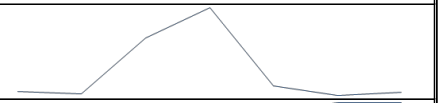
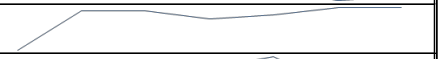
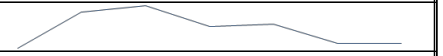
Care Unit	Successes M9-12
Urgent Care & Inpatients	• Following publication of new discharge guidance, conducted a snapshot audit to better segment the housing/accommodation issue and support proactive discharge planning
North East Essex	• Continued close partnership working through Tendring alliance including launch of Peer Support Worker model and new joint chairing of SNEE suicide prevention group
Specialist Services	• Delivered Eating Disorders specialist training to partners across local Integrated Care Systems • Implemented weekly regional referrals and screening arrangement with EoE Provider Collaborative with leadership from EPUT on Forensic Services
West Essex	• Supported establishment of Hertfordshire & West Essex informal community health collaborative with the objective of reducing unwarranted variation in care and outcomes • Supported development of West Essex Health & Care Partnership priorities with particular focus on collaborative delivery of urgent and emergency care targets
Mid & South Essex	• Delegated contract agreed for Community Collaborative with EPUT as lead provider • Approach to operational planning for 2024/25 informed by population health and local inequalities analysis
Psychological Services	• Mapped neurodevelopmental service pathway for sharing of information across Essex • Developed Lived Experience policy for MSc Clinical Associate in Psychology Programme and incorporated Lived Experience Ambassadors into training delivery

STRATEGIC OBJECTIVE 4: WE WILL HELP OUR COMMUNITIES TO THRIVE

Trust level highlights M9-12 by exception

- We measure staff locality to the services in which they work as an indicator of EPUT's economic and environmental impact as a local employer. In M12, 81% of EPUT staff live and work in the same county, the same as at M8 though we do not expect to see significant variation in this metric from one quarter to the next
- The proportion of B7+ posts held by BAME staff remains above 20%, which is above the 11.4% BAME population of Essex. 45 members of staff from black or Asian backgrounds have undertaken RISE (resilience, intelligence, strength and excellence) training this year crafted to foster professional growth and development.
- Based on value of Purchase Orders, in Q4 EPUT spent 29% of its procurement spend with suppliers based in Essex, Bedfordshire or Suffolk compared to 11% M1-8, partially driven by a large contract awarded to an Essex-based supplier in M9. Work is ongoing with anchor partners to benchmark this analysis and assess options which may enable us to increase this year on year with awarding contracts where EPUT has a choice of supplier. Purchase Orders do not account for 100% of EPUT's spend as they do not cover large, national supplier arrangements e.g. HMRC and other statutory suppliers where there is no alternative option.
- Contracts tendered include 10% evaluation weighting for social value at the point of procurement. Capturing and monitoring the social value delivered from contracts is a challenge for many organisations and plans to do this consistently across EPUT remain under discussion. There is potential to explore digital solutions in partnership with other local providers in the coming year.
- In Q4, 9 sessions of suicide prevention training have been held with 72 delegates in total and 43% of delegate places filled. This is a decrease from 79% of places filled in the previous period, largely driven by sickness of facilitators or delegates which we expect to see redressed in the coming period.
- Since M1 2024, Enable East (hosted by EPUT) has been awarded £414k of grant funding from Southend, Essex and Thurrock councils to deliver Multiply, a numeracy skills programme for adults that do not have mathematics GCSE. To date, Enable East has supported 330 people to improve their numeracy skills which we know to be a wider determinant of health outcomes.

STRATEGIC OBJECTIVE 4: WE WILL HELP OUR COMMUNITIES TO THRIVE

Metric		Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
% of workforce employed from local communities			Snapshot as atMar24: 5484 out of 6750 (81%) employed and live in same county												Data provided as a snap shot as not many changes month on month
% BAME staff in roles >B7							20.6%	20.6%	20.6%	20.7%	20.73%	20.98%	21.05%	21.37%	Figures do not include Medical staff 
% procurement spend with local suppliers			8.2%	7.0%	3.7%	41.0%	14.4%	14.7%	13.6%	51.5%	72.6%	18.7%	12.1%	14.4%	
Uptake and evaluation of suicide awareness training	Preventing Suicide by Ligature	85%	Training data between Apr-Aug 2023 not available					80.0%	90.0%	90.0%	88.0%	89.0%	91.0%	91.0%	
	Clinical Risk for Registered Staff	85%	Training data between Apr-Aug 2023 not available					87.7%	86.6%	87.3%	88.2%	88.8%	87.2%	87.2%	
	Clinical Risk for Non-Registered Staff.	85%	Training data between Apr-Aug 2023 not available					88.5%	90.0%	90.3%	89.4%	89.5%	88.7%	88.7%	
	Suicide Prevention & Self-harm Mitigation (Storm):		From 1st January 2023 -1st December 2023:- 31 courses offered, 248 delegates could have been trained. 4 courses were cancelled 151 delegates were trained (79%)									1st Jan 2024 - 31st March 2024 9 courses were offered, 72 delegates could have been trained 4 courses were cancelled			

STRATEGIC OBJECTIVE 4:

WE WILL HELP OUR COMMUNITIES TO THRIVE

Care Unit	Successes M9-12
Urgent Care & Inpatients	• Participated in local recruitment fairs to encourage those living in communities served by EPUT to consider health and care careers
North East Essex	• Good progress on development of proposed 24/7 mental health model to be piloted from EPUT site co-located with third sector partners • Participated in Joint Problem Solving Panel for Tendring 999
Specialist Services	• Launch of first inpatient drug and alcohol detoxification service in East of England region
West Essex	• Harlow inclusive recruitment event for those with a learning disability and/or autism got excellent attendance and yielded a number of concrete offers of employment
Mid & South Essex	• Launched pilot of Complex Housing Intervention programme and supported living model with Thurrock partners
Psychological Services	• Commenced monthly EDI and anti-racism reflective group practice for all staff

10. REGULATION AND COMPLIANCE

10.1 TRUST CONSTITUTION REVIEW

Decision Item | DG | 3

REFERENCES

Only PDFs are attached

Trust Constitution 05.06.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Trust Constitution Review**					
Executive Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors Governance Committee 1 May 2024 Council of Governors 23 May 2024					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A – reviewed governance document.		
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*	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 reviewed Trust Constitution for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Approve the reviewed Trust Constitution.

Summary of Key Points
The Trust is required to undertake a review its Constitution on an annual basis. The last review of the Constitution took place in May 2023, where an external review was undertaken against the new Code of Governance for NHS Providers and Health & Care Act 2022. The review of the Trust Constitution required approval from the Council of Governors and the Board of Directors. The Trust Constitution has been reviewed and minor amendments made. The Council of Governors considered the reviewed Constitution at its meeting on the 23 May 2024, following a recommendation from the Governance Committee, and agreed for onward approval process through the Board of Directors. The amended version of the Trust Constitution - Appendix 1.

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
Appendix 1: Trust Constitution

Executive Lead:

Denver Greenhalgh
Senior Director of Governance

20240631

Essex Partnership University NHS Foundation Trust

Constitution

Approved by Council of Governors 23 May 2024 and
Board of Directors 5 June 2024
Next Review Date: 30 June 2025

TABLE OF CONTENTS

Paragraph

1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the 2022 Act.

1.2 Words importing the plural shall import the singular and vice-versa.

1.3 The **2006 Act** is the National Health Service Act 2006

1.4 The **2012 Act** is the Health and Social Care Act 2012

1.5 The **2022 Act** is the Health and Care Act 2022

1.6 **Annual Members' Meeting** is defined in paragraph 13 of the Constitution

1.7 **Board of Directors** or **Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with this Constitution

1.8 **Board of Directors Nominations Committee** means a committee of the Board described in paragraph 30.4 of the Constitution

1.9 **Constitution** means this constitution which has effect in accordance with Section 37(1) of the 2006 Act

1.10 **Council of Governors or Council** means the Council of Governors of the Trust as described in paragraph 14 of this Constitution

1.11 **Chair** is the person appointed as Chair of the Board of Directors (and Chair of the Council of Governors) under paragraph 28 of this Constitution

1.12 **Chief Executive** is the person appointed as the Chief Executive Officer of the Trust under paragraph 31 of this Constitution

1.13 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.14 **Executive Director** means a member of the Board of Directors appointed under paragraph 25 of the Constitution

1.15 **Member** means a person registered as a member of one of the constituencies set out in paragraph 5 of this Constitution

1.16 **Model Election Rules** means the Model Election Rules published by Department of Health and/or NHS Providers

1.17 **NHS England** is the body corporate as provided by Section 1H of the 2012 Act

1.18 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the Constitution

1.19 **Officer** means an employee of the Trust or any person holding a paid appointment or office with the Trust

1.20 **Regulated Activities Regulations** means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended

1.21 The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

1.22 The **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.23 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30.1 and 30.3 of this Constitution

1.24 **Acting Chair** means the Non-Executive Director appointed under paragraph 30.2 and 30.3 of this Constitution.

1.25 **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried out for profit

1.26 **Working Day** means a day of the week which is not a Saturday, Sunday or public holiday in England.

2. Name

2.1 The name of the foundation trust is Essex Partnership University NHS Foundation Trust (the Trust).

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.4 In accordance with section 65Z5 of the 2006 Act the Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following—

(a) A relevant body as defined under section 65Z5(2) of the 2006 Act;

(b) A local authority (within the meaning of section 2B of the 2006 Act);

(c) A combined authority.

4.5 Where the Trust arranges for any functions exercisable by it to be exercised jointly the bodies by whom the function is exercisable jointly may—

(a) Arrange for the function to be exercised by a joint committee of theirs;

(b) Arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the constituencies in paragraph 5.2

5.2 The constituencies of the Trust shall be:

5.2.1 a Public Constituency

5.2.2 A Staff Constituency.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust subject to paragraphs 8 and 12 below

6.2 An applicant will become a member when the Trust has received and accepted the application, and the name of the applicant has been entered in the Trust's Register of Members (see Annex 9: Further Provisions paragraph 2).

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the Trust

7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 Individuals who are employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months

8.1.3 For the avoidance of doubt permanent staff are eligible to be members of the staff constituency. Temporary Staff can be a member of a Public Constituency if the criteria is met.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency; each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default – Staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10. NOT USED

11. NOT USED

12. Restriction on Membership

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency

12.3 An individual must be at least 12 years old to become a member of the Trust

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9: Further Provisions paragraph 2.

13. Annual Members' Meeting

13.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public

13.2 Annual Members' Meetings shall be conducted in accordance with paragraph 27A of Schedule 7 of the 2006 Act (and as set out in paragraph 46 of this constitution) and the standing orders for the practice and procedure of Annual Members' Meetings as set out in Annex 10: Annual Members' Meeting.

14. Council of Governors – Composition

14.1 The Trust is to have a Council of Governors, which shall comprise both

elected and appointed Governors

14.2 The composition of the Council of Governors is specified in Annex 4

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

15. Council of Governors – Election of Governors

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules adopting Single Transferable Vote (STV)

15.2 The Model Election Rules are ~~attached~~ referenced at Annex 5 but they do not form part of this constitution

15.3 A variation of the Model Election Rules by the Department of Health or NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution)

15.4 An election, if contested, shall be by secret ballot

15.5 Where a vacancy arises from amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the most recent election for that post the opportunity to assume the vacancy for the unexpired balance of the former member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

15.6 Governors must be at least 16 years of age at the date they are nominated for election or appointment

16. Council of Governors – Tenure

16.1 An elected Governor may hold office for a period of up to three Years. The period of office shall be known as the 'term'

16.2 Elected Governors shall cease to hold office if they cease to be a member of the constituency or class by which they were elected

16.3 Elected Governors shall be eligible for re-election at the end of their term

16.4 Appointed Governors may hold office for a period of up to three Years

16.5 Appointed Governors shall cease to hold office if the appointing organisation withdraws its sponsorship of them or if the appointing organisation ceases to exist and there is no successor in title to its business

16.6 Appointed Governors shall be eligible for re-appointment at the end of their term

16.7 A Governor may serve a maximum of three terms of each up to three years in office and shall be eligible to stand for election or appointment as a Governor again following a break of at least a Year

16.8 ''Year' in this clause 16 means the period commencing on the date of election or appointment (as the case may be) and ending 12 months after such election or appointment.

17. Council of Governors – Disqualification and Removal

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

17.1.3 people who have made a composition or arrangement with, or granted a Trust deed for their creditors and have not been discharged in respect of it

17.1.4 people who within the preceding five years have been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

17.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and for the removal of Governors are set out in Annex 6 paragraphs 4 and 5.

18. Council of Governors – Duties of Governors

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public

18.2 Further provision as to the roles and responsibilities of the Council of Governors is set out in Annex 6

18.3 The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – Meetings of Governors

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 of this constitution) or, in their absence the Vice-Chair or Acting Chair (appointed in accordance with the provisions of paragraph 30 of this constitution), shall preside at meetings of the Council of Governors except as otherwise provided pursuant to the standing orders for the Council of Governors as at Annex 7

19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Council of Governors if that person is interfering with or preventing the proper conduct of the meeting

19.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

20. Council of Governors – Standing Orders

20.1 The standing orders for the practice and procedure of the Council of Governors are referenced at Annex 7

20.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of this constitution.

21. NOT USED

22. Council of Governors – Conflicts of Interest of Governors

22.1 If Governors have a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, Governors shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – Travel Expenses

23.1 The Trust may pay travelling and other expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust. These expenses are to be disclosed in the Trust's annual report

23.2 Governors do not receive remuneration when undertaking their duties and role as a Governor.

24. Council of Governors – Further Provisions

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – Composition

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors

25.2 The Board of Directors is to comprise:

25.2.1 a Non-Executive Chair

25.2.2 not less than five and not more than eight other Non-Executive Directors; and

25.2.3 not less than four and not more than eight Executive Directors,

so that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive in a voting capacity.

25.3 One of the Executive Directors shall be the Chief Executive

25.4 The Chief Executive shall be the Accounting Officer

25.5 One of the Executive Directors shall be the Finance Director

25.6 One of the Executive Directors is to be a registered Medical Practitioner or a registered Dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is to be a registered Nurse or a registered Midwife.

26. Board of Directors – General Duty

26.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise

the benefits for the members of the Trust as a whole and for the public.

26.2 In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to—

(a) The health and well-being of the people of England;

(b) The quality of services provided to individuals—

(i) By relevant bodies, or

(ii) In pursuance of arrangements made by relevant bodies,

for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

(c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

27. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if:

27.1 they are a member of a Public Constituency, or

27.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

27.3 They are not disqualified by virtue of paragraph 33 of this constitution.

28. Board of Directors – Appointment and Removal of Chair and Other Non-Executive Directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors

28.2 Appointment of the Chair or another Non-Executive Director shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors

28.3 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors

28.4 The Council of Governors shall adopt a procedure for appointing/removing the Chair and/or other Non-Executive Directors in accordance with any

guidance issued by NHS England.

29. NOT USED

30. Board of Directors – Appointment of Vice-Chair, Acting Chair, Senior Independent Director and Deputy Chief Executive

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as the Vice-Chair

30.2 When the absence of the Chair has or will exceed a period of 3 months the Council of Governors at a meeting shall appoint one of the Non-Executive Directors as the Acting Chair.

30.3 Before a resolution for such appointments is passed, the Chair shall be entitled to advise the Council of Governors of the Non-Executive Director who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision.

30.4 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors as the Senior Independent Director to act in accordance with NHS England's *Code of Governance for NHS Provider Trusts (*as may be amended and replaced from time to time) and the Trust's standing orders.

30.5 The Board of Directors Remuneration and Nominations Committee, which comprises of all the Non-Executive Directors, shall appoint an Executive Director as the Deputy Chief Executive in line with agreed procedure.

31. Board of Directors – Appointment and Removal of the Chief Executive and Other Executive Directors

31.1 The Non-Executive Directors shall appoint or remove the Chief Executive

31.2 A committee consisting of the Chair and Non-Executive Directors shall appoint the Chief Executive.

31.3 The appointment of the Chief Executive shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors in accordance with the procedure agreed by the Council of Governors from time to time

31.4 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors

31.5 An Executive Director's post may be held by two individuals on a job share basis (save that the Executive positions of registered Medical Practitioner or

registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions). Where such an arrangement is in force, the two individuals may only exercise one vote between them at any meeting of the Board of Directors as in the standing orders.

32. NOT USED

33. Board of Directors – Disqualification

The following may not become or continue as a member of the Board of Directors:

33.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

33.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

33.3 people who have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it

33.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

33.5 a person who is subject of a disqualification order made under the Company Directors Disqualification Act 1986 and/or who is disqualified from being a trustee of a charity under the Charities Act 2011

33.6 people where disclosures revealed by a Disclosure & Barring Service check against such people are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute

33.7 people whose tenure of office as Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest

33.8 a person who has within the preceding two years been dismissed: otherwise than by reason of redundancy or for ill health, from any paid employment with;

33.8.1 a health service body or a local authority;
33.8.2 any other public body; or
33.8.3 a private provider or health or social care services;

unless approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.9 a person who is the subject of a Sexual Offenders Order under the Sexual Offences Act 2003

33.10 a person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

33.11 a person who is a Director or Governor or Governing Body member or equivalent of another NHS body, unless any conflict of interest has been reviewed and approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.12 a person who is a member of the Council of Governors

33.13 in the case of Non-Executive Directors, a person who is no longer a member of one of the public constituencies

33.14 in the case of Non-Executive Directors, a person who has refused without any reasonable cause to fulfil any training requirement established by the Board of Directors

33.15 a person who is a member of a Local Authority's Overview & Scrutiny Committee covering health matters or of a Local Health watch Board or of a Health & Wellbeing Board

33.16 a person who is the spouse, partner, parent or child of a member of the Trust's Board of Directors

33.17 a person who has displayed aggressive or violent behavior at any NHS establishment or against any of the Trust's staff or persons exercising functions for the Trust

33.18 a person who fails to satisfy the requirements of the Regulated Activities Regulations

33.19 a person who has failed to sign and return to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for the Board of Directors

33.20 a person who has acted in a manner inconsistent with or who has failed to comply with the Trust's terms of authorisation, standing orders, standing financial instructions and/ or the code of conduct for the Board of Directors.

34. Board of Directors – Meetings

34.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair

may exclude any person from a meeting of the Board of Directors if that person is interfering with or preventing the proper conduct of the meeting

34.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the Part 1 minutes of the meeting to the Council of Governors. A summary of Part 2 minutes will be provided to the Council of Governors.

35. Board of Directors – Standing Orders

35.1 The Board of Directors has adopted the standing orders for the practice and procedure of the Board of Directors referred to at~~,~~ Annex 8.

35.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of the constitution.

36. Board of Directors – Conflicts of Interest of Directors

36.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

36.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust

36.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity

36.2 The duty referred to in sub-paragraph 36.1.1 is not infringed if:

36.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 the matter has been authorised in accordance with the constitution if it has been considered and approved by the Board of Directors

36.3 The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest

36.4 In sub-paragraph 36.1.2, “third party” means a person other than:

36.4.1 the Trust, or

36.4.2 a person acting on its behalf

36.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must

declare the nature and extent of that interest to the other Directors

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made

36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement

36.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question

36.9 A Director need not declare an interest:

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest

36.9.2 if, or to the extent that, the Directors are already aware of it

36.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

36.9.3.1 by a meeting of the Board of Directors, or

36.9.3.2 by a committee of the Directors appointed for the purpose under the constitution

36.10 The standing orders for the Board of Directors make further provision for the disclosure of interests.

37. Board of Directors – Remuneration and Terms of Office

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors

37.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

38. Registers

The Trust shall have:

38.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong

38.2 a register of members of the Council of Governors

38.3 a register of interests of Governors

38.4 a register of Directors, and

38.5 a register of interests of the Directors.

39. Admission to and Removal from the Registers

39.1 The Trust Secretary shall be responsible for fulfilling the obligations of the Trust in relation to the maintenance of, admission to and removal from the registers under the provisions of this constitution and as set out in paragraph 38.

39.2 Directors and Governors shall advise the Trust Secretary as soon as practicable of anything which comes to their attention or of which they are aware and which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 38.

40. Registers – Inspection and Copies

40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances prescribed below or as otherwise prescribed

40.2 The Trust may withhold all or part of the registers from inspection where disclosure of information could give rise to a real risk of harm or is prohibited by law.

40.3 So far as the registers are required to be made available:

40.3.1 they are to be available for inspection free of charge at all reasonable times, and

40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract

40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. Documents Available for Public Inspection

41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution,

41.1.2 a copy of the latest annual accounts and of any report of the auditor

on them, and

41.1.3 a copy of the latest annual report

41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

41.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act

41.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

41.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act

41.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

41.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy

41.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. Auditor

42.1 The Trust shall have an auditor

42.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors

42.3 The auditor shall comply with Schedule 10 of the 2006 Act in auditing the accounts of the Trust.

43. Audit Committee

43.1 The Board of Directors shall establish a committee comprising Non-Executive Directors (at least one of whom has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate

43.2 The Audit Committee as a whole shall have competence relevant to the NHS sector.

44. Accounts

44.1 The Trust must keep proper accounts and proper records in relation to the accounts

44.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

44.3 The accounts are to be audited by the Trust's auditor

44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct

44.5 The functions of the Trust with respect to the preparation of the annual accounts, as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

45. Annual Report, Forward Plans and Non-NHS Work

45.1 The Trust shall prepare an annual report and send it to NHS England

45.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England

45.3 The forward plan shall be prepared by the Directors

45.4 In preparing the forward plan, the Directors shall have regard to the views of the Council of Governors

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so

45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

45.6.2 notify the Directors of the Trust of its determination

45.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

46. Presentation of the Annual Accounts and Reports to the Governors and Members

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

46.1.1 the annual accounts

46.1.2 any report of the auditor on them

46.1.3 the annual report

46.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one Board Director in attendance

46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

47.1 The Trust shall have a seal

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the Constitution

48.1 The Trust may make amendments of its constitution only if:

48.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

48.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments

48.2 Amendments made under sub-paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act

48.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

48.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

48.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. Actions taken by the Trust under the amended constitution, prior to the amendment ceasing to have effect, remain valid

48.4 Amendments by the Trust of its constitution are to be notified to NHS England.

49. Mergers, etc., and Significant Transactions

49.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors

49.2 The Trust may enter into a significant transaction unless it is a merger, acquisition, separation or dissolution only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction

49.3 The definition of “significant transaction” for the purposes of paragraph 49.2 and section 51A of the 2006 Act is set out in Annex 9 paragraph 1.

50. Indemnities

50.1 Members of the Board of Directors, members of the Council of Governors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust

50.2 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Board of Directors, the Council of Governors and the Trust Secretary.

ANNEX 1: THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

THE PUBLIC CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Essex Mid & South	The electoral wards covered by: • Basildon Borough Council • Braintree District Council • Brentwood Borough Council • Castle Point Borough Council • Chelmsford Borough Council • Maldon District Council • Rochford District Council • Southend on Sea Borough Council • Thurrock Borough Council	9	60
North East Essex & Suffolk	• Colchester Borough Council • Suffolk County Council • Tendring District Council	3	60
West Essex & Herts	• Borough of Broxbourne Council • East Herts District Council • Epping Forrest District Council • Harlow Council • North Herts District Council • Stevenage Borough Council • Uttlesford District Council • Welwyn Hatfield Borough Council	5	60
Milton Keynes, Bedfordshire & Luton, and Rest of England	• Bedford Borough Council • Central Bedfordshire Council • Luton Borough Council • Milton Keynes Council • Any other Council in England unless named in Annex 1 to the Trust's Constitution	2	60

ANNEX 2: THE STAFF CONSTITUENCY

(Paragraph 8.4 and 8.5)

THE STAFF CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Clinical (Mental Health)	• Registered medical practitioners and registered dentists • Registered nurses and registered midwives • Healthcare professionals • Social workers	3	60
Clinical (Physical Health)		1	60
Non-Clinical	• Support staff • Corporate Staff	2	60

ANNEX 3: NOT USED

ANNEX 4: COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

Public Governors		**19**
Essex Mid & South	9	
North East Essex & Suffolk	3	
West Essex & Herts	5	
Milton Keynes, Bedfordshire & Luton, and Rest of England	2	
Staff Governors		**6**
Clinical (Mental Health)	3	
Clinical (Physical Health)	1	
Non-Clinical	2	
Appointed and Partnership Governors		**5**
Essex County Council	1	
Southend Borough Council	1	
Thurrock Council	1	
Anglian Ruskin and Essex Universities (joint appointment)	1	
Third Sector / Voluntary Sector	1	
Total Council of Governors		**30**

ANNEX 4.1: NOT USED

ANNEX 5: THE MODEL ELECTION RULES

(Paragraph 15.2)

The Model Election Rules 2014 are included as a separate document to this constitution. (https://nhsproviders.org/resources/briefings/model-election-rules)

ANNEX 6: ADDITIONAL PROVISION – COUNCIL OF GOVERNORS

(Paragraphs 17.3, 18.2 and 24.1)

1. Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution, the Trust's license and NHS England's *Code of Governance for NHS Provider Trusts* include

1.1 General Duties

1.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts so that the Trust does not breach the terms of its license. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

1.1.2 to represent the interests of the members of the Trust and the interests of the public

2.1 Non-Executive Directors, Chief Executive and Auditor

2.1.1 to approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council of Governors

2.1.2 to appoint the Chair and Non-Executive Directors

2.1.3 to remove the Chair and the Non-Executive Directors. However, the Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of

engagement with the Board

2.1.4 to approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the remuneration committee of the Council of Governors. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors

2.1.5 to decide the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors having regard to the recommendations of the Remuneration Committee of the Council of Governors

2.1.6 to approve the appointment of the Chief Executive of the Trust

2.1.7 to approve the criteria for the appointment, removal and reappointment of the auditor

2.1.8 to appoint, remove and reappoint the auditor, having regards to the recommendation of the Audit Committee

3.1 Strategy Planning

3.1.1 to provide feedback to the Board of Directors on the development of the strategic direction of the Trust, as appropriate

3.1.2 to collaborate with the Board of Directors in the development of the forward plan

3.1.3 where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purposes of the NHS in England, to determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and notify its determination to the Board of Directors

3.1.4 where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England, approve such a proposal

3.1.5 to approve the entering into of any significant transaction (as

defined in this constitution) in accordance with the 2006 Act and the constitution

3.1.6 to approve proposals from the Board of Directors for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

3.1.7 when appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

3.1.8 to receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors

3.2 Representing Members and the Public

3.2.1 to prepare and from time to time review the Trust's membership engagement strategy and policy

3.2.2 to notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its license, and if these concerns cannot be resolved at local level

3.2.3 to report to the members annually on the performance of the Council of Governors

3.2.4 to promote membership of the Trust and contribute to opportunities to recruit members in accordance the membership strategy

3.2.5 to seek the views of stakeholders and feed back to the Board of Directors.

(Paragraphs 17.3 and 24.1)

4. Eligibility to be a Governor

4.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

4.1.1 they are a Director of the Trust, or a director of another health service body

4.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors for the Trust

4.1.3 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986

4.1.4 they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003

4.1.5 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

4.1.6 they are undergoing a period of disqualification from a statutory health or social care register

4.1.7 they have been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

4.1.8 they have been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body

4.1.9 they are a vexatious complainant as determined in accordance with the Trust's complaints procedure

4.1.10 within 5 years prior to their nomination for election or appointment to the Council of Governors, they have had their office of Governor terminated for the reasons set out in paragraphs 5.1.4 – 5.1.9 of this Annex 6.

4.1.11 they have been expelled from other NHS Bodies and /or demonstrably hold views / act in ways that are inconsistent with Trust vision, objectives and values.

(Paragraph 17)

5. Termination of Office and Removal of Governors

5.1 People holding office as a Governor shall cease to do so if:

5.1.1. they resign by notice in writing to the Trust Secretary

5.1.2 in the case of elected Governors, they cease to be member of the area of the constituency or class of the constituency by which they were elected

5.1.3. in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

5.1.4. they consistently and unjustifiably fail to attend the meetings of the Council of Governors in line with the Governor Attendance policy as agreed by the Council of Governors

5.1.5. they have refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake

5.1.6. they have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors

5.1.7. they have failed to complete a submission identifying any conflict of interest or they have knowingly provided false or misleading information in this regard.

5.1.8. they have committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders

5.1.9. they have acted in a manner detrimental to the interests of the Trust

5.1.10. they have expressed opinions which are incompatible with the values of the Trust

5.1.11. they are incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

5.2 Governors who are to be removed under any of the grounds set out in paragraph 5.1 above (with the exception of sub-paragraph 5.1.1 – 5.1.3) above shall be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present and voting

5.3 There shall be a working group/committee of the Council of Governors whose function shall be to:

5.3.1 receive and consider concerns about the conduct of any governor and/or

5.3.2 consider whether there are grounds to remove a Governor from office and to make recommendations to the Council of Governors. Membership of the working group/committee shall be determined from time to time

5.4 If the Council of Governors receives a complaint in writing about any Governor or is asked to consider whether an individual is eligible to

become or remain a Governor, the working group shall investigate the matter and make a recommendation to the Council of Governors, which may include a recommendation that a Governor is removed from office pursuant to paragraph 5.2 above

5.5 The Council of Governors may decide that whilst the working group is carrying out its investigation, the Governor concerned shall be suspended from office. Suspension is a neutral act and any decision to suspend the Governor concerned shall not be seen as an indicator of, or have any bearing on, the eventual recommendation of the working group

5.6 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until seven (7) days after the date of decision

5.7 The Governor shall be suspended from office (if they have not already been suspended from office pursuant to paragraph 5.5 above) with effect from the date of the Council of Governors' decision until the of the date set out in paragraph 5.5 above

ANNEX 7: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 19.1 and 20)

Standing Orders For The Practice And Procedure Of The Council Of Governors are included as a separate document to this constitution.

ANNEX 8: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 35)
Standing Orders For The Practice And Procedure Of The Board Of Directors are included as a separate document to this constitution.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph 49)

1. SIGNIFICANT TRANSACTIONS

1.1 In accordance with section 51A of the National Health Service Act 2006, the Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction

1.2 For the purpose of this paragraph 1 and subject to paragraph 1.4 below, "Significant Transaction" means a "transaction" as defined in paragraph 1.3 below which meets any one of the following tests:

1.2.1 the assets which are the subject of the transaction exceed 25% of the total fixed assets of the Trust (Asset Test); or

1.2.2 the income of the Trust will increase or decrease by more than 25% following the completion of the relevant transaction (Income Test); or

1.2.3 the gross capital of the company or business being acquired or divested represents more than 25% of the total capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities plus the excess of current liabilities over current assets, and the Trust's capital is determined by reference to its balance sheet) (Gross Capital Test); or

1.2.4 the Asset Test, the Income Test and the Gross Capital Test are not satisfied but the transaction, in the reasonable opinion of the Board of Directors:

(a) would impact on the manner in which health services are delivered by the Trust and/or the range of health services the Trust delivers; or

(b) exceeds a total value of £10,000,000 (£10 million) and has an overall risk rating which in the reasonable opinion of the Board of Directors is considered to be significant. The Board of Directors will assess the significance of the overall risk of the transaction against the applicable Trust's own risk management framework in force at the time the risk assessment is conducted by the Board of Directors

1.3 "Transaction" means any agreement (including an amendment to an agreement) entered into by the Trust in respect of a merger, demerger, joint venture, divestment, or any other arrangement for the acquisition, disposal or delivery of health services, but, for the avoidance of doubt, it does not include:

1.3.1 an agreement entered into or changes to the health services carried out by the Trust following a reconfiguration of the health services led by the commissioners of such health services; or

1.3.2 a grant of public dividend capital or the entering into a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust

1.3.3 For the purpose of this paragraph 1.3 the following definitions apply:

(a) "merger" means a transaction that involves one organisation acquiring / transferring the assets and liabilities of another, either wholly or in part;

(b) "demerger" means a transaction that involves the disaggregation of a single corporate body into two or more new corporate bodies;

(c) "joint venture" means a transaction involving an agreement between two or more parties to undertake economic activity together which establishes a separate legal entity.; and

(d) "divestment" means a transaction that involves the disposal, in whole or in part, of an organisation's business, services or assets and liabilities where the Board of Directors has made a decision to do so.

1.4 A transaction is not a Significant Transaction if it is:

1.4.1 a transaction which is a statutory merger, acquisition, separation or dissolution under sections 56, 56A, 56B or 57A of the National Health Service Act 2006; or

1.4.2 a transaction in the ordinary course of current business from time to time (including the expiry, termination, renewal, extension of, or the entering into an agreement in respect of the health services carried out by the Trust).

1.4.3 a transaction that involves the disposal, in whole or in part, of an organisation's business services or assets and liabilities where the Board of Directors has not made a decision and therefore is outside Trust control.

(Paragraphs 6.2 and 12.4)

2. TERMINATION OF MEMBERSHIP

2.1 A member shall not become or continue to be a member if:

2.1.1 it is reasonably suspected by the Board that in the five years prior to the individual's application for membership of the Trust or during the

period of their membership of the Trust, they have been involved as a perpetrator in what the Board reasonably considers to be a sufficiently serious incident of intimidation, threat, harassment, assault or violence against:

a) any of the Trust's employees or other persons who exercise functions for the purpose of the Trust, or against any volunteers; or
b) any employee of another health service body or any person who exercises functions for the purposes of another health service body or against any person who volunteers with another health service body; or
c) any service user, carer or visitor to the Trust or any service user, carer or visitor to any other health service body

2.1.2 they have been excluded from the Trust's premises within the previous five years

2.1.3 they are expelled from membership by resolution of the Council of Governors

2.1.4 they cease to be eligible under this Constitution to be a member

2.1.5 they die

2.1.6 they have been expelled from other NHS Bodies and /or demonstrably hold views / act in ways that are inconsistent with Trust vision, objectives and values.

2.2 It is the responsibility of members to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. Members who become aware of their ineligibility shall inform the Trust as soon as practicable and their names shall be removed from the Register of Members

2.3 Where the Trust has reason to believe that members cease to be eligible for membership or their membership can be terminated under this constitution, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

ANNEX 10: ANNUAL MEMBERS' MEETING

(Paragraphs 13 and 46)

1. Interpretation

1.1. Save as permitted by law, the Chair shall be the final authority on the interpretation of these standing orders (on which the Chair shall be advised by the Chief Executive and the Trust Secretary)

2. General Information

2.1. The purpose of the standing orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings

2.2. All business shall be conducted in the name of the Trust

3. Attendance

3.1. Each member shall be entitled to attend an Annual Members' Meeting

4. Meetings in Public

4.1. Meetings of the Annual Members' Meetings must be open to the public subject to the provisions of paragraph 4.2 below

4.2. The Chair may exclude members of the public from an Annual Members' Meeting if they are interfering with or preventing the reasonable conduct of the meeting

4.3. Annual Members' Meetings shall be held annually at such times and places as the Chair may determine

5. Notice of Meetings

5.1. Before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an officer of the Trust authorised by the Chair to sign on their behalf, shall be served upon every member at least 10 clear days before the meeting and posted on the Trust's website and displayed at its headquarters

5.2. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the Trust Secretary and shall be available for inspection by a member free of charge at the place of the meeting

6. Setting the Agenda

6.1. The Chair shall determine the agenda for Annual Members' Meetings which must include the business required by the Act

7. Chair of Annual Members' Meetings

7.1. The Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or Acting Chair shall preside. If neither the Chair, Vice-Chair nor Acting Chair is present the Directors and Governors shall elect one of their number to act as Chair

8. Chair's Ruling

8.1. Statements of members made at Annual Members' Meetings shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final

9. Voting

9.1. Decisions at meetings shall be determined by a majority of the votes of the members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote subject to the Act

9.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands

9.3. In no circumstances may an absent member vote by proxy

10. Suspension of Standing Orders

10.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of suspension

10.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting

10.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members

10.4. No formal business may be transacted while the standing orders are suspended

10.5. The Trust's Audit Committee shall review every decision to suspend the standing orders

11. Variation and Amendment of Standing Orders

11.1. These standing orders may be amended in accordance with paragraph 48 of the constitution

12. Record of Attendance

12.1. The Trust Secretary shall keep a record of the names of the members present at an Annual Members' Meeting

13. Minutes

13.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it

13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting

13.3. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 members are present.

11. OTHER

11.1 USE OF CORPORATE SEAL

Decision Item | PS | 1

REFERENCES

Only PDFs are attached

Use of Corporate Seal 24.05.2024 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	5 June 2024

Report Title:	**Use of Corporate Seal**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & 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	N/A – Information item confirming use of corporate seal		
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*	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 a summary of when the corporate seal has been used.	**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 EPUT Corporate Seal has been used on the following occasions: - St Helen's Street, Ipswich – Lease of Building - Lease of Gilmore Lodge, Meesons Lane, Grays - Lease of Avalon Bungalow, Longhouse Road, Chadwell St Mary - Asset Summaries of Programme Works at Runwell

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
None

Non-Executive Lead:
Paul Scott, **Chief Executive Officer**

11.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item SS 1

Verbal

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

Decision Item | ALL | 1

Verbal

11.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item | ALL | 5

Verbal

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

Information Item ALL 1

12. ANY OTHER BUSINESS

Information Item | ALL | 5

Verbal

13. QUESTION THE DIRECTORS SESSION

10

14. DATE AND TIME OF NEXT MEETING

1

Wednesday 7 August at 10.00, virtual using Microsoft Teams