Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

29 November 2023

10:00 GMT Europe/London

Anglia Ruskin University, Bishop Hall Lane, Chelmsford, CM1 1SQ

AGENDA

AGENDA

- Standing item

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda November 2023 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 29 November at 10:00

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION **Transition Psychology Service** Dr Esther Kiehl, Consultant Clinical Psychologist & Dr Liz Millward, Consultant Clinical Psychologist			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 27 September 2023	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING** • Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Committee Chairs Report	Chairs	Attached	Noting
(c)	Board Safety Oversight Group Assurance Report	SS	Attached	Noting
(d)	CQC Update	FB	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2022/23	PS	Attached	Noting
	Comfort Break for 15 Minutes			
9	**RISK ASSURANCE REPORTS**			
	(i) End of Life Annual Report	FB	Attached	Approval

(a)	(ii) Learning From Deaths - Mortality Review Quarterly	FB	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	Quality Improvement Strategy	FB	Attached	Approval
(b)	Research, Innovation & Commercial Strategies	ZT	Attached	Approval
(c)	Working in Partnership with People and Communities Strategy	ZT	Attached	Approval
(d)	Membership Strategy	DG	Attached	Approval
11	**REGULATION AND COMPLIANCE**			
(a)	Charitable Funds Annual Report and Accounts 2022/23	TS	Attached	Approval
(b)	Emergency Preparedness, Resilience & Response (EPRR) National Core Standards Return 2023	NL	Attached	Noting
(c)	Safe Working of Junior Doctors Quarterly Report	MK	Attached	Noting
(d)	Council of Governors relationship with the Board of Directors Policy & Procedure	DG	Attached	Approval
12	**OTHER**			
(a)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(b)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(c)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** Wednesday 31 January 2024			
16	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 27 March 2024 Wednesday 29 May 2024 Wednesday 31 July 2024 Wednesday 25 September 2024 Wednesday 27 November 2024			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Standing item | Professor Sheila Salmon | 2 minutes

2. DECLARATIONS OF INTEREST

Standing item | Professor Sheila Salmon | 2 minutes

3. PRESENTATION: TRANSITION PSYCHOLOGY SERVICE

Other | Dr Esther Kiehl & Dr Liz Millward | 15 minutes

4. MINUTES OF THE PREVIOUS MEETING HELD 27 SEPTEMBER 2023

Standing item | Professor Sheila Salmon | 3 Minutes

REFERENCES

Only PDFs are attached

BOD Part 1 - Board Minutes -September 2023.pdf

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 27 September 2023
Held Virtually via MS Teams Video Conferencing

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 Chief Finance & Resources Officer
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Frances Bolger (FB)	Interim Chief Nursing Officer
Susan Young (SY)	Interim Chief People Officer
Janet Wood (JW)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director

In Attendance:

Angela Laverick	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Coordinator
Gill Brice	Director of Major Projects (For Nigel Leonard)
Mark Graver	Head of Public Affairs
Liz Rotheram	Governor
Anna Bokobza	Director of Strategy
Mark Dale	Public Governor
Pippa Ecclestone	Public Governor
Sharon Green	Staff Governor
Jason Gunn	Public Governor
John Jones	Lead Governor
Megan Leach	Public Governor
Pam Madison	Public Governor
Stuart Scrivener	Public Governor
David Short	Public Governor
Cort Williamson	Public Governor
Georgia Warne	Staff Member
Ian Andrews	Member of the Public
Peter Blackman	Member of the Public
Kevin Marvin	Member of the Public
Keith Morse	Member of the Public
Teresa Rutterford	Member of the Public
Zoe Tidman	Member of the Public
Ekoh West	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

Signed: …… Date: ……

In the Chair

108/23 APOLOGIES FOR ABSENCE

Apologies were received from Nigel Leonard, Stephen Heppell.

SS welcomed FB and SY who had joined the Trust as Interim Chief Nurse and Interim Chief People Officer.

109/23 DECLARATIONS OF INTEREST

FB declared that she also held a midwifery role at Suffolk and North East Essex (SNEE) ICB.

110/23 PRESENTATION – HEADS UP FINAL REPORT

ZT presented the work undertaken by Enable East around the Heads Up programme and introduced Anna Bokobza, Director of Strategy to take forward the presentation.

AB provided details of the Heads Up project undertaken by Enable East and stated the importance of the evaluation and inclusion part of the project. For context, Enable East is an independent NHS team which EPUT hosts. There were two separate interrelated streams for the Enable East Team. Portfolio work – holding large grant funds and acting as a coordinator with other organisations across the wider public and voluntary sector to deliver socially impactful positive programmes of work; and secondly consultancy with commissioned pieces of work.

Heads Up was a six year programme of work which commenced in 2017. It was designed to support people across Essex, Thurrock and Southend with common mental health problems including depression and anxiety. There was grant funding totalling over £3.5m of European Social Funds associated with this programme which had touched over 1000 people's lives across the greater Essex community. Key delivery teams for this project were EPUT employment services and two voluntary services. The team took a holistic approach, tailored to individual needs and goals through a peer to peer set up and traditional style workshops and skills pods designed to deliver practical skills.

The findings of the evaluation contained within the report showed 90% of the 1000 people felt more in control with their lives as part of this, 85% reported improvement in wellbeing, 45% of those that were previously economically inactive moved into employment skills or training on leaving the Heads Up programme.

LL suggested this linked with the Social Impact Strategy on the agenda. LL queried with regards to this project, in terms of learning, what could have made the service self-sustaining and was there an attempt to determine the social return on investment. AB advised funding for European Social Fund ceased and it as it was acknowledged this would leave a gap. Work had been undertaken to build relationships with local public health teams. There are initiatives coming through three local authority health routes that have similarities but the position of Enable East and EPUT to play a part in these is optimal. In terms of social return, AB advised there was concern around putting numbers on social return as this could be taken out of context. The Social Returns on Investment (SROI) had been calculated using the UK Social Value Bank 2022. The social value has two components, wellbeing value and exchequer value – when adding the two together and multiplying by the number of people that went through the programme this would equate to £2.6m.

EL noted one KPI showed outperformance of the local target of 7% of people with mental illness to be employed, with the fact that funding has stopped, was there a risk for this indicator decreasing and how would the Trust respond to that. AB acknowledged the collective local responsibility, there was core work now for integrated care boards and EPUT is in a better position to make an impact on

wider social determinants such as employment and training. Having public health and voluntary sectors around the table is critical and we are in a good position to make an impact locally, subject to investment.

RH noted the good case studies contained within the report and queried the impact of the project ending and how will be learning and experience over the past six- years be drawn upon in relation to social impact. AB advised there was positivity in terms of the outcomes for people who undertook the programme. The learning from the programme gives leverage in developing other programmes and the partnerships developed with local voluntary agencies will help in delivering future programmes.

ZT extended thanks to all involved at EPUT, Enable East and the voluntary sector and thanked all who took a personal risk to work with the programme and enrol, participate and made this a success.

111/23 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 26 July 2023 were agreed as an accurate reflection of discussions held.

112/23 ACTION LOG AND MATTERS ARISING

The action log was reviewed and noted one action was due regarding Learning lessons from exemplar organisations regarding the staff survey. An update was provided advising NHS England was running the people promise week in November 2023 where exemplars would be showcased. The Board agreed the Trust would take lessons from that process and include within the people strategy. The Board agreed to extend the timescale for the action to January 2024 to allow this to happen.

The Board discussed and approved the Action Log.

113/23 CHAIRS REPORT

SS presented the report highlighting the following:

- SS extended a farewell to Janet Wood who was stepping down from the role of NED and Audit Chair after two full terms as a member of the EPUT Board. On behalf of the Board, SS thanked JW for her significant contribution and gave best wishes going forward.
- SS shared arrangements for interim NED coverage of board sub committees, the Board noted the changes to ensure meetings were fully quorate and functional while recruitment to the NED team took place.
- On behalf of the Board, SS bid farewell to departing governors who were stepping down. There had been an in person governor and NED session recently which had provided an opportunity to bid farewell to long serving governors. SS extended thanks and best wishes as they move forward into new chapters, and thanked departing governors for their loyal service. SS looked forward to welcoming new governors in the coming month.
- SS highlighted the recent Civil Aviation Authority (CAA) joint safety workshop, advising the trust had developed a learning relationship with the CAA through ML. This had been a fantastic workshop which was very well attended, was productive and invigorating. Learning was shared from the CAA such as the approach to mandatory training, and an approach to provide assurance on safety not responsibility. There was potential for mutual secondments and continued mutual exchange of knowledge for the two organisations.

The Board received and noted the Chair's Report.

Signed: …… Date: ……

114/23 CEO REPORT

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

PS highlighted the following:

- PS also extended best wishes to JW, acknowledging her significant contribution as a valued member of the board. PS thanked governors who provide good challenge, enthusiasm and support for what we are trying to achieve.
- An open letter had been published from the chair of the independent inquiry which advised that they will take up the position on 9 October 2023. The letter also advised that a public consultation on the terms of reference would take place. As a Trust, EPUT have made itself available for an introductory meeting should the chair wish, and continue to support and engage with the inquiry.
- It was good to see that EPUT services were continuing to be nominated for and winning awards.
- The work environment is currently challenging and which was not unique to EPUT, including challenge managing industrial action, and further action expected in early October. PS extended thanks to all staff that have ensured services have been able to continue to function, also HR and administration staff working hard to make sure systems underpinning changes made are safe and have managed to continue to provide services to patients.
- The workforce section noted progress being made and the growth in people with lived experience working alongside us. As an organisation there is recognition and appreciation of the insight and challenge that is energising and galvanising us and enabling us to improve services.

The Board received and noted the CEO's Report.

115/23 QUALITY AND PERFORMANCE SCORECARD

PS asked Executive Directors to provide brief highlights to their sections of the CEO Report, linked with the Quality & Performance Scorecard.

Operations (AG)

AG identified positive areas of movement to note.

- IAPT Southend, Castlepoint and Rochford, have achieved respective access targets. The North Essex service had also improved access rates, but this was still below target trajectory and continued to improve.
- West Essex Community health urgent response team had seen improvement in the two hour response time.
- Lighthouse service no longer had waits over 72 weeks. NHS England had stood down the need for weekly assurance meetings and were also assured around data transfer from the previous provider.

AG advised there was continued pressure being seen in inpatient services. During August the Trust had operated under OPEL 4 principles, although the threshold OPEL 4 was not reached, this had helped to mitigate risk and manage capacity. Improvement in out of area placements had been seen with 17 repatriated patients back to EPUT beds.

In accordance with sustained pressure in inpatients, AG flagged an emerging risk around 111 crisis line services, providing an update as noted in the report that 91.4% of call were answered within 60 seconds against the target of 95%. Whilst this is below target, it is worthwhile noting the average time to answer a call was 24 seconds and 22% more calls were being answered in 60 seconds

when comparing the same period last year. . This continues to be monitored as part of the accountability framework.

EL welcomed the interactive link to the Power BI dashboard which was a big step forward, and thanked Executive Directors and information teams for progressing this. EL highlighted the KPI regarding older people in employment and noted there may be elements as part of the patient pathway not controlled by EPUT. EL asked whether it was possible to include actions being undertaken by the ICB in such instances. AG advised the pandemic had impacted the care provider market and it had taken time to recover. Support was being mapped to care providers at the moment and there was improvement with accommodation in adult services but there were still improvements to be made in the older adults.

MJ stated that as an organisation, EPUT were trying to encourage people to be analytical around performance and targets and queried what impact that was having on the services that we utilise in house and how does that triangulate back into the system. AG responded there was focus within the accountability framework meetings, with accountability domains beginning to be brought through the integrated performance report, looking at interdependency of workforce, finance, strategy and delivery against strategy and impact on operational performance. .

ZT noted that the board performance report was now available publically as an interactive tool for the first time. Users can interact and click to understand more about different KPIs, complete with videos on how to use this tool. This was part of the commitment to remain open and transparent.

PS advised delivery of the Southend, Essex and Thurrock (SET) mental health strategy and bringing together other providers, local authorities and the voluntary sector allowed oversight of the collective impact on people's outcomes. There was also a discharge executive for mid and south Essex, bringing all parts of the system together led by PS / AG, bringing together local authorities, primary and secondary care, which was beginning to develop a shared understanding of each other's pressures to get a better understanding of the experience of people in the system.

People and Culture (SY)

SY highlighted the following areas:

- Staff Turnover was down to 10% which was very positive. This was a credit to teams working hard on recruitment activity.
- There had been a successful international recruitment campaign with over 200 people joining the organisation from overseas.
- SY was also pleased to see a healthy pipeline coming through for sustainable reduction in turnover and vacancies, with the Trust attracting a good number of newly qualified nursing and HCA staff. This had also had a positive impact on the use of agency staff which aids continuity of care for patients and service users. SY was pleased to see there was some strong and collaborative working with partners in systems on some of these issues with common interest.

Finance (TS)

TS reflected on a challenging year and operational and people pressures that were reflected and impacted on our financial results. TS noted the positive impact referenced by SY regarding workforce, which would be important for the second half of the year. The Trust were currently undertaking a mid-year review and forecast outturn position for the year and were looking to build upon that as part of planning for the longer term with system partners.

ML sought assurance about how the Trust would recover the deficit position at M5. TS responded that extra attention was given to finance through care unit meetings, transformation steering group

and the efficiency programme, with the deficit being addressed through non-recurrent and recurrent schemes and actions. It will be a very challenging end to the financial year and EPUT were working with system colleagues to ensure maximum benefit from system resources.

Nursing (FB)

FB highlighted the following areas:

- There had been an increase in August in falls above trajectory. Governance around falls sits within the Harm Free Group and feeding in to that was the Falls Group. The Falls Group were taking a thematic approach to learning from past falls and drilling into the data to understand the increase. The key work the group were looking at was around environment, access to Occupational Therapy and physio to enable mobility, footwear etc. These were practical pieces to enable mobilisation around clinical areas and prevent falls. RH referred to a recent article on the national HIP data report from 2022 which identified a national increase in falls. There were some driving factors including the impact of the pandemic and patients deconditioning.
- There had been a slight increase in restrictive practice, with an event taking place next week and the Restrictive Practice Group drilling down into data to identify if there were any causes for concern / anomalies.

SS noted the excellent news received regarding approval from the department of health and social care to move to joint Electronic Patient Record full business case and we look forward to working with our partners in Mid and South Essex Foundation Trust.

The Board of Directors received and noted the report.

116/23 COMMITTEE CHAIR'S REPORT

A report was presented which summarised the work of the Board Standing Committee's since the previous Board of Director meeting. The chairs of each Standing Committee were asked to provide any highlights from the report.

Audit Committee (EL)

EL advised the Committee were offered substantial assurance that local counter fraud specialist and internal audit had progressed according to plans. External auditors were currently finalising the independent review of the charitable funds accounts and this was on track.

Quality Committee (RH)

RH advised an issue had been highlighted regarding the number of trained loggists, individuals that are trained to log actions / decisions that take place within an emergency response. This had been on the corporate risk register since earlier this year, there was now access to a training programme and the team were in the process of identifying individuals to complete the programme.

Finance & Performance Committee (LL)

LL advised there was now a greater focus on longer term planning and investment taking place in transformation programmes.

People, Equality & Culture Committee (ML)

ML highlighted the Committee received assurance around the people strategy being developed. This was important for the trust and builds on the wider trust strategy. The timescale for completion is January 2024, with opportunity for the whole organisation to get behind and shape the organisation.

The Board of Directors:

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

117/23 BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

SS advised she continued to chair this group on an interim basis. The meeting frequency had moved to a bi-monthly assurance meeting with the Executive Oversight group continuing to meet regularly. SS advised the group would merge with the Quality Committee in the next year.

The Board of Directors:

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

118/23 CQC UPDATE

FB presented a report providing an update on the key Care Quality Commission (CQC) registration requirements and related activities within the Trust. The report also provided details of any guidance / updates that had been received since the previous report as at the end of August 2023.

FB advised that the final CQC inspection report was published on 12 July, with the rating overall moving from Good to Requires Improvement. FB provided a verbal update on the progress as detailed in the report.

PS added that this had been a substantial piece of work that fundamentally changed how we engage with the CQC report acknowledging this was a piece of work that goes further and longer, and there was confidence the plan would have impact which was echoed by ICB colleagues. PS emphasised the importance of following through actions and strong governance was in place with regular updates to Executive Team and Standing Committees. The progress would be shared with the Integrated Care Board through quality oversight meetings and with the three Health Oversight Sub-Committees (HOSC) in Southend, Thurrock and Essex.

SS noted that this was a very inclusive approach to how this had been developed and was collectively owned, with full buy in and engagement.

JW welcomed this new approach, acknowledging the disappointing outcome from the CQC inspection but the approach to tackling head on and working with people in the service. The Quality Committee received updates and would continue to challenge around the impact of actions and using compliance / audit functions to gain additional assurance.

RH provided a reflection from the CAA programme, with the CAA being successful on ensuring people own actions and understanding the ethos of what is trying to be delivered. RH felt there was an opportunity to look at this and draw learning to incorporate into processes of embedding actions.

DG advised the presentation on the actions delivered to the ICB included chief nurses for all ICBs covered our patch, with a meeting with Anthony MacKeever as the individual responsible for quality as chair of rapid review.

FB added that the Trust were open to external challenge, and were setting up an evidence assurance group with Mid & South Essex ICB. This would challenge and test evidence to ensure it

was sustained and embedded. Another workstream currently being looked at was the quality assurance process and testing services are providing standard of care we would expect to achieve.

SS welcomed the transparency and inclusiveness, and the invitation to challenge and important validation around assurance.

The Board of Directors:

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

119/23 BOARD ASSURANCE FRAMEWORK 2022/23

DG presented the BAF, with a key focus on items with a change in score and risk exposure. Updates were provided relating to the following risks:

- **CRR99 Capacity to Respond to Safeguarding:** Additional productivity measures in the team and controls had reduced the likelihood of the risk. There was still more work to do, but the likelihood of the risk materialising had reduced.
- **CRR94 Engagement and Supportive Observations:** This linked with the CQC action plan regarding garden access. A protocol had been signed-off through the Ligature Risk Reduction Group and patients had 24-hour safe access to gardens.
- **CR11 Suicide Prevention:** It had been considered prudent to delay the launch of the Suicide Prevention Strategy as a national strategy had recently been launched and it was important to incorporate key elements and to ensure the patient voice is considered in the development of the comprehensive strategy.
- **CR93 Continuous Learning:** There had been some delay in developing a refreshed process chart linked with the PSIRF and this would be taken forward via the Executive Team.
- **CRR98 Pharmacy Resources:** The Executive Team had acknowledged the recruitment and training of pharmacists had a long lead-in time. There had been a positive move in recruitment of pharmacy staff and the next few months should see a positive change to the risk.

RH noted a possible risk in relation increases in Covid-19 rates and whether there was confidence in primary care delivering vaccinations locally or if EPUT would be asked to undertake this as the central provider. AG advised EPUT had provided flu vaccinations to patients on its caseload and housebound individuals. Work was underway with Primary Colleagues to take any Covid-19 vaccination delivery processes forward.

The Board of Directors:

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

120/23 TRUST RESPONSE TO THE OUTCOME OF THE LUCY LETBY TRIAL

DG presented a report on behalf of NL providing assurance on the immediate and future actions taken following the outcome of the Lucy Letby trial. DG advised a letter was received in August 2023 from Amanda Pritchard seeking assurance that national initiatives had were in place for organisations, such as the medical examiner role to bring independence of review to organisations. EPUT had been an early adopter of the PSIRF framework which was now being rolled out to all organisations in the NHS.

DG advised the letter included strengthening and continuing to develop culture around Freedom to Speak Up (F2SU) and new Fit and Proper Persons (FPP) guidance from the Kark review. It was

acknowledged there was work to do and a task and finish group had been established to respond to the letter and provide assurance processes are working.

The Trust had recently appointed a new principal F2SU guardian who was nationally recognised for innovation. The next three private board seminars would include time with the principal guardian around different phases of the campaign to listen, respond and take action.

The FPP impacts all Board members, with new elements to implement on top of existing procedure around this and a timeline for actions to implement before the national deadline.

DG confirmed that there was a good process in place to see us through and give assurance back to ourselves and NHS England.

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

121/23 SOUTHEND, ESSEX AND THURROCK ALL AGE MENTAL HEALTH STRATEGY

ZT presented a report providing an update on the development of the shared Southend, Essex and Thurrock (SET) Mental Health Strategy 2023-2028. ZT advised the strategy was an example of excellent collaborative work across whole health and social care system in Southend, Essex and Thurrock. This was a joint product of all three integrated care systems, all three upper tier local authorities and provider organisations as well as other services.

This strategy had been developed through a collaborative approach based on population health needs and analysis to look at how to develop, agree and implement an all age mental health strategy that would make a difference to our population. The vision aligns strongly with our strategic plan and values and strategic objectives of the organisation. .

The board was asked to endorse the strategy and to agree and support the establishment of an implementation group.

LL congratulated all involved with the crafting of this strategy which brought in the whole system and resources needed to deploy and create effective services. LL welcomed further information from the implementation task group which would give board the assurance that the strategy would be implemented successfully. ZT advised part of the power of this was the real opportunity in how we use our resources together. There is potential to get better value and outcomes by working more effectively together.

AG commented the content was reflective of the EPUT strategy and those of the care units. This demonstrated a real commitment to a system approach to the challenges faced to deliver better experiences for people. The process of developing this strategy with partners was as important as the product and had galvanised relationships across the Essex footprint, as well as opening the door for further collaboration and opportunity. There was a commitment to look at performance and quality in a unified way across the Essex footprint which helps look at issues and reduce fragmentation.

PS extended thanks to all partners in the system that have overcome challenges around how we work together, and thanked AG and ZT for their role in leading and galvanising that collaboration. EPUT is one of only two organisations that covers the whole footprint this strategy covers, and as such have a responsibility to provide a leadership role to ensure this lands and is delivered.

The strategy was also being presented at the health and wellbeing boards at local authorities and for board approval at ICBs and as such the public statement for commitment was not limited to EPUT and all have made the public commitment to this shared strategy.

SS welcomed the extensive input and engagement from a diverse range of stakeholders and partners on this strategy.

The Board of Directors:

- **received and noted the contents of the report,**
- **endorsed the Southend, Essex and Thurrock All Age Mental Health Strategy,**
- **supported the establishment of an implementation group and welcomed future updates.**

122/23 SOCIAL IMPACT STRATEGY

GB presented the Social Impact Strategy for approval, highlighting the following key points;

- The strategy had been developed to support the achievement of strategic objective 4 – helping our communities to thrive.
- The strategy detailed EPUT should and could go further by adopting key principles of equity.
- The strategy outlined actions taken to date and future actions over a five year period.
- There is a group in place to support implementation and work is underway.

LL thanked all that had worked on the strategy, and was happy to see design thinking implemented as part of the approach. LL felt that there was still a need to go further, to change thinking in how grant funding could be invested to create sustained change. There was also potential to create a social entrepreneur scheme in Essex to help scale up innovations.

MJ thought this an interesting point and welcomed the strategy. This was the first part of being an anchor organisation and driving the way forward for how we grow into a system in line with recruitment and education. There also connected not only economic social good that organisations look to do in the commercial entrepreneur sector but also the education sector.

PS agreed that there was significant opportunity available, as well as having impact on people there was a feedback loop to innovation coming back into the organisation and preparing our services for future challenges.

ML welcomed the excellent report, and was particularly impressed with some key themes using estates for good. ML suggested that there could be more emphasis on engaging more with volunteers and third sector, with this implied within the strategy, but could be clearer.

ZT stated that delivery of services can be strengthened with grants and funding used in a resourceful way, with a number of grants and bids being pursued that are supportive of front line care and wider impact. There had also been a novel approach in the way this strategy was led, with the establishment of a social impact leadership group including colleagues from estates and procurement following a non-hierarchical approach.

The Board of Directors:

1. **Approved the proposed Social Impact Strategy as a key enabler to the Trust's five year strategic plan with its focus on the objective of helping our local communities thrive.**
2. **Publicly acknowledged the importance of its social impact mission and its members to commit to the public advocacy and visible leadership.**

123/23 EPUT DIGITAL DATA REFRESH 2023

ZT was presented the digital strategic plan for the next five years as an enabling plan to support the trust's strategic plan. Significant work had taken place with staff across the organisation and with Board members at seminar sessions to develop and strengthen the strategic plan. There had been particular focus on three areas:

- Culture
- Developing a data curious and capable culture to support patient safety and quality care.
- Transformation approach adopting a continuous service led improvement approach with patients and families at the centre, taking a focussed approach to investment.

ZT was also grateful for the national funding secured for the joint EPR programme, with work taking place with colleagues in finance and the system to make sure the right investments are made in the right way to strengthen and improve data and digital capability.

The data strategy had been attached to the digital plan which had previously received Board approval, there was a continued commitment to being transparent and the Trust were keen to ensure all enabling strategies were available in the public domain.

SS welcomed the review of the digital strategy acknowledging the board seminar time committed to the development of this, and noted the Board of Directors' approval subject to final communications team presentation work.

The Board of Directors:

1. **Approved the Digital Strategic Plan subject to final communications team presentation work.**
2. **Noted the actions now needed and discussed how those are to be monitored to provide assurance of progress.**

124/23 STRATEGIC IMPACT REPORT

ZT presented the first quarterly report of the impact of the Trust's strategic plan. ZT noted as this was the first time reporting on the impact of the five year plan, some description of progress was naturally qualitative. ZT was pleased to report progress across all areas of the strategic plan had been signed off and would be able to report on the new structure and focus on delivery of transformation projects, particularly making sure that executive sponsors were identified for all major projects, as well as Senior Responsible Officers identified at director level.

The previous operational planning process had been reviewed and the intention to commence the operational planning process earlier in the year had been set out as part of a shift to earlier and more proactive planning moving forward.

PS confirmed that there was opportunity for feedback and development of the report through the reporting period and welcomed feedback.

EL commended the structure, which was clear to follow things through. With many enabling strategies, EL queried whether other strategy implementation would follow the same suite of reporting and how these updates would be connected with the BAF.

ML thanked ZT for reflecting work with partners in this appraisal of the strategy. Success in this strategy is dependent on influencing and delivering through partners and coproduction and it was

good to see more information as reporting methodology improves on the outcomes we are securing and the success in that partnership.

ZT acknowledged the importance of partnership working and would ensure going forward, that future reports would feature the significant amount of partnership working taking place. ZT confirmed that work was underway to consolidate and refresh enabling strategies; as they come to the Board for approval they will be included within the overall reporting. As this work progresses, ZT and team were working with DG and team to ensure that risks become clearer and were fully reflected in the BAF.

The Board of Directors:

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

125/23 ANNUAL REVIEW OF GOVERNANCE DOCUMENTS

DG presented the report which provided the revised Standing Orders for the Board of Directors, the Scheme of Reservation and Delegation, Standing Financial Instructions and Detailed Scheme of Delegation for approval from the Board of Directors.

The Board of Directors:

1. **Noted the annual review of Standing Orders and the Scheme of Reservation and Delegation for 2023.**
2. **Received the recommendation from the Audit Committee for approval.**
3. **Approved the Standing Orders, the Scheme of Reservation and Delegation, the Standing Financial Instructions and Detailed Scheme of Delegation.**

126/23 SAFEGUARDING ANNUAL REPORT

FB presented the report which gave assurance and outlined how the safeguarding service was performing and promoting best practice.

LL queried how communication between services was being considered as part of safeguarding and if there were any issues it could be a good opportunity to improve this area. ZT confirmed that there were extensive information sharing agreements to support sharing of information at the right time for those that required and this facility was in place when needed.

The Board of Directors:

1. **Noted the contents of the report – the improvements made during 2022/23 and the priority areas for implementation during 2023/24.**
2. **Approved the report and agreed publication.**
3. **Did not request any further information or action.**

127/23 HEALTH AND SAFETY ANNUAL REPORT

DG presented the report, confirming that the Quality Committee had reviewed and recommended for approval. The report set out how the Trust discharged its duties in terms of the health and safety at work act. DG noted that the Trust had also brought in an individual from another trust for an independent look at the team and there is some feedback from that being taken forward.

The Board of Directors:

1. **Received and noted the content of the report.**
2. **Approved the annual report.**

128/23 USE OF CORPORATE SEAL

The Corporate Seal had been used three times since the last Board of Directors meeting:

- 01 August 2023: Alistair Farquharson Centre, Thurrock Hospital, CDC Lease – alterations.
- 15 August 2023: Canvey Care Centre ULPA – lease agreement for Canvey Primary Care Centre.
- 08 September 2023: Brockfield Settlement and Standstill Deed.

The Board of Directors:

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

129/23 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

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

130/23 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

JW noted that equality had been at the heart of all conversations and showed real maturity of discussions. JW was particularly drawn to the Heads Up programme and the support it had given to over 1000 people with improvement to their life; this was extremely powerful and JW was pleased the trust would continue to lobby for investment to build on that. Also the social impact strategy which was a key driver to addressing inequalities.

JW reflected that EPUT were at the heart of the Southend, Essex and Thurrock strategy, and needed to be a system leader and welcomed the ambition to reduce health inequalities at the heart of that.

131/23 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that all Board members had remained present during the meeting and heard all discussions subject to the following:

PS left 11:34 – 11:36

132/23 ANY OTHER BUSINESS

There was no other business.

133/23 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 29 November 2023.

134/23 QUESTION THE DIRECTORS SESSION

Signed: …… Date: ……

In the Chair

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

The meeting closed at 12:54.

Appendix 1: Governors / Public / Members Query Tracker (Item 134/23)

Governor / Member / Public	Query	Response provided by the Trust
John Jones Lead Governor	The missed targets for Out of Area Placements, for Average Length of Stay and now for the Deficit for the year to date being different to plan, have all been blamed on the increased acuity of the patients in the care of the Trust. **What definition of acuity is being used? If there is no definition what plans are there to regularise this?**	The Trust have reported improvement in terms of patient capacity in adult services and older adult health remains a challenge. There was no one definition for acuity in Mental Health, but the Finance & Performance Committee were reviewing different measures which could be used to create a single definition. The current measures looking at the level of patient need on a ward include, engagement and supportive observation levels (reviewed twice daily) and the level of violence and aggression. There is also the involvement of the police, especially around Datix reports. This was a complex area, but the Trust was committed to drawing together available tools and indicators in place to measure levels of acuity. There were clinical discussions and sit rep meetings that provide an overview of patient need. The teams also review appropriateness of admission, out of area placements and restraints. Good discussion had been held at the Finance and Performance Committee and being clear about drivers of deficit rather than blame. With work taking place around how we better articulate patient numbers, their demands and their needs and how we articulate the drivers.

Peter Blackman, Member of the Public	Until the Public Inquiry into Essex Mental Health Services is completed what will EPUT do now to start to restore the confidence of adult mental health patients, their loved ones, and the people of South Woodham Ferrers and all parts of Southend, Essex and Thurrock? What can groups like ours do to help with the necessary public engagement about this?	The Trust were working closely with local authorities and the three ICBs. A Quality Together meeting is in place where the Trust were presenting the CQC action plan and progress against it with specific deep dives into elements at their request. A weekly safety huddle is held where information about incidents that may have occurred is shared and the Trust have also opened up a number of internal meetings to ICB colleagues. A Rapid Quality Review meeting was also in place where Health Watch were invited to participate. Reflecting on the CQC report and action plan, the key part is assurance that services are safe. The Trust were looking at how partners work with us to focus on the quality of care, Health Watch had offered to help with that. Involving public, patients and families in the work we are doing is central to our strategic plan. One way is to increase the number of lived experience ambassadors, the Trust now have over 170 as well as working with many other volunteers beyond that. A coproduction conference was scheduled for 23 October which was a good opportunity to come together to talk about the Trust can go further with coproduction. The Trust were committed to working with those with lived experience to develop and improve services. The role of those with lived experience was a key part of co-designing the MHED department as well as patient safety partners to improve safety, and patient led assessments of the care environment. The Trust had also recently appointed a head of public relations who would be keen to meet with groups and also would provide regular updates to MPs.
Ian Andrews, Member of the Public	What is the current situation relating to the backlog of appointments and treatments - both due to the pandemic fallout and the recent (and on-going) strikes by Doctors and Consultants across EPUT? What specific action is being taken to reduce waiting times?	In terms of the pandemic, teams had recovered well but pressure had built up over a period of time and was being felt in our inpatient services. IAPT and psychological services were a challenge for some time but are seeing improvements in waiting times and focussed piece of work on waiting times was taking place. In terms of medical appointments, clinic appointments had been cancelled as a result of industrial action, however consultants had reviewed all patients deemed at risk. Despite cancellation of clinics, a number of consultants went ahead with clinic appointments and had been able to manage and rebook all that were cancelled.

Signed: …… Date: ……

In the Chair

Jason	**Presentation** Will you get to a point when you will measure NEET figures for this market?	The HeadsUp project was specifically funded to work with participants who were unemployed or economically inactive, and experiencing common mental health problems. Funding for HeadsUp has now finished but we are actively seeking other streams for future programmes. We are reviewing the current funding landscape and identifying where there are gaps for any future programmes. Pending the outcome of that scoping exercise it could be that NEET forms part of future plans, but at present we do not have a live funding stream available to us.
Ekoh West, Member of the Public	**Presentation** What is the overall percentage of people with mental challenges in the target area, on what basis did you choose these 1000+? How do you maintain the gains that have been made?	As our participants experienced common mental health problems such as anxiety, low mood and depression focused on how a person felt rather than a specific clinical diagnosis. All felt that their own feelings were a barrier to progressing to employment, education or training. Our participants were either referred by other organisations for example Job Centres, NHS organisations, Mind, community groups or they could refer themselves directly to us. As funding for HeadsUp ended we produced our report sharing our learning and experiences so that other organisations can use this to help form positive experiences within their own work. Enable East are also actively seeking new funding so that we can use this learning in our own future programmes.
Teresa Rutterford, Member of the Public	**Presentation** The report was really interesting - well done - I wonder how the participants were selected and if this included people with serious/chronic mental ill health who would not be able to undertake employment?	HeadsUp supported people with common mental health problems rather than more serious conditions as there was nothing available to this group at the time that we drafted our bid for funding. However, there is a significant programme for people in secondary mental health care to provide employment support, and this is through the IPS service.

Ian Andrews	**CQC Report** Outside of the ongoing Inquiry, I understand that the trust was rated as "requires improvement" by the Care Quality Commission (CQC) following inspections in November 2020 and January 2021. The CQC found serious issues in the trust's child and adolescent mental health services (CAMHS), such as unsafe environments, staff shortages and poor governance. The CQC also issued a warning notice to the trust to ensure that it addresses these concerns. What is the current status across EPUT of implementing improvements on a long-term basis?	The CQC report published on 12 July 2023 re-rated the Trust as requires improvement and EPUT submitted an improvement plan by the stated deadline of the 11 August 2023. The report presented at the Board meeting (27 September 2023) was the first formal update on progress. You can access the report on our website at Board Papers | Essex Partnership University NHS Trust (eput.nhs.uk) page 103. Of the 67 'must do' / 'should do' recommendations we broke this down into actions, with each action have a number of sub action to be taken forward (275 sub-actions in total) associated with CQC activity. As of the 14 September 2023 (as reported to Board) 3 'must do' actions have been completed overall and 109 sub-actions have been completed. In respect to the issues in our CAMHS service identified from the CQC inspection in 2021 (report published 15 September 2021), the CAMHS service was re-inspected by the CQC in March / April 2022 with an improved rating within the report published 29 July 2022. The Trust has delivered all the actions associated with the latest report.

Signed: …… Date: ……

In the Chair

Liz Rotherham	**HeadsUp Report** Thank you to Anna for report sounds incredible. However just want to know why it has taken 6 years, 1,000 what background and how did you get these figures, love that you mentioned Peer support - proven it is working in services - what funding is there available for Time to care? Does the public have access to the Heads up report? I would like to review? Last question when is a position for Lived experience to be advertised on the board?	Our funding was over this period, ending in Dec '22. As our participants experienced common mental health problems such as anxiety, low mood and depression it was more about how a person felt rather than a specific clinical diagnosis. All felt that their own feelings were a barrier to progressing to employment, education or training. Our participants were either referred by other organisations for example Job Centres, NHS organisations, Mind, community groups or they could refer themselves directly to us. Peer support was central to our delivery model, and core to the success of the programme. This along with practical employment skills development and resilience workshops really did have a positive impact on many. We also have a PSW Good Practice Report which you might find interesting and can be found at the link below. As funding for HeadsUp ended Dec '22 we produced our final report sharing our learning and experiences so that other organisations can use this to help form positive experiences within their own work. Unfortunately we are not involved with the Time to Care funding so I'm not able to answer that part of the question. Enable East are also actively seeking new funding so that we can use this learning in our own future programmes. Please see the final reports at the following link https://enableeast.org.uk/what-we-do/grant-funded-programmes/grant-funded-programmes/headsup/
Pippa Ecclestone	References to "THE" ICB which actually seem to refer only to the Mid& South ICB are not helpful for the public.	DG confirmed that presentation to ICB included chief nurses for all ICBs covered our patch, with a meeting with Anthony MacKeever individually as he holds reign for quality as chair of rapid review. However, confirmed references to ICB's will be clear on the specific ICB.

Signed: …… Date: ……

In the Chair

Kevin Marvin	Member of Southend PPG and interested in how can assist in implementing the MH strategy and integrated care strategy. How does Mid and South Essex ICB, attending meeting on 28 June, differ from EPUT strategy and how do they complement each other? And how can we as a PPG work with you working from the bottom up towards the pinnacle.	ZT advised Patient Participation Groups were so important, with a fantastic amount of work going on through those groups. EPUT work with ICBs for MSE, SNEE and HWEE and BLMK, and had been closely involved in directorate strategy and MSE strategy. The Trust had made sure when developing the strategic plan that it aligned to those of the ICB. While ICBs are responsible for commissioning of services and EPUT for the delivery, we work in an integrated way and work in collaboration aligning strategies. We work closely with PCN to make sure our staff can support local GP practices and support people in the community.

Signed: …… Date: ……

In the Chair

5. ACTION LOG / MATTERS ARISING

Standing item | Professor Sheila Salmon | 3 minutes

REFERENCES

Only PDFs are attached

BoD Part 1 - Action Log 29.11.2023.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting Action Log

Lead	Initials	Lead	Initials	Lead	Initials
Nigel Leonard	NL	Susan Young	SY		

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
093/23 July	Provide a further update to the Board regarding relevant recommendations from the Rapid Review into Data on Mental Health Inpatient Settings.	NL	January 2024	This will be presented to the January 2024 Board meeting.	Open	
057/23 May	Referring to the Staff Survey -to consider process for linking with and learning from outstanding organisations.	SY	~~September 2023~~ January 2024	The Trust will be taking part in the national 'People Promise in Action week' in October when we will be attending sessions designed to share the learning from those organisations which are cited as exemplars across the NHS. Relevant learning and actions will be built into EPUT's new People Strategy.	Open	

5.1 WORKFORCE RACE EQUALITY STANDARDS (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARDS (WDES)

Information Item | SY | 2 minutes

REFERENCES

Only PDFs are attached

WRES WDES 29 Nov Bd v2.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) acion plans					
Executive/ Non-Executive Lead:	Susan Young, (Interim) Chief People Officer					
Report Author(s):	Susan Young, (Interim) Chief People Officer					
Report discussed previously at:	People and Culture Committee, 21 September 2023 Trust Board (Part 2), 27 September 2023 Trust Board seminar, 18 October 2023					
Level of Assurance:	**Level 1**	**X**	**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)	x
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The purpose of this report is to inform the Board of the final approval process and publication of the Trust's 2023 WRES and WDES action plans.	**Approval**	
	Discussion	
	Information	X

Recommendations/Action Required

The Board is asked to:

- Note the completion of the approval process and subsequent publication of the 2023 WRES and WDES action plans.

Summary of Key Issues

The WRES and WDES data and action plans are published by NHS organisations on an annual basis and are part of our framework to improve the experience of employees with certain protected characteristics. The data for 2023 was published earlier this year and the action plans have been scrutinised by PECC in September prior to the Board reviewing these in private session in September 2023.

The board delegated final sign off, and the Chair of PECC approved the plans for publication on 30 October 2023, after which the documents were uploaded to the Trust's website:

wres-action-plan-2023-2024.pdf (eput.nhs.uk)

wdes-2023-data-and-action-plan.pdf (eput.nhs.uk)

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

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standards		
WDES	Workforce Disability Equality Standards		
PECC	People, Equalities and Culture Committee		
EDI	Equality, Diversity and Inclusion		

Supporting Reports/ Appendices /or further reading
Appendices: N/A

Lead

Susan Young
(Interim) Chief People Officer

6. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Standing item | Professor Sheila Salmon | 5 minutes

REFERENCES

Only PDFs are attached

Chair Board Report - November 2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	Date: 29 November 2023

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

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	X
	SR2 People (workforce)	X
	SR3 Finance and Resources Infrastructure	X
	SR4 Demand/ Capacity	X
	SR5 Statutory Public Inquiry	X
	SR6 Cyber Attack	X
	SR7 Capital	X
	SR8 Use of Resources	X
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Changes to the Board of Directors
- Lampard Inquiry
- Annual Members Meeting
- UK Disability History Month
- Reception with His Majesty The King

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

Acronyms/Terms Used in the Report			
		NED	Non-Executive Director

Supporting Reports/ Appendices /or further reading
Main report.

Lead
Professor Sheila Salmon **Trust Chair**

Board of Directors Part 1
29 November 2023

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Changes to the Board of Directors

As reported previously within my reports, following the departure of Executive Nurse Natalie Hammond, and Executive Director of People and Culture Sean Leahy, the Trust has undertaken two robust recruitment exercises to secure two new Executive Directors to join the Board of Directors. I am pleased that Ann Sheridan has been successfully appointed to the Executive Chief Nurse Role and will be joining EPUT in the New Year. The recruitment process for the Executive Chief People Officer role is not yet complete and an update on progress will follow in due course.

Recruitment for new NEDs to join our Board has also recently concluded and I am pleased to confirm that Dianne Leacock and Jenny Raine have been appointed and will commence in post in December and January respectively.

2.2 Essex Mental Health Independent Inquiry

Board members will be aware of the announcement from the Secretary of State for Health and Social Care that Baroness Kate Lampard CBE had been appointed as chair of the Inquiry into Mental Health Deaths in Essex, which had been given statutory powers and relaunched as the Lampard Inquiry. Baroness Lampard has launched a consultation period which is due to end on 28 November 2023, for the proposed terms of reference for the inquiry. It is anticipated that the new terms of reference will be released in the New Year. As a Board we are committed to continue to engage with the Inquiry Team in an open and transparent way and are committed to continuing to support those who are impacted by the inquiry.

2.3 Annual Members Meeting

I was delighted to welcome more than 70 members, system partners and colleagues to our Annual Members Meeting (AMM) on 6 November; this was the first AMM held in person since the Covid-19 pandemic. I was joined by Paul Scott and a number of our Executive Team who spoke about our achievements over the last year, our response to recent CQC feedback and plans to continue improving services for the communities we serve. I was particularly pleased to hear an update around the Mental Health Urgent Care Department in Basildon which has helped more than 1,200 people since opening in March. One member who attended the AMM also spoke bravely about how the unit provided them with vital care in their moment of need.

2.4 UK Disability History Month

16 November saw the beginning of the UK Disability History Month and is an opportunity to raise awareness and look at how we support disabled people in the workplace. Throughout UK Disability History Month, each week the Trust will be focussing on a different fact about disability to help educate colleagues; articles will also be shared which focuss on different perspectives and what we are doing to improve the experiences of disabled colleagues at EPUT.

2.5 Reception with His Majesty The King

Three of our EPUT colleagues were among 400 nurses and midwives invited to spend the afternoon with His Majesty The King on his birthday to celebrate the work of nurses and midwives working in the NHS. The event was held at Buckingham Palace on 14 November to mark the King's 75th birthday and ongoing celebrations of the NHS 75 birthday.

3.0 LEGAL AND POLICY UPDATE

- **The Health Care Services (Provider Selection Regime) Regulations 2023:** NHS England has published the draft Statutory Guidance and draft associated implementation products - The Health Care Services (Provider Selection Regime) Regulations 2023 (the "Regulations") were laid before Parliament on 19 October. The changes will require relevant authorities (NHS England, ICBs, Trusts and FTs, as well as local authorities/combined authorities) to operate under a new bespoke procurement/commissioning regime when awarding contracts for health care services covered by the new regime. **For Information:** Provider Selection Regime Regulations 2023 laid before Parliament - Hempsons - Hempsons

- **Immigration guidance update for the social care sector:** During July and August 2023 there have been some significant changes to the Government's immigration guidance which impacts both employers and their employees within the social care sector. The Health and Care Worker visa is a type of Skilled Worker visa, aimed at qualified doctors, nurses, allied health and adult social care professionals. It offers a fast-tracked and more affordable route to a visa option for the health and care sector. The visa's criteria includes: proof of the relevant qualifications; proof of a job offer in one of the eligible health or care professions; meeting the salary threshold; working a set amount of hours; and having a valid certificate of sponsorship from the employer. **For Information:** **Immigration guidance update for the social care sector - Hempsons - Hempsons**

- **People who have had a stroke should be offered additional rehabilitation to help them recover, NICE says in updated guidance:** People who have had a stroke and who have continuing impairment or limitations on their activities should be offered additional rehabilitation to help them recover, NICE has said in updated guidance published recently. The guideline says that people who have had a stroke should be offered, needs-based rehabilitation for at least three hours a day on at least five days of the week, covering a range of multidisciplinary therapy including physiotherapy, occupational therapy and speech and language therapy. This is an increase in rehabilitation compared with NICE's original guideline published in 2013. **For Information:** People who have had a stroke should be offered additional rehabilitation to help them recover NICE says in updated guidance | News | News | NICE

- **Sexual harassment: new duty on employers from October 2024:** A new Act on sexual harassment has received Royal Assent. The Act adds to the Equality Act 2010 and puts employers under a new duty to take reasonable steps to prevent sexual harassment of employees in the workplace. It will come in to force in October 2024. **For Information:** Sexual harassment: new duty on employers from October 2024 - Mills & Reeve (mills-reeve.com)

- **The new right to request a predictable work pattern:** Legislation due to come into force next year establishes a new legal framework for discussions about unpredictable working patterns. The right extends to any worker "where there is a lack of predictability, in relation to the work that the worker does for the employer, as regards any part of the worker's work pattern". The definition of work pattern extends not only to the number of hours worked, but the days and times on which those hours fall, as well as the period for which the worker is contracted to work. If a worker is engaged under a fixed term contact of 12 months or fewer, the period for which the worker is contracted to work is deemed to be unpredictable. **For Information:** Latest legal publications | Mills & Reeve | Mills & Reeve (mills-reeve.com)

- **Launching the Patient and carer race equality framework for mental health trusts and providers:** On the October 2023, NHS England published its first ever anti-racism framework, the Patient and carer race equality framework (PCREF), to support mental health trusts and providers to improve experiences of care for racialised and ethnically and culturally diverse communities. People from Black and Black British groups are four to five times more likely to be detained under the Mental Health Act than their White counterparts, have higher rates of being restrained in inpatient units, and are far more likely to encounter mental health services through the criminal justice system. People from other racialised groups also have poorer access to mental health care, including increased use of crisis pathways leading to more negative experiences and outcomes compared to White majority counterparts. The framework has been developed in light of this evidence. For Information: NHS England » Launching the Patient and carer race equality

framework for mental health trusts and providers

5.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Laverick
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon, Chair

7. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Standing item | Paul Scott | 15 minutes

REFERENCES

Only PDFs are attached

CEO Board Reports - November 2023 Final.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Chief Executive Report**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Paul Scott, Chief Executive Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	**X**	**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	X
	SR2 People (workforce)	X
	SR3 Finances and Resources Infrastructure	X
	SR4 Demand/ Capacity	X
	SR5 Statutory Public Inquiry	X
	SR6 Cyber Attack	X
	SR7 Capital	X
	SR8 Use of Resources	X
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

Lead
 **Paul Scott** **Chief Executive**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 New members of the Executive Team

Following a robust recruitment process, Ann Sheridan has been appointed as Executive Nurse and will join the Trust in the New Year. Ann has over 30 years' experience of working at senior level across the NHS and local authorities in a range of different health and care settings, with a successful track record of leading and inspiring teams and experience in quality improvement.

The recruitment process for the Executive Chief People Officer is underway and further updates will be provided in due course.

1.2 Statutory Inquiry Update

Board members will be aware of the announcement from the Secretary of State for Health and Social Care around the granting of statutory powers to the Inquiry into mental health deaths in Essex and the subsequent appointment of Baroness Lampard as Chair. Baroness Lampard has now launched a consultation period for the proposed terms of reference of the statutory inquiry (now renamed the 'Lampard Inquiry'), which is scheduled to end on 28 November. The Trust remains committed to engaging with the Inquiry team and acknowledges that this is clearly a difficult time for families, carers and our staff as we await clarity around proposed terms of reference and timescales. We are doing everything we can to support everyone who is impacted by the Inquiry.

1.3 Awards Nominations

EPUT and our partners were recently nominated for a number of health sector awards; I am incredibly proud that, in partnership with Mid and South Essex ICS and Arden and Gem CSU, the Electronic Frailty Coare Coordination System (eFraCCS), the Frailty End of Life Dementia Assessment (FrEDA) programme won the Data Driven Transformation Award at the recent HSJ awards in London.

1.4 Standard Operating Procedures

Patient safety is our absolute priority and to aid this, we have launched a new digital app that will help our clinical staff access Standard Operating Procedures quickly and in one place. The app, SOPHIA, will launch across the Trust in the New Year and will be available via the intranet and mobile devices.

1.5 Patient Safety Incident Response Plan

Another pivotal step in our commitment to patient safety is the roll out of the Patient Safety Incident Response Plan (PSIRP), aligning with our new Patient Safety Incident Response Framework (PSIRF). PSIRP guides how we respond to incidents, emphasising learning and collaboration and is available on the public website and staff intranet.

1.6 EPR

The excitement continues to grow across EPUT and MSEFT as we progress through the selection process for our unified electronic patient record system. Thanks to a dedicated, multi-disciplinary bid evaluation team of 200+ members, we are making good progress. Live demonstration sessions from potential suppliers are planned over the next few weeks, which will help our staff see how their technology could address the critical needs of our services and improve patient care.

2. PERFORMANCE AND OPERATIONAL ISSUES

2.1. Operations – Alex Green, Executive Chief Operating Officer

- Continued high occupancy rates in both adult and older adult inpatient mental health services at 97.9% and 93.4% respectively
- Small average length of stay improvement across adult and older adult services, with improved reporting of Clinically Ready for Discharge and Expected Date of Discharge and positive system involvement in managing constraints to discharge.
- At the end of October there were 27 people placed inappropriately in out of area beds. This is a reduction in numbers from September and ahead of our trajectory plan.
- 4,366 calls taken through Crisis 111 in October, is a call volume decrease of 5% compared with September. 93% of calls were answered within 60 seconds. Whilst not achieving the 95% target, this performance continues a steadily improving trend over the past six months and is the highest rate of calls answered within 60 seconds since November 2022.
- Challenges delivering the 95% target for physical health reviews in Drug and Alcohol Services (Essex STaRS) in North East Essex, with demand outweighing current capacity. 12-week plan in place to improve performance, with oversight through the Accountability Framework.
- The Lighthouse Services continues to report no outlying patients waiting against the 65week, 78week or 104 week thresholds that NHS England ask for in their weekly Key Line of Enquiry returns. Current performance is ahead of the national target to reduce service waiting times to under 65 weeks by the end March 2024.

2.2. Workforce – Susan Young, Interim Chief People Officer

International Recruitment

- Recruitment phase ending with final six nurses to arrive 28th November bringing the total number of registered mental health nurses to have arrived in 2023 to 45. The remaining five AHPs will arrive by February 2024, with 14 arrived in 2023.
- Nurses will arrive with Objective Structured Clinical Examination (OSCE) and undergo post-OSCE training and completion of mandatory training and aim to be ward ready within eight to 12 weeks of arrival.
- Generally, AHPs go onto their services within one month of arrival as any clinical training is provided by the team.
- All arrivals have been ward/service allocated.
- The programme will be closed once all staff are on wards/services and all are moved off the IR budget code to a ward/service budget code.
- For nurses, this will include obtaining NMC Registration.
- Expectation that this would be finalised by end of Q4 FY23/24, however delays may result due to NMC review of individual cases and anyone testing positive for TB.
- There are eight nurses under NMC review and two nurses awaiting clearance from TB.
- There are 38 nurses awaiting NMC registration and 32 on the IR budget code

Recruitment

- Staff Turnover 9.2% - down from 11.9% in June 2022
- Vacancy Rate 9.8% - down from 18.6% in June 2022
- Recruitment events, recruitment business partnering work with care units and hard to recruit to campaigns are all contributing to the lowering of vacancy rates as well

as a strong newly qualified nurse induction which will see us surpass our 148 WTE set target of newly qualified nurse starters.

Industrial Action
Between April and October 2023, there were eight periods of industrial action by the British Medical Association [BMA] involving consultants and junior doctors, including two periods of joint action in September and October 2023. Industrial action is pro-actively managed through the Trust's emergency preparedness, resilience and response planning process. There have been no matters arising during industrial action which have required regional or national escalation, and action reviews have been undertaken after each period of industrial action.

The BMA currently has a mandate for strike action by junior doctors until 29 February 2024 and for consultants until 26 December 2023. There are currently open ballots on a mandate for strike action with consultants and speciality (SAS) doctors, which close on 18 December 2023. The Hospital Consultants and Specialists Association (HCSA) also now has a mandate for strike action until 14 May 2024, the HCSA have identified two workers in the Trust who will be eligible to take part in any action arising.

Marketing and Brand
Our Countdown to Christmas is on, with a host of social media posts planned for ten days across all social channels. We continue to support recruitment with various campaigns to place a number of roles across our 111, AHP and communities teams along with consultant roles and nursing roles.

Employee Experience
On 31 October 2023, the WRES and WDES Report and Action Plan was published which includes a robust plan of activity to improve the experiences of minority staff. Following the ED&I session at the Board Seminar last month, the Transformation Team is supporting the development of programme management of ED&I work streams to ensure delivery of required outcomes.

In response to feedback from our Staff Survey, NQPS and Experience Team, plans are underway to launch a two-week health and wellbeing roadshow in early 2024, across multiple sites in the Trust. In addition, cycle sheds will be introduced, initially across three sites, each of which will include five individual lockups for staff use.

Education/OD and IR
The Trust welcomes 174 newly qualified nurses who will now commence their preceptorship across autumn and early 2024. We have a further 26 going through pre-employment checks and awaiting start dates with us. This represents a significant increase from last year where we recruited 91 newly qualified nurses.

As part of our ongoing commitment to address inequalities for staff from ethnic minority backgrounds, the RISE leadership programme is currently establishing a third cohort. One of our international recruits who graduated from the RISE programme, Prince Adoe, recently won the Rising Star - Excellence in Nursing accolade at Zenith Global Health's Global Health Awards. This is testament to Prince's commitment and hard work, and the success of the International Recruitment and RISE programmes working together to raise standards and diversity across our organisation.

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

- YTD revenue deficit £7.6m, £5.8m adverse to plan with mitigations developed.
- Continued investments in capital with YTD expenditure totalling £7.4m.

- In year forecast and resubmission of ICS financial plans completed in line with National Guidance and associated Board approvals.
- 2024/25 planning commenced.

2.4. Quality and Safety – Frances Bolger, Interim Executive Chief Nurse

At the last Board meeting, the Board was informed of the increase in the number of falls in the older adult inpatient areas for the month of August 2023, which was the first time the rate had been above the trajectory level since September 2021. However, in September 2023, the rate of falls has dropped below trajectory and continues to build on the success of previous months. The Harms Free Group will continue to monitor the rate of falls and on the implementation of improvement actions. Alongside this, the number of incidents involving restraint has also decreased from its August level, and is at its lowest rate for five months. A successful Reducing Restrictive Practice event was held on 3 October, with input from service users and staff focusing on reducing restrictive practice and sharing best practice.

Over the last few months, the Trust has been finalising the Quality of Care Strategy, which will be presented later on the agenda today. A number of workshops were held during October to identify the key performance indicators that will measure the successful implementation of the strategic vision. Some of the workshops collaborated with both staff and people with lived experience, to ensure that the new key performance indicators would truly capture their experience and feedback.

As per NHS England's guidance, provider organisations are required to create a Patient Safety Incident Response Plan. The EPUT Patient Safety Incident Response Plan has now been finalised and published, and sets out how the Trust will respond to incidents in a way which is timely, compassionate and caring. The Plan also identifies the need for effective communications so that learning can be shared.

Two members of EPUT's team have been recognised in the Southend Champions awards, run by Anna Firth MP, Member of Parliament for Southend West. Tracy Reed, Clinical Lead, End of Life Care and Spencer Dinnage, Operational Service Manager, Older People's Community Mental Health, Dementia and Frailty were named amongst the 16 'Community Champions' who were recognised at a ceremony hosted by Anna Firth and Southend's Mayor, Councillor Stephen Habermel. Several Essex MPs also visited EPUT sites and services in October and November to meet staff and experience first-hand the care and support our services provide to local communities.

8. QUALITY AND OPERATIONAL PERFORMANCE

5 minutes

8.1 QUALITY & PERFORMANCE SCORECARD

Discussion Item | Paul Scott | 5 minutes

REFERENCES

Only PDFs are attached

Mth7 Quality and Performance Board Report October2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

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

Risk Assessment of Report		
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators.	
State which of the following Strategic risk(s) this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.	

Full Report
To view the EPUT Quality & Performance Board Report (Power BI dashboard) click **HERE**.

Purpose of the Report		
This report provides the Board of Directors • 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 reports.
2. Request further information and / or action by Standing Committees of the Board as necessary.

As part of our data strategy to enable EPUT to become a data insight driven organisation, the September Board meeting sees the first instance of using the Power BI version.

The word document has now been translated into a Power BI dashboard to measure against the indicators and will look and feel similar to the word document to support a smooth transition but with an enhanced user experience and much greater functionality.

Who can access the new Power BI Board Report?

The report has no access limitations to allow for publication to the Trust website and public viewing. KPIs have been developed with the same level of detail as the previous word document, and no further.

How do I open the report in Power BI?

You can open the Board report via the following link: EPUT Quality & Performance Board Report.

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, CQC, and any measure rated as inadequate for the month.
Each Key Performance Indicator (KPI) can be selected and viewed alongside trend analysis and informative narrative.

Within performance for October there were 29 KPIs achieving targets and therefore RAG rated Green, there were 3 KPIs requiring improvement and therefore RAG rated Amber, and there were 16 KPIs failing targets and therefore RAG rated Red.

Of these KPIs highlighted to Board, the following were escalated through the Trust's Committees most recently:

Inpatient Capacity

The October occupancy rates across adult and older adult services continued to maintain the high levels reported in September against commissioned beds. Adult occupancy rose to 97.9% against a target of <93%, whilst older adult rose to 93.4% against a target of <86%. Whilst this measure is against commissioned beds, it's important to note that the occupancy rate against actual available beds in the month would be higher than this.
PICU occupancy remains stable at 83%, within the target of <88%. This measure is currently based on the Christopher unit performance, whilst the Hadleigh unit is closed, repatriation to the ward will start upon expected estate work completion in November.
There was a small reduction in the Adult average length of stay, the benchmark for discharged patients is <35 days; this performance is run both excluding the assessment units (down from 60 days in September to 56 in October), and including the assessment units (down from 42 days in September to 39 in October).
The average length of stay for older adults reduced to 92 after reporting above 100 each of the previous 3 months, against a benchmark of <74 days. Of the 40 discharges from older adult wards, 25 were considered a long stay, 60+ days. Whilst the same number of long stays as

September, they account for a lesser proportion of the discharges (62% compared to 73% in September)
PICU (Christopher unit) average length of stay remains within target at 21.6 days, against a benchmark of <50 days.
Escalation for people clinically ready for discharge with a system level constraint continues with suitable supported accommodation, residential and nursing home provision being the greatest barrier. System engagement in review of escalation structure is being taken forward in winter preparedness discussions.

Therapy for You Access Rates
Both Castle Point & Rochford, and Southend on Sea continue to achieve their respective access rate targets in October. North East Essex access rates have fallen following the brief improvement seen in August. Whilst the linear projection for next month shows a slight upwards trend, the performance is expected to remain below target. The trend over the previous 12 months does show an upward trajectory, which shows positive steps are being made.
The service continues to see high numbers of referrals through Limbic Access which was deployed on to the Therapy for You website in December 2022. This software allows patients to self-refer and book their own assessment appointments, resulting in improved engagement. In October there were 328 referrals through Limbic Access and since the start there have been 3,577 referrals for the North.

Inappropriate Out of Area Placements
Admission demand has remained high in October, as has the level of complexity and acuity within the wards, with 19 inappropriate out of area placements made (following on from 21 and 20 in Aug and Sep respectively). However the number remaining in an out of area bed at month end further reduced to 27 at the end of October (down from 39 in August and 33 in September). This performance of those remaining in a bed is in line with EPUTs reduction trajectory and demonstrates a health repatriation process and saw 20 patients either discharged or repatriated in October, exceeding the Trusts target trajectory of 29 being out of area at the end of October.

Lighthouse Childrens Centre
There are no patients waiting over 78wks, as was reported in the most recent KLOE return.
The longest wait is currently 59wks as at 13th Nov, which places performance ahead of the national target to reduce service waiting times under 65wks by the end March 2024.

CQC Action Plans
The Trust received the final CQC report on 12 July 2023; identifying 45 ‘Must do’ actions and 26 ‘Should do’ actions.
In developing the Trust improvement plan, a review of existing CQC action plans has been undertaken and all outstanding actions have been combined into the new plan. This ensures there is a single improvement framework and simplifies assurance reporting.
Oversight of the improvement plan is through a newly formed CQC Action Leads Meeting, which reports to the Executive Operational Committee on a monthly basis.
The Trust is currently in the ‘Action Plan Delivery’ phase of the CQC Action Plan Process and this is scheduled to run through until March 2024. As at the end of October over half of the CQC assurance metrics in place to monitor the action plans are either already meeting or on track to achieving target.

Financial Summary
Income and Expenditure
The Trust's YTD performance is a deficit £7.6m being £5.8m adverse variance to plan. The adverse variance includes safety related expenditure in Inpatient areas associated with acuity, observations and demand/capacity. Unplanned costs associated with strike activity and the

impact of pay award settlements have also increased costs. The Trust continues to intend to deliver a breakeven position with a combination of internal and external interventions and support required to meet this position.

Efficiency programme

In order to deliver the 23/24 financial plan, the Trust has to deliver £22.9m of efficiencies equivalent to 4.4% of operating spend. The M7 position is delivery of £10.4m against the plan of £12m, £1.6m behind plan. The position includes a number of non-recurrent schemes that have been developed to support delivery.

Temporary Staffing Costs

Total temporary staffing spend in the month was £6.7m; bank spend £4.3m and agency spend £2.4m. For 23/24, the increased deployment of International Recruitment nurses and increased financial controls will support the reduction in temporary staffing costs.

Maximising Capital Resources

The Trust has incurred capital expenditure of £7.4m at M7. Expenditure is ahead of plan by £0.5m which is associated with timing of project delivery when compared to plan. The total forecasted spend of £19.1m for the year and includes £1.4m of discretionary capital with release of these funds to be agreed via the System Investment Group.

Positive Cash Balance

The cash balance as at end of M7 is £56m, behind plan by £3.2m which includes the impact of the deficit and the timing of receipt of some debts with recovery expected in future periods.

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

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

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

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement

CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading

EPUT Quality & Performance Board Report **HERE**.

Lead

Paul Scott
Chief Executive

8.2 COMMITTEE CHAIRS REPORT

Decision Item | Chairs of Standing Committees | 10 minutes

REFERENCES

Only PDFs are attached

2023.11.29 Committee Chair's Report Part 1.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

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

Risk Assessment of Report		
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 Statutory Public Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

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

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

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

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

- Audit Committee (Elena Lokteva)
- Quality Committee (Dr Rufus Helm)
- Finance & Performance Committee (Loy Lobo)
- People, Equality & Culture Committee (Manny Lewis)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Committee Chairs Report

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

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors Part 1

November 2023

EPUT

1. 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, SFI's, etc.)

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

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

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

2. AUDIT COMMITTEE

Chair of the Committee: Elena Lokteva (Non-Executive Director)

Committee meeting held: 16 November 2023

Assurance

Internal Audit

Internal Audit Progress Report
- Good progress has been made with outstanding recommendations. Out of the 7 audit recommendations four have been closed which includes, two site visits recommendations and two from the Independent Inquiry.

Anti Crime
- An update was provided on the referral cases.

Whistleblowing
- The Trust's internal audit provider, TIAA, is working with their NHS clients to review organisational culture in respect of the above. Their findings and lessons learnt will be shared at a future Audit Committee meeting.

External Audit
- The final Charitable Fund Accounts for 2022/23 have been reviewed.

Claims Annual Score Card 2022/23
- The above was presented to the Audit Committee but were unable to form an assurance due to several queries. It was agreed that this would be brought back to a future Audit Committee.

Clinical Audit Process and Delivery Assurance Report
The above was presented and noted.

Waiver of Standing Orders
- During the period from the 1 September 2023 to 30 October 2023, competitive quotations were waived on 12 occasions totalling £414,277.
- During the period from 1 September 2023 to 30 September 2023 9 of the 12 waivers were retrospective.

Workplan 2023/24 and Future Agenda Items
- The above was discussed and noted.

NHS
Essex Partnership University
NHS Foundation Trust

AUDIT COMMITTEE

Chair of the Committee: Elena Lokteva (Non-Executive Director)

Committee meeting held: 16 November 2023

Action

Final Charity Annual Report and Accounts 2022/23

- The Committee would recommend the above are presented to the Board of Directors for approval subject for clarification regarding the charity's Trustee and Investment Fixed Assets.

Information

None for information only this month.

Alert

No alerts for the Board of Directors this month.

3. QUALITY COMMITTEE

Chair of the Committee: Rufus Helm (Non-Executive Director)

Committee meeting held: 12 October & 9 November 2023

Assurance

Quality Performance Report
- Quality and Safety dashboard data was discussed, with particular discussion around Pressure Ulcer and Complaints Handling Performance.
- Unsecured ligature rates had more than doubled, and this was being addressed by BSOG.

Learning Disability Improvement Standards Progress Report
- Oliver McGowan training received praise from several Committee members.
- Procurement for a new quality dashboard was underway. As part of the process, user feedback would be obtained to ensure the new dashboard meets the need of the Trust.

Quality Account 2023/24 Falls Mid-Year Progress Report
- The number of falls above target had peaked in August 2023, but this had improved since.
- The rationale used when setting the current falls target was discussed, and Committee members were assured that this was currently under review to ensure that it was in line with national benchmarking, and that the Trust continually improved.
- Risk assessments would be carried out at Rawreth Court and Clifton Lodge, with the aim of preventing falls through individual care planning.

The Ligature Risk Management 2023/24 Q1 & Q2 Reports
- A trend overtime for ligature incidents was presented with an increase recorded in August, and this would be reviewed.
- It was agreed that a review of Corporate Risk Entry 81 would be undertaken to triangulate with data within the report.
- Ligature training levels stood at 90%
- Concerns following the incorrect storage of ligature cutters within the CQC report had been addressed via a review of all sites, and staff refresher training.

CQC Compliance Update
- Details of new CQC guidance were noted.
- Significant progress had been made with the CQC's recommended actions.
- Rawreth Court had received a CQC report, and action was being taken to address the issues, with prescribed timelines.
- The Trust's Inspection Team was preparing for a transition to a new CQC operational manager.

QUALITY COMMITTEE

Chair of the Committee: Rufus Helm (Non-Executive Director)

Committee meeting held: 12 October 2023 & 9 November 2023

Assurance (continued)

Improving the Experience of People with Personality Disorders and Complex Needs
- Committee members noted that the independent review was now complete.
- Work to implement the recommendations was well underway.
- Due to the complexity of the review and the need to address cultural issues, it was estimated that this would take at least one year to complete.

Learning from Deaths Quarterly Oversight Report 2023/24 Q1
- The draft report was approved by Committee members for presentation to the Board of Directors in November 2023.

End of Life Annual Report
- Committee members noted that inter-collaboration work across the system had helped providers give high quality care, and further work was ongoing to find innovative ways to work collaboratively across a wide range of health services.

Quality of Care Strategy
- The draft report was approved by Committee members for presentation to the Board of Directors in November 2023.

EPRR Quarterly Report 2023/24 Q2
- The report related to the 2023/24 Core Standard, and had been produced following a self assessment and confirm and challenge process.
- Quality Committee members gave approval for the Covid-19 incident to be formally closed, subject to the production of a data archive and a process for dealing with any further communications received from the national team.

Patient Experience & Compliance Quarterly Report 2023/24 Q2
- Committee members noted that it was now possible to report responses to *I Want Great Care* at care unit level.
- Complaints were being resolved more effectively informally via PALS, resulting in the volume of formal complaints reducing by around 30%.
- Response times for formal complaints were currently high due to their complexity. The team was reviewing its processes to make improvements.

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QUALITY COMMITTEE

Chair of the Committee: Rufus Helm (Non-Executive Director)

Committee meeting held: 12 October & 9 November 2023

Information

Patient Story
- The Committee watched a video of a service user with Bipolar Disorder who shared an account of their personal experience and journey with EPUT.

Pharmacy & Medicines Optimisation Annual Report 2022-23
- A nationwide shortage of Pharmacy staff, alongside significant changes to the Trust's pharmacy services, were noted, and committee members agreed that the team was had dealt with these challenges well.
- The Annual Report was approved by Committee members.
- A briefing on the Trust's ongoing recruitment and retention plan for pharmacy staff would be presented to the People, Equality & Culture Committee.

Action

Patient Story
- The Patient Experience Team would be setting out a frame for developing how the Trust would use patient story videos in the future.

Learning Disability Improvement Standards Progress Report
- The Patient Experience Team would arrange for the Lighthouse Centre to provide a Spotlight on their improvements to neurodiversity services via co-design at a future meeting.

Alert

- On 9 November 2023, Quality Committee members gave approval for the internal Covid-19 incident management arrangements (i.e. staff covering incident inbox) to be formally closed and noted the return back to business as usual processes.

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FINANCE AND PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo (Non-Executive Director)

Committee meeting held: 19 October & 23 November 2023

Assurance

Quality & Performance

- The Chief Operating Officer presented current performance, with particular focus on inpatient capacity, out of area placements, 111 calls answered within 60 seconds, as well as waiting lists for both Psychological services and the Children's Lighthouse Centre.
- The Children's Lighthouse Centre has sustained improvement and continues to hold no clients waiting over 78 weeks. Agreement was sought and received for this to be removed from the risk section of the report.
- Two new areas of performance were escalated for First Response referrals seen within 28 days, and Essex Drug & Alcohol services (STaRS), both of which will continue to be monitored.
- The Committee received assurance that complaints are being taken forward with a deep dive by the Information Governance & Quality Committee, and the Trust's positive strides in terms of workforce are being brought forward as good news in the People, Equality, & Culture Committee.
- The Chief Operating Officer presented October performance, highlighting occupancy rates and small gains made in average length of stays. Out of area placements noted to continue marked reductions.
- The Committee noted the STaRS medical and physical health review challenges in the NE team. Improvements made in Psychological services waiting times were discussed, as were the inroads made on reducing vacancies and turnover. Two areas were noted for their improved risk positions of returning to target and two new performance risks were raised where assurance was given that these are well sighted in accountability framework meetings.

Accountability Framework Q1 & Q2

- The organisation's lead for Accountability Frameworks attended the October meeting to present the most recent escalations, risks, and domain ratings from each of the care units. Members noted there had been some improvements in domain ratings during the quarter, and requested evidence the Executive team are assured of those pathways to change domain ratings for future reports.
- The Chair of the committee reflected on the positive change over the previous 12 months.

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FINANCE AND PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo (Non-Executive Director)

Committee meeting held: 19 October & 23 November 2023

Assurance (cont'd)

Cyber Security

- The Deputy CIO presented the cyber security assessment, advising our overall risk score has remained the same at 15 and that we have four items of reduced risk around communication, ISAs, DPIAs and unsupported systems. It was explained how the risks with a score of 16 or greater are being tracked and worked with a third party to streamline the management of them. One new risk was discussed for lost and stolen devices.

Strategy Risk Assessment

- The Executive Director of Strategy, Transformation and Digital presented the Digital and Data risk to the committee for the first time with the purpose of highlighting a new BAF risk prior to going to Board at the end of the month, also noting the name change to Digital and Data.

Finance

- The Director of Finance – Operations provided an overview of the month 7 position, drawing particular attention to improved temporary staffing costs and giving assurance around the Cash balance and forecast work undertaken through the internal cash management group and the fortnightly submission to NHS to support national forecasting views.

Information

Analysis of Ligature Risk Programme impact

- The Chief Operating Officer advised this agenda item is being held within the Information Governance & Quality Committee however it has been provided to the Finance & Performance Committee to close an existing action.
- The report noted very few ligatures are made to a fixed point, and door top alarms are having a positive impact. The Ligature Risk Reduction Group regularly meetings and has been focused on therapeutic care, support, and interventions to decrease self-harm.
- The committee agreed only investment and business cases relating to subject this will be presented to the meeting in future.

Finance & Performance Work Plan

- The Executive Chief Finance Officer raised this agenda item, informing the group that the plan requires review to align timings and those responsible for each action.
- An action was agreed for the Executive Chief Finance Officer to take this forward with the Senior Director of Governance and return with an updated work plan.

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FINANCE AND PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo (Non-Executive Director)

Committee meeting held: 19 October & 23 November 2023

Action

No actions for the Board of Directors or other Board Committees this month.

Alert

No alerts for the Board of Directors this month.

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5. PEOPLE EQUALITY AND CULTURE COMMITTEE

Chair of the Committee: Manny Lewis (Non-Executive Director) **Committee meeting held:** 23 November 2023

Assurance

People Strategy
- An update on internal and external engagement carried out to inform the development of the People Strategy 2024-2028 was received.
- A copy of the draft Strategy was discussed and noted that this would be for a wider discussion at the forthcoming Board Seminar in December.

Placement Provider Self Assessment – NHSE
- The Placement Provider Self Assessment was submitted on 7 November 2023.
- Committee members agreed that a forward plan for the 2024 assessment should be produced.

Terms of Reference for the People, Equality & Culture Committee
- With some minor changes, revised Terms of Reference were approved by the Committee and will be reviewed annually.

Alert

No alerts for the Board of Directors this month.

Action

No actions for the Board of Directors or other Board Committees this month.

Information

Emergent and Topical Issues
The Interim Chief People Officer provided an update on current issues, including:
- Recent industrial action on assessment wards had been managed well. There was currently no further industrial action planned, but the Trust was making preparations should action be called.
- Vacancies had fallen below 10% with 174 newly qualified nurses joining in autumn 2023. The Trust received recognition from system partners for its work to reduce vacancies.

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PEOPLE EQUALITY AND CULTURE COMMITTEE

Chair of the Committee: Manny Lewis (Non-Executive Director)

Committee meeting held: 23 November 2023

Information (cont'd)

Time to Care
- Committee members received work stream updates, and a recruitment update for inpatients, urgent care and specialist services.
- A final staffing model and detailed plan of recruitment phasing were also received.

Working in Partnership with People Strategy
- The Working in Partnership with People Strategy was approved by Committee members.
- Committee members agreed that the strategy should be referenced in committee reports, and the Senior Director of Governance confirmed this was a consideration for new cover sheets to be developed in the new year.

Pharmacy Recruitment
- The Deputy Director of Pharmacy provided the latest position relating to staffing for the Trust's Pharmacy Service, noting that many posts had been filled but vacancies still remained.
- The HR and Pharmacy teams would consider how to learn from the recruitment drive, including anticipating in advance where potential candidates may be available.
- The Pharmacy team was also working on retention strategies.
- Committee members commended the work of the Pharmacy team for how they coped during the period of low staffing, and their recruitment success so far.

People Digital Update – Workforce Data & Reporting
Committee members received an update on:
- The current position in relation to workforce reporting and recent developments.
- Current workforce data.
- The future of workforce reporting and the national agenda.

PEOPLE EQUALITY AND CULTURE COMMITTEE

Chair of the Committee: Manny Lewis (Non-Executive Director)

Committee meeting held: 23 November 2023

Information (cont'd)

Anglia Ruskin University

- The relationship with ARU was currently very strong and productive.
- Committee members were presented with an action plan for dealing with current issues, including:
    - Staffing levels on Galleywood and Willow Wards following CQC inspection (October 2022).
    - Areas for improvement highlighted during a routine NMC visit to ARU.
    - Feedback from an ARU listening event in May 2023, during which some students were able to raise concerns.

Apprenticeships

- An update on apprenticeships included the Trust's aspirations to expand its internal and external apprenticeship portfolio to maximise the levy available.
- Committee members agreed that apprenticeship levy spending should be added to KPIs.

EPUT Leadership Programmes

- An update on the internal leadership programme was provided by the Organisational Development Team.
- The RISE and ward management development programmes had been very popular, and applications were open for the next phase.
- Committee members agreed that training should be provided for middle management, to enable them to support staff during the Lampard Inquiry.

8.3 BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

Information Item | Professor Sheila Salmon | 5 minutes

REFERENCES

Only PDFs are attached

BSOG Report 29.11.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

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

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report provides details of the following:

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

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

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

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

Acronyms/Terms Used in the Report			
ESOG	Executive Safety Oversight Group	BSOG	Board Safety Oversight Group
SOP	Standard Operating Procedure	ePMA	Electronic Prescribing and Medicines Administration
LCP	Learning Collaborative Partnership	LRRG	Ligature Risk Reduction Group
ESLMS	EPUT Safety and Lessons Management System	EMIS	Egton Medical Information Systems
SRO	Senior Responsible Officer		

Supporting Reports/ Appendices /or further reading
Board Safety Oversight Group Report

Lead
Add signature **Name:** Sheila Salmon **Job Title:** Chair

Board of Directors Part 1
29 November 2023

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

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

In this period the key areas of focus for the Executive Safety Oversight Group (ESOG) and Board Safety Oversight Group (BSOG) remains with Ligature Risk Reduction, EPUT Culture of Learning, Embedding Gold Standard SOPs and Electronic Prescribing and Medicines Administration (ePMA).

Ligature Risk Reduction

The focus of the ligature risk reduction programme remains on the environment of our in-patient estate, the pilot of the ligature related training programme, and the analysis of ligature incidents within the Trust.

Environment
An agreed programme of planned estates works is reported regularly to ESOG and BSOG with the focus currently on:

- Trust wide hinge replacements
- Trust wide door closure replacements
- Improvements at Brockfield House

A Covid outbreak caused minor delays to hinge replacement work on Ruby Ward but this has now been resolved and works are continuing.

Whilst installation of the door closers took place at the Linden Centre and The Crystal Centre, issues were identified at The Lakes which require review by the Ligature Risk Reduction Group (LRRG) ahead of final installation.

Works continue as per the plan at Brockfield House with phases 1 & 2 complete.

In addition, the teams have completed Patio door replacements at Peter Bruff Unit and Garden Improvement works at The Lakes.

Training
Following a successful ligature training pilot the training team have been conducting a scoping exercise to identify any further ligature training requirements and will take these findings to LRRG in November and then to the Executive Team in December.

Practice
The lessons team completed detailed analysis around ligatures and presented this to BSOG in November.

Embedding of Gold Standard Operating Procedures (SOPs)

Work has taken place to simplify & streamline the SOP sign-off process and to re-baseline sign-off dates in line with this new process.

Additionally, EPUT digital colleagues have been working with Carradale to finalise details for the digital platform SOPHIA including uploading this to EPUTs power platform environment. Two initial

SOPs have already been uploaded to Sophia with a further 10 ready for upload once they have been through final review and two with minor amendments to content required.

SOPHIA was demonstrated at BSOG at the beginning of November and a 'go live' date has been agreed for pilot running of the app in late November.

EPUT Culture of Learning (ECOL)

EPUTs Safety and Lessons Management System (ESLMS) was demonstrated to key stakeholders in October with a further demonstration session planned for November.

The safety dashboard received funding approval from the Capital Planning Group which will enable the final build to take place.

A dedicated Manchester Patient Safety Framework (MaPSaF) session took place at the end of September for the senior leadership group. This tool helps healthcare teams and organisations assess their progress in developing a safety culture.

In addition the EPUT training team continue to refine the redeveloped ECOL training slides in line with the ECOL handbook and these will be ready for release on the oracle learning management (OLM) system in November.

Electronic Prescribing and Medicines Administration (ePMA)

The system set-up commenced at the beginning of November, slightly later that planned due delays to the on-boarding of the project team and the deployment of the "test" and "train" Health Application Platform (HAP) infrastructure, however this has not impacted the overall programme timeline.

EMIS have released the test environment and EPUT completed the business continuity server build and released this to EMIS. EMIS were then able to commence the business continuity environment configuration and finalise the HAP infrastructure build milestone.

Report prepared by

Alison Ives,
Deputy Director of Transformation

On behalf of
Professor Sheila Salmon
Chair

8.4 CQC COMPLIANCE UPDATE

Information Item | Frances Bolger | 10 minutes

REFERENCES

Only PDFs are attached

CQC Compliance Update 29.11.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**CQC Compliance Update**					
Executive/Non-Executive Lead:	Frances Bolger, Interim Executive Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Executive Operational Committee and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The purpose of this report is to: 1. Provide an update on related CQC activities within the Trust. 2. Provide details of guidance/updates that have been received since the previous report up and to the end October 2023.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Note the progress update on the Improvement Plan
3 Request any further information or action

Summary of Key Issues

- EPUT is registered with the CQC.

- Following the unannounced inspection of Rawreth Court in September 2023, the Trust received the final inspection report 10 November 2023. The report highlights a number of good practises which were identified by the CQC inspectors during their visit. However some

concerns have been identified affording the Trust opportunities to improve. The Trust is required to submit an action plan to address the findings by 30 November 2023.

- The Trust continues to focus on implementation of the CQC improvement plan which as previously reported is a combined action plan including all actions from recent CQC visits and inspections.

- Good progress continues to be made with implementation of actions with 5 Must do actions closed in total (7%) 2 of which have been presented and accepted at the Evidence Assurance Group held with Trust ICBs. 195 sub-actions have been completed (71%) (next step evidence review before closure) .There are 7 sub-actions that are past timescale, please refer to appendix 1a

- The CQC undertook 3 MHA inspections in September 2023 and 1 MHA inspection during October 2023

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
EOT	Executive Operational Team	EAG	Evidence Assurance Group
PICU	Psychiatric Intensive Care Unit		
MHA	Mental Health Act		

Supporting Documents and/or Further Reading
CQC Compliance Report Appendix 1 – Improvement Plan Update November 2023

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC COMPLIANCE UPDATE

1. INTRODUCTION

The purpose of this report is to:

1. Provide an update on related CQC activities within the Trust.
2. Provide details of guidance/updates that have been received since the previous report up and to the end October 2023.

2. CQC REGISTRATION REQUIREMENTS

2.1 Registration Requirements

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

2.2 Rawreth Court Rating

On 10 November 2023, the Trust received the CQC final inspection report for the Rawreth Court. The CQC have rated Rawreth Court overall as Requires Improvement and issued warning notices for Regulation 12 and 17. The full report can be found on the CQC website.

The overall rating for this service remains unchanged from the previous report published 9 March 2019.

3. CQC INSPECTIONS

3.1 CQC Action plan Implementation

The Trust focus continues on the implementation of the CQC improvement plan which overseen by the CQC Action Leads meeting.

The 'Action Plan Delivery' phase is scheduled to run through until March 2024. As of the 16 November 2023:

- 5 Must do actions complete (7%)
- 2 of the above complete actions have been reviewed and closed through the Evidence Assurance Group (with the other 3 to be presented at the next meeting of the Evidence Assurance Group)
- 195 sub-actions complete (71%) (next step evidence review before closure)
- 7 sub-actions are off plan (Nb. The associated overall must/should do action remains on track), please refer to appendix 1.

The Evidence Assurance Group held their first meeting on the 6 November 2023 and was be chaired by Giles Thorpe (MSE ICB Chief Nurse). The meeting was positive with constructive challenges and questions from ICB partners, which our operational teams were able to effectively talk through and answer. There were no escalations of risk to closure and the Group approved the recommendation to close the two actions reviewed.

Assurance metrics to demonstrate sustainable change continue to be developed.

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

3.2 Unannounced Inspection Rawreth Court September 2023

Following the unannounced inspection (Sept. 2023), the Trust received the final CQC Rawreth Court report.

The report highlights a number of good practises which were identified by the CQC inspectors during their visit (10 Nov. 2023).

The report highlights a number of good practices which were identified by the inspectors.

- Staffing levels and the deployment of staff were suitable.
- Recruitment practices at the service were safe.
- Most people and their relatives told us they or their family member were treated with care and kindness.
- People were supported or enabled to take part in regular social activities.
- People were protected by the prevention and control of infection.
- Staff had received an induction and formal supervision.
- The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when needed.

However, there are identified concerns, affording the Trust opportunities to improve. The following outlines the actions the CQC have asked the Trust to address:

- Care plans were not in place for all people using the service and people did not always receive person-centred care that met their needs.
- People were not always treated with dignity and respect.
- Suitable arrangements were not in place to gain consent from people using the service or those acting on their behalf or to act in accordance with the requirements of the Mental Capacity Act 2005.
- Improvements were needed to ensure the dining experience was positive and peoples' nutritional and hydration needs were met and monitored.

The Trust is required to submit an action plan to address the findings by 30 November 2023, following which the actions will be incorporated into the main CQC Improvement Plan. The CQC have issued Rawreth Court a new ratings posters which once printed will be displayed on the premises.

On 3 November 2023, our ICB colleagues undertook a quality assurance visit at Rawreth Court.

Using the learning from the above inspection, an internal compliance visit has been undertaken at Clifton Lodge with actions being taken forward by the leadership team.

3.3 CQC Mental Health Act (MHA)

There have been three MHA inspections during September 2023, Ardleigh Ward, Gosfield Ward and Galleywood Ward and one MHA inspections during October 2023, Peter Bruff Unit.

Following each inspection, a monitoring report is received by the ward with recommendations for improvement. All wards, supported by the MHA Office, develop action plans to address these recommendations.

4 ACTION REQUIRED

The Board of Directors is asked to:

1 Receive and note the content of the report
2 Note the progress update on the CQC Improvement Plan

Report Prepared by:
Nicola Jones
Director of Risk and Compliance

On behalf of
Frances Bolger
Interim Executive Nurse

20 November 2023

Appendix 1:

CQC Improvement Plan Update

22 November 2023

CONTENTS

Introduction

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

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

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

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

Level of Assurance: Level 1

Key Messages

There are 67 'must do' / 'should do' actions being taken forward (Note: combination of some actions into one), with 274 sub-actions (as at 16 Nov'23) associated with CQC activity.

There are 54 actions associated with EPUT internal inquiry following the Dispatches Programme.

Overview:

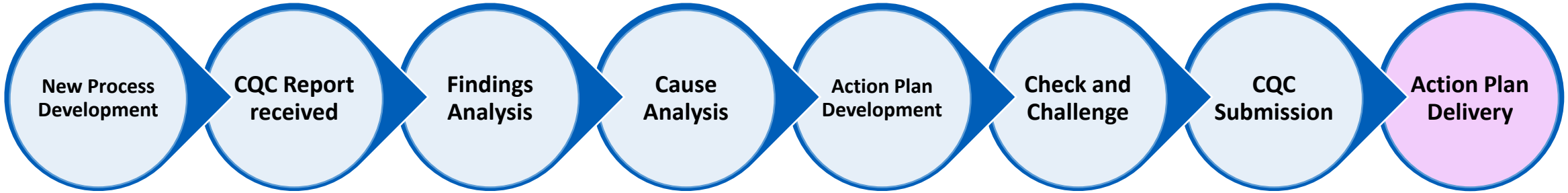
- 5 'must do' actions have been completed (with 2 being agreed for closure through the Evidence Assurance Group) and 196 sub-actions have been completed (moving to evidence assurance stage)
- 39 internal inquiry sub actions have been completed

Before actions are formally closed a review of evidence is undertaken.

7 sub-actions are past timescale (Nb. The associated overall actions remain on track)

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

2. Process Update



- Process designed
- SOP developed

- Draft CQC Report received April 23
- Factual accuracy check completed
- For note final report published 12th July 2023

- 45 Must do actions
- 26 Should do actions

Findings grouped
30 'Just do it'
42 'Solution analysis (inc Cause Identification)'

Finding owners identified (must do / should do action lead)

- Cause analysis undertaken using mix of SEIPS and Fishbone

Note: large group of stakeholders were met with (>100 individuals) and encouraged to share the 'truth and reality' behind the findings

- Solution sessions held looking at cause analysis

Solution sessions held looking at just do actions

For each action considered
action type (Remedial / Corrective / Preventative)
Action timescale
Action lead
Action Metric

- Compliance Team check and challenge

Actions presented to CQC Action Lead Group

Action plan shared with Executive Team

Action plan shared with ICBs

- Action Plan submitted to CQC

- CQC Leads Meeting
- CQC Operational Groups
- Metric Monitoring

We are here

March	April	May	June	July	August – March 24

Action Progress Update

NHS
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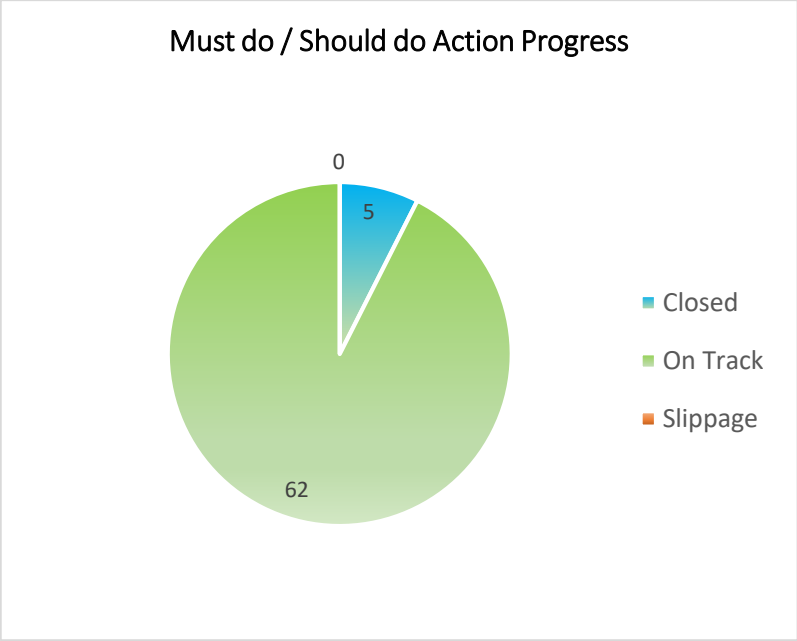
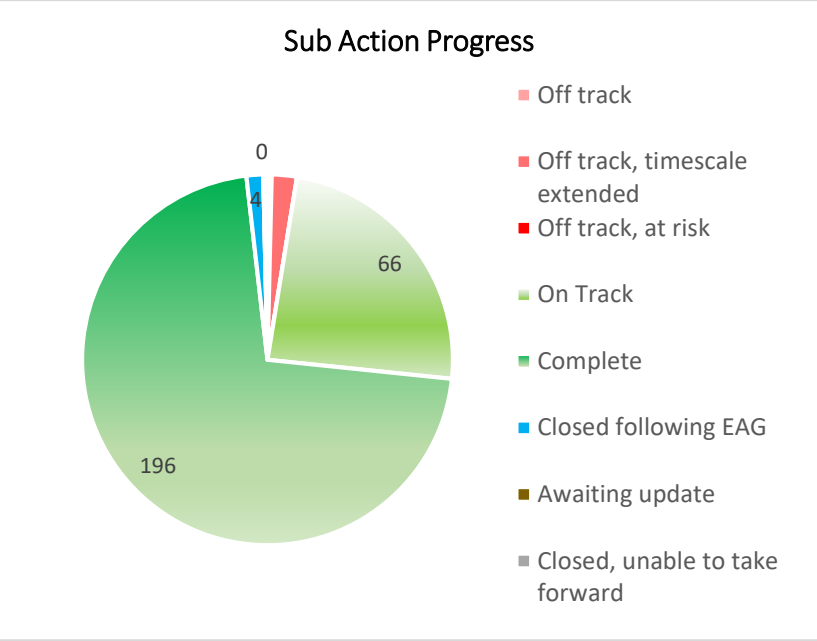
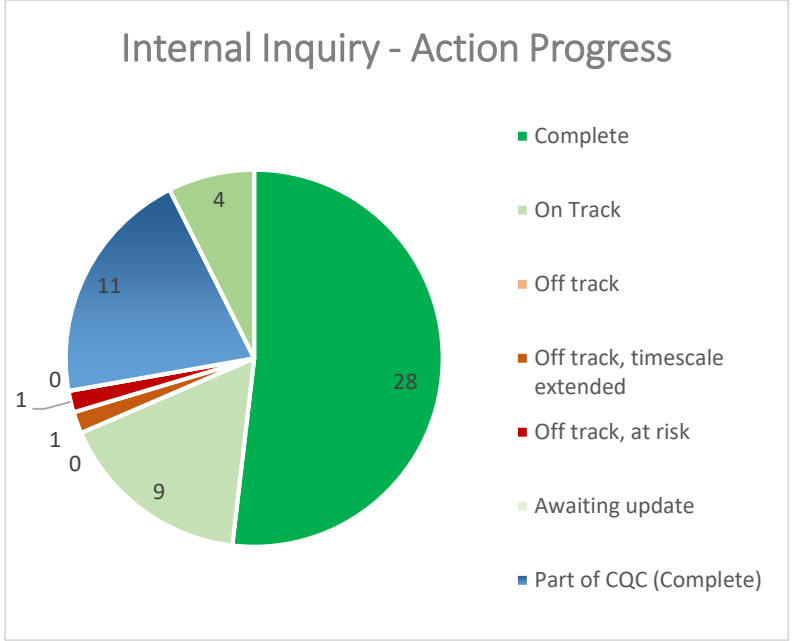
Summary of implementation status

- 67 Must do / Should do actions (note some of the original actions have been combined)
- 274 Sub-Actions identified as at 22.11.23
- 5 Must do action complete in total (7%) (2 being agreed for closure through the Evidence Assurance Group)
- 196 sub-actions complete (next step evidence review before closure)
- 7 Should do sub-actions past timescales
- 54 Internal Inquiry sub-actions with 28 complete and a further 11 complete as part of CQC actions







Summary of activities and highlights

NHS
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NHS Foundation Trust

Summary of key activities completed in the last month:

- M3 ‘SOPHIA’ host for SOP’s being piloted
- M6 Galleywood and Willow screens installed. Awareness of Datix capability for feedback developed
- M7 E-observations roll out complete on all adult wards
- M9 Restrictive practice decision making tool available online for patients. New national learning system includes function for patients, carers, public
- M14 Therapeutic Engagement and Observation learning event taken place
- M17 Old Restrictive Items List removed from wards
- M20 Racial debrief form relaunched as part of Black History Month.
- M23 CPPG agreed funding for Search Room at BMHU
- M30 Medicines Management Reference guides available
- S2 vision and values discussion in appraisals / 1-1 Support template
- S16 meaningful activities safe and appropriate for older adult developed

Actions Closed

2 actions closed this month following EAG (Ligature Cutters and Blind Spots).
There are a further 3 must do/should do actions complete and ready for closure which are being taken through evidence assurance processes

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (7 Sub-actions are past timescale)		
Action	**Current Position**	**Recovery Plan**
M9.6 - Review availability of information outlining identified restrictions on the wards for patients	New welcome pack developed	Waiting for review and sign off by Director
M10.2 - Time to care programme	Programme presented to Trust Board and now awaiting feedback from commissioners	Meeting booked
M17.2 – Restrictive items posters and lists to be included in the welcome packs	New welcome pack developed	Waiting for review and sign off by Director
S5.1 – Undertake review of HTT operational model against Royal College of psychiatry benchmarks	Underway but considerable work so taking longer than first thought	Review has been completed with findings to be written up (Nb. Delayed past the October '23 deadline as a consequence of action owner in attendance at Coroners Court.
S6.1 – Undertake an audit of current assessment of physical health against the Royal College of Psychiatrists	Underway but considerable work so taking longer than first thought	Review has been completed with findings to be written up (Nb. Delayed past the October '23 deadline as a consequence of action owner in attendance at Coroners Court.
S6.2 - link case note review into individual 1-1 Support sessions.	Assurance that practice is happening.	To strengthen process, supervision forms updated to include prompt. To go through ratification in December
S17.2 - Review how staff on long term leave are reflected on systems	Immediate risk resolved as all staff on Tower have had their training. Currently only manual process.	Percentages and mandatory statistics takes into consideration those on long term sick and maternity leave.

Focus in the next month

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Focus in the next month

- CQC Leads Group to continue receiving evidence for completed actions to undertake check and challenge
- Further development of Metrics report to ensure monitoring the impact changes we are making
- Continued implementation of practice assurance toolkit for wards/services to provide assurance of delivery and change at local level

9. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

9.1 BOARD ASSURANCE FRAMEWORK 2022/23

Discussion Item | Denver Greenhalgh | 10 minutes

REFERENCES

Only PDFs are attached

Board Assurance Framework Report November 2023.pdf

Agenda Item No: 8a

SUMMARY REPORT	BOARD OF DIRECTORS	29 November 2023

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	All high-level risks included in the Strategic and Corporate Risk Registers.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	**X**
	SR2 People (workforce)	**X**
	SR3 Finance and Resources Infrastructure	**X**
	SR4 Demand/ Capacity	**X**
	SR5 Statutory Public Inquiry	**X**
	SR6 Cyber Attack	**X**
	SR7 Capital	**X**
	SR8 Use of Resources	**X**
	SR9 Digital and Data	**X**
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	

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	No

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

Recommendations/Action Required

The Board is asked to:

1 Note the contents of the report
2 Note the addition of the new risk SR9 Digital and Data to the strategic risk register
3 Request any further information or action

Summary of Key Issues

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

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

The Board is asked to note:

- Section 1 – Board Assurance Framework dashboard providing an oversight

- Section 2 – New risks SR9 Digital and Data

  The context of this risk is the strategic ambition of the organisation to become a digitally capable, data driven organisation supported by modern digital tools, where our people will be supported to acquire the digital skills needed to operate safely and confidently in their use of modern digital platforms to deliver the highest quality and safest care possible.

  The revised Digital Strategy, alongside the Data Strategy are risk assessed together to identify the impact of non-delivery on the wider organisations strategy.

  The assessment is focused on the capacity, capability and resourcing to support the digital and data transformation set out in the digital and data strategies

  The likelihood of the risk being realised being based on the likelihood of conditions that place constraints on the ambitions of both the digital and data strategy, e.g. capability, resource availability and transformation programme prioritisation**.** A rating of 3 has been identified the strategies provide clear vision but require a clear plan with appropriate capability and resources secured to support delivery.

  The consequence should the risk be realised is based on the inability to realise the wider organisations strategic ambitions as well as the inability to maintain regulatory and compliance data security and cyber assurance. The inability to ensure that our patient data systems are fit for purpose and remain safe for use at the point of care rated at level of 5.

  This provides a risk exposure score of **15** (C5 x L3) and the risk entry provides set of action which will be taken to moderate the risk and put in place controls to either reduce the likelihood or the consequence of a risk being realised.

- Section 3 – Strategic Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer

- Section 4 – Corporate Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Responsible Officer

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	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			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			X
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

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

Supporting Reports/ Appendices /or further reading

- New risk Digital and Data (SR9)
- Board Assurance Framework Dashboard
- Strategic Risk Register
- Corporate Risk Register

Lead

Denver Greenhalgh
Senior Director of Governance & Corporate Affairs

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

29 November 2023

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

BAF Dashboard

November 2023

EPUT

Strategic Risks

NHS
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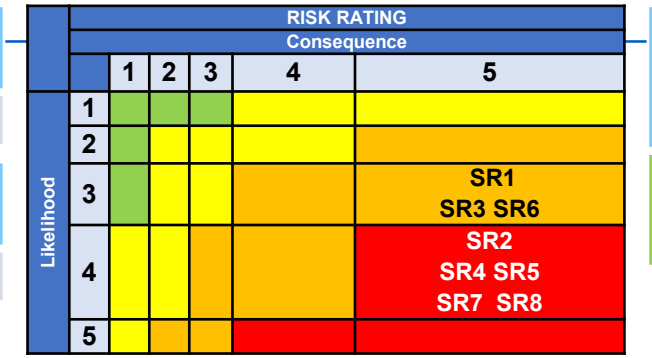
Existing Risks	Recommended New Risks	Recommended for Change in rating	Recommended for Closure
8	1	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	8	8	8



% Risks with Controls Identified	% risks with assurance identified	Actions overdue
100%	100%	4

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4=20	20 > 20 > 20	National challenge for recruitment and retention	• Vacancy and turnover rates <10%, below national averages boosted by record number of preceptors and final cohort of international recruits. • Development of the People and Culture Strategy is on track for January '23 • A recovery plan has been set for overdue HR policy reviews (impacted by industrial action) • WRES, WDES published, and new plan for equality, diversity and inclusion (EDI) in development, and incorporates the work to improve the experiences of minority staff.
SR5	1	Statutory Public Enquiry	Compliance, Reputation	NL	5x4=20	15 > 20 > 20	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	• 01 November 2023 it was announced that Inquiry would be renamed the Lampard Inquiry, with consultation on the proposed terms of reference underway. • Due to the changing nature of the inquiry note the removal of Independent Director and Independent Clinical Advisor.
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4=20	20 > 20 > 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Continuing to horizon scan to maximise opportunities both regional and national to source capital investment
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x4=20	20 > 20 > 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	• Year to date £1.6m behind plan, enhanced role of Transformation Steering Group to support efficiency development and delivery. • In-year forecast completed in line with national guidance • Trust continues with intention to deliver breakeven.

Strategic Risks (continued)

Essex Partnership University NHS Foundation Trust

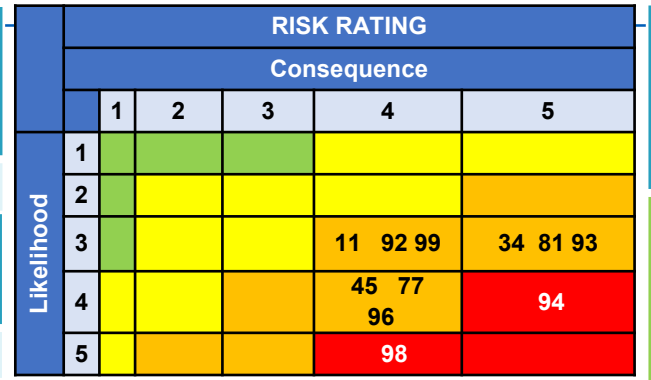
ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4=20	20 → 20 → 20	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	• Time to Care implementation of year 1 priorities progressing. • UEC / Inpatient MH Flow Action Plan developed with Year 1 and 2 priorities set. • Expanded flow team with new controls added in the form of Clinical Flow Lead and Clinical Director Flow providing oversight of purposeful admission to inpatient care. • Discharge Coordinators – all funded posts appointed to with individuals in post.
Score <20 (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x3=15	15 → 15 → 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• PSIRP has been out for comments since May including with ICBs. Now moving to executive approval and then formal ICB approval. Publication aim September 2023.
SR3	All	Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 → 15 → 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	• Commercial strategy socialised at Board Seminar (Oct '23) and to be presented to Board at its November 2023 meeting for approval. • Estates Strategy development on tack for March 2023.
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	ZT	5x3=15	15 → 15 → 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Development of business continuity and disaster recovery plan is on track. • Action from IT Security Health Check and Penetration Testing – all complete with the exception of one item. This is outstanding as the use acceptance testing phase for planned upgrades was unsuccessful and has been rescheduled for early December 2023.

Corporate Risks

NHS
Essex Partnership University
NHS Foundation Trust

Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
11	0	0	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	11	11	8



% Risks with Controls Identified	% risks with assurance identified	Actions overdue
100%	100%	6

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	• Number of actions have been completed with reassessment of risk score being undertaken (report next cycle) • New action to focus on delivery of Safe Wards Interventions.
CRR98	Pharmacy Resource	Safety	NH	4x5=20	20 20 20	Continuous state of business continuity plan	• The Pharmacy Service continues to progress with the recruitment campaign • Movement seeing vacancies to below 20 (15.1). Currently have 3.4 WTE due to join in early 2024. Pharmacy have successfully recruited and have 31.9wte in post (since last September). • Pharmacy remains in BCP; BCP reviewed monthly in team meeting. Frontline delivery is still holding up with no specific incidents linked to BCP status.
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12 15 15 15	Implementation of suicide prevention strategy	• Draft Suicide Prevention Framework is in sign off phase and is aligned to the new National Suicide Prevention Guidance issued Sept. '23. • The Framework will delivery against the priority as stated in the Quality of Care Strategy (for Board approval November '23) • Safe Wards training programme has been completed, with 160 staff trained and now focusing on implementation of Safe Wards Interventions. • STORM training available and attendance being tracked.
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	16 16 16	Implementation of suicide prevention strategy	• New version of STORM training • Continue to expand capacity of STORM facilitators within the Trust (currently have 11).
CRR45	Mandatory training	Safe	SL	4x4=16		Training frequencies extended over Covid-19 pandemic leaving need for recovery	• TASID (Therapeutic and Safety Interventions) Training on track with recovery programme for all substantive staff to be back on annual review from December 2023.

Corporate Risks (continued)

NHS Essex Partnership University NHS Foundation Trust

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR77	Medical Devices	Safe, Financial, Service Delivery	FB	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• Deep dive is concluded and the policy and procedure has been updated and approved. • 16/18 management actions arising from internal audit have been completed.
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	16 16 16	Patient safety incidents	• Development of the most effective system for recording ligature actions work is progressing. • Garden standards reviewed and being added to Ligature Policy and Ligature Inspection Tool • Risk stratification document has been reviewed and approved. This will be reviewed quarterly. • New training proposal has been approved and is being enacted.
CRR92	Addressing Inequalities	Experience	SY	4x3=12	12 12 12	Staff Experience	• EDI Hub has been developed which includes resources and guides for staff. • Induction material is in development and will replace our EDI (positive cultures) mandatory training for new starters. • EDI framework has been undated.
CRR93	Continuous Learning	Safety, Compliance	FB	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. • Quality and Safety Champions roles has been established, with 84 people on the register. • LifeQI platform contract renewed with circa 100 staff registered and 50 projects live. • The future model for QI is under development as part of the Quality Assurance Framework. • Safety and Lessons Management System (ESLMS) is in the digital test environment and if successful will move into the live environment.
CRR96	Loggists	Compliance	NL	4x4=16	16 16 16	Major incident management	• EPRR team are now able to provide in-house Loggist training • The role of Loggist has been agreed to be added to the duties of Executive Directors Pa job role.
CRR99	Safeguarding Referrals	Safety	FB	4x3=12	16 16 12	Escalation from operations and high increase in referrals	• Safeguarding forms agreed by Transformation Steering Board and now with system design for assimilation in to all 3 systems - the 'go live' decision point will be when all 3 EPRS are ready for use. • Continue to build capacity within the team through recruitment / role redesign.

New Risks

November 2023

SR9- Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 = 10*

Executives Responsible Officer: Executive Director of Strategy, Transformation and Digital
Board Committee: Finance & Performance

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

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Digital Transformation programme Plan	Feb '24	JL/AW	Road Map	Revised Digital Strategy awaiting approval.
2	Business case to support transformation programme plan (Secure funding)	Feb '24	JL/AW	Control	Revised Digital Strategy awaiting approval.
3	Data warehouse and governance implementation	Dec '23	AW	Control	Design signed off and cloud platform readiness complete, data security model approved - imple

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
4	Digital target operating model implementation	July '24	AW	Control	Maturity assessment and roadmap to HIMSS level 5 identified - Target operating model development underway
5	Cloud migration tender	Dec '23	AW	Control	Cloud landing zone complete – migration plan in development
6	Service desk transformation plan development	Mar '24	AW	Road Map	Funding agreed – negotiations with MSEFT on a shared platform using their existing system
7	Clinical safety Officer framework development	Mar '24	RP	Control	Framework under development

Strategic Risk Register November 2023

SR1- Safety (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. ***New timeline*** : in line with the PSIRP delivery timeline for March 2025. First step is to undertaken thematic analysis of the 10 key areas to information Safety Improvement Plans. 3 are complete, 2 are in progress and the final cohort will be completed in Q4.
2	Deliver Yr3 - Patient Safety Strategy (Safety First Safety Always	Mar '24	FB	Control (Road Map)	See BSOG Report.
3	Complete automation of two dashboard elements	July '23	MS	Control	Feasibility assessment to automate the transfer of data between IWGC and the Safety Dashboard has been completed and development is ongoing. Next touch point December
4	Implement Quality Improvement Programme	Mar '24	SY	Control	Contract renewed for use of LifeQI Platform, with circa 100 staff registered and 50 projects live. The future model for QI and associated resources has first review by the Executive Team and will be represented in Jan '24 for approval and consideration in the 2024/25 business planning cycle.
6	Implement EPUT Lessons Identified Management System (ESLMS)	Nov '23	MA	Control	This is in the digital test environment, for the Lessons Team, with a full proof of concept day 27 Nov '23.If successful the system will move into the live environment.
7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	July '23	SY	Assurance	Discussions ongoing with the Care Groups to establish joint team approach. Review of templates for action plans completed and implemented. Working with Datix team to ensure action plans are stored electronically and visible to action owners.

SR2- People (At a Glance)

Risk Description: If EPUT does not effectively address and manage staff supply and demand, then we may not have the right staff, with the right competencies, in the right place at the right time to deliver services, resulting in potential failure to provide optimal patient care / treatment and the resultant impact on quality of care (safety, effectiveness and experience).

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate.

Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the Sit Rep Return; staff morale; availability of key staff; attendance at key training.

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 = 15*

Executive Responsible Office: Interim Chief People Officer
Board Committee: PECC

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
People & Culture Team / Hr Policies	Leadership Team Established Interim Chief People Office - awaiting appt. of substantive CPO		
Care Unit Staffing Plans	Workforce plans in place Safer staffing reports	Quality and Performance Scorecard	CQC Inspection - regularity of temporary staffing on inpatient wards (negative assurance)
Recruitment and Retention Programme	Vacancy rate 9%, with mental health nursing in Inpatient and Specialist Services approaching full establishment	PECC reports	
Workforce Plans and Strategies	Establishment reviews Framework for health and wellbeing	PECC reports	NHSE & System Workforce returns / benchmarks
Training and Development	Training Tracker in place RISE Programme (completed)	Training and Development report to PECC	Staff Survey / OoAPT successful June '23 / Ofsted Inspection July '22 - Good
Staff Wellbeing Offer	Engagement Champions Employee Experience Managers	Employee Experience reports to PECCC	Staff Survey / Quarterly Pulse
Just Learning Culture	Behaviour Framework FTSU Guardian	Employee Experience reports to PECCC	Staff Survey
Equality and Inclusion Framework	Executive led sponsors for networks ED&I objectives in appraisal Racial abuse guidance for staff and debriefs		WRES / WDES Data

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Time to Care Programme (business case)	Complete	AG	Control	Time to Care Business Case has been approved by Board and identification of future year resourcing is through commissioning contracts. Action closed as now moved into business planning for 2024/25.
2	Develop People and Culture Strategy (incorporating previous action to implement an Education Strategy)	(Dec '23) Agreed change to Jan '24	MR	Road Map	Development of the People and Culture Strategy is on track for January '23 (date agreed by Executive Team and PECC). This action now includes action 3 from last reporting round - as will incorporate the Education and Learning Development Strategy component. (action 3 closed)
4	Review long-term strategy for smart working	Mar '24	FW	Control	Following a pause in the Flexible Work Group this is being reset with the remit of taking the thinking on SMART working into the emergent Estates Strategic Plan. Timeline amended to ensure alignment (Mar '24)
5	Recovery plan for delayed HR policies	Sept '23	DP	Control	Action remains overdue its stated timeline - A number of documents are beyond the stated review timelines, with industrial action having impacted on HR capacity to achieve the reviews. A revised recovery plan has been agreed through the Policy Oversight and Ratification Group with a staggered approach to be delivered by end of March '24 (to safeguard against further industrial action). There is a co-dependency on any changes being agreed with Staff Side. Current documents have been assessed as fit to continue in use by subject matter experts.

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
6	Produce new programme on improving inclusion, particularly for those with worst experiences, and brief Board, as the next phase of EDI plan	Dec '23	LH	Control	Presented to Board Seminar in October '23, and a new plan focusing on Executive accountability, abuse on wards and data driven outcomes is being developed. This action is a refinement on action 6 and incorporates the work to improve the experiences of minority staff component. ***(amendment to action)***
7	Deliver agreed objectives with MSE ICB to reduce vacancies and temporary staffing	Mar '24	PT	Control	MSE ICB updated in October and content. Vacancy rate at 9%, as is turnover, with mental health nursing in Inpatients and Specialist services approaching full establishment
8	Review of Operating Model and Structure of P&C Directorate to support organisation to meet its strategic objectives	Mar '24	MR	Control	Awaiting appointment of substantive CPO to inform plans
9	Ensure robust plans are in place to mitigate the impact of strike action	Ongoing	DP	Control	Ongoing business continuity preparation. Successful management of strike action this year, with effective collaboration between HR and Medical. Awaiting update from unions on further strikes

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update (Date)**
1	Develop Commercial Strategy	Draft - Jun '23 Final - Oct '23	MM	Roadmap	Commercial Strategy socialised at Board Seminar (October '23) and to be presented to Board at its November '23 meeting for approval.
2	Develop Estates Strategy & Development Plan (as informed by the 6-facet survey)	Mar '24	MM	Roadmap	Internal delivery group set up with the purpose of delivering the strategy by the end of March '24. External consultancy support has been agreed and with timescales.
4	Review tenancy responsibilities / leased property risks, staff vs property owner accountability, PFI contract deficiencies	Dec '23	JD	Control	Both PFIs have had a deep dive over the past six months, with restructured engagement with organisations to manage contractual terms.
5	Business case related to additional estates resource to be prepared prior to budget setting round 2024/25	Mar '24	LM	Control	

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 = 15*

Executive Responsible Office: Executive Chief Operating Officer
Board Committee: BSOG and F&P

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

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
1	Time to Care Programme	Dec '23	AG	Control	Time to Care Programme approved by Board moved into implementation for year 1 priorities. Conversations with commissioners are ongoing. Now in Phase 2 - submission of TTC staffing model initiative prioritisation form for integrated flow team roles completed.

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
3	Analysis piece on demand vs capacity	Phase 1 May '23 further phases to be added	JL / SG	Control	Developed demand and capacity application to assist in planning and opportunities for efficiencies. Patient admission risk application also developed to help stratify those at risk of admission to support early intervention and pathway improvements. Work ongoing on data flow. **(Looking to set timeline for further phases by next reporting)**
4	Delivery of the overarching UEC / Inpatient NH Flow Action Plan	Dec '23	Detailed actions have individual leads	Control	Action complete - Plan developed with Yr. 1 and 2 priorities set. Improving Flow Operational Group established with good progress against Yr1 priorities. Review of actions to be undertaken to ensure Yr1 and 2 are captured prior to closing this action.
4.1	Implement Governance	Mar '24	Project Group	Assurance	Governance structure in place with reporting to the Mental Health Urgent Care and Inpatient Care Unit / Accountability Framework
4.2	Reclassification of OoAP contracted beds	Mar '24	Project Group	Control	Underpinning joint working quality and continuity principles have been refreshed with providers. Contract discussions approaching finalisation. Once contracts agreed, resubmission for ongoing reclassification to 'approach OoAP' can be made.
4.3	Robust oversight on patient flow and OoAP with ownership	Mar '24	SBr/ JSE/ Community AD and OSM/ RK/ EW AG/	Control	Expanded flow team - see new control re: Clinical Flow Lead (TTC) CD Flow providing oversight of purposeful admission to inpatient care. Additional Discharge Coordinator to support timely discharge from OoAPs and repatriation. Regular Inpatient and HTT consultant flow meetings established and having impact.
4.4	Improving Sit Reps	Mar '24	AW/ SBr/ KT/ TTC/ JL	Control	PDSA to SitRep completed - incorporating safer staffing and core SMART model providing indicative OPEL status Bed Management Team transferred to MHUC Care Unit Second phase PDSA aligned to implementation of SMART demand module- plan for implementation Dec'23 Third phase PDSA to include SMART Capacity / Ward Level Data (paused awaiting outcome of TTC admin staffing)
4.5	Discharge Co-ordination	Mar '24	CW/ TR/ SBr/ JSE/ EW/ SJ	Control	All funded posts appointed to with individuals in post. TTC proposal for integrated flow team staffing resource has been scoped (pending sign off) Additional unfunded resource in place for oversight of OoAPs. 2 Essex County Council Move On Facilitators are working as core members of the Adult Discharge Team
4.6	Reducing variations across wards	Mar '24	Project Group	Control	Acute Inpatient Operating Model in development (to include purposeful admission; trauma informed care; therapeutic inpatient care; effective discharge) Plan for draft chapters to be in place for end Dec '23 with collation and review to follow.
4.7	GIRFT Ambition	Mar '24	LW/ GO/ KS/ GW/ ES/ NR/ LG/ AG/	Control	EPUT and System workshops held.
4.8	System transformation supporting alternatives to admission	Mar '24	MK/ LW/ AW/ SBr/ SG/ GW/ ZT/ LA/ JCB	Control	MSE MHUCD operational. Ambulance cars in place in MSE and NE; Crisis House / Café in place; MH accommodation pathway review and recommissioning completed NE / WE and MSE commenced. MADE events held.

SR5 - Statutory Public Inquiry (At a Glance)

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

Likelihood based on: the possibility that the Trust cannot effectively meet the requests of the Inquiry nor embed earning, resulting in damage to its reputation and potentially poor CQC ratings

Consequence based on: National media coverage, parliamentary coverage and a total loss of public confidence

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L4 =20*	*C5 x L2 = 10*

Executive Responsible Office: Executive Director Major Projects
Board Committee: Audit Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Project Team Support from external consultants with experience of inquires.	Establishment Expanded to meet increased ask	EOC and Audit Committee oversight	***Removal of Control (due to changing nature of inquiry) -*** Independent Director and Independent Clinical Advisor in place
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group Oversight	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	Reporting ET / Audit Committee and Auditors	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	***Removal of Control (due to changing nature of inquiry) -*** Independent Director and Independent Clinical Advisor
Learning from Deep Dives	Deep dive into sample of deaths in scope over 20 year period Deep dive in 13 prevention of future death notices		
Audit on Learning from Independent Inquiry		Assurance checks completed and presented to ET - approved ongoing assurance through Care Unit Accountability Frameworks	IA - opinion moderate for design and effectiveness

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
3	EPUT should assure itself that its information processes and systems are fit for purpose, and controls around data input and records management to be reviewed across the Trust to minimise risks associated with information recording and management going forward.	Mar '24 Completion of actions	GB	Control / Assurance	Records archiving provider due to transfer to a new provider (Restore). Cataloguing of records being completed in house and will be finalised by the new provider.
4	Key historical SI themes to be embedded within safety and quality initiatives across the Trust.	Complete	AW/MA	Control / Assurance	Action Complete: The Quality of Care Strategy will be presented for approval at the Board (Nov '23). Eight Quality Senates will be held per annum and will utilise evidence based knowledge, historical learning themes, listening to expert presentation and gap analysis on current practice to gain consensus recommendation and advice to the Executive (and Board) to deliver evidence based effective care.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L3 =15*	*C4 x L3= 12*

Executive Responsible Office: Executive Director Strategy Transformation and Digital
Board Committee: F&P (noting move from AC)

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	***New Control*** **:** Substantive post holder (Aug '23)	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP development plans in progress – due date Dec 23	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DPST BDO audit completed, recommendations accepted and in plan

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
2	Develop business continuity plan and disaster recovery for each system (using third party)	Initial by Dec '23	AW	Control / Assurance	Cyber Security Team has engaged and working with a third party as part of the Trust's Digital Strategy Plan to support the production of a revised IT DR/BCP. Action is on track for initial.
3	Complete actions from IT Security Health Check and Penetration Testing	Extend to Sept '23	AW	Control	Completed except for one outstanding risk - upgrades are planned and the use acceptance testing phase was unsuccessful as a result of an unacceptable service degradation to Mobius and was rolled back, this has been rescheduled for early December '23. Mitigated with extended support remaining in place.

SR7- Capital (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2023/24 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Oversight Committee Convergence and Delivery Board	OBC Agreed

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Ongoing horizon scanning for opportunities.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	NOF Rating
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2023/24			
Forecast Outturn and risk/ opportunities assessments 23/24			

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update (Date)**
2	Deliver Financial Efficiency Target	31 Mar '24	TS	Control	Year to date £1.6m behind plan, enhanced role of TSG to support further efficiency development and delivery.
3	In year forecast outturn (FOT) and associated risk and opportunities assessment	Monthly Touch Points to end Mar '24	SC	Assurance	In-year forecast completed in line with national guidance and approved via delegated authority 21/11. The Trust continues with intention to deliver breakeven.
5	Deliver Operational Plan 2023/24	Mar '24	AG/TS	Control	

Corporate Risk Register November 2023

EPUT

CRR94 - Observation and Engagement

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L2= 12*	

Executive Responsible Office: Executive Nurse
Director Lead: Director of Nursing and IPC
Leads: Deputy Directors of Quality & Safety (Inpatients and Specialist Services)
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Observation and Engagement Policy	Policy in place ***New Control***: Personalised Engagement Boards		
Weekly Ward Huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks		
Electronic observations recording tool			
Tendable Audits (quality control)	Audit results reviewed at weekly huddles		
Observation and Engagement e-learning and training videos			
Engagement resources	Purchased equipment e.g. games / newspapers etc. ***New Control***: Garden Protocol (with spots checks)		
Deep dive into unexpected deaths in inpatient services or within 3 months of inpatient admission between 2000 - 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise and assurance report to ET Apr '23	
Ward Improvements	Planning supported by patients ***New Control***: Grab Therapy Resources available		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Safe Wards training to be implemented	Complete	KS	Control	The training programme is complete, with 160 staff trained and wards now focusing on implementation of Safe Wards interventions. (See new action 10 below).
2	Commence delivery of training for regular and non-regular staff	Complete	KS	Control	As above - completed.
3	Launch the grab therapy resources in tandem with training and updated policy	Complete	KS	Control	Action complete with resources (in form of grab bag) are available and can be used by any member of staff.
4	Increased garden access and garden gyms	Complete	KS	Control	Inpatient Garden Access Protocol has been approved and shared / communicated to staff. Spot checks on garden access completed across all sites. Recent CQC visits and patient feedback confirm garden access is now available 24/7. This will continue to be monitored as part of BAU.
5	QI project Linden Centre	Complete	RP/KS	Control	Project presented to ward management team and now moved to continuous measurement (BAU).

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
6	Carers to support in production and delivery of training	Complete	KS	Control	Completed with carers supporting the creation of a podcast and leading the learning event.
7	Patient personalised engagement boards (each patient to display a poster board of things they like to talk about/ do for staff prompts)	Complete	All Ward Leaders	Control	Personalised engagement board in place and supporting personalised care. Noted as a new control.
8	a) Patients and Carers to co-produce engagement video at same time as releasing updated policy and training. b) Co-produced film to be released	Complete	KS	Control	Completed with carers supporting the creation of a podcast and leading the learning event.
9	Review of Observation and Engagement Policy and Procedure (linked to CQC action M7 / M8)	Complete	KS	Control	Policy and procedure have been reviewed and approved through Clinical Governance Sub Committee and then ratified at the Policy Oversight and Ratification Group - now live.
10	***New Action*** : Implement Safe Wards Interventions	Mar '25	LJ	Control	New action to continue the work flow.

CRR11 - Suicide Prevention

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

Initial Risk Score	*Current Risk Score*	*Target Score*
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*

Executive Responsible Office: Executive Medical Director
Director Lead: Dr Nuruz Zaman Deputy Medical Director
Leads: Glenn Westrop, Deputy Director of Quality and Safety
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Observation and Engagement Policy	Policy in place ***New Control***: Personalised Engagement Boards		
Electronic observations recording tool	In trial phase		
Wad level oversight	Tendale Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos			
Engagement resources	Purchased equipment e.g. games / newspapers etc. ***New Control***: Garden Protocol (with spots checks)		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Development of revised framework in line with national guidance	Extended timeline Jan '24	NZ	Roadmap	Draft Framework is in sign off phase and is aligned to the new National Suicide Prevention Guidance issued Sept. '23. This is now a priority within the Quality of Care Strategy (for presentation at the Board meeting Nov '23). The Framework has also been socialised with system colleagues. Plan to present for approval at Executive Team in January '24.
2	Review approach to Safe Wards and ligature risk	Complete	GW	Control	Safe Wards training programme is complete, with 160 staff trained and wards now focusing on implementation of Safe Wards interventions. (See new action 10 for CRR94) Ligature risk has been separated into a separate action (action 6)
3	Work with Care Groups to develop new governance arrangements around suicide prevention into SPG TOR	Complete	NZ / GW	Control	Suicide Prevention Group established.
4	Work with Care Groups to review the Suicide Prevention Group Terms of Reference	Complete	NZ/GW	Control	Terms of reference have been reviewed and approved, these will be kept under review.
5	Review approach to ligature risk	July '24	GW	Control	LRRG have agreed STORM training roll out of new programme which will have a greater focus on neuro diverse service user and be a extended training package. Training is available and attendance is being tracked, with continued promotion. Further work being taken forward to update safety plans and fit to leave plans.
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Next steps following approval of the Framework is to work with Lived Experience Ambassadors and our communities to take forward the actions.

CRR34 - Suicide Prevention Training

Risk Description: If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm or death and a failure to achieve our Safety First Safety Always Strategy.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C3 x 3L = 9	*C5 x L3 = 15*	*C3 x L2= 6*	

Executive Responsible Office: Executive Medical Director Director Lead: Dr Nuruz Zaman Deputy Medical Director Leads: Paul Taylor Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Trainers	13 Trainers Licences in Place Facilitators trained		
Training Provision	Schedule arranged for 2023 Interim Refresher Course Rolling programme on STORM training	MH/LD Network discussion on training	

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update (Date)**
1	Expand the capacity of trainers to deliver Skills STORM (skills based training on risk management - suicide prevention) training	Sept '23	PT	Control	There are 11 STORM Facilitators who are able to update to the version 5 training provision. An additional 4 expressions of interest in training to become facilitators have been received - for whom we are seeking dates for training from STORM. Version 4 will continue up to end of June 2024. Action will be complete when the 4 new staff members have completed their training.

CRR96: Loggists

Risk Description: If EPUT is unable to increase the number of trained loggists and increase hours available for 24/7 then there may not be sufficient loggists available to log a major incident resulting in poor decision / action audit trail in the event of a major incident.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L4 = 16*	*C4 x L1 = 4*	

Executive Responsible Office: Executive Director Major Projects Director Lead: Nicola Jones , Director of Risk and Compliance Leads: Amanda Webb Board Committee: Quality Committee	**Controls Assurance**

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Pool of trained loggists, including EPRR Team and Executive Directors PAs	All EPRR incidents have been logged to date	Command structure	EPRR Core Standards Return and EPRR Annual Report 2022/23 notes number of EPRR events in 2022/23 and that appropriate response was stood up successfully.
Loggist Training	Available from NHS EoE and from in-house provision		
Major Incident Policy	Major Incident Policy in place		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Provide in-house training for loggists	Complete	NJ	Control	EPRR team are now able to provide in-house Loggist training, to offset the short supply of places externally.
2	Proposal to ET to increase number of Loggists	Complete	NJ	Control	Executive Team approved proposal to increase the number of loggists in working hours by reinforcing all Executive Director PA's be formally trained.
3	Deliver Loggist training as per training needs analysis for new entrants on the Loggist register	Mar '24	NJ	Control	In progress.

CRR98: Pharmacy Resource

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L5 = 20*	*C4 x L2 = 8*	

Executive Responsible Office: Executive Nurse Director Lead: Tendayi Musundire Leads: Tendayi Musundire Board Committee: Quality Committee	**Controls Assurance**

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

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Continue with recruitment campaign	Ongoing	HS	Control	Recruitment progressing: 34.1wte in post with 14.4wte vacancies. Of which: - 2.0wte under offer (normal notice period waits) - 4.4wte under offer (exam dependent) -2.0wte in shortlisting phase - 4.1wte out in open advert Pharmacy remains under BCP which is reviewed on a monthly basis. Frontline delivery for patients is being delivered with no specific incidents linked to BCP status.

CRR99 Safeguarding Referrals

Risk Description: If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patient needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation.

Initial Risk Score	*Current Risk Score*	*Target Score*
C4 x L4 = 16	*C4 x L3 = 15*	*C4 x L2 = 8*

Executive Responsible Office: Executive Nurse
Director Lead: Tendayi Musundire
Leads: Tendayi Musundire
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Trust Safeguarding Team	Gap: Vacancies within Safeguarding Team	Local system to monitor child safeguarding case involvement	
Safeguarding Policies and Procedures	Policy and Procedure in place		CQC Inspection
Prioritisation for oversight of S17, S47, MAPPA and MARAC attendance at appointments and involvement in reports, as well as attendance at statutory meetings on behalf of doctors.	Prioritisation and monitoring in place		
Safeguarding Training	Training in place ad monitored	Accountability Framework Metric Performance Reporting	
Caseload Management	Team Managers monitor caseloads and circulate monthly caseload reports to Operational Teams	Safeguarding Reports	
Datix Reporting	Datix amendments for sign off and categories		
Southend Unitary Reporting Authority Open Referrals Closed	Completed 19 May '23		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
3	Incorporate safeguarding forms into patient records	Sept '23	TM	Control	Forms agreed by Transformation Steering Board and now with system design for assimilation in to all 3 systems - the 'go live' decision point will be when all 3 are ready for use. Next touch point end Dec 2023.
4	Explore options to establish Associate Safeguarding Practitioners to assist Care Co-Ordinators to facilitate safeguarding (adult patients)	Mar '24	TM	Control	Reviewed the Safeguarding Team establishment to resolve continuous additional hours and utilising temporary workforce where appropriate. Scoping the potential for redesign of existing posts within Safeguarding Team and Care Units and identify any additional resource requirements within business planning 2024/25.
5	Develop action plan to share with Southend UA to ensure all future open referrals are signed off	Nov '23	TM/ DP	Assurance	In the process of handing over cases and closing off investigations in line with developed plan. Action complete - with ongoing monitoring of cases that have been handed over.

CRR93: Continuous Learning

Risk Description: If EPUT does not continuously learn, improve and deliver service changes, then patient safety incidents will occur and vital learning lost resulting in failure to achieve our safety strategy ambitions and maintain or improve CQC rating.

Initial Risk Score	*Current Risk Score*	*Target Score*
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*

Executive Responsible Office: Executive Nurse
Director Lead: Moriam Adekunle
Board Committee: Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Patient Safety Incident Management Team (PSIM)	Established (some vacancies) Deputy Director in post	Governance Structure in place Training in place	
Quality and Safety Champions Network	84 People registered (June '23)		
Learning Collaborative Partnership and Learning Oversight Committee	Forums in place	ESOG and QC Reporting	Pan Essex CQRG
Adverse Incident Policy incl. PSIRF SOP and People and Culture Policies	Policy and Procedures in place		
Culture of Learning Project	Culture of Learning Programme live	ESOG and QC reporting	IA - Learning from the Independent Inquiry (Mar '23) Design Moderate and Effectiveness Moderate
Themes allocation to clinical / assurance / transformation groups			
Learning information sharing	Communications Plan Lesson Newsletter Internal Safety Alerts Champions Network		HSE (2021) CQC (2021, 2022) findings
Patient Safety Dashboard	Dashboard Live (Feb '23) Triage and early warning tool Power BI		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Aug '23	MA	Control	Standard Operating Procedure being drafted to incorporate Human Engine process maps
2	Develop and implement EPUT Safety and Lessons Management System (ESLMS)	Nov '23	MA	Control	This is in the digital test environment, for the Lessons Team, with a full proof of concept day 27 Nov '23. If successful the system will move into the live environment.
3	Review PSIRP process	Complete	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. Next refresh will be February 2025.
4	Develop and embed Quality and Safety Champions Network to support embedding the culture of learning	Complete	MA	Control	The Quality and Safety Champion role has been established, with 84 people on the register. There is an ongoing awareness campaign to continue to increase the numbers. (Note new action 7).

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
5	Link into UCL partnership who are implementing a range of collaboratives as part of MH Safety Programme	Complete	AW	Control	The Trust has been working closely with the UCL Partnership, in particular reducing restrictive practices. Several wards engaged with this collaborative from across the Care Units. Exemplary work to reduce restrictive practices through the use of sensory and DBT interventions. In October 2023 delivered a reducing restrictive practice summit jointly with UCL Partnership which focused on global restrictions, trauma, patient experience and improvement work by the teams. It was a successful day with just under 100 people in attendance including some of our service users. Linked with UCL has been made , with a good relationship and will continue on a range of collaboratives. Action closed.
6	Develop QI methodology	Mar '24	MA	Control	Contract renewed for use of LifeQI Platform, with circa 100 staff registered and 50 projects live. The future model for QI and associated resources has had first review by the Executive Team and will be represented in Jan '24 for approval and consideration in the 2024/25 business planning cycle.
7	Ongoing awareness campaign to continue to increase the number of Quality and Safety Champions and embed the network	Mar '24	MA	Control	Requirement of Quality and Safety Champions remains an ongoing activity and the numbers are steadily increasing (recruitment and awareness supported through induction and other communication channels).

CRR92: Addressing Inequalities

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	

Executive Responsible Office: Executive Director People and Culture Director Lead: Lorraine Hammond Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (ncl. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES	WRES and WDES plans in place Executive Sponsorship of plans		
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update (Date)**
1	Improve EDI learning offer for EPUT	Extended to Oct '23	LH	Control	ED&I Hub has been developed which includes resources and guides for all staff. External provider is currently developing a new EDI Induction training which will replace our Equality Diversity and Inclusion (positive cultures) mandatory training for new starters. In addition they are creating modules for Race Equality (incl. Active Bystander Training as well as Disability (incl. reasonable adjustments). EDI section of Management Development Programme and Learning Development Programme has now been changed from elective to mandatory to support managers in challenging discrimination, foster inclusivity and support staff from marginalised groups in line with behavioural framework. Timescale impacted due to working with external providers.
2	Implement EPUT Staff Behaviour framework	Complete	LH	Control	The framework has been launched and socialised across the Trust. Additional resources have been developed to further embed across the Trust.
3	Update the EDI framework following launch of NHSE EDI Improvement Plan	Complete	LH	Control	Framework has been update following the launch of the national NHS EDI Improvement Plan

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
4	***New Action*** : Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	Workforce Race Equality Standards (WRES) Action Plan for 2023 has been approved by Executive Team and the People, Equality and Culture Committee on behalf of the Board which had a seminar on EDI in October 2023. The Trust has signed up to UNISON Anti-Racism Charter and fulfilled 95% of the pledges. The Trust held a 'Freedom to speak up' month in October 2023. The People and Culture and Safeguarding Teams are working together to develop a process to support staff that have been impacted by abuse in the workplace and we are in the process of signing up to the Sexual Safety Charter which will demonstrate a commitment to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.
5	***New Action*** : Implement the EDI framework (including new Leadership Behaviour Toolkit)	Mar '24	LH	Control	Programme management support for the work streams to set timescales and key milestones or delivery. The Executive Team is currently developing their EDI objectives in line with the NHS ED&I Improvement Plan (High Impact Action 1). Oversight of the plan is through the Equality and Inclusion Committee.

CRR81: Ligature

Risk Description: If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions

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

Executive Responsible Office: Executive Director Operations
Director Lead: Nicola Jones / Moriam Adekunle
Board Committee: Quality Committee

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Estates Ligature/ Patient Safety Co-ordinator H&S Team and Compliance Team LRRG / EERG Ligature Project Group	Teams established LRRG in place	LRRG reports Escalations via Accountability framework	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Policy and Procedure including environmental Standards	Ligature wallet audits / ligature inspections. Policy review and approval March 2023	Annual Report	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Training (target 85%) and Tidal training	TIDAL training. OLM prevention of suicide by ligature training – August 2023 – 88% compliance	Reporting to LRRG	
Trend Analysis	Benchmark 42 per 1000 bed days. EPUT Trend analysis April 21 – March 23 remain on average slightly above benchmark. Ligature analysis 2022-23 Report	Reporting to LRRG and BSOG	
Reduced ligature environment	Range of innovations in place including DTAs and Oxevision. Estates safety/ligature annual	Annual ligature inspection for all MH wards	
Learning from incidents and safety alerts via Lessons Team/ ECOL/ 5 key messages	Enhanced learning within annual reporting utilising deep dive data		Actions completed from the CQC Brief Guide
Local Area Ligature Network and Awareness and ownership of ligature reduction work	Network Established		
Support for staff	Support package developed – debriefing facilitated by Nursing in Charge/ Ward Manager/ Matron/ Service Manager/ Clinical Lead/ Consultant (or other member of Senior Medical Team)	Here for You – signposting for individual follow up Input from Psychological Services Patient Safety Team facilitates 'cold' debrief in the form of after action review for staff support	

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Identify new system for recording ligature actions (overseen by Project Group)	Extended to Dec'23	CR	Control	A decision on how to document ligature actions with maintenance breaches to be recorded on 3i only and standard breaches to be recorded additionally on the Datix system. Work is progressed with support from a Datix system expert to enable Datix to fulfil this requirement. Action is on track for sign off of changes through LRRG in Dec '23
3	Review standards on outdoor garden furniture	Complete	MM	Control	Standards agreed at LRRG in Sept '23. These will be added to Ligature Policy and Ligature Inspection Tool to ensure implemented fully.
4	Further roll out of environmental improvements	Mar '24	MM	Control	Action continues to be on track for delivery with regular ligature/patient safety environment improvements reported to ESOG and BSOG.
5	Review environmental risk stratification document	Complete	FB	Control	The document was approved at the Sept '23 LRRG meeting and will be refreshed quarterly going forward.

Actions (to modify risks)		By When	By Who	Gap	Update (Date)
6	Pilot the project for a year followed by evaluation (in house training)	Sept '23	Project Group	Control	New training proposal submitted to LRRG in Nov '23 and approved and now being enacted.

CRR71: Medical Devices

Risk Description: If EPUT does not fund resources and the deep dive to address the clinical rationale/ pathway for medical devices, then unsafe, non-serviced, non-calibrated and inappropriate devices remain in use, resulting in a failure to achieve our safety first, safety always strategy, and reputational damage

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

Executive Responsible Office: Executive Nurse
Director Lead: Angela Wade
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance.	Established Nominated Central Alert System person ***New Control***: MDSO in post with dedication administrative support		
Medical Devices Group	Established	Overseen by Physical Health Sub-Committee	
Ergea contract for device maintenance	Medical Devices Group oversight of Monthly KPI Report		
Procurement process in place Medical Devices Policy	eQUIP Asset Register	Tendable audits – medical device safety / management	Internal Audit Report 2021/22 (Moderate / Limited Assurance)
Incident Reporting	In place		
Business Continuity Plans	Ergea BCP		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Procure a 'Deep Dive' in order to focus actions from recommendations in internal audit report	Complete	NA	Assurance	Deep dive has been completed.
1a	Implement the solutions from the outcomes of the deep dive	Mar '24	NA	Control	16 /18 management actions arising from the IA have been completed and the 2 remaining are being progressed (see Action 3 and 2 below). - Training needs analysis being developed by the Team for Medical Devices Management Training to ensure staff know how use and calibrated pieces of kit. - Working with system partners to procure quality assurance for the POCT devices.
2	Options appraisal for Capital replacement programme and Medical device replacement	Sept '23	NA	Control	Medical Devices Replacement Plan (Strategy) is in consultation phase and planned for discussion / approval at Executive Team December '23.
3	Review of Policy and Procedure to ensure clear process and monitoring set out	Complete	NA	Control	CLP17 and CLPG17 have been reviewed and amended / updated as required; approved at Policy Oversight and Ratification Group. eSOPs for Medical Device Procurement and Medical Device Decommissioning are developed and on the platform.

CRR45: Mandatory Training

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

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

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Implement recovery plan	Nov '23	Training Team	Assurance	TASID (Therapeutic and Safety Interventions)Training on track with the recovery programme for all substantive staff to be back on annual review from December 2023 (Target 85%).
2	Review mandatory training policy	Complete	PT	Control	Mandatory Training Policy has been reviewed and approved subject to minor amendments.
3	Ensure staff do not expire on their training all at the same time by spreading compliance across the year	Nov '23	PT	Control	Staff have received training in order of priority, i.e. date of last training, high risk areas. This ensures updates will fall in a logical pattern for their annual update and not cause further backlog. This is built into BAU planning for 2024-25. (BAU planning ensures staff are booked in line with training expiration.)

COMFORT BREAK FOR 15 MINUTES

10. RISK ASSURANCE REPORTS

10.1 END OF LIFE ANNUAL REPORT 2022-23

Decision Item | Frances Bolger | 10 minutes

REFERENCES

Only PDFs are attached

End of Life Annual Report 2022-23.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**End of Life Annual Report 2022-2023**					
Executive/ Non-Executive Lead:	Frances Bolger, Interim Executive Nurse					
Report Author(s):	Tracy Reed, Clinical Lead End of Life Care					
Report discussed previously at:	End of Life Sub-Committee Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	No risks – annual 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 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the Board of Directors with the End of Life report for 2022-23	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Approve the Report

Summary of Key Issues

The annual report provides details of the End of Life care provided by EPUT, in line with the EPUT Framework and national guidance documents related to End of Life Care. The Annual Report also provides key achievements against the End of Life Care Framework which is attached as 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			
EoLC	End of Life Care	**DNACPR**	Do Not Attempt Cardiopulmonary Resuscitation
PEACE	Proactive Elderly Advance Care Plan	**CCG**	Clinical Commissioning Group
TEP	Treatment Escalation Plan	**ICS**	Integrated Care System
CHS	Community Health Services	**MDT**	Multi-disciplinary Team
NACEL	National Audit of Care at End of Life	**GSF**	Gold Standards Framework
NICE	National Institute for Health and Care Excellence	**PPC**	Preferred Priorities for Care
PPD	Preferred Place of Death	**ESNEFT**	East Suffolk and North Essex NHS Foundation Trust
DIPC	Director of Infection Prevention and Control	**NEE Alliance**	North East Essex Alliance
LPA	Lasting Power of Attorney for health and welfare	**EPaCCs**	Electronic Palliative Care Co-ordination system
STaRS	Specialist Treatment and Recovery Service	**NHSI**	NHS Improvement National collaborative
PEoLC	P**alliative** and End of Life Care		

Supporting Reports/ Appendices /or further reading
End of Life Care Annual Report 2022-23 Appendix 1: End of Life Care Framework 2022-2024

Lead
F Bolger. **Frances Bolger** **Interim Executive Nurse**

Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

END OF LIFE ANNUAL REPORT 2022-23

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

END OF LIFE ANNUAL REPORT

JULY 2022 – Sept 2023

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

Dr Fiona McDowall
Old Age Psychiatrist

September 2023

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INTRODUCTION

In England in 2021 the number of deaths rose to 695,000 due to the Covid 19 Pandemic and with the ageing population this has continued to rise. High quality end of life care is an indicator of how we care for sick and vulnerable people across health and social care services. End of life care seeks to enhance quality of life in the face of death by addressing physical, psychological, social and spiritual needs of patients with life limiting diseases and their families. Good end of life care encompasses recognising the dying phase, high quality coordinated care, carer support and advice. It must be delivered in a personalised, dignified and respectful manner to the person and their families.

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

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

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

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

This report provides a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life. In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission (CQC). This was a considerable achievement and boost to services who worked very hard to improve integration and develop services. The services continue to strive to maintain and support 'outstanding' care to all those recognised as end of life irrespective of which service within EPUT they are receiving their care.

During 2022 into 2023 we have continued to see service adaptions to ensure the best outcomes for people at end of life irrespective of diagnosis or care setting. The community health services have continued to see an increase in the number of people dying at home as more people are presenting later within services following on from the Covid 19 pandemic.

END OF LIFE SUBCOMMITTEE

The End of Life Subcommittee continues to report into the Quality Committee with Leadership overview from the Executive Nurse. The subcommittee meets monthly with representation from:

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

The subcommittee is responsible for overseeing and monitoring the implementation of the End of Life Care Framework and making recommendations to the Trust in relation to the planning and provision of end of life and last days of life care. End of life care is a standing agenda item at locality Quality and Safety group meetings and the Clinical Governance and Quality sub-committee to ensure updates and lessons learned are shared at a local level across the organisation. These are also shared and reviewed with the Learning from Death oversight group.

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

CLINICAL LEAD FOR END OF LIFE CARE AND SPECIALTY DOCTOR

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

COMPETENCIES

The clinical lead has developed a competency framework for end of life care to support the enhancement of knowledge, development of skills and promotion of positive attitudes and behaviors in care delivery. The objective of the framework is to ensure staff develop professionally through reflection, supervision and through informal and formal training. The aim is to ensure staff confidently provide the highest quality care by early identification and response to patients who are recognised as end of life both in hospital and the community settings.

POLICIES AND PROCEDURAL GUIDELINES

Procedural Guideline for the care of the Deceased Patient

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

Advance Decisions and Advance Statements

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

Verification of Expected Death (VOED)

The existing guideline was last reviewed in 2021 as the national guidance since the adaption during the COVID19 pandemic has not changed. The training was adapted during the COVID19 pandemic to support staff competencies through a blended learning approach, including Train the Trainer to ensure each team have staff available to support the increase in verification of death particularly within the community services who are experiencing more deaths at home. It is accompanied by a competency framework and a register of competent staff is maintained within each locality and service.

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

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

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

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

The standard operating procedure, training programme and competency framework has been developed in partnership with hospices across Essex and the clinical lead for end of life care to support all elements of education, training and competency framework. This has resulted in us now having twenty eight senior clinical staff who have successfully completed their competencies and able to support this element of care across our community services in West and South East Essex. There another seven staff booked onto training in September.

End of Life Care Guidelines

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

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

Operational Guideline for Deactivation of Implantable Cardioverter Defibrillators

The need for development of this document as an independent guideline was the increase during the Covid 19 pandemic and with the increase of patients being treated with an implantable cardioverter defibrillator device.

In 2021 education and training were developed with the heart failure teams to support best practice and guidance for deactivation of this element of a pacemaker when someone is recognised as end of life and unable to return to hospital to have the procedure for deactivation carried out. This training is ongoing within community teams. The increase in deaths at home has seen this element of care used more frequently.

END OF LIFE CARE CHAMPIONS

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

The Clinical Lead for End of Life Care supports this role within the teams and works with each individual to support partnership working with their local specialist palliative care teams ensuring that, irrespective of a patient's environment they receive fair access to palliative and end of life care services.

END OF LIFE CARE FRAMEWORK

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

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

1. Each person is seen as an individual	
Key Achievements	The systems in place to capture incidents, compliments and complaints have continued to be strengthened during 2022/23. The clinical lead is copied into any Datix or complaints in any of EPUT's services related to end of life care so that these can support lessons learned. The use of Datix to record compliments to the teams has enhanced sharing of compliments that are sent to individual teams by a variety of other sources. The IWANTGREATCARE has been revised to include specific feedback and a post bereavement survey is now being used within our inpatient, nursing homes and specialist services. This is captured within the end of life care dashboard and reviewed by the end of life subcommittee. The implementation of the West Essex Electronic Palliative Care coordination system in line with the established South East Essex system has seen shared data to coordinate patients recognised as end of life.
Areas to be progressed	Continue to strengthen processes to gain carer feedback within inpatient service and community services. Ensure IWANTGREATCARE is utilised widely for end of life elements. Work with system partners to share locality learning and integration of services as a collaborative approach and seek system partners feedback.

2. Each person gets fair access to care	
Key Achievements	The Clinical lead for end of life care and Specialty Doctor continue to have strong links with partner organisations. The growth of integrated collaboration of services within the Integrated Care Systems (ICS) have seen joint working continuing to develop services and provide fair access for all. These include local acute services, hospices and voluntary services in all locations across EPUT. The collaboration has seen joined up policy and procedural guidance which EPUT have supported. This has also seen redesign of ICS services across footprints to support best practices and person centered care planning. With system partners introducing elements of EPUT approaches as best practice. The development and roll out of a guidance for STaRS teams to support integration of services and understanding of end of life care in North Essex has seen care delivery for these services that has positive outcomes for care and integration of services within the locality. This approach is being developed now across other areas of Essex as seen as best practice and ICB public health are keen to support this. The dashboard, capturing quality and performance indicators has been further developed and seen a growth in recognition of dementia

	and frailty through the FReDA template. This has been recognised at East of England and Nationally and the templates developed to support this are shortlisted for an HSJ award. The success of the psychological support with the development of level 4 services in West Essex has been extended and recognised as supporting best practices. South East Essex ICS are looking at this for the future across their ICB. The development of an Electronic Palliative Care Co-ordination (EPaCCs) System in West Essex has seen a growth in integrated approaches and sharing of patient choice in line with the established EPaCCs in South East Essex. This has resulted in a funded care home project in West Essex to support end of life care recognition and currently the system is increasing by 100 people a month to enhance their advance care planning process. It has seen the successful recruitment of a clinical post to support system partners and adding to the register, and is supported by the end of life care lead.
Areas to be progressed	The implementation of guidance for end of life within the STARS service in North Essex to be developed across all areas of Essex and work is currently starting in West Essex with system partners. To support future growth of EPaCCs and recognition of death across EPUT and support primary care and the ICS.

3. Maximising comfort and wellbeing	
Key Achievements	Updates to the formulary and Medicine Management Guidance across the ICS which is under review. This has included a number of documents that have been shared across the ICS and ustilised widely. The do not attempt cardiopulmonary resuscitation – DNACPR competency training for senior clinical staff. The clinical lead was instrumental in supporting the development of the standard operating procedure and training. This has been supported by the ICS who have supported funding for staff to develop and attend training delivered in partnership with the hospices across Essex. They have also provided our training department with backfill funding to support the clinical lead and integrated care staff to support this initiative. This is ongoing to support advance care planning and discussions around DNACPR.
Areas to be progressed	Continue to cascade end of life care competencies to all grades of staff in community services to ensure maximum update. Ensuring staff have skills to support clinical practice. Continued working in partnership with external stakeholders as part of co-production. This includes access to external training and development being shared across EPUT.

4. Care is co-ordinated	
Key Achievements	The Clinical Lead for end of life care and Specialty Doctor continue to have strong links with systems partners and attend the ICS meetings. This has seen a rise in identification of frailty and dementia within primary care and the personalization agenda. Monthly multi-disciplinary meetings with primary and secondary care and hospices have been established to ensure an integrated approach and co-ordination of care. These now include ambulance services and Motor Neurons Disease Association (MNDA) input and continue to impact of co-ordination of care and partnership working. Guidance has been rolled out for people with multiple organ failure and long term conditions who are on the caseload of the STaRS Team in North Essex. This is to support early recognition of end of life care. The EPACCs in West Essex and continued growth in South East Essex and frailty and dementia prognosis is now higher than cancer and other long term conditions which has allowed system sharing of patient choice wider across the ICS footprints.
Areas to be progressed	To continue with enhanced partnership working across systems to create best approaches with regard to advance care planning, individualised care plans and shared data.

5. All staff prepared to care	
Key Achievements	End of Life Care Champions are supporting staff at a local level. There are currently fifty two champions across services to support best practices and provide updates on end of life care. The ICS's are supporting training needs across localities. The competencies for EPUT have been adapted by some of the other community providers. The Clinical lead is supporting sharing training and development of standard approaches to care. EPUT continue to have in-house training and support to teams. A quarterly training report shows training delivered by clinical lead with the numbers of staff and service that have attended.
Areas to be progressed	Continue to support the roll out of end of life care competencies for all grades of staff. Continue to expand the number of End of Life Care Champions across all areas of the organisation. Continue to partnership work to support accessibility of end of life care training as an integrated approach to include specialist services delivered by the hospices.

6. Each community is prepared to help	
Key Achievements	The Trust participates in Dying Matters events on an annual basis. In 2023 this was undertaken via social media and virtually. The second Death Café was held in EPUT in partnership with the Chaplaincy and Psychological services providing staff to share their own experiences. A number of staff shared their experiences both personally and professionally, prompting positive discussions. There continues to be events in partnership working across Essex for dying matters awareness. The End of Life Clinical Lead and Specialty Doctor are members of ICS, Alliances and NHS East of England and nationally supporting End of Life Care Groups. This has supported partnership collaboration and service redesign within Essex end of life care services. It also supports EPUT to have national and local updates and share more widely best practices.
Areas to be progressed	To continue to provide public information relating to end of life care to be posted on the Trust Website and through social media to include blogs and sharing stories with staff and patient experiences. .

CLINICAL AUDIT

National Audit of Care at End of Life (NACEL)

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

There are several components consisting of an organisational level audit for the period 1st April 2022 - 31st August 2022 and a case note review of all deaths within the same period.

The case note review considers patients who meet the following

criteria:

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

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

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

Although only one patient's records met the criteria this year for the audit the results were higher than the national averages.

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

An audit of 39 patient records were reviewed using an end of life care audit tool in line with the questions of the NACEL audit as a case note review of care. The aim was to establish that the services within EPUT delivering end of life care are supporting the requirements in line with best practice and national averages. Overall EPUT services are providing above the national averages for end of life services with many elements scoring 100%. The end of life care templates within the electronic databases are supporting record keeping. These made it easy to find the relevant data and information required to complete the audit and share information across services. There were 10 other patient records reviewed but they didn't meet the criteria for inclusion in this audit for the following reasons the West Essex Team had not seen 2 patients until the day they died as not previously been referred or known to the caseload. In South East Essex there were 8 patient referred to the palliative care team to be added to the register who were still in hospital waiting discharge when they died so not known or seen by the team. This is the first time the audit has found these issues. The findings from the main audit were pleasing as there was improvement on the previous year's audits even though we have audited less patient records this year.

Audit of Do Not Resuscitate Cardiopulmonary Arrest Orders

An audit of DNACPR for those at end of life was completed in 2022-2023. The purpose of the audit was to ensure the correct processes were in place to ensure a person centered approach to all decision making and supports the Care Quality Commissioning review in 2020 of DNACPR implementations.

The audit reviewed fifty-two documents across both community health and mental health services:

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

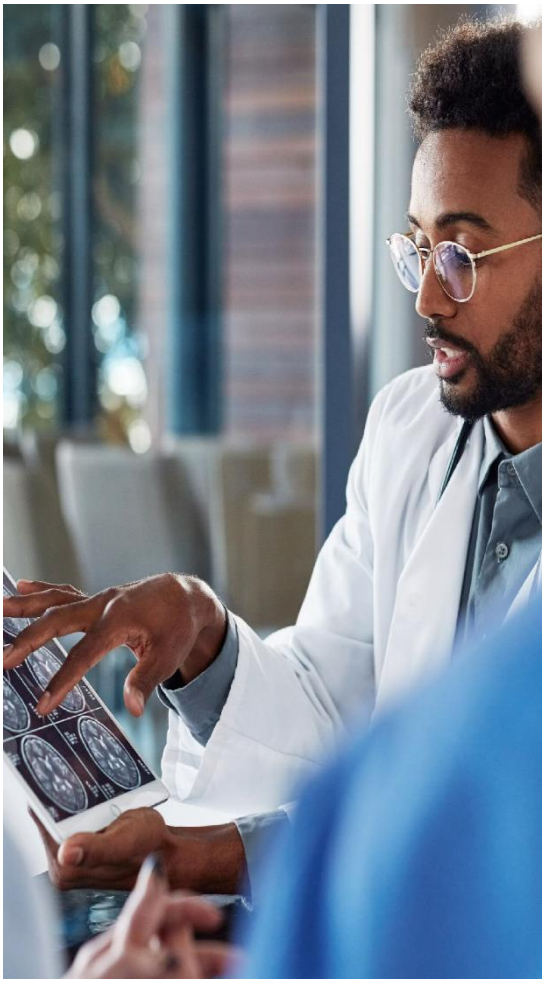
Findings

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

There was evidence documented in 100% of the records to support fair

access to care and supportive conversations with evidence of an MDT approach to implement the DNACPR forms. The end of life care templates within all our electronic data bases have supported a more unified and accessible process of recording and finding the end of life care information.

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



PATIENT STORY / LIVED EXPERIENCE

A 53 year old gentleman with cancer who was in his last days of life being cared for in a hospice expressed his wishes to come home. He changed his mind as previously was undecided what his preferred place of death was. He stated he wanted to die at home now but had been admitted to the hospice because he was bleeding from his nose (epistaxis) and this could not be controlled in the community. The medication he required via a syringe pump is not available within the community setting so he was admitted for treatment.

After 48 hours in the hospice a syringe pump of medication had stopped his nose bleeding but the infusion he had started could not be stopped as was controlling the bleeding. The clinical lead for end of life care was contacted to ask if there was any possibility the community team would support this specialist form of treatment. So he could be cared for at home in his last days and be able to die in his preferred place of choice. The community pharmacist and clinical lead worked in partnership with the hospice to develop a treatment escalation plan with the hospice agreeing to provide the medication as primary care pharmacy do not stock this. They also supported education to the community nursing team to ensure safe practice.

An ambulance was arranged and discharge home that afternoon. This gentleman was well known to the community team so they agreed to support his care and treatment at home to support his needs. He

returned home and slept with his wife again in his own bed which was his request with his family around him. The community team supported him at home for his last days of life. He died peacefully in the arms of his wife with his symptoms managed. The hospice and community team worked in partnership to support his care needs. For his family they got great comfort from him being in his preferred place for his care and death. They complimented the teams on the care compassion and dignity that was provided to him in his last days of life. The integrated approaches to partnership care enhanced the patient, carer and health professionals involved with a positive outcome and fulfillment of patient choice.

NHSI AND EOE END OF LIFE CARE COLLABORATIVE

The Clinical and Medical Leads for End of Life Care are members of the NHSI PEoLC collaborative which supports shared best practice across a variety of settings across England, Scotland and Wales. The work undertaken by the Trust in accordance with the Ambitions for End of Life Care has been presented both nationally and at the East of England. EPUT have represented a sharing best practice event in Cambridge to show case the work that is currently being undertaken within the Dementia and Frailty services for the second year in a row this was requested. The end of life care dashboards have been recognised locally within the ICS localities and there is ongoing work across ICB's for other providers to align to this. The integration of the mental health and physical health services is starting to show that the dashboard has more representation of dementia and frailty than cancer diagnosis. Nationally it has been recognised as best practice and the growth of identification of dementia and frailty through the FReDA template as best practice has been nominated for an HSJ award.

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

DEVELOPMENTS IN MENTAL HEALTH

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

A clinical pathway for patients under the care of STaRS (Specialist Treatment and Recovery Service) in the Northeast was launched and in practice for over a year. This was developed jointly with support of Farleigh Hospice and has been showcased nationally. Work with the North Alliance has seen training and support available to all services who support STaRS and joint working with St Helena Hospice and ESNEFT

who cover this locality.

The end of life lead and medical lead are working with the NE Alliance to restart Advance Care Planning meetings for patients with a dementia diagnosis when they still have capacity to take part in these discussions. The local Alzheimer's society were working with EPUT community staff together and had received joint training with St Helena's Hospice and EPUT. However the contract has just been awarded to Age Well East. Who we are currently building relationships with to mirror the previous partnership working and training support with St Helena's Hospice and EPUT. The Advance care planning clinics will be audited and feedback gathered for patients to evaluate the service and provide opportunities for service improvement.

The end of life lead and medical lead

The success of this guidance is now being supported by working with system partners to develop the same approaches. This has been influenced by the work in the North being shared and the wider elements of Essex wanting to mirror this service.

DEVELOPMENTS WITHIN NURSING HOMES

The two nursing homes Clifton Lodge and Rawreth Court continue to have strong links with the specialist palliative care team and primary care within the South East Essex area. The two homes are managed by the same manager, which has had great benefits in reducing variations in end of life care and support strong working relationships with the general practitioners who support the home. Patients are identified using the prognostic indicators and are added to the electronic EPaCCs Register. They use the Gold Standards Framework prognostic indicators to identify patients at end of life and manage their symptoms accordingly. This incorporates all elements of advance care planning and patient choice is recorded inclusive of their loved ones. The shared data sharing has further strengthened joint working and coordinated care between Primary Care, the integrated teams and the care home staff. The homes have received a number of compliments and high praise from bereaved relatives for the approaches of personalised care their loved ones received with compassion and dignity and felt extremely supported by all members of the teams.

CONTINUED SUPPORT WORKING WITH THE COVID-19 PANDEMIC AND PARTNERSHIPS

The COVID - 19 pandemic had required a re-focus of all services and the development of staff in 2019 so that they were able to provide the highest quality end of life care across all settings both to patients and carers/relatives. This has continued to be ongoing with the growth of end of life care patients within EPUT community services.

The Clinical Lead and Specialty Doctor have continued to support the development and implementation of a wide range of initiatives including enhanced skills and guidance around early recognition of end of life and symptom management. These include:

- Working with the integrated care systems in each of the localities across EPUT. This includes the Mid and South Essex (MSE), West Essex and Herts and the North Alliance. This supports a number of initiatives to support integrated partnership working. Including competencies and training for end of life care, Electronic palliative care co-ordination and dashboard – EPaCCs, Procedural guidance documents and aligning services. Learning from current services across the end of life care services in each of area.
- Electronic palliative care co-ordination and dashboard – EPaCCs in West Essex locality in line with the South East Essex model. Pilot of implementation of EPaCCs, which resulted in successful recruitment of a nurse to support this in the care co-ordination centre working as a member of the MDT. This post holder is now well established and making a difference to the support of all system partners in early recognition of end of life care
- Care home project in West Essex for community matrons and the EPaCCs nurse to ensure all residence with long term conditions whether in a residential or nursing home are identified and their preferences are recorded in there records and added to EPaCCs in a more timely way.

- Implementation of the Dependency guidance at end of life for the STaRS Team in North Essex to support best practice. Working with St Helena Hospice to deliver training to all the multi-professional agencies involved. There are plans to support future developments across all STaRS teams.
- Working with Herts Partnership an Advance Care plan and a decision to refuse treatment document has been developed for those with a learning disability – (LD). This is supported by EPUT LD teams and has supported records and inclusion of end of life care conversations with people with LD and their families. Support for LD training on advance care planning and difficult conversations. Working to provide collaboration

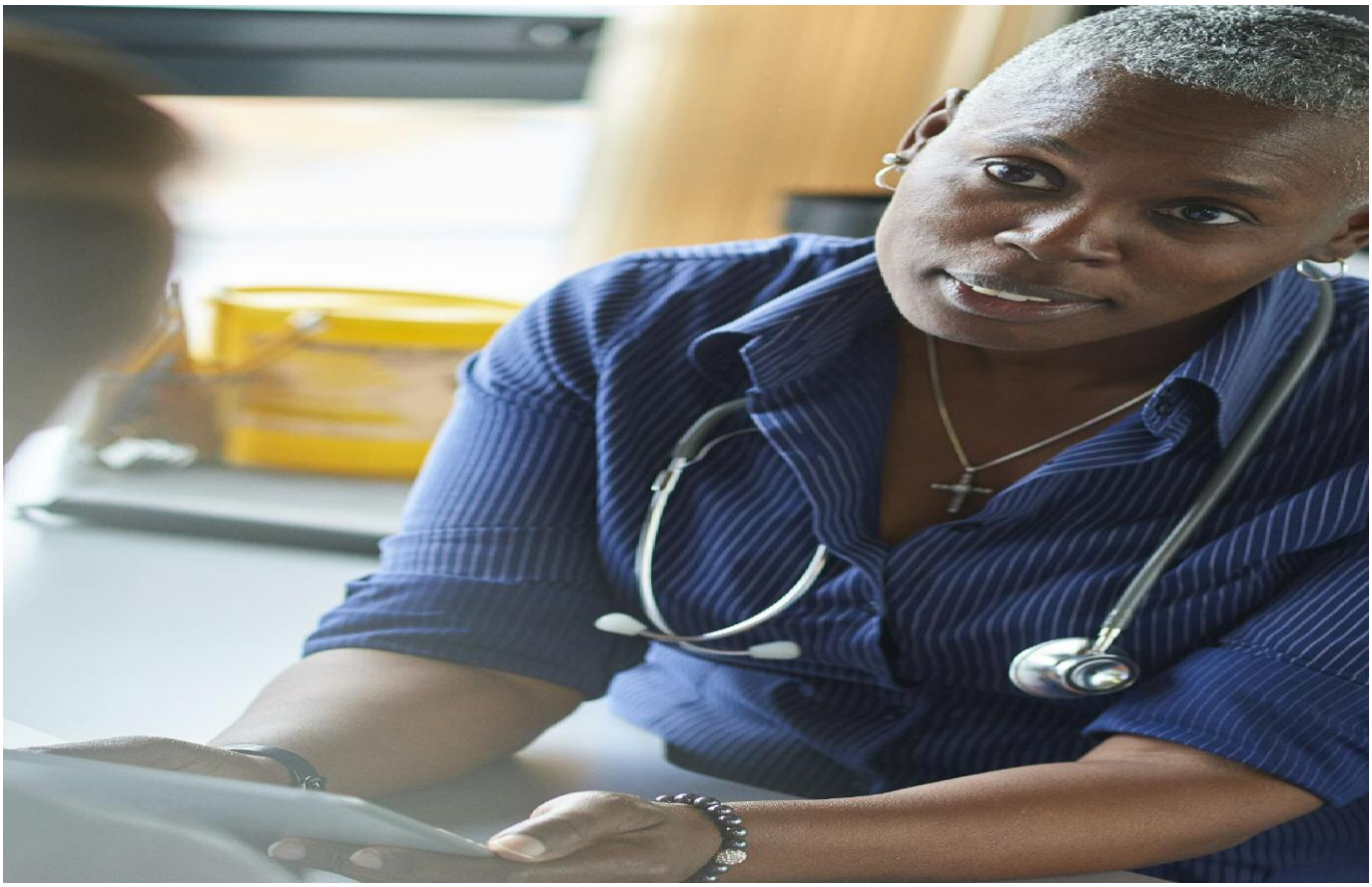
for sharing and educating the whole community.

- Person centred approaches to care: complete roll out of Treatment Escalation Plans (PEACE documents across Essex and ReSPECT document in North Essex Alliance) to record discussions and choices including PPC/PPD/DNACPR/Requesting treatment.
- Training relating to a number of aspects of end of life care delivered virtually and face 2 face to ensure end of life competencies for staff are met.
- Training podcasts to support training and provides accessibility to all staff.
- Collaborative redesign of the specialist palliative care service working with system partners. The EPaCC's has double in terms of patient accessing services for end of life and they don't all require specialist palliative care. The numbers of this caseload have doubled. It is important that together we work to support best practices and person centred accessible care for all irrespective of care setting.
- Expert support/advice provided on a daily basis to clinical teams and staff members working outside of their usual area of expertise.

ABBREVIATIONS

EoLC	End of Life Care
PEACE	Proactive Enhanced Advance Care Plan
TEP	Treatment Escalation Plan
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
CCG	Clinical Commissioning Group
ICB	Integrated Care Boards
ICS	Integrated Care Services
CHS	Community Health Services
NACEL	National Audit of Care at End of Life
NICE	National Institute for Health and Care Excellence
MDT	Multi-disciplinary Team
GSF	Gold Standards Framework

PPC	Preferred Priorities for Care
PPD	Preferred Place of Death
DIPC	Director of Infection Prevention and Control
LPA	Lasting Power of Attorney for health and welfare
STaRS	Specialist Treatment and Recovery Service
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
NEE Alliance	North East Essex Alliance
EPaCCs	Electronic Palliative Care Co-ordination system
NHSI	NHS Improvement National collaborative
PEoLC	Palliative and End of Life Care



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END OF LIFE CARE FRAMEWORK.

2022-2024

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

Natalie Hammond
Executive Nurse

Amanda Sherlock
Non-Executive Director

NATIONAL AMBITIONS

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

INTRODUCTION

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

Our Services Include:

Mental health services

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

Community health services

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

Learning disabilities services

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

END OF LIFE CARE

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

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

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

BACKGROUND

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

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

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

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

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

THE FIVE PRIORITIES FOR CARE

1. Recognising that someone is dying

2. Communicating sensitively with them and others important to them

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

4. Providing support

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

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

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

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

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

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

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

5. **Education and training** - Every professional must be competent and up to date in the knowledge and practice that enable them. It is vital that every locality and every profession has a framework for their education, training and continuing professional development, to achieve and maintain this competence to play their part in good end of life care.

6. **Involving, supporting and caring for those important to the dying person –** Ensuring we listen to feedback and build upon this to improve our services.

7. **24/7 access -** Every person at the end of their life should have access to 24/7 services as needed as a matter of course.

8. **Co-design -** The people who know the most about what services should look like are those that are using them. Therefore, all health and social care systems should involve people who have personal experience of death, dying and bereavement.

9. **Leadership –** Strong leadership that works with local partners and commissioners to provide care that is suited to the needs of the population.

HOW WE WILL ALIGN WITH THE NATIONAL AMBITIONS

AMBITION 1

Each person is seen as an individual.

"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."

EPUT Ambition

We pledge that all of your personal needs and wishes will be explored through honest conversations about dying, death and bereavement at a time when you feel ready to have them; this will include you and the people that are important to you.

Our staff will deliver care that is person centred and will ensure that choices about your care are recorded, supporting you to retain as much control as you wish to have. We will provide you and those important to you with information, advice and support to enable you to make timely decisions about your care.

We will achieve this through:

Strengthening our skills in honest and well informed conversations regarding dying, death and bereavement by cascading our Competency Framework.

Continuing to develop and implement individualised care plans for everyone receiving end of life care in our services.

Building on our relationships with our local partners to ensure access to the best clinical assessment and care delivery in an environment that meets your needs and choice.

Working with you and those important to you in preparation for bereavement and signposting to appropriate services.

AMBITION 2

Each person gets fair access to care.

"I live in a society where I get good access to care, regardless of who I am, where I live or the circumstances of my life."

EPUT Ambition

Dying, death and bereavement affects everyone; we will ensure that you get the care that works for you personally. You and those important to you have the right to expect services at the end of your life that are coordinated and provide you with all.

We recognise that there are vulnerable groups and individuals who may find it more challenging to access end of life services. Achieving equity, access and responsiveness will be at the centre of the day to day care we provide.

We are committed to understanding what outcomes are important to you in relation to your care, recognising that these are key in helping us to make continuous improvements.

We will achieve this through:

Using all available data sources to better understand the reach of our services and identify any gaps in the provision of end of life care. We will generate and use this data to inform us how we may need to improve care. We commit to using national, regional and local data to further guide and develop services that will improve care for you.
Continuing to strengthen relationships with our acute, local authority and hospice providers to maintain clear and open communication to facilitate an ease of transition of your care between services, where this is required. We will continue to work with primary care to support you in your local area.

Working with you and those important to you to develop a set of measurable, person centred outcomes so that we can continue to improve services in the future.
Ensuring you know how to access services 24 hours a day, 7 days a week, 365 days per year.

AMBITION 3

Maximising comfort and wellbeing.

“My care is regularly reviewed and every effort if made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.”

EPUT Ambition

We know that many people approaching death may be fearful of being in pain or distress. We will recognise and respond your concerns, assess the cause and identify what might help you 24 hours per day, 7 days per week, 365 days of the year.

We know that access to early, good quality palliative care can improve outcomes. We will maintain and develop the existing palliative care service that we provide. Where this is not present, we will utilise the skills of external Specialist Palliative Care services to ensure that all your needs are supported.

We will achieve this through:

Continued rollout of the competency framework for all clinical staff to ensure skilled assessment and symptom management.

Working with you and supporting you to achieve your personal goals whilst maximising your independence and embedding the use of an individualised care plan both in an inpatient and community setting.

Equipping our staff with the knowledge of how to access expert advice, medicines and equipment so they can respond rapidly to your changing needs.

AMBITION 4

Care is coordinated.

“I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time, day or night.”

EPUT Ambition

We understand that fragmented care can be a source of anxiety and frustration. We are committed as a partner in Integrated Care Systems to develop a more coordinated response that is proactive to your needs and uses a full range of services.

We commit to providing services that sustain excellent care outside of inpatient services. We will continue to work with our local partners.

We will achieve this through:

The continued roll out of the Proactive Elderly Advance Care Plan and patient held information.

Active participation in multi-disciplinary meetings and care reviews.

Implementation of the Electronic Palliative Care Coordination System in west Essex.

Continued recruitment and support of End of Life Care Champions.

Signposting to relevant services available to you locally and nationally.

AMBITION 5

All staff are prepared to care.

"Wherever I am, health and care staff bring empathy, skills and expertise to give me competent, confident and compassionate care."

EPUT Ambition

We will adhere to values-based recruitment at all levels of our organisation. We remain open to new ways of learning and interacting with the people we support. We are committed to providing our staff with the correct education and skills to help them to best meet your needs.

We will listen to your voice and ensure that any themes or trends identified are reported through governance and reporting structures to enable shared learning across the organisation.

We will undertake regular audits to establish adherence to best practice and make changes to practice where these are required.

We will achieve this through:

Providing opportunities for clinical supervision and peer support in all clinical teams to allow for reflection and learning.

Continued participation in the National Audit of Care at End of Life and will undertake local audits to enable us to review the quality of care that we provide to you and make improvements where issues are identified.

The provision of bespoke and blended learning opportunities for all staff.

Clinical leadership and executive support for excellent end of life care.

AMBITION 6

Each community is prepared to help

"I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways."

EPUT Ambition

We believe that it is important to work with partner organisations to help support you and those close to you.

We are committed to increasing public awareness of the difficulties faced by those who are dying.

We will continue to promote openness around end of life issues in our communities.

We will achieve this through:

Continuing to develop signposting systems through the Trust website and easy read leaflets.

Raising awareness around the importance of early discussions relating to end of life and supporting staff so that they have the competence and confidence to undertake difficult conversations.

Accountabilities and Responsibilities

Delivery of this Framework is overseen by the End Of Life Sub-Committee which reports to the Trust Board via the Quality Committee. Individual service leads are responsible for embedding this Framework at local level. Service leads are also responsible for delivering the strategic goals at an operational level, with support from the End of Life Care Sub-Committee.

10.2 LEARNING FROM DEATHS - QUARTERLY OVERVIEW OF LEARNING & DATA (QUARTER 1 2023/24)

Discussion Item | Frances Bolger | 10 minutes

REFERENCES

Only PDFs are attached

Learning from Deaths 2 Q1 2023-24 Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 1 2023/24)**					
Executive/ Non-Executive Lead:	Frances Bolger, Interim Executive Nurse					
Report Author(s):	Michelle Bourner					
Report discussed previously at:	Learning from Deaths Oversight Group Learning Oversight Sub-Committee Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
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.	Not applicable	
Describe what measures will you use to monitor mitigation of the risk	Not applicable	

Purpose of the Report		
In line with the National Guidance on Learning from Deaths, the attached report presents to the Board of Directors: • An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result; • Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements (Appendix 1); • Data relating to deaths recorded on Datix (the Trust's incident management system) for Q1 2023/24 (1st April – 30th June 2023) (Appendix 2); and • Updated data for deaths relating to previous years (Appendix 3).	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the report; and 2 Request any further information or action.

Summary of Key Issues
1. The Trust implemented a new Learning from Deaths Policy and Procedural Guidelines from 1st April 2022. 2. The attached quarterly report provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. This learning is presented on a monthly basis to the Trust's Learning from Deaths Oversight Group, Learning Collaborative Partnership and Learning Oversight Sub-Committee. There are a number of immediate actions that are being taken as a result of the learning identified, as well as longer term actions that will form part of the Trust's Safety Improvement Plans. 3. The attached report also presents data that the Trust is nationally mandated to report to public Board of Director meetings on a quarterly basis – i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. There are no issues of concern to note from the Q1 data, which is in line with that of previous quarters. The presentation of the Q1 data to the Board has been deferred by 2 months from the usual reporting schedule to enable the implementation of strengthened processes for data production. Monthly monitoring of deaths reported continued to be undertaken throughout this period. Normal governance reporting schedules will be resumed for Q2 2023/24 data onwards. 4. The new scope for deaths included within the Trust's Learning from Deaths arrangements has brought a larger number of deaths into scope, enhancing the Trust's ability to learn from deaths. As at the date of preparation of the report, a total of 123 deaths from 01/04/23 – 30/06/23 have been subjected to a Stage 1 learning from deaths review by a local service manager to ascertain learning and identify those for further detailed review. This is a local review stage that did not form part of the previous Mortality Review arrangements and has thus increased local reflective practice and the Trust's ability to identify learning locally. 5. As part of the Trust's mortality surveillance arrangements, a comparison to the categories under the previous Mortality Review arrangements is also being undertaken whilst a longer period of comparative data under the new arrangements is built up. This enables identification of any increases in death numbers against the previous scope categories which are outside of Statistical Process Control limits and should thus be investigated further. Again, there are no issues of concern to note. 6. It should be noted that all data in this report is taken as at 25/09/23. Any updates to information after this date will be included in future reports.

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

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

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

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

Acronyms/Terms Used in the Report			
LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	EDAP	Essex Drug and Alcohol Partnership
ICB	Integrated Care Boards	DNA	Did Not Attends

Supporting Documents and/or Further Reading

Attached –

Report: Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 1 2023/24)

Appendix 1 – Context of mortality data and surveillance under the Trust's Learning from Deaths Policy

Appendix 2 – Summary of 2023/24 mortality data

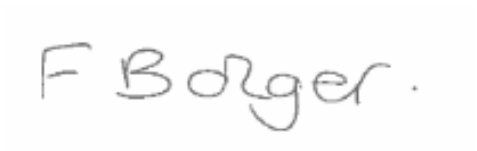
Appendix 3 – Summary of previous years mortality data

Links -

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

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*
PowerPoint Presentation (england.nhs.uk)

Lead



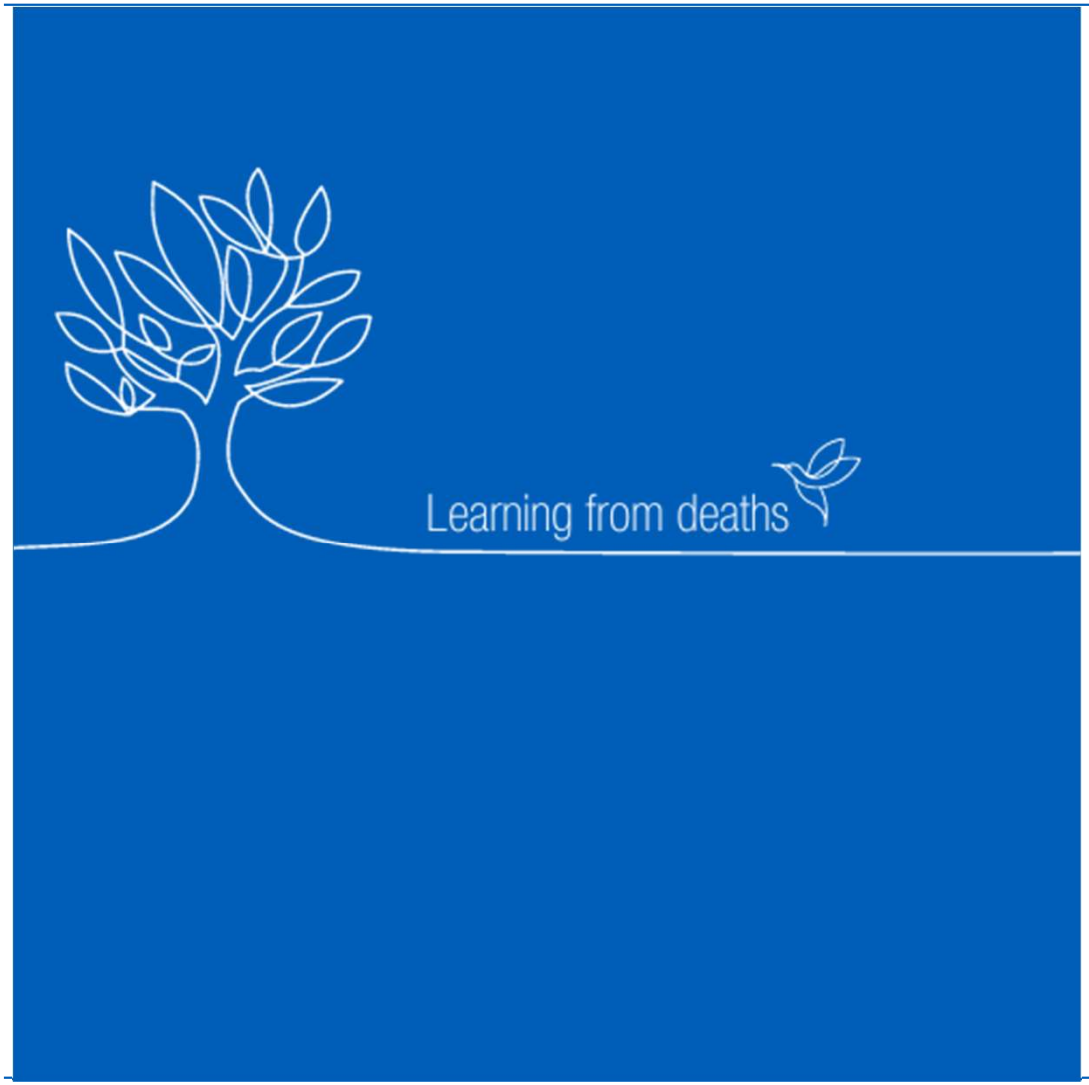
Frances Bolger
Interim Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 1 - 2023/24

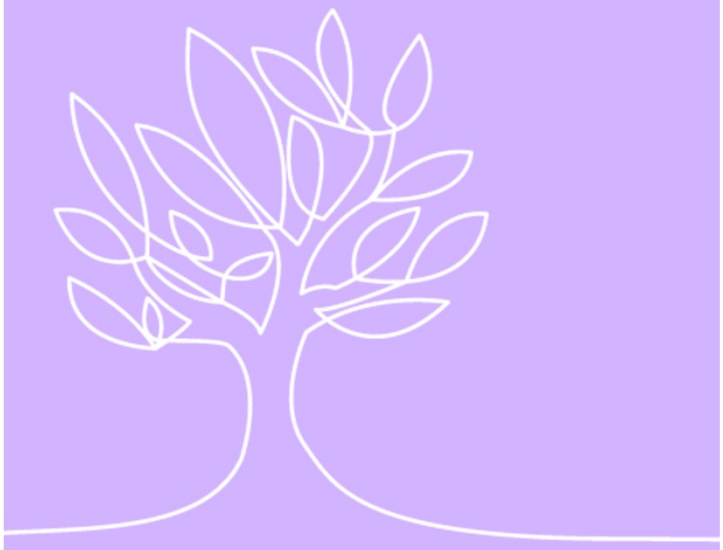


PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (July 2023) – ie learning identified between June – August 2023;
- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1st April 2022 (Appendix 1);
- Data relating to deaths recorded on Datix for Q1 2023/24 (1st April – 30th June 2023) (Appendix 2); and
- Updated data for deaths relating to 2022/23 and previous years (Appendix 3).

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT



The aims of the Trust's Learning from Deaths Policy are to provide a robust governance framework for undertaking mortality review in order to:

- improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it;
- further develop systems of care to continually improve their quality and efficiency;
- improve the experience for patients, their families and carers wherever a learning issue from the review of deaths is identified;
- improve the use of valuable healthcare resources; and
- improve the working environment for staff in relation to their experiences of reviewing deaths and associated reviews / investigations.

The Trust sets out to achieve these aims by:

- ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice, or conversely problems in care, to be identified on an individual basis;
- ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;
- ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; and
- ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action.

LEARNING FROM DEATH REVIEWS June – August 2023

This section on learning details:

- Sources of learning
- Examples of good practice identified
- Learning emerging from Stage 1 reviews
- Learning emerging from Stage 2 reviews
- Learning emerging from PSIRF reviews
- Examples of actions being taken to address and action learning from learning from deaths reviews

Sources of learning:

- Completed Stage 1 local service reviews
- Approved Stage 2 clinical case note reviews
- Approved Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews
- Completed Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative reviews
- Completed National Learning Disability and Autism Mortality Review Programme (LeDeR) reviews

Examples of good practice identified in reviews June – August 2023

- Discussed inter team/organisational working with Learning Disability team and no concerns raised. Good feedback received in terms of communication across services and professionals. No areas of concern noted. LeDeR review due to commence.
- It was difficult to identify learning in this case, patient's care was appropriate to her level of need and risk. It appears that the Trust were responsive to her needs and that the Home First Team offered care and support at a time when patient was at increased risk.
- This resident has slowly deteriorated over the last year. Family have been fully informed and worked with nursing team. EOL/GSF was put in place in January 2023.
- Triaging clinician's documentation was of a high standard and will be used as an example to existing and new members of the team.
- Patient was known to misuse alcohol and did not wish to address the issues despite numerous attempts to encourage engagement within appropriate services.
- It was the reviewer’s opinion that in the weeks leading up to his death, Trust staff had done everything they should have done to support this patient.
- Clinician had used SBARD, documented the assessment and risk and evidence that family involved in discharge planning.

Learning themes emerging from Stage 1 reviews June – August 2023 [1]

CONTINUING THEMES:

- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues re timing of PSIRF / Stage 2 reviews)
- Opportunities to **strengthen communication** to improve care of service user and following death (eg notification of death):
  - Within teams (eg between team members)
  - Between Trust teams (eg clear plan on handover between different services provided by the Trust)
  - With partner agencies (eg with acute Trust following death of patient)
- Majority of the deaths reviewed are from **physical health causes** (both rapid deteriorations and long term conditions) - opportunities to strengthen management of physical health issues:
  - Management of physical health of patients on EPUT inpatient units
  - Monitoring of physical health of patients in community and supporting access to physical health care
- **Record keeping** – eg ensuring next of kin details updated at every contact, ensuring these details are passed on when referring to another service, timely documentation of MDT discussions and risk assessments

Learning themes emerging from Stage 1 reviews June – August 2023 (2)

- Need to ensure **proactive follow up of disengagement** – eg importance of face to face contacts with clients
- **Clients not open to services at time of death –** eg Coroner Do You Know? enquiries
- **Dual diagnosis** clients - eg patient known to misuse alcohol but did not engage with EDAP despite numerous attempts to encourage

EXAMPLES OF NEW LEARNING:

- Strengthening **processes on referral** – eg ensuring referrals are sent to the appropriate service provider for the patient's needs.
- Strengthening **processes on discharge** – eg importance of ensuring all patients referred to the service have a discharge letter completed on discharge.
- Strengthening **care planning arrangements** – eg need for clear plans to be made and actioned at the time of, or as close as is reasonable to, the referral.

Learning themes emerging from Stage 2 reviews / EDAP collaborative reviews approved June – August 2023

STAGE 2 CLINICAL CASE NOTE REVIEWS:

- There have been no Stage 2 reviews approved between the last report to the Board of Directors and the end August 2023. There are therefore no learning themes to report within this report. Three Stage 2 reviews were approved in September 2023 and learning will be included in the next report to the Board of Directors.

ESSEX DRUG AND ALCOHOL PARTNERSHIP (EDAP) MULTI-AGENCY COLLABORATIVE REVIEWS:

- **Good practice** examples included:
  - engaging well with recovery workers, after off script there had been many attempts to contact
  - excellent care in place – death not due to drug use

- **Learning** examples included:
  - **Communications** - Translator to be sought and migrant support services to be explored
  - **Medications** – Issues to be explored in terms of situations where partner collects medication
  - **Communications** – When clients are not open to MH services, MARAC discussions are not available to safeguarding team
  - **Transition between CAMHS and Adult Services** – Inclusion of CAMHS workers in the Dual Diagnosis workstream meeting to be explored

Learning themes emerging from PSIRF reviews approved June – August 2023

Similar themes continue to emerge from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Communication with / involvement of others - particularly other EPUT teams or partner agencies
- Record keeping
- Clinical care
- Referrals
- Staffing
- Training

Examples of actions being taken in response to learning from deaths (1)

- Local immediate actions by services – eg reminder to team to ensure that all patients referred to the service having a discharge letter completed on discharge; high standard of triaging clinician's documentation identified on review to be used as an example of good practice to existing and new members of the team.
- Learning presented to and considered monthly by Learning Collaborative Partnership – included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate
- Learning used to inform topic areas for "Learning Matters" MST development sessions – eg record keeping, identification and care of the deteriorating patient (physical health on inpatient wards)
- Thematic learning being used to inform the Trust's Safety Improvement Plans. These will be the subject of separate reports to the Board of Directors.
- Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. The learning is also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

Examples of actions being taken in response to learning from deaths (2)

- Specific actions arising from reviews that have been pursued and concluded include:
  - Implementation of enhanced processes (extending good practice already in place in another locality area) to actively support clients in referrals to Drug and Alcohol Services with staff making the referrals directly rather than relying on self-referral
  - Clinical Lead for Dual Diagnosis supported in the development of a locality Dual Diagnosis Network with multi-agency membership which is now operational
  - In response to learning from the death of a patient receiving end of life care, a plan and flow chart of appropriate actions has been developed by the Trust's End of Life Care Lead. This has been communicated internally and also shared with the external CHC team who commission care for onward communication with all their domiciliary care providers as part of the commissioning of care. The Trust's End of Life Care Lead also offered to work with commissioners in other localities covered by the Trust to produce similar guidance
- Multi-disciplinary work being facilitated to address Trust wide issues - eg :
  - Physical health – learning from deaths lead continues to link with Trust leads for physical health and the care of the deteriorating patient to ensure learning continually informs work in these areas
  - Reviewing and strengthening the pathways between prison healthcare and EPUT services is now being taken forward as a Trust Quality Improvement initiative, led by the Deputy Director of Quality Improvement and Director of Specialist Services
  - A Dual Diagnosis Learning Implementation Group is now operational to consider specific learning emerging from the review of deaths of dual diagnosis clients and to jointly agree actions to be taken across EPUT and Essex Drug and Alcohol Partnership services

MORTALITY DATA - Context

- The context for the collection and reporting of mortality data under the Trust's Learning from Deaths arrangements (2022/23 and 2023/24) is outlined in **Appendix 1**. This includes details of the deaths which are mandated for report on the Trust's incident management system (Datix) and review.
- Regardless of the mandatory requirements for a formal review detailed in Appendix 1, services are also being encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for Q1 – Q4 2022/23 and Q1 2023/24.
- It should be noted that data in this report was extracted as at 25/09/23. Any updates to information after this date will be included in future reports.
- Detailed mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee for review and approval.
- A summary of mortality data for Q1 2023/24 is attached at **Appendix 2**; and for previous years at **Appendix 3**.
- To comply with the National Guidance on Learning from Deaths, this details:
  - the number of deaths in scope;
  - the number of these deaths subjected to review;
  - the level of review to which the deaths are being subjected; and
  - the determination of whether or not the deaths were more likely than not to have been due to problems in care.

- A review of mortality data processes and reporting has been undertaken within the Trust and refinements put in place to streamline and automate some previously manual processes, utilising more advanced technologies available to the Trust.
- This has included the building of an additional section on Datix which is now completed for each death reported. This enables corporate oversight of progress of the death through the learning from deaths review processes and of the outcome of reviews, previously undertaken manually.
- The refinements made are intended to strengthen efficiency, accuracy and resilience in the production of meaningful data.
- It was agreed that presentation of the Q1 data to the Board would be deferred by 2 months to enable building and using the new processes in the data production. Monthly monitoring of deaths reported was still undertaken throughout this period.
- Normal governance reporting schedules will be resumed for Q2 2023/24 data onwards.

Summary of Quarter 1 2023/24 mortality data (1) *Refer Appendix 2 (1) and (2)*

- **Total number of deaths reported:** There were a total of 163 deaths reported on Datix for Q1 2023/24 (including those not falling within the scope for mandatory reporting). This is similar to quarterly totals reported in 2022/23 which range from 114 (Q1) to 161 (Q4). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 172 Datix reports made in respect of the 163 deaths.

- **Total number of deaths in scope for mandated reporting:** To date, a total of 51 deaths in Q1 2023/24 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 21 deaths which is required to determine whether they are in scope for mandated reporting). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 (Q1 – 62 Q2 – 61 Q3 – 55 Q4 – 58). The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

- **Inpatient / Nursing Homes deaths:** Of the 163 deaths reported in Q1, 4 were inpatient deaths and 6 were nursing home deaths. All of the 4 inpatient deaths and all of the 6 nursing homes deaths have been confirmed as due to natural causes.

- **LeDeR reporting validation:** All reported Learning Disability deaths in Q1 2023/24 have been reported to the national LeDeR programme.

- **Level of review:** Thus far, 61% of deaths in Q1 2023/24 have been closed at Stage 1; 7% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 12% have been referred for Stage 3 full PSIRF review. 16% are awaiting the level of review to be determined. Table 2 in Appendix 2 details how these proportions compare with previous years.

Summary of Quarter 1 2023/24 mortality data (2) *Refer Appendix 2 (1) and (2)*

- **Stage 1 reviews:** A total of 123 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the 163 deaths in Q1. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 21 outstanding Stage 1 reviews for Q1 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 12 deaths in Q1 have been identified for Stage 2 mortality clinical case note review / thematic review thus far, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 20 deaths in Q1 have been identified for PSIRF review. To date one review has been completed and learning ascertained.
- **Completion of Stage 2 and Stage 3 (PSIRF) reviews:** Continued progress was made over the quarter with completion of Stage 2 and Stage 3 reviews relating to 2022/23 deaths, with 80 now completed set against a total of 70 completed in the Q4 report to the Board of Directors. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews and there is some slowing of progress of completion of Stage 2 reviews due to capacity. This is monitored by the Learning from Deaths Oversight Group and mitigating actions to ensure timeliness of review and learning identification are being pursued.
- **Problems in care assessment –** There are 0 deaths for Q1 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The assessment is still to be determined for 56 deaths in Q1. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 126 out of the total of 520 deaths for the full year. This data will continue to be updated in future reports as reviews are completed and the likelihood is determined.

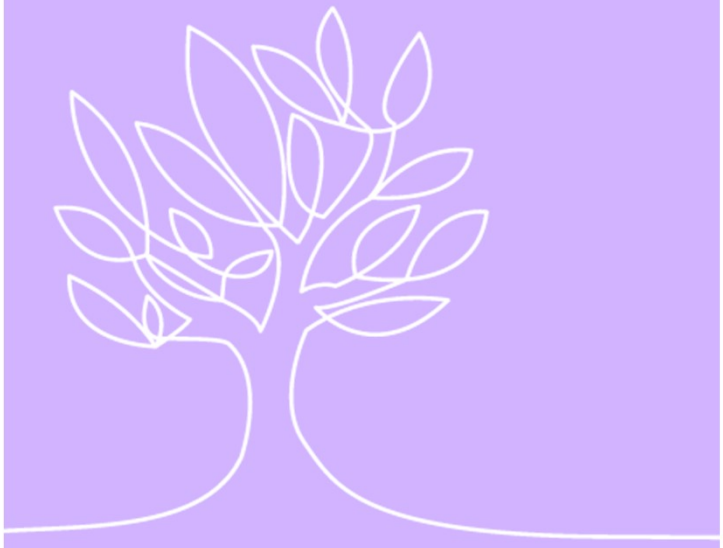
Assessment of Q1 2023/24 data against historic scope (for mortality surveillance) *Refer Appendix 2 (3)*

- An analysis has been undertaken of the Q1 2023/24 data using the previous "scope" categories and reporting groupings, in order to identify any trends of potential concern in relation to death numbers in established categories (as substantial historic data under the new groupings does not yet exist). This indicates that reported numbers of deaths are in line with numbers reported under the previous arrangements for periods not impacted by COVID-19 and that the service breakdown also remains consistent with previous months.
- Currently the number of deaths in Q1 2023/24 falling within the previous scope (n. 43) is slightly lower than for previous quarters. However this is again potentially related to the fact that there are a number of Stage 1 reviews requiring completion and thus these deaths awaiting Stage 1 review have not been assigned to a confirmed category. However, even if all those awaiting completion indicated a death that would fall within the previous scope categories, this would result in figures significantly within the upper control limit thus figures do not indicate a cause for concern. Figure 1 in Appendix 2 indicates that the number of deaths in scope in Q1, using the previous scope, fall within control limits.

Summary of previous years' mortality data (2017/18 – 2022/23) *Refer Appendix 3*

- Mortality data for previous years (2017/18 – 2022/23) is attached at **Appendix 3** detailing the mandated requirements of the National Learning from Deaths Guidance.
- In summary:
  - 2022/23 data is presented in the new format and indicates that, since the last report to the Board of Directors:
    - 18 deaths have been closed at Stage 1 review
    - 3 deaths have had a Stage 2 (clinical case note) review approved
    - 7 deaths have had a Stage 3 (PSIRF) review approved
  - 16 death reviews for deaths in 2021/22 have been closed since the last report to the Board of Directors with only 5 now remaining open (4 x PSIRF reviews and 1 x under determination). These are all being actively progressed.
  - The 3 death reviews remaining open for deaths in 2020/21 have now been completed and thus all death reviews for 2020/21 are now closed.
  - The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

CONCLUSIONS AND ACTIONS REQUIRED



- This report provides information in relation to the learning emerging from reviews of deaths being undertaken under the learning from deaths arrangements; as well as mortality data mandated for report and data to support mortality surveillance.

- It also provides assurance that the learning emerging is being acted upon. Given the focus on strengthening mortality data processes over the past quarter, there has been reduced capacity within the workstream to drive forward some of the developmental work identified. However, alternative approaches via other workstreams were identified where possible and, given that the new data processes are now in place, capacity should be available within the workstream to focus on developmental work alongside data collation.

- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q1.

- Given the outcomes outlined, it provides the Trust Board of Directors with assurance that there are robust processes in place in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing and ensuring that patients are receiving safe, high quality care. It also highlights the work that has been undertaken, and continues, to strengthen mortality data reporting processes and implement refined processes.

- The Board of Directors is asked to note the information presented; and request any further information or action.

NHS
Essex Partnership University
NHS Foundation Trust

APPENDICES

APPENDIX 1 Mortality Data – Context (1)

From 1st April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust. This is as follows:

- All deaths that have occurred within Trust inpatient services (this includes mental health, community health and learning disability inpatient facilities).
- All deaths in a community setting of patients with recorded learning disabilities or autism. *All deaths of patients with recorded learning disabilities or autism, whether in an inpatient or community setting, will be referred into the national LeDeR programme and are thus subject to different review processes than other Trust deaths.*
- All deaths meeting the criteria for mandatory review under the Trust's Patient Safety Incident Response Framework (PSIRF) – both the nationally and locally determined categories. The review undertaken under the PSIRF constitutes the review of the death for the purposes of the Learning from Deaths Policy and Procedural Guidance.
- Any other deaths of patients in receipt of EPUT services not covered by the above that meet the national guidance criteria for a Stage 2 Clinical Case Note Review. These deaths will be any deaths where:
  - Family, carers or staff have raised concern about the care provided; or
  - The death was unexpected and the individual:
    - had a diagnosis of psychosis (including schizophrenia, bi-polar, episode of non-organic psychosis, personality disorder, complex and severe depression) or eating disorder during the last episode of care;
    - was an inpatient at the time of death or had been discharged from EPUT inpatient care within the last 30 days;
    - was under the care of a Crisis Resolution Home Treatment Team at the time of death.

APPENDIX 1 Mortality Data – Context (2)

- In addition, deaths of clients under the care of services provided by EPUT as part of the drug and alcohol services care pathway (EDAP) are subject to specific reporting and mortality review processes including a collaborative multi-agency review. These deaths are therefore also included within mortality surveillance data.
- Regardless of the above mandatory requirements for a formal review, services are being encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for 2022/23 and for Q1 2023/24. It should be noted that this will not reflect negatively on the Trust in terms of potential to appear as an "outlier" set against other Trusts mortality figures. The national guidance was clear that, given there is no standard national definition for deaths that should be included in Trust mortality data, no comparison or benchmarking should take place between Trusts – the data should be used solely internally to the organisation to support mortality surveillance and quality development. We are however starting to explore with other local mental health trusts their approach to reporting deaths and data provision to establish whether it is possible to locally determine benchmarks etc.
- As the scope of deaths included has changed from the previous mortality review arrangements, there is no historic data prior to Q1 2022/23 against which to make comparisons. As a result, as well as analysing the data under the new arrangements, the data for 2022/23 and for Q1 2023/24 has also been analysed using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data. A decision will need to be taken in due course in terms of the period of time such analysis will be undertaken under both methodologies (ie at what point the Trust is satisfied that there is sufficient historic data under the new arrangements to provide assurances).

APPENDIX 1 Mortality Data – Context (3)

- Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. Deaths reviewed under the Patient Safety Incident Response Framework (PSIRF) from 01/05/21 were not subject to this determination as the methodology encourages focus on quality learning outcomes. A local methodology was initially put in place to make this determination for deaths reviews under PSIRF from 01/04/22; however this has now been paused whilst further research is undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination for deaths reviewed under PSIRF given that the PSIRF methodology has not been designed for this purpose. This approach to PSIRF deaths is reflected in the data in Appendix 2 & 3.
- The Trust's established mortality data dashboard was amended from 1st April 2022 to enable recording of data in line with the new arrangements, whilst still retaining the ability to use the process as a validation exercise to ensure deaths are reported on both Datix and clinical information systems and that learning disability deaths have been reported to the national LeDeR mortality review programme. A validation exercise between Datix and Clinical Information Systems is undertaken each quarter and actions taken to ensure deaths are reported appropriately on both systems. Work has been undertaken with the Trust Datix, systems and information teams to review the mortality data reporting processes to streamline and automate previously manual processes based on developments over the past year and new technologies available to the Trust since original establishment of the dashboard arrangements.
- It should be noted that data in this report was extracted as at 25/09/23. Any updates to information after this date will be included in future reports.

APPENDIX 2 Q1 2023/24 mortality data (1)

The table on the following page provides a summary of mortality data for Q1 2023/24. The following "Notes" are referenced in the left hand column of the table.

Notes:

1) There were a total of 163 deaths reported on Datix for Q1 2023/24 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 172 Datix reports made in respect of the 163 deaths.

2) 1 of these deaths occurred 4 days after transfer from EPUT inpatient unit to acute Trust

3) These figures denote the total number of Stage 1 reviews completed in full – 33 Stage 1 reviews in Q1 were terminated at the point of identifying that the death did not fall within the scope of the Trust's Learning from Deaths review arrangements as the patient had not been under the care of the Trust services within the 6 months leading up to the death or the death had immediately been identified for PSIRF review.

Table 1: SUMMARY OF 2023/24 MORTALITY DATA (UPDATED AS AT 09/2023)	Q1 2023/24 (stated in Q1 report)	Q1 2023/24	Q2 2023/24 (stated in Q2 report)	Q2 2023/24	Q3 2023/24 (stated in Q3 report)	Q3 2023/24	Q4 2023/24 (stated in Q4 report)	Q4 2023/24	YTD (stated in Q1 report)	YTD
DATA ON NUMBER OF DEATHS										
Total death reports on Datix ***Note 1***	N/A	*172								*172
Relating to x deaths ***Note 1***	N/A	*163								*163
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	N/A	51								51
Total inpatient deaths ***Note 2***	N/A	**5								**5
Total nursing homes deaths	N/A	6								6
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes) ***Note 3***	N/A	***123								***123
Total deaths awaiting completion of Stage 1 review	N/A	21								21
Total deaths closed at Stage 1 and learning ascertained	N/A	105								105
Total deaths referred on for Stage 2 clinical case note review	N/A	2								2
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis)	N/A	10								10
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	N/A	20								20
Total deaths for which Stage 2 review complete and learning ascertained	N/A	0								0
Total deaths for which PSIRF review complete and learning ascertained	N/A	1								1
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	N/A	7								7
Total deaths undergoing LeDeR (national learning disability mortality review) processes	N/A	4								4
Total deaths for which level of review under determination	N/A	6								6
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	N/A	0								0
Assessed as not more likely than not due to PIC	N/A	105								105
Assessment of likelihood of death being due to PIC still underway	N/A	56								56
Not applicable (EDAP and LeDeR reviews utilising different methodology)	N/A	11								11

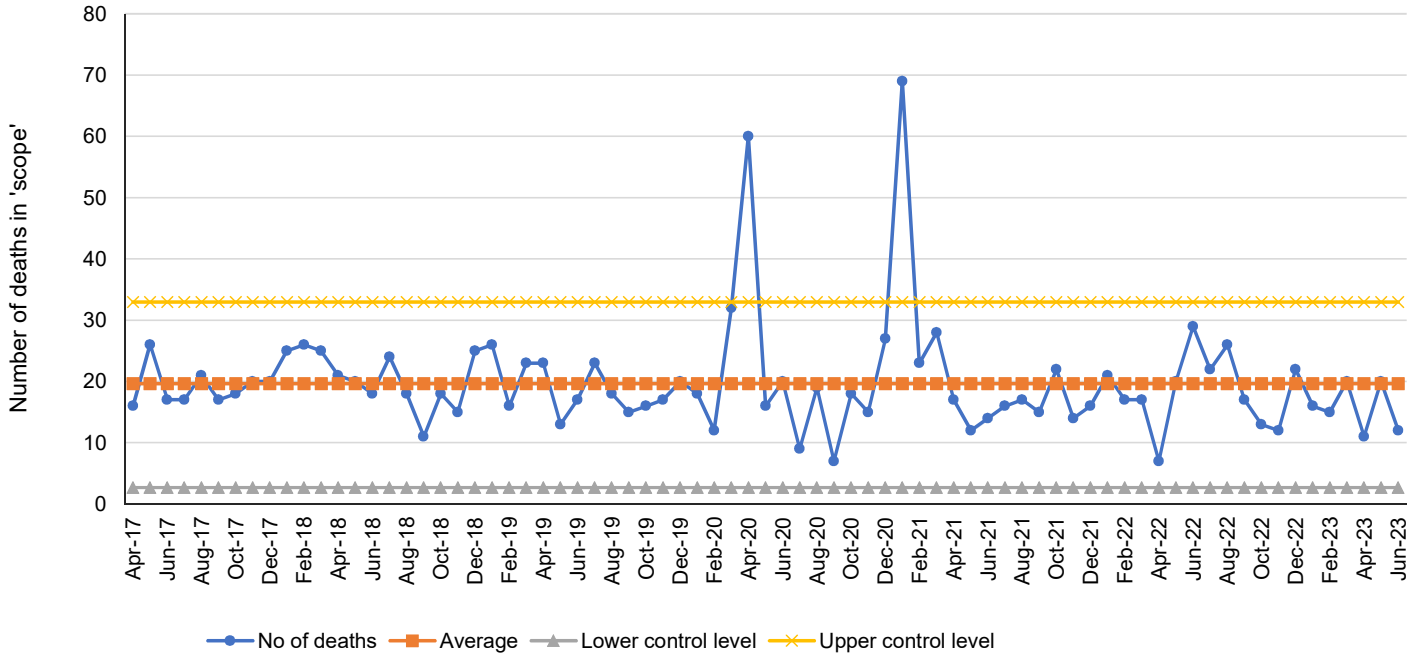
APPENDIX 2 Q1 2023/24 mortality data (2)

Table 2: Confirmed levels of reviews under new Learning from Deaths arrangements compared to previous years

Level of review	Number of deaths 2022/23	As a percentage of total deaths 2022/23	Number of deaths Q1 2023/24	As a percentage of total deaths Q1 2023/24	Average percentage in previous years
Total number of deaths	520		172		
Closed at Stage 1	288	**55%**	105	61%	**65%**
Stage 2 review underway (Clinical Case Note Review or Thematic Review)	81	**16%**	12	7%	**6%**
Stage 3 review underway (PSIRF)	80	**15%**	20	12%	**29%**

APPENDIX 2 Q1 2023/24 mortality data (3) – comparison against historic scope

Figure 1 below shows the total number of deaths that fell within the scope of the previous Mortality Review Policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. The two months where the number of deaths fell above the upper control limit were peaks of COVID-19. Figure 1 below indicates that the number of deaths in scope in 2022/23 and in Q1 2023/24 using the previous scope, fall within control limits.



APPENDIX 3 – Previous years' mortality data

The following two pages detail data (updated as at 25/09/23) for deaths as follows:

- **Table 3:** Deaths occurring in 2022/23 (reported and reviewed under the Trust's updated Learning from Deaths arrangements)
- **Table 4:** Deaths occurring in 2017/18 – 2021/22 (reported and reviewed under the Trust's previous Mortality Review arrangements)

TABLE 3: SUMMARY OF 2022/23 MORTALITY DATA (UPDATED AS AT 25/09/2023)	Q1 (stated in Q4 report)	Q1 current	Q2 (stated in Q4 report)	Q2 current	Q3 (stated in Q4 report)	Q3 current	Q4 (stated in Q4 report)	Q4 current	YTD (stated in Q4 report)	YTD Current
DATA ON NUMBER OF DEATHS										
Total deaths reported on Datix	114	114	115	115	130	130	161	161	520	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	62	62	61	61	55	55	58	58	236	236
Total inpatient deaths	4	4	6	6	9	9	4	4	23	23
Total nursing homes deaths	6	6	6	6	3	3	4	4	19	19
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes)	110	111	110	112	118	123	143	153	481	499
Total deaths awaiting completion of Stage 1 review	4	3	5	3	12	7	18	8	39	21
Total deaths closed at Stage 1 and learning ascertained	55	55	56	57	71	76	92	100	274	288
Total deaths referred on for Stage 2 clinical case note review	20	20	17	14	5	6	2	4	44	44
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis)	5	6	1	5	15	15	11	11	32	37
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	18	18	28	28	12	12	22	22	80	80
Total deaths for which Stage 2 review complete and learning ascertained	12	14	5	6	2	2	0	0	19	22
Total deaths for which PSIRF review complete and learning ascertained	17	17	22	24	7	8	5	9	51	58
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	11	4	4	9	9	10	11	34	35
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	3	4	4	5	5	5	5	17	17
Total deaths for which level of review under determination	5	3	5	3	13	7	20	10	43	23
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	3	3	0	0	0	0	0	0	3	3
Assessed as not more likely than not due to PIC	78	82	73	76	75	81	93	101	319	340
Assessment of likelihood of death being due to PIC still underway	19	15	34	31	41	35	53	45	147	126
Not applicable (EDAP and LeDeR reviews utilising different methodology)	14	14	8	8	14	14	15	16	51	52

APPENDIX 3 – Previous years' mortality data 2017/18 – 2021/22

Table 4: Summary of deaths closed

Year	Number of deaths in scope *	Number closed	% closed at Grade 1 desktop review	% closed at Grade 2 clinical case note review	% closed at Grade 3 critical incident review	% closed at Grade 4 serious incident review	% deemed more likely than not due to PIC
2017/18	248	248	60%	5%	0.5%	35%	1%
2018/19	235	235	63%	8%	0%	29%	4%
2019/20	228	228	64%	7%	0.5%	29%	2.5%
2020/21	311	311	73%	4%	0%	23%	**0.3%
2021/22	195	190	67%	4%	0%	26.5%	**0%

* ***Note:*** Scope in place 2017/18 – 2021/22 under Mortality Review Policy was different to scope from 2022/23 onwards under Learning from Deaths Policy

** ***Note:*** From 01/05/21 on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements until 01/04/22 (introduction of Learning from Deaths arrangements), the Trust did not undertake this determination for deaths reviewed via PSIRF arrangements as the focus of this methodology was on quality learning outcomes. The determination was made for all other deaths in scope.

The five death reviews remaining open for 2021/22 deaths are as follows:

- 1 death for which further information is awaited from operational services to determine the level of review to which the death should be subjected
- 4 deaths still undergoing PSIRF review – 2 of these reviews have been completed and are awaiting consideration and sign off via the Trust's governance process; and the remaining 2 reviews are on-going Patient Safety Incident Investigations

11. STRATEGIC INITIATIVES

11.1 QUALITY IMPROVEMENT STRATEGY

Decision Item | Frances Bolger | 10 minutes

REFERENCES

Only PDFs are attached

Quality of Care Strategy Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Quality of Care Strategy**					
Executive/ Non-Executive Lead:	Frances Bolger Interim Executive Chief Nurse, Dr Milind Karale Executive Medical Director and Zephan Trent Executive Director of Strategy, transformation and Digital					
Report Author(s):	Angela Wade - Director of Nursing and IPC Moriam Adekunle - Director of Safety, Matthew Sisto - Director of Patient Experience Anna Bokobza - Director of Strategy					
Report discussed previously at:	Board Seminar, Strategy Steering Group, Executive Committee and Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Development of the Trust's Quality of Care Strategy	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with the final draft of the Quality of Care Strategy which has been further developed and has been approved by the Executive Committee on 7th November and Quality Committee on 9th November.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Approve the content of the Quality of Care Strategy

Summary of Key Issues

The strategy development has had significant engagement over the past 6 months with a broad range of key stakeholders and a variety of forums taking a 'Start with People' approach to ensure its creation is co-produced and has been refined following feedback from stakeholders.

The strategy forms part of a streamlined suite of enabling strategies and creates the foundation for interdependent strategies to build upon. The strategy will sit within the governance of the Quality Committee of the Board and contribute to the clinical model for the Trust.

As the Trust's Safety Strategy will complete at the end of 2023, the Quality of Care Strategy will build on the achievements of safety first, safety always, then continue to set the organisational direction for the next 3 years. It will equally balance the 3 core elements of Quality of Care: Safety, Effectiveness and Experience and have critical interdependencies with other Trust strategies to achieve the Trust's strategic priorities. The strategy provides the opportunity to reset at EPUT and drive a care culture where people together create safety, effectiveness and experience.

People are at the heart of this strategy, demonstrating the importance of organisational understanding of where we have been and where we are now. The strategy, as requested by the people we involved in its development, emphasises the importance of a collaborative journey which is guided by learning from the past, by listening to those who have or could receive care from us, and ensuring that the people of Essex and beyond create partnerships with us to take the Quality of Care journey together.

The strategy is encompassing of all of our care services and aligns with our Trust objective to deliver integrated care services for people through community and inpatient settings.

It will also be important in the current national context for our mental health services and therefore, vital that we take the opportunity to learn, respond to and collaborate with our system and national partners adopting recommendations that will enable us to improve quality of care and sustain high standards reliably and consistently.

Taking the developed content forward, the strategy will drive the following by adopting a quality care 7 step model delivery plan :

- Establish collaborative leadership roles for safety, effectiveness and experience with executive sponsorship
- Agreed approach to socialisation and implementation with a communication plan, including a launch video, variety of communication forums and approaches and patient story resources which are relatable to our care giving teams
- Ensure quality governance structures are robustly in place rationalising meetings and providing assurance and evidence of delivery to Quality Committee and Executive Committee
- Adopt a quality management systems approach to strategic delivery. There will be an established baseline for strategy success measures set which then follow an improvement trajectory incrementally over the 3 year period covered by the strategy
- There will be a detailed programme plan for each core element
- The strategy sets the foundation of quality of care at EPUT and will be achieved with the interdependencies and the financial impact will be set through existing business planning and budgeting setting programmes

If approved is received at today's meeting, the strategy will be launched in January 2024.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Quality of Care Strategy

Lead

F Bolger.

Frances Bolger
Interim Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUALITY OF CARE STRATEGY

PEOPLE TOGETHER CREATING SAFETY, EFFECTIVENESS AND EXPERIENCE

CONTENTS

Welcome

As we continue our journey to deliver our strategic priorities and vision for EPUT, it is important to understand our journey so far and our next steps to reaching our ambitions.

We must ensure the steps we take on this journey are guided by learning from the past, and ensure the care we deliver today and everyday will continue to be guided by actively listening to the people we care for and all of our workforce. We will ensure that we create collaborative partnerships connecting with the people of Essex and beyond to make that journey together, with a commitment to person centred care, tailored to the individual and adopting principles for continuous improvement and sustainability.

It is vital that we always take the opportunity to learn. For our physical health services this means through system partnerships and collaborations supporting population health. For our mental health services this means learning from the Lampard enquiry to support a continuous journey of improvement. Collaborating with partners at a local, regional and national level will enable us to improve quality of care and sustain high standards reliably and consistently.

We provide a breadth of services which support holistic and empathic care within our local communities and inpatient settings. EPUT services encompass promotion of healthy life choices, prevention of illness, therapeutic acute care, rehabilitation and end of life care. Our services are available to all people ranging families and their babies before birth, through childhood and adolescence, throughout adulthood and older age.

Our aspiration is to be innovative and develop best practice guidance through partnership working, collaboration and research that will influence local, regional and national recommendations in the future. The development of this strategy will build an organisational approach for quality of care co-created using what our people have told us quality of care means to them, along with the National Quality of Care Principles.

Learning from Lived Experience

> As a person with living experience of services, one of the things that stands out for me is the quality of care I receive. Also, as a person whose family has used services, the quality provided by our NHS is of paramount importance. It's a real privilege and pleasure to be one of our Trust's Patient Safety Partners. Complementing the 'Safety First, Safety Always' mantra, this strategy becomes the golden thread to keep quality and safety at EPUT's heart.

> A someone with lived experience of using NHS Services and now working in partnership with EPUT, I believe lived experience plays a critical role in ensuring positive outcomes for patients and staff. Quality care prioritises patient safety and implements structures to improve service and support for all. Rather than looking at the past, let's concentrate on what we can do to help the future of patients and the care we provide in a safe and supportive manner. Working together, sharing ideas, listening to difference of opinion, respect, commitment, education and collaboration are key within this strategy. By adopting these key practices, we can deliver the highest standard of care to our patients and hope for our future generation.

> As someone with lived experience, I am pleased to see EPUT is practising what they are preaching in terms of the concept of co-production, involving all parties from the beginning of the Quality of Care Strategy development.

Context for this strategy

We are adopting a 'Start with People' approach, we asked people of Essex with lived experience of EPUT services to tell us what quality of care means to them. We've used this to create our vision for Quality of Care for EPUT.

People will feel in control and hopeful for their future

Treatment with **understanding, compassion, kindness** and without stigma or discrimination.

Listening and responding, receptive to people and their comments.

Actively seeking and valuing feedback and and listening to people and making changes as and when we need to.

Shared decision making with **empowered people**, their families, loved ones and supporters.

Consistently timely, **proactive, understandable and accessible communication** with families, loved ones and supporters.

Reliable and **consistent** provision of **evidence-based** care.

Three key components of quality of care

We are adopting the NHS constitution and WHO definition of quality of care. Care is evidence-based to ensure it is safe, effective and provides positive experiences.

SAFETY

Defining the next phase of our safety journey commencing January 2024, following on from Safety First, Safety Always 2020-2023.

EFFECTIVENESS

How our services ensure care is evidenced based and effective, building towards greater consistency, reliability, equity and driving improved outcomes for all.

EXPERIENCE

Those who we care for, their friends, families and carer's experiences are vital indicators of quality of care. Our workforce's experience is also an essential factor to create a culture of quality.

QUALITY OF CARE

The context of this strategy

- This strategy will promote the equal importance of all 3 components of Quality of Care. Taking the opportunity to build on the previous Trust Safety and Quality strategies and reflective of our Trust vision and priorities. This strategy includes Safety, along with Experience and Effectiveness.
- This strategy ensures the people we care for, their families, loved ones and supporters are partners in driving quality of care. They will do this through collaboration, sharing experiences, educating, supporting our learning culture and defining what quality of care means to shape our outcome measures.
- This strategy endorses evidence-based models of care and quality outcomes. Enhancing leadership, culture, systems and process improvement principles.
- This strategy provides a foundation of quality to integrate our services with a person centered and collegiate approach.
- This strategy will endorse our journey of continuous learning by adopting the findings of the Lampard Enquiry and ongoing partnerships within integrated care collaboratives.
- This strategy aligns with key national strategies such as the NHS Long Term Plan, National Quality Board Improving Experience of Care, Culture of Care Standards for mental health inpatient services, CQC Quality statements and NHS National Safety strategy.

This strategy reflects alignment to the quality strategies of our four local systems:

Mid and South Essex Integrated Care System

NHS East of England Provider Collaboration

Hertfordshire and West Essex Integrated Care System

NHS Suffolk and North East Essex Integrated Care Board

EPUT's Quality of Care Strategy contributes to the delivery of the Trust's five year Strategic Plan.

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.

OUR VISION

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

OUR VALUES

WE CARE.

WE LEARN.

OUR PURPOSE

We care for people every day. What we do together matters.

WE EMPOWER.

This strategy is part of a streamlined suite of enabling strategies

EPUT's core business is to provide care services. The Quality of Care strategy **drives** care quality principles as a foundation for other enabling Trust strategies. The interdependencies of these strategies will together deliver our Trust strategic vision.

TRUST STRATEGIC VISION

Our Care Unit delivery strategies	Our professional strategies	Our Estates strategies	Our clinical model strategies	Our Data strategies	Our Workforce, People and Culture and Education strategies
to ensure that our Care Unit operational delivery plans are achieved with place based and service need prioritisation	to ensure that professional strategies such as medical, psychological, Pharmacy and Collaborating of care, which brings which brings Nursing and Allied Health Professional practice together.	to ensure that our physical environments are conducive to high quality care and we achieve our Green Plan.	to ensure that clinical excellence is built with the core principles of quality. Our Pharmacy strategy which provides medicine optimisation for EPUT.	to ensure quality interventions are directed to areas of greatest need.	to ensure we are empowering staff to achieve their potential.

QUALITY OF CARE STRATEGY

SAFETY | **EFFECTIVENESS** | **EXPERIENCE**

The aims of the Quality of Care Strategy

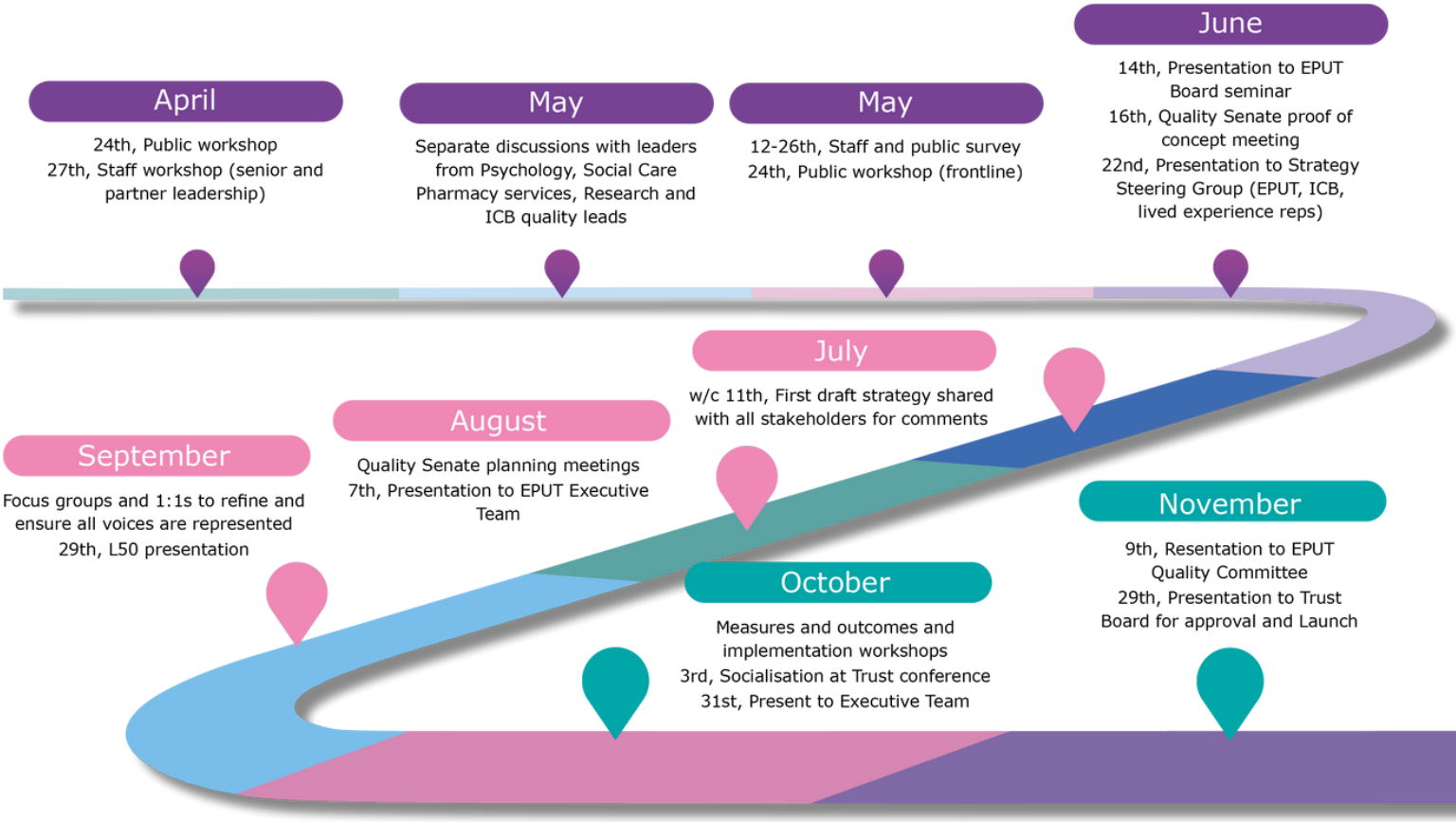
- Put **people** first: the people we care for, their families, loved ones and supporters and all of our workforce.
- Ensure the three components of quality - **Safety, Effectiveness and Experience** - collectively underpin how care is designed and delivered.
- Create collaborative, equitable **partnerships** to listen, learn and improve.
- Improve our approach to delivering current **evidence based**, best practice care.
- Support the development of collegiate, professional, caring, **high performing teams.**
- Move from providing reassurance to **assurance** through the introduction of a Quality Assurance Framework.
- Develop a **suite of Quality Outcome measures** that align with EPUT and Integrated Care Systems' Quality of Care priorities.
- Ensure EPUT's safety agenda is **aligned with national strategies** and builds on the safety journey to date, with continuous improvement and safety systems and cultures.
- Ensure safety at EPUT through a sustained **culture of learning**, using thematic review, data intelligence, collaboration and partnership.

Approach to Strategy Development

This strategy has been shaped by listening to a range of important voices.

Representatives bringing experience of physical and mental health services begun the strategy development and whose views and wishes then guided the approach taken thereafter.

- Workshops for people with lived experience, carers, Governors, volunteers, Patient Safety Partners and Healthwatch. Two multi-disciplinary staff workshops including a diverse range of colleagues from across all of our care units, covering a wide range of services, colleagues from a variety of different professions, roles, experience and quality leads from all of our Integrated Care Systems and our regional specialist collaborative.
- Survey responses from EPUT staff and people with lived experience who weren't able to attend workshops in person
- Voices of our Patient Safety Partners who share the experiences of our patients through their visits and involvement
- Presentation at Board development, and subsequent EPUT governance approval forums
- Nominated directors as senior responsible officers for the three components of Quality of Care
- 1:1s and small focus groups, with many key stakeholders to co-create the final strategy.



Principles

Building trust through empowerment, collaboration and partnership.

Staff workshops identified how the strategy could support learning and the continuous improvement of quality of care.

- Streamline polices and guidelines and ensure ease of use.
- Promote working partnerships.
- Foster a culture of learning and continuous improvement.
- Create the opportunities for evidence based care delivery.
- Focused systems and processes in place to be more effective.
- Support empathy, respect and connection in our culture and behaviours.
- Prioritise the experience of people we care for, their families and supporters.
- Opportunity to build the pride of our workforce.
- Enable completion of meaningful Quality and Equality Impact Assessments.

Implementing this strategy will take EPUT on a journey from providing reassurance to assurance.

- Assurance to our local population, people with lived experience, their families, loved ones and supporters.
- Assurance to our Board.
- Assurance to system partners.
- Assurance to our workforce.
- Assurance to regulators.

Across all EPUT services we will be able to provide

Assurance that quality of care is:

- Current; based on best practice / clinical evidence.
- Co-designed in partnership with our patients, their families, loved ones and supporters.
- Multi-professionally agreed, in partnership with our patients, their families, loved ones and supporters.
- Suitably integrated.
- Aware of context of existing concerns.
- Positively influencing EPUT's Culture.
- Co-designed with equity, with equality and quality impact assessments.

Quality of Care Strategy Vision at a Glance

People will feel in control and hopeful for their future

People will work together to support listening, learning and continuous improvement

Trust, consistency, reliability and pride will be our building blocks.

PEOPLE TOGETHER CREATING SAFETY, EFFECTIVENESS AND EXPERIENCE

We will consistently improve patient safety through involvement and insight.

Culture and systems will be our key foundations to improve patient safety.

The care we provide will be beneficial, evidence-based, and effective.

Care will be provided by staff that are confident, competent, and Knowledgeable.

We will enhance care by understanding people's experiences and collaborating with them and their loved ones.

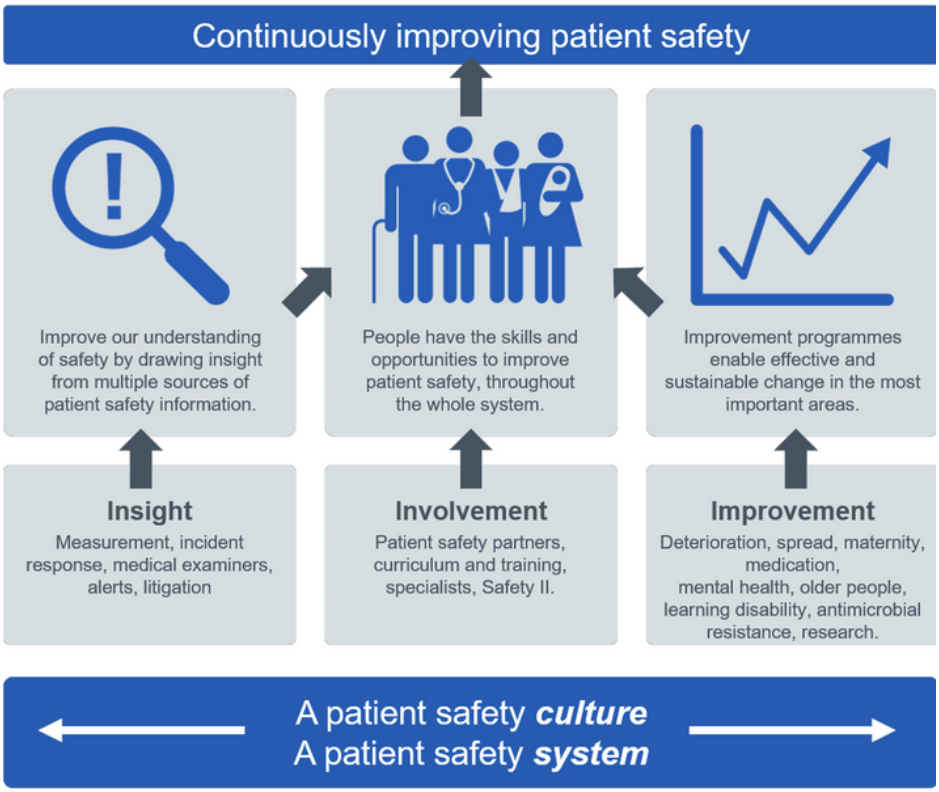
We'll start with people, ensuring valuable processes for care, celebrating achievements, and facilitating improvement.

Safety at EPUT

Senior Responsible Officer
Moriam Adekunle, Director of Safety, Patient Safety Specialist

Executive Sponsor
Frances Bolger, Interim Chief Nurse
Ann Sheridan, Executive Chief Nurse from 2024

Our vision is to continuously improve patient safety, built on two foundations set out in the NHS National Patient Safety Strategy: A patient safety culture and a patient safety system.



There are three strategic principles that will support our development. Our ambition is to have no avoidable patient harm within the organisation by the end of 2026.

1 Insight

Improving understanding of safety by drawing intelligence from multiple sources of patient safety information.

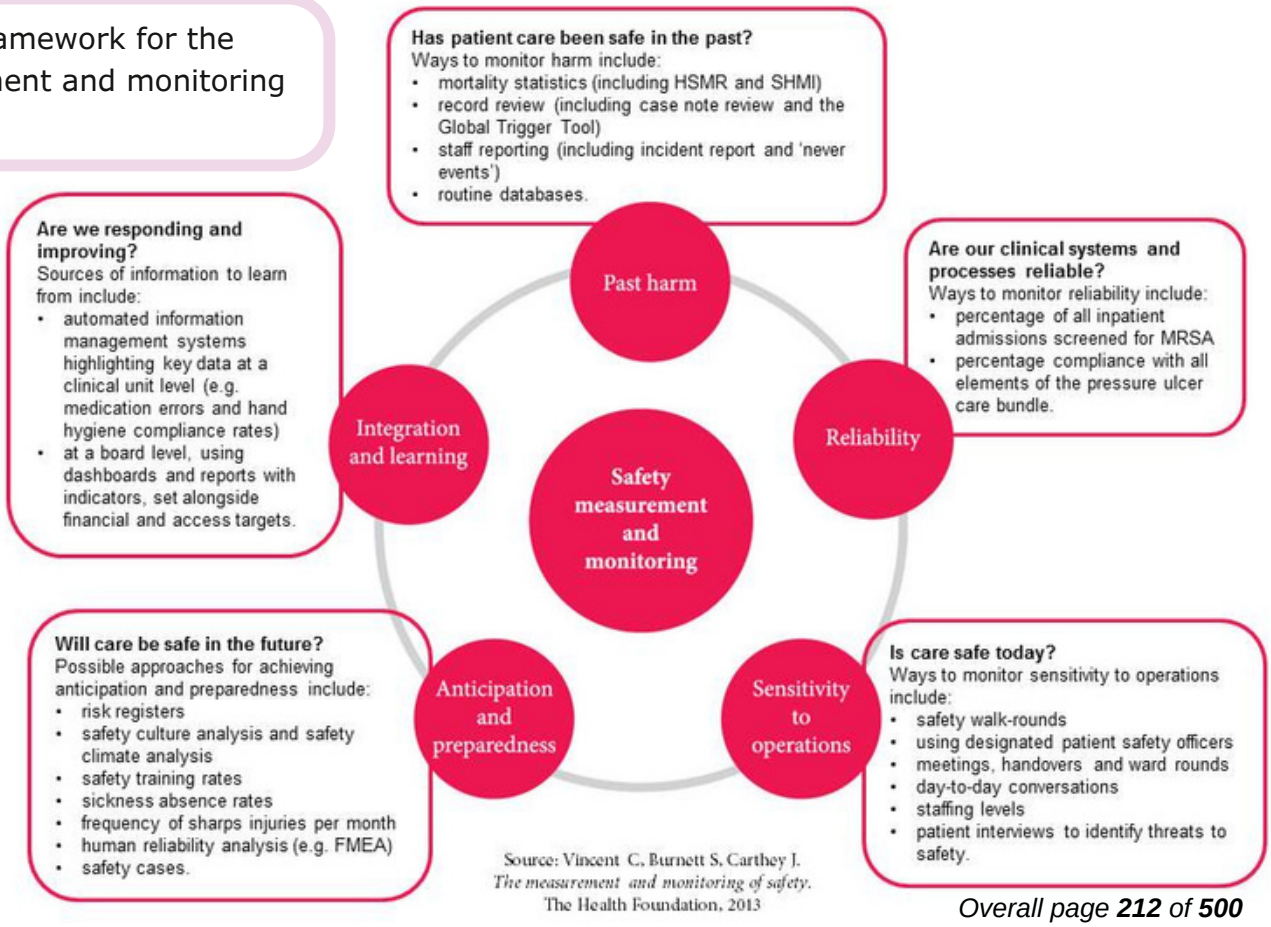
2 Involvement

Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.

3 Improvement

Designing and supporting programmes that deliver effective and sustainable change in the most important areas.

Using a framework for the measurement and monitoring of Safety.



Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2013

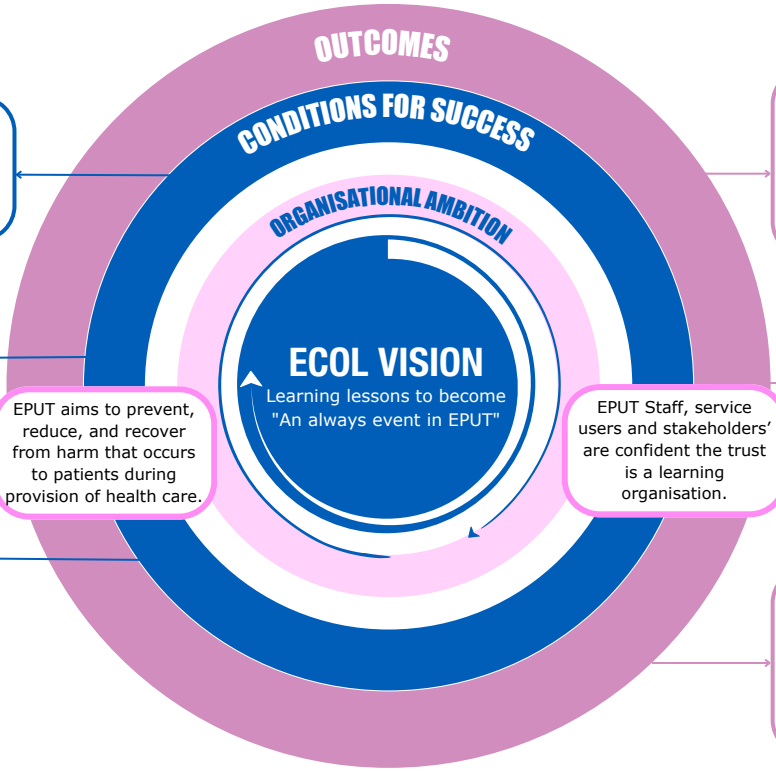
EPUT Culture of Learning Quality Benefit Realisation

Ensuring our culture of learning creates conditions for success and realises safety benefits.

Cascading Information
Redesign 5 Key messages, Webinars & Newsletters. Develop a Trustwide Lessons Training. Embed Just, Caring and Learning Culture.

Digital Systems & Tools
Improve data collection on Datix. Develop a Safety Dashboard. Develop a Safety & Learning. Management System.

Organisational Structure & Processes
Revise the Learning Oversight Sub Committee (LOSC).
Convene a Learning Collaborative Partnership (LCP).
Develop a Lessons Handbook.
Implement Lessons Team intervention.
Develop sustainable Quality.
Improvement infrastructure.

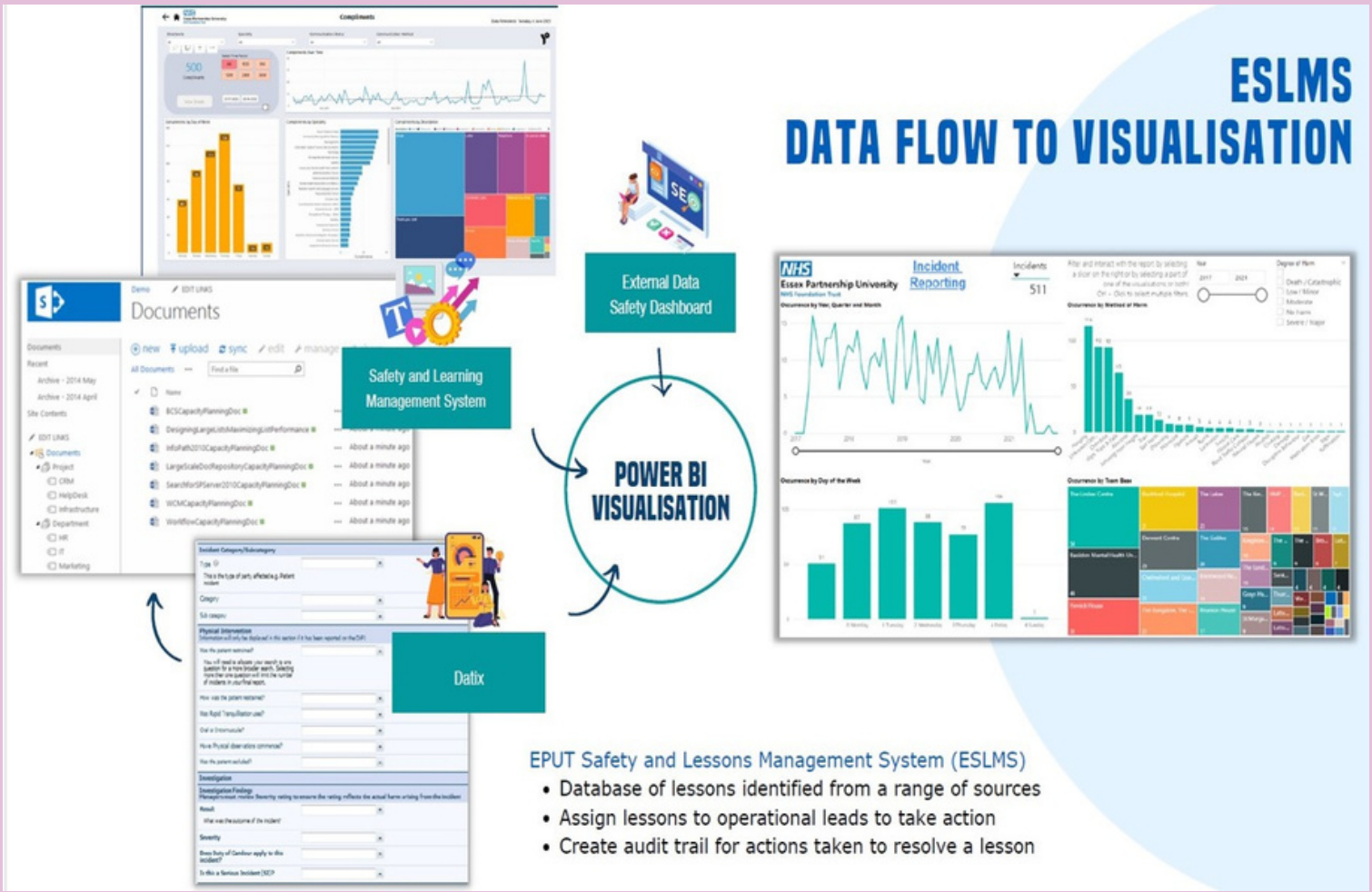


Improvement in quality of information collected via Datix. Improved visualisation of amalgamated data from different intelligence sources. Improvement in reporting of incidents. Improvement in Lessons identified from incidents recorded on DATIX.

Dedicated resource to improve organisational learning Develop a procedural document for learning lessons. Establish governance structure to support identification and cascading of lessons. Establish governance process for LOSC & LCP meeting. Establish Quality and Safety (Q&S) Champion Network

Improved Trust-wide learning events and create space for learning. Improved shared learning resource. Improved level of engagement with cascaded learning resources. Improved analytics for cascaded lessons information.

Develop EPUT's Safety and Lessons Management System to ensure all care providing teams can access data to support learning.



Effectiveness at EPUT

Senior Responsible Officer
Angela Wade, Director of Nursing, Infection Prevention and Control

Executive Sponsor
Dr Milind Karale, Executive Medical Director

There will be five main approaches to support our effectiveness ambition

Our vision is to ensure that everyone receives the care they need which is beneficial, evidence based and effective. Provided by teams who are confident, competent and knowledgeable within a culture of quality care. Our aim: To build consistency, reliability, equity and driving improved outcomes for all.

Evidence based sources	Quality Senate	Quality Assurance Framework	Quality outcome measures	Work in partnership with peers
• National publications. • Professional publications and guidance. • Structured literature review of published research. • Historic Trust learning. • Expert presentation. • Local and system learning and audit. • Regulatory quality statements.	• Collaboration and partnership. • Provide expert and trusted advice for agreed priority topics. • Accountable for clinical guidelines. • Create a space of professional curiosity. • Promote quality and equality impact assessments.	• Create a robust methodology for quality planning, controls, assurance and improvement. • Drives Trust quality priorities.	• Create a suite of measures in partnership with our people. • Reflect national and system tools to measure agreed outcomes. • Data dashboard. • Report into the Executive Effectiveness Sub-Committee.	• Always consider experience and safety. • Governance structures to provide assurance and evidence from ward to Board.

Quality Senate

Creation of a Quality Senate designed to:

- Enable the care we provide to be best practice and evidenced based
- Create space for collaboration and partnership
- Create a trusted reputation of supportive advice to guide and enable care delivery across our organisation and integrated care systems
- Build on National Quality board principles
- Provide expert advice to the organisation for agreed priority topics
- Be accountable for clinical guidelines
- Create a space of professional curiosity, shared ownership and psychological safety where collaborative partners want to be
- Promote quality and equality impact assessments.

The Quality Senate will provide the Trust with a new process to enable, support and endorse effectiveness through collaborative partnerships. It will review current evidence in priority areas and undertake gap analysis of current practice, providing recommendations and clinical advice to the Trust Board. The quality senate process will result in the formulation of topic advice templates which will be received into the relevant subcommittees and operational Care Unit accountability framework meetings to influence care service change. The Trust board will also be advised of all senate decisions to provide them with assurance EPUT care services have the most current evidence based recommendations available to drive improvement.

We will replace Clinical Governance & Quality Sub-Committee and be the new source of multi-professional and collaborative partnership recommendations and clinical advice to the Trust.

The senate Terms of Reference have been agreed.	**The senate membership and minimum quoracy confirmed.**	**Processes to ensure the effectiveness of the senate meetings developed.**
The creation of evidence evaluation and Trust advisory templates designed.	**The frequency of senate has been agreed at eight per year with clear rationale.**	**Through facilitated discussion the senate members have proposed the first eight topics.**
Recognition of working within the financial context and available NHS provision.	**What needs to stop as no evidence of effectiveness and could be more harmful.**	**To have the "golden thread" of person centeredness.**

Recognises the importance of coproduction and partnerships, informed choices, honesty and openness.	**Trust wide collegiate approach of clinical support and reduce custom and practice due to fear and resulting risk aversion.**

People we care for at the heart of quality
Our patients and population of Essex, Luton, Bedfordshire, and Suffolk are at the heart of each element of the QAF.

1. Quality Planning – how Trust-level quality is measured and cascaded and what the requirements of annual quality planning are.
Defining what quality means at Trust level, its key areas (e.g. Patient Safety) and corresponding measures in alignment with best practice and regulatory guidelines. There needs to be in place a clear plan for annual activities to ensure quality governance, assurance and improvement as well as a clear reporting structure to track progress against priorities in the annual Quality Plan.

2. Quality Improvement - how our teams are supported and empowered to continuously improve quality of care. A system of QI tools, routines and behaviours that enable teams to identify quality improvement areas, address these with sustainable countermeasures and be supported and coached by their leadership and Trust's QI experts in this journey.

4. Quality Assurance – how our ICBs, Board, staff and people we care for are assured of high-quality standards through the provision of evidence.
Based on the outputs from workshops and task and finish groups, a high-level plan is provided for the Trust's key quality assurance processes such as joint ICB / EPUT quality visits, evidence gathering standards, team accreditation, CQC compliance and response processes, and the quality governance structure to provide assurance to all parties.

3. Quality Control – how all staff within EPUT take responsibility for the daily checks required to ensure quality is maintained.
The checks and responsibilities for each team or service have been defined in alignment with annual quality planning to ensure that daily processes comply with standards and guidelines using team and peer audits, quality control checks and standard operating procedures.

The Quality Assurance Framework will provide a Trust wide cyclical methodology to support the Trust's quality of care principles.

Experience at EPUT

Senior Responsible Officer
Matt Sisto, Director of Patient Experience, People Participation and Lived Experience

Executive Sponsor
Zephan Trent, Executive Director of Strategy, Digital and Transformation

Our vision is to fully understand people's experience of care in order to improve. Working in partnership with the people we care for, their loved ones and their supporters. To do this, we are committed to adopting the 10 principles as set out in the national statutory guidance from NHS England and the Department for Health and Social Care.

Starting with people is key to the successful delivery of the Trust's Strategic Plan and, as a guiding principle, we will adopt national best practice in accordance with statutory guidance, taking a coproduction first approach.

It is also important to recognise, however, that engagement, consulting and informing people are still value-adding activities which we will continue to do.

We will adopt learning from principles of "what it feels like..."

- **It feels like being listened to.**
- **It feels like someone's thinking of me and looking out for me.**
- **It feels like being seen.**
- **It feels like knowing support is there for me.**
- **It feels like I can be myself.**
- **It feels like it is about my problems, not their problems.**
- **It feels like I have support.**
- **It feels like everyone is being honest.**
- **It feels like I am being helped in the way I want to be helped.**
- **It feels like we're working together.**
- **It feels like instead of being shown the door, that they are holding the door open for me to walk through.**
- **It feels like they are going beyond signposting.**

https://www.centreformentalhealth.org.uk/publications/what-feels-like-poem/

We will adopt the National Dignity Council's 10 dos to support our culture of respect: www.dignityincare.org.uk

1. Have a zero tolerance of all forms of abuse.
2. Support people with the same respect you would want for yourself or your family.
3. Treat each person as an individual by offering a personalised service.
4. Enable people to maintain the maximum level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people's right to privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people's loneliness and isolation.

Dignity in the heart, mind & actions

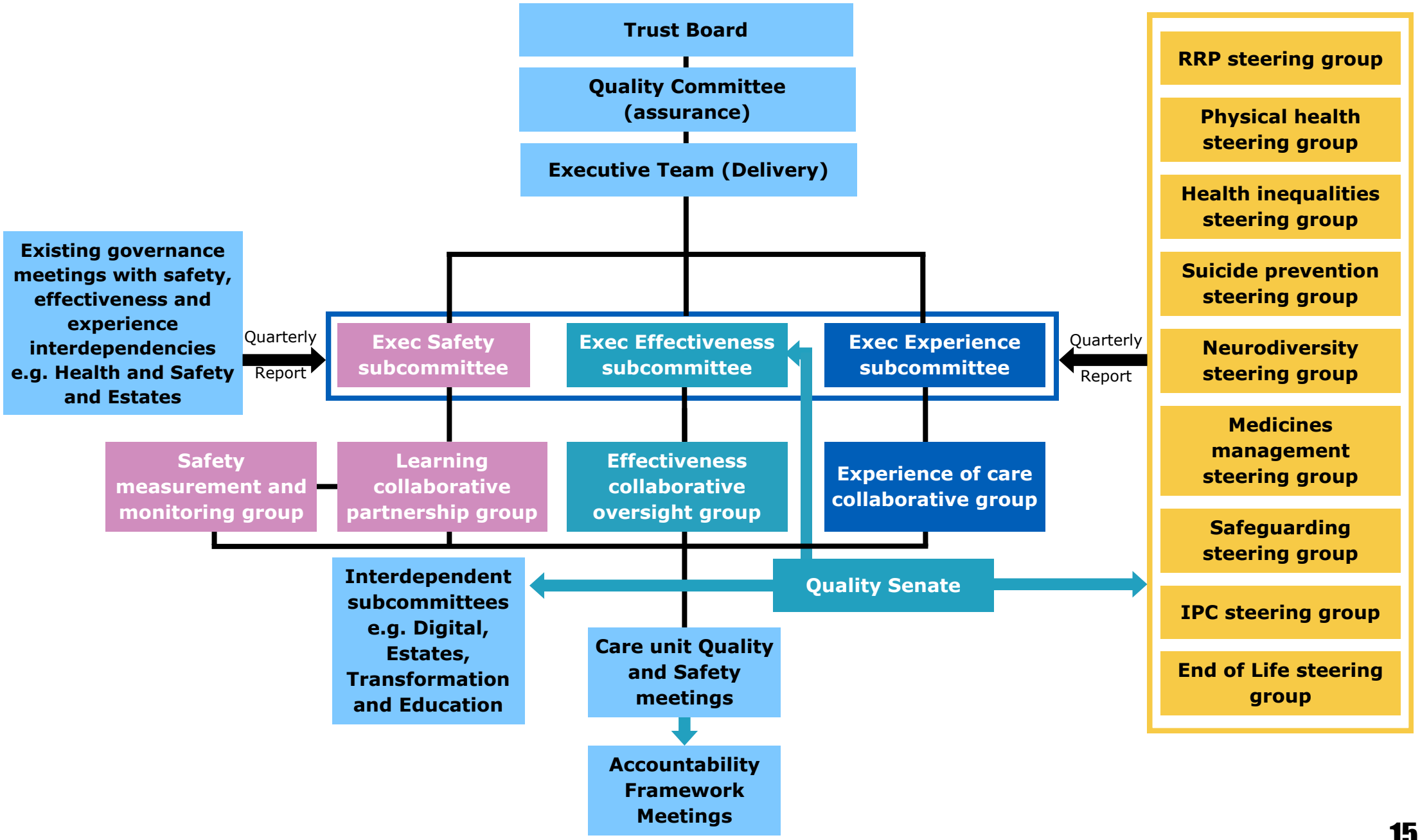
Staff experience of care

We will improve staff experience of care they deliver by listening, supporting, learning, and developing a confidence, competence and pride through role development.

- Restorative supervision
- Team forums
- Professional forums
- Education and training
- You said, we did opportunities
- Pulse surveys
- Annual surveys
- Freedom to Speak Up
- Celebration and recognition.

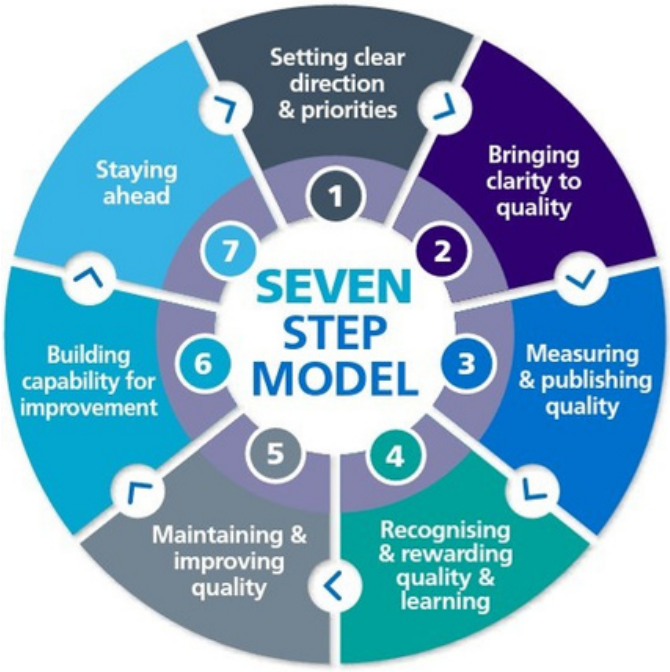
The proposed governance structure for Quality of Care

Reporting lines to Quality Committee of the Board



Putting principles into action

EPUT will utilise the NHS England principles of delivering quality care when developing our delivery plan



1	**Setting clear direction and priorities** To deliver a new service model for the 21st century, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.
2	**Bringing clarity to quality** setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities.
3	**Measuring and publishing quality** Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making.
4	**Recognising and rewarding quality and learning** Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.
5	**Maintaining and improving quality** Working together to maintain quality, reduce risk and drive improvement.
6	**Building capability for improvement** Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.
7	**Staying ahead** By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy.

Over the next thee years, EPUT will implement a plan to deliver against the strategy:

- Follow Quality Care seven Step Model as delivery plan stages.
- Establish a leadership roles: Executive sponsor and SRO for Safety, Effectiveness and Experience.
- Agree methodology for communication, socialisation and readiness for strategy implementation.
- Ensure quality governance structures are robustly in place, rationalising meetings and providing assurance and delivery to Quality committee and Executive team.
- Set EPUT's Quality of Care expected outcomes, key deliverables and measures for Safety, Effectiveness and Experience with our local people through the governance structures.
- Deliver an end of year benefits realisation report for Board.
- Ensure financial impact assurance through business planning and budget setting.
- We are clear on the potential barriers to success, so that we can consider these when developing our implementation plans, creating risk logs with mitigations for monitoring.
- Provides safety systems through Patient Safety Incident Response Framework (PSIRF) and the updated Trust Patient Safety Instant Response Plan (PSIRP) delivery.
- Culture of Learning and digital safety platform supporting safety culture.
- Review and design Quality outcome measure suite using coproduced approach.
- Develop staff competence training and development reset quality of care culture though confidence competence and leadership.
- Adopt the national Dignity Council's Dignity Dos.
- Establish EPUT's Quality Senate with an annual programme of eight predefined quality focus topics and stand up capabilities.

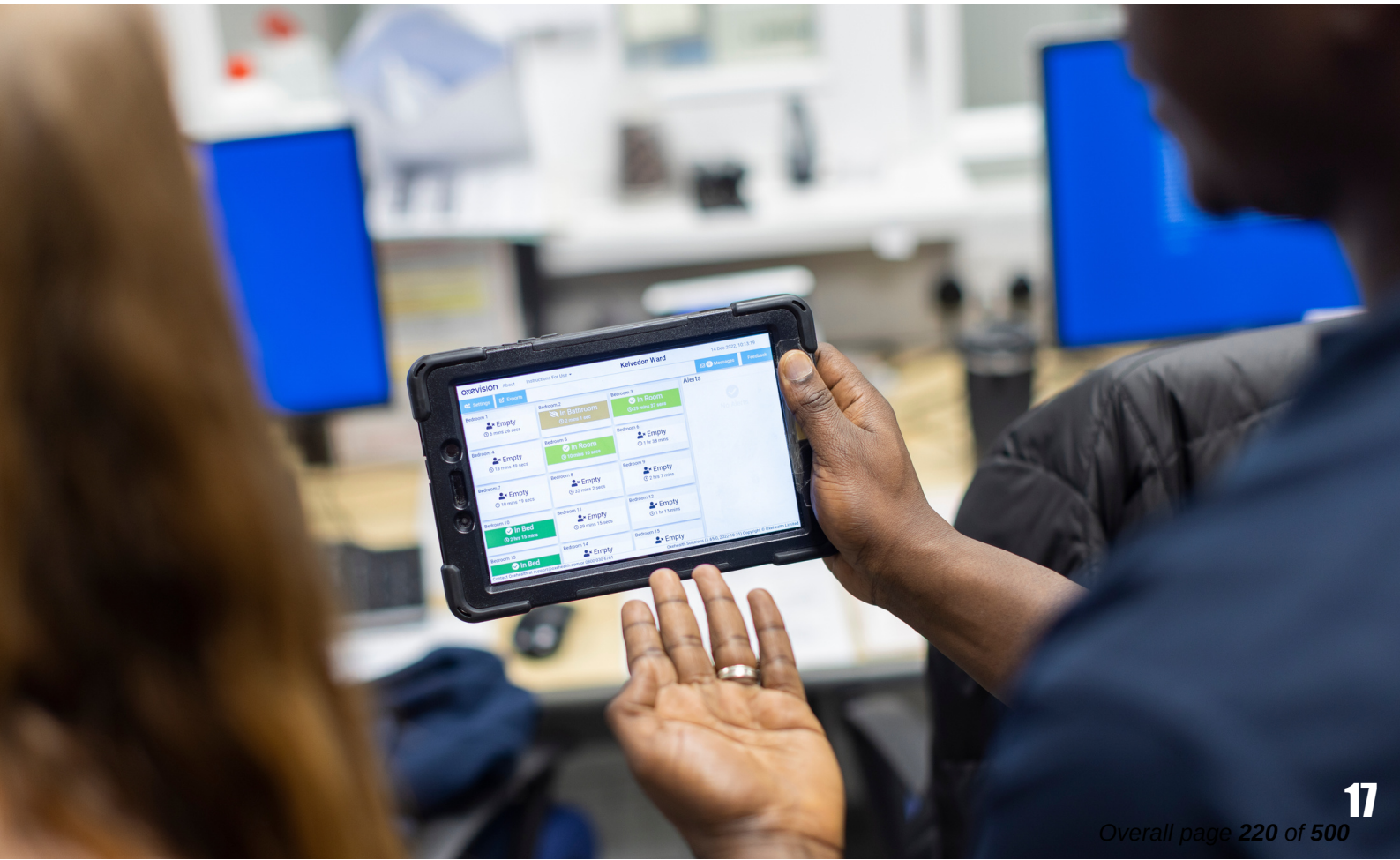
First year Quality Senate topics

Quality senate members considered the first year priority topics. There were many suggestions, it was agreed that there opportunities for alignment and grouping to achieve 8 main proposed topics.

- **Population health**
- **Virtual services**
- **Trauma Informed Care**
- **Safety Planning**
- **Neurodiversity**
- **Move away from Care Programme Approach (CPA)**
- **Personalised care**
- **Dementia and Mild Cognitive Impairment**

Carers' experience was suggested as a topic. This will require consideration under every topic and therefore requires both the senate membership of lived experience and literature searches to ensure carers' experience is always in available to inform the senate's work

AI was also felt to be a consideration across all topics with close alignment to any senate support of the Digital Strategy and clinical leads' requests.



2024-2026 EPUT Quality of Care Programme Plan

	Pre Strategy Launch	Year 1		Year 2		Year 3	
Evaluate	Review and align system partner and national strategies and plans. Evaluate Safety First, Safety Always 2023.		Evaluate Year 1, check alignment with corporate strategy. Sustainability Check.		Evaluate Year 2, check alignment with corporate strategy. Sustainability Check.		Evaluate Year 3, check alignment with corporate strategy. Benefits Plan Review & Sustain Plan.
Engage	Lived Exp. Staff and public workshops and Survey for engagement and co production. Focus Gps. Board seminar, ET, Quality Committee. NHS Impact care unit self assessment workshops and a pre-mortum for quality of care reset.	Launch socialisation programme trust and system wide: key focus of quality reset, creating a cultural 'people together' movement of change. Establish Team forums, Professional forum, You said, we did opportunities, align interdependencies, Freedom to speak up, celebration and recognition events. Establish quality of care programme of events annually.					
		Review quality account and complete new quality account priorities. Propose and agree trust wide corporate lead quality priorities with engagement and governance steering groups.		Review Quality account and complete new Quality account priorities. Propose and agree trust wide corporate lead quality priorities with engagement and governance steering groups.		Review Quality account and complete new Quality account priorities. Propose and agree trust wide corporate lead quality priorities with engagement and governance steering groups.	
Outcomes	Workshop with ELAs to agree approach for quality outcomes measurement which evidence achievement of ELA developed vision.	Review and design Quality outcome measure suite using coproduced approach with Digital team.	Launch new Care Plan with GBOs and GAS OMs.	Launch digital PROMS, REQOL, DIALOG+, POEM, GBO's, CORE 10, LEA QOC, standardised across all quality governance.		Review Quality outcome suite for Impact and refinement.	Build contracting and service specification model based on outcome commission and provision and launch formally in contract.
			Develop support and education systems and processes for use of Quality outcome data and the outputs from outcome measures including a full review of expected clinical outcomes against NICE and other guidance.				
Safety	Review safety governance structure. Set vision, aims and deliverables. Continue which existing work programme for 2023.	Launch new PSIRF policy and New PSIRP. Continue with ECOL structure. Hold Annual Safety Conference.		Operationalise three strategic principles of Insight, involvement and improvement Hold Annual Safety Conference.		Hold Annual Safety Conference Launch new safety and learning Research & Innovation systems and process for care staff.	
		Launch new Governance meeting structure. Socialise safety annual work plan and safety framework.					
		Complete development and launch Safety and Lessons management system.					
Effectiveness	Review and Propose Effectiveness governance structure. Set vision, aims and deliverables. Establish TOR, quorum and 1st year topics for senate.	Board approve 8 topics. Hold 8 Quality Senates with Gap analysis and recommendations. Develop new EQIA. Establish process for clinical guideline review.		Board approve 8 topics. Hold 8 Quality Senates with Gap analysis and recommendations.		Board approve 8 topics. Hold 8 Quality Senates with Gap analysis and recommendations.	
		Launch QAF trust wide Design Effectiveness element of BI dashboard. Launch new governance meeting structure. Socialise effectiveness annual work plan. Hold annual effectiveness grand round.		Review effectiveness of QAF for Continuous Improvement against quality outcome data analysis complete build and then launch Interactive effectiveness dashboards – Power BI. Hold effectiveness grand round.		Demonstrate 360 Cycle of Improvement to deliver effective care following QAF principles. Hold effectiveness grand round. Evaluate impact of quality senate and review.	
Experience	Review experience governance structure. Set vision, aims and deliverables. Continue which existing work programme for 2023.	Launch new Governance meeting structure. Socialise experience annual work plan. Hold coproduction event.		Deliver a trauma informed care service trust wide. Ensure LEA care unit leadership partners. Hold experience conference.		Demonstrate culture based people first experience across care units and monitor impact. Hold experience event.	
		Launch the National Dignity Council's 10 Do's. Update IWGC to include feels like and dignity.		Launch restorative supervision through PNA programme and psychologies services.		Launch care accreditation process for all care unit services which are led by LEAs.	
		Review and redesign T&D programme.	Coproduced and delivered T&D programme rollout across care roles. Leadership and culture OD programme and evaluation review. Re Launch Schwartz rounds. Develop process for recruitment for care roles with LEAs.				

Strategic Delivery Success Measures

Adopting a Quality measurement system approach will support our ability to evidence success.

1. **Design**
2. **Build**
3. **Deploy**
4. **Control**
5. **Measure**
6. **Review**
7. **Improve**

Year 1 will focus of elements 1-3 and Years 2 and 3 management of elements 4-7

Yr. 1 - Establish baseline data in order to demonstrate future impact of the strategy. Year 1 will focus on a quality reset with a socialisation programme to drive a movement of change through people partnership, competence, leadership and evidence base and creating the methodologies to measure quality outcomes for our people. Utilise the NHS Improving Patient Care Together (IMPACT) self assessment baseline data as a systematic approach to evidence continuous improvement into years 2 and 3.

Yr. 2 Benchmark against ourselves and incrementally improve on year 1 baseline setting. Set board approved Incremental % improvement trajectory. Commence measurement of People reported quality outcome sets using the overarching strategy vision and its principles. Commence staff experience measures and developmental evaluation that is adopted and used to continually assess implementation.

Yr. 3 Benchmark against ourselves and incrementally improve on year 2 baseline setting Set board approved Incremental % improvement trajectory. Incrementally improvement of People reported quality outcomes and staff experience measures baselined in yr.2 using the overarching strategy vision and its principles.

Qualitative evaluation - Review vision statements for Safety, Effectiveness and Experience for end of year 3 to demonstrate strategic impact. Has the vision been realised? Evaluate using a five stage maturity matrix.

Safety - Past safety evidence baseline from 2023

- Mortality data
- PSIRF activity
- Staff and Patient Datix themes and avoidable harm level
- Safety dashboard utilisation

Care processes reliable

- What care processes are in place for 2023
- What are missing – Gap analysis

Care safety today

- Patient safety partner thematic review and activity 2023
- Patient led Safety huddle evidence
- Safety walk rounds
- Safe staffing

Care being safe in the future

- Move from Safety 1 to Safety 2 measures for 2023
- Current risk register status
- Safety culture and climate analysis results for 2023
- Safety training rates for 2023

Response and Improvement

- Learning information management systems in place for care units 2023
- Safety and learning dashboard utilisation to assure board 2023
- Hierarchy of Effectiveness SEIPS transition from weaker to stronger actions for 2023

Effectiveness - Past effectiveness evidence baseline from 2023

- Quality senate gap analysis for each topic
- Current evidenced based competency provision and evaluation
- QAF team unitisation baseline
- Current Quality outcome data to baseline PROM, CROM, GAS
- Current QIA utilisation and risk
- Current service delivery and accessibility data

Experience - Past effectiveness evidence baseline from 2023

- LEA partnerships in place
- Complaint themes
- IWGC activity indicators
- Restorative supervision activity and evaluation
- Forums established and evaluation 2023
- Staff survey results 2023
- Freedom to speak up thematic review 2023
- Design and development of staff experience evaluation

Acknowledgements

Over the past six months we have heard voices, ideas and experiences from people of Essex; those with lived experience, their supporters and a wide range of EPUT's staff and partner stakeholders have come together to create a vision of Quality of Care: the foundation to build our care services upon.

This strategy and delivery plan will bring people together to create safety, effectiveness and experiences so that people will feel in control and hopeful for their future.

Thank you to everyone who has contributed to the development of this strategy and all those who will work in collaborative partnerships to achieve our quality of care vision.

11.2 RESEARCH, INNOVATION & COMMERCIAL STRATEGIES

Decision Item | Dr Milind Karale & Trevor Smith | 10 minutes

REFERENCES

Only PDFs are attached

Research Innovation and Commercial Strategies Nov 2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Research, Innovation and Commercial Strategies**					
Executive/ Non-Executive Lead:	Milind Karale, Executive Medical Director Trevor Smith, Chief Finance and Resource Officer					
Report Author(s):	Anna Bokobza, Director of Strategy Liz Brogan, Director of Contracting, Business Development and Procurement					
Report discussed previously at:	Strategy Steering Group Executive Committee 2 October and 7 November Board development seminar 18 October Finance and Performance Committee 23 November 2023					
Level of Assurance:	**Level 1**	**X**	**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	X
	SR2 People (workforce)	X
	SR3 Finance and Resources Infrastructure	X
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	X
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	X
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	This trio of strategies serve as partial mitigations to a number of Strategic risks as, in combination, they will support safety improvements (SR1), support recruitment, retention and workforce development plans (SR2), build our corporate infrastructure to enable operational delivery (SR3) and improve use of resources (SR8)	
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	

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
To present to the Board for approval EPUT's new Research, Innovation and Commercial strategies	**Approval**	X
	Discussion	
	Information	

Recommendations/Action Required

1 The Board is asked to approve the proposed Research, Innovation and Commercial strategies as key enablers to the Trust's five-year strategic plan.

Summary of Key Issues

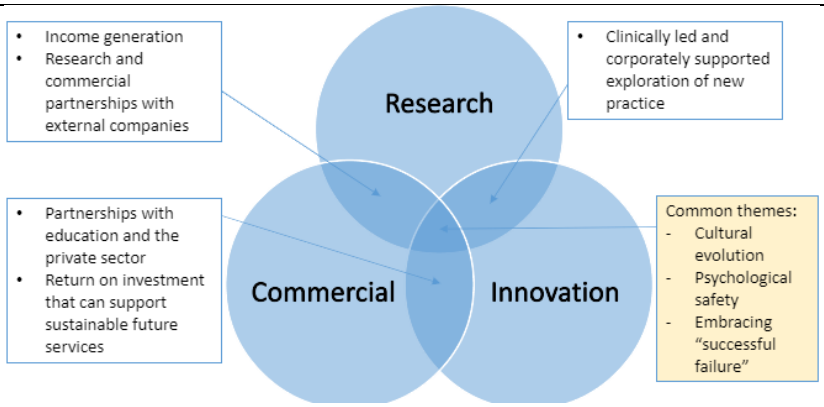
In January 2023, the Board approved the new EPUT Strategic Plan 2023/4-2027/8. In support of the Strategic Plan, a streamlined suite of 12 enabling strategies are in development, of which the Research, Innovation and Commercial strategies represent three. They build on the pre-existing Research & Innovation strategy 2019-2021. The development of the Trust Commercial Strategy was paused during the pandemic and the landscape within the NHS has significantly changed during this time with increasing emphasis on co-production and collaboration balanced with leveraging commercial opportunities for the Trust.

The challenges and vision for each are summarised in the table below:

	Diagnostic: current challenges	Vision: what will be different in three years?
Research	• R&D team not yet fully modernised post-merger / relationships with care units and research leaders to be strengthened • Engagement in clinical research is not yet consistent across EPUT's services / value of research not widely accepted • Different professions not always aligned in their endeavours • Not yet leveraging EPUT's strengths of scale and scope to position as generators of research studies • Balance of priorities and staff allocation with direct clinical care	**Best research together** • Evidence of increased research awareness across the Trust; • Active research led by the full range of EPUT's professional groups; • Evidence of partnership working people that use our services in shaping the research portfolio; • A more diverse research portfolio that leverages NIHR and other funding opportunities, including some growth in commercial trials; • An appropriate balance between theoretical and applied research.
Innovation	• Diffuse operating model straddling a number of different functions • Diverse views on definition of "innovation" – tendency to over index on futuristic technological innovation rather than starting with Internet of Things and Quality Improvement • Different professions now always aligned in their endeavours • Service user involvement not yet standardised • Internal decision making process not always clear • Not yet taking full advantage of local ICB relationships	**Embracing curiosity** • Evidence of a strong culture of innovation including embracing SpaceX's concept of a "successful failure" • Appropriate systems and processes in place for learning, continuous improvement and innovation, balanced with space for organic ideas generation and development • Evidence of some impact to share
Commercial	• Recruitment challenges post restructure • Lack of shared common approach embedded within the Trust culture • Internal and collaborative alignment emerging – income / expenditure • Lack of procurement maturity • Awareness, training and support for colleagues • Effective leverage / maximisation of commercial opportunities • Competing priorities	**Towards commercial maturity** • High level of procurement maturity – benchmarked and evaluated annually • Measurement of realisable benefits from commercial partnerships • Embedding support, awareness and continuous learning for staff on commercial activities, income & expenditure • Expertise within Care Units / virtual bid teams • Clearly articulated SOP for commercial activities • Measurement against Commercial Culture Maturity Roadmap

All three focus in the short to medium term on driving cultural evolution across EPUT to create an environment in which curiosity is actively supported and in which all colleagues feel psychologically safe to try new things and raise the collective level of ambition and aspiration. A theme of embracing "successful failure" runs through the three strategies, taken from recognised leaders in innovation in other sectors. For this reason, explicit links are made with the developing Workforce, People & Culture strategy as well as EPUT's strategies for Quality of Care, Data and Digital and Working in Partnership with People & Communities. There are also links to the Social Impact strategy approved by the Trust Board on 27 September as research, innovation and commercial partnerships have the potential to bring benefit to local communities in terms of employment, education and local investment.

At EPUT, Research and Innovation will remain closely aligned with each other and with the Commercial strategy through a revised leadership structure under the Medical and Finance executive portfolios, and through the adoption of a common set of principles that have been co-produced with internal and external stakeholders. The diagram below illustrates the relationship between the three disciplines for the next three years, after which revisions could be considered.



The proposed principles for adoption in Research, Innovation and Commercial development at EPUT are:

- Focus on building sustainable foundations, rather than a big bang approach;
- Grass roots identification of problems and innovative solutions, with corporate infrastructure and support in place to set up for success;
- Clinically led, multi-professional and inclusive approach accessible to all;
- Strong focus on partnerships in Commercial approach;
- Scope beyond, but including, digital innovation;
- Appropriate balance of organic ideas generation and robust process management;
- Alignment with local Integrated Care Boards' research, innovation and commercial strategies;
- Continuous review of dynamic strategy in partnership with stakeholders.

Whilst the Trust strategic plan runs for five years, the Research, Innovation and Commercial strategies are designed for a three-year term due to the changing nature of the external environment that governs these disciplines. It also promotes the necessary short term focus on cultural change, after which strategies will need to be revised and refocussed on delivery of transformed care.

All three strategies have been developed in partnership with multi-disciplinary representatives from across EPUT, discussion with executive and non-executive directors, consultation and engagement with local partners, benchmarking with comparable organisations and – most importantly – shaped by what matters most to the Lived Experience partners who have been part of the strategy development teams.

The Trust Commercial Strategy was presented to the Finance and Performance Committee 23 November 2023 and was approved for recommendation for approval to Trust Board. Feedback from the Committee will ensure that social impact considerations are firmly embedded and the detailed and measurable implementation plans will provide assurance of the benefits realised through the defined governance arrangements included within the Strategy.

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

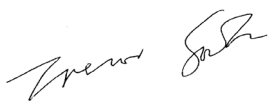
Communication and consultation with stakeholders required			X
Service impact/health improvement gains			X
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			X
Impact on patient safety/quality			X
Impact on equality and diversity			X
Equality Impact Assessment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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

1. Research Strategy: Best Research Together
2. Innovation Strategy: Embracing Curiosity
3. Commercial Strategy: Towards Commercial Maturity

Lead



Trevor Smith
Executive Chief Finance Officer

Dr Miland Karale,
Executive Chief Medical Officer

NHS
Essex Partnership University
NHS Foundation Trust

Research Strategy 2023-2026

Best Research Together

FINAL – v9

EPUT

Foreword from EPUT's Medical Director

The best healthcare research is produced when researchers and communities work together, listening and exchanging knowledge. Reflecting on the COVID-19 pandemic, the value of clinical research became clear in the national consciousness as vaccines and treatments were rapidly developed. In order to position EPUT as a centre of excellence in research, now is the time to take the positive influences from the pandemic and build on government policy and investment commitments and raise our ambition for Research and Development at EPUT. We already have some of the foundations at EPUT that we need to succeed in this research journey, drawing on expertise from staff, people who use our services, their supporters, our collaborators and the public.

This strategy sets out an ambitious overall vision but recognises we have work to do in evolving the way we approach research to be inclusive, proactive, co-designed with lived experience partners, supportive and broad in its scope and application. Only by building a culture that supports research and embraces "successful failure", balanced with appropriate risk assessment, can we achieve our vision of being a leading health and wellbeing service in provision of mental health and community care.

As executive lead for research at EPUT, I want to personally encourage anyone with an idea to consider a research project – whatever the scale – and leaders in our organization to come together to clear the barriers that lie in the way of high quality research.

The national vision for clinical research is rightly ambitious

In 2021 the UK, including its devolved governments' set out a vision

Saving and Improving Lives: The Future of UK Clinical Research Delivery [1]

The ambition is to create a world-leading UK clinical research environment that is more efficient, more effective and more resilient, with research delivery embedded across the NHS.

"A digitally enabled, pro-innovation and people-centred clinical research environment is key to realising the ambitions to make the UK a world-leading hub for life sciences that delivers improved health outcomes for our citizens and attracts investment from all over the world. We will harness the explosion in innovative technologies to benefit patient outcomes and make a tangible difference to people's lives across the UK. Clinical research is crucial to these efforts, as the lynchpin to driving improvements in healthcare".

[1] Full document available in Appendix 2

What does the evidence tell us about research active organisations?

Developing a research-active culture brings a host of benefits for patients, clinicians and the NHS, driving innovation, giving rise to better and more cost-effective treatments, and creating opportunities for staff development.

- **Research-active Trusts appear to do better in overall performance**.
  Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, Thompson MM, et al. Research Activity and the Association with Mortality. PLoS ONE 10(2).
- **Academic output correlates with better mortality rates.**
  W.O. Bennett, J.H. Bird, S.A. Burrows, P.R. Counter, V.M. Reddy http://www.ncbi.nlm.nih.gov/pubmed/22795835 Does academic output correlate with better mortality rates in NHS trusts in England? Public Health 126 (2012) S40 eS43.
- **Treatment of patients on clinical trials is associated with considerable cost savings.**
  Liniker E, Harrison M, Weaver JM, Agrawal N, Chhabra A, Kingshott V, Bailey S, Eisen TG, Corrie PG. Treatment costs associated with interventional cancer clinical trials conducted at a single UK institution over 2 years (2009-2010). Br J Cancer. 2013 Oct 15;109(8):2051-7.

- **Benefiting from the `research effect. Trusts can find it easier to recruit and retain high-quality clinical staff when they are able to offer opportunities to actively participate in research**
  www.rcplondon.ac.uk/projects/outputs/benefiting-research-effect

We want research to be something in which anyone can participate

This strategy adopts the philosophy that "**research can be everyone's future**", whether that is a patient being treated at the Trust who chooses to be a part of a research project or a member of staff who wants to run a research project or develop a research career.

Research is so often seen by healthcare staff as outside of their day to day responsibilities and something of an elite activity; we want to change that. It is often perceived as accessible for the few, done by university academics and involves drug companies in new medicines development or novel techniques that are out of reach of most staff. Rather, we aim to develop a narrative to break down barriers and make research activities something in which anyone can get involved.

Research develops the skills of staff and involves patients, service users and the public in the pursuit of knowledge that may benefit them and others.[2] Our commitment is to see research as an essential part of healthcare such that people that use our services and their loved ones can expect to be actively involved in the generation of evidence driving effective prevention, diagnosis, treatment and have access to the most cutting-edge treatments and technologies.

[2] https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

Research at EPUT can be both theoretical and applied

If we consider research only in its purist definition we will fail to realise the full benefits of the very valuable work undertaken at EPUT in the form of audit, service evaluation, quality improvement and service development.

We must bring together and embrace the broad range of research work already being done on a regular basis within the Trust to solve local problems.

Linking activities theoretical and applied research activities provides a uniform and streamlined approach, consistency in learning and develops strong, evidence-based practice as set out in the Quality of Care strategy. Acknowledging the importance of the entire healthcare workforce in the delivery of research and empowering those to be involved will be critical to successful delivery.

EPUT's vision for research

Where do we want to be by 2026?

With a deliberate focus on clearing the barriers to research, EPUT should aim to have the following in place within three years:

- Evidence of increased research awareness across the Trust
- Active research led by the full range of EPUT's professional groups
- Evidence of partnership working people that use our services in shaping the research portfolio
- A more diverse research portfolio that leverages NIHR and other funding opportunities, including some growth in commercial trials.

Strengthening EPUT's research culture is in direct support of its overarching strategic plan

VISIBILITY & AWARENESS
Embedding research as core business ensures the development of a strong research-active community bringing a host of benefits to benefits to people that use our services, their supporters, staff and wider society. Patients and their families will be able to access new treatments and care pathways

WORKING TOGETHER
A thriving research community provides development opportunities for our current staff and helps attract more research active staff

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

WORKFORCE DEVELOPMENT
Increasing the impact of evidence based practice within the Trust is a critical enabler to ramping up the pace and scale of change to deliver better outcomes

INVESTMENT
'Working Together' with our Care Units in promotion and support of our research delivery improves health, quality of care and cost-control; further translating scientific developments into benefits for people that need care contributes to economic growth by exporting innovation and expertise.

Stakeholders have shaped a set of overarching principles to underpin EPUT's research, innovation and commercial development strategies

Focus on building sustainable foundations, rather than big bang approach

Grass roots identification of problems and innovative solutions

Clinically led, multi-professional and inclusive approach accessible to all

Scope beyond, but including, digital innovation.

Digital as key enabler for innovation

Appropriate balance of organic ideas generation and robust process management

Alignment with local ICBs' research, innovation & commercial strategies

Continuous review of dynamic strategy in partnership with stakeholders

Stakeholders have defined three current challenges and barriers to research

Feedback from engagement workshops revealed consistent themes relating to three areas of focus: workforce, diversity of funding sources, and communication.

1. Our skilled **workforce** encounters challenges in allocating time, capacity, tools, space and access for individuals to train in research methods and becoming involved in research projects. With demand for services unlikely to decrease in the short to medium term, if service managers are helped to appreciate the value of research, they will be more inclined to allocated staff time to it. Due to significant workforce challenges in some areas, it is sometimes not possible to identify suitable backfill even when funding is available.

2. The government's ambition is to treble industry contract and R&D collaborative research in the NHS over ten years, to **nearly £1 billion**. There are significant amounts of **funding** available through the NIHR, academic institutions and higher education facilities dedicated to the training of professionals in undertaking research career pathways. It is not always easy to access these funds. EPUT will need to be more creative in its pursuit of a range of revenue sources to support its research ambitions.

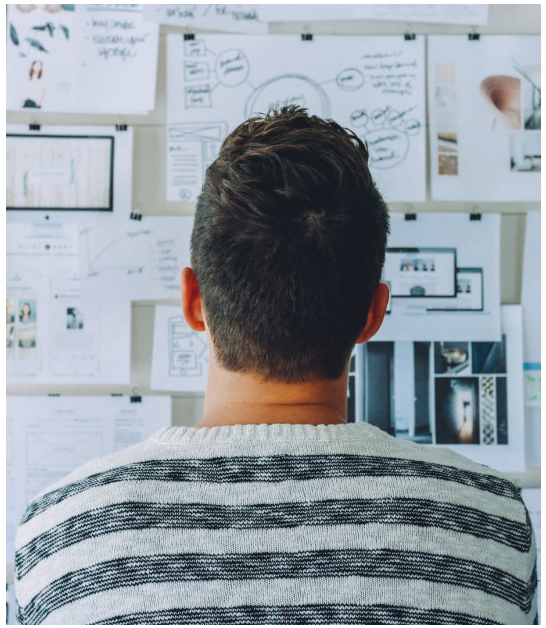
3. **Communication** is the key that links all of our challenges together. Better use of technology will be necessary to communicate key messages to target audiences. Accessible and transparent communications across a range of channels will be critical to improving research awareness and confidence across EPUT, sharing learning from research and working effectively with our partners, people and communities.

Many of the fundamentals are already in place but we must continue to evolve

The Trust is already research active with our main studies coming through the NIHR[3] whereby the provision of research leadership and funding to support research is via the NIHR Regional Research Delivery Networks (RRDN). EPUT is currently a partner organisation with the North Thames region but we will align to the East of England from 1 October 2024.

NIHR funding is received to cover direct staff costs, some overheads, along with some research capacity and capability funding (RCF)[4] totalling in the region of £500,000 (23/24).

The Trust also hosts a mixture of studies funded via other grants, some that are commercially-sponsored and studies that support the training and development of staff through higher degrees. The volume of this activity varies significantly driven by availability of suitable studies and numbers of patients recruited.



[3] National Institute for Health and Care Research http://www.nihr.ac.uk/
[4] Research capability funding | NIHR

Completing the modernization of our Research function means we will be able to reduce barriers to research once and well for everyone

By embracing and recognising the strengths that exist within EPUT through the NIHR infrastructure already in place we can complete a modernisation of the Research function, delivering a high quality integrated research management, support and delivery service to Trust clinical services, staff, and the people for whom we care.

Maintaining robust and effective research governance is fundamental to the safe and high quality conduct of research and it is crucial that our patients are confident that the research they take part in is conducted to the highest standards. Our strong foundations will be further developed to improve both our oversight of research and support to researchers.

World-class research requires world-class infrastructure for its delivery

We must continue to strengthen our existing NIHR infrastructure

Staff

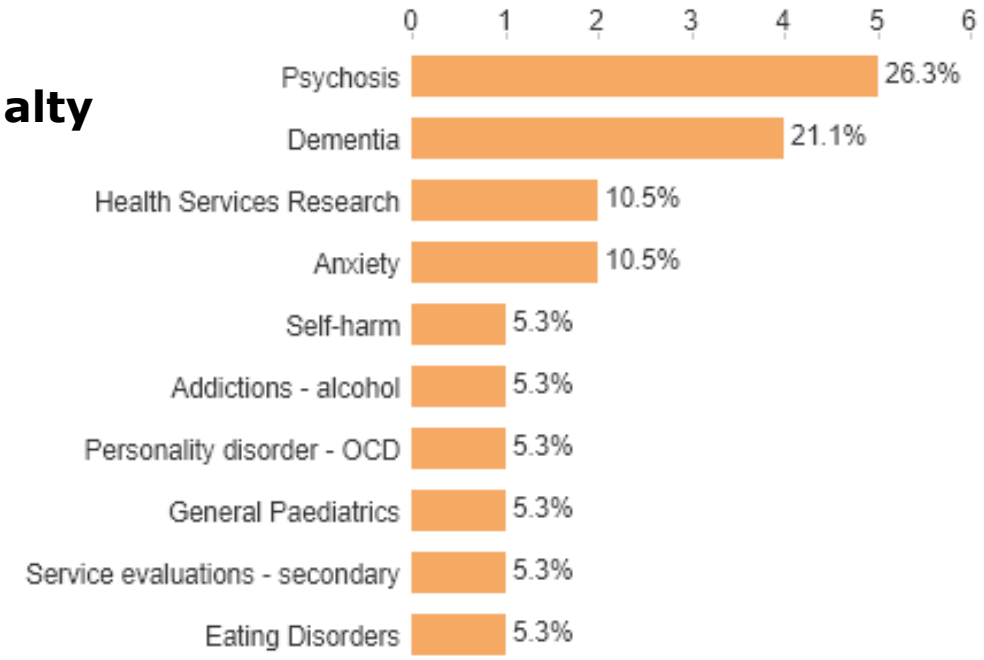
We have a central Research office with significant NIHR-trained expertise delivering recruitment of participants to national high quality studies:

- 1 WTE Research Manager (funded by EPUT)
- 12 members of NIHR funded Research Delivery Staff bands 5-7.

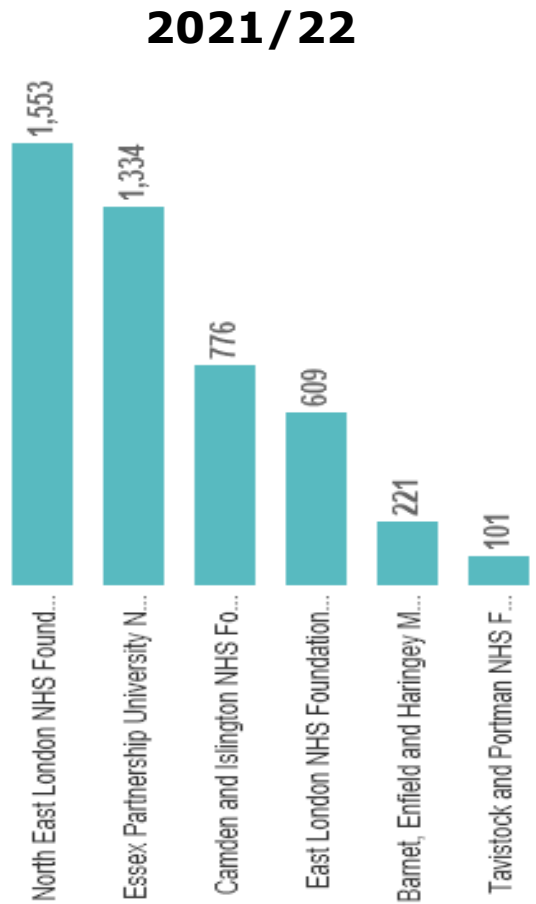
Study Activity

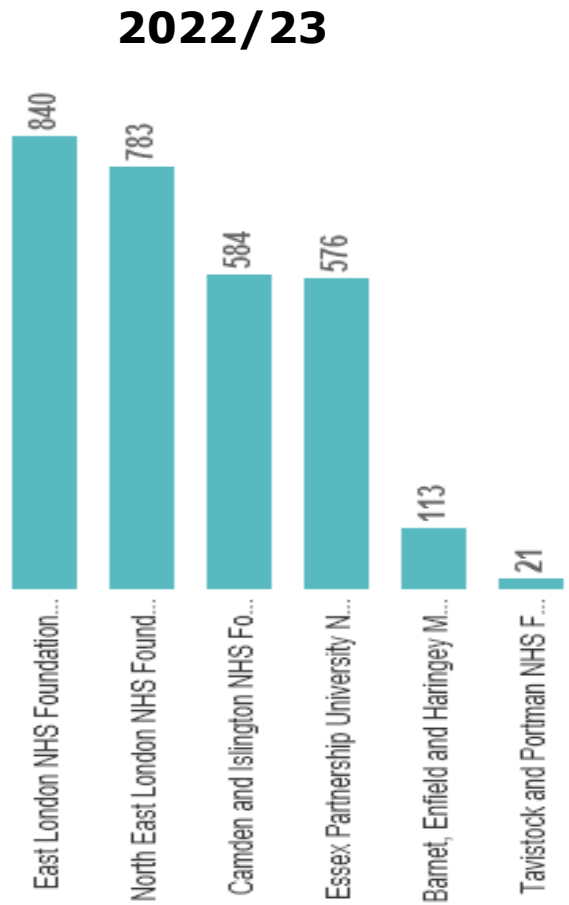
As at M7 2023/24, we have recruited 1,076 participants from over 12,000 individuals screened across 20 studies.

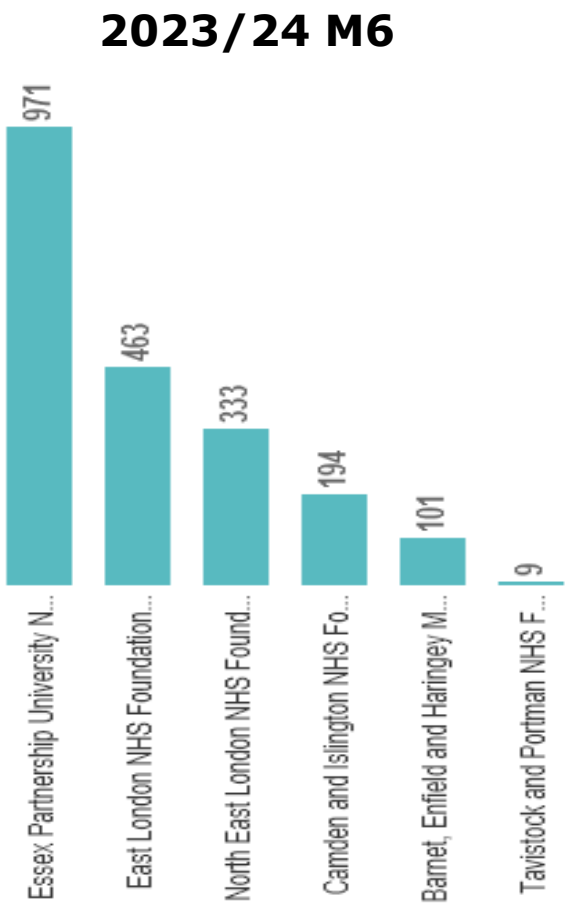
Primary Subspecialty



EPUT benchmarks favourably with its peers in recruitment to trials







Delivery of the strategy widen the research base across EPUT's clinical services

Engagement in clinical research is not yet consistent across the wide range of EPUT's services. The delivery of this strategy will be contingent on:

- A programme of inclusive and consistent partnership development with all care units and clinical service areas designed to promote the benefits of research involvement and advertise the corporate support offering
- Nurturing relationships with EPUT's clinical academics and leveraging their insight – alongside that of a diverse stakeholder group – in co-designing a set of research priorities for EPUT over the next three years.

We will build on our strong portfolio to develop and diversify

Audit is routinely undertaken within EPUT by clinical teams supported by the Clinical Audit team. On average 56 audits are undertaken on an annual basis.

Non NIHR Non-Commercial studies

We currently have nine studies open[5] and a further three in set up[6]

Quality Improvement Projects - since inception in March 2018 the Trust has 43 cumulative active projects; four of these have been created in the last 90 days

Service Evaluation is a valuable tool and used widely across the Trust to inform service development. This strategy gives greater emphasis to the work being undertaken by EPUT's students and trainees with support from academic partners. The outcomes from service evaluation should be widely shared and, where appropriate, developed into full research projects.

We currently* have 47 service evaluations open:

19 Psychological Services
8 EPUT Staff (Trust-Wide)
7 Secure Services
5 Memory Services
3 Perinatal Services
3 EIP
1 Better Start, Southend
1 IAPT

And 18 service evaluations currently* in set-up

(* Snapshot timeline of 1st October 2023)

[5] Details in Appendix 3
[6] Details in Appendix 4

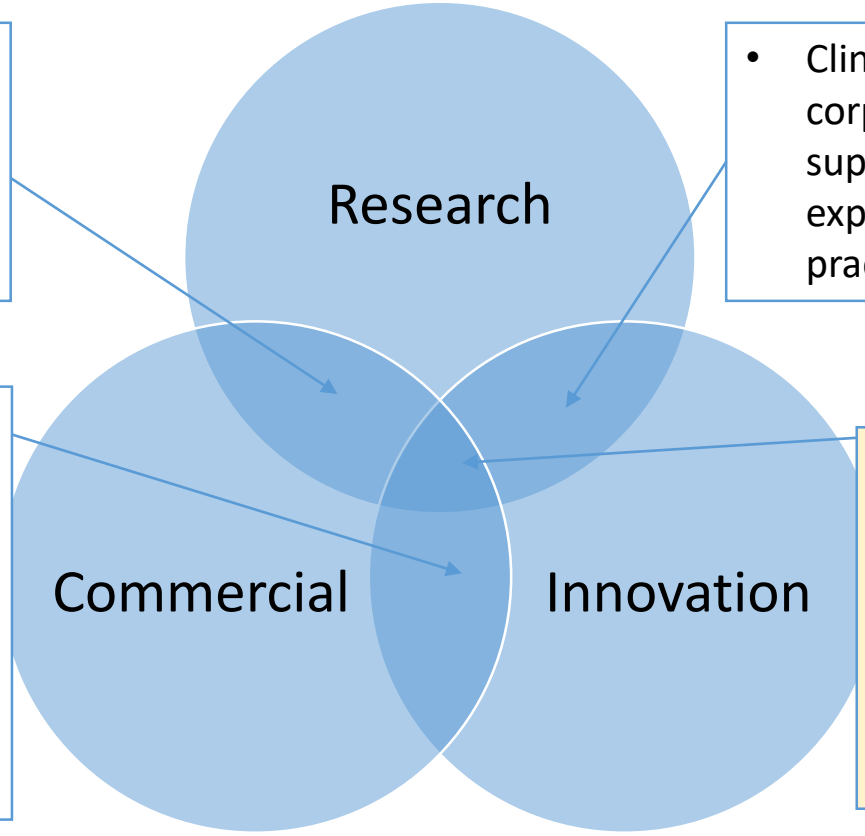
Research, innovation and commercial development at EPUT remain closely linked

These strategies will initially function independently and the links between them firmly established during a three year period 2023–26 with the potential to develop a unified five-year strategy for 2027 onwards.

Three related strategies are linked through a new leadership structure and common principles

- Income generation
- Research and commercial partnerships with external companies

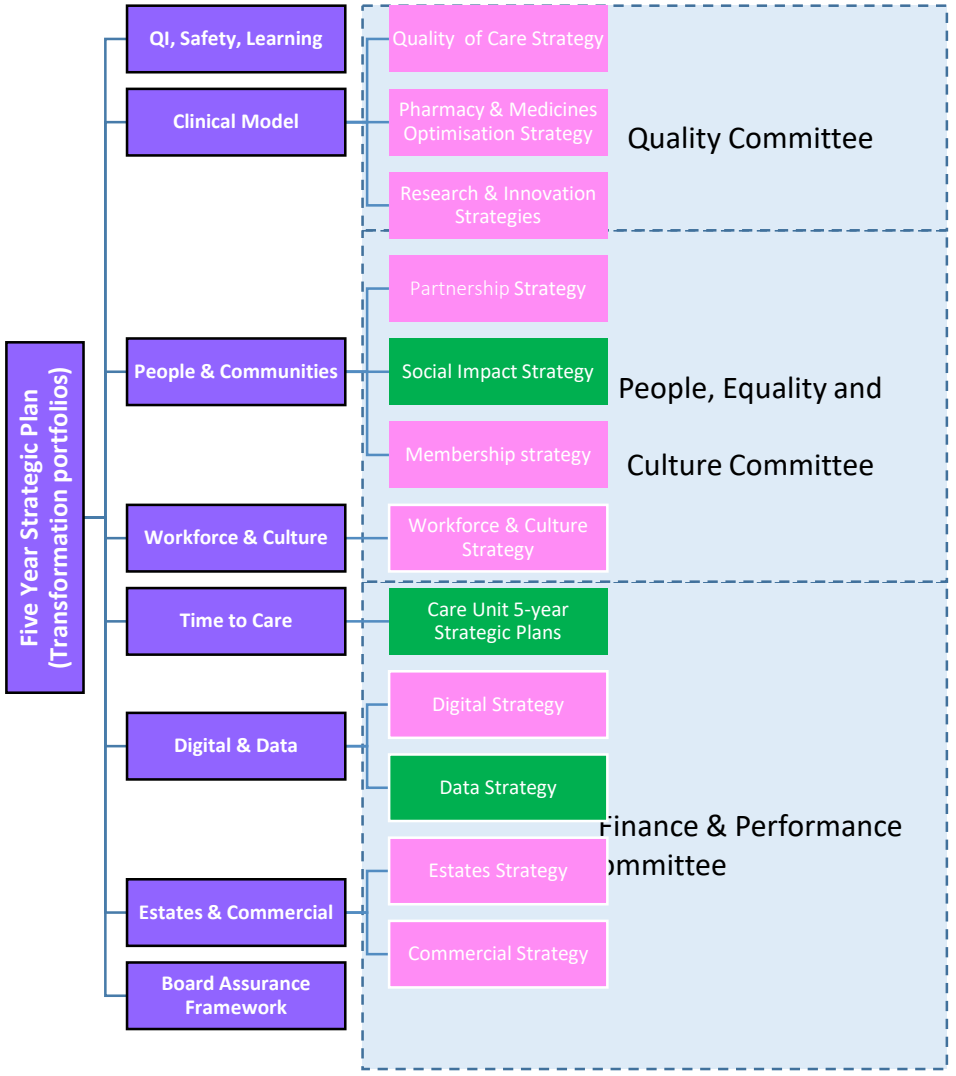
- Clinically led and corporately supported exploration of new practice



- Partnerships with education and the private sector
- Return on investment that can support sustainable future services

Common themes:
- Cultural evolution
- Psychological safety
- Embracing "successful failure"

The research strategy relates closely to a range of other enabling strategies



The Research Strategy makes particular reference to:

- Quality of Care Strategy and the role of the Clinical Senate in developing EPUT into an evidence-led organisation
- Data Strategy and the role of the proposed data platform in supporting evaluation and impact of research
- Workforce, People & Culture Strategy and the role of research in recruitment and retention of talent
- Working in Partnership with People & Communities strategy and the importance of lived experience in shaping our research priorities and projects.

Key to status as of September 2023:
Board approved strategy in place
New/Updated strategy due for Board approval 23/24
Proposal to be completed

We recognise the strength of robust long-term academic partnerships which we will maintain and build upon

We have five university partners that we currently work with and closely align to:

- Anglia Ruskin University (ARU)
- University of Hertfordshire (UH)
- University of East Anglia (UEA)
- University of Essex
- University College London (UCL)

The strength of academia in developing our professional workforce is recognised and fostering partnerships with other universities across the UK and even wider on an international level is a key objective to supporting our research growth.

We have just completed a research project collaboration with ARU involving our Woman Veterans Service through an NIHR RfPB grant award of £150,000 and are currently collaborating on a research project involving our Family Group Conferencing (FGC) service with the University of Birmingham having been awarded an NIHR Health Services and Research Delivery (HS &RD) Program grant of £1,000,000. This project will run for 33 months.

We should take up the opportunities presented by the Life Sciences Industry to grow our commercial activity

We currently have a modest base of commercial activity predominantly because the Life Sciences Industry has not historically prioritised mental health. In recent years there have been more funding calls to support the Dementia pathway to which EPUT has been able to respond. We run on average one commercial study each year but these can be very labor intensive and opportunities are assessed through cost/benefit analysis.

To adequately strengthen our commercial activity in the field of clinical trials which predominantly involves medicines we need to develop our core Pharmacy team to support us before we can build closer partnerships with pharmaceutical companies.

The Life Sciences Industry Strategy[8] introduced in 2017 and updated in 2021 is seen as a key UK government strategy supporting economic growth. It details a number of opportunities for the NHS which we will explore as part of strengthening and driving forward our commercial activity.

[8] Full documents available in Appendix 5

EPUT's research strategy must leverage the strengths of our local Integrated Care Boards' (ICB) work in this space

We are committed to maximising the impact of research for patients within our geographical service areas across the East of England which encompass four ICBs:

- Bedfordshire, Luton and Milton Keynes
- Hertfordshire and West Essex (HWE)
- Mid and South Essex (MSE)
- Suffolk and North East Essex (SNEE)

EPUT is actively engaged in the delivery of the HWE Integrated Care System (ICS) Research Engagement and Network (REN) development program funding by NHS England's Research and Life Sciences team is an example of how we will help address community health priorities and to plan for healthier futures. The delivery of this will increase diversity in research participation through development of new or existing research networks and activity, using existing NIHR infrastructure.

We are equally committed in our aligned partnership working with the Mid and South Essex ICB on a number of projects including our unified electronic patient record which will greatly enhance our data quality and robustness as a valuable research resource.

[9] Research document available in Appendix 6

We know that different communities require different support to access healthcare and research studies

Continuing to develop relationships with local people means we can better shape our research questions and ensure we reflect the needs and priorities of the communities and people we serve.

In the delivery of this strategy, and in alignment with its Working in Partnerships with People & Communities strategy, EPUT will seek all possible opportunities to learn from people that access our care as well as their families and carers to identify research priorities, shape research proposals, design methodologies and evaluate impact of our research.

EPUT is a committed contributor to the yearly NIHR National Patient Research Experience Survey (PRES) and uses the feedback from this to inform processes and build upon our engagement with research participants. Recent survey results are shown in Appendix 10.

EPUT commits to a programme of change in R&D for the next three years

Strategic objectives

We have four strategic objectives to achieve our vision:

VISIBILITY & AWARENESS
1. We will make research visible in all aspects of the Trust's core business
2. We will increase awareness of the value and impact of clinical research

WORKFORCE DEVELOPMENT
3. We will support development of and nurture a sustainable workforce
4. We will empower staff to promote evidence based practice

WORKING TOGETHER
5. We will empower patients and staff together in high quality research
6. We will collaborate to align our research activities with care units and with other provider partners

INVESTMENT
7. We will embed integration of learning through evidence based practice
8. We will grow our aspirations to become a recognised centre of excellence

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

Key Commitment: VISIBILITY & AWARENESS

1. We will make research visible in all aspects of the Trusts core business

i) To optimise access to research of all types at all sites to offer a research opportunity to at least 10% of our 1.3 million patient population, that's 130,000.

ii) To listen and work with clinical teams to establish and focus research in areas of strategic and clinical priority as the main agenda of our current Research & Innovations sub-committee.

iii) Build upon the strength of our current 'change makers' through membership of our current Research & Innovations sub-committee.

iv) To develop effect ways of working more efficiently to harness data capture that is meaningful and can be readily accessed in terms of analysis.

v) To support staff alongside EPUT lab to challenge conventional practice, and facilitate the dialogue between academics and clinicians which will lead to research that identifies best practice and delivers change in clinical performance.

vi) To implement the on-line guide developed by the NHS R&D Forum – ' Best patient care, clinical research and you' [13]

[10] Best Patient Care, Clinical Research and You - NHS R&D Forum (rdforum.nhs.uk)

2. We will increase awareness of the value and impact of clinical research

i) To involve more staff and patients in commercially sponsored clinical trials through engagement and communication of the benefits.

ii) To communicate research performance information Trust wide

iii) To collect and publicise research impact and outcome data to demonstrate the links between research evidence and practice.

iv) To disseminate research findings and translate into clinical care

v) To produce regular research newsletters and distribute across the organization including clinic waiting areas

vi) To ensure all research related publications are visible and give due recognition to the authors.

vii) To ensure service evaluation outcomes are disseminated appropriately and assessed for implementing changes in practice

viii) To highlight and raise awareness of the Trust as a research active organisation through the provision of establishing a standardised Trust wide 'opted in' communications template which enables patients to participate in research; include this communication in all recruitment adverts.

ix) To define and delivering coherent and aligned messages, making research real on the front line is key to the overall transformation of services

Key Commitment: WORKFORCE DEVELOPMENT

Redesigning the existing workforce initiatives with research in mind

Research is specifically identified in the NHS Long Term Plan as a key driver for all professions to improve future health outcomes. For England, the Department of Health and Social Care (DHSC) directs all NHS organisations to actively support research activities and to ensure evidence informed practice to improve care quality and outcomes.

By implication, all staff should have the knowledge, skills and confidence to apply research within their own scope of practice: a relatively smaller proportion may choose to undertake research and/or innovation as part of their career pathway.

"For me, Research means acting on professional curiosity and turning anecdote into something others can learn from."
EPUT senior nurse

3. We will support development of and nurture a sustainable workforce

i) To increase our NIHR recruitment target by 10% per year through delivering at least one portfolio study within each clinical service encouraging the development of our pool of Principal Investigators.

ii) To attract research active staff through provision of and developing staff career pathways supported by our valuable resource of the Workforce development team

iii) To develop combined academic and clinical career pathways for all, building on the strength of our links with Universities including fostering support for service evaluation together with research considered as part of standard clinical delivery.

iv) To include a research awareness session within the corporate Trust induction

v) To allocate dedicated resources including access to expertise, space and analysis software to support all services in undertaking research and evaluation.

vi) Build in research and evaluation as a core element of all roles to provide much needed dedicated time.

vii) Design and provide a suite of dedicated specific training courses to increase knowledge, skills and confidence to all staff in applying research within their own scope of practice.

viii) Encourage professional development through the uptake of NIHR joint external academic research posts and funded fellowship awards

4. We will empower staff to promote evidence based practice

i) Encouraging existing and new principal investigators to take a lead on the development of their own studies and becoming Chief Investigators .

ii) Through undertaking new NIHR studies and gaining experience our principal investigators will see the benefits and can take a lead on sharing their experiences through development of a local based mentoring program.

iii) To use our NIHR funded research infrastructure to support all EPUT research investigators to open more research studies.

iv) To provide necessary support and guidance for dissemination of outcomes and research based evidence

v) To encourage the use of the NIHR evidence portal[15] for verified good quality data on research outcomes as well as identifying areas of need for more research.

vi) To use all social media platforms to improve knowledge about research and the benefits of participation

vii) To support the implementation of the Chief Nursing Officer for England's Strategic Plan for Research: Making research matter (Appendix 10).

viii) To support the implementation of the HEE Allied Health Professions Research and Innovation Strategy for England (Appendix 11)

ix) To support the Life Sciences Industry Strategy in driving forward our commercial activity

[11] NIHR Evidence | Informative and accessible health and care research

Key Commitment: WORKING TOGETHER

5. We will empower patients and staff together in high quality research

i) To provide more research opportunities through involvement in more NIHR funded studies that we are a participating site for.

ii) Enable more people to engage in public and patient involvement (PPI) activities, ensuring participant feedback is routinely collected and made publicly available.

iii) Engage with the Patient and Staff Experience teams to deliver research that is important to and prioritised by patients and staff.

iv) To build research capability across the Trust utilizing leverage of the volunteer and our Lived Experience Ambassadors.

v) To support service development and evaluation and dissemination of best practice.

vi) To develop closer joint research office working with academic partners to work up projects and grants.

vii) To increase research income through focusing our research on areas which are of strategic importance and likely to have most impact on our services

viii) To promote and encourage sign up to the NIHR be of part of research campaign

6. We will collaborate to align our research activities with care units and provider partners

i) By ensuring that equality of access to research information is provided to all patients and all communities locally we will deliver research studies to the right person, at the right time and in the right setting for them.

ii) Ensuring research is clearly defined as an integral part of all the care groups and services

iii) Maintaining our close working relationships with the NIHR in ensuring a seamless transition to the newly aligned NIHR East of England RRDN

iv) Developing our Life Sciences commercial and industry partnerships to generate research income

v) To become generators of NIHR adopted studies through successful receipt of NIHR grant awards

vi) To take a leading role in development and implementation of all ICS research strategies

vii) To raise our profile as experts in research management, governance and delivery through collaborative working and Partnering with more NHS, not for profit organisations and the Voluntary Community and Social Enterprise (VCSE) building upon our solid reputation.

viii) Applying for more grants to lead to holding grants in our own right enabling development of our own Chief Investigators

ix) To establish a working partnership with Enable East to ensure compliance with national research governance and ethical guidelines.

Key Commitment: INVESTMENT

7. We will embed integration of learning through evidence based practice

i) Review and reshape the research governance workforce to ensure we have a lean, integrated team to deliver effective operational management of activity, priorities and risks related to the governance of research which is aligned to national agendas.

ii) Develop a high quality support service for researchers throughout the research lifecycle, from early planning, to set up, conduct, close down, archiving and publication.

iii) To work with colleagues in the Trust and across our ICSs to develop the information technology that enhances access to healthcare data for research from patients receiving care in hospital, virtual wards and in the community

iv) To provide equity in research through engagement with all communities to cover a diverse portfolio

8. We will grow our aspirations to become a recognised centre of excellence

i) To focus on and foster our priority areas of research where we have the greatest strength of potential to be world-leading.

ii) Strategically plan expansion in research facilities at EPUT as research activity grows, especially aiming for new clinical academic developments

iii) Focus on opportunities available within Essex's first School of Medicine based at ARU in Chelmsford, to influence what they might be thinking about in terms of future research

iv) Strategically plan for how we can be operational in the development journey with ARU for a new school of Pharmacy.

Effective Research Governance is fundamental to the safe and high quality conduct of research

The **UK Policy Framework for Health and Social Care Research** sets out principles of good practice in the management and conduct of health and social care research in the UK. It replaces the separate Research Governance Frameworks in each UK country with a single, modern set of principles for the whole UK. The Health Research Authority (HRA) and the health departments in Northern Ireland, Scotland and Wales have developed the policy framework following public consultation.

These principles protect and promote the interests of patients, service users and the public in health and social care research, by describing ethical conduct and proportionate, assurance-based management of health and social care research, so as to support and facilitate high-quality research in the UK that has the confidence of patients, service users and the public.

It is for organisations and individuals that have responsibilities for health and social care research. This includes funders, sponsors, researchers and their employers, research sites and care providers.

Users of our services must be confident the research they take part in is conducted to the highest standards

The UK policy framework applies to health and social care research involving patients, service users or their relatives or carers. This includes research involving them indirectly, for example using information that the NHS or social care services have collected about them.

There are two main approvals required for research undertaken in the NHS; NHS Research Ethics Committee (REC) Approval and Health Research Authority (HRA) approval.

HRA Approval replaced the approvals issued by each NHS organisation (R&D approval or NHS permission). HRA Approval combines an assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent REC opinion provided through the UK research ethics service.

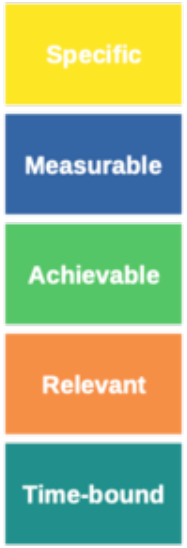
It replaced the need for local checks of legal compliance and related matters by each participating organisation in England negating the need for any local R&D committees. This allows participating organisations to focus their resources on assessing, arranging and confirming their capacity and capability to deliver the study which is the activity supported by local R&D teams. All project-based research requires HRA approval.

Our internal quality assurance compliments national governance systems

Bi-monthly Research Sub-Committee meetings are constituted with the focus on raising research awareness, encouraging engagement, review of service evaluation outcomes, monitoring delivery of the research strategy; along with presentation of performance data to provide assurance on research delivery. Bi-monthly Research & Innovation Assurance reports are presented to the Quality Committee of the Board.

Bi-annual Research & Innovation Group meetings are constituted to provide oversight of the Research sub-committee work and from these an annual report will be presented to the Trust Board to update and provide assurance on delivery research and the new strategies. The Terms of Reference of the Group will reviewed during the early period of strategy implementation.

Measuring progress in delivering the strategy



A number of key actions have been formulated to create measurable outcomes in delivering on the key commitments of the strategy.

Measuring the impact of what we do will require the creation of a local SMART impact dashboard that will use current national databases and data sets that monitor research activity along with data collected through the key actions.

Metrics will align to the three challenges this strategy is designed to address: workforce, funding and communication. Each metric will set a baseline measure of where we are starting from and evidence the progression over time associated with key actions.

Key milestones

Year 1	Evidence of increased research awareness across the Trust, together with evidence of partnership working with people that use our services
Year 2	Evidence of increase in research activity led by the full range of EPUT's professional groups, and an increase in NIHR funding
Year 3	Evidence of an increased and more diverse NIHR research portfolio with an appropriate balance between theoretical and applied research; increased involvement of commercial clinical trials

Year 1 : Evidence of increased research awareness and partnership with people

0-3 months	Complete a baseline survey to establish current awareness across the Trust including our Co-Production Champions Network.
3-12 months	Run a series of research engagement and awareness workshops across the Trust. Maintain our intranet and internet sites, providing regular news items through corporate communication channels.
6-9 months	Conduct follow up survey across the Trust.
9-12 months	Analyse the data captured to determine the evidence and inform further engagement and awareness events together with defining and shaping a future research portfolio.

Year 2 : Evidence of increase in research activity led by different professions, and increase in NIHR funding

0 - 3 months	Undertake a scoping exercise to map research activity in previous year including service evaluations and QI against services to identify areas with and without activity Segmentation of research portfolio by professional leadership Analyse the NIHR Research portfolio and the NIHR evidence portal to identify potential projects that services could undertake to gain experience and hence increase research activity.
0 – 12 months	Engagement of services in undertaking research through monitoring participation and recruitment through the National Central Portfolio Management System (CPMS) and analysis of the dashboard Evidence of increased participant recruitment numbers along with increased number of studies running against previous year on CPMS demonstrates an increase in activity.

Year 3: Evidence of a more diverse NIHR research portfolio and increased involvement of commercial trials

0 - 3 months	Review of research activity through CPMS and analysis of the dashboard in previous year identifying the diversity and balance across theoretical and applied research including commercial and non–commercial activity Identify eligible commercial projects alongside our dashboard to further develop focus areas and partnerships.
0 – 12 months	Engage and support services in undertaking feasibility assessments and completing expressions of interest (EOI) for commercial research Evidence of submitted EOIs that convert into successful selection as a recruiting site Increased participant recruitment numbers to commercial trials recorded on CPMS as recruited on time to target will provide additional income and further demonstrates an increase in activity subsequently providing a good track record to support future grant funding applications.

Appendices

Appendix 1

Wide-ranging engagement has been crucial to the development of this strategy

May: Review of the 2021 updated Life Sciences Industry Strategy

June–July: 2 x Research & Innovation workshops with 20 participants including non-executive directors, multi-professional research leads, and senior professional leads.

July-October: 1:1 discussions with executive and non-executive directors, senior clinical researchers, corporate functional directors, multi-professional clinical leaders, Lived Experience Ambassadors, NIHR funded research team.

August: Review of professional bodies Research Strategies – Chief Nursing Officer for England's Strategic Plan for Research: Making research matter and the Health Education England (HEE) Allied Health Professions

September: Review of Integrated Care Board (ICB) Research and Innovation Strategies

22 September: Nursing workshop, led by Prof Fiona Nolan

12 October: Presentation to Strategy Steering Group

18 October: Presentation to Board seminar

31 October: Presentation to Suffolk and North East Essex ICB Research & Innovation Collaborative

7 November: Presentation of final draft to Executive Team

Appendix 2

Saving and Improving Lives – The Future of UK Clinical Research Delivery

Adobe Acrobat
Document

Click on PDF object to open document

Appendix 3

9 Non NIHR Non-Commercial studies Open:

Organisation	Project Short title
NHS Foundation Trust, Cumbria, Northumberland, Tyne and Wear	An exploration of Art Psychotherapy practice in general adolescent Inpatient units: Challenges and Benefits: A Qualitative research study
University of Essex	Professional Identity in Psychological Wellbeing Practitioners. V1.
NHS Fife Jennifer Shaw	Suicide by patients in contact with drug and alcohol services
EPUT	Joint working partnership in an OPD community pathway V1.0
Nottinghamshire Healthcare NHS Foundation Trust	Psychometric evaluation of the ECOS measure
South London and Maudsley NHS Foundation Trust	The experience of taking antipsychotic medication for paranoia
University of Essex	Improving heart failure supportive and palliative care. Version 1.0
Anglia Ruskin University / EPUT	A multi-site evaluation of technology in mental health inpatient wards, specifically the use of Vision Based Patient Monitoring Systems (VBPMS) and Body Worn Cameras (BWC)
University of Leicester	Predictors of Staff Wellbeing in NHS Talking Therapies Services

Appendix 4

3 Non NIHR Non-Commercial studies in set up:

Organisation	Project Short title
Essex Partnership University NHS Foundation Trust	Attitudes to Positive Mental Health among Mental Health Professionals
University of Essex	Experiences of FGCs in Adult Mental Health Services
University of Essex	Models of psychiatric practice in inpatient settings

Appendix 5

Life Sciences Industrial Strategy 2017

Adobe Acrobat Document

Click on PDF object to open document

Life Sciences Industrial Strategy Update 2021

Adobe Acrobat Document

Click on PDF object to open document

Appendix 6

Research Strategy for Suffolk and North East Essex (SNEE) Integrated Care System (ICS) 2022 - 2027

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Document

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Appendix 7

Engaging People with Lived Experience in Research at University Health Network

A toolkit to support authentic engagement of patients, families, and care partners in research

Adobe Acrobat
Document

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Appendix 8

Making research matter : Chief Nursing Officer for England's strategic plan for research

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Document

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Appendix 9

Allied Health Professions' Research and Innovation Strategy for England

Adobe Acrobat
Document

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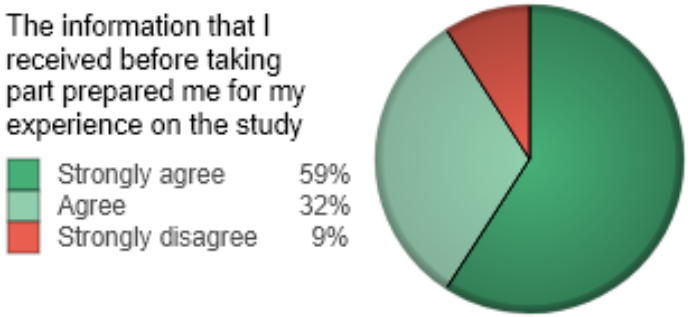
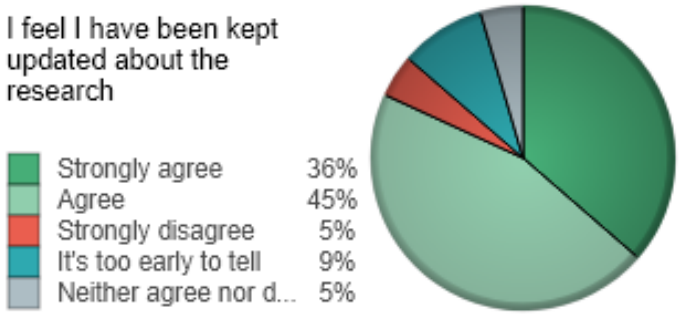
Appendix 10 - What do our patients say about research participation ?

The yearly NIHR National Patient Research Experience Survey (PRES) runs over a 9 month period. So far the survey at EPUT in 23/24 has yielded the following information:

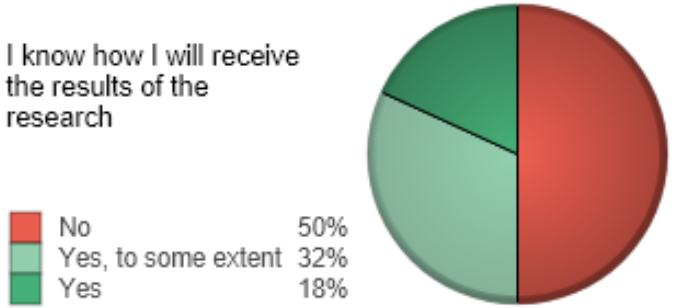
The information that I received before taking part prepared me for my experience on the study



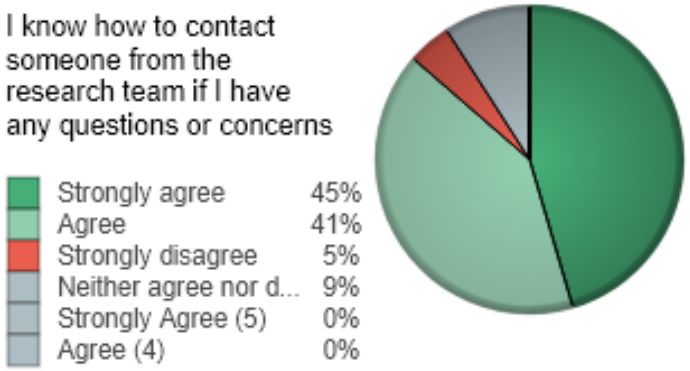
I feel I have been kept updated about the research



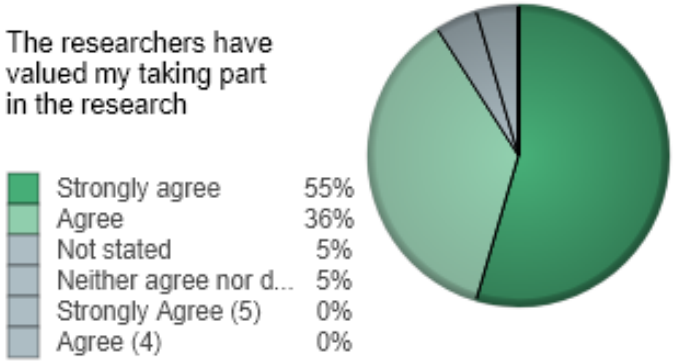
I know how I will receive the results of the research



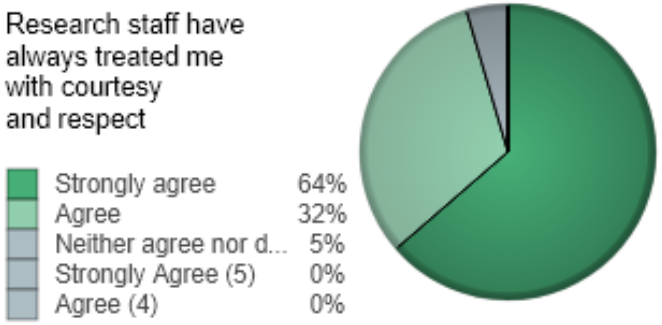
I know how to contact someone from the research team if I have any questions or concerns



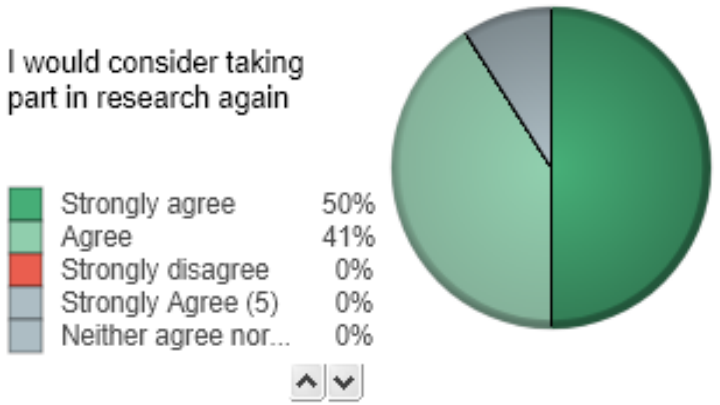
The researchers have valued my taking part in the research

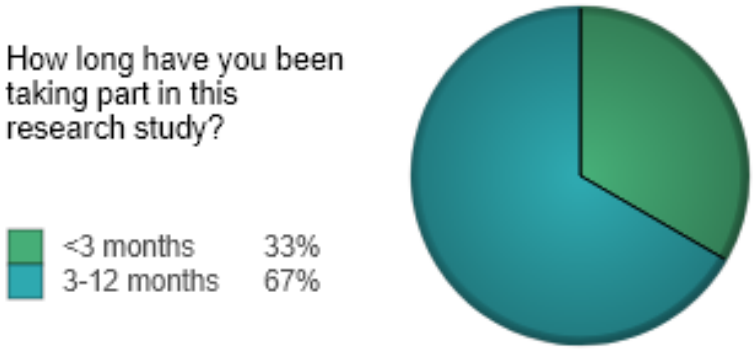


Research staff have always treated me with courtesy and respect



What do our patients say about EPUT research participation? (continued)





I felt validated as someone listened to me.

The research team have communicated well and I have felt like my contribution was appreciated.

What was positive about your experience?

It has allowed me time to understand what my condition is and how I can help myself now and if needed in the future.

Feels good doing something helpful

NHS
Essex Partnership University
NHS Foundation Trust

Innovation strategy 2023-2026: Embracing curiosity

FINAL– v7

EPUT

Foreword from EPUT's Medical Director

To achieve our vision of being the leading health and wellbeing service in the provision of mental health and community care, it is essential that EPUT becomes adept at accessing and translating new knowledge and evidence into practice in a timely manner.

As executive lead for Research and Innovation, I am fully committed to building EPUT into an organisation in which all colleagues can be **curious** and **aspirational** in their work. For EPUT's staff, creating a strong culture of innovation will mean everyone will be supported to identify ways to improve the way we do things, in delivery or care and in clinical support services. In this way we can all raise our ambitions for the standards of care EPUT will deliver to local people, which will require us all to move away from a mindset of risk avoidance and towards risk optimisation.

Innovation should be something that everyone can get involved in, from across all professional disciplines, with psychological safety. I want to encourage our teams to try new things and celebrate all attempts, even those that do not bring about the desired results the first time. Rather, we should all challenge ourselves to think like world-leading innovators and embrace "successful failure" as part of our Culture of Learning. In this strategy, EPUT commits to working in partnership with those that receive our care to identify innovation opportunities and solutions, leveraging the strengths of our local partners so we can all play to our strengths.

Context


PROGRESS
PROGRESS
OIL AND GAS
OIL AND GAS
AUTOMOBILES
AUTOMOBILES
TEXTILES AND GARMENTS

Innovation is a key enabler of the Trust strategy

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

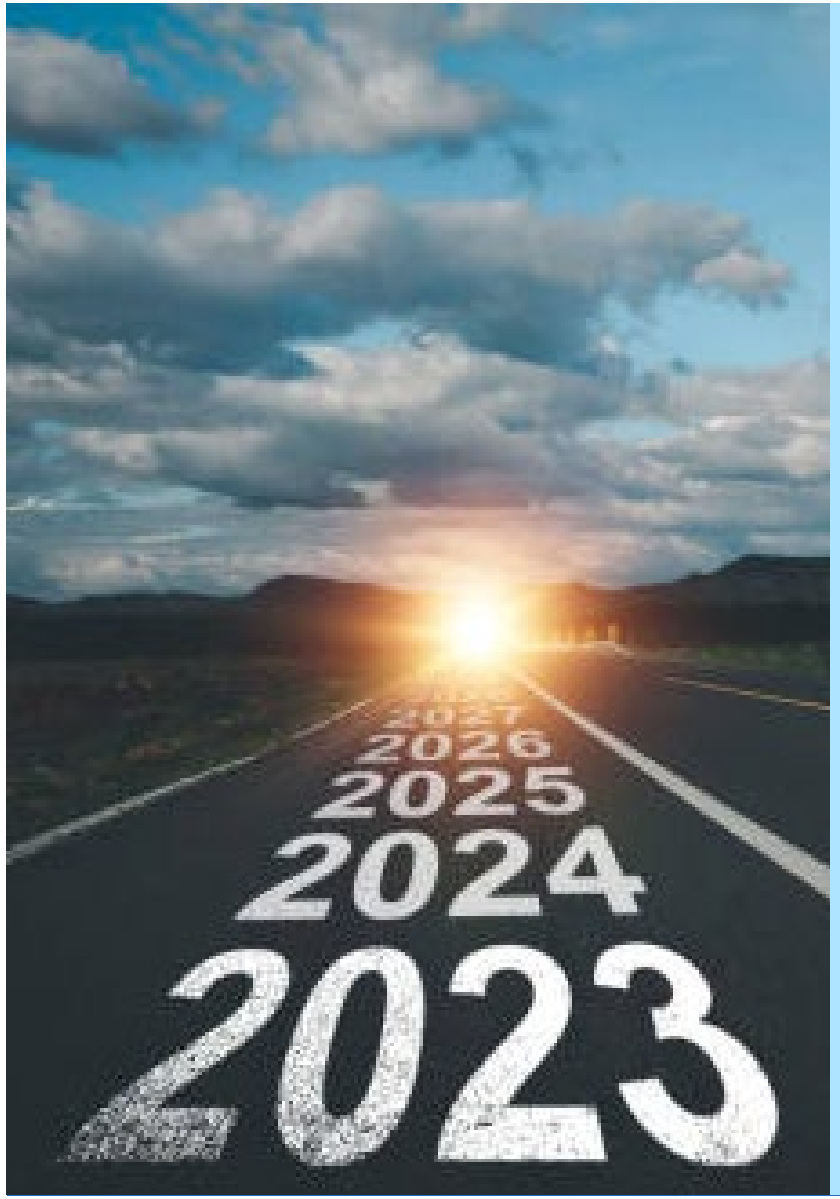
To achieve our vision, it is essential that EPUT becomes adept at accessing and translating new knowledge and evidence into practice in a timely manner.

Innovation is the embodiment of EPUT's core values

We care: we will push the boundaries and embrace change to drive improvements for those we care for, and those that care about them

We learn: we will strengthen our culture of experimentation and learning and embrace "successful failure" as a positive result

We empower: we will build the capacity and capability within our teams to be bold and try new things in a structured and supported way



EPUT's vision for innovation

Where do we want to be by 2026?

With a deliberate focus on building the foundations of innovation, EPUT should aim to have the following in place within three years:

- Evidence of a strong culture of innovation including embracing the concept of "successful failure"
- Appropriate systems and processes in place for learning, continuous improvement and innovation, balanced with space for organic ideas generation and development
- Evidence of some impact to share.

A three-year term for this strategy is considered most appropriate as it dovetails with the likely timescales of the Essex Mental Health Inquiry, the response to which will require innovation and deep change.

Innovation directly supports the delivery of EPUT's strategic objectives

We will deliver safe, high quality, integrated care services

- Using evidence is critical to delivering best practice and improving outcomes for patient care
- Offering the opportunity to participate in innovative and cutting-edge interventions
- Evidence of innovation is a key requirement of commissioner-led procurement of services

We will work with our partners to make our services better

- Aligning our innovation practice to that of our system partners enables each organisation to deliver maximum value
- Co-producing research, innovation and services changes that matter to the people who use our services
- Positioning EPUT as a desirable partner for commercial sector players

We will enable each other to be the best we can be

- Creating an enquiring and improvement-focused environment with psychological safety that rewards trying as much as succeeding
- Attracting and retaining staff by providing development opportunities, mentoring and support
- Offering opportunities for personal development and to support improved job satisfaction

We will help our communities to thrive

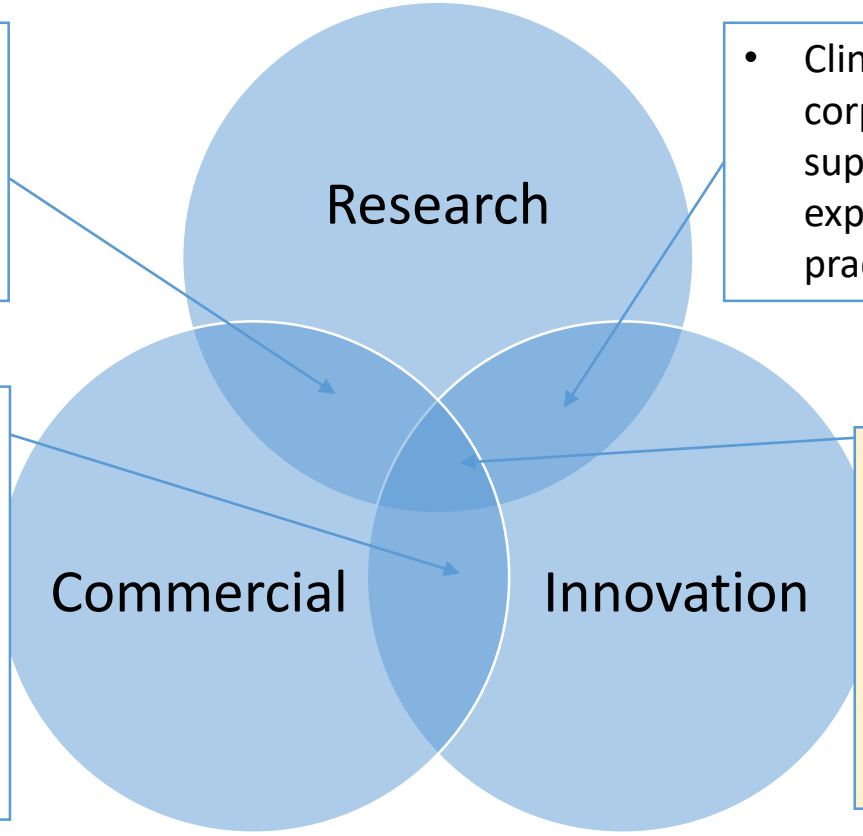
- Ensuring access to research and innovation opportunities for all
- Promoting race equality, diversity and inclusion in our projects, and through active engagement with all our communities and stakeholders
- Supporting local voluntary and community sector partners to innovate with us
- Boosting long term economic growth through driving innovative improvements in health and care across Essex

Research, innovation and commercial development at EPUT remain closely linked

Three related strategies are linked through a new leadership structure and common principles

- Income generation
- Research and commercial partnerships with external companies

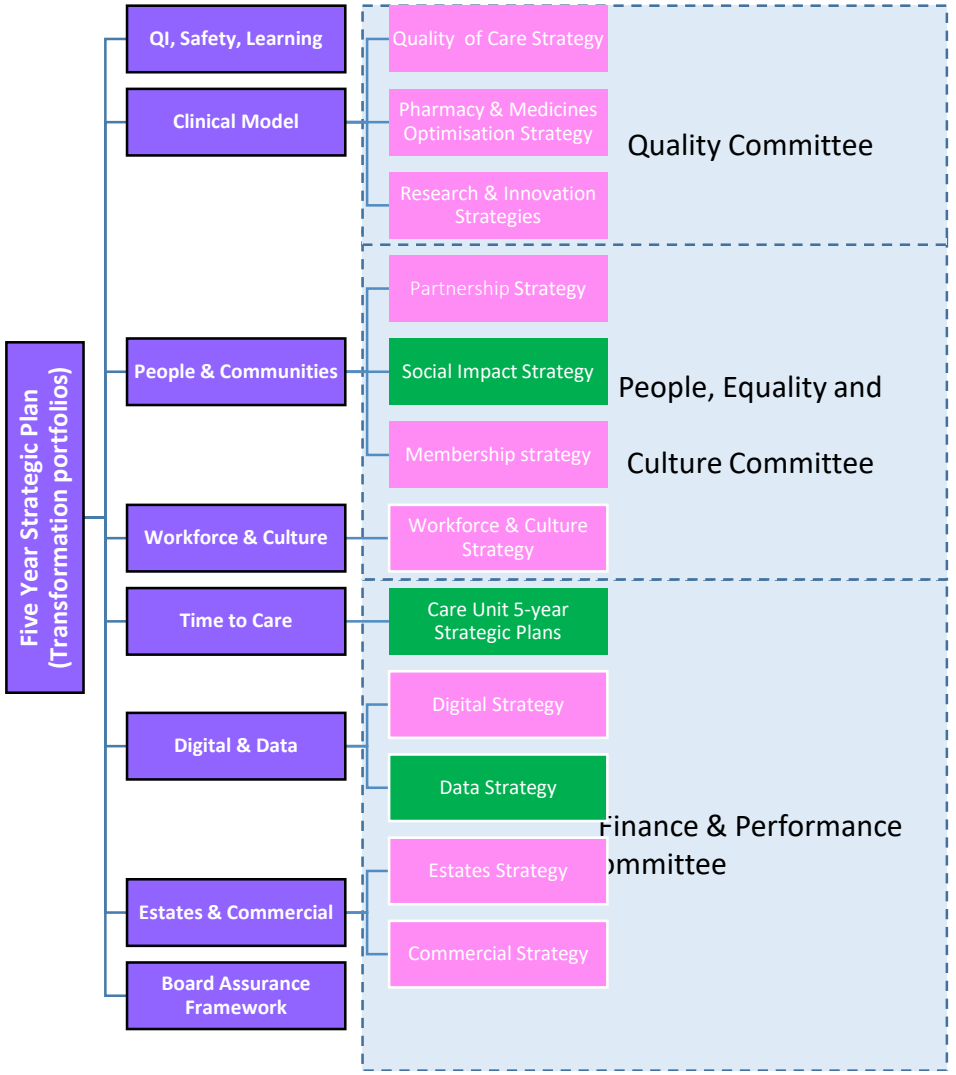
- Clinically led and corporately supported exploration of new practice



- Partnerships with education and the private sector
- Return on investment that can support sustainable future services

Common themes:
- Cultural evolution
- Psychological safety
- Embracing "successful failure"

The innovation strategy relates closely to a range of other enabling strategies



The Innovation Strategy makes particular reference to:

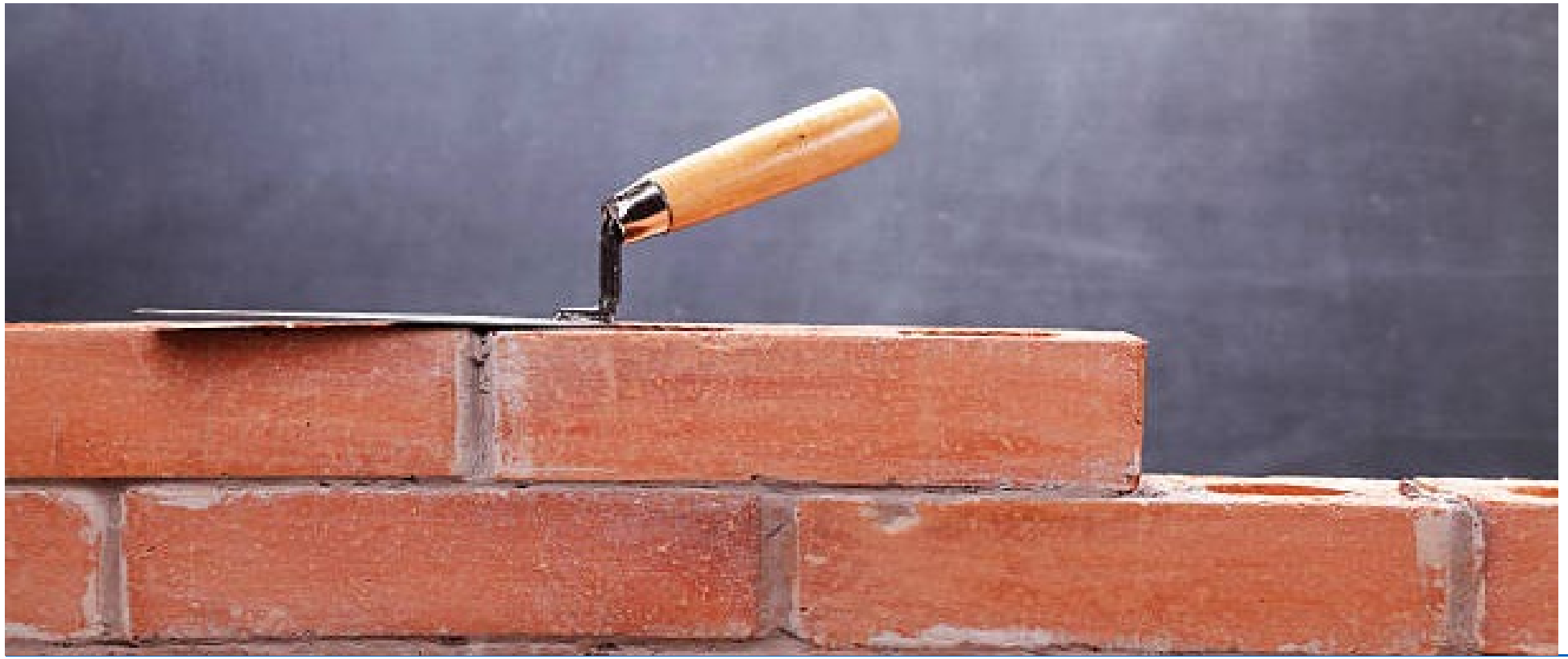
- Quality of Care Strategy and the role of the Clinical Senate in developing EPUT into an evidence-led organisation
- Data Strategy and the role of the proposed data platform in supporting evaluation and impact of innovation
- Workforce, People & Culture Strategy and the role of innovation in recruitment and retention of talent
- Social Impact Strategy and EPUT's focus on driving and enabling innovation for the good of local communities through commercial partnerships with organisations that have aligned Environmental & Social Governance missions.

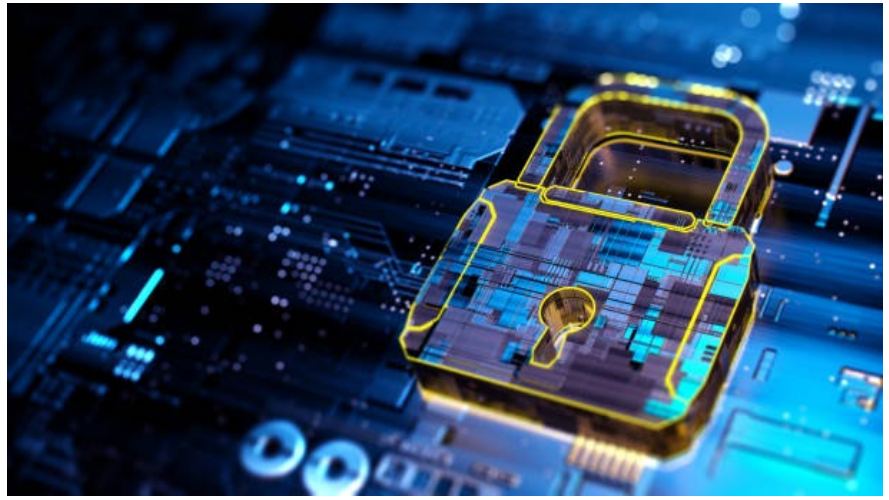
Key to status as of September 2023:
Board approved strategy in place
New/Updated strategy due for Board approval 23/24
Proposal to be completed

EPUT's innovation strategy has been developed to leverage the strengths of our local ICBs' work in this space

- Mid & South Essex (MSE) Foundation Trust hosts the MSE Integrated Care Board (ICB) Innovation Programme
- **As a partner in MSE ICB, EPUT's Innovation strategy should link closely to the ICB's innovation work rather than duplicate or compete**
- MSE Foundation Trust's Innovation strategy is heavily focused on building a **culture of innovation** as a key enabler to successful change and core competent of the Trust's workforce and OD agenda
- MSE ICB runs an annual Innovation Fellowship Programme open to all NHS staff in the Integrated Care System (ICS)
- MSE Foundation Trust is a Clinical Entrepreneur Programme Innovation site designed to evaluate clinical innovations in a real world setting and generate evidence of impact
- Suffolk & North East Essex (SNEE) ICB is establishing quarterly Research & Innovation Collaborative of which EPUT will become a member
- **SNEE ICB's Innovation team leads on horizon scanning in Mental Healthcare which would be of benefit to EPUT**
- **Hertfordshire & West Essex (HWE) ICB is planning to launch a virtual Research & Innovation Hub in partnership with University of Hertfordshire with a two year-proof of concept.** This could be an ideal environment in which EPUT could collaborate with partners on innovation in holistic care – both physical and mental health.

Diagnostic: where are we now?





Innovations are the source of all human development and improvement of quality of life. At the same time, they challenge existing standards, solutions and societal patterns. In health care in particular, innovations enable us to treat previously incurable diseases or to make better use of scarce resources.

Flessa S, Huebner C. Innovations in Health Care - A Conceptual Framework. International Journal of Environmental Research & Public Health, September 2021

The scope of innovation should not be limited to digital

Innovation in healthcare should follow a three-part sequence:

1. Optimising our physical infrastructure and digitally connected devices as part of the Internet of Things (leveraging EPUT's strategic partnership with BT for infrastructure support);
2. Quality improvement and innovation in working practice;
3. Digital and technological innovation.

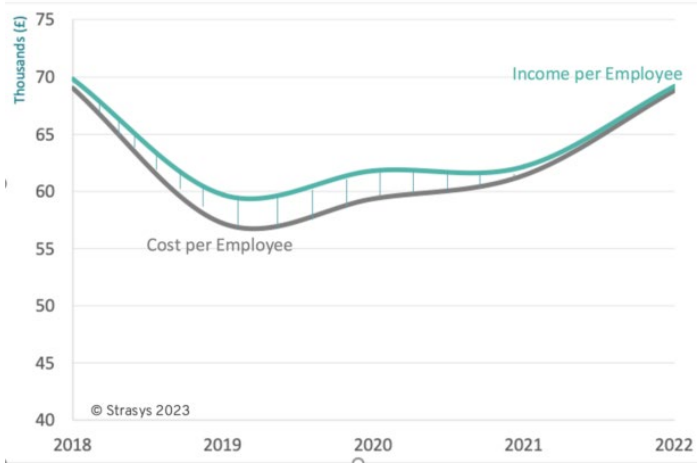
EPUT's current innovation model straddles a number of different functions

- Research and Innovation sit together within the portfolio of the Executive Medical Director
  - Director of Strategy – Senior Responsible Officer
  - Head of Research & Innovation – 0.1 WTE
  - Clinical Academic Chair in Mental Health Nursing jointly appointed with ARU – 0.1 WTE
- Digital team plays a driving role
  - EPUT lab is the currently the main locus of innovation and forum for presentation and discussion of innovative ideas for improving clinical practice (not just digital). It is a well established, clinically led group that meets monthly and has a track record of generating and supporting innovation in clinical and operational practice with a modest ring-fenced fund for investment
  - Though some Patient Safety Partners have declared interest in the work of EPUT lab, involvement of people with lived experience is an acknowledged area for improvement
  - EPUT has partnered with Anglia Ruskin University to convene a group of academics and clinicians to co-produce ideas for innovation in practice, under the umbrella of a Digital Health Innovation Hub
- Quality Improvement as a discipline is led by the Patient Safety function with support from Transformation
- EPUT Culture of Learning Programme is led by the corporate nursing directorate.

EPUT is building from a solid base but engagement has revealed some areas to be strengthened

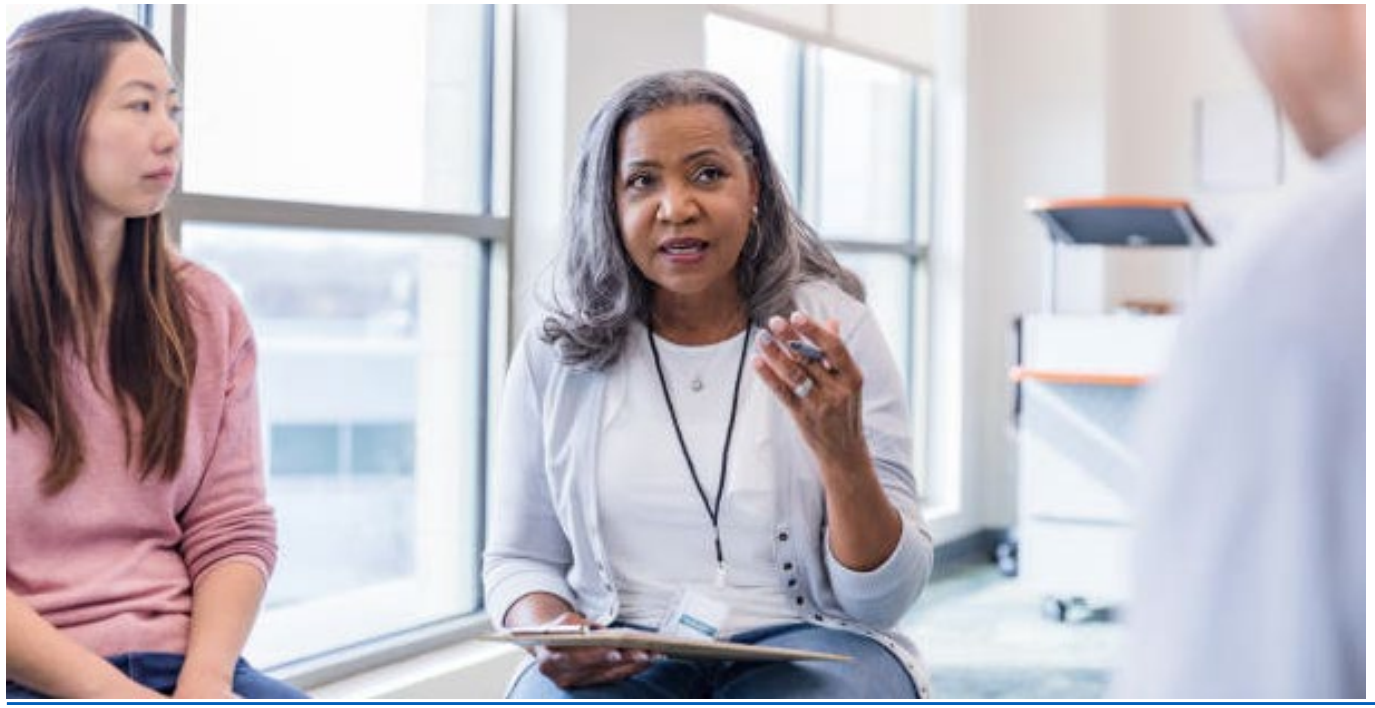
The volume of innovation currently coming from community and mental health practitioners remains far lower than other parts of the NHS.

- Innovation as a discipline is not generally resourced and has an unrecognized opportunity cost. The administration and management of innovation processes at EPUT are minimally resourced which is presently limiting success
- Different professions not always fully aligned in their endeavours
- EPUT's income and operating cost per employee are converging leading to decreasing headroom to innovate year on year based on audited accounts



- Developing relationships with local universities but room to strengthen locally and create new links with recognised academic centers of innovation nationally and internationally
- Colleagues across EPUT hold a range of innovation-related fellowships and academic placements but this is not comprehensively tracked or corporately supported
- Internal decision making process could be streamlined and clarified to make it easier for EPUT to innovate
- There is no clear route into EPUT for voluntary and community sector (VCSE) partners looking for partnership or support to innovate
- EPUT is not yet taking full advantage of its local ICB relationships and innovation opportunities that presents e.g. Mid & South Essex Innovation Fellowship programme

Principles for Research, Innovation and Commercial development at EPUT



Stakeholders have shaped a set of overarching principles to underpin EPUT's research, innovation and commercial development strategies

Focus on building sustainable foundations, rather than big bang approach

Grass roots identification of problems and innovative solutions

Clinically led, multi-professional and inclusive approach accessible to all

Scope beyond, but including, digital innovation.

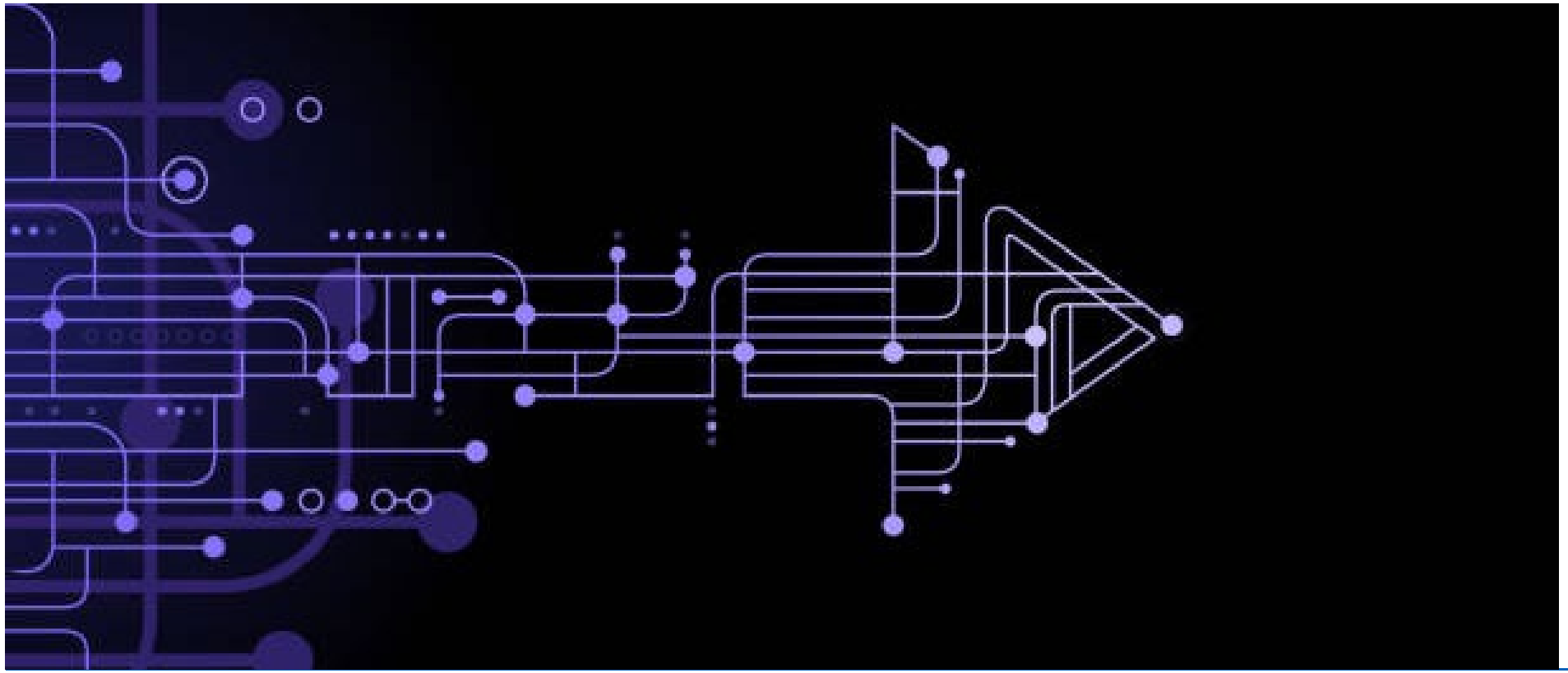
Digital as key enabler for innovation

Appropriate balance of organic ideas generation and robust process management

Alignment with local ICBs' research, innovation & commercial strategies

Continuous review of dynamic strategy in partnership with stakeholders

Getting from A to B: a three year action plan



Informed by our innovation principles, EPUT commits to a three year action plan that will address the challenges identified

Embed an culture of innovation	•Conduct cultural baseline review – consider support from MSE ICB Innovation team •Roll out Commercial Innovation framework •Develop SMART impact dashboard based on International Development Innovation Alliance's (IDIA) framework •Plan annual EPUT innovation conference •Develop innovation micro-site on Input and social media plan
Grow capacity and capability	•Develop business case in Y2 of strategy for small central innovation support function •Support EPUT staff to apply for MSE Innovation fellowships in line with personal development plans •Embed innovation in relevant Job Descriptions / clinical Job Plans •Develop mentorship offer for EPUT innovators
Improve clinical effectiveness	•Board to agree and communicate risk appetite •Co-design innovation framework to ensure all initiatives supported are aligned to Trust strategic plan and priority areas for improvement •Engage with SNEE ICB Innovation team to take advantage of horizon scanning activities
Develop lasting partnerships	•Re-establish Research & Innovation Steering Group with diverse internal and external membership •Identify academic and commercial partnerships to develop locally and nationally •Leverage impact of Digital Health Innovation Hub and partnership with Anglia •Ruskin University with evidence of innovations progressed through this route, starting with a reset prioritization framework for investment •Clarify and publicise EPUT's offer as NHS partner
Amplify lived experience partners and families' voices	•Work with Patient Experience team to identify options for increasing patient and family partnership in innovation activities e.g. service user reference group •Ensure strong lived experience partnership opportunities through re-established Research & Innovation Steering Group •With lived experience partners, use Integrated Performance Report to identify priority improvement areas and align resource to address through innovation •Develop and publicise clear route into EPUT for VCSE partners with lived experience to engage with EPUT for support or partnership

Measurement for impact: KPIs, governance and reporting

Innovation needs balance between freedom, oversight and transparency in governance

Current arrangements:

- Innovative ideas are currently taken to EPUT lab for initial consideration by a range of clinical and corporate functional leaders in a deliberately "governance light" forum
- Go / no go decisions are made by the digital leadership team
- Digital innovations are progressed via the Digital Steering Group (DSG) within its ring-fenced budget
- Some innovations are discussed at the Digital Health Innovation Hub (DHIH) partnership meetings with ARU
- Non-digital change ideas are developed via the Single Front Door (SFD) and progressed, if appropriate via the Transformation Steering Group (TSG), with some overlap with DSG discussions
- DSG and TSG report separately to the Executive Committee.

Recommendations for strengthening current arrangements:

- EPUT lab membership to include lived experience partners
- All digital innovation ideas to go from EPUT Lab to triage by SFD and progressed, if appropriate via TSG
- DSG Terms of Reference to focus on oversight and delivery of Digital and Data strategies
- Innovation commitments in annual operating plans to be reviewed through Accountability Framework
- Delivery and oversight of Innovation Strategy via Strategy Steering Group
- Terms of Reference for DHIH to be strengthened through agreement of criteria for investment in selected innovations through this partnership with its joint budget
- Build in regular sharing of EPUT innovation work via MSE quarterly Innovation Advisory Group
- Re-established EPUT Research & Innovation Steering Group, chaired by Executive Medical Director, reporting to Executive Committee and Quality Committee of Board.

Implementation planning will focus on the development of a SMART impact dashboard

LEADING INDICATORS	OUTCOME INDICATORS
DOMAIN: Impact on Beneficiaries Indicators: ■ Expected lives saved & improved ■ Projected lives saved & improved ■ Available evidence supporting effectiveness ■ Potential to impact the most vulnerable / in need and target equity / gender groups ■ Adherence to 'Do No Harm' principle	**DOMAIN: Impact on Beneficiaries** Indicators: ■ Actual lives saved & improved ■ Projected lives saved & improved ■ Direct measurement, 'use of evidence-based interventions' and new knowledge gained ■ Equity measures and disaggregated data by gender and vulnerable / high-need target populations impacted ■ Externalities and unintended effects
DOMAIN: Scale Indicators: ■ Viable Business model (including IP if applicable) ■ Expected demand / market readiness	**DOMAIN: Scale** Indicators: ■ Replication of business model in different geographies ■ Actual and projected market demand
DOMAIN: Sustainability Indicators: □ Smart partners (especially from country governments and companies/investors) willing to co-fund □ Expected revenue generated □ Potential to influence policy / systems change □ Proven entrepreneurial success of the team	**DOMAIN: Sustainability** Indicators: □ External funding or support attracted (especially from country governments and companies/investors) □ Actual and projected revenue generated □ Policy / systems change □ Improvements in innovator capacity

Measuring the Impact of Innovation, The International Development Innovation Alliance, June 2017

This will be based on the IDIA's *High-Level Architecture for Measuring the Impact of Innovation* due to its focus on equity and need.

Early input measures could include:

1) Quantified time and finances invested in innovation
2) Number of innovation projects per care group
3) Conversion rate of ideas in care units to smart plan
4) Value of Intellectual Property held.

The IDIA notes the challenges that relate to:

- Measuring system level change
- Predicting future impact
- Balancing innovation-specific with standardised reporting

An annual Research & Innovation report will be presented to the Trust Board to update and provide assurance on delivery of the new strategies.

Strategic development process

Engagement with a range of colleagues has informed this strategy

- June-July: 2 x Research & Innovation workshops with 20 participants including non-executive directors, multi-professional research leads, and senior professional leads
- July-September: 1:1 discussions with executive and non-executive directors, senior clinical researchers, corporate functional directors, multi-professional clinical leaders, Lived Experience Ambassadors, 3 x ICB innovation leads
- August: Review and analysis of comparator NHS Innovation Strategies
  - Greater Manchester Mental Health NHS Foundation Trust
  - Northamptonshire Healthcare NHS Foundation Trust
  - Sheffield Health & Social Care NHS Foundation Trust
  - Central London Community Healthcare NHS Trust
  - MerseyCare NHS Foundation Trust

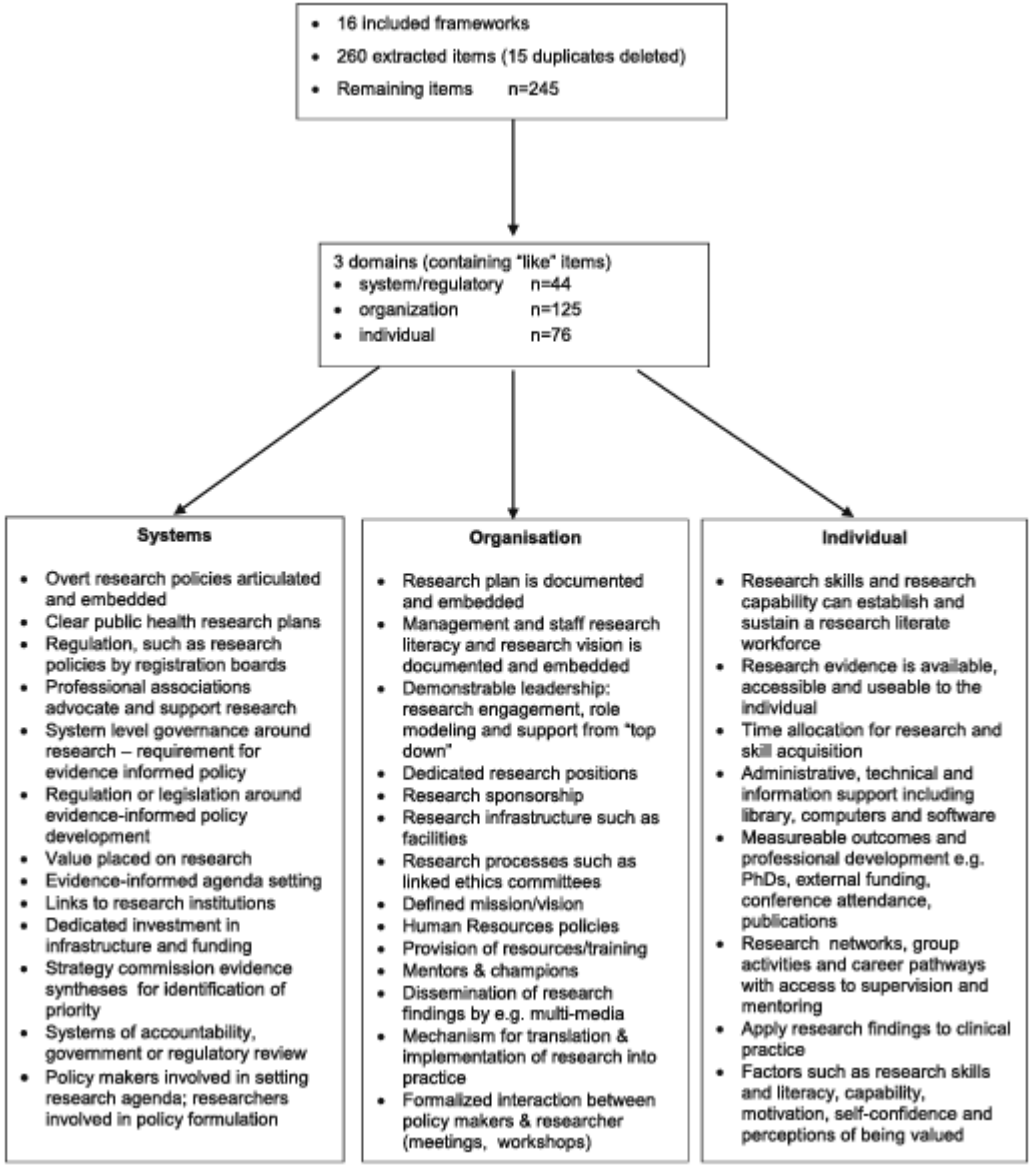
Note common approach of linking innovation to workforce, OD and culture strategies

- 7 September: presentation and discussion with EPUT lab attendees
- 22 September: nursing workshop, led by Prof Fiona Nolan
- September: learning from UCLP on measurements for improvement
- EPUT strategy steering group: 31 August and 12 October
- Executive Committee: 2 October and 7 November
- Board seminar: 18 October
- Presentation to SNEE ICB Research & Innovation Collaborative: 31 October

Appendices

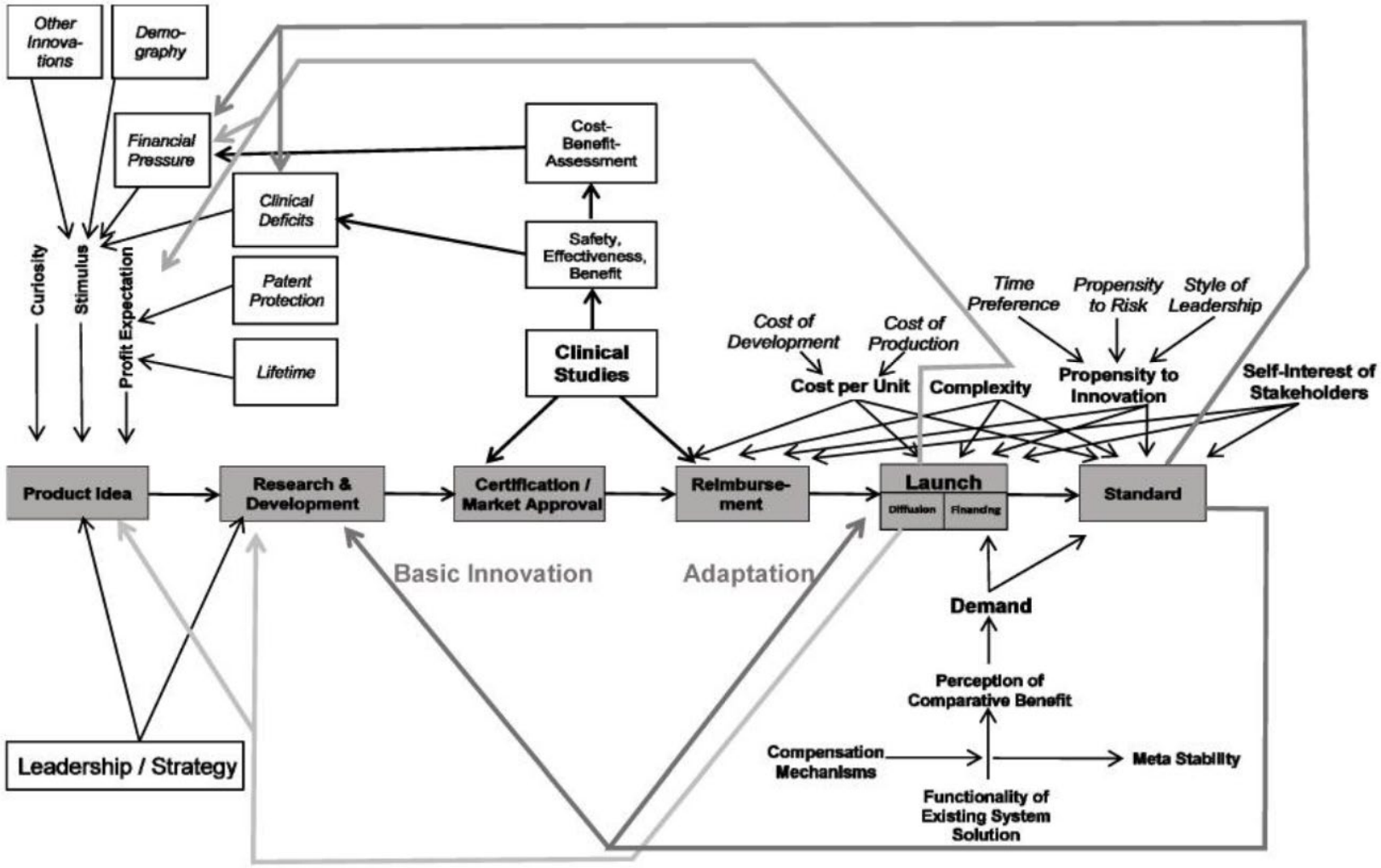
Appendix 1: Key features of a culture of innovation

Source:
Frameworks for embedding a research culture in allied health practice: a rapid review
Slade et al Health Research Policy and Systems, 2018



Appendix 2: Cycles of innovation in healthcare

Source:
Flessa S, Huebner C. Innovations in Health Care - A Conceptual Framework.
International Journal of Environmental Research & Public Health, September 2021



Appendix 3: MerseyCare exemplar

Mersey Care NHS Foundation Trust and the University of Liverpool have teamed up to create the first ever Mental Health Research for Innovation Centre (M-RIC), where service users co-design the innovations they need and want, alongside health professionals, researchers, industry partners, and public advisers.

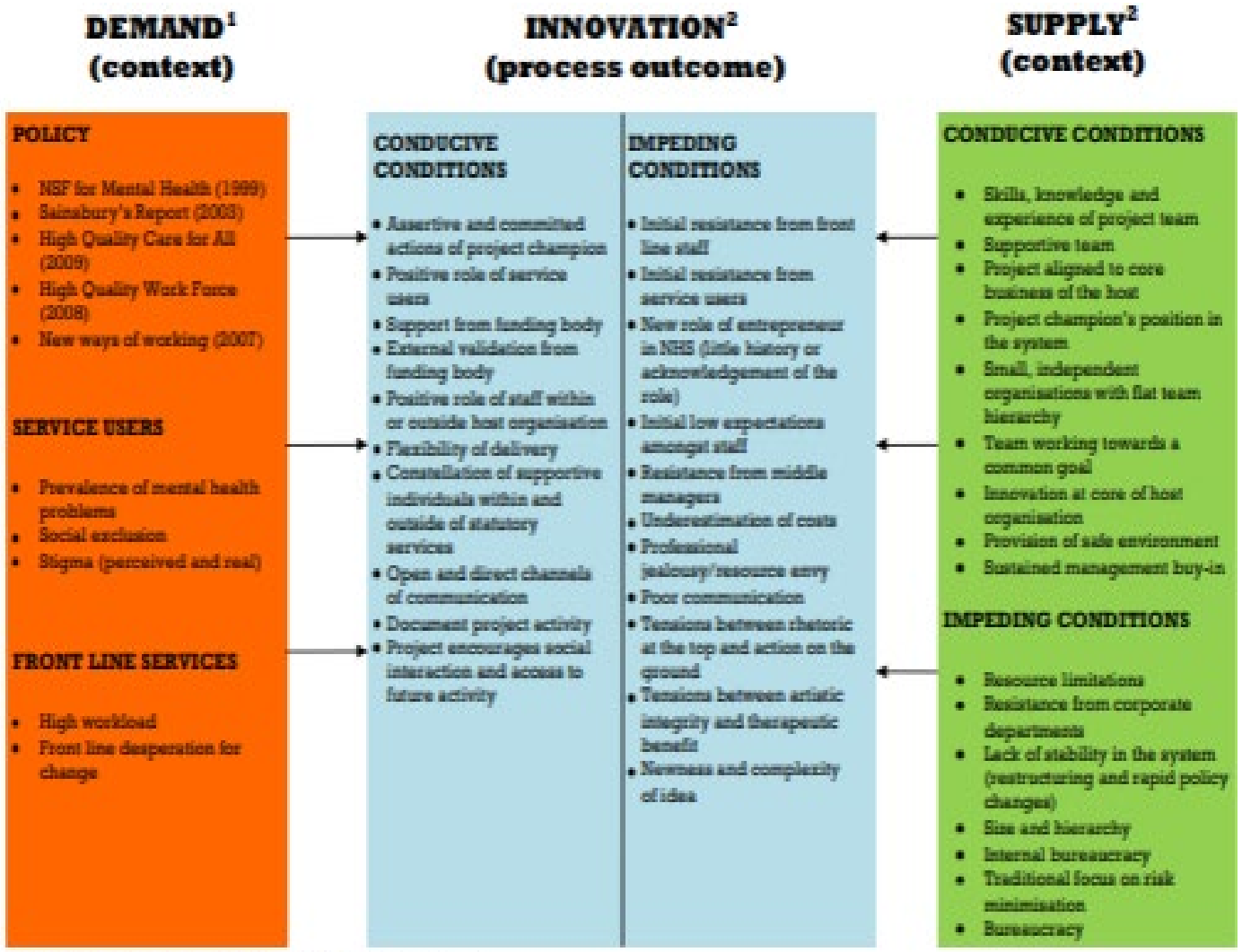
The Centre will be awarded £10.5 million of government funding from the Office for Life Sciences and the National Institute for Health and Care Research. It is part of the national 'Mental Health Mission' which aims to accelerate mental health research through the National Institute for Health and Care Research (NIHR) Mental Health Translational Research Collaboration which includes M-RIC in Liverpool.

M-RIC will create a world first 'learning system' where treatments improve the more they are used, studied and refined. The focus will be on under-researched areas such as early intervention in psychosis, depression, and children and young people's mental health. Research will underpin Liverpool City Region's commitment to service users, providing easy access to clinical trials and increasing their involvement in better care, closer to home.

Appendix 4: Understanding barriers and enablers of innovation

In addition to the conditions identified in the literature that will be conductive to, or impede, innovation, stakeholders have identified other potential barriers specific to EPUT that we must design out of our innovation strategy:

- Competition with many other priorities (e.g. EPR implementation)
- Fear of reporting failure
- Incorrect definition of the problem



[1] Items derived from review of the relevant literature.
[2] Items derived from primary data collection.

Source:
Innovation in mental health services: what are the key components of success?
Brooks et al. Implementation Science 2011

NHS
Essex Partnership University
NHS Foundation Trust

TRUST COMMERCIAL STRATEGY

2023 – 2026

EPUT

INTRODUCTION

Most commercial strategies are rooted in competition, setting out how organisations plan to increase market size and share, at the expense of their competitors. The way healthcare is commissioned and provided is changing, with collaboration increasingly taking the place of competition and individual interests giving way to ever greater integration. The Trust will maximise opportunities for commercialisation through innovation, partnership working and collaboration.

Providing the leading mental health and community care of the future will mean working closely with system partners, with other providers, with communities and, crucially, with patients and their families. This is core to the Trust's Strategic Plan. Our commercial strategy therefore sets out how we will develop our commercial acumen and deploy entrepreneurial thinking to deliver our four strategic objectives:

- Delivering safe, high quality, integrated care services
- Enabling each other to be the best we can be
- Working together with our partners to make our services better
- Supporting our communities to thrive

Having engaged with Care Unit and Business Unit leaders across the Trust, five themes have been identified that set out how the benefits of a commercial approach can be leveraged across the organisation and wider system to create value for patients, staff and partners.

This strategy sets out how EPUT will adopt a collaborative commercial approach.

A COLLABORATIVE COMMERCIAL STRATEGY

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC CONTEXT

Our vision

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

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.**

OUR values

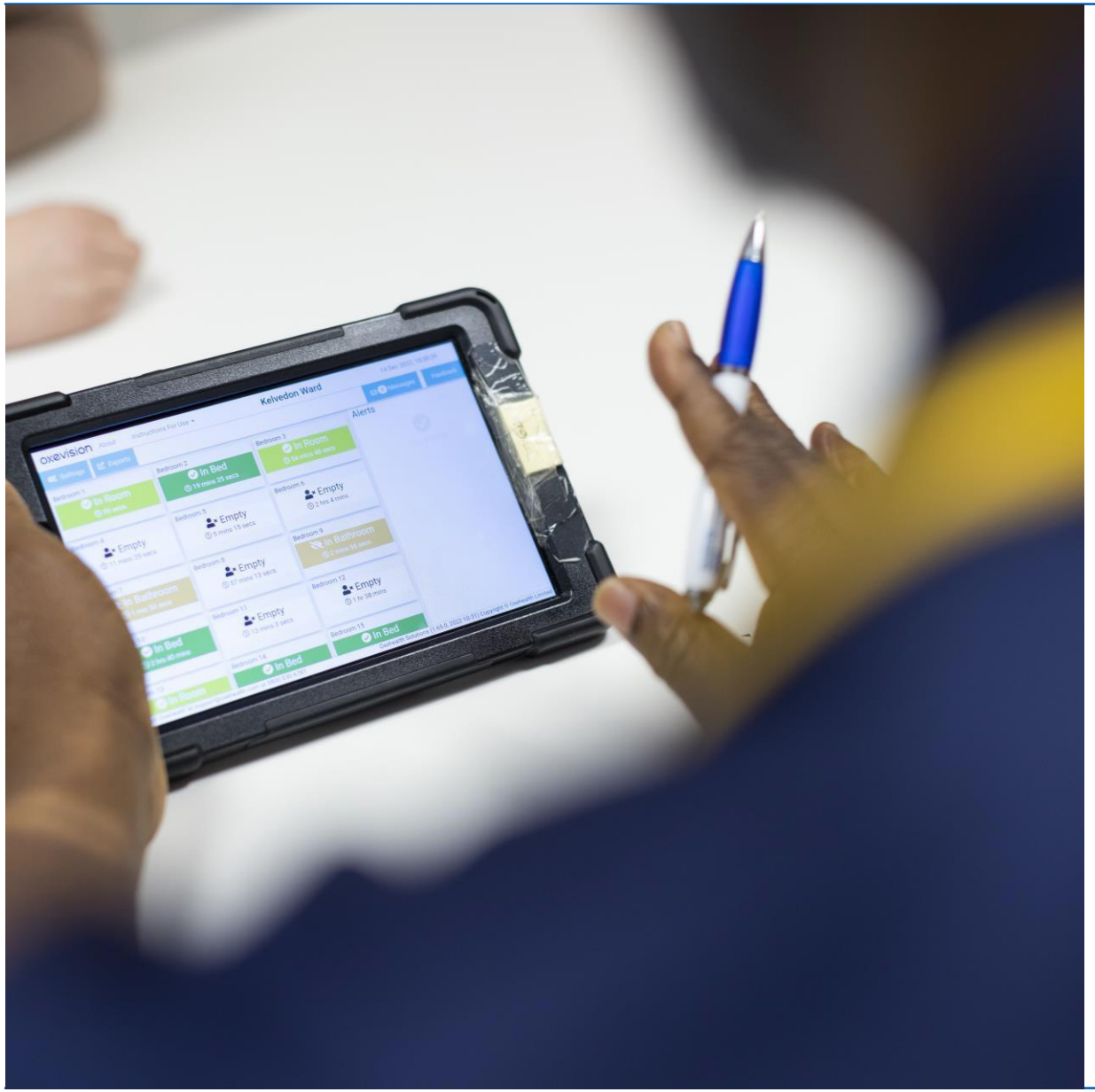
we care

we learn

OUR PURPOSE

We care for people every day. What we do together matters.

we empower



STRATEGIC THEMES

1. STRATEGIC ALIGNMENT
2. SERVICE DESIGN
3. COMMERCIAL INNOVATION
4. PROCUREMENT AND CONTRACT MANAGEMENT
5. CULTURE, SKILLS AND ENGAGEMENT

THEME 1

STRATEGIC ALIGNMENT

The purpose of our commercial strategy is to support our Strategic Plan and our vision:

"To be the leading health and wellbeing service in the provision of mental health and community care."

The Trust's Strategic Plan sets out four strategic objectives that must be the essential focus of our efforts in order to achieve this vision. Our commercial activities must contribute to this by creating a culture of entrepreneurship and innovation that protects and enhances the quality of services and the safety of care. In turn, this will protect and enhance the organisation's reputation and build confidence among stakeholders and partners that EPUT is a provider that is trusted to provide the safest possible care.

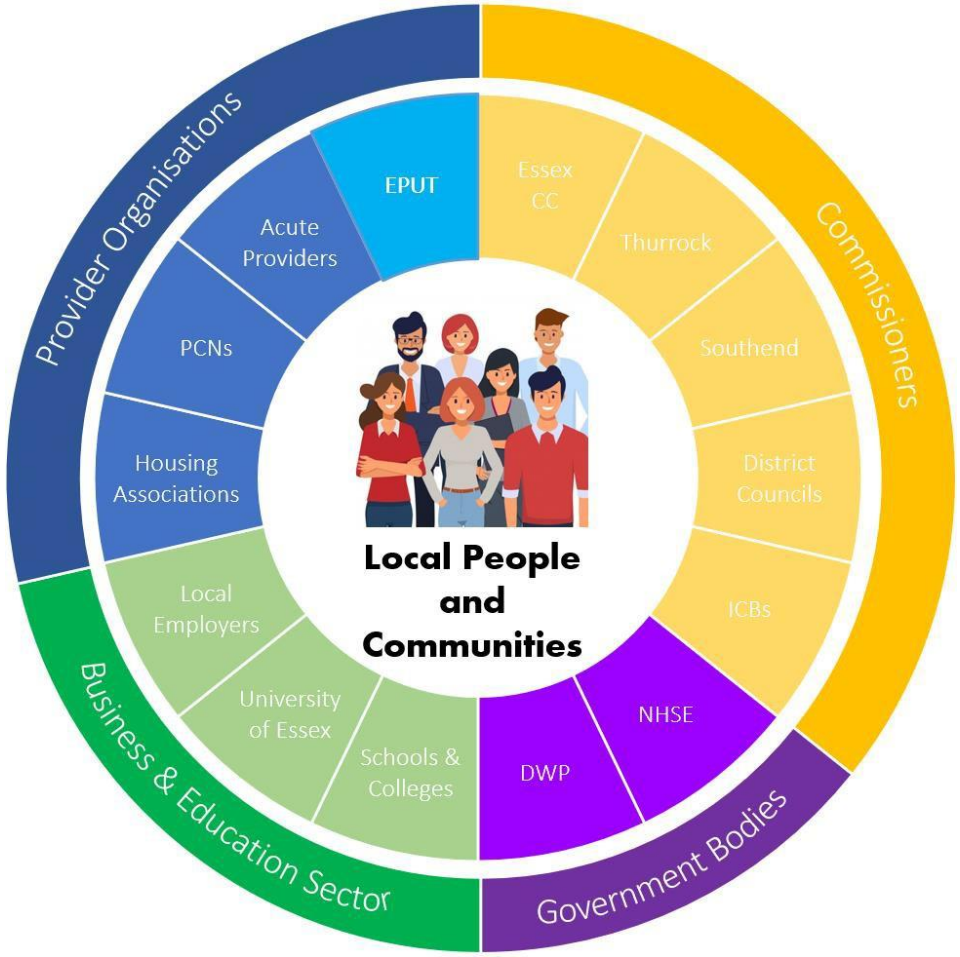
By making patient safety, quality of care, effective partnership working and community wellbeing the essential ingredients of the EPUT brand, commissioners and partners will want to invest in the services the Trust provides, creating a virtuous circle.

To that end, this strategy combines both elements of collaboration and commercialisation. Our focus is not rooted in how we can gain competitive advantage over others. We believe instead that collaborative advantage will better serve the Trust, our partners and, crucially, our patients in our new operating context, which is one of system integration and joining up services around patients and communities. We have already seen evidence of the benefits of this through provider collaboratives. This strategy builds on this ethos to set out a collaborative and entrepreneurial way of delivering and transforming services.

A COLLABORATIVE COMMERCIAL STRATEGY

Traditional commercial strategies place an organisation at the centre of a competitive landscape, with customers to be acquired, competitors to be defeated and profits to be maximised. Our collaborative commercial strategy recognises the need to work in partnership to leverage opportunities within the Trust and the wider systems within which we work:

- Patients, families and local communities are at the centre of the healthcare system. We will work closely with partners to make access to services as seamless as possible, no matter who provides them, and design services that fit around people's lives.
- We'll think and act preventatively, bringing more services closer to communities and providing more community based support – better for health outcomes and better for the public purse.
- We'll turn our competitors into partners, working with other providers in the NHS, private and voluntary sectors to provide the best quality services, centred around people who use them.
- We'll seek to maximise outcomes, investing in services that will provide the best quality of life for patients and communities, embedding social value within our commercial ventures.



TARGET OPERATING MODEL

The Trust has adopted a new operating model based around Care Unit, led my multidisciplinary teams and supported by Business Units that provide corporate infrastructure and support services.

Care Units have developed their own strategic plans which set out how they will deliver their local priorities within the framework of the Trust's Strategic Plan. Care Units will likewise implement the themes of this commercial strategy by developing their own commercial plans, supported by the capacity and capabilities within the corporate Business Units.

THEME 2

SERVICE DESIGN

Designing innovative services, with, and for patients and communities, will create services so good that commissioners and partners have the confidence to invest in them.

BUILDING BETTER HEALTHCARE AWARDS 2022

We have started to make great strides forward in this. We've recruited more people with lived experience than ever before to help us design services with those that use them in mind. We're involving service users in the design of our wards and to promote wellbeing, inclusivity and creativity. Some of these projects have even won awards.

We'll also increase the capacity, accessibility and reach of our services by radically embracing the opportunities of digital, data and technology. This priority already forms part of the Trust's Strategic Plan and we'll make sure we maximise the opportunities of data and technology to design better, more inclusive services at lower cost.

We'll embed a culture of innovation, co-production and continuous learning in all of our services. This will mean not relying on what we've done in the past but taking the design of some services back to the drawing board and asking patients, families, communities and staff how we would design services to achieve outcomes in the 21st century.

We'll support this by training staff in service design methodologies, working with communities and partners.

SERVICE DESIGN

Our award-winning refurbishment of Basildon Mental Health Unit engaged staff and service users in the design process to improve patient safety and create an environment of wellbeing and creativity. The project won the Best Patient Safety Initiative category in the Building Better Healthcare Award and was shortlisted for Best Interior Design and Best External Environment.

"OUR RELATIONSHIP WITH EPUT AS A STRATEGIC PARTNER HAS ENABLED US TO ENSURE THAT PATIENT VOICE IS INTEGRAL TO ALL THE DECISION-MAKING" – HEALTHWATCH ESSEX

"This is the best ward I have been to; it is like a hotel. I would be happy to pay for my stay here. The ward environment is therapeutic"

A huge effort to recruit Lived Experience Ambassadors means that more people with lived experience than ever before are helping us to design and improve our services. This is a key selling point for the Trust and the way in which we will build a trusted brand. Ensuring that our services provide safe, good quality care and that they are shaped by people who use them will provide better outcomes for patients, build Trust among stakeholders and lead to financial and organisational sustainability.

We'll build on these achievements going forward to ensure that **user-centred design** is a key feature of all of our services. This will be a key component of the EPUT brand and an essential part of what we are known for – providing the safest possible care with patient-led innovation at the heart of services.

480%

INCREASE IN LIVED EXPERIENCE AMBASSADORS SINCE 2021

THEME 3

COMMERCIAL INNOVATION

Commercial innovation and partnerships will help to enhance the brand of the Trust and its financial and reputational sustainability. The Commercial and Innovation Strategies will align to achieve this vision.

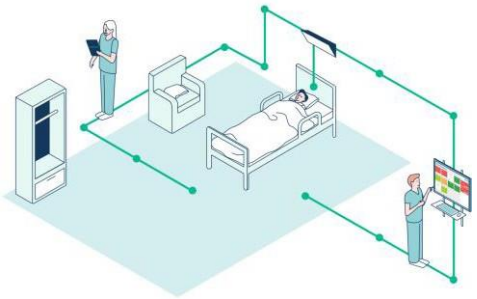
Embracing innovation is not new to EPUT. The Trust has an established track record of engaging in innovative practices, including partnerships with education and the private sector. This includes our collaboration with Oxehealth, the work of EPUT Lab and our award-winning Clinical Associate Psychologist apprenticeship.

The Trust is not always strong at reaping the benefits of innovation. We often lead on creating value for others but don't always secure value for our own organisation. This is the key aspect of what it means to commercialise innovation in a healthcare context – not for our own sake or for pure financial gain, but in order to create return on investment that can support sustainable future services for our patients and service users.

THE CREATION OF VALUE IS A DEFINING CHARACTERISTIC OF INNOVATION.

We need to make investment in the commercial acumen of our staff in order to maximise the benefits of opportunities. This is particularly important when the Trust has invested the time and expertise of our staff in partnership initiatives, making sure that we get a fair share of the value this creates and that our patients benefit from it. This will be underpinned by a new commercial innovation framework which will help us to concentrate our time and resources on the areas that best complement the Trust's strategic objectives at a time of limited resources.

COMMERCIAL INNOVATION



EPUT has collaborated with Oxehealth to implement a safety monitoring system on our wards.

The Oxevision system allows us to take remote measurements of patient vital signs, to supplement in-person observations. 91% of staff agree that it has improved patient safety on the wards.

We have created a suite of Standard Operating Procedures (SOPs) using a digital solution called Sophia. These SOPs have been created in a 'white label' way, which means that they have a neutral brand and could be shared with any healthcare provider involved in providing similar services.

As well as helping to improve the quality and consistency of the patient experience, this has the potential to generate a financial return, enhance our reputation in the sector as a healthcare innovator, or both.

The Trust's innovative Apprenticeship Scheme for Clinical Associate Psychologists won the HSJ Award for Workforce Initiative of the Year 2022. This sets EPUT up to be a respected leader in workforce development nationally. Capitalising on the reputational capital this creates will enhance the quality and visibility of the Trust's profile regionally, nationally and even internationally.

WINNER OF THE

FOR HEALTHCARE LEADERS
HSJ
AWARDS

WORKFORCE INITIATIVE OF THE YEAR

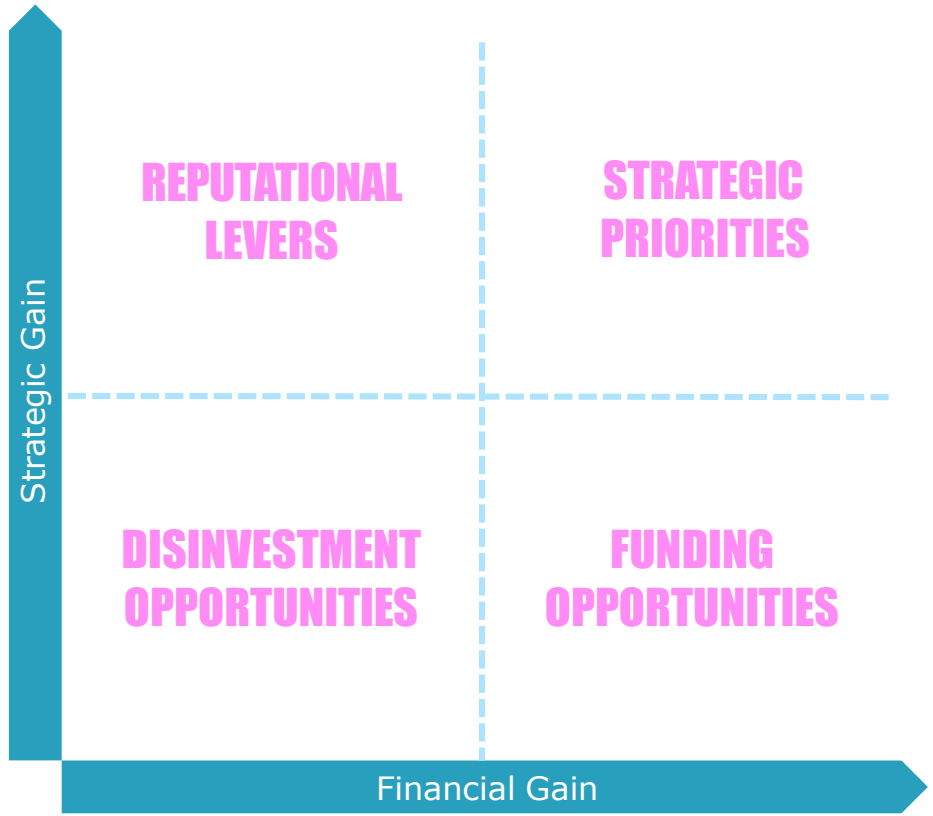
COMMERCIAL INNOVATION FRAMEWORK

The Trust has many priorities competing for the organisation's focus and resources. The Trust Strategic Plan sets out four strategic objectives that must be the essential focus of organisational efforts in order to succeed. Any commercial activities must contribute to delivering the Strategic Plan.

We will therefore introduce a new **commercial innovation framework** which will help us to prioritise those opportunities that not only generate financial benefits but create positive strategic positioning for the Trust. This is the essence of what it means to be commercial in our new model.

The framework will classify opportunities as one of four types:

- Strategic Priorities – which generate both financial and strategic RoI
- Reputational Levers – which will create brand value for the organisation
- Funding Opportunities – additional funding to support vital services
- Disinvestment Opportunities – where savings can be made by stopping



THEME 4

PROCUREMENT AND CONTRACT MANAGEMENT

Effective procurement and contract management is integral to good commercial practice on the supply side. Managing our supplier base effectively is critical in evidencing our approach to achieving value for money.

This has been an area of historic under-investment for the Trust and our organisational maturity is relatively low, as indicated by a recent external review in partnership with PWC.

With more than £120m of the Trust's budget spent in our supply chain, we recognise this as an area of significant opportunity to create value for the Trust and with system partners.

As all parts of the public sector look to address the dual challenge of rising demand and constrained funding, we will look for opportunities to work with system partners to reduce costs while maintaining quality through collaborative procurement. The opportunities will be at a local level with ICBs, other providers and local authorities, at a regional level with other Trusts and the East of England Procurement hub, or nationally through NHS Supply Chain and the Central Commercial Function of NHSE.

A new approach to procurement will help us to stratify our expenditure and determine the right sourcing approach for each category of supplies, works and services. This will embed a robust approach to procurement in line with new legislation.

We'll also invest in our technology, skills and capabilities to enable better commercial management of our third party contracts and investments.

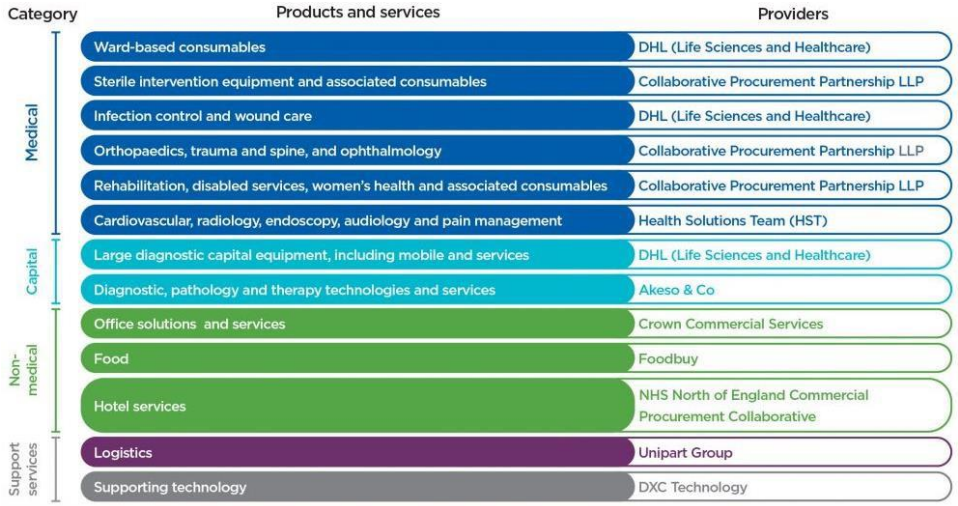
PROCUREMENT AND CONTRACT MANAGEMENT

Work is underway to author a suite of Standard Operating Procedures (SOPs) for clinical activities, to reduce unwarranted variation and reduce clinical risk and serious incidents. We'll transfer this principle to creating gold-standard SOPs for procurement and contract management activities, in order to reduce commercial risk and create value for the organisation in line with legislative requirements.

Our current way of working can be reactive and we recognise that there are significant opportunities from adopting a more strategic, commercial and proactive approach to procurement. By adopting a 'category management' model for procurement, we will maximise the value of our spending power and make it easier to identify opportunities for collaborative procurement with other Trusts and local authorities. This approach will be consistent with the NHS Supply Chain 'category tower' model, and the Central Commercial Function Commercial Strategy, helping us to develop strategies for what to procure at local, regional and helping us to develop strategies for what to procure at local, regional and national levels.

We also recognise that, no matter how effective our procurement is, a great deal of value can be lost throughout the lifetime of a contract if it is not managed effectively. That's why we propose to invest in our contract management capabilities, developing a new framework with clear roles and responsibilities and joined-up working between clinical and corporate staff to form multi-disciplinary contract teams.

We'll support staff to perform this role effectively and improve the Trust's access to actionable management information by investing in technology, introducing a new procurement and contracts system.



THEME 5

CULTURE, SKILLS & ENGAGEMENT

Creating the right culture is key to ensuring the successful delivery of our collaborative commercial strategy.

All of our staff have chosen careers in healthcare in order to improve people's lives. It may not be obvious to everyone how this fits with a commercial agenda – and yet finding new ways of funding services is vital to ensuring their quality and sustainability. We need to effectively communicate how these goals complement each other in order to secure buy-in.

The kind of culture we want to create needs to be carefully communicated to make sure that staff and partners understand the nature of our strategy – working with people to achieve financial sustainability and sustainable services, rather than a traditional, competitive approach.

To guide us on this journey, we have developed a commercial culture roadmap that sets out not only what actions we will take to embed a commercial mindset but how this form positive connections in people's minds between commercial activities and our ability to provide great quality care.

This will be rolled out alongside our other culture, skills and engagement priorities in the Trust, including embedding a digital first ethos to transformation and an inclusive approach to service design and delivery that leaves nobody behind.

COMMERCIAL CULTURE MATURITY ROADMAP

A COLLABORATIVE COMMERCIAL STRATEGY

	Year 1 – Establishing	Year 2 - Embedding	Year 3 - Practising	Year 4- Enhancing	Year 5 - Leading
	2023	2024	2025	2026	2027
Visibility and Awareness	Commercial Strategy has been endorsed by Trust Board. Executive sponsor of the programme in place. A simplified version is published internally and externally and communicated to staff.	The Trust's commercial context is included in staff induction. This can be tailored to different roles.	There is widespread awareness of the Strategy and how it links to both organisational goals and personal development. Commercial is visible (at some level) in the values of the organisation.	Strategy is refreshed to reflect current context, including ICS working, Trust's market position, local and national health sector context. Refreshed strategy is communicated to staff and partners.	There is widespread awareness, internally and externally, of the Trust's commercial ethos and how this supports innovative working and better outcomes for people. 'Everyone knows' that EPUT is a commercial and innovative Trust.
How people work	Commercial thinking is introduced, at a high level, to the organisation, beyond staff for whom it is an existing part of their role. A cross-organisation bid team is established to supplement the corporate Business Development team on key projects.	Key commercial tools and intranet resources are introduced to assist both the core bid team and staff across the Trust seeking to innovate. A cross-organisation network of commercial champions is formed who promote and role model the desired attitude and behaviours.	Business cases and service plans are consistently driven by robust analysis of both demand and supply, including customer needs, forecast demand, market growth, competition, supply risks and market trends. Data starts to be gathered and shared on a systematic, not ad hoc, basis.	Innovation and new solutions come from staff at all levels – not just leadership and management. Data on customers, competitors and market trends is gathered across the organisation, supported by technology, and is systematically refined into intelligence.	The Trust blends expert technical skills with an entrepreneurial mindset. Collaboration is natural, not just internally but with partners, service users, customers and suppliers. People act in the present and think in the future; the Trust is adept at exploiting existing capabilities while concurrently exploring new ones.
How performance is managed and developed	Performance appraisals for relevant staff includes specific commercial objective(s).	Key staff have received training in commercial skills and thinking. Simple reward and recognition scheme in place for commercial ideas and innovation.	Commercial thinking is recognised as a desired behaviour for all staff, with specific objectives for those in relevant roles. Corporate curriculum of transferable commercial skills available to all staff, with specialisms certain roles.	Commercial thinking is included in competencies and selection criteria for all relevant roles. Targeted refresher training takes place, based on Trust's latest position Key staff receive advanced training in commercial skills.	Skills are constantly developed and the organisation is recognised as a leading source of knowledge and a training ground for top talent. There are direct and visible links between organisational and individual performance, rewarded appropriately.
How the culture will feel	Staff at all levels recognise that the Trust is now a 'challenger' in some markets, rather than the incumbent; mindsets towards customers and commissioners begins to shift accordingly. Fear of failure begins to erode as staff come to understand the Trust's risk appetite and the boundaries within which they can take risks.	Successes are celebrated but never taken for granted; the Trust assumes it will need to compete at its best to win every new contract opportunity. Experimentation is encouraged and 'low cost mistakes' are culturally accepted within the Trust's risk appetite. 'Good attempts' at innovation are recognised, alongside successes.	The Trust respects and values its competitors and systematically learns from them to improve its own performance. Staff, and the Trust as a whole, persevere in the face of failure and incorporate the learning into new innovations.	There is a 'growth mindset', both for individuals and the organisation. The Trust's ambitions for commercial growth are explicitly linked to its learning and development strategy. There is a 'learn-it-all' culture, not a 'know-it-all' culture, with staff at all levels recognising that the way things have been done before will not position the Trust for the future.	People feel proud to work for EPUT – not only as an NHS Trust but because of its reputation for innovation and entrepreneurship. Commercial culture pervades the organisation at all levels, recognised by internal and external awards. This never leads to complacency – the Trust is a learning organisation that is constantly reinventing and innovating.
How the organisation is perceived	The Trust is recognised as a good NHS provider organisation that is established and successful at winning contracts. Externally, people recognise that the Trust is beginning to be more innovative in its thinking.	The Trust is known to be developing more sophisticated commercial thinking and behaviours, fit for its future in a more integrated system. Outside organisations begin to show interest in this and enquire about the approach.	The Trust is recognised as a commercially minded NHS provider with a record of consistent delivery. People outside the organisation are aware of EPUT's commercial ambition and achievements.	The Trust is widely recognised as being in the top 25% of commercially innovative NHS Trusts; the organisation shares best practice and trains others. Achievements are publicised and used as part of talent attraction strategy.	Public sector and commercial organisations seek out the Trust as the obvious NHS partner for commercial innovation. The Trust is an employer of envy for entrepreneurial people and naturally attracts new commercial talent.
Measures and Metrics	• Staff awareness of strategy % • Downloads / views of strategy • Relevant staff who can relate strategy to their roles % • Performance objectives in place • Observed language and behaviours	• Staff awareness of strategy % • Downloads / views of strategy • Commercial network in place • Skills programme metrics • Reward and recognition in place • Observed language and behaviours	• Commercial linked to Trust values • Commercial in target behaviours • Key words in staff survey • Skills programme metrics • Observed quality/consistency of work • Observed language and behaviours	• Strategy refreshed • Staff awareness of strategy % • Commercial in selection process • Skills programme metrics • Observed language and behaviours • External perceptions – news and articles	• Staff awareness of strategy % • Key words in staff survey • Observed language and behaviours • External perceptions – awards and achievements • External partnership approaches

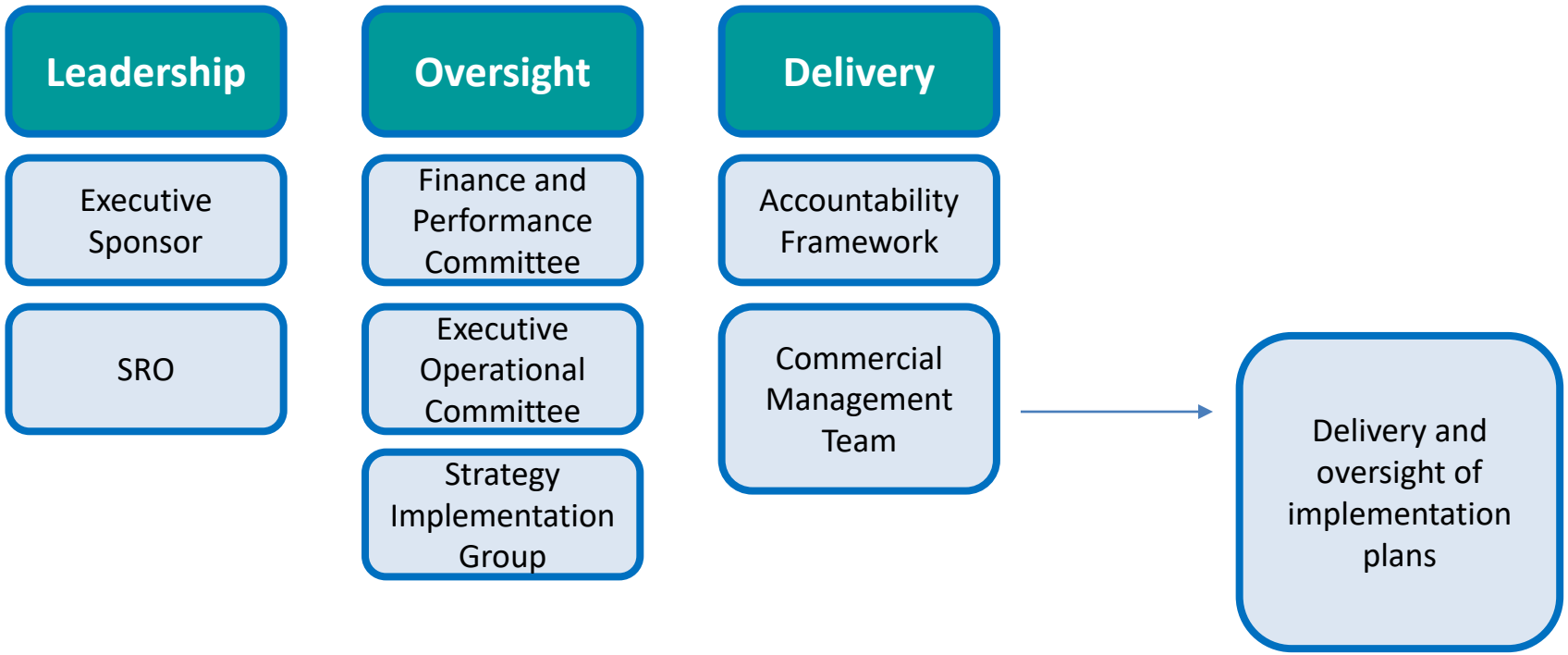
NHS
Essex Partnership University
NHS Foundation Trust

DELIVERY - OUR CONSOLIDATED PLAN

EPUT

Governance and Oversight

We will use the existing governance structure as far as possible to ensure the delivery of the enabling Commercial strategy. However a Commercial Management Team will be established to ensure the actions identified are actioned and assurance provided to the oversight Committees as to the impact of the new strategy.



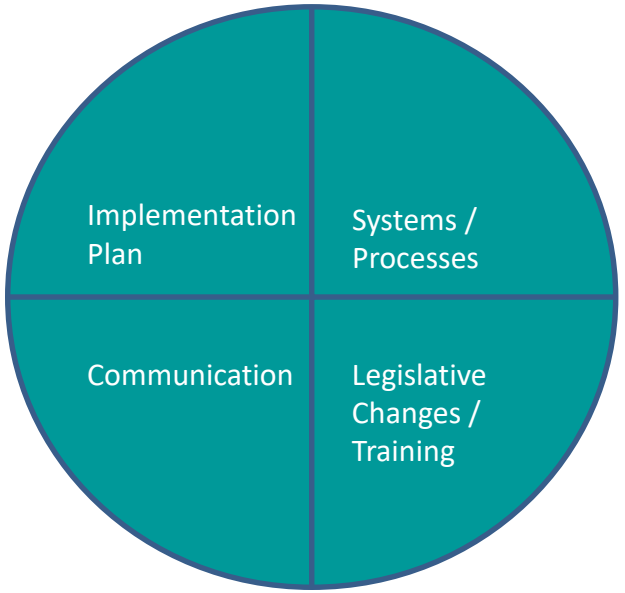
A COLLABORATIVE COMMERCIAL STRATEGY

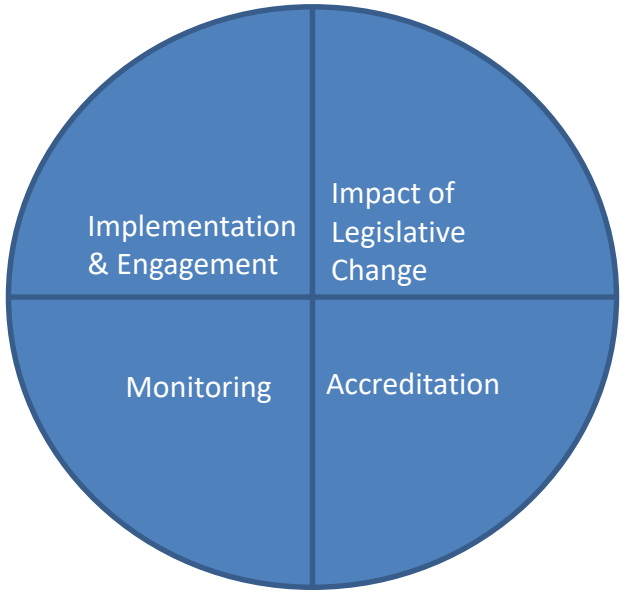
Years 1 2 3

Implementation Planning Communication

Delivery / Governance Assurance

Benefits realisation Future planning





Continuous cycle of review

11.3 WORKING IN PARTNERSHIP WITH PEOPLE AND COMMUNITIES STRATEGY

Decision Item | Zephan Trent | 5 minutes

REFERENCES

Only PDFs are attached

Working in Partnership Strategy Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Working in Partnership with People and Communities Strategy**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital					
Report Author(s):	Matthew Sisto, Director of Patient Experience					
Report discussed previously at:	People Equality and Culture Committee, Executive Committee, Board Development Seminar, Strategy Steering Group, Patient and Carer Steering Group, Senior Leadership Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with a final version of the refreshed, Working in Partnership with People and Communities strategy for final approval	**Approval**	✓
	Discussion	
	Information	

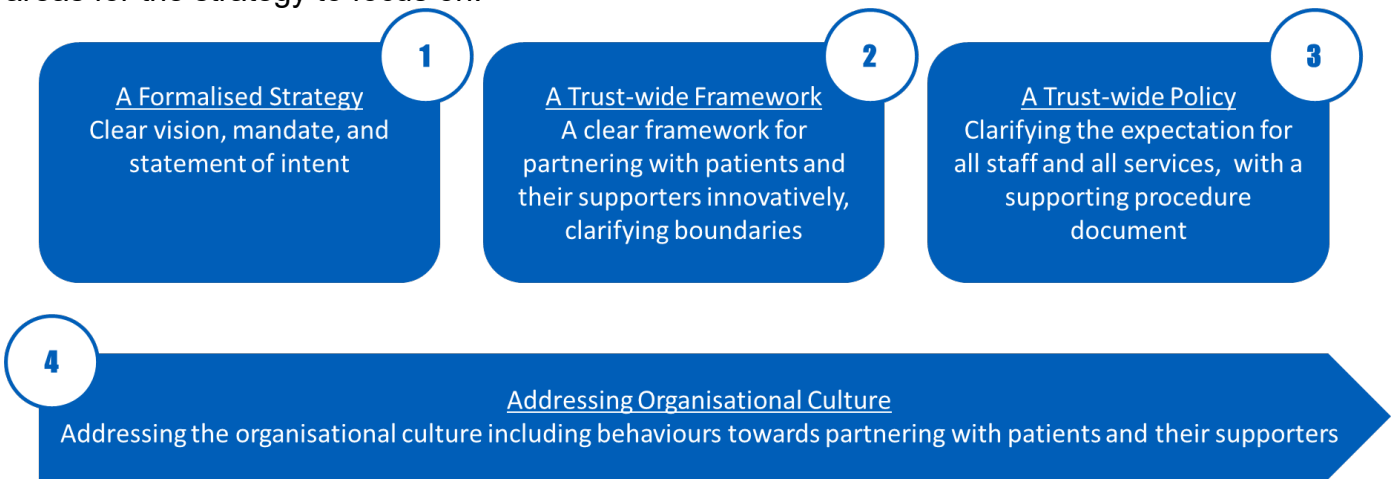
Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the report 2 Approve the strategy to move forward into delivery

Summary of Key Issues

The working in partnership with people and communities enabling strategy underpins the 'EPUT Strategic Plan 2023-2028' (Launched January 2023) and is anchored in the national guidance for 'Working in Partnership with People and Communities' which was released in October 2022 by NHS England (NHSE) and Department for Health and Social Care (DHSC). This guidance was coproduced with people and communities and sets out 10 principles for partnership working.

The core premise for the statutory guidance is partnering with patients or service users, and their supporters in shared decision-making, co-design, and co-delivery of services. The benefits are multifaceted and the evidence tells us that we will have better decisions, better services, less waste, better relationships due to transparency, and improved health for those who are involved. To make this happen, it requires a key change in perspective which is viewing our patients and their supporters as partners in service design and delivery.

Given the progress made in the last 2 years at EPUT with the involvement strategy, and, the new statutory guidance released by NHSE and DHSC, the focus to date on the strategic diagnosis with the development of this strategy has been with the senior leaders and our workforce. It has also be shared with a number of EPUT's lived experience team for review and approval. An outcome of the diagnosis phase identified that all participants were supportive of the move to partner more effectively with our patients and their supports, and to do so identified 4 priority areas for the strategy to focus on:



Furthermore, as output from the diagnosis phase 3 guiding principles have been identified to support the delivery of the strategy:

1. **Equitable Partnerships at every level of the organisation:** with those on the receiving end of services, relinquishing power and control whilst maintaining our responsible to care for people.
2. **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.
3. **Coproduction First**: Everything we do, we do in partnership with those on the receiving end of services. Actively seeking and Encouraging feedback, good or bad

However, within the strategic development it became clear that to deliver this strategy effectively it will require a number of trust wide changes in the following areas:

- Training

- Finance
- Recruitment
- Supporting capabilities
- Systems and processes
- Internal and external communications

Because of this, it is suggested that the Working in Partnership with People and Communities Strategy spans the full 5-year period of the Trust's Strategic Plan.

Finally, it is important to note that, the strategy focuses on a number of key issues and the activities but does not capture everything being undertaken to enhance working in partnership with people and communities. There is lots of great work happening across the Trust which we will continue to support. We have also worked to ensure that it intersects effectively with both the Social Impact Strategy and Quality of Care Strategy.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Working in Partnership with People and Communities

Lead

Zephan Trent
Executive Director of Strategy, Transformation and Digital

EPUT

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WORKING IN PARTNERSHIP WITH PEOPLE AND COMMUNITIES

PARTNERING WITH OUR PATIENTS AND THEIR SUPPORTERS

'PEOPLE FIRST, PEER LED'

CONTENTS

Foreword from the Executive Director of Strategy, Transformation and Digital

Essex Partnership University NHS Foundation Trust (EPUT) has been on a journey of improvement and we remain committed to driving forward change, to learning, listening, and innovating, so that we deliver the highest quality and safest care possible. In January, we published our Strategic Plan 2023 – 2028, after extensive engagement with our service users, and their carers and families, as well as our staff and partners. As part of this we committed to ensuring service users and their families and carers are at the heart of everything we do.

To make this happen, it requires a key change in perspective, which is viewing our patients, their supporters and the communities we serve as partners in service design and delivery. We must consistently involve our patients and their supporters in shared decision-making, co-design, and co-delivery across all of our services. The benefits are multifaceted and the evidence tells us that we will have better decisions, better services, less waste, better relationships due to transparency, and improved health for those who are involved.

Our new Working in Partnership with People and Communities plan puts this commitment into practice by setting out some of our key achievements to date and our plans for the future. We already have some great work going on in our service user networks, a growing team of over 170 lived experience ambassadors, community and inpatient based peer support workers and wide ranging partnerships with public sector and third sector organisations. We want to go further. We have developed this plan in partnership and through engagement with people who use our services and their supporters, our staff and wider partners to make a real difference with measurable improvements to how we operate.

Furthermore, we recognise that partnering with our patients and their supporters is an integral part of the wider objective of helping our communities thrive. Therefore, it is extremely important for our new Working in Partnership with People and Communities plan to work in a supportive and enabling way for the many other community engagement initiatives evident in the realisation of that objective.

Such as the social impact strategy, initiatives like the Trauma Alliance and the Rough Sleepers Project, Enable East, any locality community initiatives, and clinical service engagement with service users and their carers such as the active engagement sought from service users and carers in Eating Disorders Services, in the Perinatal service, and the Personality Disorders and Complex Needs Service User Network.

As a trust, our values are that we learn, we care and we empower. These values could not be more relevant to working in partnership with people and communities. We all use NHS services and we all have something to contribute in making NHS services better. Our purpose at EPUT is: We care for people every day. What we do together, matters. This means: together with service users; together with their families and supporters; together across professions and services; and together with our partners.

We need your help to make this happen so please get involved!

Zephan Trent - Executive Director of Strategy, Transformation and Digital

Keynote from the Trust Lived Experience Lead for Coproduction and Participation

On July 20th, 1969, astronaut, Neil Armstrong made a statement as he stepped onto the surface of the moon, that it was 'One small step for man, one giant leap for mankind. Now of course I'm not equating our working relationships with the people and communities you serve, with stepping onto the moon.

BUT! Sometimes it needs a small step to make the biggest difference, slowly but surely the ethos of a cultural change will be the very air we breathe because those small steps of inclusivity, of an open mind will create EPUT, to fully embrace the real benefits of this partnership approach. We just need to keep taking those steps.

Mark Dale - Trust Lived Experience Lead for Coproduction and Participation

STRATEGIC CONTEXT

Local Context

In January 2023 Essex Partnership University NHS Foundation Trust launched its new 5-year strategy, central to which is Lived Experience and partnership working with those on the receiving end of our services.

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.**

OUR VISION

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

OUR VALUES

WE CARE.

WE LEARN.

OUR PURPOSE

We care for people every day. What we do together matters.

WE EMPOWER.

The people that use our services and their supporters are our number one stakeholder and central to everything we do.

National Context

The Working in Partnership with People and Communities Statutory Guidance was published by NHS England and The Department for Health and Social Care in October 2022.

This guidance was coproduced with people and communities and sets out 10 principles for partnership working.

Our people and communities

[redacted]

Our workforce + our Patients + their supporters

In everything we do, our patients and their supporters are our partners.

SO1
We will deliver safe, high quality, integrated care services.

SO2
We will enable each other to be the best we can be.

SO3
We will work together with our partners to make our services better.

SO4
We will support our communities to thrive.

Partnering with our patients and their supporters

'Empowering our service users, families and carers'

'To build capabilities including volunteers and lived experience roles'

'Continue to build our partnerships with our services users, carers, and their families'

'Engage proactively with our communities to build on their existing strengths and priorities'

Building blocks

As an organisation EPUT has made steady progress in this space since April 2021, establishing many of the foundations that are required to propel us to the next level of participation, coproduction, and partnership working. This is evidenced in the 2023 Patient Experience Annual Report.

Lived Experience Team	The EPUT Lived Experience Team was formed due to the work underpinned in the Involvement Strategy 2021 – 2023. This is now 190 strong, and growing at rapid rate. It is formed of people with lived or living experience of community and mental health services, be it as a patient, service user, or a supporter, parent or carer. Their input is invaluable to everything we do together.
Coproduction Lead, champion network, & involvement Leads	Since March 2023 EPUT has had a Lived Experience Lead for Coproduction and Participation, and we now have a developing network of coproduction champions. Furthermore, the very first EPUT Coproduction Conference took place in October 2023. In addition to this the Trust has some great examples of coproduction in action with our involvement leads, and having a real tangible impact on our services.
Director and supporting corporate functions	Since April 2021 EPUT has had a Director of Patient Experience, and professional lead for developing the Trusts capability for public participation and Lived Experience. Further to this the Patient Experience directorate is now well established, and continuously improving.
Refreshed corporate Strategy & Concluded Involvement Strategy	The 2 year Involvement Strategy agreed in 2021 is now concluding and delivered what it set out to do, as set out in our Patient Experience Annual Report for 2022/23. The new Trust Strategic Plan launched in Jan 2023, with Lived Experience, Service User Involvement, Coproduction, Patient Partnership, and Peer Support highlighted throughout.
Reward and recognition policy	The Reward and Recognition Policy is now well established and being utilised to remunerate our lived experience team. Along with this there are supporting systems and processes that have made getting involved less complicated.
I Want Great Care and Peer Networks	I Want Great Care launched at EPUT in January 2022 and whilst uptake started slow we have seen a progressive increase in response rates from those on the receiving end of our services. In addition to this, we are nurturing a network of peer networks to support and enhance our ability to listen to, and collaborate with, people using our services.

Strategic Development

The development of this strategy has happened in 4 stages and took place April to November 2023.

1

Analysis:

- Current State: The Patient Experience Annual Report April 2023
- Statutory Guidance: The Working in Partnership with People and Communities Statutory Guidance October
- Best practice: Looking beyond the organisation to our peers for best practice

2

Hypothesis of Core Issues:

- Led by the analysis stage, identifying the core issues that if addressed will drive the biggest change

3

Testing the Hypothesis:

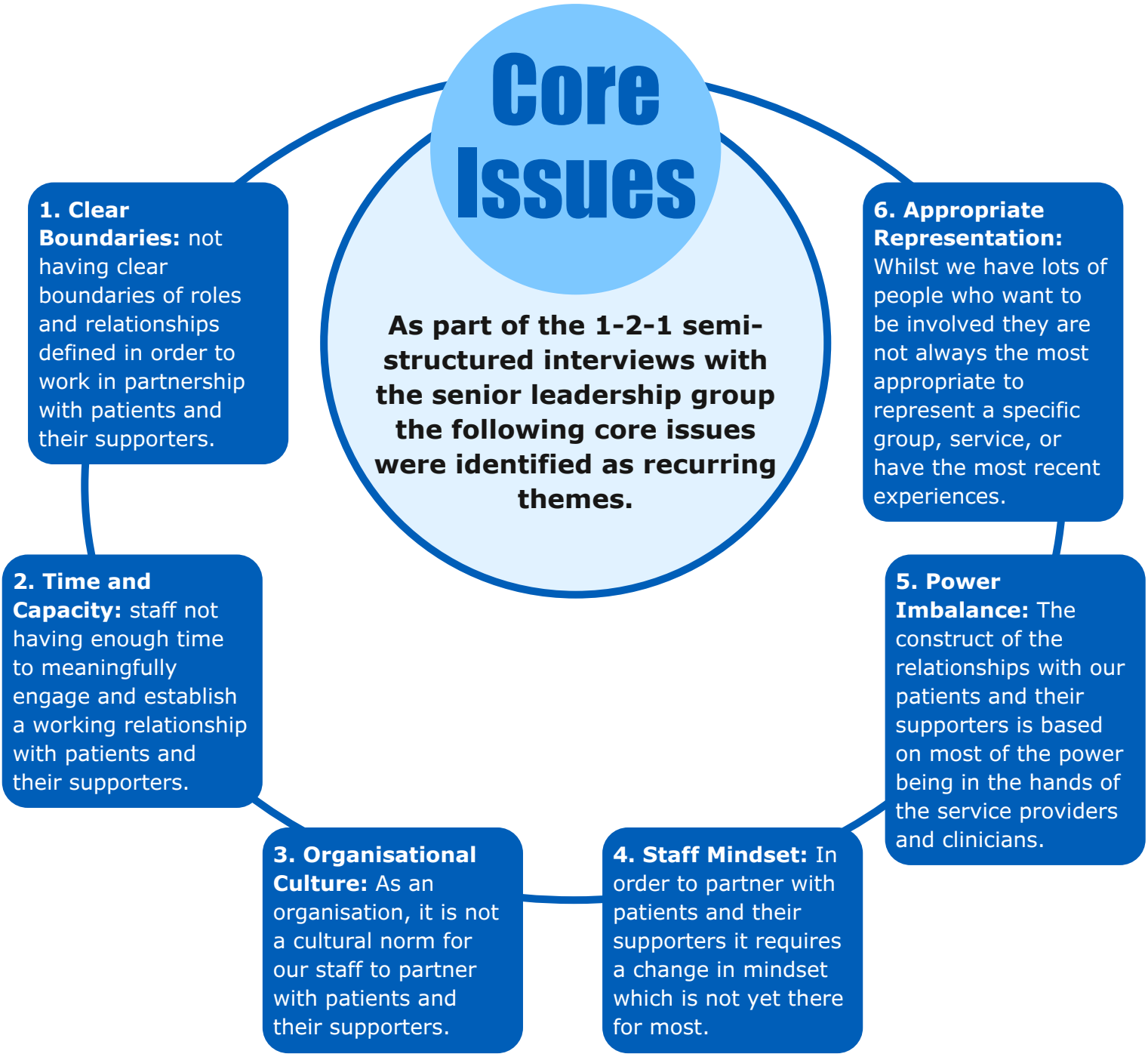
- Senior Leadership Interviews: Through a series of 1-2-1 private and confidential interviews with the senior leadership group, and from a mix of professions
- Thematic Analysis: Having transcribed the interviews, themes were identified and gathered to pull together a prioritisation survey

4

Prioritisation of Strategic Direction:

- A trust-wide survey, led by the thematic analysis of the senior leadership group interviews identified the core themes and areas of focus for a wider group to prioritise and feedback on.

STRATEGIC DIAGNOSIS



Vision

The vision for the strategy has four key aims which have been coproduced with our people based on the core issues identified above.

1. We have equitable partnerships with patients and their supporters

2. We are innovative with how we partner with patients and their supporters

3. Partnering with patients and their supporters is an organisational norm

4. We have an extensive training programme for all involved (staff, patients, and their supporters)

Priorities

The following priorities for the strategy have been coproduced and ranked with our people.

1. A clear vision, mandate, and statement of intent.
2. A trust-wide framework for partnership working with patients and their supporters.
3. A focus on addressing the organisations culture including behaviours towards partnering with patients and their supporters.
4. A formalised strategy for partnership working with patients and their supporters.
5. A trust-wide policy for partnership working with patients and their supporters.

STRATEGIC DELIVERY PLAN

Guiding Principles

As part of this strategic delivery plan we have identified 3 guiding principles which should continuously challenge us.

1. **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.
2. **Lived Experience Practice (LXP) is what we do, its 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.
3. **Coproduction First:** Everything we do, we do in partnership with people using our services. Actively seeking and Encouraging feedback, good or bad.

The First Next Steps

1 **Clear vision, mandate and statement of intent**

2 **A Formalised Strategy**

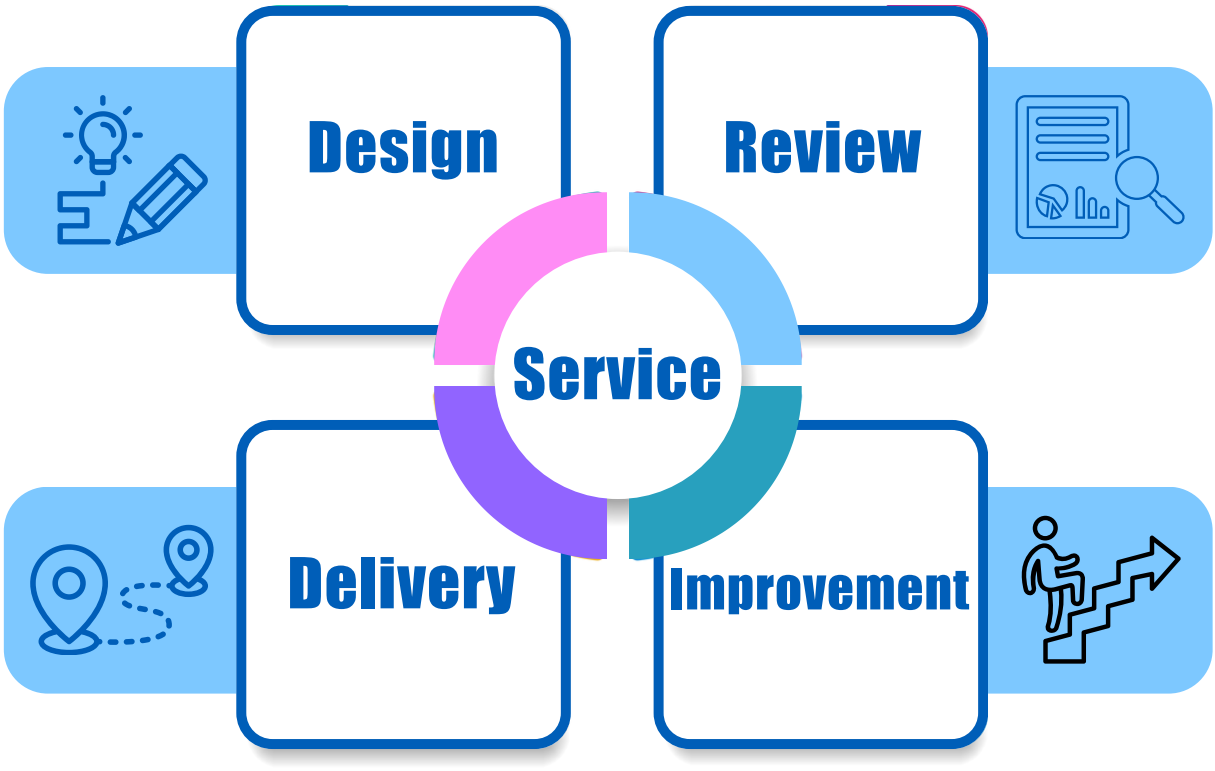
3 **Addressing Organisational Culture**
Addressing the organisational culture including behaviours towards partnering with patients and their supporters.

4 **A Trust-wide Framework**
A clear framework for partnering with patients and their supporters innovatively, clarifying boundaries.

5 **A Trust-wide Policy**
Clarifying the expectation for all staff and all services, with a supporting procedure document.

Coproduction First

We know that working in partnership with those who have lived and living experience of services improves care and we already have some fantastic evidence to support this (The buddy Scheme, The Personality Disorder and Complex Needs Service User Network (PD&CN SUN), The Lighthouse Service, and Complaints Redesign) Now we need to go further to embed coproduction across all areas of service design, delivery, and improvement.



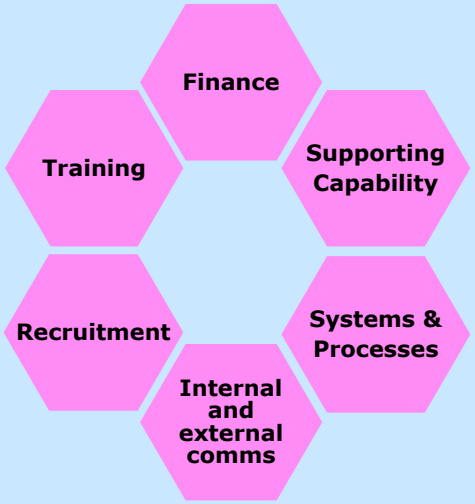
Operational Challenges

Training	Training generally for our lived experience team is challenging; access, and a clear programme of training development is key. For our workforce many feel ill equipped to working co-productively with our lived experience team.
Finance	All involvement activity that qualifies for reward and recognition is funded centrally. Perhaps now is the time to consider distributing this cost across the services, care units, and budgets so that all teams feel empowered to involve lived experience ambassadors in their work.
Reward and recognition policy	Although our lived experience team is growing rapidly, along with our volunteers team. Many of our services feel underrepresented or misrepresented due to a lack of targeted recruitment from within their patient cohort. Involving people who understand our services from a diverse range of communities is vital for us to partner in a meaningful way. EDI must underpin our development.
Supporting Capability	Although each care unit and service manager has a desire to partner with our patients and their supporters, sometimes they lack the confidence to do it in a meaningful way, and fear doing the wrong thing. Because of this, they need specialist capability to bridge the gap. The People Participation team is working hard to support all our services, but has limited capacity to do everything we would want to.
Systems and Processes	Giving our lived experience team access to our training environment is difficult, and requires them being set up on ESR and having an NHS mail account. This takes time and creates pressure in the ESR team. Our method for remunerating our lived experience team is largely paper-based and time consuming for all parties.
Internal and External Comms	Despite the development the Trust has experienced in this area since 2021, there is limited awareness both internally and externally of the opportunities for our workforce to partner with our patients and their supporters, furthermore many of our patients and their supporters are unaware of the opportunities to influence change across the organisation.

Delivery Plan

November 2023 → **March 2028**

- Working with People and Communities Strategy
- Lived Experience Practice (LXP) Framework
- Working with People and Communities Policy



Deliver, Evaluate, and Evolve

Addressing Organisational Culture

Reviewing the behaviour toolkit the behaviour toolkit	Updating the recruitment policy to encourage lived experience	LEA's and LXP roles for every service	Developing the Peer Support offer	Reciprocal Mentoring LXP and senior leaders	Staff Lived Experience Network	Staff LXP Allyship Program	PROM's for all services	Board is inclusive of LXP

Building Blocks

- Director and supporting corporate functions
- Refreshed Strategic Plan and concluded involvement strategy
- Reward and recognition policy
- Lived Experience Team
- Coproduction Lead and champion network
- I Want Great Care and Peer Networks

Success Measures

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 award 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.

GOVERNANCE AND OVERSIGHT

To ensure the successful delivery of this strategy we require leadership, oversight, and delivery capability underpinned by the corporate functions.

Executive Sponsor	As part of having a clear mandate and statement of intent, this enabling strategy will be sponsored by the executive team, with a nominated executive sponsor. Furthermore, the executive sponsor will lead by example, demonstrating the guiding principles, and inclusive and collaborative leadership. They will hold the organisation and the strategy owner to account, ensuring the delivery of the strategy and its change priorities to deliver successfully what we set out to achieve.
Senior Responsible Owner	To drive forward the delivery of the strategy the Director of Patient Experience will be the senior responsible owner of the strategy, accountable to the executive sponsor, the Executive Director of Strategy, Transformation and Digital. The senior responsible owner will be the driving force, and accountable for the successful delivery of the strategic ambitions at every organisation level. The professional lead for LXP, Coproduction, and Patient and Carer Partnerships.
Governing Committees	The governing committee will be key to ensuring the strategic direction of the strategy is right, and providing overall governance and making key decision for the direction of travel, evaluation and evolution of the organisational changes. Key governing committee will be: • The patient and carer experience steering group • The Quality Committee • The Executive Management Comittee • The Trust Board
Informal Leadership Group	We recognise a key point of feedback from the diagnostic phase was that making these changes at a senior and corporate level alone is not enough, and to make the changes lasting, effective and impactful at all levels we need to harness the power of our informal leaders across all services, professional roles, and places. This informal leadership group will help embed the guiding principles of the strategy within the operational day to day. It will be the working group that makes change happen. Empowering our informal leaders.

Governance Structure

Whenever possible we will use the existing resource, and governance structure to ensure the delivery of the enabling strategy. However we will introduce a new group as part of the delivery capability of the strategy, which is the 'Informal Leadership Group'.

This group will be made up of our Lived Experience Team, and the Authentic Informal Leaders from across the organisation, essentially those that have no formal leadership role but are influential in making change happen within their respective areas of practice because they are widely recognised by their peers as informal leaders.

Leadership	Oversight	Delivery
Executive Sponsor	Quality Committee	Informal Leadership Group (New)
Senior Responsible Owner	Executive Management Committee	Patient Experience Portfolio
		Patient and Carer Experience Steering Group

Case studies

Examples of good practice

By Your Side Case Study

By Your Side
Essex Maternal Mental Health Service

EPUT's By Your Side is a maternal mental health service focusing on perinatal loss (loss that occurs during pregnancy, birth or postnatally) and has recently launched in October 2023.
Throughout the process of procurement and implementation every effort has been made to keep the patient voice and experience at the centre of service design.

Procurement: The Pan Essex Perinatal Steering group through the NHS Long Term Plan identified the requirement for a Maternal Mental Health Service (MMHS) to be available by March 2024. Enable East were commissioned to conduct an Essex wide scoping exercise of stakeholders and services as well as service users and through this a core group of parents volunteered to support the development of the MMHS. A focus group was held to gather their experiences of services following their perinatal losses and this informed the business case and how the service should be formed.

Mobilisation of service: The parents with lived experience were involved in the design of the services, its name, logo, and branding for example. They also co-designed the leaflet and information sources for parents to access. During the launch a parents experience was read out to set the context of the service need and aspirations for the future.

Forward looking: There is a real desire for this service to listen to the lived experiences of parents moving forward and the services are committed to doing so through collaboration and partnership working.

A quote from the team: 'I cannot speak for the parents regarding their experience but the feedback I have received suggests it to be a positive one. I think one of the challenges is how to engage with people when they have busy lives working and raising families. We held the focus group in the evening and tried to be as flexible as we can to speak with them when it works for them. We still have a long way to go in developing our co-production approach but this have been a positive experience and one we are learning from.'

Psychological Services for Older People

Dr Maina Amin, Principal Clinical Psychologist and Clinical Lead, Psychological Services for Older People in South Essex, interviewed a person with lived experience to understand opportunities and experiences of coproduction in older people's mental health services. This interview has shaped thinking in Codesign and coproduction within those services.

What types of co-production have you been involved in?
The person with lived experience has been involved in many different projects including teaching and training staff at university level, ward inspections (including ligature inspections), staff interviews, buddy scheme, EPUT staff induction, involved commissioners meetings including 2 year plan for NHS 111 Option 2… to name a few.

With Psychological Services for Older People, the person with lived experience first became involved through the patient experience team because they met the opportunity criteria for a service user over 65. Since the first contact a few years ago, the person with lived experience has been involved in interviewing all Assistant Psychologists and interviewing nearly all qualified clinical/counselling/art therapy staff. They have co-produced selection and wording of interview questions and have taken an equal role in interviews and selection of candidates – their opinion is highly valued and responses go a long way towards who is selected for roles.

Together with the service, the person with lived experience has also co-produced a ½ day teaching session on the Clinical Psychology Doctorate course at Essex University Course which is a service user session part of the Older Adult Teaching Block. This has been successfully delivered annually since 2022.

Any hesitation you've had about getting involved with co-production?
The person with lived experience spoke about being careful who they engage with and what they give their time to due to some challenging experiences where at times they have felt less valued or if professionals are not willing to pay for their time and expertise. They do feel able to say no when there is piece of work that they do not wish to engage in.

What is your experience of involvement – what have you gained and what challenges have you identified?
The person with lived experience has had some difficult experiences in meetings; in a recent meeting, a fellow service user made a comment in the chat which was offensive and it had a significant impact on their wellbeing.

"The positives of involvement for me are people making me feel valued and explaining to me – please don't feel that you're talking too much as we learn a lot from you. I talk for the people who can't talk for various reasons and usually this is very much appreciated by professionals. I'm also talking to help professionals understand the service user's perspective and needs (for example – encouraging professionals to talk to service users about what is happening to them and give them an explanation and a rationale for decisions that are made about them. It is important for service users to feel that they are not being pushed away to other people). It feels good to be valued, wanted and needed and to know that I'm making a difference".

Inpatient Settings Review and Service Innovation

The Early Interventions in Psychosis Team facilitated a Lived Experience Group with Families and Services users to review the experience of inpatient settings. This feedback gathered during the process has go towards service improvements and innovation, such as the Family and Carer Ambassador role as part of the Time to Care programme.

Themes discussed tended to be around the traumatic nature of a hospital admission and what this was like to negotiate, particularly in the early stages. See below for some examples of the feedback captured as part of this project which has gone towards service improvements:

- **Better information to explain the various types of Medication:** 'Feels very confusing, what everything is for, how it might impact them, being informed of side effects, changes being discussed and reason for this and how this can impact families'.
- **Clearer process for family members to navigate admissions:** Managing the admission process as a family member is difficult. Seeing loved ones being sectioned, not understanding what this means or looks like if this is the first time. It can be a traumatic process for all and feels very isolating as often own friends and family aren't able to offer advice.
- **Improved Information sharing:** Brief and important information needs to be given, can feel overwhelming or can be very difficult to get information from the ward. Practical information would be very helpful for families and loved ones, perhaps a handbook of sorts.
- **Named point of contact for families:** As the ward office is often hard to contact with staff busy, we suggest a named person not based on ward who can be main liaison point. They offer general information to families and direct queries to appropriate professionals and respond.
- **Improved opportunities for families to speak with their loved ones:** it can be difficult to make contact with loved ones in the wards. This raises anxieties for all those involved, families and lived ones.
- **A summary sheet for professionals:** having to tell our stories over and over again can be frustrating and triggering.
- **Communicating new information:** sometimes families first hear new information about things that have happened on the ward during the weekly ward review meeting which can make it hard to hear and understand. There should be a process of briefing families ahead of ward review.
- **Triggers:** sometimes triggers are unknown on both sides, families and professionals, and being clear what they are for people can keep them safe. Having an open discussion about this and recording them can help people stay safe and well.
- **Client's interests:** being more aware of peoples personal interests can help to have more 'tailor made' interventions, recognising what a persons interests are.
- **Signposting:** having support from professionals to signpost to trust information. Sometimes web searches can be very unhelpful
- **Family supporting on wards:** when people are really unwell, catatonic or in deep psychosis, they can neglect personal care and hygiene. In this case family members and supporters could come in and support the services to help with their loved ones
- **Reception area:** can be quite clinical looking and uninviting. Having team photos, key info, put a face to the name prior to meeting professionals is helpful.
- **Glossary of language:** Sometimes in meetings lots of different medical terms can be used and it's not explained to families and supporters. It would help to have an accessible glossary of terms used to for families and supporters.

Complaints Redesign

The complaints team launched a redesign project for the complaints process and systems end to end. This was based on the evidence that people who used the service were unhappy with the outcomes, expectations were not being met, and the time to respond was too long. Furthermore, the lived experience of people using the service married up to what the data was saying in terms of the annual reporting around delays, time to respond, complaints being reopened, and referrals to the Parliamentary and Health Service Ombudsman (PHSO).

The complaints team established a co-design collective made up of service users, service leads, and the complaints team. Together the group discussed issues and perspectives from all sides. Identifying key issues around time and capacity, impartiality, misunderstanding due to the lack of broken and sporadic dialogue, and conflicting priorities for services to give care whilst needing to respond to complaints investigation. Over the period of 6 months the co-design collaborative collectively worked through the issues and agreed solutions for each, co-designing a new process from end to end which has resulted in systemic change across the organisation including significant policy changes, and investment in the newly established Complaints Liaison function.

The anticipated outcomes of the Complaints redesign work were threefold:

1. Better outcomes
2. Improved Experience
3. Greater Learning

After evaluation the outcomes achieved were much greater then what was intended:

1. Complaints are being resolved more quickly and informally, with a reduction of nearly 20% in formal complaints, nearly 70% increase in informally resolved complaints
2. So far throughout the year to date, we have seen a 100% reduction in referrals to the PHSO
3. We have seen nearly a 15% reduction in reopened complaints with 92.5% of all formal complaints being resolved without being reopened
4. As part of the Non-Executive Director assurance process, we have seen an overall approval rating of the complaints reviewed move to 100% in 2023 from 70% in 2022
5. Learning has also improved with 63% of formal complaints identifying learning and improvement actions in 2023

Quotes from Service users:

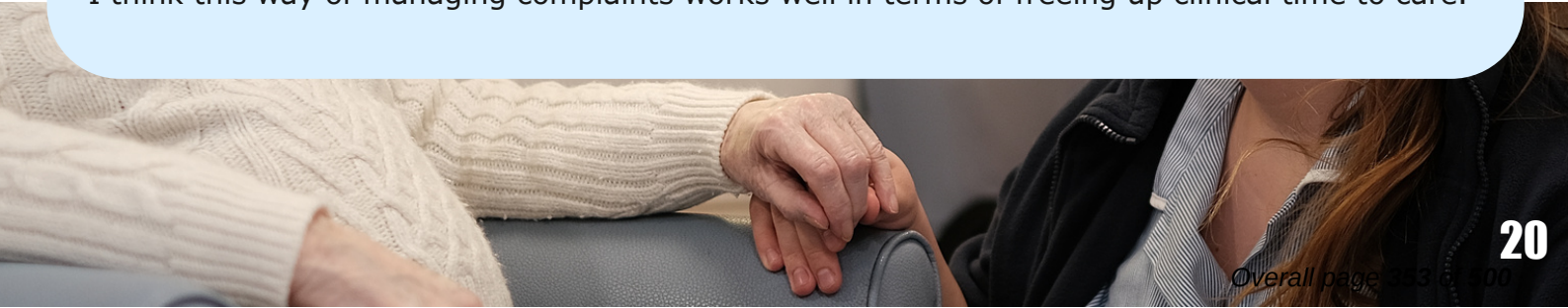
‘I was so grateful that you called me. I was listened to and given the space and time to offload my frustrations. I really appreciated it.’

‘Thank you for arranging a resolution meeting for me. I’m glad I had a chance to address my concerns directly with the doctor. I felt that his apology for the upset caused was heartfelt and that meant a lot to me’

Quotes from Staff:

‘With regards to the process it was much easier thank you! A lot of the time consuming work was taken out and I could just review the notes and take actions as necessary’

‘I think this way of managing complaints works well in terms of freeing up clinical time to care.’



Trauma Informed Waiting Rooms

The Service Development Collaborative (SDC) is a stream within the Service User Network for Personality Disorders and Complex Needs, and is comprised of a group of volunteers support the development of projects and use their lived/living experiences of Personality Disorder and Complex Needs and mental health systems to help transform services.

Following feedback from the members, improvements to community mental health waiting rooms were made to be more aligned with trauma-informed care principles, to create spaces that felt more safe, empowering and collaborative. The waiting rooms were described as places which were “dark and depressing” with “no sense of safety,” with major contributing factors being the lack of privacy from other service users and staff, and feelings of entrapment.

Trauma-informed care aims to bring hope and empowerment to reduce the disparity between those who use services and those providing them (Filson & Mead, 2016), and addresses the large role of trauma in the lives of many who come into contact with mental health services. The general principles of trauma-informed care are Safety, Trust, Choice, Collaboration, and Empowerment and Cultural consideration.

Current literature supports natural light and access to windows, connection with nature and colour are all significant contributions to improvements in waiting rooms (Arneill and Devlin, 2002; Nelson Worldwide, 2020). Research has also shown that a design that reinforces segregation can exacerbate feelings of threat for service users. Sensory adjustments and inclusivity are further important considerations.

To address this, the group was awarded a £1000 bid to charitable funds and decided to focus on two waiting rooms to concentrate their efforts and create a template that could be applied to other sites across EPUT. After much deliberation, the waiting rooms based at Reunion House Clacton-on Sea, and Coombewood Centre Rayleigh were selected.

The group worked towards making the following key areas present for each waiting room:

- Access to as much natural light as possible
- Increasing nature in decoration and displayed artwork
- Available sensory box with free-to-take items
- Up-to-date information and reading materials

At The Coombewood Centre, the initial visit to the site showed that there could be improvements to the design and layout of the space as the waiting area was located in a busy corridor. This sparked conversations around the inclusion of Experts by Experience in the layout of trust premises from their initial design so that the space could have been designed differently. Within the scope of this project, the design of the buildings was unable to be altered, and many of the additional changes that the group were proposing were reactive to the layout of the space, which could have been prevented. There were barriers within the Coombewood Centre which prevented many of the proposed changes from going forward. The sensory box and updated reading materials were the only suggestions which were able to be implemented in the centre.

At Reunion House, the same problems arose due to the design and layout of the existing space being narrow and poorly lit. There was also a small sign-in hatch at reception which was perceived as segregating and made service users feel like they were “children in primary school,” and is supported by literature to contribute negatively to healthcare outcomes (Liddicoat, 2020). The group were able to understand from the estate managers that the property was rented out and therefore no major changes could take place to open up the hatch.

The additional changes that were able to be implemented at Reunion House were decorations of honeycomb and nature-themed wall decorates, cushions which were made by a volunteer, artificial plants and small reflective mirrored panels which could enhance the natural light available in the space. Moving forward the group showed the importance of Experts by Experience being consulted in the initial planning of waiting room spaces in community mental health buildings.

Produced by:
Matthew Sisto
Director of Patient Experience
Professional Lead for Lived Experience and Participation

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

11.4 MEMBERSHIP STRATEGY

Decision Item | Denver Greenhalgh | 5 minutes

REFERENCES

Only PDFs are attached

Membership Strategy Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Membership Strategy**					
Report Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Membership Committee 6 December 2022, 28 June 2023 Working Group 19 July 2023 EPUT Forum 7 August 2023 Strategy Group August 2023 Your Voice August 2023 Joint Board / Council Seminar Session 18 October 2023 Membership Committee 14 November 2023					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	n/a	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	n/a	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with the Membership Strategy for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The Membership Strategy for 2023-2026 sets-out the Trust approach to Foundation Trust membership, identifying key priorities for the next three-years. The Membership Committee agreed the priorities in December 2022 and the overall Strategy agreed in June 2023.

The Membership Committee established a working group in July 2023 to identify key actions / milestones for each of the priorities. The Strategy was subsequently presented in a number of forums for consultation and feedback has been considered and incorporated within the document.

The Board of Directors is asked to approve the Membership Strategy, following which it will be presented to the Council of Governors on the 13 December 2023 for joint approval.

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 Documents and/or Further Reading
Membership Strategy 2023-2026

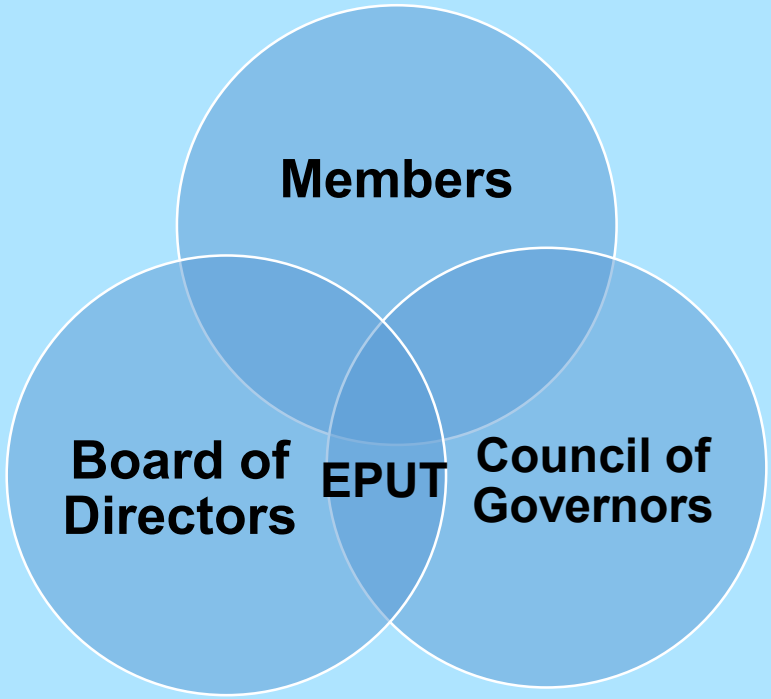
Lead
Denver Greenhalgh **Senior Director of Governance**

NHS
Essex Partnership University
NHS Foundation Trust

MEMBERSHIP STRATEGY

2023-2026

INTRODUCTION



As a Foundation Trust (FT), Essex Partnership University NHS Foundation Trust is accountable to the local community, the patients it cares for and the people it employs through its membership.

By becoming members, local people, patients, carers and our staff can have a say in how services will be designed and delivered, and by becoming or voting for Governors, perform a vital role in holding non-executive Board members to account for the performance of the Board.

As such an involved, informed, representative and vibrant membership is integral to the anchoring of the Trust to its area and delivering outstanding services that listen to and respond to the needs of the community.

This strategy therefore seeks to:

- Reiterate the Trust's commitment to its membership
- Outline our vision for the next three years
- Understand our current membership picture and the challenges
- Identify actions to ensure we meet the challenges.

COUNCIL OF GOVERNORS MEMBERSHIP COMMITTEE

The Trust has a Membership Committee, which is a sub-committee of the Council of Governors. The Committee meets on a quarterly basis and is made-up of Governors interested in engaging with Members.

The Committee is the main conduit for engaging with our members and will be the lead Committee in monitoring and implementing this strategy. The Committee is currently chaired by Mark Dale, Public Governor, Essex Mid & South and Mark says:

"This Membership strategy will embed what we will do as a trust to engage, inform and to enable the diverse people and communities who use all of our services or have family, friends and supporters who take on the important responsibilities of caring to have a meaningful and lasting voice. We will develop new ways to work in collaboration with partner NHS providers, Our Social Care Colleagues, and the Community and Voluntary sector to underpin this aim. Because What we do together really matters"

Why Membership Matters

This strategy sets out our commitment for engagement with our Foundation Trust members and the communities we serve. Their involvement is important in helping us to achieve our goal of providing outstanding care.

As an NHS Foundation Trust, we are accountable to our patients and the public. Our members have a key role in the Trust's governance; they elect representatives to sit on our Council of Governors, which in turn appoints the Chair and other Non-Executive Directors to the Board of Directors and hold the Non-Executive Directors to account for the Board's performance.

Members are our staff, our patients and members of the public. We believe that involving our members, patients, and the public in decisions about services is an integral part of meeting the needs of the communities we serve.

We have developed this strategy based on good practice from other Foundation Trusts and NHS Providers, and statutory and regulatory requirements.

The development of the strategy has been led by our Council of Governors through its Membership Committee.

The strategy is supported by an action plan which sets out what we will do in practice across the next three years to achieve our vision.

Our Membership Community

Who can be a member?

Public members
As a local provider of services we offer all those who have an interest in or connection to the Trust, the opportunity to become a member. This could be as a service user, carer, relative or someone living in the community we serve interested in healthcare. No special skills or experience are required. It is free and open to anyone 12 years of age or older. Members come from our geographical constituencies for the purpose of electing Governors.

Staff members
Our staff colleagues are also members of the Trust. Any staff colleagues employed by the Trust on permanent contracts or fixed term contracts of 12 months or longer become a member.

As a member you will:

- Receive information about the Trust
- Be able to vote for representatives on the Council of Governors and standing for election to the Council of Governors (for those 16 years of age or older)
- Be able to take part in surveys and consultations
- Participate in patient involvement initiatives

One of our aims through this strategy is to improve our communication with members and add to the benefits above.

Disqualification from membership
We want to encourage the widest possible membership but where a member's actions or behaviour are detrimental to the Trust or its values, for example acts of verbal or physical abuse against our staff, it may be necessary for the Trust to revoke their membership.

The Benefits of being a Member

BENEFITS FOR MEMBERS

Get involved in health care in a way that allows members to choose what involvement they give

Builds members understanding of the health care system and how it's changing to help make informed decisions about care and the advice and support to give people in the community

Help to improve the health of the community by sharing information about health and services at the Trust such as sharing and liking the Trusts' social posts

BENEFITS FOR EPUT

Allows the Trust to engage more people in the community as part of a range of approaches

Greater understanding of the local population – managing expectations and sharing knowledge of optimum health and care pathways

Share key health messages with the widest number of people. Access to an extensive database of public who have expressed a willingness to give their views

The Benefits of being a Member

BENEFITS FOR MEMBERS	BENEFITS FOR EPUT
Help drive continued quality improvement at the Trust by sharing experience and giving views	Supports the Trust and its continued development of quality services. A direct line to members of the community to explain developments
Be a 'friend' of the Trust. Learn directly about developments at the Trust. Support the Trust and help its continued development	Greater understanding of the local population – managing expectations and sharing knowledge of optimum health and care pathways
A first step to getting further involved, e.g. by becoming a volunteer / becoming a Governor or developing understanding for those considering a career in health care	Link from volunteering to membership can also operate the other way. Could potentially help to break down barriers to considering health careers

The Benefits of being a Member

BENEFITS FOR MEMBERS

Take a part in the governance of the Trust by voting in elections for Governors who play an important role in the Trust

Voting for Governors to sit on the Council and play a critical role in representing members and holding the Non-Executive Directors to account for the performance of the Board

BENEFITS FOR EPUT

Trust staff develop an interest in Governor positions, encouraging strong candidates reflecting the whole community

Engaged and informed Governors are key to supporting the delivery of Trust objectives

PATIENT EXPERIENCE / SOCIAL IMPACT

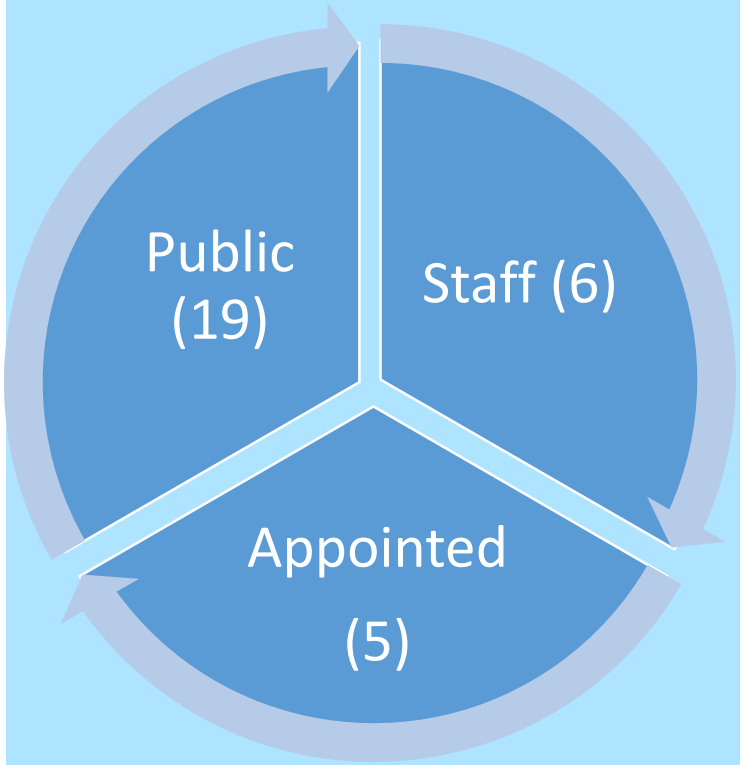
The Foundation Trust membership, via the Council of Governors can have a say in how services are designed and delivered. This will have a vital impact on how patients experience services provided by EPUT. The Membership Strategy directly impacts two of the Strategic Objectives:

- EPUT Strategic Objective 3: We will work together with our partners to make our services better
- EPUT Strategic Objective 4: We will help our communities to thrive

Partners include individuals with an interest in services, either through direct experience or through the experience of family members and friends. The experiences and views of these individuals, provided to their Governor representatives, can help shape how services are developed and improve overall patient experience.

The members are also members of the local community and can often represent the views of the local community without realising. When people access local services, they automatically have an opinion on how these services are provided. This kind of intelligence, included as part of other areas of involvement, can help shape services by understanding how people experience them and where the improvements can be made. This combined can help improve services for the local community and provide real social impact.

COUNCIL OF GOVERNORS



Members' views and opinions are heard through the Council of Governors, whose role is to represent the interests of members and hold the Non-Executive Directors to account for the performance of the Board.

The Council of Governors is made up of 19 elected public Governors, 6 elected staff Governors and 5 appointed Governors from stakeholder / partner organisations.

All public members aged 16 or over are allowed to stand as a Governor or vote for a Governor.

All staff colleague members are able to stand as a Governor or vote for a Governor within their staff constituency.

There are also local stakeholder organisations that are represented on the Council of Governors.

COUNCIL OF GOVERNORS

The Council of Governors is responsible for:

- Representing the interests of members and the public
- Holding the Non-Executive Directors to account for the performance of the Board of Directors
- Appointing the Chair and other Non-Executive Directors, and holding them to account for the performance of the Board
- Approving the appointment of the Chief Executive by the Non-Executive Directors
- Receiving the Trust's Annual Report and Accounts
- Appointing the Trust's external auditors
- The Trust is committed to developing and supporting Governors to enable them to carry out their role and contribute fully to the work of the Council of Governors
- Further details of the composition of the Council of Governors are set out later in this document

Our Membership Priorities

- Establish a membership that is representative of the population served by EPUT
- Communicate effectively with members and ensure their views are represented within EPUT
- Develop a process to ensure membership engagement operates across the system and with Integrated Care Boards

Priority 1: Establish a membership that is representative of the population served by EPUT

The members, whether they are Foundation Trust Members or Members of the public are fundamental to the way we operate as a Foundation Trust. We are accountable to our members, so it is important to ensure our formal Foundation Trust membership is representative of the population we serve.

We can do this by ensuring we understand our local demographics and target areas that are under-represented to ensure their voices are heard.

We can then continue to monitor so we understand the impact of our engagement work we are doing on the diversity and representation of our membership.

What we will do:

- ☑ Understand the demographics of the population served by EPUT and compare against the membership of the Trust.
- ☑ Identify and undertake engagement with members of the public to increase membership in any areas that are not represented.
- ☑ Regularly review membership demographics to confirm engagement is working and identify solutions where it is not working.

EPUT Strategic Objective 4: We will help our communities to thrive

Priority 2: Communicate effectively with members and ensure their views are represented within EPUT

One of the key roles of the Council of Governors is to represent the views and interests of the members and members of the public.

One of the fundamental parts of this is to have a regular dialogue with these members to ensure their views are understood and can form part of any conversations Governors have with the Board of Directors.

It's important we regularly communicate with members and this is an areas that we need to strengthen. Any communications need to be two-way.

What we will do:

- ☑ Develop a membership communications strategy which:
- ☑ Establishes regular communication between Governors and members / members of the public.
- ☑ Creates a two-way channel so that members' have a voice and have clear feedback on issues raised.

EPUT Strategic Objective 3: We will work together with our partners to make our services better)
EPUT Strategic Objective 4: We will help our communities to thrive

Priority 3: Membership in the context of system working

The Health and Care Act 2022 has changed the emphasis for Foundation Trusts. Foundation Trusts are now required to make any decisions in the context of the wider healthcare system.

Any views expressed by Members must be represented at both the organisation and the wider healthcare system.

System working and Integrated Care Boards is relatively new to the NHS, so it is important to establish our aims whilst also being agile as system working matures over the next few years.

What we will do:

- ☑ Understand the role of Foundation Trusts and Membership as part of system working.
- ☑ Ensure the views of members of the Foundation Trust are represented in decision making at a system level.
- ☑ Communicate with Governors and members to encourage understanding of system working and the importance / impact of their views.

EPUT Strategic Objective 3: We will work together with our partners to make our services better

Implementing the Strategy and Measuring Success

Implementation:

We have developed an action plan which sets out the practical steps we will take in each year to implement the strategy so that it is clear how we will put our plans into action. The action plan is set out as an appendix to this presentation. It will evolve and develop as the strategy is implemented.

We envisage a phased approach over three years to deliver and fully implement the strategy, with the first year focused on laying the essential groundwork and years two and three focusing on embedding engagement.

It is important the strategy remains a live document and can change as we move through the year.

Evaluating success:

The Council of Governors is ultimately responsible for the delivery of the strategy and it will be supported in this by the Membership Committee which will undertake the detailed monitoring of implementation and will report regularly to the Council on this.

Implementing the Strategy and Measuring Success

The principal ways in which we will assess the success of the strategy will include:

Analysing the profile of the Trust's membership
We will conduct this analysis on a regular basis and look in depth at the profile of the Trust's public membership and identify any under-represented groups. This will help us to understand whether our targeted campaigns have been successful and whether we are succeeding in maintaining the size and diversity of our membership. The results will be analysed by the Membership Committee.

Analysing involvement
We also need to understand the extent to which our efforts in promoting a more active and involved public and staff colleague membership have been successful. To do this, we will look at new ways of analysing involvement, not just using the membership database statistics. This can include engagement with social media posts, attendance at engagement events, surveys with the members to assess their views.

Analysing impact
We want to understand and evaluate the impact of the membership on the Trust's services. Surveys of members will assist with this. We can also look at wider outcomes that are not just restricted to membership, for example, if we engage with members about a subject such as volunteers, has that encouraged some people to volunteer that have not previously? Or if we engage with members about Carers, has that directly helped anyone in their role as a carer or seeking carer support?

APPENDIX 1: COMPOSITION OF THE COUNCIL OF GOVERNORS

Constituency/No Governors	Constituency Area	
Essex Mid & South 9 Governors	Basildon Borough Council Braintree District Council Brentwood Borough Council Castle Point Borough Council Chelmsford City Council	Maldon District Council Rochford District Council Southend on Sea Borough Council Thurrock Council
North East Essex & Suffolk 3 Governors	Colchester Borough Council Suffolk County Council Tendring District Council	
West Essex & Herts 5 Governors	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
Milton Keynes, Bedfordshire & Luton and Rest of England 2 Governors	Bedford Borough Council Central Bedfordshire Council Any other Council in England	Luton Borough Council Milton Keynes Council

APPENDIX 1: COMPOSITION OF THE COUNCIL OF GOVERNORS

Constituency/No Governors	Constituency Area	
Staff Governors **6 Governors**	Registered Medical Practitioners Registered Dentists Registered Nurses Registered Midwives	Healthcare Professionals Social Workers Support Workers Corporate Staff
Appointed Governors **5 Governors**	Essex County Council Southend Borough Council Thurrock Council	Anglia Ruskin and Essex Universities Third Sector / Voluntary Sector

Appendix 2: Membership Strategy Action Plan

Priority	Key Objective	How we will deliver the priority		
		Year One	Year Two	Year Three
Priority 1: Establish a Membership that is representative of the population served by EPUT.	Understand the demographics of the population served by EPUT and compare against the membership of the Trust.	Establish an accurate source of demographical information for the population served by EPUT, which can be regularly updated.	Once the data is established, analyse the information to identify gaps in membership representation to focus engagement.	
	Identify and undertake engagement with members of the public to increase membership in any areas that are not represented.		Undertake focused engagement with members of the public to increase membership in any areas that are not fully represented.	
	Regularly review Membership demographics to confirm engagement is working or identify solutions where it is not working.		Continually review membership against demographical data to determine if engagement is having a positive effect on membership. Review and alter any engagement depending on the outcome of the analysis.	Review overall demographics and engagement outcomes to establish if the membership is representative of the wider population and revise any engagement activity as required.

Appendix 2: Membership Strategy Action Plan

Priority	Key Objective	How we will deliver the priority		
		Year One	Year Two	Year Three
Priority 2: Communicate effectively with members and ensure their views are represented within EPUT	Develop a membership communications strategy	Develop a communications plan to establish different channels of communication. Establish a who, what, where, when of communication as part of the communications plan.	Implement marketing plan.	Review marketing plan to ensure it is delivering expected communication levels and adjust as required.
	Establishes regular communication between Governors and members / members of the public.	Identify opportunities for Governors to communicate directly with members and members of the public, ensuring we are providing them with the right information and resources needed.	Governors regularly engage with members and gather their views.	Review levels of engagement and take action as required.
	Creates a two-way channel so that members' have a voice and have clear feedback on issues raised.		Develop a process for ensuring the views of the members are represented and this captured and fed-back to them.	Review the process to ensure there is evidence of membership views being represented in the Trust.

Appendix 2: Membership Strategy Action Plan

Priority	Key Objective	How we will deliver the priority		
		Year One	Year Two	Year Three
Priority 3: Membership in the context of system working	Understand the role of Foundation Trust's and Membership as part of system working.	Understand the role of a Foundation Trust and Membership as part of system working and be able to articulate this to Governors and Members.	Review and update Governors and Members as the role of system working and ICBs develops.	
	Ensure the views of members of the Foundation Trust are represented in decision making at a system level.		Establish processes to ensure any views expressed by Members are represented to the ICBs and throughout the wider system.	
	Communicate with Governors and members to encourage understanding of system working and the importance / impact of their views.		Regularly engage with the ICBs and ICS on a regular basis and ensure this information is shared with Governors and Members.	Review and adjust as required

12. REGULATION & COMPLIANCE

12.1 CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS 2022/23

Decision Item | Trevor Smith | 5 minutes

REFERENCES

Only PDFs are attached

Charitable Funds Annual Reports and Accounts 2022-23.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Final Charity Annual Report and Accounts 2022/23**					
Executive/Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:	Executive Operational Committee (12 September 2023) Audit Committee (16 November 2023)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	n/a	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	n/a	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
As Trustees of the EPUT Charity, the Board of Directors are required approve the final Charity Annual Report and Accounts for 2022/23, including the review of going concern.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the final Charity Annual Report and Accounts for 2022/23
3. Approve the Letter of Representation for signing by the Chair of the Audit Committee and the Executive Chief Finance Officer
4. Approve the going concern concept as the basis of accounts preparation to the Board of Directors
5. Request any further information or action.

Summary of Key Issues

The charitable fund accounts for 2022/23 have been prepared in line with accounting guidelines, and are attached at appendix 1. In line with the 2011 Charities Act, a full audit was not required for the 2022/23 accounts and the Trust's external auditors have completed an independent examination. This identified an immaterial unadjusted difference of £600 in respect of the independent examination fee for the 2022/23 financial year. A draft copy of their report is attached at appendix 2.

The EPUT Board of Directors is the Trustee of the Charity (as opposed to its individual members) and as part of the annual accounts process are required to confirm that the Charity continues as a going concern. The financial position of the Charity is reviewed by the Charitable Funds Committee, with the current fund value as at the end of October 2023 totalling £1.1 million. The Charitable Funds Committee have not raised any concerns around the future financial viability of the charity and as such, the Audit Committee recommend the Board of Directors approve the going concern concept as the basis for preparing the accounts.

The Trust is also required to submit a Letter of Representation to the Auditors. A copy is attached at appendix 3 for the Boards approval.

Following formal approval by the Board of Directors, and the signing of the necessary certificates and Letter of Representation, the Auditors will sign their certificate for inclusion in the final documents. The final accounts will then be submitted to the Charity Commission in advance of the deadline of 31 January 2024.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

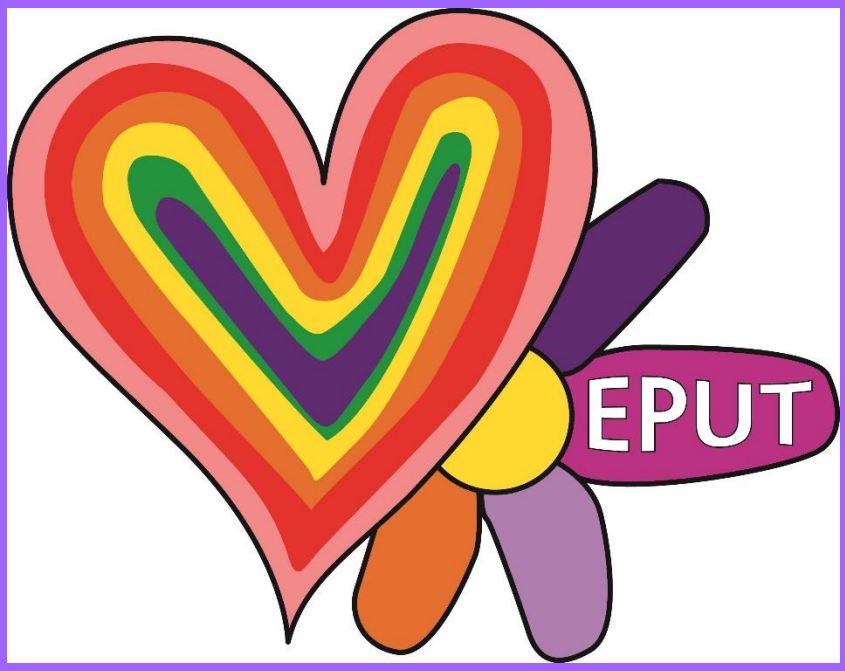
Appendix 1 – Final Charity Annual Report and Accounts 2022/23
Appendix 2 – Independent Examiners Report
Appendix 3 – Letter of Representation

Lead

Trevor Smith
Executive Chief Finance Officer

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST CHARITIES



ANNUAL REPORT AND ACCOUNTS 2022/23

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST CHARITIES

ANNUAL REPORT & ACCOUNTS

2022/23

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SECTION A

SECTION B

SECTION A

CHARITY INFORMATION

Name:	Essex Partnership University NHS Foundation Trust Charities
Trustees:	The Board of Directors of Essex Partnership University NHS Foundation Trust
Charity Number:	1053793
Charity Offices:	Essex Partnership University NHS Foundation Trust Head Office The Lodge Lodge Approach Runwell Wickford Essex SS11 7XX
Independent Examiners:	Ernst and Young LLP 400 Capability Green Luton LU1 3LU
Bankers:	Lloyds Banking Group 34 High Street Grays Essex RM17 6LX
Investment Brokers:	BlackRock Investment Manager (UK) Ltd 33 King William Street London EC4R 9AS M&G Securities Ltd Laurence Poutney Hill London EC4 0HH CCLA Investment Management 80 Cheapside London EC2V 6DZ

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2023

Introduction

The Essex Partnership University NHS Foundation Trust Charities (referred to as the Charity for the purpose of this document) was renamed from the legacy organisations name (South Essex Partnership University NHS Foundation Trust Charity) on the 1st April 2018, as a result of the merger of the former North Essex Partnership University NHS Foundation Trust and the South Essex Partnership University NHS Foundation Trust and their associated Charities.

The purpose of this report is to inform users of the accounts on the structure, policy and objectives, and governance arrangements of the Charity. The report also covers funding arrangements and a high level financial review for the year.

Going Concern

These accounts have been prepared on the basis that the Charity is a going concern. This means that the assets and liabilities of the Charity reflect the ongoing nature of the Charity's activity.

Scope

The objective of the Charity is that the funds are made available to benefit the patients and staff of the Essex Partnership University NHS Foundation Trust (the Trust), or for any other NHS organisations on behalf of whom the Trust administers funds.

The Charity is sub-divided into a number of linked funds, each of which has a specific purpose and this determines the type of expenditure that can be incurred. Each linked fund is further broken down into smaller funds which are assigned an individual fund number. Each fund has a designated fund manager who is responsible for approving expenditure against the fund, monitoring fund levels and co-ordinating fund raising activities where appropriate in accordance with the scheme of delegation.

Objectives and Strategy

The objective of the Charity during the current and future years is to support the needs of patients and staff of the Trust, in improving standards of care and facilities, within the scope of provision included above.

In seeking to achieve the Charity's objective, the Charity actively encourages donations and fundraising.

Funds

Unrestricted funds are those which are not subject to any specific restriction, but can be used in accordance with the general purpose of the Charity, to improve standards of care and facilities for patients and staff within the scope of the Charity.

Restricted funds are funds which are subject to specific restrictions, over and above the general purpose of the Charity.

Structure and Governance

The charitable trust, which is an umbrella Charity, is an unincorporated body, with each separate restricted and unrestricted fund within the charitable trust being governed by its own model declaration of trust. The model declaration of trust sets out the specific or general purpose of the fund by way of its objects. This structure enables donations received into the restricted funds to be used for the purpose intended by the donors and those donations given for general purposes to be controlled.

The Charitable Funds Committee has delegated authority from the Board of Directors to approve applications for funds up to £10,000 in accordance with agreed criteria and the Charities objects. This Committee is overseen and monitored by the Board of Directors. The Corporate Trustee for the Charity is the Essex Partnership University NHS Foundation Trust, with responsibility for the management of the Charity undertaken by the Board of Directors. Any provision for training and induction of Trustees is therefore covered under the ongoing requirement of the Board of Directors.

Reserve Policy

Fund managers are encouraged to use the funds available to them. The Trustees aim to ensure the value of the overall fund value is maximised in line with the Investment Policy and will ensure that the capital value of endowment funds are maintained in perpetuity. The funds will continue to be used to improve the standards of care and facilities provided to patients and staff.

Investment Policy

The Charity has an investment policy which aims to achieve a split of funds between investment in the unit trust and deposit style investments. This is maintained in order to meet the spending plans of the organisation. This also provides detail around the Charities corporate, social and ethical responsibilities in terms of where investments are made.

Funds are currently invested with the following investment managers:

BlackRock Investment Management
M&G Securities Ltd
CCLA Investment Management

The Committee is responsible for reviewing and updating this Investment Policy on a regular basis.

Risk Statement

The risk to the Charity is that equity investments may be adversely affected by a material fall in stock market values. The Committee will continue to monitor risks at its meetings, and obtain professional advice where appropriate with respect to its investments.

Funding

Income is received from direct contributions from the public, in addition to income from dividends and interest receivable. Fund raising activities are encouraged by staff or the public.

Each fund receives a proportion of dividends and interest received from the investments in accordance with the average fund value. This basis of apportionment is also applied to capital losses/gains, administration expenses and the management fees of the investment managers. The Committee consider this apportionment equitable.

The investments are made in accordance with the Trustee Act of 2000. The investment advisers have been instructed to exclude any direct investment in the tobacco industry, as this is considered inappropriate for an NHS Charity.

The Charity also follows the 2017 Money Laundering, Terrorist Financing and Transfer of Funds Regulations which came into force on the 26 June 2017 (superseding the 2007 Regulations). These regulations aim to ensure that there are robust arrangements in place to ensure incoming resources, especially cash donations, are not the proceeds of crime.

Financial Report for the Year

The attached accounts give full details of the income and expenditure for the year and the value of the assets and liabilities at the year end. The information below is given to supplement these formal accounts.

The value of the Charitable Funds as at 31 March 2023 was £1,071,000 (2021/22: £1,140,000). The net movement in value is a decrease of £69,000 (2021/22: £100,000 increase) which was attributable to;

1. Total income of £69,000 (2021/22: £119,000)
2. Total expenditure of £93,000 (2021/22: £95,000)
3. Unrealised loss on investment which amounted to £45,000 (2021/22: £76,000 gain)

The direct charitable expenditure is charged to the accounts on an accrual basis, and was in line with the objectives of the Charity. The total expenditure for the year of £93,000 can be further analysed as follows,

- Expenditure on patient welfare of £58,000 including an additional palliative care support service, cycling sessions, music therapy, games and leisure activities and improvements to outside areas
- Expenditure on staff welfare of £2,000 including courses and books
- Expenditure on fundraising activities £1,000
- Expenditure on support costs of £32,000.

The General Charitable Fund does not directly employ any staff; however a governance (support) cost to cover staff time was made by Essex Partnership University NHS Foundation Trust. Governance costs are charged across the funds based on the proportion of funds held, and are considered each year by the Charitable Funds Committee.

Open Arts Project

Open Arts is a charitable community arts and mental health service managed by the Trust, which helps to improve and maintain mental health and wellbeing. Open Arts is not funded by the NHS but operates completely on external funding, donations and fundraising by participants, volunteers and local businesses.

The Trust is proud of the awards and recognition received for Open Arts:

The UK's Mental Health and Wellbeing Awards

2021 Open Arts shortlisted in the 'Support During the Pandemic' category

2021 Jo Keay shortlisted in the 'Public Nomination for a Mental Health Professional' category

During this past year, the Open Arts service has delivered:

2,597 Client Studio, Course 'In the Open Arts' sessions/Zoom Sessions
6,761 hours of Open Arts delivery
1,133 hours volunteer time
16,112 estimated people attending community engagement activities

As a result of Open Arts participation, substantial benefits have been reported, including improved mental health, increased social activity, greater confidence and self-esteem, reduced use of mental health services and increased take up of wider community based opportunities. Some feedback from our participants is as follows:

'Open Arts has been a lifeline for me, it has given me back a purpose and opened up a whole new outlook on life'

'When I started attending Open Arts I had very little self confidence and now I have achieved so much'

'Throughout the Lockdowns and even now we are still together and stronger through the Open Arts Studio Members Facebook page, zoom calls and meeting up in open spaces. Now as life is gradually returning to normal. It's great to see us all coming together with sharing ideas and showing of works'

'Jo has been wonderful at ensuring that we are okay from weekly phone calls, emails and providing art Materials and details of some free Art Courses. Thanks to my increasing confidence that I have continued to gain, I was able to do 4 courses online…This is something I would not have been physically able to do before I joined Open Arts'

'Thank you Open Arts for giving me the encouragement support and helping me on my journey through the mine field of mental health and bring back the colour on my hardest days' Sarah P, Open Arts member

'Thank you to the Open Arts team; our artists and volunteers, friends, members and participants. For the funding and support received from NHS Charities Together, Castle Point Mayor, Barchester Charitable Foundation, Sanctuary Housing/ Rochford Council, Southend On Sea Art Club and EPUT.'

If you can help support Open Arts or would like information on how you can, please contact epunft.open.arts@nhs.net or call Jo Keay Open Arts manager on 07580 982462 www.openartsessex.org

You can donate online via CAF www.cafonline.org search for **Essex Partnership NHS Foundation Trust Charities or 1053793.** Please make sure you type **For Open Arts** in the message box. Thank you.

	NHS Charities Together £	EPUT £	**Total Open Arts £**
Incoming Resources from:			
Donations, grants and legacies	-	10,027	**10,027**
Investment income	-	1,471	**1,471**
Other income	-	1,469	**1,469**
Total income	**-**	**12,967**	**12,967**
Resources Expended on:			
Charitable activities	(21,313)	(5,762)	**(27,075)**
Total expenditure	**(21,313)**	**(5,762)**	**(27,075)**
Net gain / (loss) on investments	-	(909)	**(909)**
Net income / (expenditure)	**(21,313)**	**6,296**	**(15,017)**
Reconciliation of funds			
Total fund balance bought forward	22,926	28,050	**50,976**
Total fund balance carried forward	**1,613**	**34,346**	**35,959**

Trustees

The Board of Directors of the Essex Partnership University NHS Foundation Trust is the Corporate Trustee for the Charity. As at 31 March 2023, the Board of Directors consisted of the following individuals:

Paul Scott
Alexandra Green
Trevor Smith
Dr Milind Karale
Nigel Leonard
Professor Natalie Hammond (until 31/07/2023)
Sean Leahy (until 02/07/2023)
Marcus Riddell (from 01/12/2022 until 30/04/2023)
Zephen Trent
Denver Greenhalgh

Professor Sheila Salmon
Manny Lewis
Janet Wood (until 30/09/2023)
Jill Ainscough (from 30/11/2022 to 31/03/2023)
Amanda Sherlock (until 30/09/2022)
Dr Rufus Helm
Dr Alison Rose-Quirie (until 30/10/2022)
Dr Mateen Jiwani
Loy Lobo
Professor Stephen Heppell (from 20/11/2022)
Elena Lokteva (from 01/03/2023)

All appointments to the Board of Directors of the Essex Partnership University NHS Foundation Trust Board are also the appointed Trustees of the Essex Partnership NHS Foundation Trust General Charitable Fund. Non-Executive Directors are normally appointed for a fixed term of three years.

Administration Arrangements

The Trust holds bi-monthly Board of Directors meetings, which include an update from the Charitable Funds Committee at least twice a year. The day-to-day management of the restricted funds has been delegated to Fund Managers who have delegated authority to approve expenditure of up to £5,000 or the balance of fund (whichever is lower).

The Board of Directors has delegated the management of the unrestricted funds to the Chief Executive of the Trust.

The Board of Directors has retained approval of expenditure commitments of a recurring nature and approval of expenditure over £10,000, with the Charitable Funds Committee approving expenditure of between £5,000 and £10,000.

Independent Examiners

NHS Funds held on Trust are subject to the 2011 Charities Act, which superseded the 2006 Charities Act and states that all Charities with a gross income of more than £25,000 are required to have some form of external scrutiny of their accounts. In addition, if the Charity has gross income in excess of £1 million in the period of account, or if its gross income exceeds £250,000 and the aggregate value of assets (before deduction of liabilities) exceeds £3.26 million, then the accounts will be subject to a full audit.

For the year ended 31 March 2023 the Charities income was below the £1 million threshold and as such the annual report and accounts will not therefore be subject to a full audit. However, due to the Charities having income in excess of the £25,000 threshold, they will instead be subject to an independent examination as required by the Charities Act 2011.

Acknowledgements

The Trustees acknowledge the generous contributions and donations made by the public, as well as the time and commitment of staff.

Approval

This report was approved by the Trustees and signed on their behalf.

Professor Sheila Salmon
Chair

29 November 2023

STATEMENT OF TRUSTEES' RESPONSIBILITIES

The Trustees are responsible for:

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 2011;
- establishing and monitoring a system of internal control; and
- establishing arrangements for the prevention and detection of fraud and corruption:

The Trustees are responsible for the preparation of financial statements in accordance with the Charities Statement of Recommended Practice (FRS 102) Accounting and Reporting by Charities for each financial year. The Charity Commission directs that these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with Charities SORP (FRS 102). In preparing these accounts the Trustees are required to:

- apply on a consistent basis, accounting policies laid down by applicable accounting standards;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts: and
- prepare the accounts on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation.

The Trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1 to 12 attached, have been compiled from and are in accordance with the financial records maintained by the Trustees.

By Order of the Trustees

Sheila Salmon
Chair

Trevor Smith
Executive Chief Finance Officer

29 November 2023

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST GENERAL CHARITABLE FUND

To be inserted post Board approval

SECTION B

FUNDS HELD ON TRUST ACCOUNTS 2022/23

Foreword

These accounts have been prepared by the Trust under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The Essex Partnership University NHS Foundation Trust is the corporate trustee of the funds held on trust under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

The Essex Partnership NHS Foundation Trust Charitable Funds Held on Trust are registered with the Charity Commission. The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the aforementioned organisations.

If you require any further information regarding these accounts please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268 739666

Trevor Smith
Executive Chief Finance Officer

Statement of Financial Activities for the Year Ended 31 March 2023

	Note	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*2021/22 Total £*
Incoming Resources from:						
Donations, grants and legacies	2	10,648	10,027	-	**20,675**	*75,550*
Other trading activities	3	964	1,623	-	**2,587**	*2,555*
Investment income	4	19,391	26,112	-	**45,503**	*41,268*
Total income		**31,003**	**37,762**	**-**	**68,765**	*119,373*
Resources Expended on:						
Charitable activities	5	(62,114)	(30,621)	-	**(92,735)**	*(94,785)*
Total expenditure		**(62,114)**	**(30,621)**	**-**	**(92,735)**	*(94,785)*
Net gain / (loss) on investments	6	(19,795)	(25,268)	-	**(45,063)**	*75,689*
Net income / (expenditure)		**(50,906)**	**(18,127)**	**-**	**(69,033)**	*100,277*
Reconciliation of funds						
Total fund balance bought forward		459,581	652,418	28,116	**1,140,115**	*1,039,838*
Total fund balance carried forward		**408,675**	**634,291**	**28,116**	**1,071,082**	*1,140,115*

The Statement of Financial Activities includes the income and expenditure account.

The notes are at pages 5 to 12 and form part of this document.

Balance Sheet as at 31 March 2023

	Note	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*2021/22 Total £*
Investment Assets						
Investments	7	390,038	605,363	26,834	**1,022,235**	*1,067,605*
		390,038	**605,363**	**26,834**	**1,022,235**	*1,067,605*
Current Assets						
Debtors	8	751	1,167	52	**1,970**	*1,632*
Short term investments & deposits	9	4,519	7,013	311	**11,843**	*11,535*
Cash at bank and in hand	10	18,683	28,998	1,285	**48,966**	*71,697*
		23,953	**37,178**	**1,648**	**62,779**	*84,864*
Current Liabilities						
Creditors: amounts falling due within one year	11	(5,316)	(8,250)	(366)	**(13,932)**	*(12,354)*
Net Current Assets		**18,637**	**28,928**	**1,282**	**48,847**	*72,510*
Total Assets less Current Liabilities		408,675	634,291	28,116	**1,071,082**	*1,140,115*
Creditors: amounts falling due after more than one year		-	-	-	**-**	-
Provisions for liabilities and charges		-	-	-	**-**	-
Total Net Assets		**408,675**	**634,291**	**28,116**	**1,071,082**	*1,140,115*
The Funds of the Charity						
Total restricted funds	12	-	634,291	-	**634,291**	*652,418*
Total unrestricted funds	12	408,675	-	-	**408,675**	*459,581*
Total endowment funds	12	-	-	28,116	**28,116**	*28,116*
Total charity funds		**408,675**	**634,291**	**28,116**	**1,071,082**	*1,140,115*

The notes are at page 5 to 12 and form part of this document.

Sheila Salmon
Chair
29 November 2023

Statement of Cash Flow at 31 March 2023

	Note	2022/23 Total £	*2021/22 Total £*
Cash flows from operating activities			
Net cash provided by / (used in) operating activities	10.2	(68,234)	*(16,375)*
Cash inflow / (outflow) from other activities	12	-	-
		(68,234)	*(16,375)*
Cash flows from investing activities			
Dividends, interest from investments	4	45,503	*41,268*
Proceeds from sale of investments	7	-	-
Purchase of investments		-	-
Net cash provided by / (used in) investing activities		**45,503**	*41,268*
Cash flows from financing activities			
Repayment of borrowings		**-**	-
Cash flows from borrowing		**-**	-
Net cash provided by / (used in) borrowing activities		**-**	**-**
Change in cash and cash equivalents during the year		**(22,731)**	**24,893**
Cash and cash equivalents at the beginning of the year		**71,697**	*46,804*
Cash and cash equivalents at the end of the year		**48,966**	**71,697**

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting Policies

The financial statements have been prepared under the historical cost convention and in accordance with the Statement of Recommended Practice issued in 2015 - Accounting and Reporting by Charities (FRS 102), and with accounting standards and policies for the NHS approved by the Secretary of State.

There have been no changes to accounting policy for the 2022/23 financial year.

1.2 Incoming Resources

a) Incoming Resources

All incoming resources are included in full in the statement of financial activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the Charity's right becomes legally enforceable;
ii) certainty - when there is reasonable certainty that the incoming resource will be received;
iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability

b) Gifts in Kind

i) Assets given for distribution by the Charity are included in the Statement of Financial Activities only when distributed.
ii) Assets given for use by the Charity (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.
iii) Gifts made in kind but on trust for conversion into cash and subsequent application by the Charity are included in the accounting period in which the gift is sold.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the Charity or the amount actually realised. The basis of the valuation is disclosed in the annual report.

c) Intangible Income

Intangible income (eg the provision of free accommodation) is included in the accounts with an equivalent amount in outgoing resources, if there is a financial cost borne by another party. The value placed on such income is the financial cost of the third party providing the resources.

1.3 Resources Expended

The Funds Held on Trust account is prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the accounts when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Resources expended are split into two main categories being the costs of generating funds and the actual costs of charitable activities. The costs of generating funds are the costs associated with generating income for the Funds Held on Trust. A grant is any payment which is made voluntarily to any institution or to an individual in order to further the Charity's objectives, without receiving goods or services return.

The cost of activities in the furtherance of charitable activities is expenditure incurred on the provision of services or goods. Support costs are an integral and material part of the costs of activities in the furtherance of charitable activities and/or expenditure incurred in paying grants. Management and administrative expenditure includes direct and indirect costs (as distinct from directly pursuing charitable activities). Direct costs include those of external and internal audit and legal advice for trustees, the indirect costs include office and communication costs.

1.4 Tangible Fixed Assets and Donated Assets

The General Charitable Fund has no retained fixed assets or donated assets.

1.5 Investment Assets

Investment assets are shown at market value.

Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividend.

Other investment assets are included at trustees' best estimate market value.

Unrealised and realised gains and losses are shown in the statement of financial activities and represent the difference between the market value and the original purchase cost.

1.6 Structure of Funds

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds. The major funds held within these categories are disclosed in note 11.

As at 31 March 2023 the Charity held one endowment fund.

1.7 Pension Contributions

There have been no pension contributions made by the Charity in the financial year ended 31 March 2023.

1.8 Prior Year Adjustments

There have been no prior year restatements.

1.9 Pooling Scheme

The General Charitable Fund is a Charitable Fund Umbrella which comprises general and specific purpose funds. As such funds are pooled for investment purposes. The funds included within the General Charitable Fund are as follows,

Essex Partnership University NHS FT General Fund
District Nurses Fund
Mental Health Charity
Primary Care Charity
Continuing Care Services Fund
Psychiatric Research Fund
Primary Care Trust Staff Welfare Fund
Mental Health Research Foundation
Learning Disabilities Psychiatry Academic and Research Foundation
The Margaret Ethel Bolton Fund
Cancer Care General Fund
Child Health Directorate Fund
Cancer Relief Fund

The scheme was registered with the Charity Commission on 18 December 2002.

1.10 Consolidation of Charity Accounts with EPUT Annual Accounts

IAS 27 on Consolidation and Separate Financial Statements, requires consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. The Essex Partnership University NHS Foundation Trust is the corporate Trustee for the Charity and hence controls it. The purpose of the Charity is to assist NHS patients, and hence the Trust benefits from its activities. As such, IAS27 would normally be applicable in the preparation of the Trust's main accounts and the Charity would be consolidated.

However, IAS1 on Presentation of Financial Statements confirms that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity represent 1% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trusts main accounts. The Audit Committee have noted and approved that the Charity Accounts will not be consolidated into the main Trust accounts for 2022/23. This is subject to an annual materiality review.

2. Analysis of donations and legacies

	Unrestricted	Restricted	Endowment	**2022/23 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2021/22 Total*
	£	£	£	**£**	*£*	*£*	*£*	*£*
Donations	10,448	10,027	-	**20,475**	*21,016*	*7,534*	*-*	*28,550*
Legacies	200	-	-	**200**	*-*	*-*	*-*	*-*
Grant income	-	-	-	**-**	*42,000*	*5,000*	*-*	*47,000*
	10,648	10,027	-	**20,675**	*63,016*	*12,534*	*-*	*75,550*

3. Analysis of income from other trading activities

	Unrestricted	Restricted	Endowment	**2022/23 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2021/22 Total*
	£	£	£	**£**	*£*	*£*	*£*	*£*
Income from other fund raising activities	622	-	-	**622**	*1,421*	*-*	*-*	*1,421*
Other income	342	1,623	-	**1,965**	*1,134*	*-*	*-*	*1,134*
	964	1,623	-	**2,587**	*2,555*	*-*	*-*	*2,555*

4. Analysis of income from investments

	Unrestricted	Restricted	Endowment	**2022/23 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2021/22 Total*
	£	£	£	**£**	*£*	*£*	*£*	*£*
BlackRock Investment	3,317	4,494	-	**7,811**	*2,899*	*3,898*	*-*	*6,797*
M&G Charities	12,877	17,321	-	**30,197**	*11,543*	*15,580*	*-*	*27,123*
COIF Charities Investment Fund	3,197	4,298	-	**7,495**	*3,122*	*4,226*	*-*	*7,348*
	19,391	26,112	-	**45,503**	*17,564*	*23,704*	*-*	*41,268*

5. Analysis of expenditure on charitable fund activities

	Unrestricted	Restricted	Endowment	**2022/23 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2021/22 Total*
	£	£	£	**£**	*£*	*£*	*£*	*£*
Patients welfare & amenities	46,030	12,154	-	**58,184**	*44,776*	*14,852*	*-*	*59,628*
Staff welfare & amenities	1,996	-	-	**1,996**	*992*	*306*	*-*	*1,298*
Support costs (see note 5.1)	13,721	18,467	-	**32,188**	*14,070*	*19,018*	*-*	*33,088*
Other - fundraising expenditure	367	-	-	**367**	*771*	*-*	*-*	*771*
	62,114	30,621	-	**92,735**	*60,609*	*34,176*	*-*	*94,785*

5.1 Analysis of support costs by type

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Audit fee	2,296	3,104	-	**5,400**	*2,683*	*3,617*	-	*6,300*
Admin fee	11,425	15,363	-	**26,788**	*11,387*	*15,401*	-	*26,788*
	13,721	18,467	-	**32,188**	*14,070*	*19,018*	-	*33,088*

5.2 Analysis of support costs by activities

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Patients welfare & amenities	13,266	17,854	-	**31,120**	*13,769*	*18,634*	-	*32,403*
Staff welfare & amenities	455	613	-	**1,068**	*301*	*384*	-	*685*
	13,721	18,467	-	**32,188**	*14,070*	*19,018*	-	*33,088*

6. Gain / (loss) on investments revaluation

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
BlackRock Investment	(299)	(20)	-	**(319)**	*6,843*	*8,758*	-	*15,601*
M&G Charities	(15,198)	(19,715)	-	**(34,913)**	*17,256*	*21,548*	-	*38,804*
COIF Charities Investment Fund	(4,428)	(5,710)	-	**(10,138)**	*9,128*	*12,156*	-	*21,284*
COIF Charities Deposit Fund	130	178	-	**308**	-	-	-	-
	(19,795)	(25,268)	-	**(45,063)**	*33,227*	*42,462*	-	*75,689*

7. Investments assets

7.1 Changes in investment assets

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Market value at 1 April	409,963	630,809	26,834	**1,067,606**	*397,124*	*568,463*	*26,329*	*991,916*
Transfers / disposals	-	-	-	**-**	-	-	-	*0*
Dividends re-invested	-	-	-	**-**	-	-	-	*0*
Net gain / (loss) on revaluation	(19,925)	(25,445)	-	**(45,370)**	*33,227*	*42,462*	-	*75,689*
	390,038	605,363	26,834	**1,022,235**	*430,351*	*610,925*	*26,329*	*1,067,605*

7.2 Analysis of Investment assets by investment manager

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
BlackRock Investment Managers (UK) Ltd	87,025	135,070	5,988	**228,083**	*92,068*	*130,700*	*5,633*	*228,401*
M&G Securities Ltd	204,659	317,645	14,080	**536,383**	*230,289*	*326,918*	*14,089*	*571,296*
CCLA Investment Management	98,353	152,650	6,766	**257,770**	*107,994*	*153,307*	*6,607*	*267,908*
	390,037	605,365	26,834	**1,022,236**	*430,351*	*610,925*	*26,329*	*1,067,605*

8. Analysis of receivables due within one year

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Sundry debtors	751	1,167	52	**1,970**	*658*	*934*	*40*	*1,632*
	751	1,167	52	1,970	*658*	*934*	*40*	*1,632*

9. Short term investments and deposits

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
COIF Charities deposits funds	4,519	7,013	311	**11,843**	*4,650*	*6,601*	*284*	*11,535*
	4,519	7,013	311	**11,843**	*4,650*	*6,601*	*284*	*11,535*

10. Analysis of cash and cash equivalent

10.1 Analysis of cash and cash equivalent

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Cash at bank	17,668	27,422	1,216	**46,306**	*27,618*	*39,317*	*1,688*	*68,623*
Cash in hand	1,015	1,576	70	**2,661**	*1,237*	*1,761*	*76*	*3,074*
	18,683	28,998	1,285	**48,966**	*28,855*	*41,078*	*1,764*	*71,697*

10.2 Reconciliation of net income / (expenditure) to net cash flow from operating activities

	2022/23 Total £	*2021/22 Total £*
Net income/(expenditure) for the year as per the SoFA	**(69,033)**	*100,277*
(Gain) and losses of investment	**45,063**	*(75,689)*
Dividends, interest from investments	**(45,503)**	*(41,268)*
(Increase)/decrease in stocks	**-**	-
(Increase)/decrease in debtors	**(338)**	*305*
Increase/(decrease) in creditors	**1,577**	-
	(68,234)	*(16,375)*

11. Analysis of creditors

	Unrestricted £	Restricted £	Endowment £	**2022/23 Total £**	*Unrestricted £*	*Restricted £*	*Endowment £*	*2021/22 Total £*
Amounts falling due within 1 year:								
Intercompany creditors	840	1,304	58	**2,202**	*921*	*1,311*	*56*	*2,288*
Accruals	4,476	6,946	308	**11,730**	*4,053*	*5,766*	*247*	*10,066*
	5,316	8,250	366	13,932	*4,974*	*7,077*	*303*	*12,354*

12. Reconciliation of fund balance at 31 March 2023

	Balance at 01/04/2022 £000	Income £000	Expenditure £000	Unrealised Gain/(Loss) £000	**Balance 31/03/2023 £000**
Restricted funds	652,418	37,762	(30,621)	(25,268)	**634,291**
Unrestricted funds	459,581	31,003	(62,114)	(19,795)	**408,675**
Endowment	28,116	-	-	-	**28,116**
	1,140,115	68,765	(92,735)	(45,063)	**1,071,082**

13. Trustee and related party transaction

Essex Partnership University NHS Foundation Trust is the Corporate Trustee (the Trust) of the Essex Partnership University NHS Foundation Trust Charities. During the year the Charity paid £26,788 to the Trust, to cover costs incurred in administering the Charity on its behalf.

14. Trustees remuneration and benefits

There was no remuneration or other benefits paid to Trustees during the year.

15. Staff costs and other benefits

There was no remuneration or other benefits paid to Trustees during the year.

16. Contingencies

There are no contingent losses or gains known by the Trustees.

17. Commitments, Liabilities and Provisions

There are no commitments, liabilities or provisions known by the Trustees.

18. Post balance sheet events

There are no post balance sheet events for the reporting period.

Essex Partnership University NHS Foundation Trust Charities

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

Tel: 0300 123 0808

@EPUTNHS

Independent examiner's report to the trustees of Essex Partnership University NHS Foundation Trust Charities

I report on the accounts of the Charity for the year ended 31 March 2023**,** which are set out on pages 1 to 12.

Responsibilities and basis of report

As the charity trustees of the Charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the Charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act, which are available in the Charity commission guidance for independent examination of charity accounts: Directions and guidance for examiners.

Independent examiner's statement

I have completed my examination. I confirm that no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in respect of the Charity as required by section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 10 May 2023. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustees as a body, for this examination, for this report, or for the statements made.

Name: Debbie Hanson
For and on behalf of Ernst & Young LLP
Relevant professional qualification or body: CIPFA

Address: 400 Capability Green, Luton, LU1 3LU

Date:

Essex Partnership University
NHS Foundation Trust

29th November 2023

Ernst & Young
400 Capability Green
Luton
LU1 3LU

The Lodge Trust HQ Runwell
Lodge Approach
Wickford
Essex
SS11 7XX

Tel: 01268 739666
Email:Trevor.Smith9@nhs.net

Dear Debbie,

This letter of representations is provided in connection with your independent examination of the financial statements of Essex Partnership University NHS Foundation Trust Charities ("the Charity") for the year ended 31 March 2023. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your independent examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your independent examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect:

- the accounting records were not kept in respect of the Charity as required by section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances and is not designed to identify – nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the terms of the engagement letter dated 10 May 2023, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP).

3. We acknowledge, as trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Charity in accordance with the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP), and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

5. As trustees of the Charity, we believe that the Charity has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP) that are free from material misstatement, whether due to fraud or error. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the conflict and related sanctions in Ukraine, Russia and/or Belarus on our system of internal controls.

6. We believe that the effects of the unadjusted difference relating to the incorrect disclosure of the 2022/23 audit fee in note 5.1, accumulated by you during the current independent examination and pertaining to the latest period presented is immaterial, both individually and in the aggregate, to the financial statements taken as a whole. We have not corrected these differences because of their immateriality.

B. Non-compliance with laws and regulations, including fraud

1. We acknowledge that we are responsible to determine that the Charity's business activities are conducted in accordance with laws and regulations and that we are responsible to identify and address any non-compliance with applicable laws and regulations, including fraud.

2. We acknowledge that we are responsible for the design, implementation and maintenance of a system of internal control to prevent and detect fraud and that we believe we have appropriately fulfilled those responsibilities.

3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Charity (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters:

    - Involving financial improprieties

- Related to laws or regulations that have a direct effect on the determination of material amounts and disclosures in the Charity's financial statements

- Related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Charity's business, its ability to continue in business, or to avoid material penalties

- Involving management, or employees who have significant roles in internal control, or others

- In relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

   - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

   - Additional information that you have requested from us for the purpose of the independent examination ; and

   - Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and all material transactions, events and conditions are reflected in the financial statements, including those related to the conflict and related sanctions in Ukraine, Russia and/or Belarus.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: 27 July 23.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the period end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

6. From 30 November 2022, the date of our last management representation letter, through to the date of this letter, we have disclosed to you, to the extent that we are aware, any (1) unauthorised access to our information technology systems that either occurred or is reasonably likely to have occurred, including of reports submitted to us by third parties (including regulatory agencies, law enforcement agencies and security consultants), to the extent that such unauthorized access to our information technology systems is reasonably likely to have a material effect on the financial statements, in each case or in the aggregate, and (2) ransomware attacks when we paid or are contemplating paying a ransom, regardless of the amount.

D. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent. We have not given any guarantees to third parties.

E. Going Concern

1. There are no matters of which we are aware that are relevant to the Charity's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

F. Subsequent Events

1. There have been no events including events related to the conflict and related sanctions in Ukraine, Russia and/or Belarus, subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report and Accounts 2022-23.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Climate-related matters

1. We confirm that to the best of our knowledge all information that is relevant to the recognition, measurement, presentation and disclosure of climate-related matters has been considered and reflected in the financial statements.

2. The key assumptions used in preparing the financial statements are, to the extent allowable under the requirements of the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP), aligned with the statements we have made in the other information or other public communications made by us.

I. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

Trevor Smith
Executive Chief Finance Officer

Elena Lokteva
Chair of the Audit Committee

12.2 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR)

NATIONAL CORE STANDARDS RETURN 2023

Information Item | Nigel Leonard | 5 minutes

REFERENCES

Only PDFs are attached

EPRR Core Standards Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29th November 2023

Report Title:	**Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2023**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Major Projects & Programmes (EPRR AEO)					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	EPRR training availability by NHSE	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2023-24 completion of which is a requirement for all NHS organisations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Trust Board of Directors are asked to:

- Note the final Emergency Preparedness, Resilience and Response national core standards 2023-24 assurance level for EPUT

Summary of Key Issues

The NHSEI Emergency Preparedness, Resilience and Response (EPRR) Framework 2022 places a responsibility on the Trust to have effective emergency preparedness, resilience and response arrangements in place to ensure that it can respond so far as is reasonably practicable, in the event of an emergency.

All NHS organisations are required to complete an annual self-assessment which is submitted to NHSEI. Following submission a core standards peer review confirm and challenge meeting is held, at which there is an opportunity to revise submission.

On 24th May 2023, the Trust received communication from the regional EPRR team at NHSEI (East) informing the Trust of the newly published national EPRR core standards and the process for the national annual assurance process for 2023.

The Standards are split into two sections, the main EPRR Core Standards and a Deep Dive which changes each year. For 2023, the deep dive is in relation to 'EPRR Training.

The following process was used within the Trust to complete the Core Standards self-assessment:

1. Review of all standards by EPRR Team to complete initial self-assessment identifying how the Trust meets the standards, any gaps and actions required
2. Review of initial self-assessment by the EPRR AEO, Director of Risk and Compliance, AD of Risk & Compliance and the Head of Compliance and Emergency Planning.
3. Review and challenge of self-assessment by Health Safety and Security Committee (HSSC)
4. Review of Self-Assessment by Executive Operational Team

As part of the national process, the next step following submission of the Core Standards was for the Trust to attend a "confirm and challenge" meeting with the Regional EPRR team. This took place on 13th October 2023.

Following the "self- assessment" and "confirm and challenge" process; the position reported by the LHRP is that EPUT are substantially compliant with 96.5%; this is an improvement from the 90% reported in 2022-23. 56 out of the 58 EPRR Core Standards have been assessed as compliant, with 2 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months) and the deep dive has been assessed as partially compliant. The following standards were assessed as partially met:

Ref.	Domain	Action to be taken
21	Command & Control – Trained On Call Staff	Continue to escalate and seek improvements regarding on-call (particularly at a GOLD level) training compliance, with the AEO raising the importance of said training at senior level
66	Hazmat / CBRN – Exercising (New indicator for 2023)	Continue the roll of out of these exercises across the whole organisation.

The NHS England Core Standards inform the Trusts annual EPRR work Programme which is overseen by the Health Safety and Security Committee.

The full '2023-2024 Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance Report' is attached as 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			
EPRR	Emergency Preparedness Resilience and Response	LHRP	Local Health Resilience Partnership
NHSEI	NHS England and NHS Improvement		

Supporting Documents and/or Recommended Further Reading
Appendix 1 - 2023-2024 Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance Report

Lead
 Nigel Leonard, Executive Director of Major Projects & Programmes (EPRR AEO)

2023-2024
Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance Report

Essex Partnership University NHS Trust (EPUT)

Table of Contents

Document Control

Version	Date	Distribution
Draft report	13/10/2023	Amanda Webb (EPUT) Comfort Sithole (EPUT) Nigel Leonard (EPUT) Lara Brooks (EPUT) Grainne Stephenson (HWE ICB)
Response received	30/10/2023	-
Revised draft report issued	30/10/2023	-
Proposed final report issued	30/10/2023	-
Final report issued	30/10/2023	EPUT MSE ICB HWE ICB SNEE ICB NHS England East of England EPRR Team

1. Executive Summary

1.1 Background

As part of the NHS Emergency Preparedness Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to business continuity, critical and major incidents while maintaining services to patients.

The NHS Core Standards for EPRR sets out the minimum requirements expected of providers of NHS Funded services in respect of EPRR. These core standards are the basis of the EPRR annual assurance process. For more information please refer to NHS EPRR Annual Assurance Guidance.[1]

Mid and South Essex Integrated Care Board (MSE ICB) are responsible for monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable core standards and lead the local assurance process.

This report documents the outcome of the 2023-2024 EPRR annual assurance process for EPUT.

1.2 Outcome

Organisation EPRR Assurance Rating	
Fully	It was agreed that EPUT is substantial compliance having reached 96.5% against the 2023-24 Core Standards for EPRR.
Substantial	
Partial	
Non-complaint	

[1] https://www.england.nhs.uk/long-read/emergency-preparedness-resilience-and-response-annual-assurance-guidance/

2. Assurance Review Process

The assurance process was conducted as follows:

Assurance Element	Date	Attendance / Distribution
Self-Assessment and Evidence	Received 14/08/2023	-
Confirm and Challenge Session	13/10/2023	ICB Jim Cook Jo Martindale Grainne Stephenson EPUT Amanda Webb Comfort Sithole Nigel Leonard Lara Brooks
Assurance Report	30/10/2023	ICB Jim Cook Jo Martindale Grainne Stephenson Christopher Chapman EPUT Amanda Webb Comfort Sithole Nigel Leonard Lara Brooks

3. Overall level of compliance

Core Standards

The overall EPRR assurance rating is based on the percentage of core standards each organisation assess itself as being 'fully compliant' with. The table below details EPUT's compliance against the relevant standards and agreed actions where not 'fully compliant' or further action was agreed to maintain compliance.

Core Standards	Total applicable	Fully compliant	Partially compliant	Non-compliant	Agreed actions
Domain 1: Governance	6	6			

Domain 2: Duty to risk assess	2	2			
Domain 3: Duty to maintain plans	11	11			1
Domain 4: Command and Control	2	2			1
Domain 5: Training and exercising	4	3	1		1
Domain 6: Response	5	5			
Domain 7: Warning and informing	4	4			
Domain 8: Cooperation	4	4			
Domain 9: Business Continuity	10	10			
Domain 10: CBRN	10	9	1		1
TOTAL	58	56	2		
Overall compliance (%)	95.6%				

Deep Dive

Following key themes and common health risks raised as part of last year's annual assurance process, the 2023/24 EPRR annual deep dive focused on EPRR responder training. Note the deep dive does not contribute to the overall compliance level but may affect relevant Core Standards:

Deep Dive	Total applicable	Fully compliant	Partially compliant	Non compliant	Agreed actions
Training	10	10			

4. Assurance Review Outcomes

Assurance Meeting Outcomes

The organisation received Amber or Red ratings for the following Core Standards:

- Command and Control – Trained on-call staff.
- Hazmat/CBRN – Exercising.

Full details can be found in Appendix A.

Agreed Actions

Identified areas of good practice

The following areas of good practice were identified:

- Use of the EPRR core standards self-assessment document throughout the year to track EPRR compliance and ongoing improvements made against the standards.
- Very comprehensive EPRR annual report to the organisations board.
- Strong links between the EPRR responsible NED and the audit committee process
- Process for assessing and tracking newly identified risks, including maintaining a watching brief.
- Overall Governance process for EPRR and Risk Management

5. Next Steps: Action Plan and Governance

This report should be signed off by EPUT's Accountable Emergency Officer and formally reported to the organisations Board or Executive.

6. Conclusion

EPUT have continued to make excellent progress against the EPRR Core Standards and are demonstrating numerous areas of best practice. This is all the more impressive when considering the ongoing disruption and challenges to healthcare at present and the size of the EPRR resource. The team and I are looking forward to seeing the development of the organisations inhouse automated BCM dashboard. On behalf of NHS Mid and South Essex ICB thank you for your hard work and support working for the good of our patients and communities.

Jim Cook

Deputy Director for EPRR, Operations and Resilience

Appendix A – 2023 EPRR Core Standards Assurance: Outcome and Action Plan

	Previous Years Rating (2022/23)	2023/24 Rating Self-Assessment	2023/24 Rating Agreed
Overall Compliance Rating	Substantially complaint	Substantially complaint (↔)	Substantially complaint (↔)

ID	Domain	Core Standard	2022/23 Rating	2023/24 Rating Self-Assessment	2023/24 Rating Agreed	Action	Owner	Timescale
1	Governance	Senior Leadership						
2	Governance	EPRR Policy Statement						
3	Governance	EPRR Board Reports						
4	Governance	EPRR Work Programme						
5	Governance	EPRR Resource				ICB to conduct a benchmarking exercise regarding resourcing across the region. EPUT to review system benchmarking when available.	Jim Cook & Jo Martindale Nigel Leonard	December 2023 March 2024
6	Governance	Continuous Improvement						
7	Duty to risk assess	Risk Assessment						
8	Duty to risk assess	Risk Management						

9	Duty to maintain plans	Collaborative Planning						
10	Duty to maintain plans	Incident Response						
11	Duty to maintain plans	Adverse Weather				Sign-off changes to the Cold Weather Plan following review to align to UKHSA Adverse Weather and Health Plan	Amanda Webb	November 2023
12	Duty to maintain plans	Infectious disease						
13	Duty to maintain plans	New and emerging pandemics						
14	Duty to maintain plans	Countermeasures						
15	Duty to maintain plans	Mass Casualty						
16	Duty to maintain plans	Evacuation and shelter						
17	Duty to maintain plans	Lockdown						
18	Duty to maintain plans	Protected individuals						
19	Duty to maintain plans	Excess fatalities						
20	Command and Control	On-call mechanism						
21	Command and Control	Trained on-call staff				Continue to escalate and seek improvements regarding on-call (particularly at a GOLD level) training compliance, with the AEO raising the importance of	Nigel Leonard	March 2024

						said training at a senior level.		
22	Training and exercising	EPRR Training						
23	Training and exercising	EPRR exercising and testing programme						
24	Training and exercising	Responder training						
25	Training and exercising	Staff Awareness & Training						
26	Response	Incident Co-ordination Centre						
27	Response	Access to planning arrangements						
28	Response	Management of business continuity incidents						
29	Response	Decision Logging						
30	Response	Situation Reports						
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	n/a	n/a	n/a			
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	n/a	n/a	n/a			
33	Warning and Informing	Warning and informing						
34	Warning and Informing	Incident Communication Plan						

35	Warning and Informing	Communication with partners and stakeholders						
36	Warning and Informing	Media Strategy						
37	Cooperation	LHRP Engagement						
38	Cooperation	LRF / BRF Engagement						
39	Cooperation	Mutual aid arrangements						
40	Cooperation	Arrangements for multi area response	n/a	n/a	n/a			
41	Cooperation	Health tripartite working	n/a	n/a	n/a			
42	Cooperation	LHRP Secretariat	n/a	n/a	n/a			
43	Cooperation	Information Sharing						
44	Business Continuity	BC Policy Statement						
45	Business Continuity	Business Continuity Management System scope and objectives						
46	Business Continuity	Business Impact Analysis/Assessment (BIA)						
47	Business Continuity	Business Continuity Plan (BCP)						
48	Business Continuity	Testing and Exercising						
49	Business Continuity	Data Protection and Security Toolkit						
50	Business Continuity	BCMS monitoring and evaluation						
51	Business Continuity	BC Audit						

52	Business Continuity	BCMS continuous improvement process						
53	Business Continuity	Assurance of commissioned providers / suppliers BCP's						
54	Business Continuity	Computer Aided Dispatch	n/a	n/a	n/a			
55	Hazmat/CBRN	Governance	New for 2023					
56	Hazmat/CBRN	Hazmat/CBRN risk assessments						
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	New for 2023					
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements						
59	Hazmat/CBRN	Decontamination capability availability 24 /7	New for 2023	n/a	n/a			
60	Hazmat/CBRN	Equipment and supplies						
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	New for 2023					
62	Hazmat/CBRN	Waste disposal arrangements	n/a					
63	Hazmat/CBRN	Hazmat/CBRN training resource	New for 2023					
64	Hazmat/CBRN	Staff training - recognition and decontamination						
65	Hazmat/CBRN	PPE Access						
66	Hazmat/CBRN	Exercising	New for 2023			Continue the roll of out of these exercises across the whole organisation.	Amanda Webb	March 2024

67	CBRN Support to acute Trusts	Capability	n/a	n/a	n/a			
68	CBRN Support to acute Trusts	Capability Review	n/a	n/a	n/a			
69	CBRN Support to acute Trusts	Capability Review Frequency	n/a	n/a	n/a			
70	CBRN Support to acute Trusts	Capability Review report	n/a	n/a	n/a			
71	CBRN Support to acute Trusts	Train the trainer	n/a	n/a	n/a			
72	CBRN Support to acute Trusts	Aligned training	n/a	n/a	n/a			
73	CBRN Support to acute Trusts	Training sessions	n/a	n/a	n/a			

Deep Dive

ID	Domain	Core Standard	2023/24 Rating Self-Assessment	2023/24 Rating Agreed	Action	Owner	Timescale
1	EPRR Training	EPRR TNA					
2	EPRR Training	Minimum Occupational Standards					
3	EPRR Training	EPRR staff training					
4	EPRR Training	Senior Leadership Training					
5	EPRR Training	Access to training materials					
6	EPRR Training	Training Data					

7	EPRR Training	Monitoring					
8	EPRR Training	JESIP doctrine					
9	EPRR Training	Continuous Improvement process					
10	EPRR Training	Evaluation					

12.3 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

Information Item | Dr Milind Karale | 5 minutes

REFERENCES

Only PDFs are attached

Safe Working Junior DRs report Nov 2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Safe Working Hours of Junior Doctors, Quarterly Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr P Sethi, Consultant Psychiatrist					
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 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
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*	Yes/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to Dr Karale.	

Purpose of the Report		
This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors Committee is asked to:

1 Note the contents of the report

Summary of Key Issues

- There are 4 Exception Reports raised by trainees between July and September 2023.
- Trust is fined for an exception report raised by a senior trainee for stepping down in their role as a junior doctor to cover the weekend on call. Please see the details in the main report. There are gaps in the on call rota which are filled by MTI and LAS doctors. No agency locums were used.
- Gaps in the rota are slightly more compared to the last quarter, but the number of posts have increased by 15.
- Junior Doctors participated in the industrial action in July, August and September 2023. In total 953.5 hours were covered by internal locums. Trust spent £106.556 to cover the gaps in the shifts in order to ensure patient safety and smooth running of the services.

- Study leave policy needs a review and update, this was discussed at JLNC.
- Senior trainees lack opportunity to conduct Mental Health Act assessments during on-call periods, matter has been escalated to the Medical Director.

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			
MTI	Medical Training Initiative	LAS	Locum Appointment Service
JLNC	Joint Local Negotiating Committee		

Supporting Reports/ Appendices /or further reading
Quarterly Report on the Safe Working of Junior Doctors Pay & Conditions Circular (M&D) 4/2023 7 August 2023

Lead
Dr Milind Karale  Executive Medical Director

Quarterly Report on Safe Working of Junior Doctors

1 Purpose of Report

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

This is the twenty fifth quarterly report submitted to the Board on Safe Working of Junior Doctors for the period 1 July 2023 to the 30 September 2023 The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reports: A total of 4 Exception reports were raised in this quarter.

22 August 2023: Exception report raised by senior trainee for working extra 1 hour 30 minutes on the ward due to work load. Time off in lieu was given.

23 August 2023: 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.

30 August 2023: 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 Doctor will be paid £670.25 as per the stepping down guidance. The Trust will be fined and the Guardian will receive £1116.95 (as per the 2023 Pay and Conditions circular (M&D) 4/2023 guidance). The Guardian will use this money for the welfare of the Junior Doctors. The Human Resources department is liaising with finance department to set up this fine in a separate budget code.

4 September 2023: 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.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 2 August 2023

Doctors in Training Data

Total number of posts	**158**
Number of doctors in training posts (total inclusive of GP and Foundation)	**158**
Number of doctors in psychiatry training on 2016 Terms and Conditions	**93**
Total number of vacancies	**11**
Total vacancies covered LAS/ MTI/Agency	**7**
Total gaps	**4**

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick/COVID	172	172	0	1649	1649
Total	172	172	0	1649	1649

Junior Doctor Industrial Action

There have been three episodes of industrial action taken by junior doctors (13 - 17 July 23, 11 - 14 August 2023 and 20 - 22 September 2023) The Trust ensured that patient safety was not compromised and a shadow rota was set up so that there was both day and night cover across all five areas of the Trust. On the 20 September 2023 both junior doctors and consultants took joint industrial action and the doctors scheduled to be on call were required to work as there was a Christmas Day service provision.

In total 953.5 hours were covered by internal locums and a total of £106,556 was spent on the shadow rota and daytime cover where authorised for all periods of industrial action.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.
3. 11 Fellows under the EPUT Advanced Fellowship programme have been appointed last year

The number of vacancies and gaps in the rota are slightly higher compared to the last quarter, however the number of posts have increased by 15 compared to the last quarter.

Fines: The Trust was fined for an exception report raised by a senior trainee for stepping down to do a junior role during their on-call. The Doctor will receive £670.25 and Guardian will receive £1116.95 (which will be sent to trainee's budget) as per the guidelines. The money will be used for the welfare of the junior doctors. Please refer to page 11 on the "Pay and Circular conditions" document attached with this report.

Issues Arising:

1. Junior Doctors felt supported by the Trust on the recent Industrial Actions.
2. Study leave policy needs to be updated and in line with the Health Education England policy, this has been discussed in JLNC.
3. Senior trainees raised concern on the lack of opportunity to conduct Mental Health Act assessments during their on-call periods (as doctors from outside the Trust are being called by AMPH services). This matter has been escalated to Medical Director and data gathering is in process.

3 Action Required

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

On behalf of:

Dr Milind Karale
Executive Medical Director

7 August 2023

Pay and Conditions Circular (M&D) 4/2023

Pay award for hospital medical and dental staff, doctors and dentists in public health, the community health service and salaried primary dental care (England)

Summary

This circular informs employers of the pay arrangements for staff covered by the national medical and dental terms and conditions of service in England, which apply from 1 April 2023.

Action

The revised national salaries, fees and allowances set out in this circular apply in full with effect from 1 April 2023. Please implement the new awards as soon as possible.

Increases to national salary scales from 1 April 2023

1. Salary scales for medical and dental consultants have been increased by 6% to basic pay from 1 April 2023.

2. Salary scales for doctors and dentists in training have been increased by 6% to basic pay, plus an additional consolidated increase of £1,250 to each pay point, from 1 April 2023.

3. Salary scales for the staff grade, specialty and associate specialist group of practitioners on pre-2021 contracts have been increased by 6% to basic pay from 1 April 2023. Salary scales for specialty doctors on the 2021 contract and the specialist grade have been increased by 3% on top of the basic pay rates for 2023/24 which were set out in the 2021 Framework agreement. The figures in Pay Circular 2/2023 have been superseded by these new rates as of 1 April 2023.

4. The value of Flexible Pay Premia has been increased by 6% from 1 April 2023.

5. The values of Local Clinical Excellence Awards, National Clinical Impact Awards, and predecessor awards are unchanged.

Salaried Primary Care Dental Staff

6. The pay scales for salaried primary care dental staff have been increased by 6% to basic pay from 1 April 2023.

Salaried GPs

7. The minimum and maximum of the pay range for salaried GPs employed on the salaried GP contract have been increased by 6% to £68,975 and £104,085 respectively from 1 April 2023.

Dental Foundation Training (DFT) Payments

8. Following dental qualification, it is compulsory for dentists to undertake a year of training with a primary care provider if they intend to work in the NHS. This year is called Dental Foundation Training (previously known as the Vocational Dental Practitioner year). During this period, they are paid an allowance. This allowance is set through the General Dental Services Statement of Financial Entitlements (Foundation Training Amendments) Directions issued annually by the Department of Health and Social Care. Historically this value has been included in this circular for information. The value of this payment is confirmed following the publication of the GDS SFE (FTA) Directions and will now be published in a separate circular.

GP and Dental Educator Payments

9. The GP and Dental Educator pay scales have been increased by 6% to basic pay from 1 April 2023.

Enquiries

10. Employees must direct personal enquiries to their employer. NHS Employers cannot advise on individuals' personal circumstances.

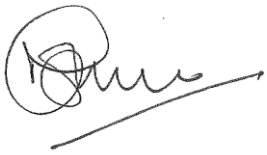
11. Employers should direct enquiries to: doctorsanddentists@nhsemployers.org.

12. Copies of this circular can be downloaded from: www.nhsemployers.org.

13. Prior to the establishment of NHS Employers in November 2004, responsibility to inform the NHS of changes to pay and allowances rested with the Department of Health and Social Care. Changes were published in Advance Letters. Copies of Advance Letters going back to 2000 may be obtained from the national archives: http://www.webarchive.org.uk/wayback/archive/20060506120000/http:/www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/AdvancedLetters/fs/en.html

14. For Advance Letters prior to 2000, please contact the Department of Health and Social Care: https://contactus.dhsc.gov.uk/

Issued by



Paul Wallace
Director of Employment Relations and Reward
NHS Employers

Pay and Conditions Circular (M&D) 4/2023

Pay award for hospital medical and dental staff, doctors and dentists in public health, the community health service and salaried primary dental care (England)

Contents

Annex A: Section 1: Doctors and Dentists in training (2016 contract) basic salary and allowances

Doctors in training basic pay

Grade	Stage of training	Grade code	Nodal point	Value (£)
Foundation Doctor Year 1	FY1	MF01	1	32,398
Foundation Doctor Year 2	FY2	MF02	2	37,303
Specialty Registar (StR) (Core Training)	CT1	MC51	3	43,923
	CT2	MC52		
	CT3	MC53	4	55,329
Specialty Registrar (StR) (Run-Through Training) / Specialty Registrar (StR) (Higher-Training) / Specialist Registrar (SpR)	ST1 / SpR1	MS01	3	43,923
	ST2 / SpR2	MS02		
	ST3 / SpR3	MS03	4	55,329
	ST4 / SpR4	MS04		
	ST5 / SpR5	MS05		
	ST6 / SpR6	MS06	5	63,152
	ST7 / SpR7	MS07		
	ST8 / SpR8	MS08		

Dentists* in training basic pay

Grade	Stage of training	Grade code	Nodal point	Value (£)
Dental Core Training	CT1	MC51	3	43,923
	CT2	MC52		
	CT3	MC53	4	55,329
Dental Specialty Training *(note, in dental specialties only, dentists begin Specialty Training at ST1 following Dental Core Training, instead of ST3/4. This is purely a result of nomenclature used in dental training. Therefore all dentists in Dental Specialty Training (ST1 onwards) should be placed on nodal point 4).*	ST1	MS11	4	55,329
	ST2	MS12		
	ST3	MS13		
	ST4	MS14	5	63,152
	ST5	MS15		
	ST6	MS16		
	ST7	MS17		
	ST8	MS18		

*For doctors in Oral and Maxillofacial Surgery training programmes, refer to the Doctors in training table above.

The grade codes above must only be used for doctors and dentists in national training posts. They must not be used for doctors other than doctors in training, as defined in the terms and conditions of service.

Employers wishing to pay doctors on local contracts (trust doctors, clinical fellows etc) under pay arrangements that mirror those for doctors in training must use the following grade codes:

Nodal point 1 (£32,398) local appointment grade code – MT01
Nodal point 2 (£37,303) local appointment grade code – MT02
Nodal point 3 (£43,923) local appointment grade code – MT03
Nodal point 4 (£55,329) local appointment grade code – MT04
Nodal point 5 (£63,152) local appointment grade code – MT05

There is however no requirement to use these pay values for such appointments, as local terms and conditions of employment are a matter for local determination.

On-call availability allowance*

Nodal point	Value (£)
1	2,592
2	2,985
3	3,514
4	4,427
5	5,053

* payable only to doctors working on-call rotas, as defined in paragraphs 9-13 of Schedule 2 of the 2016 TCS.

LTFT allowance

A doctor who is training less-than-full time will be paid an annual allowance of £1,000. This allowance will be paid on top of the doctor's salary and will be spread over the year, paid in monthly instalments.

Those trainees who are in receipt of the £1,500 transitional LTFT allowance, which was introduced under the terms of the 2016 contract, will continue to receive this as per Schedule 15, but will not receive the £1,000 permanent allowance on top of this. Once their entitlement to the transitional £1,500 allowance ends, they will then be eligible to receive the £1,000 allowance.

Weekend allowance

A doctor rostered to work at the weekend (defined as one or more shifts/duty periods beginning on a Saturday or a Sunday) at a minimum frequency of 1 in 8 across the length of the rota cycle will be paid an allowance. These will be set as a percentage of full time basic salary in accordance with the rates set out in the table below:

		Nodal point 1	Nodal point 2	Nodal point 3	Nodal point 4	Nodal point 5
Frequency	Percentage	Value (£)	Value (£)	Value (£)	Value (£)	Value (£)
1 in 2	15%	4,860	5,596	6,589	8,300	9,473
<1 in 2 – 1 in 3	10%	3,240	3,731	4,393	5,533	6,316
<1 in 3 – 1 in 4	7.50%	2,430	2,798	3,295	4,150	4,737
<1 in 4 – 1 in 5	6%	1,944	2,239	2,636	3,320	3,790
<1 in 5 – 1 in 6	5%	1,620	1,866	2,197	2,767	3,158
<1 in 6 – 1 in 7	4%	1,296	1,493	1,757	2,214	2,527
<1 in 7 – 1 in 8	3%	972	1,120	1,318	1,660	1,895
<1 in 8	No allowance	No allowance	No allowance	No allowance	No allowance	No allowance

The weekend allowance for less than full time (LTFT) staff is explained in schedule 2 paragraph 6 of the 2016 TCS.

Flexible pay premia

Table 1:

Name of premium	Applicable training programme		Eligibility	Full time annual value (£)
Hard to fill training programmes	General Practice	Payable to ST1, ST2, ST3, ST4 during general practice placements only.	9,693	
	Psychiatry Core Training	Payable to Psychiatry Core Trainees.	3,941	
	Psychiatry Higher Training	Payable to Psychiatry Higher Trainees.	3 year higher training programme:	3,941
			4 year higher training programme:	2,956
	Emergency Medicine	Payable to ST4 and above only.	Dependent on length of training programme, see table 2 below.	
Dual qualification – OMFS	Oral and Maxillofacial Surgery, as per paragraph 42-44 of Schedule 2 of the TCS	Payable to ST3 and above only.		
Histopathology	Histopathology	Payable to ST1 and above only	4,729	
Academia	As per paragraphs 36-41 of Schedule 2 of the TCS	Upon return to training following successful completion of higher degree.	4,729	

Table 2:

Length of training programme*	Full time annual value (£)
3 years	7,881
4 years	5,911
5 years	4,729
6 years	3,941
7 years	3,378
8 years	2,956

Note.

This is the length of the eligible training programme as specified by the curriculum, it is not the number of years that any particular trainee has remaining on their eligible training programme. For example, trainees joining an eligible training programme part way through their training programme or transferring to the 2016 TCS part way through their training programme will not be entitled to the full FPP amount.

The FPP values listed in table 2 above are payable to Emergency Medicine (from ST4 and above) and dual qualified OMFS trainees (from ST3 and above). The total amount (£23,643) is divided over the eligible years of training, meaning that if a trainee is due to receive their certificate of completion of training (CCT) following completion of their ST6 year, they should receive £7,881 per annum for the three years (ST4, ST5, and ST6).

The Psychiatry pay premium is applied to the full length of the training programme. The total amount is evenly distributed between the two applicable parts of the programme so that £11,823 is available in core training and £11,823 in higher training. The length of training in each applicable part of the programme will be used to determine the annual value the trainee should receive, as set out in table 1 above.

The Histopathology pay premium is applied to any trainee entering the eligible training programmes of histopathology, forensic histopathology, diagnostic neuropathology, and paediatric and perinatal pathology at ST1 from August 2018 onwards.

Trainees will continue to be paid this annual amount until they exit this training programme, so if a trainee's CCT date is put back by a year, they should receive the annual amount for that additional year. LTFT trainees will receive the FPP amount pro-rata.

Trainees who transition or join the programme part-way through may only receive part of the FPP; for example, those who transition into ST5 of a programme where the annual FPP is £7,881 would receive £7,881 per annum for each of the remaining two years at ST5 and ST6 only, instead of the full £23,643.

Trainees who are pay protected under Schedule 15 Section 2 will not receive the FPP but will instead be paid as per the provisions of that section.

Note – doctors paid according to Schedule 15 section 2 are paid according to their previous incremental scale and banding system, therefore flexible pay premia do not apply to this group of doctors.

Note – for the purpose of Schedule 2 paragraphs 28-35, hard-to-fill training programmes are General Practice training programmes, Emergency Medicine training programmes at ST4 and above, and Psychiatry training programmes

Pay points for doctors in training transferring from Scotland, Wales, NI and Defence

Pay points for doctors in training transferring from Scotland are available here.

Pay points for doctors in training transferring from Wales are available here.

Pay points for doctors in training transferring from NI are available here.

Pay points for doctors in training transferring from defence medical training programmes are available here

Please note that these figures may be updated following the publication of updated pay scales for all four UK countries.

As per the 2016 TCS, Schedule 15 paragraph 1, doctors moving from Health Education England and Defence Medical training programmes, as well as those in the devolved nations, are eligible for transitional pay protection. The table on the next page is to be used for the purposes of calculating the basic salary of the total cash floor amount for doctors transitioning from training programmes set out in paragraph 5 for section 1 pay protection, or the basic salary for section 2 pay protection. The doctor's basic salary on the day before transition shall be protected at the value of the equivalent 2002 TCS value for *England* of the incremental pay point they moved from, as above. Defence medical trainees are to have their pay protected at the value of their salary the day before they took up training on the 2016 TCS.

As described in the TCS, in order to provide equity for trainees within a cohort, pay protection should be applicable until either the doctor exits training, or until four years of continuous employment have elapsed from the point that the doctor is first employed on these TCS, or four years from the date at which that trainee *would have* transferred with their relevant cohort of trainees had they been in England, whichever is the sooner. Those who have not received this protection to date will need to have their pay backdated accordingly

				ENGLAND	SCOTLAND	WALES	NI	DEFENCE
Grade	**Stage of training**	**Grade code**	**Pay Point**	**Value (£) for the purposes of applying 2016 DiT TCS Schedule 15 paragraph 9**				
Foundation Doctor Year 1	FY1	MF01	1 2 3	28,274 29,960 31,647	Pay Point Min Pay Point 1 Pay Point 2	Pay Point 1 Pay Point 2 Pay Point 3	Pay Point 1 Pay Point 2 Pay Point 3	OF1
Foundation Doctor Year 2	FY2	MF02	1 2 3	34,769 36,960 39,152	Pay Point Min Pay Point 1 Pay Point 2	Pay Point 1 Pay Point 2 Pay Point 3	Pay Point 1 Pay Point 2 Pay Point 3	OF2 (level 1) *Non-accredited*
Specialty Registrar (StR) (Core Training)	CT1	MC51	1 2 3 4	37,068 39,260 42,321 44,171	Pay Point Min Pay Point 1 Pay Point 2 Pay Point 3	Pay Point 1 Pay Point 2 Pay Point 3 Pay Point 4	Pay Point 1 Pay Point 2 Pay Point 3 Pay Point 4	OF2 (level 2) OF2 (level 3) OF2 (level 4) *Non- accredited*
	CT2	MC52						
	CT3	MC53	5 6	46,404 48,637	Pay Point 4 Pay Point 5 tra	Pay Point 5 Pay Point 6	Pay Point 5 Pay Point 6	
Specialty Registrar (StR) (Run-Through Training) / Specialty Registrar (StR) (Higher-Training) / Specialist Registrar (SpR)	ST1 / SpR1	MS01	1 2 3 4 5 6 7 8 9 10	37,068 39,260 42,321 44,171 46,404 48,637 50,871 53,103 55,336 57,570	Pay Point Min Pay Point 1 Pay Point 2 Pay Point 3 Pay Point 4 Pay Point 5 Pay Point 6 Pay Point 7^ Pay Point 8^ Pay Point 9^	Pay Point 1 Pay Point 2 Pay Point 3 Pay Point 4 Pay Point 5 Pay Point 6 Pay Point 7 Pay Point 8 Pay Point 9 Pay Point 10	Pay Point 1 Pay Point 2 Pay Point 3 Pay Point 4 Pay Point 5 Pay Point 6 Pay Point 7 Pay Point 8 Pay Point 9 Pay Point 10	OF2 (level 2) *Non-accredited*
	ST2 / SpR2	MS02						OF2 (level 3) *Non-accredited*
	ST3 / SpR3	MS03						OF2 (level 4) *Non-accredited*
	ST4 / SpR4	MS04						OF2 (level 5) *Non-accredited*
	ST5 / SpR5	MS05						OF3-OF5 (level 1)
	ST6 / SpR6	MS06						OF3-OF5 (level 2)
	ST7 / SpR7	MS07						OF3-OF5 (level 3)
	ST8 / SpR8	MS08						OF3-OF5 (level 4)

Penalty rates and fines

i) Penalty rates and fines for hours worked at the basic hourly rate.

Nodal point	Total hourly (x4) figure	Hourly penalty rate (£), paid to the doctor	Hourly fine (£), paid to the guardian of safe working hours
1	63.56	23.83	39.73
2	73.56	27.59	45.97
3	87.04	32.64	54.40
4	110.32	41.38	68.94
5	126.52	47.45	79.07

ii) Penalty rates and fines for hours worked at the enhanced hourly rate.

Nodal point	Total hourly (x4) figure	Hourly penalty rate (£), paid to the doctor	Hourly fine (£), paid to the guardian of safe working hours
1	87.08	32.64	54.44
2	100.78	37.79	62.99
3	119.25	44.72	74.53
4	151.14	56.68	94.46
5	173.34	65.01	108.33

For information on which hours attract a 37% enhancement see schedule 2 paragraphs 16-18 of the 2016 TCS.

Penalty rates are now fixed and are based on the NHSI locum rates as set out in pay circular 3/2018.

Annex A: Section 2: Consultant (2003 contract) basic salary and allowances

Threshold	Years completed as a consultant	Basic salary (£)	Period before eligibility for next threshold	Pay scale code	
				Substantive	Locum
1	0	93,666	1 year	YC72 Point 00	YC73 Point 00
2	1	96,599	1 year	YC72 Point 01	YC73 Point 01
3	2	99,532	1 year	YC72 Point 02	YC73 Point 02
4	3	102,465	1 year	YC72 Point 03	YC73 Point 03
5	4	105,390	5 years	YC72 Point 04	YC73 Point 04
	5	105,390	4 years	YC72 Point 05	YC73 Point 05
	6	105,390	3 years	YC72 Point 06	YC73 Point 06
	7	105,390	2 years	YC72 Point 07	YC73 Point 07
	8	105,390	1 year	YC72 Point 08	YC73 Point 08
6	9	112,356	5 years	YC72 Point 09	YC73 Point 09
	10	112,356	4 years	YC72 Point 10	YC73 Point 10
	11	112,356	3 years	YC72 Point 11	YC73 Point 11
	12	112,356	2 years	YC72 Point 12	YC73 Point 12
	13	112,356	1 year	YC72 Point 13	YC73 Point 13
7	14	119,323	5 years	YC72 Point 14	YC73 Point 14
	15	119,323	4 years	YC72 Point 15	YC73 Point 15
	16	119,323	3 years	YC72 Point 16	YC73 Point 16
	17	119,323	2 years	YC72 Point 17	YC73 Point 17
	18	119,323	1 year	YC72 Point 18	YC73 Point 18
8	19	126,281	-	YC72 Point 19	YC73 Point 19

Applicable ESR pay codes for this group of staff also include YC, YM, YK, and YL.

Awards open to new applications (CEAs and NCIAs)

Local Clinical Excellence Awards (from 1 April 2022)

The value of these awards will be determined locally. From 1 April 2022 the minimum amount invested and paid annually within each employing organisation will be no less than £7,900 per eligible full time equivalent (FTE) consultant, excluding on costs.

National Clinical Impact Awards

The national Clinical Impact Awards scheme, previously known as the national Clinical Excellence Awards, has been reformed. Further information on the reforms can be found at Gov.uk. National Clinical Impact Awards (CIAs), effective from 1 April 2022.

Awarded by ACCIA	
Level 1	20,000
Level 2	30,000
Level 3	40,000

Awards closed to new applications

Local Clinical Excellence Awards (granted between 1 April 2018 and 31 March 2021)

Awarded by local committees	
Unit Value of an employer-based award (equivalent to one point	3,092

Pre-2018 Local CEAs

Local clinical excellence awards granted prior to 1 April 2018 under existing local clinical excellence awards schemes in place as at 31 March 2018.

Awarded by local committees	
Level 1	3,016
Level 2	6,032
Level 3	9,048
Level 4	12,064
Level 5	15,080
Level 6	18,096
Level 7	24,128
Level 8	30,160
Level 9	36,192

National CEAs

The award structure as was applied under the previous National Clinical Excellence Awards scheme has been retained here for the purposes of applying protection arrangements as set out in Schedule 30 of the Terms and Conditions – Consultants (England) 2003.

Awarded by ACCEA	
Level 9 (Bronze)	36,192
Level 10 (Silver)	47,582
Level 11 (Gold)	59,477
Level 12 (Platinum)	77,320

Discretionary Points*

Pay Scale Code	1	2	3	4	5	6	7	8
MC10/KC10	3,268	6,536	9,804	13,072	16,340	19,608	22,876	26,144

Distinction Awards*

A+ award	77,415
A award	57,048
B award	32,601

*Information on Discretionary Points and Distinction Awards is included for those consultants in receipt of Discretionary Points and/or Distinction Awards which have not been subsumed by a new award under the current Clinical Excellence Awards scheme.

Other supplementary payments

Additional supplement for Directors of Public Health (Chief Officer Supplement) including those who are consultants in dental public health

Supplement band	Minimum	Maximum	Exceptional maximum
Band A (Regional Director of Public Health)	16,986	24,657	
Band B	6,577	13,168	16,986
Band C	5,499	10,959	13,168
Band D	4,384	8,766	10,959

This supplement is payable under both the pre 2003 and the current contract. Further information for the current contract can be found in Schedule 16 Terms and Conditions - Consultants (England) 2003 and for the pre 2003 contract in HSG(92)12. Note pay scales KE01 – KE31 are now closed, no further appointments should be made on these scales.

Intensity Supplements (paid yearly) – pre 2003 consultant contract only

Daytime intensity supplement	1,586
Out of hours intensity Band 1 (low intensity)	1,195
Out of hours intensity Band 2 (medium intensity)	2,382
Out of hours intensity Band 3 (high intensity)	3,560

Pay points for consultants transferring / transferred from the pre-2003 consultant contract to the 2003 consultant contract

Pay progression for consultants appointed before 31 October 2003.

Pay Scale	Seniority at transfer	Years after transfer before threshold level changes																		
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
YC51	1	93,666	95,130	99,532	102,465	105,390					112,356					119,323					126,281
YC52	2	94,398	96,599	102,465	105,390					112,356					119,323					126,281	
YC53	3	95,130	98,063	102,465	105,390				112,356					119,323					126,281		
YC54	4	95,868	99,532	102,465	105,390			112,356					119,323					126,281			
YC55	5	102,465	103,927	105,390				112,356					119,323					126,281			
YC56	6	103,927	105,390				112,356					119,323					126,281				
YC57	7	105,390					112,356					119,323					126,281				
YC57	8	105,390					112,356					119,323					126,281				
YC58	9	105,390				112,356					119,323					126,281					
YC59	10	105,390				112,356				119,323					126,281						
YC60	11	105,390				112,356			119,323					126,281							
YC61	12	105,390			112,356			119,323					126,281								
YC62	13	105,390			112,356		119,323					126,281									
YC63	14	105,390			112,356		119,323				126,281										
YC64	15	105,390			112,356	119,323				126,281											
YC65	16	105,390			112,356	119,323			126,281												
YC66	17	105,390		112,356		119,323		126,281													
YC67	18	105,390		112,356	119,323		126,281														
YC68	19	105,390	112,356		119,323		126,281														
YC69	20	105,390	112,356		119,323	126,281															
YC70	21-29	105,390	112,356	119,323	126,281																
YC71	30 +	112,356	119,323	126,281																	

*For consultants with seniority of 1, 3 or 5 years on transition, the first pay threshold is for transitional purposes.
Applicable pay codes for this group of staff also include YC, YM, YK and YL.

Annex A: Section 3: Specialty Doctor (2021 contract) basic pay

Specialty Doctor pay scale

Pay scale code	Years of experience	Basic Salary (£)
MC75 – 01	0	52,530
MC75 – 02	1	52,530
MC75 – 03	2	52,530
MC75 – 04	3	60,519
MC75 – 05	4	60,519
MC75 – 06	5	60,519
MC75 – 07	6	67,465
MC75 – 08	7	67,465
MC75 – 09	8	67,465
Threshold		
MC75 – 10	9	74,675
MC75 – 11	10	74,675
MC75 – 12	11	74,675
MC75 – 13	12	82,400
MC75 – 14	13	82,400
MC75 – 15	14	82,400
MC75 – 16	15	82,400
MC75 – 17	16	82,400
MC75 – 18	17	82,400

Annex A: Section 4: Specialist basic pay

Specialist pay scale

Pay scale code	Years of experience	Basic Salary
MC70 – 01	0	83,945
MC70 – 02	1	83,945
MC70 – 03	2	83,945
MC70 – 04	3	89,610
MC70 – 05	4	89,610
MC70 – 06	5	89,610
MC70 – 07	6	95,275

Annex A: Section 5: Salaried GP

Salaried GP salary range

Minimum	Maximum
68,975	104,085

GP Educators Pay scale

Point	Grade	Description	Indicator	Scale Value
GP00	KP01	Preparatory year course organiser or tutor	Contribution to backfill service provision in general practice	103,336
GP01	KP02	Established course organiser or tutor	Standard scale point for VTS course organisers, GP tutors and primary care tutors	107,643
GP02	KP03		Advanced point for special responsibilities and lead roles in developing new initiatives	111,226
GP03	KP04	Associate adviser, associate director, associate postgraduate dean	Standard scale point for associate directors, associate advisers. Period of maintenance work plus person professional development	115,538
GP04	KP05		Established lead work and lead on new initiatives	119,123
GP05	KP06		Lead role on national organisations that enhance deanery performance	122,711
GP06	KP07	Deputy director	Leadership role, sharing some director duties, footprint extends beyond the deanery, and wider than education management	127,018

Annex A: Section 6: Salaried Dental Staff

Terms and Conditions for Salaried Primary Care Dental Staff (2008)

	Salary Point	Salary (£)
Band A LD01	1	47,653
	2	52,947
	3	60,889
	4	64,860
	5	68,831
	6	71,479
Band B LD11	7	74,126
	8	76,773
	9	80,744
	10	82,730
	11	84,715
	12	86,701
Band C LD21	13	88,686
	14	91,334
	15	93,981
	16	96,628
	17	99,276
	18	101,923

- Salary point 7 is the entry level to Band B but is also the Extended Competency Point at the top of Band A.
- Salary point 13 is the entry level to Band C but is also the Extended Competency Point at the top of Band B.
- Salary points 13-15 represents those available to current Assistant Clinical Directors under the new pay spine.

Maximum salary points for band C managerial dentist posts are identified by complexity levels as follows:

Standard complexity maximum pay point 16
Medium complexity maximum pay point 17
High complexity maximum pay point 18

Service complexity, for band C managerial dentists, is represented as follows within the pay scale:

Service complexity				
		Standard	Medium	High
Pay point range	13			
	14			
	15			
	16			
	17			
	18			

Training supplement for Band A Salaried Primary Care Dentists

The training supplement for Band A salaried Primary Care Dentists with responsibility for the supervision of a Dental Foundation Trainee or an undergraduate dental student is as follows:

Year	Annual value (£)
From 1 April 2023	2,486

Indicative Training Allowance for Salaried Primary Care Dental Staff (for information only)

Adjustments to the Indicative Training Allowance (ITA) are determined by the general award to salaries under this contract as determined by the Review Body on Doctors' and Dentists' Remuneration. The values of the ITA since 1 April 2011 are as follows:

Year	Annual value (£)
From 1 April 2011	769
From 1 April 2012	769
From 1 April 2013	777
From 1 April 2014	777
From 1 April 2015	777
From 1 April 2016	785
From 1 April 2017	793
From 1 Oct 2018	809
From 1 April 2019	829
From 1 April 2020	852
From 1 April 2021	878
From 1 April 2022	917
From 1 April 2023	972

Dental Foundation Training (for information only)

The Dental Foundation Training salary is set through the Primary Dental Services Statement of Financial Entitlements Directions issued annually by the Department of Health and Social Care. The updated figure will be added to this circular for information when confirmed. Previous figures can be found in past medical and dental pay circulars.

Dental Educators Pay scale

Point	Grade	Description	Indicator	Scale Value
GP00	KP01	Preparatory or initial year for dental foundation training programme adviser, workforce development or transformation dental tutor (dentist)	Induction and probationary 12-month period	103,336
GP01	KP02	Established dental foundation training programme director or adviser, workforce development or transformation dental tutor (dentist)	Standard scale point for dental foundation training programme directors, advisers and dental tutors	107,643
GP02	KP03		Advanced point for special responsibilities and lead roles in developing new initiatives	111,226
GP03	KP04	Regional adviser or initial year of associate dean for dental foundation training	Standard scale point for regional VT adviser. Period of maintenance work plus personal professional development	115,538
GP04	KP05	Associate postgraduate dental dean	Established lead work and lead on new initiatives	119,123
GP05	KP06		Lead role on national organisations that enhance deanery performance	122,711

Annex A: Section 7: Locum appointments

Locum consultants should be employed on the 2003 consultant contract. Basic salary should be determined using Schedule 22 of the Terms and Conditions, and the consultant placed on the appropriate point of the YM73 scale set out in this document. Weekly consultant locum rates are calculated by dividing the appropriate point on the scale by 365 and multiplying the daily figure by 7. To calculate the rate per Programmed Activity, divide the weekly rate by 10.

Locum tenens rates for SAS doctors

SAS locums providing short-term cover can be paid the rates in the table below.

	Rate (£) per week	Rate (£) per programmed activity / notional half day
Specialty Doctor MC76	£1,007.50	£100.75
Specialist MC71	£1,610.00	£161.00
Specialty Doctor MC47 (CLOSED)	£1,077.70	£107.77
Associate Specialist 2008 MC42 (CLOSED)	£1,465.70	£146.57
Associate Specialist MC03 (CLOSED)	£1,264.23	£114.93
Part time Medical/Dental Officer (paras 94-105) ME11 (CLOSED)	N/A	£112.70
Hospital Practitioner MD02 (CLOSED)	N/A	£129.48
Staff Grade MH02 (CLOSED)	£1,066.20	£106.62

Annex A: Section 8: Pay for grades closed to new entrants

The Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 are applicable for the grades below. Information on closed grades is only included for practitioners who were placed on these scales prior to them being closed. No further practitioners should be placed on these grade codes.

Succeeded by 2016 TCS	Grade code	Min	1	2	3	4	5	6	7	8	9	10	11	12	13
Foundation Doctor Year 1	MN13	28,274	29,960	31,647											
Foundation Doctor Year 2	MN15	34,769	36,960	39,152											
Specialty Registrar (Core training)	MN39	37,068	39,260	42,321	44,171	46,404	48,637								
Specialty Registrar (FT)	MN35	37,068	39,260	42,321	44,171	46,404	48,637								
Specialty Registrar (full)	MN37	37,068	39,260	42,321	44,171	46,404	48,637	50,871	53,103**	55,336**	57,570**				
Dental Core Training (1)	MN21/KA01/LF21	N/A (3)	36,960	39,152	41,344	43,536	45,728**	47,920**							
Closed grades															
Specialist Registrar	MN25/KA31/LF25	38,619	40,470	42,321	44,171	46,404	48,637	50,871	53,103**	55,336**	57,570**				
Consultant pre 2003	MC21/KC11LC01/LC10	77,769	83,334	88,900	94,464	100,810									
Associate Specialist pre 2008	MC01	48,089	53,183	58,276	63,368	68,462	73,555	80,281	86,110	88,529*	91,685*	94,841*	97,997*	101,152*	104,311*
Staff Grade	MH01	43,504	46,958	50,411	53,865	57,319	60,771	64,225	67,678						
		MH03	**MH03**	**MH03**	**MH03**	**MH03**	**MH03**	**MH05**	**MH05**	**MH05**	**MH05**	**MH05**	**MH05**		
Staff Grade (2)	MH03/05	43,504	46,958	50,411	53,865	57,319	61,385	64,225	67,678	71,131*	74,585*	78,038*	81,493*		
SCMO	KB11	58,892	62,477	66,060	69,644	73,229	76,812	80,396	83,981						
CMO	KB01	41,676	43,932	46,188	48,445	50,701	52,957	55,213	57,471						
Hospital Practitioner	MD01-41	5,751	6,084	6,418	6,751	7,083	7,416	7,749							

*Discretionary points and optional points - guidance on application of discretionary points is contained in AL(MD)7/95, guidance on application of optional points is contained in AL(MD)4/97.
**To be awarded automatically except in cases of unsatisfactory performance, see AL(MD)7/98.

1. This scale is closed to new entrants and was previously listed as "Dental Trainees in Hospital Posts (DTHP)" and before that the SHO grade. Dental Core Training now falls under the 2016 TCS. Doctors should not be placed on this scale as the SHO grade closed in 2007.
2. This pay scale refers to Staff Grade practitioners employed under the Terms and Conditions outlined in AL(MD) 4/97.

LTFT Doctors and Dentists in Training (pre-2016 contract)

Foundation Doctor Year 1 Flexible Trainee	Grade code	Min	1	2
Annual Rate	MT57	28,274	29,960	31,647
F5	MT57	14,137	14,980	15,824
F6	MT57	16,965	17,976	18,989
F7	MT57	19,792	20,972	22,153
F8	MT57	22,620	23,968	25,318
F9	MT57	25,447	26,964	28,483

Foundation Doctor Year 2 Flexible Trainee	Grade code	Min	1	2
Annual Rate	MT58	34,769	36,960	39,152
F5	MT58	17,385	18,480	19,576
F6	MT58	20,862	22,176	23,492
F7	MT58	24,339	25,872	27,407
F8	MT58	27,816	29,568	31,322
F9	MT58	31,293	33,264	35,237

Specialty Registrar Flexible Trainee	Grade code	Min	1	2	3	4	5
Annual Rate	MT60	37,068	39,260	42,321	44,171	46,404	48,637
F5	MT60	18,534	19,630	21,161	22,086	23,202	24,319
F6	MT60	22,241	23,556	25,393	26,503	27,843	29,183
F7	MT60	25,948	27,482	29,625	30,920	32,483	34,046
F8	MT60	29,655	31,408	33,857	35,337	37,124	38,910
F9	MT60	33,362	35,334	38,089	39,754	41,764	43,774

Specialty Registrar Flexible Trainee	Grade code	Min	1	2	3	4	5	6	7	8	9
Annual Rate	MT59	37,068	39,260	42,321	44,171	46,404	48,637	50,871	53,103**	55,336**	57,570**
F5	MT59	18,534	19,630	21,161	22,086	23,202	24,319	25,436	26,552	27,668	28,785
F6	MT59	22,241	23,556	25,393	26,503	27,843	29,183	30,523	31,862	33,202	34,542
F7	MT59	25,948	27,482	29,625	30,920	32,483	34,046	35,610	37,173	38,736	40,299
F8	MT59	29,655	31,408	33,857	35,337	37,124	38,910	40,697	42,483	44,269	46,056
F9	MT59	33,362	35,334	38,089	39,754	41,764	43,774	45,784	47,793	49,803	51,813

Specialty Doctor 2008 contract (CLOSED to new entrants from April 2021)

Pay scale code	Scale value	Basic salary	Period before eligibility for next pay point
MC46-01	Min	46,958	1 year
MC46-02	1	50,973	1 year
MC46-03	2	56,193	1 year
MC46-04	3	58,991	1 year
MC46-05	4	63,022	1 year
Threshold 1			
MC46-06	5	67,037	2 years
MC46-07		67,037	1 year
MC46-08	6	71,142	2 years
MC46-09		71,142	1 year
MC46-10	7	75,249	2 years
MC46-11		75,249	1 year
Threshold 2			
MC46-12	8	79,356	3 years
MC46-13		79,356	2 years
MC46-14		79,356	1 year
MC46-15	9	83,461	3 years
MC46-16		83,461	2 years
MC46-17		83,461	1 year
MC46-18	10	87,568	-

Associate Specialist 2008 contract (CLOSED to new entrants from 1 April 2008)

This grade closed on 1 April 2008, and no new entrants should be placed on this grade. Doctors on the pre 2008 Associate Specialist contract can elect to transfer to the 2008 Associate Specialist contract.

Pay scale code	Scale value	Basic salary	Period before eligibility for next pay point
MC41-01	Min	65,837	1 year
MC41-02	1	71,130	1 year
MC41-03	2	76,421	1 year
MC41-04	3	83,409	1 year
MC41-05	4	89,465	1 year
Threshold 1			
MC41-06	5	91,978	2 years
MC41-07		91,978	1 year
MC41-08	6	95,257	2 years
MC41-09		95,257	1 year
MC41-10	7	98,536	2 years
MC41-11		98,536	1 year
Threshold 2			
MC41-12	8	101,814	3 years
MC41-13		101,814	2 years
MC41-14		101,814	1 year
MC41-15	9	105,093	3 years
MC41-16		105,093	2 years
MC41-17		105,093	1 year
MC41-18	10	108,375	-

Annex A: Section 9: Mileage and transport allowances (excluding the 2016 contract)

Note – the rates below are not relevant for practitioners employed on the 2016 contract. These practitioners are reimbursed at the rates set out in Section 17 of the NHS Terms and Conditions of Service Handbook.

1. Public transport rate: 24 pence per mile.
2. Regular user rates:

Motor cars with three or four wheels:

Engine capacity	(cc)	**501 - 1,000**	**1,001 - 1,500**	**Over 1,501**
Lump sum	(£)	508	626	760
Up to 9,000 miles	(pence)	29.7	36.9	44
Over 9,001 miles	(pence)	17.8	20.1	22.6

A practitioner using a four-wheeled car under 501cc shall be paid at the rates for cars of 501 to 1,000cc engine capacity.

3. Standard rates:

Motor cars with three of four wheels:

Engine capacity	(cc)	**501 - 1,000**	**1,001 - 1,500**	**1,501 - 2,000**	**Over 2,000**
Up to 3,500 miles	(pence)	37.4	47.3	58.3	58.3
3.501 - 9,000 miles	(pence)	23	28.2	33.5	41
9,001 - 15,000 miles	(pence)	17.8	20.1	22.7	25.5
Over 15,001 miles	(pence)	17.8	20.1	22.6	22.6

4. Other motor vehicles (Includes motor cycles and combinations, motor scooters, mopeds and motor-assisted bicycles):

Engine capacity	(cc)	**Up to 125**	**Over 125**
Up to 5,000 miles	(pence)	17.8	27.8
Over 5,000 miles	(pence)	6.7	9.9

5. Passenger allowance: 5 pence per mile for each passenger.

6. Pedal cycles: For local agreement, subject to a minimum of 10 pence per mile.

Lease Cars (Crown Cars), private use:
Where the cost to the employing authority of hiring the car includes Road Fund Licence and/or Insurance, these items should be extracted and the net cost used in calculating the charge per 1,000 miles.

A. The current rates of:

Road fund licence, e.g.	£155
Insurance for private use (national call-off contract), e.g.	£88
Including cover for private use, e.g.	£128
Handling charge	£95

Crown Cars, while used solely on NHS business, are not required to be taxed or insured for the purposes of the Road Traffic Act 1972. Any private mileage requires that the vehicle be taxed and insured.

B. Fixed Annual Charge per 1,000 private miles (for each year of the contract or notional contract), determined as follows:

$$\frac{\left(\text{Cost of Contract Hire at maximum quoted mileage}\right) - \left(\text{Cost of Contract Hire at minimum quoted mileage}\right)}{1000}$$

Plus total excess costs for non-base vehicle, where appropriate,
Plus VAT on total charge to practitioner (A+B).

Annex A: Section 10: Other fees, charges and allowances

London weighting:	**Payable for each:**	Non-resident staff (£)	Resident staff (£)
London Zone from 1 April 2005	Year	2,162	602
Extra-territorially managed Units from 1 July 1979	Year	527	147
Fringe Zone 1 July 1981	Year	149	38

Para / Schedule (2002 TCS)	**Nature of fee**	**Payable for each:**	**Rate (£)**
32.b / Sch 10 & 11	Radiology and pathology tests (routine screening of employees)	Item of service	4.58
49	Medical Superintendent of Psychiatric Hospitals Allowance	Year	6,522.22
88	**Staff fund**		
	Payment for each eligible bed	Year	830
91.a	Payment for provision of a casualty service:		
	Higher rate	Year	10,231
	Lower rate	Year	5,116
	12 hours per day Monday to Friday	Year	3,658
91.b	Payment for each notional half-day of clinical work per week:	Year	5,819
91.b	Payment for one hour or less of clinical work per week	Year	1,549
91.b	Payment for one hour but not more than two hours of clinical work per week: (i.e. 2x hourly rate)	Year	3,098
93	Payment for each casualty seen, where the number is less than 200 per annum:	Casualty seen	33.43
94 & 105	Payment to part-time medical and dental officers: per weekly notional half day	Year	5,876
94 & 105	Maximum annual payment (i.e. for 9 sessions)	Year	52,884
94 & 105	Where the number of hours per week is not more than 2 (Payment for 1 hour or less)	Year	1,564
94 & 105	Payment for more than 1 hour but not more than 2 hours (i.e. twice hourly rate)	Year	3,128

Para / Schedule	**Nature of fee**	**Charge or Allowance**	
		Payable for each:	**Rate (£)**
141 & 142 / Sch 11	**Domiciliary consultations**		
	Standard Rate	item of service	104.28
	Intermediate Rate	item of service	52.14
143 / Sch 11	Maximum fee in connection with anti-coagulant therapy or treatment with cytotoxic drugs	series of visits	312.88
145 / Sch 10	Combined fee for completion of form CVI	item of service	159.05
	For re-examination (provided previous form CVI available)	item of service	135.88
146	Lower rate	item of service	26.12
155	Exceptional consultation by a consultant		195.36
157	Exceptional consultation by a general practitioner		64.49
165 / Sch 11	**Fees for lectures to nurses, etc**		
	Consultants	lecture	75.68
	Associate Specialists, Senior Registrars, Specialist Registrars at incremental point 3 or above, Hospital Practitioners and Practitioners holding appointments under paragraph 94.	lecture	59.97
	Other grades	lecture	44.06
166 / Sch 11	Lecture fee for Postgraduate Medical Education	lecture	95.86

Emergency rota allowance (in accordance with paragraph 25a-e)

Protected salary scale (Para 25a – e of the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002).

Emergency rota allowance (CMO/SCMO).

Number of duties	Rate per half year
4 to 11	230
12 to 17	460
18 to 23	690
24 to 29	920
30 to 35	1,150
36 to 41	1,380
42 to 47	1,610
48 to 53	1,840
54 to 59	2,070
60 to 65	2,300
66 to 71	2,530
72 or more	2,760

Annex A: Section 11: Family planning fees and miscellaneous

The following fees and allowances do not form part of the Terms and Conditions of Service for Hospital Medical and Dental Staff, and are included solely for the convenience of users. Employers should note the principles outlined in the relevant Terms and Conditions the doctor is employed under governing receipt of additional fees.

Family planning fees	Operating fee (£)	Anaesthetist's fee (£)
Fee per case of male sterilisation performed:		
a. as a separate procedure	150.06	74.04
b. during the course of another procedure	101.44	49.07
Fee per case of female sterilisation performed:		
a. as a separate procedure	202.87	99.08
b. during the course of another procedure	135.69	66.00
Fee for the reversal of male sterilisation	230.71	115.28
Fee for the reversal of female sterilisation	322.70	161.69
Fee per case for the insertion or removal (on family planning grounds) of an intra-uterine contraceptive device):		
a. as a separate procedure	101.44	74.04
b. during the course of another procedure	67.11	49.07
c. where the removal of a mis-placed device involves laparoscopy or laparotomy	322.70	161.69
Examination and report on pathological specimens referred in connection with NHS family planning cases	Case	27.78
Radiological services provided in connection with NHS family planning cases	Case	27.78
Notional half-day special family planning session	Session	172.52

Miscellaneous	£
Fee for College or Faculty nominee attending a consultant Advisory Appointment Committee:	
Full day	161.60
Half day	80.80

12.4 COUNCIL OF GOVERNORS RELATIONSHIP WITH THE BOARD OF DIRECTORS POLICY & PROCEDURE

Decision Item | Denver Greenhalgh | 5 minutes

REFERENCES

Only PDFs are attached

Governors Engagement with the Board Policy & Procedure.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 November 2023

Report Title:	**Council of Governors Policy & Procedure for Engagement with the Board of Directors**					
Report Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors Governance Committee Council of Governors 24 August 2023					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	n/a	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	n/a	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Council of Governors Policy & Procedure for Engagement with the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report.
2 Approve the reviewed Policy & Procedure.

Summary of Key Issues

The Council of Governors Policy and Procedure for Engagement with the Board of Directors provides the mechanisms in place for the Council to routinely engage with the Board of Directors and the action to be taken should there be a dispute. The policy and procedure are subject to three-yearly review.

The Assistant Trust Secretary completed a review of the Policy and Procedure with minor amendments made in relation to language and references to the new Code of Governance for NHS Providers. The Council of Governors Governance Committee considered the policy and procedure and agreed to recommend it for approval by the Council of Governors. The Council of Governors approved the policy and procedure at its meeting on the 24 August 2023.

The Board of Directors is asked to approve the policy and procedure.

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

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

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

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Council of Governors Policy for Engagement with the Board of Directors Council of Governors Procedure for Engagement with the Board of Directors

Lead
Denver Greenhalgh **Senior Director of Governance**

THE COUNCIL OF GOVERNORS POLICY FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

POLICY REFERENCE NUMBER:	CP56
VERSION NUMBER:	002
KEY CHANGES FROM PREVIOUS VERSION	n/a
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Council of Governors Governance Committee, Council of Governors, Board of Directors
IMPLEMENTATION DATE:	September 2020
AMENDMENT DATE(S):	n/a
LAST REVIEW DATE:	September 2023
NEXT REVIEW DATE:	September 2026
APPROVAL BY COUNCIL OF GOVERNORS	24 August 2023
APPROVAL BY BOARD OF DIRECTORS	TBC
COPYRIGHT	EPUT

POLICY SUMMARY
This Policy and associated Procedure outlines the mechanisms by which Governors and Directors will interact and communicate with each other. It supports their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.
The Trust monitors the implementation of and compliance with this Policy in the following ways:
This Policy will be subject to a three-year review, and monitored by the Trust Secretary's Officer.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Policy is the Senior Director of Corporate Governance

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS POLICY FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS POLICY & PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

Assurance Statement

The purpose of this Policy and associated Procedure is to ensure a process is in place for engagement between the Council of Governors and the Board of Directors. It includes when the Council of Governors need to engage with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence or the welfare of the Trust in line with the requirement Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023).*

1.0 INTRODUCTION

1.1. This Policy has been developed with the Council of Governors to take account of the recommendations in Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*to address engagement between the Council of Governors (Council) and the Board of Directors (Board).

1.2. The principles in this Policy may be applied to engagement between the Council and committees and working groups of the Council and the Board.

1.3. The Council of Governors (Council) is responsible for representing the interests of Trust members as a whole and the interests of the public.

1.4. The Council is required to hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board. This includes ensuring the Board does not act in a way which results in the Trust breaching the terms of its provider licence.

1.5. Governors are required to act in the best interests of the Trust and should adhere to its values and the Code of Conduct for the Council of Governors.

1.6. Governors are required to discuss and agree with the Board how they will undertake these duties and any other additional roles, giving due consideration to the circumstances of the Trust, the needs of the local community and emerging best practice. It is envisaged that the process used to exercise their responsibility will be one of mutual agreement between the Council and the Board.

1.7. This Policy and associated Procedure outlines the mechanisms by which the Council and the Board will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council has concerns about:

1.7.1. the performance of the Board of Directors

1.7.2. compliance with the Trust's provider licence

1.7.3. other matters related to the overall wellbeing of the Trust

1.8. The resolution of disputes between the Council and the Board is also covered in SO9 of the Council's Standing Orders and SO14.4 of the Standing Orders of the Board.

1.9. The relationship between the Council and the Board is also covered under SO 10 of the Council's Standing Orders and SO 15 of the Board's Standing Orders.

1.10. All new and / or revised Council of Governors procedures will include a section detailing action to be taken in circumstances where the Council disagrees with a recommendation made by the Board in any decisions requiring Council approval.

2.0 DEFINITIONS

In this Policy, the following definitions apply:

2.1 **Board of Directors (Board):** means the Board of Directors as constituted in accordance with the Trust's Constitution

2.2 **Chair:** means the person appointed in accordance with the Constitution to that position. The expression 'Chair' shall be deemed to include the Vice-Chair / Acting Chair if the Chair is absent from a meeting or otherwise unavailable

2.3 **Chief Executive (CEO):** means the CEO appointed in accordance with the Constitution

2.4 **Constitution:** means the Constitution of the Essex Partnership University NHS Foundation Trust

2.5 **Council of Governors (Council):** means the Council of Governors as constituted in accordance with the EPUT Constitution

2.6 **Director:** means a person appointed as a Director (whether an Executive Director or a Non-Executive Director) in accordance with the Constitution

2.7 **Governor:** means a member of the Council of Governors

2.8 **Independent Regulator:** is the regulator of Foundation Trusts as NHS England, following its incorporation of NHS Improvement

2.9 **Lead Governor:** is the Governor appointed by the Council of Governors in accordance with the Constitution

2.10 **Provider Licence:** means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006

2.11 **Regulatory Framework:** means the NHS Act 2006, Health & Social Care Act 2012, the NHS Provider Licence, and any directions or guidance issued by the independent regulator (NHS England)

2.12 **Standing Orders:** means the Standing Orders of either the Council of Governors or Board of Directors

2.13 **Trust:** means Essex Partnership University NHS Foundation Trust

2.14 **Trust Secretary:** means the secretary/company secretary of the Trust or any other person or body corporate appointed to perform the duties of the secretary of the Trust, including a joint/assistant or deputy secretary

3.0 KEY PRINCIPLES

3.1 Informal, formal and frequent communication between the Council and the Board are an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

3.2 Directors and Governors are expected to act in such a manner as to comply with this Policy.

3.3 Chair:

3.3.1 The Chair acts as the principal link between the Council and the Board and has the main role in dealing with issues raised by Governors, involving the Chief Executive and/or other Executive or Non-Executive Directors as necessary.

3.3.2 The Chair ensures that the Board and Council work together effectively and enjoy constructive working relationships (including the resolution of any disagreements).

3.3.3 The Chair ensures good information flow from and between the Board, Committees, Council and members.

3.3.4 The Chair ensures that the Council and Board receive accurate, timely and clear information that is appropriate for their respective duties.

3.3.5 The Chair constructs the agendas for both the Board and Council (with the input of others as appropriate).

3.3.6 The Chair has the most formal contact with Governors and should supplement with informal contact where possible.

3.3.7 The Chair shall:

(a) Operate an open door Policy

(b) Support informal meetings outside of formal Council meetings with the CEO and/or any Director (via the Trust Secretary Office) to answer questions or confirm decisions taken by the Board (where appropriate).

(c) Encourage the participation of Directors in induction and training of Governors.

3.4 Chief Executive:

3.4.1 The CEO ensures the provision of information and support to the Board and Council, and ensures that Board decisions are implemented.

3.4.2 The CEO facilitates and supports effective joint working between the Board and Council.

3.4.3 The CEO supports the Chair in their task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive Directors, elected and appointed members of the Council, and between the Board and Council.

3.4.4 The CEO with the Chair ensures that the Council and Board receive accurate, timely and clear information that is appropriate for their respective duties.

3.4.5 The CEO with the Chair constructs the agendas for both the Board and Council (with the input of others as appropriate).

3.5 Senior Independent Director (SID)

3.5.1 The SID acts as an alternative source of advice to Governors.

3.5.2 The SID is available to Governors and members if they have concerns, which contact through the normal channels of Chair, CEO and Executive Chief Finance officer has failed to resolve or for which such contact is appropriate.

3.6 Lead Governor and Governors

3.6.1 Individual Governors have a responsibility to raise concerns (as defined in this Policy) and to assure themselves that issues have been resolved.

3.6.2 The Lead Governor shall make themselves available to provide informal advice to any Governor who may seek it in advance of a concern being raised.

3.6.3 The Lead Governor will be the conduit for direct communication between NHS England and the Council. This would be in exceptional circumstances where every attempt has been made to resolve any concerns locally either through the Chair or any other Board member.

3.6.4 The Council as a body has a duty to inform NHS England if the Trust is at risk of breaching the terms of its provider licence.

3.7 Directors

Directors shall cooperate with any requests from the Chair (via the Trust Secretary Office) to attend informal meetings outside of formal Council meetings to answer questions from Governors and confirm decisions taken by the Board (where appropriate).

3.8 Trust Secretary

3.8.1 The Trust Secretary will be the first point of contact for any Governor or group of Governors who wish to raise a concern covered by this Policy.

3.8.2 The Trust Secretary will, where possible, resolve the matter informally and/or advise as to whether it is appropriate to take the concerns to the Chair.

3.8.3 The Trust Secretary will arrange informal meetings between Governors and Directors outside of formal Council meetings to answer questions and confirm decisions taken by the Board (where appropriate) where requested by the Chair.

4.0 SCOPE

4.1 This Policy applies to the Council of Governors and Board of Directors.

5.0 MONITORING AND REVIEW

5.1 The Senior Director of Corporate Governance has the overarching responsibility for this Policy.

5.2 The Trust Secretary is responsible for ensuring the Policy follows the appropriate Trust format and complies with the recognised development, consultation, and approval and ratification process.

5.3 This Policy will be kept under review and revised in accordance with any regulatory and/or statutory changes and emerging best practice and guidance.

5.4 Awareness of this Policy will be raised at Governor and Board induction.

5.5 In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this Policy and procedure in response to the identification of any gaps or because of the identification of risks arising from the Policy. This may be prompted by incident review, external reviews or other sources of information and advice including but not limited to commissioned audits and reviews, detailed data analysis, etc.

5.6 This Policy will be reviewed at least every three years; changes to legislation, guidance or the outcomes of any investigations or reviews may result in the Policy being reviewed earlier.

6.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION

- Code of Governance for NHS Providers (April 2023)
- Trust Constitution including Board of Directors and Council of Governors Standing Orders
- Code of Conduct for the Council of Governors
- Lead Governor Role Description
- NHS Providers *Foundations of good governance: a compendium of best practice* (3rd edition)
- (Monitor) NHSE *Your statutory duties: a reference guide for NHS foundation trust governors (2013) and Addendum (October 2022)*

END

THE COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

PROCEDURE REFERENCE NUMBER:	CPG56
VERSION NUMBER:	002
KEY CHANGES FROM PREVIOUS VERSION	n/a
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Council of Governors Governance Committee, Council of Governors, Board of Directors
IMPLEMENTATION DATE:	September 2020
AMENDMENT DATE(S):	n/a
LAST REVIEW DATE:	September 2023
NEXT REVIEW DATE:	September 2026
APPROVAL BY COUNCIL OF GOVERNORS	24 August 2023
APPROVAL BY BOARD OF DIRECTORS	TBC
COPYRIGHT	EPUT

PROCEDURE SUMMARY
This Procedure and associated Policy outlines the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. It describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.
The Trust monitors the implementation of and compliance with this Policy in the following ways:
This Procedure will be subject to a three-year review and monitored by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Procedure is The Senior Director of Corporate Governance

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

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COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

Assurance Statement

The purpose of this Procedure is to ensure there is a process in place for engagement between the Council of Governors and the Board of Directors. It also covers when the Council of Governors need to engage with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence or the welfare of the Trust in line with the requirement. Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*

1.0 INTRODUCTION

1.1. This Procedure has been developed by the Council of Governors to take account of the recommendations in Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*to address engagement between the Council of Governors (Council) and the Board of Directors (Board).

1.2. This Procedure outlines the mechanisms by which the Council and the Board will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council has concerns about:

1.2.1. the performance of the Board of Directors

1.2.2. compliance with the Trust's provider licence

1.2.3. other matters related to the overall wellbeing of the Trust

1.3. The resolution of disputes between the Council and the Board is set out under SO9 of the Council's Standing Orders and SO14.4 of the Standing Orders of the Board.

1.4. The relationship between the Council and the Board is set out under SO10 of the Council's Standing Orders and SO15 of the Standing Orders of the Board.

2 SCOPE

2.1 Informal, formal and frequent communication between the Council and the Board are an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

2.2 Directors and Governors are expected to act in such a manner as to comply with this Procedure.

3.0 ENGAGEMENT

3.1 A duty of the Council is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board.

3.2 Governors and Board Directors should have the opportunity to meet at regular intervals with Governors feeling comfortable in asking questions regarding the management of the Trust. Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community.

3.3 The relationship between the Council and Board is critical and should be based on the Trust's values (We Care, We Learn, We Empower) as well as respect, candour and trust. There are a number of ways an open and constructive relationship can be achieved between the two; these are not limited to the examples below:

- Receiving the agenda and minutes of Board meetings and requesting any specific papers
- Minutes of Part 1 Board of Director meetings and a summary of discussions for Part 2 Board of Director meetings
- Governors are invited to attend Board meetings and have the opportunity to ask questions of the Board on the agenda items
- Receiving quarterly finance, quality and performance update reports at Council meetings and asking questions on and/or challenging their content
- The attendance of the CEO, other Executive and Non-Executive Directors at Council meetings and using these opportunities to ask them questions as required
- Confidential briefing session by the CEO prior to the quarterly Council meeting with opportunity to ask questions
- Attending Annual Members Meeting
- NEDs/Governors informal meetings and local constituency meetings
- Involvement of Governors at Quality visits with Executive and Non-Executive Directors
- Establishment of joint working groups, e.g. Membership Framework Task & Finish Group; Appointment of Auditors Working Group
- Briefing session by the ECFO on the annual accounts
- Receiving the annual report and accounts and asking questions on their content
- Receiving performance appraisal information for the Chair and other NEDs (through the Council's Remuneration Committee)
- Receiving information/being kept up to date on issues or concerns likely to generate adverse media (or in response to media coverage) and providing Governors with the opportunity to raise questions or seek information or assurances
- Receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions, and questioning Directors on these (in the first instance through the Governors Significant Transactions Group)

- Receiving relevant development sessions/workshops/briefings by Board Directors as appropriate ensuring that Governors are equipped with the skills and knowledge they require to fulfil their role

- Involvement of Governors in the Trust's strategy and planning process through attendance at the Trust's stakeholder planning event and also through a meeting of the Governors Strategic Planning Working Group

- Chair's report on the activities of the Non-Executive Directors at each Council meeting

- Reports from the chairs of Board standing committees highlighting the work and key issues reviewed by the committee on an annual rolling basis

- Views of Governors on the performance of the Chair are fed through the Senior Independent Director

- Your Voice meetings for members and the public in each of the Trust's constituencies.

4.0 RAISING CONCERNS

4.1 Governors should raise concerns through existing channels as outlined in section 3.0 of this procedure. Any concerns raised will, be recorded and monitored via the relevant committee (when raised formally) or via a Governor Requested Action Log (when raised informally).

4.2 Governor(s) should not raise concerns that are not supported by evidence. In raising their concerns, Governors will need to demonstrate the following:

4.2.1 any written statement must be from an identifiable person(s) who must sign the statement and indicate that they are willing to be interviewed about its content

4.2.2 other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

Newspaper or other media articles will not be accepted as prima facie evidence but may be accepted as supporting evidence.

4.3. The CEO as the Accounting Officer will routinely present reports on performance, finance and compliance at Board and Council public meetings. Any Governor or member of the public in attendance may also raise any concerns relating to the performance, finance and/or compliance through the Chair at these meetings at the time, to address issues in a timely manner.

4.4 If the above does not address the concerns of the Governor(s), para 19.3 of the Trust's Constitution may be invoked. The clause states that the Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties.

4.5 While recognising the key role of the Chair in providing the link between the Council and the Board, if concerns are identified and persist, any Governor(s) who have concerns covered by this Policy should:

4.5.1 in the first instance, consult the Trust Secretary for advice and guidance and who will seek to resolve the matter informally. The Trust Secretary will advise the Governor(s) on the issues raised and whether it is appropriate to take their concerns to the Chair

4.5.2 the advice of the Trust Secretary, however, is not binding upon the Governor(s) concerned who retain at all times the right to raise the matter with the Chair directly

4,5.3 if the above steps fail to resolve the matter or contacting the Trust Secretary or Chair (in the case of his/her own performance) was felt inappropriate, the Governor(s) should contact the SID to address the concerns

4.6 The Chair will investigate all concerns brought to them by Governors involving the Chief Executive and/or other Board members. The investigation will include a review of the evidence offered and discussions with Trust officers as appropriate.

4.7 As soon as practicable after the conclusion of the investigation, the Chair and Trust Secretary (or SID) will meet with the Governor(s) to discuss the findings. This meeting has three possible outcomes:

4.7.1 Governor(s) are satisfied their concerns were unjustified and withdraw them unreservedly; in this case, no further action is required

4.7.2 Governor(s) are satisfied their concerns have been resolved during the course of the investigation. The Chair will write a report on the concerns and the actions taken and present this at a closed session of the next scheduled meeting of the Council. If the majority of those Governors present at the meeting agree that the matter is resolved, then no further action is required. However, should a majority of the Council in attendance disagree, the process for escalation described in section 5 will be initiated

4.7.3 The matter is not resolved to the satisfaction of the Governors. The Chair will call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution to consider the matter further. The meeting may choose either, to take no further action or, if the majority of those Governors present and voting agree, to initiate the escalation process described in Section 5. The Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties

4.8 The minutes of the meeting(s) shall record the outcome of the discussions.

5.0 ESCALATING CONCERNS

5.1 Where the matter is not resolved following the completion of steps outlined in section 4 then the following actions will be taken:

5.2 The SID takes over the lead role from the Chair. Should the SID be unavailable or prevented from participating because of a conflict of interest, then the Council may choose any other Non-Executive Director to fulfil the role.

5.3. The first duty of the SID is to establish the facts of the concern. This will be accomplished by reviewing the evidence offered by Governors, the process of the investigation and any documentation produced and by meetings/interviews with

Governors and any Trust officers involved. In carrying out this process, the SID will seek the agreement of all interested parties and will have the authority to commission whatever legal or other advice is required following internal protocols.

5.4 Once facts are established, to the SID's satisfaction, the SID will make a decision on the course of action to be followed in the best interests of the Trust and will describe the reasons for that decision in a written report. In the first instance, the SID will present the decision and the report to Governors and to interested parties within the organisation.

5.5 The Chair will at the SID's request, call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the SID to present their report and decision, and for the Council to give its response. Three outcomes are possible:

5.5.1 The Council accepts the SID's decision. No further action is necessary

5.5.2 The Council does not accept the SID's decision but chooses not to escalate the matter further. No action is prescribed by this Policy but the Council may choose to keep the matter under review at future meetings

5.5.3 The Council votes to make a formal notification to NHS England through the Lead Governor under the terms of guidance from NHS England

5.6 The timescale for completion of this process from raising the concern to receipt of the response should be no more than 14 calendar days unless there are exceptional circumstances resulting in agreement to an extension, which is acceptable to all parties.

6.0 DISAGREEMENTS BETWEEN THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

6.1 It is important that the Council of Governors discusses and agrees with the Board how it will undertake its statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice, as set-out in section 10.1 of the Standing Orders.

6.2 The Board of Directors must ensure the Council of Governors is provided with all information and involvement where a statutory decision by the Council is required.

6.3. For any statutory decisions to be made by the Council of Governors a report will be presented establishing the context and process followed and make a recommendation to the Council of Governors.

6.4 The Council of Governors should consider and discuss any recommendation made prior to approving or not approving the recommendation.

6.5 If the Council of Governors does not approve the recommendation, the Trust Secretary must ask the Council to provide a rationale and record this in the minutes of the Council of Governors.

6.6. The Trust Secretary will report to the Board of Directors that the recommendation has not been approved by the Council of Governors and provide the rationale provided.

6.7. The Board of Directors will determine if the non-approval of the recommendation creates a significant risk to the Trust and if so, request the Senior Independent Director (SID) to undertake mediation.

6.8. The SID will meet with Governors who did not approve the recommendation to understand the rationale and try to find a way forward.

6.9 Following mediation by the SID, the Board of Directors will decide the next steps to be taken, including re-presenting the resolution to the Council of Governors.

7.0 DISPUTES

7.1 Where a Governor is declared ineligible or disqualified from office or his term of office as a Governor has been terminated (other than a consequence of his own resignation) and that person disputes the decision, he shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive. The Chair and Chief Executive shall use their best endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute, which may have arisen but the Chair, and Chief Executive shall not be entitled to rescind or vary the decision, which has already been taken.

END

13. OTHER

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

Discussion Item | All | 2 minutes

13.2 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Discussion Item | All | 5 minutes

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

Discussion Item | All | 2 minutes

14. ANY OTHER BUSINESS

Discussion Item | All | 5 minutes

15. QUESTION THE DIRECTORS SESSION

Discussion Item | All | 10 minutes

16. DATE AND TIME OF NEXT MEETING

Information Item | Professor Sheila Salmon | 1 minute

Wednesday 31 January 2024