NHS
Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors

Wednesday 28 September 2022

EPUT

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 28 September at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION **Health Outreach – Supporting Marginalised Adults Across Suffolk** **Adrian Kirkby, Service Manager**			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 27 July 2022	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Board Standing Committees Annual Evaluation	DG	Attached	Noting
(c)	Safeguarding Annual Report	AW	Attached	Approval
(d)	Workforce Disability Equality Standard Data Analysis (WDES)	SL	Attached	Approval
(e)	Workforce Race Equality Standard Data Analysis (WRES)	SL	Attached	Approval
(f)	A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Report	MK	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Verbal	Noting
	(ii) Charitable Funds Committee	AS	Attached	Noting

	(iii) Finance & Performance Committee	LL	Attached	Noting
	(iv) Quality Committee	RH	Attached	Noting
	(v) People, Equality and Culture Committee	ML	To follow	Noting
(c)	Board Safety Oversight Group	AR-Q	Attached	Noting
(d)	Policy Oversight and Ratification Group	DG	Attached	Approval
9	**RISK ASSURANCE REPORTS**			
	(i) Ligature Risk Management Q1	AG	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
(a)	CQC Report and Action Plan	DG	Attached	Noting
(b)	Annual review of: • Standing Orders for the Board of Directors • Scheme of Reservation and Delegation (SoRD) • Detailed Scheme of Delegation • Standing Financial Instructions	DG	Attached	Approval
(c)	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2022	NL	Attached	Approval
11	**OTHER**			
(a)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(b)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(c)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(d)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 30 November 2022 at 10:00			
15	**DATE AND TIME OF FUTURE MEETINGS** TBC			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 27 July 2022
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Sean Leahy (SL)	Executive Director of People and Culture
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Administrator
Simon Covill	Director of Finance (for Trevor Smith)
Paula Grayson	Governor
Jason Gunn	Governor
Pamela Madison	Governor
Kristy Jaggard	Community Team Lead, South Uttlesford Community Nursing
Judith Woolley	EPUT Member
John Jones	Lead Governor
Keith Bobbin	Governor
Pippa Ecclestone	Governor
Matt Sisto	Head of Patient Experience
Johnny Townson	Senior Business Support Manager
Paul Walker	Governor

SS welcomed Board members, Governors, members of the public and staff joining this virtual meeting and reminded attendees of Microsoft Teams meeting etiquette.

The meeting commenced at 10:00

073/22 APOLOGIES FOR ABSENCE

Apologies were received from Mateen Jiwani, Loy Lobo and Trevor Smith. SS noted that SL would be leaving the meeting before the scheduled end due to an unannounced Ofsted inspection of the Trust.

074/22 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

Signed: …… Date: ……

In the Chair

075/22 PRESENTATION: CO-PRODUCTION AT THE HEART OF TRANSFORMATION

AG introduced a video that told the story of the integrated primary care approach in Thurrock, working with colleagues in the voluntary sector and social care to provide different types of care for people with mental illness. AG was very proud of this service and was delighted for the opportunity to showcase to the Board. AG confirmed that this also linked to the transformation piece for discussion later on the agenda.

The video described how within the Mid and South Essex system, a new model of care had been developed at primary care level to work with partners to meet patient needs in different ways with patient needs at the forefront. This model took a multi-disciplinary approach with close collaboration between system partners to break down barriers and allow patients to access appropriate treatment quickly and easily.

SS acknowledged that it was very powerful to hear from a service user within the video and demonstrated the way in which we are working around service user experience in partnership.

ARQ agreed that this was a fantastic presentation, commenting that in a previous role promoting integrated care in GP services, there had been many barriers and obstacles which had made the objective very difficult and was pleased to see this successful example of integrated working. ARQ also agreed that the service user voice is important to shape what services look like. ARQ did not underestimate the work that had gone on behind scenes to allow collaboration between system partners, adding that to hear different disciplines talking with one voice was an amazing achievement.

PS echoed ARQ's sentiment, stating that it was incredible to see this excellent example of co-design and service user engagement to improve people's lives. PS agreed that this model was a shift in the way we work, with integrated services blurring organisational boundaries requiring a lot of groundwork to build trust to enable this to flourish. AG stated that this was just one example of integrated working with initiatives also happening in other areas. AG continued that the model had been a success through like-minded people coming together from a range of disciplines and a range of organisations to work through cultural issues and bring down barriers between exclusion and inclusion criteria of services to focus on the needs of individuals. It is too early for formal evaluation at this time, however feedback and motivation of staff to be involved and deliver this and continuing feedback from service users indicates that the model is successful and well received. Throughout the presentation were examples of collaboration, partnership, working together, and removing barriers – these are the things that are difficult to measure but are key to success. AG acknowledged that there had also been a rise in demand in MH across the board and pondered how services may have coped if this model of working differently had not been initiated.

ML agreed that this was a stimulating presentation with comments from ARQ and PS setting the context of the challenges to implement this model, which further highlighted how impressive this achievement had been. ML queried whether this model could be rolled out across other areas in a systemised approach, acknowledging that this firmly anchored the Trust strategic objective to work with partners to improve services. AG confirmed that there is an ambition to bring together integrated and primary care services; West Essex services have also recently presented their community model. It is important to take overarching principles that have worked but also to allow local identity of the service to do what is right in each area. AG stated that there was an assurance that each of our areas and services are aligning to PCNs and delivering similar models of care.

ZT commented that this was a great example that showed what can be achieved in partnership and could be linked with all of our Trust strategic initiatives. ZT noted that change in legislation on 01 July with regards to the Health and Care Act really solidifies the common purpose of EPUT and partner

organisations across the health and care sector; this is a collective endeavour working with partners and would not be possible without engagement and commitment from all involved.

Regarding measuring outcomes, ARQ acknowledged that feedback from service users was important but suggested that there was a need to find a way of quantifying this feedback. ARQ sought assurance that systems and processes to capture this were in place. AG confirmed that this was the case; however it was too early to give meaningful data. AG also confirmed that there is a steering group in place to oversee the implementation of the model and capturing outcomes.

PS acknowledged the real challenge for health care in general following the change in legislation and change in approach. It is important to be able to articulate the impact of our changes on the health of the population

In terms of what next; the Executive Team are reviewing data regarding health inequalities and access to mental health services; this data highlights the disproportionate detention of people from the BAME community. There is potential for a platform to think about shaping our services for those that are not accessing services in a proportionate way and how we can adjust our services to encourage people to come forward when they need to. AG added that there is currently work being undertaken in Thurrock on a bid to strengthen some of our services in acknowledgment of some of the health inequalities as well as various pieces of work across the Trust.

All agreed that the presentation was a powerful start to the meeting which sets tone regarding partnerships happening across the organisation and system, and coproduction with service users. SS commented that the video platform was a good way of capturing and sharing the patient story and worked well to showcase what we are doing and how we are working across various ICS.

MK thanked Thurrock commissioners who worked closely with EPUT and were willing to commit resources and funds to enable delivery of this model.

076/22 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 25 May 2022 were agreed as an accurate reflection of discussions held.

077/22 ACTION LOG AND MATTERS ARISING

The action log was reviewed and noted that there were no other matters arising that were not on the action log or agenda. Responses to questions raised by governors were noted.

The Board discussed and approved the Action Log.

078/22 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

The Chair presented a report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust.

SS formally acknowledged the results of the recent Governor Election process and was pleased to welcome new Governors as well as pre-existing Governors successfully re-appointed to serve a further term. SS extended thanks to departing Governors their contribution – Peter Cheng, Michael Waller and Judith Wooley, as well as Nosi Murefo, Staff Governor.

NH extended congratulations to Mark Dale on the achievement of becoming a Platinum Champion. Mark has helped invest in the staff for the future, working with Student Nurses and Student AHPs and

acknowledged the passion he gives to his work. The Board of Directors congratulated Mark on this significant achievement.

The Board received and noted the Chair's Report.

079/22 CEO REPORT

PS acknowledged the significant pressures colleagues continue to face across the trust. Staff continue to work in an incredible way to meet the rise in demand of services seen across health and care as well as during the recent heatwave. Board members also acknowledged the dedication, compassion and resilience colleagues show. PS reported encouraging news from CAMHS Tier 4 services, noting the tremendous pressure in the height of pandemic and the restrictions imposed from CQC during that period. PS recognised the effort of the team during this challenging time, working incredibly hard to reset those services which had now seen restrictions lifted and are able to provide services as planned.

Across the Trust there is an ambition to think differently regarding innovation and how services are configured to meet changing needs. PS was pleased to report that the launch of the Time to Care initiative recently took place to generate ideas and give permission for creativity regarding how we think differently to deliver our services.

The Board received and noted the CEO's Report.

080/22 QUALITY AND PERFORMANCE SCORECARD

People and Culture
SL acknowledged perseverance and dedication of colleagues during a sustained challenging period, adding that there is a commitment to enhancing systems and looking at new systems to enable the organisation and the people we serve to be more effective; adding that ease of use for people systems is essential. A new e-expense system has recently been implemented and a new Occupational Health referral management tool is to be launched. Work continues to review the optimisation of the electronic staff record, which will also improve reporting and data.

The Annual Employee Relations Activity Report for 2021/22 was presented to the People, Equality and Culture Committee (PECC) and SL was pleased to see the reduction from 84 cases in 2020/21 down to 33 in 2021/22. This demonstrated significant achievement which had been achieved by taking a person centred approach, looking at individual circumstances and encouraging an early resolution approach.

Sickness absence had increased slightly to 5.58%, which is just above our targeted recovery rate. An increase in COVOD-19 related sickness had also been seen.

The Trust reported a vacancy rate of 18.6% in May 2022 and a turnover rate of 11.8% against a target of 12%.

During the month of May 2022, the Trust had a total of 135 substantive new starters, of which 44 were internal promotions. Time to hire had also reduced significantly to 20.2 days. Work continues in a business partner approach, feedback is staff feel supported and are able to deal with issues at a much faster pace.

SL noted that Ofsted were currently undertaking an inspection of the Trust and was pleased for the opportunity to share the positive work taking place across the Trust with them.

With regards to starters and leavers, ARQ noted a net figure of new people joining the Trust was 47 and there have been 48 leavers. ARQ appreciated the need for healthy turnover and acknowledged that this was a national issue, however suggested we could not afford to go backwards. SL advised that due to challenges in recruiting to some roles, a deep dive in to starters and leavers will commence, the findings of which will be presented and discussed at a future PECC. SL continued that it was important to understand that the figure for leavers does include promotion but will ask for promotions to be removed from starter data. SL reiterated that a deep dive into data to fully understand the position will take place and will be presented to PECC. PS commented that the work going on to improve processes is fantastic but agreed there was a national challenge and scarcity of staff. Under SL's leadership, conversations had taken place leading to bigger changes to enhance recruitment. SL stated that the people the Trust were attracting now are a far different calibre than in the past across many roles and this was a testament to the organisation and leadership within.

Safety and Quality
NH congratulated the success of 47 individuals that had recently completed the RISE programme, each of which would now become Quality and Safety Champions, working on projects related to safety in their current role.

The Executive Safety Oversight Group (ESOG) continues to meet weekly and feeds into the four weekly Board Safety Oversight Group (BSOG). A monthly deep dive into themes within the Safety Strategy was also taking place. This draws in from all parts of the organisation and lets us realise the scale of what is being achieved in the safety agenda.

NH advised that the Learning Lessons Team was now fully resourced and were recently joined by senior operational directors to meet Brigadier Guy Boxall, working alongside the MASS team to bring systemised learning across the organisation. This is an innovative piece working in partnership.

AS queried how the Trust is building on and taking forward the advantages of being a PSIRF early adopter, learning from that programme and cascading across the organisation. NH responded that a key feature to demonstrate this will come from the governance review. The mortality review paper submitted as part of the agenda of this meeting draws in some of the learning, although NH agreed that going forward greater detail is needed and this will come to fruition through the learning collaborative. Governance is being worked through, however the process will be for learning to be presented and discussed at the learning collaborative and learning oversight group which will feed into the Quality Committee as detailed reports on learning. NH advised that the Trust has achieved success as an early adopter of the PSIRF process, with requests from other organisations across the country to share learning. The Trust's PSIRF plan was also recognised by national team. EPUT PSIRF implementation has also garnered interest from system partners; with system wide investigations now taking place with system partners using the PSIRF model. MK added that national review of PSIRF had taken place to which EPUT had contributed, this review took place with the aim of bringing learning from various early adopters together. EPUT have also shared learning at national conferences.

Finance
SC reported that the Trust financial position at month 3 was in a good position compared to the plan in terms of revenue position. In the main, this is due to over delivery of the Trust efficiency programme and pleasing delivery within the estates function and tangible benefits coming from this. Discussion has taken place regarding the overall annual plan position and the requirement of an efficiency programme. A number of schemes have been identified to address the £17m ask within the plan, but there is still more to do.

There is a slight underspend against the forecast capital position, mainly due to timing, however assurances continue to be given at monthly capital meetings. There is more clinical engagement in

the planning of capital development programme and input from clinical and operational colleagues to help pinpoint priorities.

The outline business case for the Mental Health Emergency Department has been submitted to the national team and the Trust are keen to secure national funding to progress this project which has a real system benefit. Capital allocation may not fulfil all requirements and as such there is a need to review the system capital programme and internal potential funding.

The Agenda for Change pay award announcement has now been released. National allocations will be taken through into the system, EPUT like all partners, will then be allocated funding. JW queried whether the pay award was dependent on funding coming into the system and whether there was a sense of timing of when it will be known what the allocation is to compare with real cost. SC advised that there is a plan for national funding to go to systems in August, most organisations will then have a schedule for payment in September 2022. The structure of the pay award is complex and there is sufficient funding to cover this however it is important to ensure the mechanics and algorithms are correct with the payroll provider.

PS noted that the Trust had not quite met internal CIP target of 100% of the plan by Q1 but acknowledged the Board were not alerted of concerns at this time as there are ideas and projects in the pipeline.

PS acknowledged MK's leadership in driving forward the MHED project and thanked MK and all involved for the work to date on this very important and exciting development for the service we provide.

Major Projects
NL advised that the Essex Mental Health Independent Inquiry (EMHII) project team continue to work closely with the EMHII secretariat. Input from the independent director and independent medical advisor had also been very helpful. NL confirmed that the Trust are up to date with all requests for information received. NL continued that as a Board, we are grateful to all who have shared their experience with Inquiry team so far. The Inquiry is currently in Phase 2 – information gathering, with patients, carers and service users. NL confirmed that the Trust Board would actively encourage anyone who wishes to be involved in this process to do so.

The Mass Vaccination Team are approaching 1.4m vaccinations delivered by EPUT staff. It is expected to see a slight slowing down in numbers of vaccinations as the end of the spring booster programme is reached. The Mass Vaccination Team have made special arrangements to make vaccination centres child friendly and with the downturn in vaccinations have moved to part time opening. This has enabled the team to work with the system and support colleagues in primary care to vaccinate individuals working with care homes, local libraries, festivals etc. to reach as many groups as possible. NL added that the vaccination busses continue to operate and an encouraging number of people have come forward for their first vaccination. The Trust continues to operate an evergreen offer where individuals can get any vaccination at any time.

The Trust are working with system partners regarding the autumn booster programme and are awaiting further information from the JCVI to give guidance around when the booster programme will start, Board and Executive colleagues will continue to be updated accordingly.

Operations
AG began by reflecting on the fantastic news that the restrictions placed on Tier 4 CAMHS services had been lifted, stating that the impact on the patient cohort and the number of patients waiting for acute care as well of the impact on staff and levels of motivation cannot be underestimated. AG continued that staff were delighted to be able to care for patients in the units without restriction and are cognisant of lessons learned through the process.

In terms of performance, AG noted the long standing contract performance notice by MSE CCG with regards to the first response team in MH and seeing people within 28 days had now been removed. This was reflective of the different type of relationship with commissioners the Trust now had to learn and address issues together.

There are a number of small issues within the contractual KPI being under target, however overall the position remains the same.

COVID continues to have an impact on flow and capacity and staff sickness and absence, however operational performance has remained relatively stable.

AG was pleased to report that delayed transfers of care is well under target. AG reflected on a fulsome discussion at a recent Essex Health and Wellbeing Board where challenges of demand in MH were discussed and renewed ownership to address this challenge together. The Trust continue to take action to improve the position and continue to have good oversight of OOP and staffing on inpatient areas.

With regard to community services, AG clarified that podiatry waiting times related to podiatric health and not podiatric surgery. A delay in south east had been seen due to an increase in clinic times to allow adherence to infection control policies during the pandemic, however the services were now moving back to 30 minute slots.

AG referred to a question received from Pippa Ecclestone, Governor, regarding data quality metrics and advised that this was as a result of additional data required which is being validated and so an improvement should be seen once this has taken place. AG advised that EPUT are one of the top performing organisations in the country in this regard, with average compliance reported at 60%. AG confirmed that there are things to address, but overall this was a positive position for EPUT. The real time position is West Essex at 100%, NE Essex at 97% and MSE at 87%.

JW advised that robust conversation had taken place at the F&P Committee as it is the same four red areas that need improvement for a number of months now. The challenge raised at F&P was how to depict this differently and take areas where there are challenges and link into what is happening that we have no control over. There is a question around linking to the immense transformation taking place – if the Trust are truly transforming services there should be impact on areas where we are holding risk. AG accepted this challenge to forecast and show the impact of interventions in a more meaningful way. AG continued that unseen demand that is putting pressure on services is not always reflected, for example the 100% increase in demand for community services. AG agreed that there is a need to get better at demonstrating where capacity is but also where flow is impeded.

AG advised that during a difficult two year period, the Trust has continued to transform services yet continue to see areas that are extremely challenged. AG had no doubt that community transformation is having an impact, but it is having an impact in light of the context of new demand and increased acuity and complexity. Where people are detained in A&E there is an onus to find a treatment bed immediately, which results in those already placed in an assessment unit being delayed. AG confirmed that there is good dialogue with police and working together in relation to section 135/136. AG hoped that this gave some rational as to what operational services were seeing at the acute end of services while we begin to see impact of transformation. JW stated that this demonstrated the complexity and provided an opportunity to consider our own measures of success / patient experience measures that can give Board assurance.

RH thanked AG for the comprehensive response, noting that lot of this was driven by targets at a national level, and queried whether there was a feel for what is currently happening on a national basis so we can understand our context against that. AG agreed, stating that there is a need to

consider if these measures are still meaningful and confirmed this discussion was taking place regionally. Regional performance is healthy when looking at comparators of partners. All are struggling with average length of stay and numbers of people detained under the MH act. There is a big question regarding what are we measuring nationally and are benchmarks achievable in the context of what we know regarding rising demand.

ARQ suggested that the performance scorecard should be rating ourselves on things we have control over, if there is no control it is difficult to hold to account. ARQ suggested the possibility of a system organisational score card, acknowledging this was a large piece of work and did not underestimate the complexity.

ARQ noted that within the report it is highlighted because of an issue with CPAS, system partners were looking to move away from CPA for a more universal offer and queried whether this was nationally mandated. AG confirmed that a new framework published in July 2021 replaced CPA with a more universal approach for people with MH challenges. This puts the onus on the system to respond and is a care coordination approach for everybody. AG referred to the earlier example of transformation in the Thurrock area which gives a good example of how a move away from CPA can be managed. It is anticipated that implementation will take place in January 23 and a trust wide steering group chaired by Dr Kallur Suresh and Mark Travella has been established to manage EPUT's approach in regards to moving away from CPA. AG was cognisant of the fact it is still a measure, but will see that measure change in time with new model of care.

PS welcomed the conversation to understand the complexity of the services we provide in light of performance. AG confirmed that conversations held at F&P enabled operational colleagues to relay in a coherent way some of the challenges faced. There is an increasing need to connect performance to delivery to quality and safety and AG was conscious is set of metrics and data that tell a story so far. The further development of care unit KPIs will also allow some of the softer intelligence to be discussed. ZT confirmed that the Trust are working on improving how data is used within the organisation and are developing the business intelligence transformation plan with a move to adopting MS Power BI. As part of the BI Transformation Plan, an improved process for validation of KPIs is also in development. A key part of that is to understand what is being measured and why. This gives assurance that work is being undertaken to improve how data is used to improve clinical, operational and corporate decision making.

Medical
MK agreed that successful transformation should address current pressures through changes being introduced.

MK acknowledged the joined up work taking place across the Trust and was heartened to see a number of clinicians were involved in pilot schemes such as the North Essex care unit pilot supporting Colchester GPs with addressing patients depended on primary care prescribed medication that are habit forming. This one year pilot project aims to use a holistic approach in supportive reductions delivered by a multi-disciplinary team.

It is important to note the links to other parts of the organisation, for example Dr Gupta and the Rainbow unit have paired with EPUT Lab to develop an app to support and improve the involvement and contact of the second parent with their child. This will allow staff to write notes, upload photos and short videos to the second parent. MK acknowledged that there was a real clinical voice in organisation.

The Board of Directors received and noted the report.

081/22 EMERGENCY PREPAREDNESS AND RESILIENCE ANNUAL REPORT

NL advised that overall responsibility for emergency preparedness and resilience sits with PS, although there are two additional board members with the roles of Accountable Emergency Officer (NL) and Deputy Accountability Officer (JW).

This had been an unprecedented year for the emergency planning team, JW and NL extended thanks to the team and to staff for the professional response to critical issues during the course of this year.

Key highlights:

- COVID - There had been lots of transitional periods with the Trust stepping down from a Level 4 incident, before again stepping up to Level 4.
- EU Exit
- Fuel disruption in Q3
- Localised issue of power outage at Brockfield House in Q3
- Q4 anti vaccination protests at vaccination sites

During this the organisation has also kept up with cultural changes and training changes in the Trust and department. NL was pleased to report that one senior lead had now completed their level 4 diploma in Health Emergency Preparedness, Resilience and Response.

The Trust must meet a number of core standards. Assurance comes from the regional emergency planning team who complete an assessment against our self-assessment; the Trust received a score of 92%. There are some areas to continue to work on, including more work around business continuity which will be subject to audit for further assurance later this year, as well as a response to Hazmat and CBNE. This is mainly an issue for police, fire and acute partners, but there is a need to have a Trust plan in place should such an event impact on trust services.

As NED lead, JW echoed NL's comments. The last 2 years show the importance of investment in EPRR people and processes. JW extended commendation and thanks to NL and all of the team. SS also thanked JW for her input and support.

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

082/22 INFECTION CONTROL ANNUAL REPORT 2021/22

NH noted the continued challenges during the COVID-19 pandemic and advised that the report outlined activity relating to COVID, incidents of infection and training compliance. Bi monthly Board assurance is also received – this is no longer mandated, however the team have continued to provide this to ensure the Board have full oversight.

It is acknowledged that EPUT is the lead provider in the community collaborative for IPC and our policies and procedures have been adopted across the collaborative.

NH commended the IPC team for their visibility during the pandemic advising that there have been no incidents of outbreaks where the team have not physically attended to support staff on site.

NH noted that there are a number of formatting amendments required, however this does not affect or materially change the content of the report.

AS congratulated the team for their continued dedication throughout this extremely challenging time, in particular supporting nursing home services and support to the wider sector. AS queried whether

it was anticipated that the current level of national regulation and guidance would continue. NH advised that this was unclear at this point, however as we move towards living with COVID it is expected that there will be a reduction in regulation with some relaxed. There is continual moving and adaption of policies that we continue to have in this space. Regulation has eased somewhat but must remain in constant preparedness for peaks and troughs of this pandemic.

PS thanks to all staff involved acknowledging the workload been incredible. PS added that this was also an emotional piece, with judgements made regarding implementation of IPC often challenged from within the organisation. NH commented that there are no grey areas in IPC, requiring strict adherence therefore communication is key. The number of live briefs and training materials produced by the team had been phenomenal and had also been taken on board by other system partners.

The Board of Directors:

1. **Received and noted the content of the report.**
2. **Confirmed acceptance of assurance given in respect of risks and actions identified.**
3. **Did not request any further information or action.**

083/22 MENTAL HEALTH ACT ANNUAL REPORT 2021/22

NH presented the Mental Health Act Annual report, noting this is the fifth annual report which showed an overview of activity, detention and some statistics.

Nationally data regarding ethnic minority detention is quite stark and was a driver for review through parliament, although this is not highlighted as an issue for EPUT. The Trust have consciously focussed on ethnic detention rates looking for indicators of a need to put in a programme of work.

The report outlines internal audit assurance, and CQC inspections. Inspection by the MHA team had remained vigorous throughout pandemic and insight and learning had been taken into the process. Generally the outcome had been positive with key areas adopted through the MH safeguarding committee. The report shows that the team continue try and develop innovative solutions where possible and stretch the approach of the team. The team are also developing e-learning documentation and an operational manual. NH advised the Board that a preparation plan for the new MHA bill as it comes into force was in development, and the Team are ready to bring into fruition as a forward plan for the coming year.

AS sought assurance that with regards to the draft MHA bill, that significant changes are well in train for the organisation. NH confirmed that the Trust were foresighted through the review by Professor Simon and plan had been put in place. The Team are working to understand what the new bill will mean for EPUT and how this is acknowledged in a governance sense before bringing to practical application. There are some unknowns regarding what will be impacted and when, and it may be some time before the full bill is seen in action.

MK thanked NH and the team particularly regarding SLA agreements with acute hospitals, this allows us to support acute colleagues and treat patients in the acute setting where medical requirement takes over from MH needs.

SS, thanked associate hospital managers who bring independence and objectivity which is key to this area.

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

084/22 LEARNING FROM DEATHS – MORTALITY REVIEW QUARTER 4 2021/22

NH presented the quarterly mandated report on mortality advising that it had also received scrutiny from the Quality Committee.

Within the quarter, the number of deaths in scope was in line with quarters not impacted by COVID-19. Actions and learning from both the mortality and PSIRF process is extensive, with those listed significant that change pathways, systems or approaches.

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

085/22 HEALTH SAFETY AND SECURITY ANNUAL REPORT

DG presented the report which provided an update on the activity of the Health Safety and Security Team from 01 April 2021 – 31 March 2022, which provides assurance that the Board and the Chief Executive as accountable office had discharged their responsibilities under the Health and Safety at Work Act.

It is positive to see the team building expertise for the organisation, which will strengthen advice and support and provide a proactive approach to risk management.

The significant reduction in RIDDOR incidences from the previous year was highlighted and was identified to be connected with the requirement to report where staff had a positive COVID test that may be related to their duties.

DG thanked the team and colleagues in the organisation for engagement and taking a personal responsibility for health and safety.

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

086/22 BOARD ASSURANCE FRAMEWORK 2021/22

DG presented the new style report which aimed to give more understanding in an easy to follow format, noting that this continued to be a generative piece that will continue to evolve.

Section 2 of the report provided a high level summary of strategic risks and corporate high level risks and gives a dashboard approach of risk score, notes the number of new risks and notes closed risks. As with high level risks, management plans take time to enact so risk scores take time to change (sometimes over a life cycle of an organisational strategy).

Section 3 of the report detailed new risks, noting SR7 the availability of capital to support delivery of trust plans and SR8 on efficient use of the resources we have available. The Board noted the corporate risk on the uncertainties of the mass vaccination programme which was predicated by unknown future format of the programme. DG added that it was important as we move forward to ensure robust controls assurance will flow through sub committees, and assurances around mitigations.

Section 4 of the report provided details of risks for closure and the rationale with six recommended for closure within the reporting period.

SS thanked DG for her leadership on this significant piece of work.

ARQ acknowledged the work to get to this stage, stating that this was a significant improvement and a user friendly format. ARQ noted the risk regarding funding of the mass vaccination programme, highlighting that this had been fully funded until now and whether there was any information available to suggest this may change. ARQ in reference to risk SR4 demand and capacity suggested a review of the actions.

AG advised that this was something that had been considered over a number of seeks. AG agreed the need to include some system transformation, there is a flag to the target operating model, place based directors and their influence and ability to manage EPUT input into the system transformation, but this is not articulated robustly enough.

ML stated that the quality and pertinence of this emerged from active risk discussions from the Executive Team and senior colleagues, and queried how they are engaged in this process to ensure live and real assessment. ML also suggested that whilst comprehensive, which is positive, this format posed a maintenance burden and sought assurance as to how to keep on top of populating accurately and comprehensively or whether there was a need to review after the first quarter to ensure it is deliverable on ongoing basis.

JW welcomed the format and commented that it was excellent to have risk on a page and understand actions and controls assurance. JW queried how often it would be reviewed whether there was capacity to manage in this level of detail. With regard to SR8, JW welcomed the risk and how it was articulated, but suggested a need to elaborate on the system side.

SC agreed with the inclusion of system. With regard to mass vaccinations and funding, original plans were set for 6 months in accordance with national guidance. At present this is reimbursed on a full basis but there is risk there may be a change away from cost reimbursement. Until this is confirmed it is impossible to assess the risk but it is risk flagged in terms of future direction of travel.

In terms of capacity, leadership oversight and maintaining accuracy, DG confirmed that the Radar system once set up should be able to automate reports, commenting that this will only be as good as the information put into the system. In response to a question from RH, DG confirmed that the expectation committee and specific issues in the BAF was for Board committees to draw a link between the reports and assurance received and the BAF. As work continues around committee forward plans, this will come together.

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

087/22 STANDING COMMITTEES

(i) Audit Committee (for January / March)

The financial year 2021/22 has now finished in its entirety, with accounts and the Trust annual report laid before parliament. The Trust are now focussing on 2022/23, looking at governance and accountability arrangements. The terms of reference for the plans of work have now been agreed through the Executive Team and the Audit Committee will be holding internal audit to account for delivery, with a schedule set for delivery of reports to the audit committee.

The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) Finance and Performance Committee

Going forward the Finance and Performance will receive progress reports on the Time to Care project.

The Board received and noted the report and confirmed acceptance of assurance provided.

(iii) Quality Committee

The committee discussed flow and heard from NH regarding evolving plans from PSIRF. There is a request from the Quality Committee that the patient experience subcommittee be re-established. Patient stories continue to be shared at the Committee, RH reflected on the powerful patient story heard at the beginning of the Board meeting, commenting this is a good medium to hear directly patient's experience.

The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) People, Equality and Culture Committee including Terms of Reference Approval

ML highlighted the intensity of the work SL and team are driving in terms of recruitment, advising that 137 staff have transferred from bank to substantive positions from November, 135 international recruits are expected to be in post by December, large scale recruitment events are planned including for clinical positions, a reduction in time to hire timescale by 45%. ML commended SL and team for the drive in this significant piece of work. PS acknowledged the systemic and structural problems the NHS is facing regarding clinical recruitment.

The Board received and noted the report and confirmed acceptance of assurance provided.

(v) Board Safety Oversight Group

ARQ advised that the I Want Great Care project has been put on hold for short while to take stock. ARQ commended the safety first safety always update added to report, which demonstrated significant progress over the last 18 months in the field of leadership (although this does also intertwine with others). ARQ commented that a show case of what has been done to improve patient safety is beginning to form with processes put in place starting to come together and come to fruition.

The Board received and noted the report and confirmed acceptance of assurance provided.

088/22 TRANSFORMATION UPDATE REPORT

In addition to report, ZT provided the following verbal update.

The Trust has undertaken a significant piece to work with staff, service users and partners to put vision and strategic goals in practice through the Trust strategic plan. Significant engagement is taking place to prepare the strategic plan to set out how we achieve the vision of becoming the leading mental health and community services provider and plans then can be put into practice in our operating plan. This has been discussed informally with board members and a further update will follow.

AG advised that a transformation steering group has been established to help coordinate and drive forward the massive programme of change the Trust are working through. This is a significant scale of change and is very exciting to see how services have improved and the positive impact the transformation programme is having. The Trust continues to ensure governance and resources are in place to support this, with the steering group key in driving this forward.

A digital strategy group has also been established to drive through the interim digital strategy across the trust.

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

089/22 CQC COMPLIANCE UPDATE

The report was noted.

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

090/22 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT (APRIL, MAY, JUNE)

MK presented the report which highlighted any concerns / issues trainee doctors may have. MK confirmed that any concerns raised had been addressed locally. The Trust continues to recruit internationally and there is a good fill rate for trainees this August. There were no significant concerns to bring to the board's attention.

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

091/22 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

The following items of correspondence have been circulated to Board members since the last meeting:

- NHS England Workforce Disability Equality Standard 2021 data analysis report for information.
- NHS Providers Government reshuffle following cabinet resignations (biographies of new health ministers).

092/22 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.

093/22 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

AG advised that all discussions today could be linked to health inequalities, which is a key strategic objective for the Trust. Key reflections from discussions were:

- Coproduction sets the tone for reducing health inequalities and integration across the system. This is not only about equality for those we support but also about professional equality and all being valued for their professional input, moving away from professional demarcations. There is a clear move within the integrated teams to bring about staff and occupational equality as well as equality of health provision.
- EPUT Culture of Learning – aims to reduce health inequalities and make sure learning is made and mistakes are not repeated.

- MH ED development – is about providing equality for MH alongside physical health. We are starting to see parity between physical and mental health. The MHED is a fantastic initiative for those in crisis.

- There is greater ownership by the system to address MH, with funding anticipated to be available for MHED to bring about this parity.

- NL talked about approaches taken on board to ensure all have access to vaccinations – taking the service to people reluctant or unable to come to us. By taking the service out to people and hard to reach groups this really demonstrates the desire to make services we offer open to everyone and not have demarcation in relation to access.

094/22 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 with the following exceptions:

10:50 SL left
12.16 Loy joined.
12.17 NH left – re-joined 12:21
12.23 PS left – re-joined 12:25

095/22 ANY OTHER BUSINESS

There was no other business.

096/22 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 28 September 2022, which will be held virtually via the MS Teams video conferencing facility.

097/22 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:57.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 098/22)

Governor / Member / Public	Query	Response provided by the Trust
Pippa Ecclestone	Quality and Performance Scorecards Section 4 – Oversight Framework, Quality of Care Outcomes. There has been a significant fall in the number of 'MH inpatient follow ups within 7 days of discharge ….' Is further explanation available? Why no data since March?	Picked up in operational update
Pippa Ecclestone	Operational Metrics: within the Data Quality Matrix Index, the MH Service Data Set has dropped below target, what does this mean or involve?	Picked up in operational update
John Jones	1. Re ICB – widespread concern amongst regional and nationally governors there is a lack of accountability at ICBs, particularly as a number chose to hold their board meetings in private. Aware we have NEDs in 3 out of 4 ICBs, what are plans for reports from those NEDs to the Board and COG – we as governors have an accountability to the public. NEDs are the only link to these groups. 2. What are the plans for local boards for inviting public into board meetings?	1. ZT advised it is helpful to note PS is a member of the ICB Board in MSE as a partner member. In addition ZT will be member of ICP in Suffolk and NEE and AG in HWE, so across the three integrated systems there is good representation for the trust. At the request of PS ZT is working on developing an engagement strategy for systems, taking into account how the Trust may influence and report back. This extends further to place based alliances. It is important for us to achieve the Trust vision and strategic goals a systematic process is in place, ZT provided assurance those mechanisms are in place. PS noted that there are contradictions in the way the NHS is being set up regarding ICBs. ICBs are welcomed as they are changing the conversation and have new statutory responsibilities to support reduction of health inequalities and are empowering and allowing work such as that demonstrated in Thurrock. ICBs are a positive move but not without challenge and the leadership team will keep updated and represent Governor views during discussions. SS also provided assurance that she and NEDs continue to be engaged. 2. PS - MSE committed to public boards in person.
Judith Wooley Via Chat Function	How do the privatised segments of mental health care become integrated in this way of working? Or do they?	

Signed: …… Date: ……

Matthew Sisto Via Chat Function	A reflection on the conversation, as an informed observer, I wonder if we are doing enough to recognise service users, parents, carers, voluntary and community groups as strategic partners. As well as other providers and system colleagues.	Manny Lewis responded via Chat Function That was part of my point in asking how we roll out co-production into the emerging EPUT strategy, operational plan and accountability framework. I hope to see a systematic approach even though as Alex says there may not be a fixed blueprint
Paula Grayson Via Chat Function	Please can we be careful in the use of acronyms? I have not yet worked out what MH ED OBC might mean for our finances (Chief Executive's Report)	Zephan Trent responded via Chat Function • Mental Health Emergency Department • Outline Business Case
Pippa Ecclestone Via Chat Function	"Care Units"…..? New name for directorates? …. Or something else? Thanks Alex…….are they therefore geographically linked leadership teams?	Alex Green responded via Chat Function: Our services are structured into care units, the real change is now where there will be integrated multi-disciplinary leadership teams leading the care units. Simon Covill responded via Chat Function: Six core care units; Specialist, Inpatients, Mid & South, North East, West Essex and Psychological Services. Alex Green Responded via Chat Function: Yes we really wanted to focus on leadership teams that were local system facing and it's been really well received. We do have a dedicated focus for our inpatient areas and specialist areas too.
Paula Grayson Via Chat Function	NHS Providers indicated that the pay award will not be fully funded by NHSE/I so will need to be topped up by our own income	

Signed: …… Date: ……

Paula Grayson Via Chat Function	I noted in several performance comments that in addition to numerical rising demand, acuity is continuing to increase in mental ill health for our service users. Governors have received two case studies in which service users felt that they could not really be assisted by their existing GPs, so were referred to EPUT. Governors also received a case study in which a hospital and a GP surgery were not sharing medication information safely	Kallur Suresh replied in email: I acknowledge the increase in acuity of mental illness and this is reflected in our referrals and activity levels too. It is common for GPs to refer patients to EPUT when they feel they can no longer safely manage their patients' care and treatment in primary care. We have teams in every area to receive referrals and prioritise them on the basis of clinical urgency. There are also crisis and home treatment services that offer urgent help where needed. In terms of sharing information about medications, there are policies and processes in place to share this vital information when a patient is transferred between GPs and EPUT. If this has not worked in specific instances, please bring it to the attention of the local consultant or the MDR and they can look into specific cases. In general, we are trying to give access to our doctors to patient medication records held in primary care. Our pharmacists already have this access and do regular medicines reconciliation for all out admitted patients. Happy to clarify further if necessary.
Paula Grayson Via Chat Function	Noting the report to Finance and Performance: MSE ICB Finance Strategy The Director of Commercial Finance highlighted that the system is in a challenging financial position, looking at projections the Trust predicts that this will stretch out further over a 4 to 5 year period. The Trust is looking to address this through various ways," Please can the some of the financial implications be discussed in an appropriate meeting?	Janet Wood responded via Chat Function: Paula - we shall be picking this up at F&P and impact on resources strategic risk like 1

Paula Grayson Via Chat Function	Thanks to F&P for demonstrating Board assurance processes. Please can Governors have an update at an appropriate time and in an appropriate meeting?	Answer from Loy Lobo: 1. We have a refreshed BAF being implemented. 2. A new risk management tool is to be procured soon. 3. Work on data strategy is underway, which will feed into performance dashboards and reporting at all levels of EPUT. The above three workstreams would be intertwined to create a robust, data driven assurance framework. This would need to evolve over time as each round of use would reveal greater potential. Therefore, we need to stay close to this programme of work over the next 12 months.
Paul Walker Via Chat Function	Good to hear of areas of progress. CAMHS especially encouraging. Also recruitment changes from Bank to permanent. Keep up the good work all. Chaplain Paul	

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 27 July 2022)

Lead	Initials	Lead	Initials	Lead	Initials

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
No Open Actions						

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- HM Queen Elizabeth II
- Non-Executive Director Recruitment
- Farewell to Amanda Sherlock
- Independent Inquiry
- Annual Members Meeting
- Service Visits
- 15 Step Quality Visits

- Joint EPUT / Anglia Rusk University (ARU) Conference

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

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

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

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

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors Part 1
28 September 2022

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 HM Queen Elizabeth II

Following the sad passing of Queen Elizabeth II, the Trust shared information with colleagues of the online book of condolence, to give all colleagues and patients who wished to do so, the opportunity to share their sympathies and memories of Queen Elizabeth II. As Head of State, she has been a constant throughout our lives and a shining example of devotion to public duty and has been a source of pride and inspiration to many. I was honoured to lead a short online event and to observe a minute silence for colleagues to reflect on the life of our monarch.

2.2 Non-Executive Director Recruitment

In light of the passing of Queen Elizabeth II and the period of national mourning, the decision was taken to postpone the interviews for the recruitment of two Non-Executive Directors that were scheduled to take place during the period of national mourning. A new date for interviews has been agreed in October and I will keep the Board and Governors updated of the outcome of these interviews.

2.3 Farewell to Amanda Sherlock NED

Amanda Sherlock, non-executive director and the serving senior independent director, leaves the Trust at the end of September at the conclusion of her second term of office. I would like to formally note on behalf of the Board, our sincerest thanks to Amanda for her outstanding contribution to EPUT and the former NEP over the past seven years. Amanda has been a proactive and fully engaged member of the Board of Directors, drawing on her wealth of experience to contribute and challenge where needed, to ensure the best possible care for our patients. We wish Amanda every success in her future endeavours.

2.4 Independent Inquiry

All staff have recently received a letter from the Essex Health Independent Inquiry team with an update on how to share their views and give evidence to the Inquiry. The Board actively encourage colleagues to engage with the Inquiry team in a professional, open and honest way. Acknowledging that this may be an anxious time for colleagues, the Inquiry team have outlined support and information within their letter, and there is also support in place within the Trust.

2.5 Annual Members Meeting

To observe the national period of mourning following the death of Queen Elizabeth II, our Annual Members Meeting was postponed from the originally scheduled date and is reset to take place on 27 September.

2.6 Service Visits

The NEDs and I are pleased to continue with the schedule of face-to-face visits to services to gain a real insight into the challenges experienced by our staff, but also to see the exceptional care provided and dedication of our workforce. Recent visits by NED colleagues and myself have included Plane Ward, Pain management team, Herrick House, Wren House, International Recruitment Team and the Derwent Centre.

2.7 15 step quality visits

I am pleased to report that the programme of 15 step quality visits has also recommenced. These visits are undertaken to a specific service area by a panel including an Executive Director, Non-Executive Director and Governor, with officer support. These visits follow a 15 step quality methodology. I was delighted to join the Chief Executive Officer with an elected Public Governor for a visit to the Rainbow Mother and Baby Unit last month. More are in the pipeline, the outcomes of which are reported to our Council of Governors and are also captured within the Quality sub-committee of the Board of Directors.

2.8 Joint conference, EPUT with Anglia Ruskin University, Mental Health and Wellbeing
I was privileged to open the first Joint Conference, held on 8th September in the Medial School on the ARU Chelmsford Campus. In my address I reflected on the strength of our strategic partnership, the synergies and shared aspirations that are already producing productive translational research and innovation, creating positive and far reaching impact for people and communities that we jointly serve. The exciting programme brought together leaders and researchers from our two organisations, sharing key objectives and important findings. I was delighted to be joined by other EPUT colleagues who co-presented during the day including, Dr Milind Karale, Chief Medical Director and Jan Leonard, Director of Information Technology and Telecoms who co-led sessions and also by Dr Mateen Jiwani, Non-Executive Director, who facilitated an aspirational session to conclude the day.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 The new Mental Health Bill has recently been published. What are the key reforms? Purpose of the Bill is to "reform and modernise the MHA to provide an effective framework for services to support people experiencing the most serious mental health conditions. The Bill does not repeal the existing Mental Health Act 1983 but rather amends its provisions, as has been done previously: For information: Link

3.2 The Building Safety Act 2022. The Building Safety Act 2022 ('the BSA') is now in force. Further changes effected by the BSA which have received less comment relate to the introduction of section 2A into the DPA, and further recourse against those responsible for defective buildings including Building Liability Orders, Remediation Orders and Remediation Contribution Orders. For information: Link

3.3 New standards of transparency and accountability in the management of social and environmental risk: From 2024, large companies will need to publicly disclose information about the way they operate and manage social and environmental risks: For information: Link

3.4 More support needed for people with mental health difficulties at work: The Royal College of Psychiatrists is calling for better support for people with mental health problems to find, return to, and remain in good work, and for employers and Government to recognise the valuable contribution these people make to the workforce**. For information: Link**

3.5 RCPsych welcome focus on mental health in new anti-smoking proposals: Many people still wrongly believe that smoking has a positive impact on their mental wellbeing, helping them to relax, or deal with stress and anxiety.

3.6 Study finds COVID-19 lockdown measures coincided with an increase in serious self-harm: A recent study found that emergency hospital visits for self-harm were twice as likely for boys, and three times as likely for looked-after children, compared to pre-pandemic levels. For information: Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.
2. Request any further information or action

Report prepared by
Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon, Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the content of the report

Summary of Key Issues

The report attached provides information in respect of Covid-19, Performance and Strategic Developments.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 6
Board of Directors Part 1
28 September 2022

Chief Executive Officer Report

1.0 INTRODUCTION

Following the deeply saddening news of the passing of Her Majesty Queen Elizabeth II last week, we held a minute's silence, led by our Chair, to pay tribute to an extraordinary example of public service. We have been encouraging colleagues to express their condolences and help our service users share their thoughts and memories through the online book of condolence.

Cost of Living Support

Many of our people will be increasingly anxious about the rising cost of living, especially with energy prices increasing this autumn. We are continuing to look at ways in which we can help to ease some of the impact on our people and their families, particularly around fuel costs, food and tea and coffee for our inpatients and community teams. In July, the Government announced a pay rise for some NHS staff which will be implemented this month and backdated to April 2022.

Independent Inquiry Visit

Dr Geraldine Strathdee, Chair of the Essex Mental Health Independent Inquiry, visited three of our sites last week to gain a better understanding of the services we provide. We have welcomed and engaged with the Inquiry with openness, honesty and transparency and are committed to learning and improving so that we can deliver the best and safest care possible to the people who need our help. The Inquiry has written to all staff about how they can share they views and give evidence.

Clinical Leadership and Devolved Decision Making

I am delighted that we have completed our recruitment to Deputy Medical and Deputy Quality Director posts. These will join the Director of Operations as part of a multi-disciplinary leadership team in our newly formed care units. These care units are designed so that our local places have a leadership team that can be present in integrated care discussions and we also have a care unit for inpatient services and specialist services. I hope that, by bringing our talented medical and clinical staff much closer to decision making, we can ensure that our decisions will always be balanced and will always recognise the needs of the patient. As the teams mature we will use the accountability framework to define and devolve increased decision making rights.

Time to Care Programme

The Time to Care programme is focused on providing our patient-facing teams who work on mental health inpatient wards more time to do what they do best – caring for people who need our help. Since the programme kicked off in July, the Time to Care team has been engaging with staff at all levels at EPUT through interviews, workshops, select ward visits and briefing meetings. A more detailed outline of the programme will be presented later in the meeting, but I wanted to take this opportunity to thank those who have already provided input and who are working alongside our Deloitte partners, and engaging with teams on our wards. This is just the beginning of our journey, and I look forward to providing further updates on the programme and its developments in the months to come.

Award Nominations

I am delighted to share that colleagues from EPUT have been shortlisted in two categories in this year's Nursing Times Workforce Awards. Our recruitment team have been shortlisted in the Best International

Recruitment Experience category, whilst our Director of Safety and Patient Safety Specialist Moriam Adekunle has been shortlisted for the Diversity and Inclusion Champion of the Year award, recognising the significant impact Moriam and the Trust have had championing diversity in our health and care workforce.

Our work to develop a national apprenticeship scheme for Clinical Associates in Psychology (CAP) has been shortlisted for two HSJ Awards. Alongside our partners East London NHS Foundation Trust and Sheffield Health and Social Care NHS Foundation Trust, we have been shortlisted for Workforce Initiative of the Year and Provider Collaboration of the Year. Just under 400 staff are either in training or have qualified through the apprenticeship scheme since November 2020. The apprentices have already contributed to improving patient care in various healthcare settings, including eating disorder services, rehabilitation, acute wards, primary care and community mental health services, and their contribution to patient care has had overwhelmingly positive feedback from colleagues, service users and commissioners.

Four of our services have been shortlisted for the Positive Practice in Mental Health Awards 2022, including our Adult Mental Health Family Group Conference Service, The Service User Network for Personality Disorder and Complex Needs, Brockfield House, and our Child and Adolescent Mental Health Service.

Finally, Oxehealth and EPUT has been selected as a finalist for the Academic Health Science Network (AHSN) Innovate Awards 2022.

I would like to extend my congratulations to all our staff involved in these award nominations. It is testament to all your hard work and commitment to providing the best possible care to our communities, and demonstrates the improvements we continue to make as a Trust.

3.0 PERFORMANCE AND OPERATIONAL ISSUES

Operations – Alex Green, Executive Chief Operating Officer

August was a challenging month for many services with Opel 4 status declared for a 6 day period in response to unprecedented pressures on mental health inpatient admissions. In response, measures were put in place to manage demand so that we could better support patients, staff, and system partners.

The number of inadequate performance measures rose from four to five with the escalation of Safer Staffing. A number of projects and work streams are currently underway to ensure our wards are safely staffed and clinical time is used appropriately, these include the Time to Care and International Recruitment initiatives.

CPA reviews, Inpatient Capacity, Out of Area Placements, and Psychology waiting times are the remaining four inadequate items, with a marginal improvement in CPA performance and a sustained pattern of improvement in delayed patient transfer of care and psychology wait times. We are delighted to have the opportunity to work with GIRFT (Getting it Right First Time) programme from early October with the aim increasing our productivity, reducing unwarranted variation and improving the quality of our care.

Performance against commissioner contracts has remained steady and there have been no additional contracts arising with inadequate KPI's. Two of the six contracts with inadequate KPI's have witnessed an increase in the number of items they report below target however there are a further 11 contracts that do not have any inadequate measures. There have been no contract performance notices.

Whilst August has been a pressured month for our frontline services, I am pleased to report that services were maintained, action plan and mitigation work continued, and patient safety remained the focus of care we delivered.

Safety and Quality – Natalie Hammond, Executive Nurse

We continue to review our progress and provide assurance that the promises made in the Trust's "Safety First, Safety Always" strategy will be addressed via our deep dive reporting. These reports are presented monthly to the Board Safety Oversight Group (BSOG).

Safety Strategy Update

In line with the strategy, over 60 activities and initiatives have been identified as contributing to the implementation of "Safety First, Safety Always". This portfolio is regularly reviewed by the Executive Team to ensure all relevant activities are captured and that outcomes and measures demonstrate their contribution to achieving our goal. This is an evolving document which will then form the basis of a published Board report in January 2023.

The "Safety First, Safety Always" strategy is split into seven priorities and of these we have completed deep dives into leadership, culture and continuous learning. Our initial analysis of these three themes identified 31 activities, of which 9 were complete, 9 were in progress and 13 were unknown. Following our deep dive into each of these we have identified 32 activities (1 additional theme identified) of which 15 are now complete and 17 are in progress.

Our investigations have demonstrated the significant progress EPUT has been making in the area of safety, such as the development of a co-production framework that outlines how we can better integrate the views of our service users as well as their family, friends and carers. We have demonstrated the progress we have made with our Equality, Diversity and Inclusion Framework, where we are trying to ensure that EDI is considered in all areas of our organisation and processes. Another example is our work around enhancing environments which has had a huge impact on our patients.

Deep dives for the areas of wellbeing, innovation, enhancing environments, and governance and information are planned to be completed over the next 4 months.

Medical Directorate – Dr Milind Karale, Executive Medical Director

Deputy Medical Director Appointments

On Wednesday 7th September 2022 there was a selection event to recruit to the two remaining posts of the newly created deputy medical director roles for community services in North East and Mid and South Essex. The first part of the process was a stakeholder presentation, where candidates were asked to present to a panel of Trust operation directors along with the MSC chair and a representative from our service user volunteer group which was followed by a Q&A session. The second part was a panel interview with Chief Executive Paul Scott, Executive Chief Operations Officer Alexandra Green, Executive Director of People and Culture Sean Leahy and Executive Medical Director Milind Karale. From this recruitment process we were able to successfully appoint two candidates:

Dr Parvathy Pillay-North East Community Services
Dr Feena Sebastian-Mid and South Community Services

We have now appointed to all five Deputy Medical Director roles across the Trust and welcome them to the senior leadership team. We look forward to the strategic, clinical and professional leadership they will bring across the organisation.

Mental Health Urgent Care Department (MHUCD)

The Diversion pathway went live in late January 2022 in Basildon and has supported system pressures by:

- Diverting between 18% and 22% of mental health attendances at Basildon emergency department (a current cumulative total of 656 patients who would have occupied spaces within the emergency department)

- Diversion rooms occupation is between 95% and 99%
- Provided system support over the recent OPEL 4 pressures
- Provides an area for patients awaiting admission beds to free up space in the emergency department

Following the development of the Diversion service, focus turned to the implementation of a full Mental Health Urgent Care Department (MHUCD) model within EPUT by Feb 2023.

The MHUCD service is a 24 hour service for patients in the Mid and South Essex area who are aged 18 or over experiencing mental health crisis. This service is provided as an alternative urgent care pathway to support increasing system and operational pressures. The service will complement and support the services offered by the local Emergency Departments, Mental Health Liaison Teams, Crisis services and Sanctuary, and improve experiences for not only mental health patients but physical health patients requiring urgent and emergency support within the system.

Between late March 2022 and early September 2022 key success points are summarised as:

- Creation of the lived experience involvement group which facilitates coproduction of the services with those with lived experience
- Creation of the system led project update group which include senior leaders from the Acute MSE, EPUT, MSE ICS, ambulance services, police services, the voluntary sector and
- Review of other UK models and NHSE review of this type of model
- Development of the MHUCD service brief based on other models within the UK and EPUT/MSE system structures, requirements and current urgent care pathway.
- Design of the MHUCD and MHAU site in the Basildon mental health building
- Completion, submission and approval of NHSE Capital BID for £1.2m of funding
- Completion, submission and approval of SOC for system allocation of £2.7m revenue and £1.3m capital funding
- Development of the project structure, timelines and governance processes including operations, staffing, estates, data and IT and lived experience coproduction.
- Review of the MHUCD alongside the urgent care patient pathways to determine service specifics

Digital, Strategy and Transformation – Zephan Trent, Executive Director of Digital, Strategy and Transformation

We continue to develop our strategic plan to support delivery of the vision, purpose, strategic objectives and values we agreed last year. We have reviewed the strategies of EPUT's partners across Essex, Southend and Thurrock as well as national policy to ensure that EPUT's strategy supports its partners' aims and ambitions. Over the summer, we held over 80 engagement events with around 600 people. This includes service users, carers, families, staff and colleagues in partner organisations, and I would like to thank all those who have contributed to this work. We are currently working to develop a strategic plans for individual care units, and will use these to develop our overall trust strategic plan over the next two months.

We have continued to develop and mature our project and change management processes through the Transformation Steering Group which is supported by our consistent end to end change methodology. Since its inception, over 90 submissions have now been through the "Single Front Door" for transformation. The new processes and governance have been broadly accepted and supported by the executive and leadership team within the Trust. Our focus now moves to projects and initiatives as they proceed through their lifecycle from initiate to close and reporting their progress and status. The Transformation and Finance teams are working together to identify and capture efficiencies and ensure these are being realised at each gateway. To support the triage process for new submissions, we have developed a project prioritisation methodology. This is based on a recognised model which assesses the value of the opportunity to the Trust and our ability

to deliver this. This transparent process will ensure that we are focussing on the initiatives which deliver the greatest value and how we commit our resources to support these. The model is being trialled on Time to Care and other key projects with the intension that this will form part of the Trust business planning process in the future.

We are developing our trust Data strategy (including Business Intelligence) and have completed three well attended workshops and a number of interviews with staff which have been facilitated by KPMG. This will complement the Interim Digital Strategy. The future state and vision of data and business intelligence as the enabler for change and transformation is taking shape. The patient safety dashboard as the visualisation of serious incidents (Datix) has been developed to promote the culture of learning opportunities. This is the first power BI dashboard to be published on the back of the aggsoft Power BI mobilisation and paves the way for how data can be visualised to promote better and more accurate and accountable decision making.

We are really pleased that the digital challenges identified by the time to care programme are already captured in the Digital Strategy and are part of the digital roadmap for service improvement, the Digital team are working with Delioitte to synchronise priorities with the outcomes from the programme. The success of the digital e-observations pilot for MH Inpatient wards has empowered the decision to begin planning for a wider rollout. This is a significant milestone towards safer patient observation tracking and recording. Partnerships with BT and Microsoft are maturing and are enabling strong collaborative working on key digital initiatives such as the Standard Operating Procedure (SOP) mobilisation and Lessons Learned management. By adopting the Microsoft development toolbox, the possibilities for application development at pace can be fully realised and promote opportunities for external partner working and reusable/resaleable capability.

The cyber incident that compromised the Advanced hosting provider was successfully managed to a safe conclusion by the EPUT cyber team and the EPUT finance team in partnership with the wider system partners. Access to the eFinancial systems has been fully restored and would like to thank our finance and digital teams for working so diligently to restore normal service whilst ensuring the cyber safety of our trust.

People and Culture – Sean Leahy, Executive Director of People and Culture

Pay and Pensions

On 19th July the Secretary Of State for Health and Social Care, announced the NHS pay award for the current financial year 2022-2023. All pay awards and the arrears dating back to April 2022 will be made in September unless otherwise stated below.

Education, Training and Development

Apprenticeships

As expected Ofsted visited us July 27th -29th. Our last monitoring visit took place in July 2019 and as a main provider of apprenticeships the inspectorate team are required to complete a full inspection within a three year window. The Inspection was rigorous and explored all aspects of our apprenticeship provision. Our overall outcome was good, a result we can be proud of and a credit to education team.

Mandatory Training

Mandatory Training compliance for August is 93%, an increase of 2% from the previous month. There is also an increase of 1% for the Pre-COVID update frequencies compliance and sits at an overall of 89%.

Recruitment and Retention

170 nurses, and 150 HCAs, and 107 student nurses have been recruited since November 2021. We also remain on track to recruit 195 international nurses by the end of the calendar year. Our turnover rate remains just under the 12%, whilst vacancy rate is now at 18.6%.

Equality, Diversity and Inclusion

Workforce Race and Disability Equality Standards (WRES / WDES)

We are currently reviewing the workforce and staff survey data for the WDES and WRES and engaging staff on actions plans for the next 12 months. Reports for both standards will be discussed in detail later in the agenda.

Civility and Respect Pilot

Mid and South Essex's collaborative partnership has secured a bid to create and implement a pilot with a focus on micro aggressions as part of our wider Civility and Respect project. EPUT is the lead partner for the pilot.

Employee Relations

There has been a slight increase in Employee Relations activity in August 2022 in relation to both disciplinary and harassment cases, the majority of which relate to temporary worker (bank) cases. Sickness absence related to both general sickness and Covid-19 sickness has decreased since last reported and is now at 3.69% (as at 30 August 2022).

Staff Engagement

Planning is underway to deliver the annual staff survey to eligible EPUT staff from 22 September 2022 onwards. The survey will close on 25 November 2022 which will give staff over eight weeks to complete the survey.

Major Projects – Nigel Leonard, Executive Director of Major Projects and Programmes

Essex Mental Health Independent Inquiry

We continue to support the Essex Mental Health Independent Inquiry, who are still in phase 2, collecting evidence from a range of people. Initially, the Inquiry has been focusing on hearing evidence from families, friends, and carers of inpatients who died during the relevant period and others with lived experience of Essex Mental Health services. We understand that those evidence sessions are now drawing to a close and the Inquiry is moving to the next stage and giving an opportunity for staff with experience in working in mental health services to speak with them. The Inquiry team have confirmed that they would like to hear from doctors, nurses, psychologists and occupational therapists, as well as care workers, social workers, pharmacists, catering staff, cleaners and porters. We have asked staff members who are invited or volunteer to give evidence to fully engage with the Inquiry Team. EPUT welcomes the Inquiry and will continue to work with the Inquiry team. Patient safety remains our top priority and is at the forefront of everything we do.

Vaccination Programme

The Autumn Covid-19 vaccination booster programme started on 5 September 2022. We are beginning to see an increase in bookings, and we expect this to continue throughout September, October and November. At this point the latest information received from NHSE/I is the programme will be largely completed by mid-December 2022.

The Trust is continuing to support Mid & South Essex and Suffolk & North East Essex Systems in the administration of Covid-19 vaccinations. Vaccinations will be available from the acute hospitals, GPs, Pharmacists and from the four delivery models established by EPUT.

During the autumn booster campaign, we will deliver vaccinations in a variety of different ways and these include large vaccination centres, outreach services, popup clinics and mobile services which includes the deployment of two vaccination buses. Following a request from each system, EPUT will now be supporting primary care in the delivery of vaccinations to housebound patients and care homes. This is seen as an urgent requirement so that those residents receive the maximum protection in advance of the approaching winter period.

The Board will be aware that two bivalent vaccines have now been granted a UK licence and the new modified Moderna and Comirnati vaccines will be utilised alongside other vaccines during the autumn programme as these vaccines have been modified to increase protection against the new variants of the Covid-19 virus. As previously noted by the Board, the Trust has no control over the vaccine that we will be allocated, and it is likely that a variety of vaccines will be used throughout the programme.

The Joint Committee for Vaccinations & Immunisations have confirmed that the following groups will be entitled to receive the autumn booster:

- residents in a care home for older adults and staff working in care homes for older adults;
- frontline health and social care workers;
- all adults aged 50 years and over;
- persons aged 5 to 49 years in a clinical risk group;
- persons aged 5 to 49 years who are household contacts of people with immunosuppression; and
- persons aged 16 to 49 years who are carers.

Each provider organisation has been asked to examine the possibility of co-administering the Flu and Covid-19 Vaccines during the autumn programme. However, this will be dependent upon vaccine supply.

This autumn booster programme will be funded in a different way for lead providers. Up until 31 August 2022 NHSE/I paid all of the expenses incurred in the delivery of the vaccination programme but with effect from 1 September 2022 lead providers, including EPUT, will be funded in a different way. The Executive Team and Project Team are confident that, with the changes made, the programme can be delivered effectively over this period.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Trust revenue position is £0.3m better than plan reporting a year to date actual deficit of £2.3m compared to a £2.6m plan. Temporary staffing costs continue to reduce. Trust continues to forecast a year end breakeven position.

Trust's capital position is £3.4m behind plan, year to actuals of £2.5m compared to plan of £5.9m. The variance relates to timing of delivery of schemes with full recovery expected in future months.

The ICS is reporting an actual deficit of £38.4m, £27.1m adverse to plan with recovery actions underway and further actions being developed.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

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

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

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

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

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 5 (August 2022)

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for August 2022.

Five inadequate indicators (variance against target/ambition) have been identified at the end of August 2022 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Psychology

There is one inadequate indicator which is an Oversight Framework indicator for August 2022

- Out of Area Placements

There are three inadequate indicators in the EPUT Safer Staffing Dashboard for August 2022.

- Day Registered Fill Rates
- Number of wards with fill rates of <90%
- Wards with more than 10 days of unfilled shifts

There are no inadequate indicators within the CQC scorecard. All Must Do actions are within timescale.

Within the Finance scorecard one item has been RAG rated inadequate for August:

- Temporary Staffing

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

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

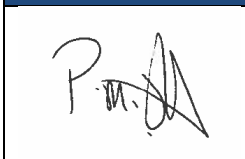
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

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

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

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

Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
August 2022

Are we Safe? | Are we Effective? | Are we Caring? | Are we Responsive? | Are we Well Led?

Report Guide

Use of Hyperlinks

Hyperlinks have been added to this report to enable electronic navigation. Hyperlinks are highlighted with an underscore (usually blue or purple colour text), when a hyperlink is clicked on, the report moves to the detailed section. The back button can also be used to return to the previous place in the document.

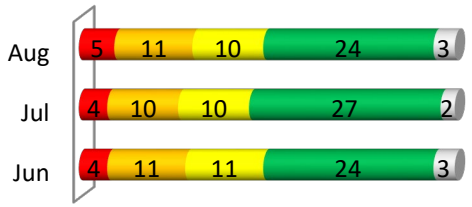
How is data presented?

Data is presented in a range of different charts and graphs which can tell you a lot about how our Trust is performing over time. The main chart used for data analysis is a Statistical Process Chart (SPC) which helps to identify trends in performance a highlight areas for potential improvement. Each chart uses symbols to highlight findings and following analysis of each indicator an assurance RAG (Red, Amber, Green) rating is applied, please see key below:

Statistical Process Control (Trend Identification)					
Variation				Assurance	
					
Common Cause – no significant change	Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting and passing and falling short of the target	Variation indicators consistently (P)assing the target	Variation Indicates consistently (F)alling short of the target
Assurance (How are we doing?)					
Meeting Target EPUT is achieving the standard set and performing above target/benchmark	Requiring Improvement EPUT is performing under target in current month/ Emerging Trend	Inadequate EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL	Variance Trust local indicators which are at variance as a whole or have single areas at variance / at variance against national position	For Note These indicate data not currently available, a new indicator or no target/benchmark is set	Indicators at variance with National or Commissioner targets. These have been highlighted to Finance & Performance Committee.

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

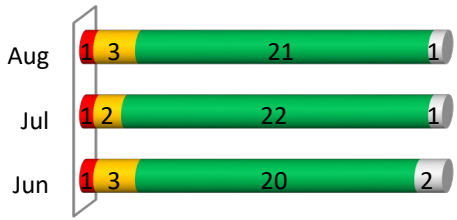


August Inadequate Performance

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Psychology

Please note indicators suspended over COVID period and those that are for note are colour coded grey.

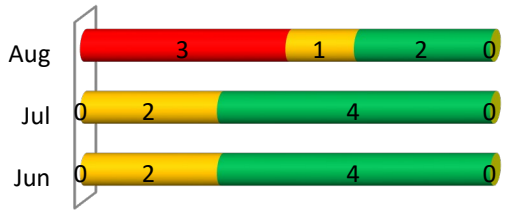
Summary of Oversight Framework Indicators



August Inadequate Performance

- Out of Area Placements

Summary of Safer Staffing Indicators



Three inadequate items identified within the Safer Staffing section:

- Day Registered Fill Rates
- Number of wards with fill rates of <90%
- Wards with more than 10 days of unfilled shifts

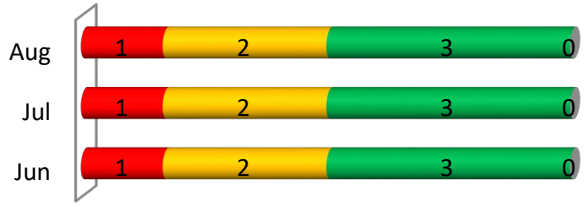
This data is collected from SafeCare.

Summary of CQC Indicators

The CQC undertook an inspection of the CAMHS Wards in March and April 2022 and have made 6 ‘must do’ recommendations and 7 ‘should do’ recommendations.

A CAMHS improvement planning group has been established with MDT membership which has reviewed the report and recommendations and has developed an improvement plan. The improvement plan was submitted to the Executive Team for review and approval, before being submitted to the CQC on 25th August 2022, which was within the deadline set by the CQC.
Action progress against this plan will be reported in September’s report.

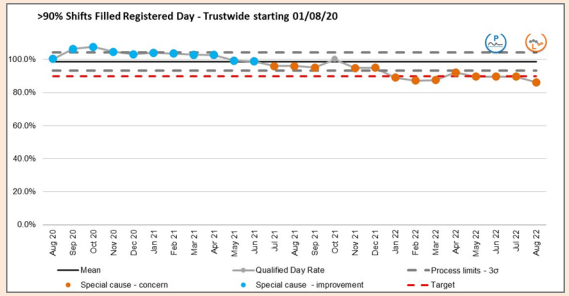
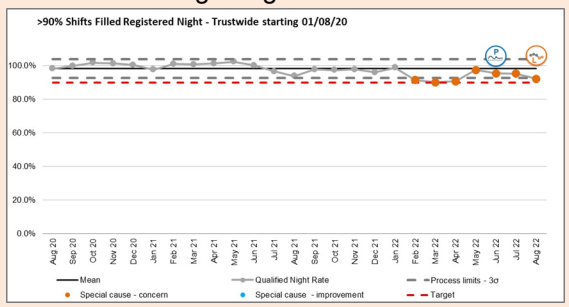
Finance Summary

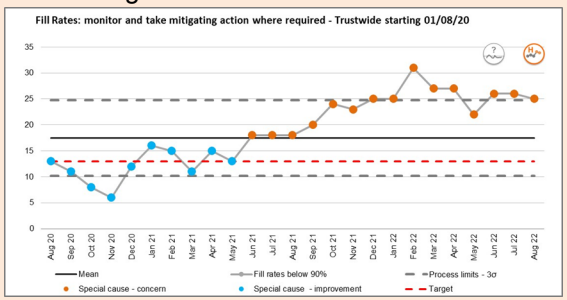
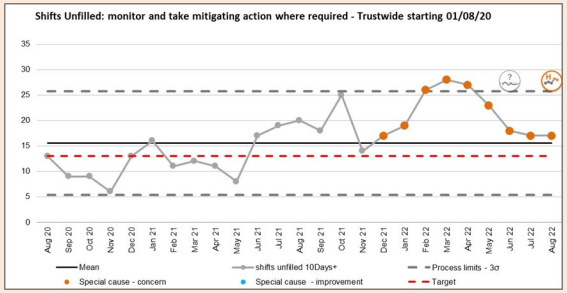


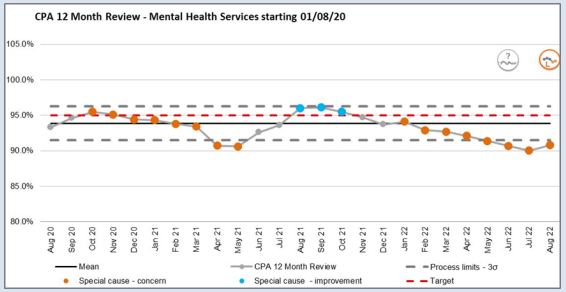
August Inadequate Performance

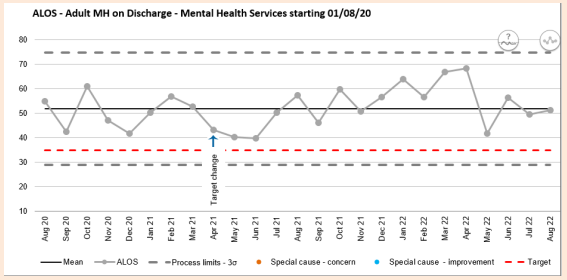
- Temporary Staffing

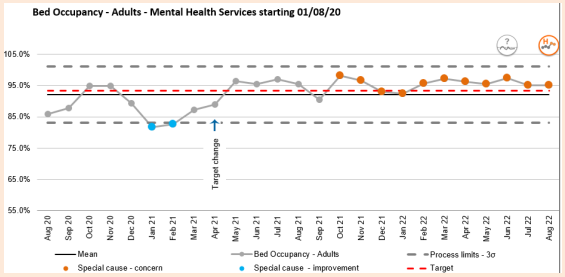
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

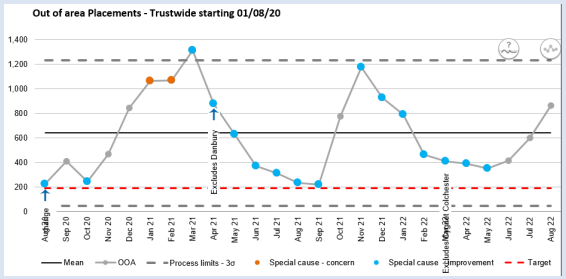
Safe Indicators							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.7 Safer Staffing Committee: Quality Indicator : National Data Quality RAG: **Blue**	**Inadequate** A number of projects and work streams are currently underway to ensure our wards are safely staffed and clinical time is used appropriately, these include the Time to Care, GIRFT, and KPMG initiatives. Wards are currently utilising bank and agency staff to fill vacancies and unfilled shifts where possible, and ward staffing is continuously monitored through daily sitrep calls. The Trust is currently not meeting target for Day Registered Staff Fill Rates and two further measures regarding fill rates and number of days with shifts unfilled. From February 2022 this data is extracted from SafeCare.						
	1.7.1 Day Qualified Staff Fill Rate 90% of above	86.2%		Trend above target = good 	N/A	Special cause of concern, trend of decrease.	
	1.7.3 Night Qualified Staff Fill Rate 90% of above	92.2%		Trend above target = good 	N/A	Special cause of concern.	

Safe Indicators							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	1.7.5 Fill Rates: We will monitor fill rates and take mitigating action where required	25	●	Below Target = Good 	N/A	Special cause of concern with increasing number of wards with less than 90% fill rates. Performance continues to be outside the expected performance variation.	
	1.7.6 Shifts Unfilled: We will monitor fill rates and take mitigating action where required	22	●	Below Target = Good 	N/A	22 wards where there were more than 10 days with shifts unfilled.	

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: **Amber**	**Inadequate** CPA Reviews remains as inadequate in August, overall performance remains below target at 90.8%, however this is a small improvement on the position reported in July (90.0%). In August North East & West witnessed a further decline, whilst Mid & South improved from last month, both do however remain below target. Specialist services remained consistently above target and whilst Trust wide services have improved, they do remain below target. Flow and capacity leads continue to work closely with individual care coordinators to identify CPA reviews that require booking. Staff vacancies, annual leave, sickness, and high demand from additional activities by management (i.e. attendance at coroners court) are all contributing factors to this performance. A Red, Amber, Green ratings system is in place to enable staff to monitor, prioritise and undertake regular client calls. Staff can also use the MaST tool (management and supervision tool) to assist with identifying emerging risks and for caseload management.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	90.8%	●	Above Target = Good 	●	There were nine Teams (eight MH and one Specialist MH) in the South, three Teams in Mid, five Teams in NE, two Teams in West and one Trust Wide Team below target.	

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** Inpatient Capacity performance was expected to decline in August. A black alert was declared in response to unprecedented pressures on inpatient admissions with OPEL 4 status from the 14th– 20th August 2022. In August adult average length of stay increased slightly and remains outside the benchmark of <35 with performance at 51.2 (48.9 in July). There were 104 discharges in August, 25 of whom were long stays (60+ days). There have been more discharges and more long stays in August. Length of Stay data has also now been run to include the Assessment Units, this resulted in an August position of 35.9, just outside the <35 target. Adult occupancy rates have remained consistent at 95.1% in August, compared with 95.0% in July. This does remain outside the benchmark of <93.4%. Positive performance continues to be seen in adult delayed transfers of care with August at 2.8% which continues to be within the benchmark of <5%. There were 8 clients delayed in August, reduced from 11 in July. Topaz currently has the highest number of delays (4). All PICU inpatient indicators are within benchmark, with the exception of ALoS which has risen to 126.7 against a target of <50. There were three discharges in August (all of whom were long stays (60+ days)). Monthly inpatient Quality & Safety meetings continue to take place with pressures regularly discussed and actions are cascaded to front line teams. The Purposeful Admissions steering group work is ongoing and the therapeutic offer on wards is being increased with activity coordinator roles. The therapeutic programme (MDT) is to be reflected in all care plans, and be more visible and consistent across all units. The Productivity team continue reviewing clinical records for all individuals with an extended 28+day LOS to ensure there is a clear treatment plan and discharge planning with an estimated date of discharge in place. The System Escalation of Delayed Transfers of Care weekly meetings continue to take place as well as the Joint Inpatient and Community review meetings. These provide oversight of clinical progression, discharge planning, and LOS reviews, all informed by the Red to Green Principles.						
	2.9.2a Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	51.2 days		Below Target = Good 		Consistently failing target 104 discharges in August (25 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	95.1%	●	Below Target = Good 	●	Adult Acute 2020 benchmark EPUT result was 99.7%, against a National mean of 93.4%.	N/A

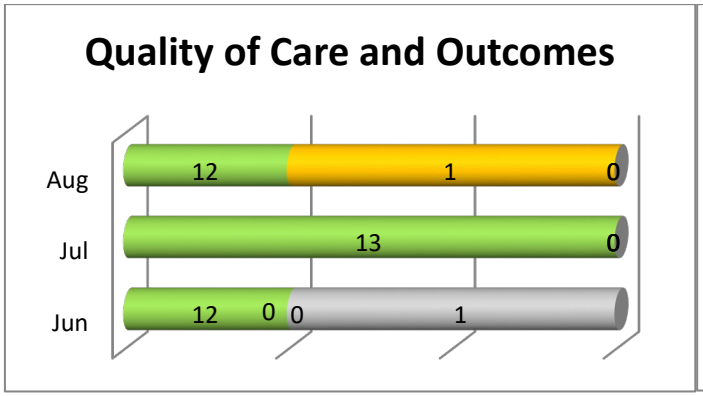
Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M5**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: Amber	August has seen a further increase in out of area bed days, 866 (excluding Danbury & Cygnet). These increases in placements reflect the higher demand for inpatient admissions, and placements were expected to rise following the declaration of a Trust Black Alert at OPEL 4 status from the 14th - 20th August 2022. A Whole Essex System Flow and Capacity group has been established to review current and future bed modelling. An NHS England Data Scope development is in progress to inform purposeful admission and future bed modelling discussions. The revised NHSE/I target has been set to 0 placements by the end of March 2023. There continues to be comprehensive action plans in place across the Trust to meet this. Neighbouring Trusts also face similar challenges in reducing their placements. The Trust continues to hold contracts with the Priory (Danbury ward) and with Cygent Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. Wider conversations are in progress with System, Operations, Finance and Contract teams to explore opportunities for financial efficiencies and improved quality. 21 new clients were placed OOA (17 Adult & four PICU) in August, and following the repatriation of 17 (16 Adult & one PICU), there were 27 remaining (19 Adult & eight PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	866 Days		Below Target = Good 		Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Mar 2023

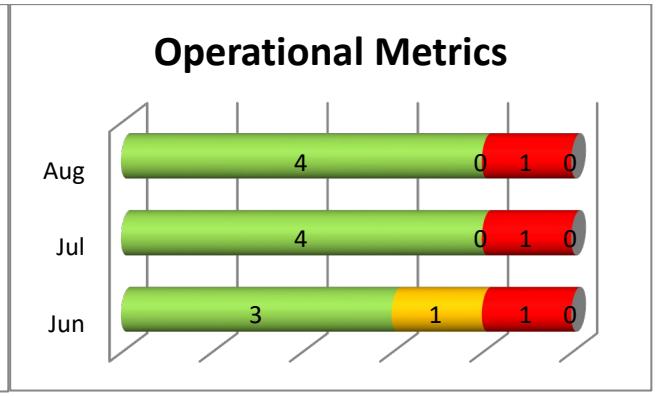
Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M5**
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Referrals for South East Adult Community Psychology remains overall stable, resulting in demand continuing to match outset resource with the historical loading of waits having some, albeit reducing, impact. The service has continued to prioritise increasing accessibility to complex needs screenings for DBT/STEPPS and offering more STEPPS group to reduce wait times. This is evidenced with a significant reduction in wait times and numbers waiting for DBT and STEPPS. The Service's intention is to contribute to more skilful management of crisis to avoid admissions and reduce the potential for patient safety incidents. Average wait times and the number of people waiting for specialist psychological therapy (EMDR, schema therapy, complex trauma work) continues to remain overall stable and consistently lower than this time last year. There continues to be an integrated interface with Therapy for You and Therapy for You+. The service is continuing to run a trauma stabilisation group quarterly, which results in some build of waiting numbers, which will always be cleared within 3 months. The service is closely monitoring an increase in DNA's over July and August for online assessments. We are scoping feedback from people who have missed sessions to identify any actions we can take to reduce resource wastage. Clinicians job plans are routinely reviewed quarterly to ensure available capacity is being used as smartly as possible. Recruitment of a Preceptorship post is underway to boost Southend resource for 1 year, using pockets of underspend. The waiting times across localities in the South West were stable for some time before step 4 was introduced and afterwards. They are now continuing to show a pattern of reducing. It is a positive step showing that despite no reduction in demand the service is starting to reduce the backlogs in both adult community psychology and DBT/STEPPS pathways. An overall increase in resource which has now been introduced is expected to help further reduce waiting times. There is an ongoing recruitment drive to fill vacancies to ensure adult community psychology South West are fully resourced and more able to meet demand. Risk calls continue to be made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented. Waiting List update: South East – There are 236 clients awaiting intervention. Face to Face DBT/STEPPS currently has the longest average wait time with 15.6 months, there are just 13 clients waiting for this. South West – There are 197 awaiting intervention. Individual DBT informed therapy currently has the longest wait at 27.5 months. There are 8 clients waiting for individual DBT informed therapy

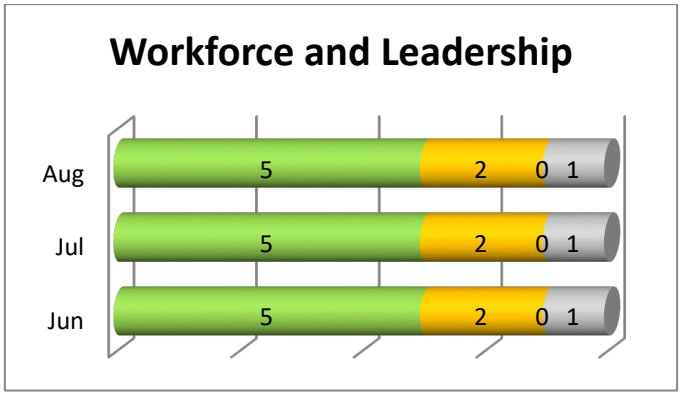
SECTION 4 - OVERSIGHT FRAMEWORK

Click here to return to summary page

Please note this reporting is against the national Oversight Framework published in August 2019. A new NHS System Oversight Framework has been published and a project is underway to develop reporting for this.





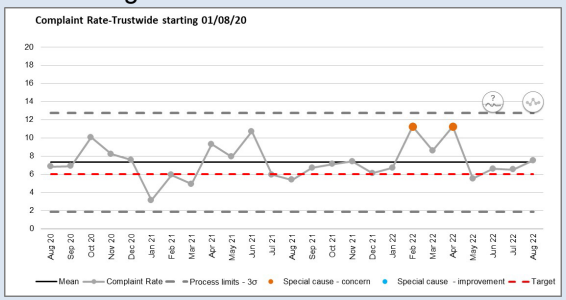


Inadequate

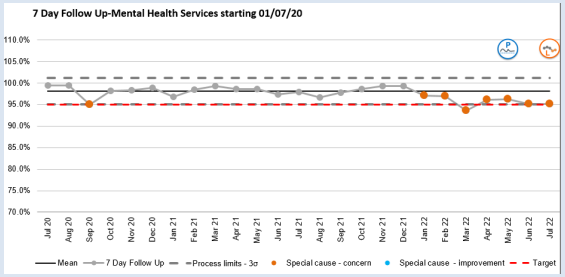
- Out of Area Placements

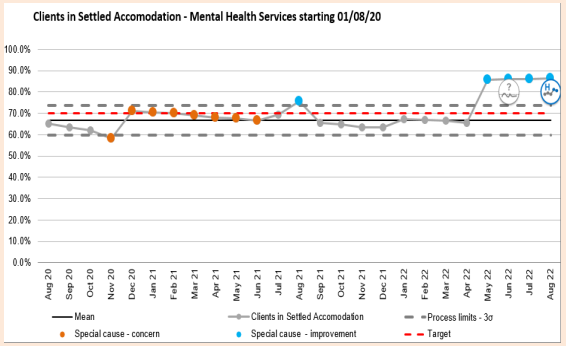
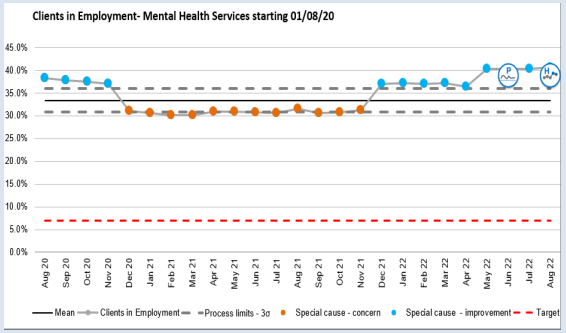
Requires Improvement

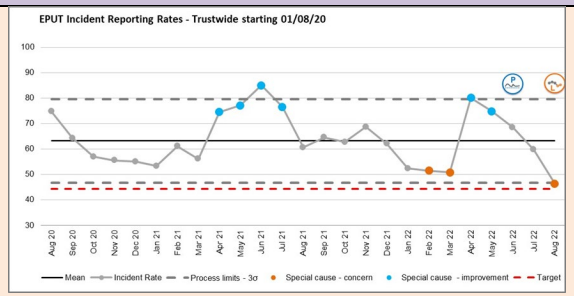
- Complaint Rate
- Staff Sickness
- Tempoaray Staff (Agency)

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good	●	The restrictions on our children and adolescent mental health services (CAMHS) have been removed by the CQC.			
	No action plans past timescale		●	As previously reported the CQC undertook an inspection of the CAMHS Wards in March and April 2022 and have made 6 'must do' recommendations to address breaches in regulations observed by the inspection team and 7 'should do' recommendations. A CAMHS improvement planning group has been established with MDT membership which has reviewed the report and recommendations and has developed an improvement plan. The improvement plan was submitted to the Executive Team for review and approval, before being submitted to the CQC on 25th August 2022, which was within the deadline set by the CQC. The CAMHS improvement planning group is currently meeting fortnightly to monitor progress and ensure identified actions are completed in a timely manner. Progress on the Action Plan will be reported from September's performance report.		
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	7.5	●	Below Target = Good 	●		N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	National Quarterly Pulse Survey Results	The Staff FFT has been replaced with the National Quarterly Pulse Survey. In the most recent publication released in July, 449 responses were received in total. Response rates have seen a positive increase with 109 more respondents than Q1. A robust communications campaign has supported this and we also encouraged staff to fill in the survey at meetings, inductions and training. This support our drive to embed feedback and the NQPS as BAU and work will continue to develop the campaign after the National NHS Staff Survey has taken place. Quarter 4 will launch in January 2023. We received 301 unique comments. Key themes of comments: 70 in relation to rest/break areas, 66 in relation to support for staff, 27 relating to working from home, 24 relating to management, 14 relating to staffing, and 22 in relation to training. Staff requesting adequate areas to rest and take breaks is still a notable theme through the comments.					
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2019/20 Outturn 0**		●	Year to Date 0	●		N/A
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.1 MH Patient Survey Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	The 2021 survey results have now been published. 1,250 EPUT clients were invited to take part, and 324 responded. This is a response rate of 27%. EPUT achieved "about the same" for 26 questions in the 2021 survey when compared with other Trusts. 2 questions scored "somewhat worse than expected". These 2 questions fell under the NHS Talking Therapies domain.					
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)	89.9%	●	I Want Great Care was implemented across the Trust from 23rd January 2022. We are awaiting further FFT configuration. We are hoping to hear from the I Want Great Care team shortly	●	89.9% for the positive score in August. This is currently not split between MH and CHS.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%				●		
2.8.1 Mental Health Discharge Follow up Committee: Quality	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%**		●	Above Target = Good 	●	Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. Awaiting August update Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%	

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Blue**	(Adult Acute 2020 Benchmark 98%)						
2.4 MH Patients in Settled Accommodation Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	86.5%	●	Above Target = Good 	●	August performance : Paris 88.4% Mobius 79.8% (New valid (Settled Accommodation) codes added to Paris, not previously used)	N/A
2.5 MH Patients in Employment Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	40.6%	●	Above Target = Good 	●	August performance : Paris 47.2% Mobius 17.5% Assurance indicates consistently passing target.	N/A
1.8 Patient Safety Incidents Reporting	Incident Rates will be in line with national benchmark **>44.33** MH Benchmark	46.3	●	Above Target = Good	●	This is achieving target for August, with the EPUT total at 46.3 Staffing pressures are impacting on the time available for staff to sign off all incidents. This data is also extracted very early in the month due to reporting	

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Amber**						timescales and does usually improve on refresh.	
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in August	N/A		N/A

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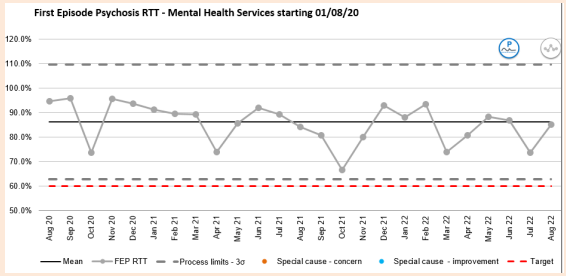
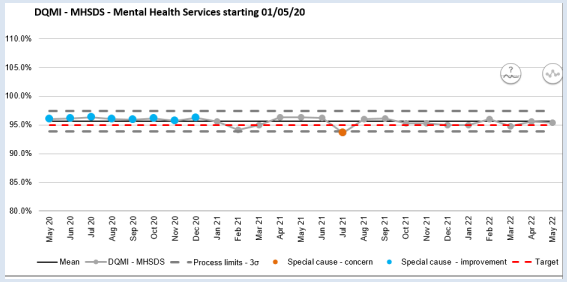
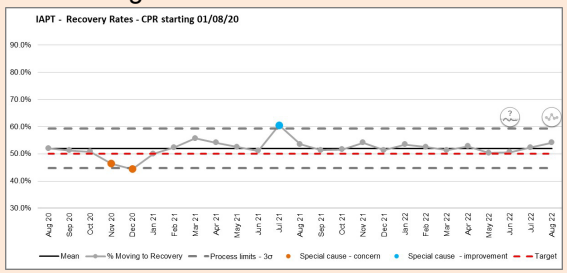
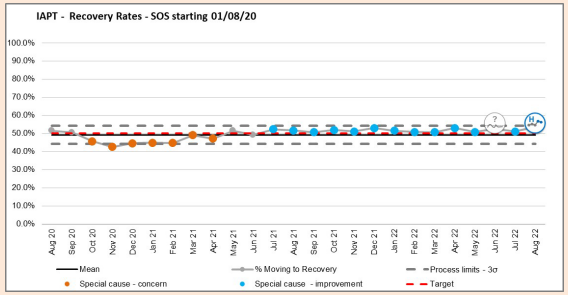
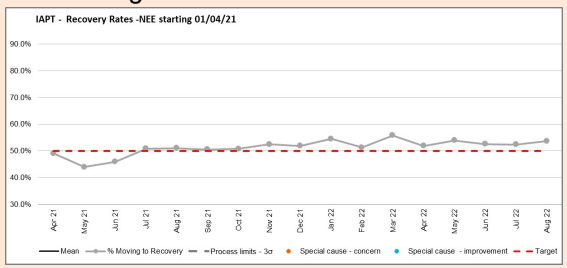
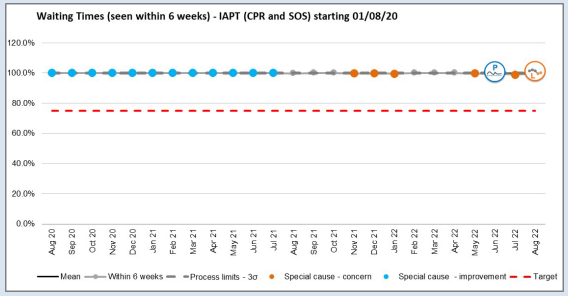
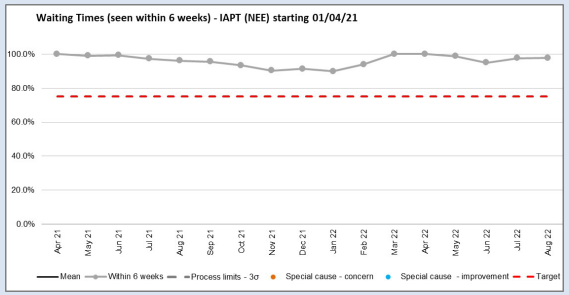
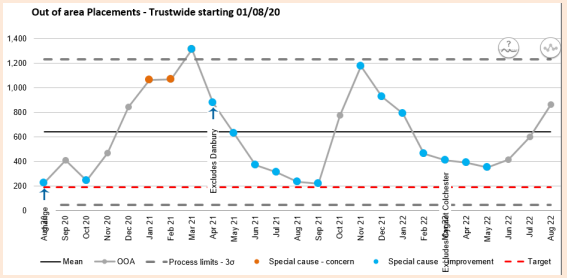
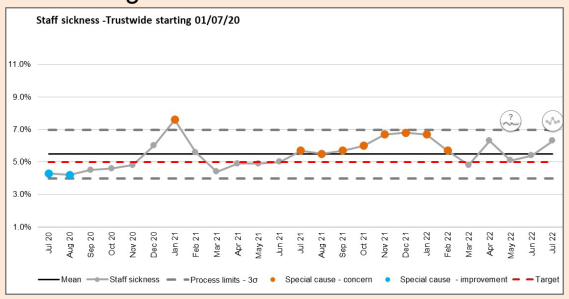
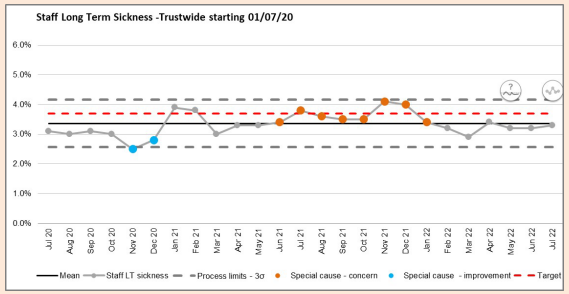
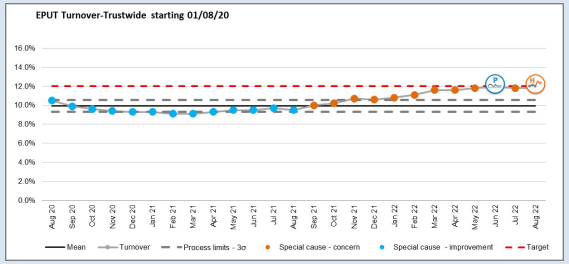
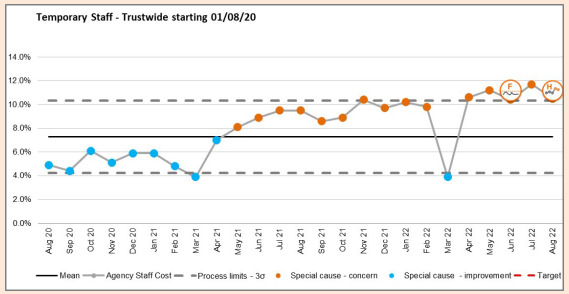
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	85.2%	●	Above Target = Good 	●	August performance represents: 23 / 27 patients.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	95.4%	●	Above Target = Good 	●	Latest published figures are for May 2022. A Data Quality Improvement Plan for Mental Health has been produced to identify the areas of the MHSDS that we can improve upon.	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	54.1%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	53.6%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	53.7%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	99.5%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	97.7%	●	Above Target = Good 	●		
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	99.5%	●	Above Target = Good	●		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	●	Above Target = Good	●		
4.5 Out of Area Placements ●	August has seen a further increase in out of area bed days, 866 (excluding Danbury & Cygnet). These increases in placements reflect the higher demand for inpatient admissions, and placements were expected to rise following the declaration of a Trust Black Alert at OPEL 4 status from the 14th - 20th August 2022. A Whole Essex System Flow and Capacity group has been established to review current and future bed modelling. An NHS England Data Scope development is in progress to inform purposeful admission and future bed modelling discussions. The revised NHSE/I target has been set to 0 placements by the end of March 2023. There continues to be comprehensive action plans in place across the Trust to meet this. Neighbouring Trusts also face similar challenges in reducing their placements.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	The Trust continues to hold contracts with the Priory (Danbury ward) and with Cygent Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. Wider conversations are in progress with System, Operations, Finance and Contract teams to explore opportunities for financial efficiencies and improved quality. 21 new clients were placed OOA (17 Adult & four PICU) in August, and following the repatriation of 17 (16 Adult & one PICU), there were 27 remaining (19 Adult & eight PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of June 2022**	866 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Mar 2023

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	6.3%		Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. National data April 2022: The overall sickness absence rate for England was 5.8%. This is lower than March 2022 (6.0%) but higher than April 2021 (4.1%). Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence (20.4%). EPUT reported above the England average for this period at 6.1%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.3%		Below Target = Good 	N/A		
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	11.8%		Below Target = Good 		Special Cause of concerning nature of higher pressure due to higher values. Performance remains outside of the limits of expected variation. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7.3 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: **Green**	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	10.5%			N/A		
5.5 Staff Survey Committee: FPC Data Quality RAG: **Green**	5.5 Outcome of CQC NHS staff survey	The 2022 Staff Survey will launch on the 22nd September 2022 and this year the biggest change is that bank only workers are now able to participate. The results of the survey will be produced in spring 2023. **<u>Information from the 2021 Staff Survey</u>** The Staff Survey ran from September to November 2021. This year saw the biggest change in how results were formalised. The themes have been aligned to the People Promise which means in some areas we are unable to compare results against previous years. The Trust was measured against nine themes in the 2021 Survey. EPUT scored above average in three themes, in line with average on three themes, and below average against three themes. **Actions:** • Internal Communications Campaign to share results after embargo is lifted. This is to be a regular item moving forward to ensure engagement and staff feedback is a continuous topic and agenda item at EPUT. A clear focus on 'you asked, we delivered'. • Focus groups with staff to understand the survey results co-create solutions/ actions to tackle from areas of focus below, share good practise and work on improvements in their local areas. • Focus groups to support with the development of a trust wide action plan. • Update to Engagement Champions with a focus on their role in sharing results and supporting with 'you asked, we delivered'.				

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

Areas of Focus:

- We are recognized and rewarded-Pay, benefits, recognition and value.
- We each have a voice that counts-autonomy, empowerment, control and raising concerns.
- We are a team-Team working and Line management
- Morale-in relation to work pressures and particularly retention of staff.
- Discrimination in relation to ethnicity

Highlights of each theme:

Theme: We are Compassionate and Inclusive	**Score**
89% agree or strongly agree and 2% above average. In reference to questions about compassionate culture, we can celebrate the fact that people are fulfilled and can understand how their day-to-day role affects service users.	Average

Theme: We are Recognised and Rewarded	**Score**
My level of pay; 31.9% were satisfied or very satisfied and is 6% below the average. In employee surveys, questions on pay are traditionally lower scoring. There is an opportunity for us at EPUT to look at our overall benefits package for staff.	Below Average

Theme: We each have a voice that counts	**Score**
I am trusted to do my job; 92.1% agree or strongly agree and 1% above average. This is a positive story around autonomy and control and a very high scoring question.	Below Average

Theme: We are Safe and healthy	**Score**
I am able to meet all the conflicting demands on my time at work; 49% agree or strongly agree and 5% above average. This question really captures the context of how we are performing in comparison to other organisations like us. Work and staffing pressures are not unique to EPUT and actually, with this question, the average was 44.9%.	Above Average

Theme: We are always Learning	**Score**
It helped me to improve how I do my job; 25.2% selected yes definitely to this question on appraisals and this was 5% above average. This is a positive message on the impact of the new appraisal process.	Average

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

Theme: We work flexibly	**Score**
I can approach my immediate manager to talk openly about flexible working; 78.3% selecting agree or strongly agree and 1% above average. Conversations around flexible working with line managers is scoring very well and is a positive message for work-life balance.	Average

Theme: We are a team	**Score**
My immediate manager takes a positive interest in my health and wellbeing; 77.2% said agree or strongly agree In reference to the questions on line management, there is a positive message that shows that even through unprecedented circumstances and change, managers are showing resilience. Line managers often get a tough time, but the results show that managers are supporting.	Below Average

Theme: Staff Engagement	**Score**
I am enthusiastic about my job; 72% selected often/always and 2% above average. In reference to questions about motivation, here we can see that there is an opportunity for us here at the trust as despite the pressures our staff members are facing, they are still passionate about their roles and purpose.	Above Average

Theme: Morale	**Score**
I will probably look for a job at a new organisation in the next 12 months; 20.5% agreed/strongly agreed. In reference to questions relating to retention/ thinking about leaving, this area warrants concern as we already have staffing levels pressures.	Above Average

SECTION 5 - SAFER STAFFING SUMMARY

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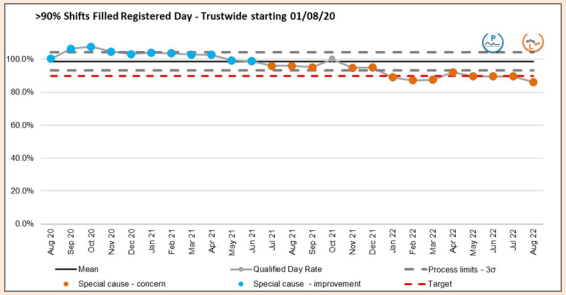
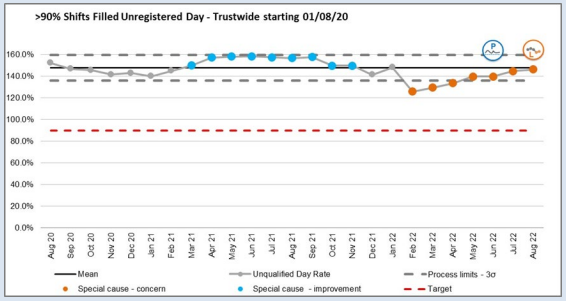
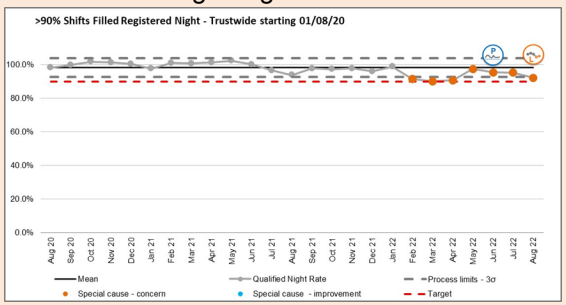
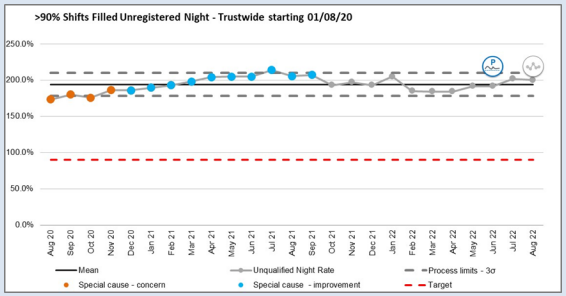
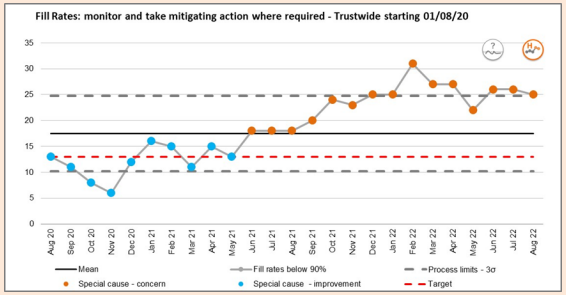
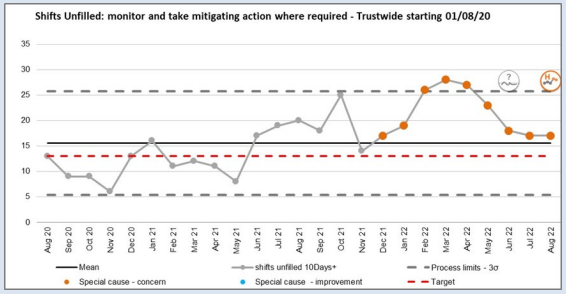
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M05 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. From February 2022 this data is being extracted from SafeCare. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	86.2%		Trend above target = good 		The following wards were below target in August: Adult: Ardleigh, Willow, Finchingfield, Galleywood, Gosfield, Cherrydown Adult Assessment - MHAU CAMHS: Larkwood, Longview, Poplar CHS: Cumberlege Centre Nursing Home: Rawreth Court, Older: Beech(Rochford) , Meadowview, Ruby, Specialist: Alpine. Edward House, Fuji, Lagoon, Rainbow Adult Assessment: Basildon MHAU, Peter Bruff	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	146.3%		Trend above target = good 		The following wards were below target in August: Adult: Finchingfield, Specialist: Rainbow, CHS: Cumberlege, Poplar Nursing Home: Rawreth Court	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	92.2%		Trend above target = good 		The following wards were below target in August: Adult: Ardleigh, Willow, Gosfield CHS: Cumberlege CAMHS:, Larkwood, Longview, Poplar Nursing Home: Rawreth, Clifton Specialist: Rainbow, Alpine Older: Tower, Beech Adult Assessment: Peter Bruff	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	200.1%		Trend above target = good 		The following wards were below target in August CHS: Beech, Cumberlege Specialist: Edward House, Rainbow	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	25		Below Target = Good 	N/A	The following wards had fill rates of <90% in August Adult:, Ardleigh, Willow, Gosfield, Cherrydown Finchingfield, Galleywood, Adult Ass: Basildon MHAU, Peter Bruff CAMHS: Longview, Larkwood, Poplar Nursing Homes: Rawreth Court, Clifton Lodge Older: Beech, Meadowview, Ruby, Tower	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M05**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						Rehab: Ipswich Road Specialist: Alpine, Edward House, Fuji, Rainbow, Lagoon CHS: Cumberledge, Beech, Poplar	
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	22		Below Target = Good 	N/A	The following wards had more than 10 days without shifts filled in August: Specialist: Fuji Edward House CHS: Avocet Adult: Ardleigh, Cedar, willow, Chelmer, Finchingfield, Gosfield, Kelvedon, Cherrydown Adult Assessment: MHAU Basildon, Peter Bruff CAMHS: Longview, Laarkwood, Poplar Older: Beech, Topaz, Tower PICU: Christopher, Hadleigh Nursing Home: Rawreth	N/A

Fill Rates

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Jun-22				Jul-22				Aug-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
MH ADULT ACUTE												
ARDLEIGH WARD	72.5%	147.7%	104.4%	185.0%	61.0%	177.2%	99.9%	201.5%	71.4%	125.4%	73.5%	145.4%
CEDAR	119.4%	263.6%	102.1%	256.6%	122.5%	221.7%	103.7%	262.4%	103.0%	234.2%	99.2%	270.2%
WILLOW	70.9%	225.8%	111.2%	312.3%	84.8%	220.2%	113.0%	329.3%	75.2%	251.9%	88.5%	366.9%
CHELMER WARD	86.7%	323.3%	95.3%	509.1%	91.6%	360.3%	92.2%	650.2%	92.0%	382.8%	99.2%	700.1%
FINCHINGFIELD WARD	42.7%	60.8%	182.6%	177.1%	39.6%	63.8%	174.2%	154.6%	38.8%	67.6%	190.0%	168.9%
GALLEYWOOD WARD	59.5%	71.0%	90.0%	96.7%	67.0%	85.5%	92.5%	111.4%	59.0%	90.1%	98.4%	101.0%
GOSFIELD WARD	91.7%	240.0%	102.0%	360.0%	88.3%	292.1%	101.5%	464.5%	80.4%	244.0%	85.3%	402.9%
KELVEDON	76.7%	235.2%	109.9%	310.9%	90.2%	271.8%	108.6%	356.7%	127.1%	324.8%	111.4%	426.6%
STORT WARD	102.7%	149.7%	93.3%	272.9%	98.0%	155.2%	99.1%	212.2%	99.1%	166.3%	91.9%	280.1%
CHERRYDOWN	78.0%	387.3%	100.7%	571.4%	67.9%	147.1%	104.0%	521.6%	70.7%	321.0%	100.2%	493.3%
MH ASSESSMENT UNIT												
BASILDON MHAU	93.5%	346.6%	112.9%	372.3%	75.3%	336.8%	106.6%	408.4%	74.5%	359.9%	105.0%	401.0%
PETER BRUFF UNIT	79.6%	173.7%	94.5%	203.1%	91.0%	187.7%	94.4%	234.5%	85.6%	198.5%	78.9%	261.5%
MH OLDER ADULT												
BEECH (ROCHFORD)	87.0%	162.2%	85.8%	384.9%	84.9%	162.0%	90.3%	402.4%	76.3%	173.4%	79.8%	401.7%
GLOUCESTER	109.4%	165.9%	100.0%	211.5%	101.6%	176.9%	98.4%	204.0%	90.3%	202.5%	98.4%	249.2%
HENNEAGE WARD	88.3%	239.5%	93.2%	329.7%	86.9%	229.6%	98.8%	335.3%	95.3%	209.8%	91.4%	379.9%
KITWOOD WARD	99.3%	132.2%	146.7%	138.1%	111.0%	157.7%	142.6%	168.0%	99.7%	153.5%	143.2%	151.9%
MEADOWVIEW	88.8%	157.0%	98.3%	199.3%	97.4%	181.8%	100.0%	283.4%	82.9%	227.1%	98.2%	304.2%
RODING WARD	105.1%	172.5%	140.0%	178.3%	106.6%	170.5%	151.9%	177.5%	100.8%	151.3%	142.2%	151.5%
RUBY WARD	55.0%	297.7%	177.0%	232.1%	54.0%	342.7%	197.4%	301.8%	52.4%	309.1%	183.9%	246.3%
TOPAZ WARD	93.4%	79.1%	97.1%	259.9%	78.9%	91.4%	97.3%	285.6%	91.4%	103.4%	96.8%	306.5%
TOWER	78.0%	387.3%	100.7%	571.4%	67.9%	147.1%	60.6%	181.5%	93.9%	147.4%	77.4%	164.5%
MH ADULT PICU												
CHRISTOPHER UNIT	101.9%	237.5%	100.0%	288.9%	111.5%	225.4%	96.5%	262.7%	90.9%	183.8%	93.5%	211.8%
HADLEIGH PICU	97.2%	250.7%	108.6%	485.0%	93.5%	234.6%	114.3%	451.9%	104.5%	262.4%	109.6%	496.2%
MH ADULT REHAB												
IPSWICH ROAD	110.2%	112.8%	108.3%	206.7%	85.4%	98.9%	102.5%	200.0%	90.1%	100.3%	97.6%	196.8%
CAMHS SERVICES												
LARKWOOD	100.3%	226.5%	81.6%	326.9%	79.8%	211.0%	60.3%	130.2%	70.0%	194.9%	60.1%	148.2%
LONGVIEW	78.0%	180.8%	63.9%	98.9%	94.9%	229.5%	74.8%	341.8%	74.1%	238.0%	59.8%	307.1%
POPLAR	82.7%	256.1%	85.7%	301.5%	93.6%	266.2%	92.2%	317.0%	71.8%	281.2%	88.7%	328.9%

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Jun-22				Jul-22				Aug-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
SPECIALIST SERVICES												
EDWARD HOUSE	73.0%	111.4%	98.3%	93.8%	76.3%	106.7%	101.6%	85.0%	73.5%	104.1%	103.0%	83.5%
ALPINE	98.9%	94.1%	100.0%	100.9%	94.0%	106.7%	83.7%	112.2%	86.3%	114.3%	74.6%	113.8%
AURORA	115.2%	100.8%	100.0%	100.0%	110.6%	98.7%	96.6%	100.0%	98.7%	93.8%	100.0%	100.0%
CAUSEWAY	221.9%	164.2%	98.5%	101.1%	198.5%	207.5%	97.1%	106.4%	143.2%	145.6%	98.5%	100.0%
DUNE	99.1%	97.0%	96.5%	98.3%	104.0%	128.5%	95.5%	98.3%	96.7%	111.2%	97.1%	99.6%
FOREST	159.1%	102.7%	95.2%	98.3%	151.5%	118.9%	95.3%	91.4%	161.1%	145.8%	91.9%	127.1%
FUJI	82.5%	125.8%	96.8%	121.9%	84.6%	152.7%	95.4%	135.8%	79.6%	131.3%	90.2%	111.8%
LAGOON	88.0%	133.2%	100.5%	131.7%	100.8%	104.7%	100.2%	110.7%	84.1%	110.7%	98.4%	106.4%
ROBIN PINTO UNIT	131.9%	120.5%	96.0%	226.7%	119.8%	122.3%	99.1%	227.0%	113.9%	125.3%	97.0%	222.6%
WOODLEA CLINIC	118.5%	110.3%	103.4%	122.0%	116.3%	105.1%	100.0%	113.1%	121.8%	115.4%	117.3%	107.8%
RAINBOW UNIT	78.8%	48.7%	50.0%	68.9%	83.4%	63.4%	49.9%	79.4%	87.1%	62.7%	53.2%	68.4%
LEARNING DISABILITY SERVICES												
HEATH CLOSE	98.0%	117.4%	98.5%	113.5%	92.8%	117.4%	97.1%	123.0%	100.8%	111.5%	100.0%	121.5%
NURSING HOMES												
CLIFTON LODGE	99.9%	110.2%	77.7%	224.0%	90.1%	114.2%	71.8%	222.9%	97.8%	112.0%	85.5%	211.8%
RAWRETH	66.2%	84.3%	51.8%	173.2%	79.1%	79.2%	50.0%	168.4%	78.3%	79.2%	50.0%	170.0%
COMMUNITY HEALTH SERVICES												
CUMBERLEGE ICC	58.6%	58.1%	63.3%	83.2%	69.6%	59.2%	65.6%	83.7%	60.7%	57.7%	66.7%	80.7%
AVOCET	118.7%	105.5%	91.8%	115.1%	108.8%	95.8%	97.3%	135.0%	104.2%	90.5%	91.2%	104.6%
BEECH WARD	114.8%	99.9%	100.0%	87.3%	115.9%	88.1%	106.7%	86.5%	100.1%	96.0%	101.7%	83.2%
PLANE	127.5%	96.3%	103.3%	98.7%	108.5%	95.8%	103.2%	97.7%	129.0%	101.7%	100.4%	96.7%
POPLAR UNIT	99.3%	76.6%	100.0%	103.3%	119.8%	68.9%	96.8%	107.8%	123.1%	78.8%	100.1%	112.1%

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SECTION 5 – CQC

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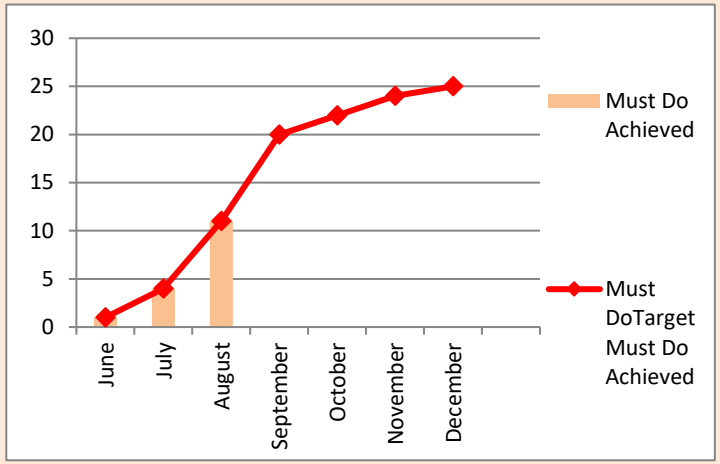
The CQC undertook an inspection of the CAMHS Wards in March and April 2022 and have made 6 'must do' recommendations to address breaches in regulations observed by the inspection team.

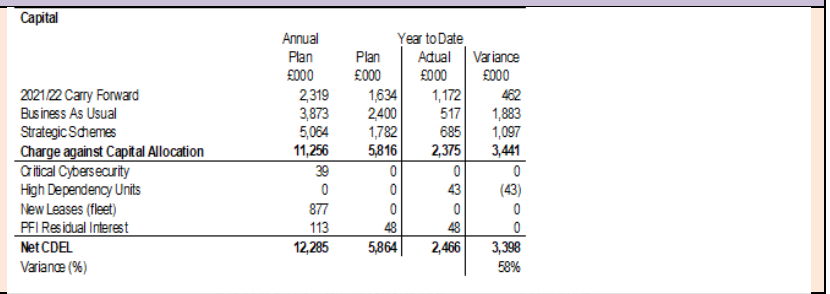
A CAMHS improvement planning group has been established with MDT membership which has reviewed the report and recommendations and has developed an improvement plan. The improvement plan was submitted to the Executive Team for review and approval, before being submitted to the CQC on 25th August 2022, which was within the deadline set by the CQC.

The CAMHS improvement planning group is currently meeting fortnightly to monitor progress and ensure identified actions are completed in a timely manner.

RAG	Ambition / Indicator	Position M5	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of August 0 actions were past timescale	Achieve target = good performance 	0 CQC Must Do action is past timescale at the end of August 2022

SECTION 6 - Finance

Click here to return to summary page

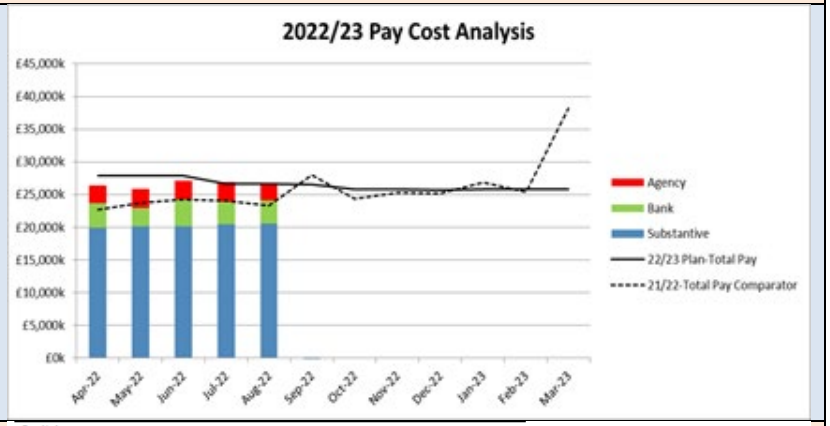
RAG	Ambition / Indicator	Position	Trend
Capital Expenditure	Maximising Capital Resources	The Trust plan for 22/23 is £12.3m (of which £11.3m relates to system allocation). As at M5, the Trust has incurred capital expenditure of £2.5m against YTD plan of £5.9m. The underspend mainly relates to timings of planned ICT related projects and Estates related works. These are expected to recover in future months.	
Income and Expenditure	Income and Expenditure	The YTD month 5 position was a deficit of £2.3m, £0.3m favourable variance which remains broadly in line with plan. The Trust continues to FOT a breakeven position.	

Capital

	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
2021/22 Carry Forward	2,319	1,634	1,172	462
Business As Usual	3,873	2,400	517	1,883
Strategic Schemes	5,064	1,782	685	1,097
Charge against Capital Allocation	**11,256**	**5,816**	**2,375**	**3,441**
Critical Cybersecurity	39	0	0	0
High Dependency Units	0	0	43	(43)
New Leases (fleet)	877	0	0	0
PFI Residual Interest	113	48	48	0
Net CDEL	**12,285**	**5,864**	**2,466**	**3,398**
Variance (%)				58%

RAG	Ambition / Indicator	Position	Trend
Efficiency Programmes	Efficiency programme	The YTD reported delivery is £2.4m against the plan of £3.6m, £1.2m behind plan. The position mainly arises due to the timing of a single scheme in the original plan which is now expected to occur in later months. The Trust has identified additional schemes with £14.8m of the planned £17.3m now identified.	
Temporary Staffing	Temporary Staffing Costs	In month temporary staffing was £6.2m (£6.4m in M4); bank spend £3.5m and agency spend £2.7m. The continued reduction relates to COVID spend in Inpatient services.	
Capital Resources	Maximising Capital Resources	The Trust plan for 22/23 is £12.3m (of which £11.3m relates to system allocation). As at M5, the Trust has incurred capital expenditure of £2.5m against YTD plan of £5.9m. The underspend mainly relates to timings of planned ICT related projects and Estates related works. These are expected to recover in future months.	

	Efficiencies £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000
	£000s	£000s	£000s	£000s
Identified	7,087	1,321	791	(530)
Unidentified	10,203	2,267	1,570	(697)
Total	**17,289**	**3,589**	**2,361**	**(1,227)**



Capital

	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
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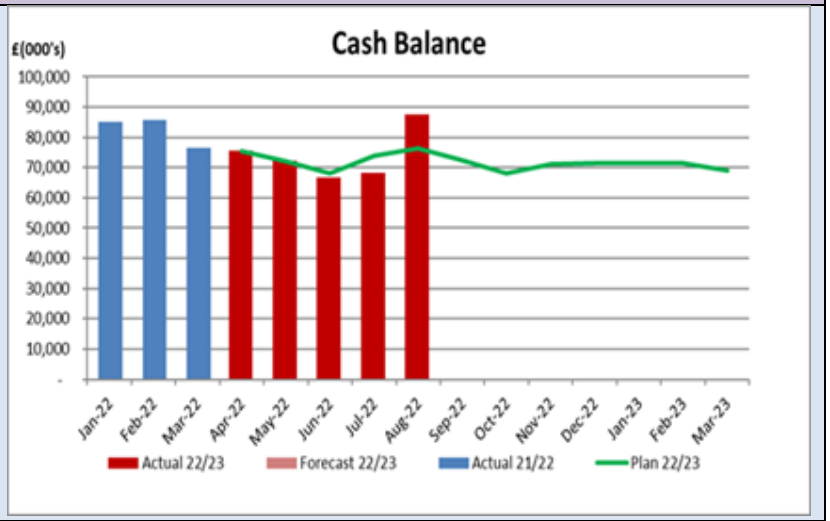
PFI Residual Interest	113	48	48	0
Net CDEL	**12,285**	**5,864**	**2,466**	**3,398**
Variance (%)				58%

RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	Cash balance as at end of M5 was £87.4m against plan of £76.4m, £11m above plan and impacted by National system unavailability during August.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Outcome of the Standing Committee Effectiveness Review 2022**					
Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Board Standing Committees					
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 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The report provides details and key findings of the self-assessment undertaken by members of the Board Standing Committees to assess its effectiveness in 2021/22 and inform our governance business flow going forward.	**Approval**	
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and noted the outcome of the overall self-assessments.
2. Note the positive assurance provided for higher scoring statements.
3. Note that the identified lower scoring statements will be addressed with the review of wider governance business flow.

Summary of Key Issues
It is good practice to undertake reviews of the effectiveness of governance processes within organisations in order to ensure these are designed and operating effectively. The self-assessment was undertaken by Non-Executive Director members of each of the Board of Director Standing Committees. The self-assessment questionnaire was completed by Committee members with the responses scoring between 'Strongly Agree – Strongly Disagree' and provided a score for each of the responses to give an overall percentage. The majority of responses were "Strongly Agree" or "Agree" (77%), with 12% neutral responses. 3% of the responses were Disagree and less than 1% Strongly Disagree. Full details of the results are included in the report.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Main Report

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

Agenda Item 7b
Board of Directors Part 1
28 September 2022

OUTCOME OF THE STANDING COMMITTEE EFFECTIVNESS REVIEW 2022

1.0 PURPOSE OF REPORT

The report provides details and key findings of the self-assessments undertaken by members of the Board Standing Committees to assess its effectiveness in 2021/22.

2.0 EXECUTIVE SUMMARY

It is good practice to undertake reviews of the effectiveness of governance processes within organisations in order to ensure these are designed and operating effectively. The self-assessment was undertaken by Non-Executive Director members of the following Standing Committees:

- Audit Committee
- Charitable Funds Committee
- Finance and Performance Committee
- Quality Committee
- Remuneration and Nomination Committee

The People, Equality and Culture Committee was established in November 2021 and therefore will undertake its first review at the end of 2022/23 to ensure that a sufficient number of meetings had been held to undertake such an assessment.

3.0 STANDING COMMITTEE REVIEW FINDINGS

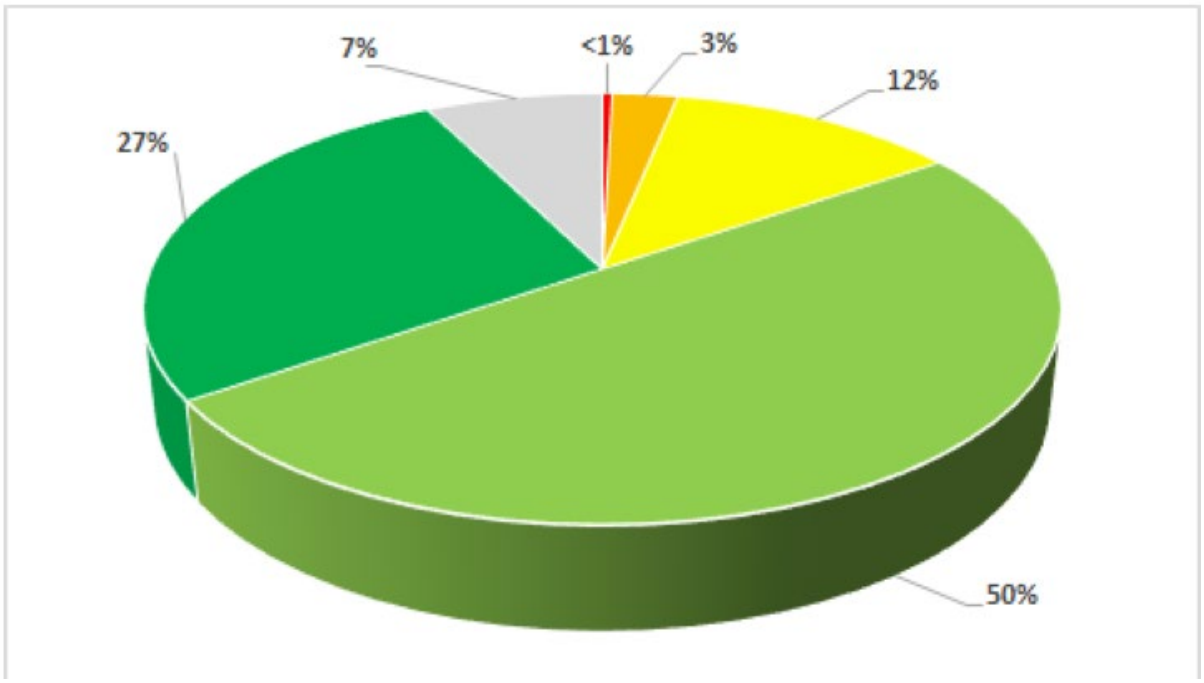
The self-assessment questionnaire was completed by Committee members using an online portal based on best practice. The responses were scored between 'Strongly Agree – Strongly Disagree' and provided a score for each of the responses to give an overall percentage. The chart below provides a key to the charts and the scoring used:

Key and Scoring

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

The charts below shows the overall results for the Standing Committee 2022 Self-Assessment:

							Score	%age
Overall Results	3 [<1%]	20 [3%]	89 [12%]	362 [50%]	197 [27%]	54 [7%]	2,746/3,360	82%



The charts show the majority of responses were 'Strongly Agree' or 'Agree' (77%), with 12% neutral responses. 3% of the responses were 'Disagree' and less than 1% 'Strongly Disagree'.

The following statements within the questionnaire appeared in the top positive response for more than one Standing Committee:

- I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions. (4 Committees)
- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance. (3 Committees)
- The committee provides a written summary report of its meetings to the Governing Body. (3 Committees)
- Committee meetings are chaired effectively and with clarity of purpose and outcome. (3 Committees)
- Committee members contribute regularly across the range of issues discussed. (3 Committees)
- The quality of committee papers received allows me to perform my role effectively. (2 Committees)
- The committee Chair provides clear and concise information to the governing body on the activities of the committee and the implications of all identified gaps in assurance/control. (2 Committees)
- Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc. (2 Committees)

The following statements received lower scored responses across more than one Committee:

- At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc. (5 Committees)

- The committee receives clear and timely reports from other governing body committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework. (3 Committees)

- I can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified. (2 Committees)

- Other committees provide timely and clear information in support of the committee thereby eradication the potential for 'surprises'. (2 Committees)

The full results of the self-assessments has been shared with each Standing Committee, except for the Remuneration and Nomination Committee which is due to be presented at its next meeting.

5.0 RECOMMENDATIONS

The Board of Directors is asked to:

- Receive and noted the outcome of the overall self-assessments.

- Note the positive assurance provided for higher scoring statements.

- Note that the identified lower scoring statements will be addressed with the review of wider governance business flow.

Report prepared by:

Chris Jennings
Assistant Trust Secretary

On behalf of

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Safeguarding Annual Report**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Tendayi Musundire, Associate Director, Safeguarding					
Report discussed previously at:	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 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes	
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 an account of the safeguarding activities undertaken across services and with partners during the year 01 April 2021 to 31 March 22, and priority areas for 2022/23	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report, the improvements made during 2021/22 and the priority areas for implementation during 2022/23

2 Approve the report and for its publication

Summary of Key Issues

- The report gives assurance that safeguarding of children, young people and adults is considered to be core business and is a shared responsibility with the need for effective joint working between partner agencies and professionals
- The annual report outlines how the safeguarding service is performing and promoting best practice
- 2021/22 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients
- Recognition that the pandemic has impacted our populations in a variety of emerging ways and consequently can be seen in the impact on safeguarding services

- Safeguarding training meets the national standards as identified in the Intercollegiate Guidance 2019 (Children) and the RCN Intercollegiate Guidance 2018 (Adults)
- The Annual report provides a breakdown of the work undertaken by the safeguarding team during the period 2021 – 2022

Key Issues to Highlight:

Significant increase in the safeguarding activity

- 3312 safeguarding adult concerns received which is a 27% increase from previous year
- 63.91% enquiries were investigated within 90 days, a 4.46% improvement from 2019-20 (despite a 14.82% increase in the number of enquiries)
- 160 children known to the Trust were subject to a Child Protection Plan in May 2020, compared to 202 in May 2021 (and 282 in May 2022)

Training

- 38.29% increase in adult safeguarding level 3 training
- 46.31% increase in adult safeguarding level 3 training

Safeguarding Reviews

The organisation has been involved in the following reviews during the reporting period:

- 12 Domestic Homicide Reviews (DHRs). There have been no DHRs published during the report period
- 11 Child Safeguarding Practice Reviews (CSPR) none of which have been published during the reporting period
- 13 Safeguarding Adult Reviews (SARs). Four of these have been combined reviews, bringing together the SAR requirements with a Domestic Homicide Review (DHR)

There has been one published review for SAR by Essex Safeguarding Adults Board. However, five reviews will be finalised and approved for publication in 2022/23.

Duty System

The Service has a safeguarding duty system operating between the hours of 9-5 Monday to Friday. The duty system has proved invaluable in providing a reflective space to discuss and clarify safeguarding concerns and to provide support to practitioners on next steps. In total, 1226 advice calls have been undertaken by duty, along with the screening of the 3312 concerns raised. The service also quality assures all safeguarding enquiries and mental capacity assessments undertaken by practitioners within the Trust.

Challenges

Provision of effective safeguarding functions to include mandatory training, supervision and support in a landscape of successful service acquisition and increased demand, in the absence of identified resources within safeguarding.

Increase in safeguarding activity post pandemic and the need to provide support from safeguarding within operational teams to support timely, robust and rigorous safeguarding enquiries.

Responding and being involved with various Safeguarding Adult and Child Practice Reviews across the SET Area.

Success

- Key partners of the MSE provider collaborative
- The ability for the team to work creatively/innovatively in order to meet the increasing demand without additional resources

- The safeguarding Team managed to effectively engage with our partner agencies in a positive way (partnership boards, subgroups and also with operational teams)
- Development of a single point of access for practitioners from both Adults and Children's Services to obtain prompt safeguarding advice and support using a "Think Family" approach
- Successful implementation of innovative approaches to safeguarding training
- Undertaken a review of all safeguarding training packages
- Delivered a programme of Safeguarding Champions' events on key themes
- Produced a monthly newsletter which highlights the key themes
- Delivery of bespoke training packages in response to operational teams training needs
- A conversational style webinar opened up to staff working in the hospital, community or home within the health and social care setting, to reflect on the challenges and impact of delivering a safeguarding service during these unprecedented and sometimes immensely difficult times
- The safeguarding Team has taken a proactive role to contribute to the EPUT Safety First, Safety Always Strategy and chairing the Sexual Safety Sub-Committee
- Our specialist knowledge was recognised by an independent London provider who commissioned us to support the successful disaggregation of their 0-19 service

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**	

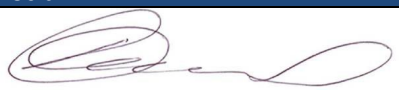
Acronyms/Terms Used in the Report			
MARAC	Multi-Agency Risk Assessment Conferences	CCG	Clinical Commissioning Group
MAPPA	Multi-Agency Public Protection Arrangements	SU	Service User
MHA	Mental Health Act	MDT	Multi-Disciplinary Team
LADO	Local Authority Designated Officer	SAR	Safeguarding Adult Review
SAB	Safeguarding Adults Board	DHR	Domestic Homicide Review

CMHT	Community Mental Health Team	LAC	Looked After Children
RHA	Review Health Assessments	MCA	Mental Capacity Act
DoLs	Deprivation of Liberty Safeguards	LPS	Liberty Protection Safeguards
DA	Domestic Abuse	CSPR	Child Safeguarding Practice Review
EHCP	Education, Health Care Plan	HEF	Health Executive Forum
ICS	Integrated Care System	MACE	Missing and Child Exploitation in Essex
SEND	Special Educational Needs	SET	Southend, Essex and Thurrock
SETDAB	Southend, Essex and Thurrock Domestic Abuse Board	STP	Sustainability and Transformation Plan

Supporting Reports/ Appendices /or further reading

Safeguarding Annual Report 2021/22

Lead



Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT 2021-2022

REPORT CONTENTS

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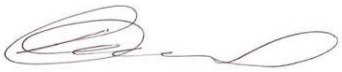
FOREWORD BY NATALIE HAMMOND, EXECUTIVE NURSE

It gives me great pleasure to introduce the 2021/2022 Safeguarding Annual Report.

As we move into 2022, the Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements in 2021-22. We continue to make good progress in relation to our ambitions as set out in our 2020/2021 Annual Report. Essex Partnership University Trust (EPUT) recognises that one of the most important principles of safeguarding is that it is 'everyone's responsibility'.

This report demonstrates the Trust has continued its commitment towards safeguarding. In addition, it gives assurance that safeguarding is fully recognised as one of the Trust's key organisational priorities and is included within our Corporate Objectives.



Safeguarding children and adults is at the heart of the service we provide. Staff within the Safeguarding Team are committed to the safeguarding agenda, they take pride in delivering high quality, safe services and at all times strive to protect the people referred to them and keep them safe from harm. Emphasis is placed on ensuring that staff are able to develop their skills and knowledge in order to provide a service that meets the needs of their patients, whilst taking into account and adapting to changing situations, i.e. the Covid-19 virus. The pandemic has resulted in the Safeguarding Team operating very differently, both within EPUT and with our partner agencies.

Safeguarding is complex and challenging and our plans for the year ahead are ambitious but they are achievable. Driven by our Safeguarding team in association with system partners we will ensure our service is patient-centred, fair, collaborative, accountable and empowering. My vision for the future is to ensure that the Trust continues to maintain the very highest standards of quality and excellence for safeguarding adults and children, that the Safeguarding Team continue to provide in depth, first-rate training to EPUT staff and that people referred to the team can be assured that they will receive a service that is second to none.

WHAT IS THE ROLE OF THE SAFEGUARDING TEAM?

Safeguarding Structure

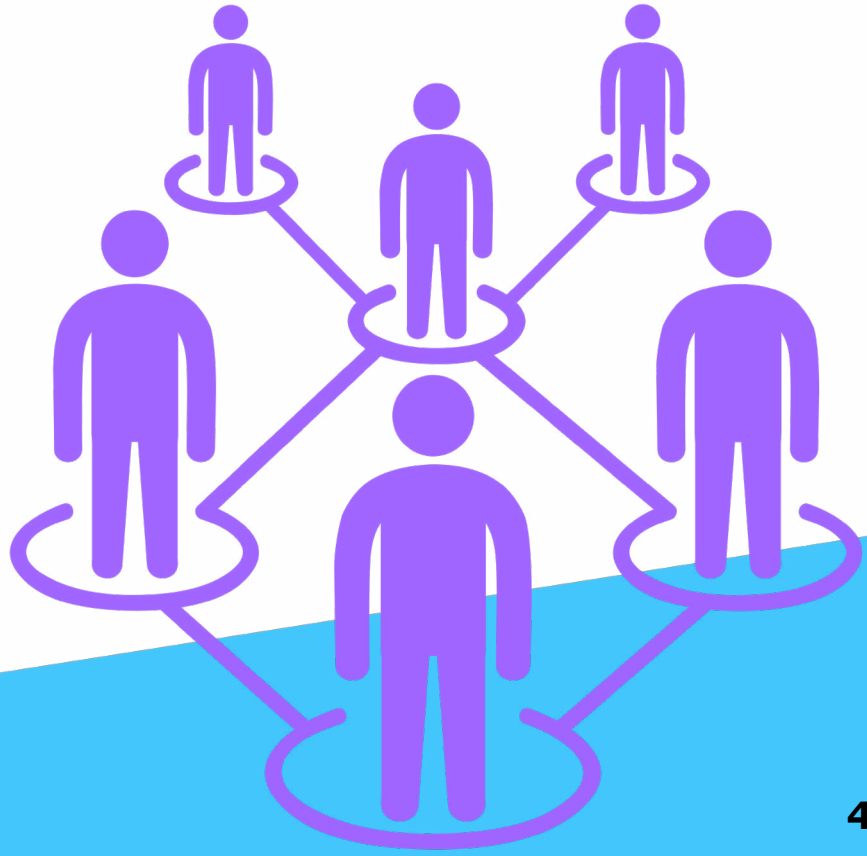
Within Essex Partnership University Trust (EPUT), the Executive Nurse is responsible for the delivery of the Safeguarding Service which includes the Mental Capacity & Deprivation of Liberty service, Domestic Abuse, MARAC, MAPPA, PREVENT and the Looked after Children service.

The Safeguarding Service is led by the Associate Director for Safeguarding covering Mental Health and Community Health Services. The team additionally provide a Safeguarding Children Service to the Southend Children, Young People and Family Public Health Service (SCYP&FPHS)

The team has adopted a "Think Family" philosophy and are providing an integrated approach to safeguarding provision, which is facilitated by joint meetings and peer support.

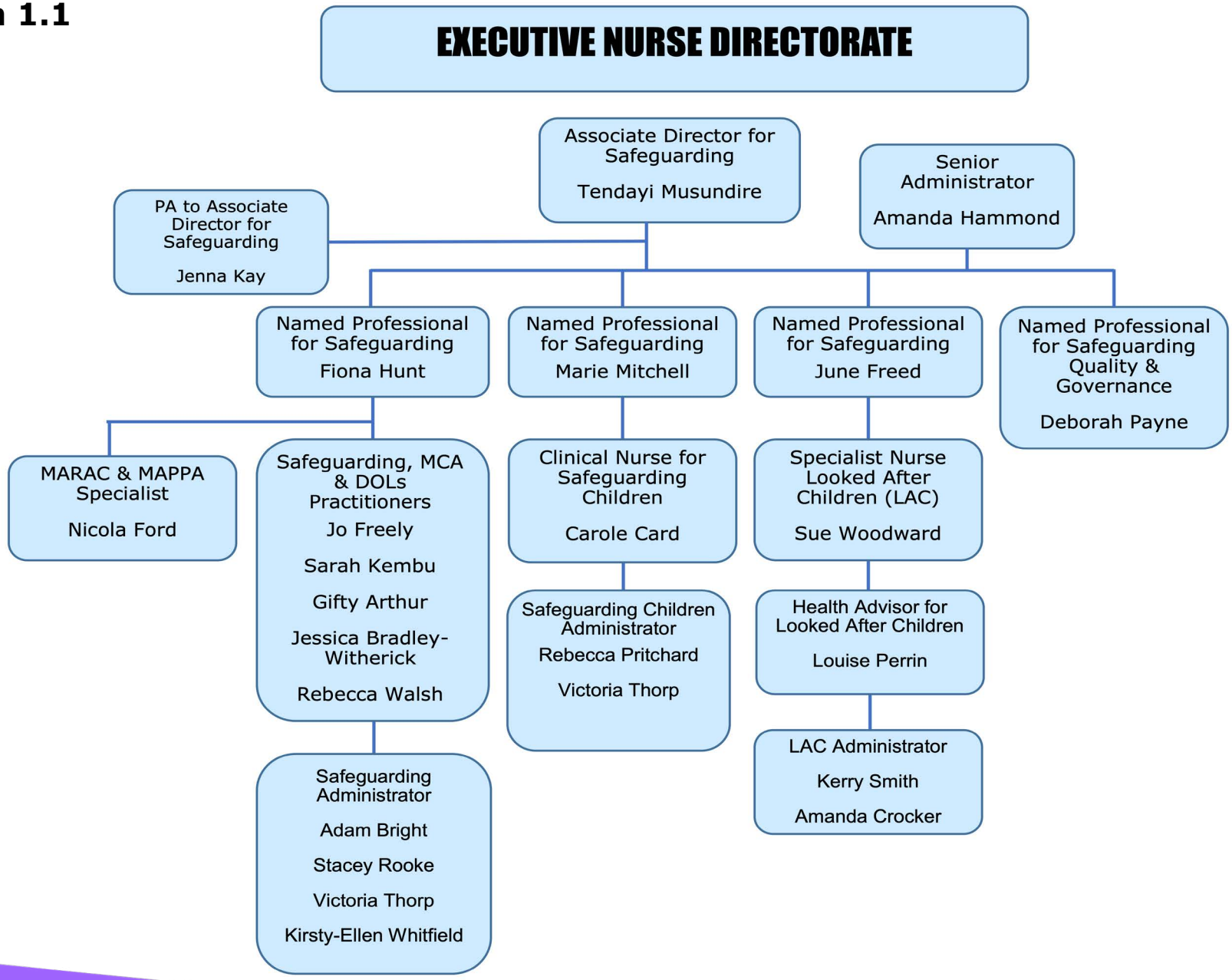
The team consists of a variety of professionals such as Registered General and Mental Health Nurses, Health Visitors, Social Workers, Midwives and an Occupational Therapist, all of whom bring additional expertise to the service.

The safeguarding adult team operate a duty system between the hours of 9-5 Monday to Friday and aim to extend this to the children's provision.



The following diagram shows the existing Safeguarding Service structure.

Diagram 1.1



Mental Health Act and Safeguarding Sub-Committee

Safeguarding oversight within EPUT is assured via the Trust Mental Health Act and Safeguarding Sub-Committee which is chaired by the Executive Nurse and meets bi-monthly. The Sub-Committee reports to the Quality Committee.

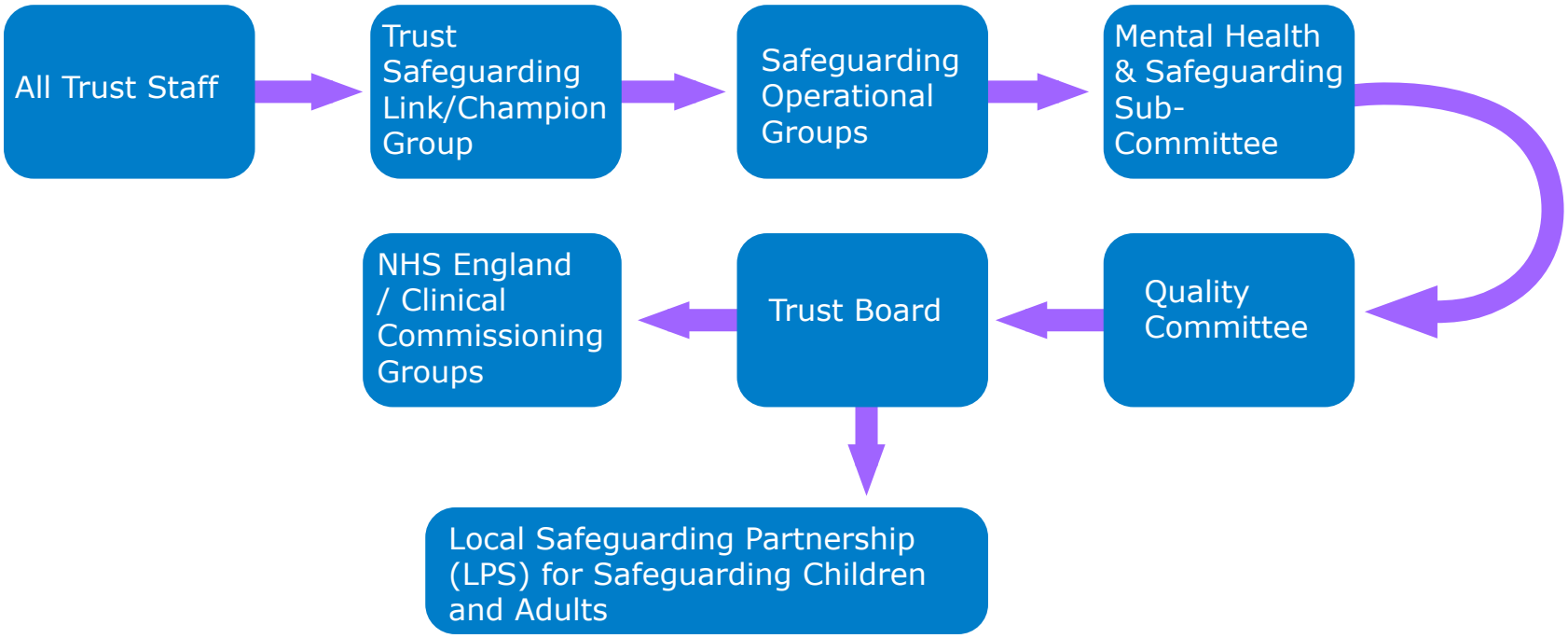
The membership on the Sub-Committee also includes a Non-Executive Director. The terms of reference have been agreed by the membership which includes senior managers/clinicians from operational teams, senior members of the teams from the Mental Health Act ("MHA") Office and the senior team members from the Safeguarding Team. All Trust safeguarding and partnership reports, policies and protocols, are agreed at the Safeguarding Group meeting, then presented to the MHA and Safeguarding Sub-Committee before being presented for Trust approval.

The MHA and Safeguarding Sub-Committee is supported by operational safeguarding groups within both community and mental health services. The group reviews an action plan of the Trust's strategic, safeguarding and forward plan ensuring alignment with the local area safeguarding partnerships, business plans and priorities. The Sub-Committee also provides oversight for the effecitve implimentation of safeguarding reviews.

Cases where 'lessons learnt' have been identified are presented at the meeting and cascaded to clinical teams.

Safeguarding Service Pathway

The diagram below demonstrates the reporting pathway for the Safeguarding Service within the Trust.



The Trust has robust reporting systems in place which ensures the Trust Board and associated committees are updated regularly on safeguarding performance, trend analysis and quality issues. The Trust Safeguarding Service provides regular reports for the Local Authority, Clinical Commissioning Group (CCG) and NHS England.

Business Support

The Safeguarding Administrative Team provide secretarial and administrative support to the Safeguarding Service. The administrators manage 'the Duty Line', a single point of access number which feeds into the team.

Business Support provide the administrative function for the safeguarding clinicians in the provision of mandatory, informal and group supervisions for practitioners within EPUT and Southend Children, Young People and Families Public Health Services within Southend City Council. This involves organising the supervision dates for the year, management of the booking systems and provision of monthly reports for approximately 30 teams. The administrators also support the child death review process by notifying safeguarding clinicians of the receipt of a child death notification within Essex, so that they can identify the relevant practitioners that have been involved in the child's care.

Business Support receive and disseminate domestic abuse notifications to the children service workforce and and for pregnant women, to hospitals in the South East locality. The administrators receive child protection minutes and invitations and ensure that the relevant practitioners within operational teams are aware so that they can contribute information.

The team action requests for information from the National Crime Agency, the Assessment and Interview Team and Essex Police to trace children and ensure that appropriate safeguarding can be initiated.

The safeguarding clinicians run Level 3 Safeguarding Children and Adults training for EPUT, Southend Borough Council and Mass Vaccination staff. Business Support provide all the administration needs for the training programme to include: organisation of Microsoft Teams invitations; management of break out rooms and attendance; provision of support on the day; closure of the course so training trackers are updated and evaluations completed.

Duty System

The Service has a safeguarding duty system operating between the hours of 9-5 Monday to Friday. The duty system has proved invaluable, providing a reflective space to discuss and clarify safeguarding concerns and to provide support to practitioners on next steps. Safeguarding specialists provide support to operational teams in cases where the safeguarding threshold has not been met, but operational teams require guidance on forward actions to manage emerging risks. Positive feedback regarding the system reveals that staff view this service as a valuable resource to guide them in their safeguarding practice.

The service operates a single point of access for all safeguarding matters, which has steamlined processes and supports timely access to specialist safeguarding support. Core duty functions are as follows:

- Triage all queries from police and local authorities to establish if a person is open to an EPUT team.
- Where a person is open to EPUT, triage the concern and confirm if it meets criteria for a Section 42 Safeguarding enquiry or an Alert, sharing the relevant information with the team(s) supporting that person.
- Provide advice to clinical and all Trust staff and agree a plan for any safeguarding concerns/queries.
- To discuss/explore issues that may be preventing staff from raising a safeguarding concern or delay conducting a safeguarding enquiry.
- Review completed Mental Capacity Assessment forms and discuss any issues with all Trust staff.
- Deal with complex issues from both local authorities, police and EPUT staff.
- Providing relevant information about specific individuals for Multi-Agency Risk Assessment Conferences (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA) processes as requested.
- Provide a reflective space to contain anxiety, sharing the responsibility for decisions, shared accountability.
- Educating practitioners by talking through a situation, so that they understand why this issue is a major concern, and why something else is not.
- Point of contact for advice to partner agencies. Promoting multi-agency working. Maintaining links with key staff/ teams within other agencies to support this approach.

Themes from Duty System

There are several themes that emerged from the Duty System. These are as follows:

- Advice and support on next steps when identifying an adults or children's safeguarding concern.
- Guidance on adult safeguarding procedures from identification of concerns through enquiries, planning and closures.
- Cases regarding domestic abuse or historical sexual abuse, especially when the victim is unwilling to share person identifiable information. The victim may also not want to report to the police but are happy to share with the staff involved in their case.
- Increased cases with complex needs where there are comorbid issues like physical ill health, substance misuse, hoarding and self-neglect.
- Escalation in cases where staff are concerned at the outcome of a referral or cases closed where the level of risk posed to child/adult remains high, requiring specialist advice and support to challenge.
- Support and guidance on writing a robust referral that effectively communicates the strengths and presenting the risks to inform assessment. Additionally, how to engage with the service user, considering consent and capacity of the individual.
- Impact of the toxic trio – mental health, substance misuse and domestic violence on children and young people.
- Management of child/adolescent abuse towards parents.
- What to do after domestic or sexual abuse disclosure.
- Frequent queries received are about how to proceed with domestic abuse where the alleged victim does not wish to proceed with the safeguarding enquiry or they do not want any support from services.

Supervision

There are a variety of models used within the Trust for safeguarding children supervision, including individual, group or peer supervision and pre and post case conference supervision. Safeguarding Professionals within the Safeguarding Team are trained to offer supervision across the Trust.

Supervision enables both the supervisor and the supervisee to reflect on, scrutinise and evaluate clinical practice. It is both educative and supportive whilst facilitating the supervisee to explore their feelings about the work and the family. The Team offer formal supervision to both Adult and Children's Services. The frequency of supervision is mapped to the roles that staff undertake within the organisation. Supervision covers safeguarding concerns in regard to both children and adults safeguarding.

Children's Services are expected to comply with a mandatory three monthly supervision session which is monitored closely for compliance. Adult Services are also offered three monthly supervision sessions, for children or adult concerns, or on demand as required if telephone advice via duty is not considered sufficient to meet the need of a case.

The model offered is a flexible one, with most of the supervision contact taking place via Microsoft Teams since COVID or face to face within a community base or inpatient setting. The Safeguarding Team offer individual supervision to practitioners managing a safeguarding caseload or a group supervision model to support joint reflection and learning, building knowledge and skills in those roles where safeguarding is not a key function. Joint supervision across roles, where staff are working with the same family, is actively encouraged in the Trust. In line with the organisation's active ethos of "Think Family", both adult and children concerns can be considered, and a plan agreed and documented.

Benefits of Supervision

The benefits of supervision are well documented, and the model adopted by the Safeguarding Team covers the four areas below:

- Management (ensuring competent and accountable performance/practice)
- Engagement/mediation (engaging the individual with the organisation)
- Development (continuing professional development)
- Support (supportive/restorative function)

Supervision

Moving to a group format, facilitated by Maria, has brought great benefits to the team and we have found the sessions very helpful. Whilst on a practical note it increases compliance, I feel the greater benefit is the shared learning and reflection. Bringing the team together to reflect on the complex cases we hold as a service enables us to think through the obvious and the subtle aspects to safeguarding infants. Maria provides a containing and safe space in which to share the difficulties and the stuckness that can arise from safeguarding concerns. These sessions enhance the quality of our risk and safeguarding plans we develop as a service.

- Dr Ellen Auty, Together With Baby Consultant Clinical Psychologist & Clinical Lead of Parent Infant Mental Health Service & Head of Perinatal Psychology

I think the safeguarding supervision we have is brilliant. It enables us to discuss as a team the patients and review from a group perspective.

- Nicola Hendy, Modern Matron for the Paediatric Community Nursing Team, Paediatric Asthma & Allergy Service & Paediatric Continence Service

We also are very lucky to have the team on hand to discuss any issues that may present day to day. We have had multiple occasions recently where urgent advice from the team has been needed, and they have always facilitated this.

- Connie Brown, Clinical lead for Paediatric Community Nursing Integrated Team & Oncology and Haematology

CHALLENGES AND INNOVATIONS

Challenges

- Provision of effective safeguarding functions to include mandatory training, supervision and support in a landscape of successful service acquisition and increased demand in the absence of identified resources within safeguarding.
- Increase in safeguarding activity post pandemic and the need to provide support from safeguarding within operational teams to support timely, robust and rigorous safeguarding enquiries.
- Raising awareness within the organisation regarding the application of the Mental Capacity Act (2005) in preparation for introduction of Liberty Protection Safeguards introduced by the Mental Capacity (Amendment) Act 2019.
- Responding and being involved with various Safeguarding Adult and Child Practice Reviews across the SET Area.

CHALLENGES AND INNOVATIONS

Innovations and Achievements

- Through a shared records approach the LAC Service has develop a greater understanding of the health journey of Looked After Children.
- Creation of a new clinical specialist providing mental health support to the Multiagency Risk Assessment Conferences (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA) processes across Southend, Essex and Thurrock, in respect of eligible service users within EPUT.
- Development of a single point of access for practitioners from both Adults and Children's Services to obtain prompt safeguarding advice and support using a "Think Family" approach.
- Commissioning of 12 Best Interest Assessor Training places in preparation for changes and responsibilities required of the organisation under the Liberty Protection Safeguards.
- A review of the LAC Service provision.
- Successful recruitment to all vacant posts.
- Successful implementation of innovative approaches to safeguarding training.
- Undertaken a review of all safeguarding training packages.
- Delivered a programme of safeguarding champions events on key themes.
- Delivery of bespoke training packages in response to operational teams training needs.
- A conversational style webinar opened up to staff working in the hospital, community or home within the health and social care setting, to reflect on the challenges and impact of delivering a safeguarding service during these unprecedented and sometimes immensely difficult times.

FORWARD PLAN 2021/22

Objectives 2021/22	Action Taken for Success
Think Family.	Adapted the safeguarding concern form, to trigger the identification of safeguarding concerns within people in the same household. The safeguarding training was reviewed, Level 1, 2 and 3 both adults and children. A newsletter was produced, focusing on 'Think Family' in November 2021.
The Trust will implement the new Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support its implementation.	This was put on hold following the publication of the letter from department of health stating the delay in the implementation of LPS. The letter was published on 16th of December 2021. We had set up a steering group that was looking at the implementation of LPS. Initial scoping of number of referrals has commenced Initial training needs analysis has been implemented with additional MCA training being delivered to specific staff groups
Align the Safeguarding service to the new Sustainability and Transformation Plans (STP) and Integrated Care Systems (ICS) systems and processes.	We actively engaged in the provider collaborative for the Mid and South Essex ICS. The Health Executive Forum was regularly updated of the actions of the provider collaborative.
Implementation of the Trusts Safeguarding Strategic Framework.	The Annual Report provides evidence that demonstrates delivery of the objectives in the strategic framework.
Review and submission of the Children Section 11 Audit in 2021.	Section 11 audit successfully submitted, September 2021.
Creation of Looked After Children (LAC) team EPUT dashboard to enable service analysis of lac population/cohort.	This action has not been completed due to lack of capacity and resources from the transformation team.

PARTNERSHIP WORKING

The Trust is actively represented on all the Local Authority Safeguarding Children and Adult Partnerships by Executive Directors, Directors and the Associate Director for Safeguarding within the areas where the Trust provides care. This representation is an important part of developing and influencing services for Trust service users and demonstrates the commitment the Trust places on the safeguarding agenda and working relationships with other agencies.

These arrangements give assurance and oversight to the Safeguarding Partners of the work EPUT is involved in. The Partners seek help and expertise from the Trust in developing strategies/ protocols which include aspects of mental health etc.

One Local Authority has co-commissioned with the CCG and the EPUT Safeguarding Children team to support the Southend Children, Young People and Families Public Health Services. Reports and audit outcomes are presented to the Local Safeguarding Partnerships. Minutes of these Partnership meetings are routinely placed on the agenda of the Trust's Safeguarding Groups and presented by the EPUT representative.

Each Safeguarding Partnership has a number of sub groups, which include the Health Executive Forum, Learning and Development, Performance, Audit, Quality and Assurance, Case Review, Policy Development etc. These are attended by members of EPUT Safeguarding Team who actively participate in achieving the aims of the business plans of the individual Safeguarding Partnerships.

PARTNERSHIP WORKING

A Safeguarding Service specification for both children and adults has been agreed with Essex CCG's. Monthly and quarterly reports containing updates on the agreed specifications are presented to the respective Clinical Quality Review Group.

The Trust continues to be represented at the Health Executive Forum (HEF). EPUT senior staff also represents the Trust at the Serious Case Review Panel, Safeguarding Adults Review meetings, Domestic Homicide Review Core Group, MAPPA, Prevent Strategic & Operational Group, DA Health Sub Group, SET DAB and the MACE Group.

EPUT and Essex County Council Safeguarding Adult Service continue to improve collaborative working with regular meetings being held with relevant professionals. The Safeguarding Team has several joint projects with the general hospital. We have agreed partnership arrangements with MARAC on how we can effectively work together. Our lead for Domestic Abuse chairs some MARAC meetings and there is increased involvement from EPUT staff. We also have representatives that attend MAPPA meetings across Essex for all EPUT Safeguarding cases and to support cases with mental health concerns. The service has successfully recruited a new post of Specialist Practitioner for MAPPA/MARAC to support multiagency working and operational teams.

EPUT and children social care teams in West Essex are exploring ways of working more collaboratively. There are regular meetings for EPUT safeguarding members to meet with relevant service managers to discuss ways of improving collaborative working, with scheduled workshops for practitioners.

The Safeguarding Team produce a monthly newsletter with updates, themes and events and deliver a monthly safeguarding event with guest speakers from partner agencies and other relevant professionals. The topic of these events is based on key themes for safeguarding.

PARTNERSHIP WORKING

Feedback

> Partnership working with EPUT is extremely effective for the safeguarding of children. There have been various opportunities for co-production and joint working between EPUT and Mid and South Essex Foundation Trust Safeguarding Children Services which have successfully progressed the response locally to safeguarding children agendas with the aim to improve outcomes for children.
> **- Yvonne Shaw, Deputy Associate Director for Safeguarding, Mid and South Essex NHS Foundation Trust**

> Over the year of 2021/22 there continued to be a close working relationship between the EPUT and NEECCG safeguarding leads from all aspects of the "Think Family" agenda. Through regular virtual meetings, sharing of ideas, discussions and review of quality reports, safeguarding assurance has been gained. The EPUT Safeguarding Team are always pro-actively responsive when there is any system safeguarding partnership issues and work collaboratively to resolve. There is always transparency from the team and a willingness to share their lessons learnt and any innovations they are implementing.
> **- Jane Whitington, NHS North East Essex Clinical Commissioning Group, Safeguarding Adults**

> EPUT were invited to become a full member of the Essex Safeguarding Adult Board (ESAB) during 2021/22 and have had 100% attendance since the invite was accepted. The Board representative has provided an overview and regular updates on the Patient Safety Strategy that EPUT implemented during the year and responded to any safeguarding queries that ESAB had, providing assurance to the board that improvements are being undertaken and ongoing work that is intended to take place within the organisation. Outside of the Board meetings, EPUT had regular representation by the Safeguarding Team at the ESAB Sub-Committees, providing input into a number of Safeguarding Adult Reviews (SARs) taking place and contributing to the updating of Policies and Procedures that cover Southend, Essex & Thurrock (SET).
> **- Michaela Jury – Essex Safeguarding Adults Board**

PARTNERSHIP WORKING

Feedback

The CCG Safeguarding Teams and EPUT Safeguarding Teams have maintained collaborative working relationships during 2021/22. The continued challenge presented to the NHS by the COVID-19 pandemic has at times resulted in major pressures on the delivery safeguarding function. The CCGs have supported EPUT in helping partner agencies to understand the rationale for temporary adjustments to the delivery of the service. Through local Safeguarding Partnerships we have collaborated on the implementation of the Graded Care Profile for neglect and improving the recognition and response to sexually harmful behaviours. We have also worked to improve the response to domestic abuse through the Domestic Abuse Health Subgroup which has supported the implementation of health components of the SETDAB strategy outcomes. The administration of Looked After Children (LAC) health assessments has been challenging due to low capacity of community paediatricians. The LAC team have worked with the Designated Nurse LAC and stakeholders to resolve issues as they arose. It is anticipated that the recommissioned service at the Lighthouse Child Development Centre will provided longer term stability in the system.

- Sharon Connell - NHS Castle Point & Rochford and Southend Clinical Commissioning Groups

- Our working relationship with EPUT is very good. We receive prompt responses to any queries we make or if we have any general enquiries, the team are always happy to help. Their service of supplying our team with the registered GP for members of the public, is invaluable.
- The other feedback I would provide is that the Adult Triage Team is happy to receive enquiries about cases we are involved in so we can update EPUT on the progression of the case. However if we are not involved or the query concerns a crime investigation ongoing, then the Officer in Charge of the case is always the best source of that information and they will need to be contacted directly.
- Sometimes we receive information 'just to make us aware' which is not helpful. If there is Police action required or the sharing is for a policing/safeguarding purpose then this is of course encouraged.

-DC Lucy Shewring – Essex Police Adults Triage Safeguarding Team

COMMUNICATIONS

Safeguarding Champions

Safeguarding Champions act as conduit of information between the Safeguarding Team and their clinical area by raising awareness of safeguarding practice and initiatives and supporting the identification of team learning needs.

The following Champions events have been held during the reporting period to support this function:

- April 21 ECC Children & Family Hubs
- May 21 Safeguarding Adult Reviews
- June 21 Independent Domestic Violence Advocates
- Aug 21 Family Group Conferencing
- Sept 21 Multi Agency Public Protection arrangements
- Oct 21 SEE Trauma Alliance
- Jan 22 Transitional safeguarding
- Feb 22 Child Protection
- Mar 22 Fire Safety

COMMUNICATIONS

During the week of the 15th November 2021 the Safeguarding Team presented a programme of safeguarding sessions on the theme of financial abuse supported by specialist speakers

Topic areas included:

- Safeguarding overview
- Substance Treatment and Recovery
- Office of the Public Guardian

Safeguarding Newsletter

The newsletter is published on a monthly basis and is circulated to all Safeguarding Champions and Operational Leads for wider distribution within the organisation. Topics reported over the past year include:

- Multi Agency Risk Assessment
- Oakwood Sexual Assault Referral Centre
- Female Genital Mutilation
- Perinatal Mental Health
- Together with Baby Service
- Older Peoples Health and Dementia
- Mental Capacity and Liberty Protection Safeguards
- Advanced Decisions
- End of Life
- Criminal Exploitation
- Domestic Abuse
- Child and Young Peoples Mental Health
- Family Group Conferencing
- Suicide Prevention
- Sexual Safety
- Discharge Planning
- Think Family
- Modern day Slavery
- Freedom to Speak up
- Whistle Blowing

EXAMPLE CASE & LESSONS LEARNT

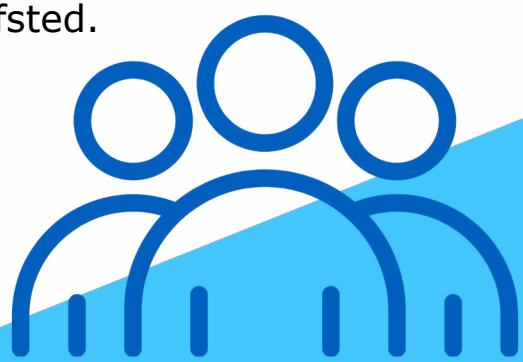
A Safeguarding Children concern was brought to the attention of the Safeguarding Team regarding a service user (SU) who was being assessed for an organic brain disease, who worked in a supervisory role providing childcare to young children.

Further information of their symptoms was sought so that an assessment could be considered into the impact on their work, and the safety of the children in their care. It showed that the service user could be caring for up to five children at a time, their ages varying from one year to school age. The assessment was still in progress, therefore the SU did not yet have a diagnosis, although significant changes were evident on the brain scan.

The Safeguarding Team advised that given their short term memory deficit, there could be a number of risks to the children, and they should stop working in their current role. The practitioner spoke to the family who were reported to react with anger to the request for the SU to stop working. They felt that it would be safe for the SU to continue to work for a further three months. The practitioner reported back to the Safeguarding Team for advice and support as this was a difficult situation to manage. The family felt that the staff member was acting in a cruel and 'inhuman' way and were concerned regarding the SU's financial situation.

The Safeguarding Team member attended the virtual MDT for the patient, at which time it was agreed that the children were at risk whilst under the SU's care. In spite of the sensitivity of the situation, EPUT staff needed to act immediately to protect the children. The Safeguarding Team contacted the Local Authority Designated Officer (LADO) for advice from Ofsted, who regulate childminders. The LADO gave the response that until the SU had a diagnosis of dementia, the LADO could not approach Ofsted.

They further said that the SU had no duty to inform Ofsted until they had a firm diagnosis. The Safeguarding Team then considered approaching Children's Social Care, since the children remained at risk in their care, the LADO expressed that this was not appropriate but the Safeguarding Team member remained of the view that it was.



It was identified that the SU came under another authority's LADO who accepted the referral, contacted Ofsted and they contacted the SU. The service had informed the client of the actions they planned to take to safeguard the children in their care. When contacted by Ofsted, the SU said that they had stopped working, apart from looking after the children of their own family.

Lessons Learnt

Practitioners should have emphasised with the client and family their duty to safeguard the children in the SU's care, and prioritise the children's needs, from the first discussion about the work role. The SU should have understood from the beginning that if they did not cease work, due to the presenting risk to children in their care, it was the duty of the practitioner to contact the relevant authorities.

The clinical team identified that they should have placed more emphasis on this from the beginning and continued to address it at each contact. They should have followed up on the assurance that the SU would retire soon and checked that this had happened. Bearing in mind the nature of the client's work and supervision of children, this should have been pursued in a time relevant manner to ensure children were safeguarded.

The Named Nurse understood from the first LADO that there were boundaries as to under what circumstances they could contact Ofsted. The practitioner however, remained concerned that the children were at risk and pursued the second LADO for an opinion. If there was still a concern, they would then approach Children's Social Care via a child protection referral if necessary.

The learning is that if a child is at risk, or is thought to be at risk, then action must be taken, regardless of a technicality such as a diagnosis. If that were the rule, then practitioners would be prioritising the adult's right to confidentiality over the children's right to safety. It is important to remember that the parents of those children were unlikely to be aware of the risk.

SAFEGUARDING REVIEWS & RECCOMENDATIONS

Safeguarding Adults Reviews

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs).

Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm.

During 2021, the organisation has been involved in 13 Safeguarding Adult Reviews (SARs). Four of these have been combined reviews, bringing together the SAR requirements with a Domestic Homicide Review (DHR). There has been one published review for SAR Alan by Essex Safeguarding Adults Board. However, five reviews will shortly be finalised and approved for publication.

SAR Alan

- Alan was 58 years old at the time of his death, having attempted to take his own life whilst at home and later being pronounced deceased at hospital.
- He had lived alone and independently for a number of years, in accommodation provided by the local authority. He had a long history of poor mental health and had been supported by mental health services over a thirty-year period.
- He had a diagnosis of bipolar affective disorder, complicated by alcohol and drug addiction.
- At the time of his death, he was being supported by mental health services provided by the Essex Partnership University NHS Foundation Trust.

Key Themes

Policy development and review

- Development of policies to support the implementation of the new mental health framework for adults and older adults.
- An update in the Active Engagement Clinical Guideline (Disengagement Guideline) CG77 to include specific guidance in the use of police welfare checks.

Risk Management

- Further development of competencies for managers and professionals in CMHT teams for the management of risk following clinical disengagement.

Communication

- Promotion of partnership working through the use of strategy and professional meetings.

Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) are multi-agency reviews, commissioned by community safety partnerships, into the deaths of adults which may have resulted from violence, abuse, or neglect; by a person to whom they were related or with whom they had an intimate relationship, or where they were a member of the same household.

During 2021, the organisation has been involved in 12 DHRs. There have been no DHRs published during the report period. However, in March 2022, the Home Office published a key findings analysis report of DHRs representing key information drawn from 124 DHRs reviewed by the Home Office for 12 months from October 2019.

Key Themes

- **Contact:** the need for greater contact with victims and recognition that the perpetrator can control the victim's contacts with agencies.
- **Assessment:** the need to improve risk assessments, carer's assessments, or mental health assessments.
- **Records:** information can be missing and not shared between agencies.
- **Support:** for staff whose work involved cases of domestic abuse and cases where support for victim was not identified or, where the need for support was identified, but there was no plan to provide it.
- **Information:** the need to improve information sharing between agencies, to hold accurate information and then use it effectively to manage risk.
- **Risk:** the right risk level needs to be identified, with information held by other agencies included.
- **Referrals:** are not always made when needed.
- **Training:** the need to update training and make it accessible.
- **Policy:** occasions when action taken was not in line with policy and there were agencies without a domestic abuse policy.

Key Themes from Wider Learning

Care planning

- Safeguarding concerns or disclosures need to form part of the service user's day-to-day care and care plans. Care plans must be updated and include all known risks and concerns to reflect the current risk status.

Professional Curiosity

- Ensure safeguarding information shared with staff by service users is not discounted on the basis they are mentally ill e.g. psychotic episode. Staff need to remain curious regarding information/ allegations and reflect on what the service user has told them – exploring with service users once mental health status improves.

Discharge

- Robust information sharing regarding safeguarding concerns needs to be discussed in relation to discharge planning and the transfer of information at discharge and between EPUT units/services.
- The safeguarding concerns, whether closed or open, should be clearly evidenced on the discharge/ transfer information even where the concerns did not reach the threshold for safeguarding enquiry.

Transition

- Young people and their families need to be supported through a multiagency approach for transition to adult services. There needs to be a clear understanding of the EPUT Transition Protocol and how this interacts with the protocols of partner agencies.

Key Themes from Wider Learning

Mental capacity

- Adults' capacity can fluctuate and therefore completion of a mental capacity assessment should be viewed as an iterative process in order to enable best interest decisions to be made where capacity is lacking.
- The individual has the right to make decisions that others might think are unwise but staff must also consider the impact of mental ill health, coercive control and substance misuse when assessing mental capacity and the need for practitioners not to use this as a reason to disengage entirely.

Care planning

- Guidance development on the use of virtual meetings to ensure the circumstances of each child/ young person is assessed and steps taken to mitigate risks associated with this contact method.

Robust understanding of the legal framework supporting discharge of young people from mental health provision

- Young people admitted to a mental health unit require a child and family assessment and a child in need plan under s17 Children's Act 1989.
- Where a young person is detained on a mental health section they also have a right for their needs to be assessed and provision made for their aftercare under s117 Mental Health Act 1983.

Criminal Exploitation

- Increased understanding and awareness by staff of the risk of exploitation where capacity can be impacted by coercive control in both adults and young people.

LOOKED AFTER CHILDREN

- The Looked After Children's Service (LAC) adhere to the provision of service detailed within the Statutory Guidance - Promoting the Health and Well-Being of Looked After Children (2015, DFE).
- The service offer is to address the health needs of all Looked After Children and young people placed in the South East locality, regardless of which authority placed them there. Additionally, the team is responsible for co-ordinating and monitoring the health needs of all children and young people who are looked after and placed by the South East locality elsewhere in the country.
- The EPUT LAC Service provides support to frontline staff working with the LAC population, as well as direct client care to young people who are over the age of sixteen. This also includes young people who are not in education and have no universal services practitioners caring for them.
- The service raises awareness of the needs of LAC by providing up-to-date, accessible, informative and appropriate training, on health-related topics to both EPUT staff and Foster Carers. Provision of evidenced-based training supports the development of practitioner's clinical skills in undertaking robust Review Health Assessments (RHAs), which support a holistic review of the health and developmental needs of the child or young person.
- The LAC Team continue to work in partnership with statutory agencies to promote the overall outcomes for LAC under the duty of the Corporate Parenting Responsibilities. The specialist nurses remain active members of the Corporate Parenting Group and the Multi-Agency Operational Groups. This has been beneficial in striving to improve the outcomes for children who are "looked after" in foster care and residential homes, as well as reviewing the pathways for transition to adult services for Care Leavers as they move to independent living.
- The statutory frameworks that support quality and assurance within the LAC Service include peer reviews, training, attendance at professional meetings, attendance at the East of England LAC Forum, regular Designated Nurse updates and quarterly supervision.

LOCAL PICTURE 'LAC'

The current LAC caseload held by the service within the **South East Locality** is **709**, which is broken down by area as:

CPR 215	SOUTHEND 417	76 CARE LEADERS
Under 18 years of age children	18 years of age children	18 to 19 years old

In the last five years the population of Looked After Children in the UK is reported to have increased by 10%, from 93,013 to 102,291 (NSPCC March 2021).
The number of Looked After Children increased by 2% from 78,140 last year to 80,080 on 31 March 2020. This is a rate of 67 per 10,000 children, up from 65 last year. This national trend is also reflected locally and additionally to that, the complexities are increasing as mentioned above.

Key Themes

- Increase of county lines, injuries and criminal activity. This has resulted in some effective disruption work by partners led by Social Care. Unfortunately some young people continue to be at risk and are now in the penal institutions or still within the gangs.
- A need for a planned and coordinated transition to adult service especially for those Care Leavers with increased vulnerabilities. This area has seen an increase in activity following the extension of provision to Care Leavers aged 21-25, particularly for children with EHCP or SEND needs. NICE (2021) also include in this group young people who identify as LGBTQ+.
- An increase in Looked After Children attendances at A&E for complex mental health needs.
- An increase in unaccompanied migrant children who during their journey may have been subject to modern day slavery, trafficking, enforced separation from family by traffickers, abuse at the camps as well as trauma.

KEY SAFEGUARDING FACTS

Training

Safeguarding training is mandatory for all staff within the Trust; all staff undertake level 1 and 2 training (including basic awareness of Prevent, MCA and DoLS) during their induction. Level 3, 4, MCA and DoLs, and safeguarding investigations training is dependent on individual's roles and responsibilities.

Our training is in line with Safeguarding Adult and Children Partnership Boards and intercollegiate guidance for both adults and children. Assurance that training has been undertaken is provided via the online training tracker, which prompts staff to undertake refresher training. In addition, the safeguarding team attend regular team meetings.

Competency of staff is demonstrated through planned and live supervision. If it is felt that staff require more support or training this will be identified and provided.

The Safeguarding Team also offers additional training to teams where there are identified concerns regarding MCA / DoLS documentation or safeguarding practices. The safeguarding training explores different scenarios through a case study approach incorporating lessons learned and key themes from safeguarding adult reviews.

The LAC Team have developed a Level 3 Looked after Children's Training. This ensures that the key LAC drivers are embedded into best practice when completing Review Health Assessments (RHAs) in order to be able to provide a holistic review of the health and development of Looked After Children.

20 Safeguarding Adults Level 3 Sessions Delivered to 910 Staff	**+38.29% from previous year**
21 Safeguarding Children Level 3 Sessions Delivered to 799 Staff	**+46.31% from previous year**

Between August 2021 and March 2022 we trained **378** Mass Vaccination staff, in Level 3 Safeguarding Children and Level 3 Safeguarding Adults.

899 (or 50.7%) attendees fed back that they felt Very Confident following Level 3 safeguarding adults, compared to 9% pre-course.

766 (or 43.8%) attendees fed back that they felt Fairly Confident following Level 3 safeguarding adults.

Feedback Themes

- Training is engaging and interactive.
- Motivation remained by using different mediums, including videos, quizzes and breakout rooms.
- More confident in contacting the Safeguarding Team.
- Helpfully covered a variety of topics under the Safeguarding umbrella.
- Trainers have been very inviting, knowledgeable and approachable.
- Training with people from other teams and professions has shown to be interesting and also challenging with different ways of working and viewpoints.

KEY SAFEGUARDING FACTS

Training Feedback

> I really enjoyed the Safeguarding Adults Level 3 training. It was very good quality, considering it was delivered online. The trainers on the 26th November did an excellent job and were clearly service matter experts, and this shone through in the ability to engage the audience and deliver confidently for that length of time online.
> **- Senior Public Health Principal**

> I work in a COVID vaccination centre where I have seen people aged 12 + coming in for their vaccination. I'm always looking out for any signs of harm to patients and staff ensuring that everyone is safe and their well-being is promoted.
> **- COVID Vaccination Clinical Manager**

> The update was a good opportunity to refresh my safeguarding skills and knowledge. I have an increased awareness of issues around ' County Lines' involving children. The session was delivered on line via MST and although it was a full day session, the trainer was knowledgeable and informative.
> **- Paediatric Continence Nurse**

KEY SAFEGUARDING FACTS

Supervision

Mandatory (Including Group) and Telephone supervision totals

April to March	2020-21	2021-22
Mandatory	468	478
Group Mandatory (No. of Participants)	160	254
Additional (Telephone)	323	216
Total	951	948

The chart shows supervision data from 2017-2022. The data shows the number of practitioners supervised, but not the number of cases brought to supervision. Essentially one practitioner may bring 5 cases, but it is their attendance which is counted – i.e. one attendance.

Safeguarding Children

660 Mandatory Safeguarding Supervisions Undertaken → **-13% from previous year**

860 Mandatory, Group and Informal Supervision Sessions Undertaken → **-15% from previous year**

We undertook 249 mandatory supervision sessions with Southend Borough Council Health Visitors and School Nurses in 2021-2022 compared to 336 in 2020-21.

We undertook 217 mandatory supervision sessions with Perinatal staff compared to 118 in 2020-21 (and 36 in 2019-2020).

KEY SAFEGUARDING FACTS

Safeguarding Children

Child Protection Conferences

We had **160** children on a Child Protection Plan in May 2020, compared to **202** in May 2021 (and 282 in May 2022).

May 2021 Child Protection Plan categories

Emotional Abuse	62
Emotional Harm	10
Neglect	104
Physical Harm	0
Physical Abuse	4
Sexual Abuse	3
Sexual Harm	0

Age Breakdown

	Unborns / Under 1's	1-5 Years Old	Over 5's
01 February 2022	38	62	183
Neglect / Neglect +	18	27	74
Emotional / Emotional +	5	22	64
Physical / Physical +	1	0	0

We received **2110** domestic incident reports between April 2020 and March 2021. Between April 2021 and January 2022, we received **1794**.

The highest monthly total in this reporting period was in June 2021, where we received **204**, then reached **200** for the month of December 2021.

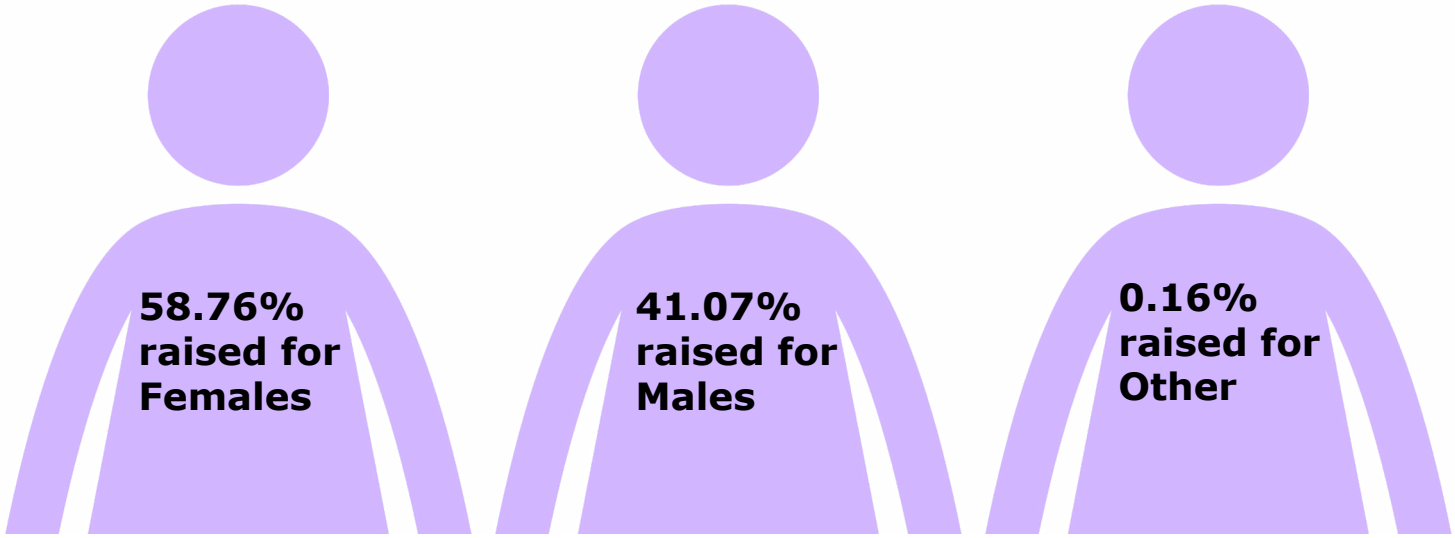
KEY SAFEGUARDING FACTS

Safeguarding Adults

3312 Safeguarding concerns received

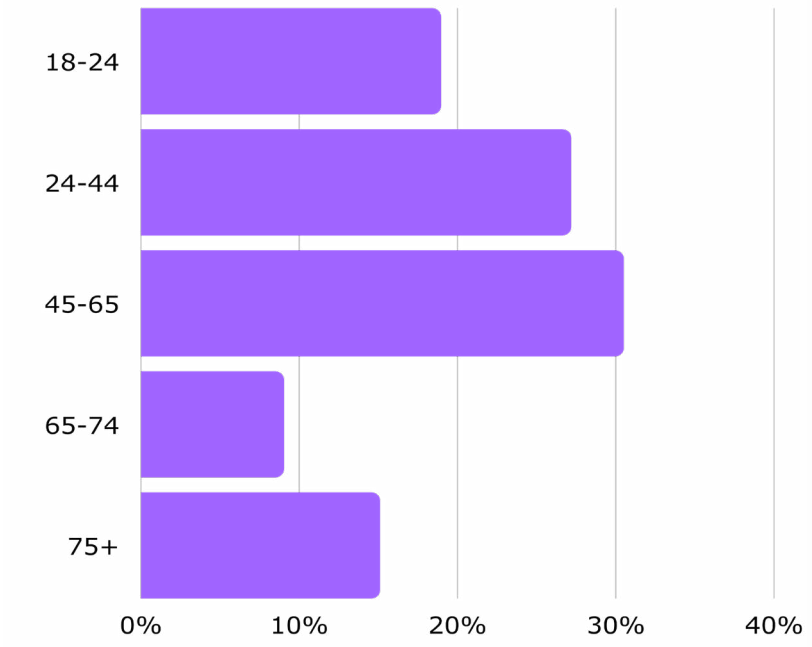
+27.09% from previous year

63.91% enquiries were investigated within 90 days, a 4.46% improvement from 2019-20 (despite a 14.82% increase in the number of enquiries)



Safeguarding Adults

Ages of Enquiries



Person Alleged to Have Caused Harm

Self	23%
Not Known	13%
Partner	11%
Other EPUT Service User	9%
Family Member	7%
EPUT Staff Member	4%
Other	4%
Ex-Partner	4%
Friend	4%
Domiciliary Care Staff	3%

Source of Referral

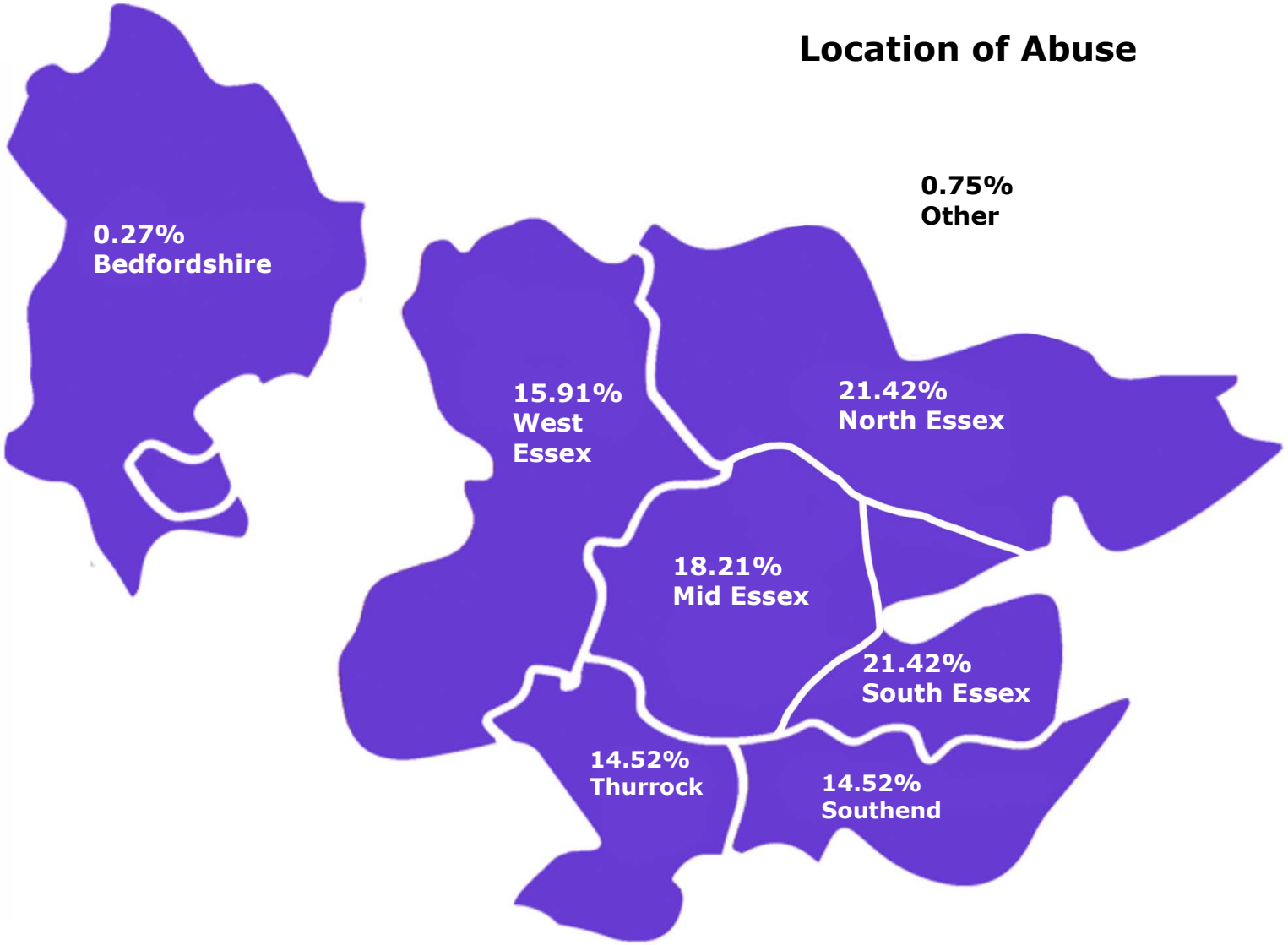
EPUT: Mental Health	30%
Police	29%
Local Council	5%
Adult Social Care	5%
Acute/General Hospital	5%
EPUT: Community Health	4%
Ambulance Service	4%
Family	3%
Residential Care Home	3%
Supported Housing	2%

Safeguarding Adults

Type of Abuse

Self Neglect	19.9%
Domestic Abuse	15.9%
Financial	14.5%
Psychological	14.3%
Physical	13%
Neglect	7.9%
Sexual	6.1%
Not determined	4.6%
Organisational	2.7%
Modern Slavery	0.5%
Discrimatory	0.4%
Radicalisation	0.3%

Location of Abuse



Conclusion

Substantiated	31.33%
Inconclusive / Not Determined	18.91%
Investigation Ceased at Individuals Request	18.63%
Partly Substantiated	15.9%
Unsubstantiated	15.24%

11.2% increase in applications
59.7% increase in applications assessed

13.5% increase

Is the Vulnerable Adult Satisfied With the Outcome?

Yes	88.72%
Not Applicable / Known	6.51%
No	4.77%

Risk Level

Risk Reduced	56.59%
Risk Removed	26.44%
Risk Remains	16.98%

FORWARD PLAN 2022/23

The Trust's Safeguarding Service will continue to develop and improve services for clients. The forward plan focuses on key areas for the coming year as demonstrated in the table below;

Objectives 2022/23	Success Criteria
Think Family	Assessments and care plans demonstrate the impact of parental issues on children in the family and promote the Think Family approach. To ensure children are visible and consider the risk to other family members and friends. Safeguarding referrals demonstrate that risk to all members of the family have been identified and care plans include the actions and changes to mitigate risk. Learning lessons demonstrate Think Family care has been delivered by staff.
Domestic Abuse	Develop Training- coercive control, stalking, knowledge linked to mental health, substance misuse and domestic abuse and trauma perceptive practice. Raise awareness regarding risk assessments, carer assessments and Mental Health assessments. Identify staff within safeguarding team to complete train the trainer course for DASH risk assessment, and deliver to operational teams. Review our DA procedure with regards to staff who are involved in DA.
The Trust will implement the Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support said implementation.	Effective implementation of LPS with sufficient resourcing to support Scoping of the potential assessments has been undertaken. Training implementation plan in place. LPS standing agenda item on the MHA and Safeguarding Sub-Committee. Review of Mental Capacity Act Policy. Engage with partner agencies regarding implementation of LPS Review existing Safeguarding Team systems to determine resources required to implement and support LPS Delegated responsibility for LPS from other NHS providers.

FORWARD PLAN 2022/23

Objectives 2022/23	Success Criteria
Multi-agency working and information sharing	The need to create effective process to share information across safeguarding forums and other partners to enable coordinated and targeted joint risk Management plans. Develop closer working relationships local authorities, in particular undertaking coordinated safeguarding activity under Section 75 agreement. Partnership working with the police to support information sharing and risks and care planning for patients known to the police. Create effective systems regarding MAPPA and MARAC/T arrangements. To create partnership arrangements that are supported by signed agreements and effective joint protocols.
Review and submission of the Safeguarding Adults Self Assessment Audit.	Ratification of the Safeguarding Adults Self Assessment Audit. Submission of the Audit to partners to demonstrate the Trust has discharged its statutory responsibilities.
Young person transition to adult services leaving care	To support young people and practitioners with transition by developing an early referral pathway to adult services to ensure continuity of care. To create partnership arrangements that are supported by signed agreements and effective joint protocols
Creation of Looked After Children (LAC) team EPUT dashboard to enable service analysis of lac population/cohort.	LAC team have had project meetings with information team. Caseloads changed ready for dashboard. Data cleansing of cohort completed. Work with the information analysis team on this project. Caseloads to be changed on system one, ready for dashboard.
Effective collaboration with EPUT Culture of Learning to support system wide learning and safe practice.	Active participation with the Learning partnership Collaboration and Learning oversight committee. Produce relevant reports for the meetings. Contribute to the safety action alerts. Ensuring that there is joint up approach with the implementation of recommendations from SARs, DHR, CSPRs and the patient safety incidents.

GLOSSARY OF TERMS

CCG	**Clinical Commissioning Group**
CSPR	**Child Safeguarding Practice Review**
DA	**Domestic Abuse**
DHR	**Domestic Homicide Review**
DoLS	**Deprivation of Liberty Safeguards**
EHCP	**Education, Health Care Plan**
HEF	**Health Executive Forum**
ICS	**Integrated Care System**
LAC	**Looked After Child**
LADO	**Local Authority Designated Officer**
LPS	**Liberty Protection Safeguards**
MACE Group	**Missing and Child Exploitation in Essex Group**
MAPPA	**Multiagency Public Protection Arrangements**
MARAC	**Multiagency Risk Assessment Conference**
MCA	**Mental Capacity Act**
MHA	**Mental Health Act**
RHA	**Review Health Assessment**
SAB	**Safeguarding Adults Board**
SAR	**Safeguarding Adults Review**
SEND	**Special Educational Needs**
SET	**Southend, Essex and Thurrock**
SETDAB	**Southend, Essex and Thurrock Domestic Abuse Board**
STP	**Sustainability and Transformation Plan**

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Workforce Disability Equality Standard Report 2022**					
Executive/ Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Lorraine Hammond, Director of Employee Experience					
Report discussed previously at:	People, Equality and Culture Committee on 22 September 2022					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

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

Purpose of the Report		
This report provides the Board of Directors: • Oversight of Trust performance relative to the 13 Metrics within the Workforce Disability Equality Standard (WDES). • Seek approval for the publication of the data set in line with National reporting requirements	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the content of the report

2 To note that the People, Equality and Culture Committee have reviewed the detail and recommend the report to the Board of Directors.

3 To approve of the data for publication in line with National requirements

Summary of Key Issues

The report will show progress against a number of Metrics of workforce equality for disabled and non-disabled staff, as well as staff with a long term conditions (LTC), and to understand the experience of staff as well as the nature of the challenges.

The in-year trend in WDES Metrics in 2022 relative to 2021 shows positive improvements reported in a range of staff experience Metrics. Whilst continuing to support staff across the Trust with disability and LTC's, the focus for 2022/23 will be Bullying and Harassment faced by staff with disabilities and long term conditions. It was also observed through our wider work and staff feedback that there should be a focus on how we as an organisation support those with invisible conditions (disabilities or long term conditions that aren't visually noticeable).

The WDES Action Plan 2022-2023 will be fully refreshed to address the key themes and maintain delivery on priority actions. The plan will be submitted to the Executive Team for approval and implementation across the Trust and progress will be overseen by the People, Equality and Culture Committee (PECC).

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

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

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

Acronyms/Terms Used in the Report			
WDES	Workforce Disability Equality Standard	LTC's	Long Term Conditions
ESR	Electronic Staff Record		
AfC	Agenda for Change		

Supporting Reports/ Appendices /or further reading
WDES Breakdown and Metrics – Appendix 1

Lead
Sean Leahy **Executive Director of People and Culture**

Agenda Item: 7d
Board of Directors Part 1
28 September 2022

WORKFORCE DISABILITY EQUALITY STANDARD 2022

1.0 PURPOSE

The Workforce Disability Equality Standard (WDES) enables organisations to review performance across 13 metrics to improve the experiences of staff members with disabilities and long-term conditions (LTC's) in comparison to their non-disabled counterparts. This data provides a structure for an action plan to drive improvements across the year to ensure that those with disabilities and LTC's are not at a disadvantage within the organisation.

2.0 INTRODUCTION

As part of our statutory requirement under the Public Sector Equality Duty. The WDES is comprised of ten metrics relating to the experiences of EPUT staff with disabilities and LTC's within our wider workforce. These metrics utilise both NHS Staff Survey data and workforce data from our Electronic Staff Record (ESR) to cover a range of areas including representation throughout the hierarchy of the organisation, recruitment and involvement in formal capability processes, bullying and harassment and career progression. The final Metric relates to the level of representation at board level

3.0 EXECUTIVE SUMMARY

At EPUT in 2022, 4.31% of staff are recorded as having a disability in the Electronic Staff Record (ESR) system which has grown by 0.73% within the last year and by 1.3% over the last four years. As such the key thrust of the WDES is important to the Trust as we seek to maintain and further develop an inclusive organisational culture.

Overall, EPUT has seen an **improvement** overall **in eleven out of the thirteen metrics**. This compares favourably to 2021 where we only saw improvement in eight out of thirteen. Metric 9 also requests a short summary of our actions as an organisation to facilitate the voices of those with disabilities and long term conditions since the previous report.

In comparison to national averages published in 2021, we have seen improvements in **seven** of these factors with **six showing deterioration**.

Whilst this is a positive improvement for the organisation, there is still a need for **improvement in EPUT** to enhance the experience of our disabled and staff with LTC in our workforce.

4.0 EPUT WDES PERFORMANCE

This data is taken from both our Electronic Staff Record (April 2021 – March 2022) and our Staff Survey (2021) and this data has been shared with NHS England's WDES Team via a Data Collection Framework on August 31st 2022. Progress against these indicators has been measured against the previous WDES 2021 report and the 2021 national averages. The detail of each Metric is presented below:

Metric 1: Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

This Metric has seen a steady improvement since the previous report, **383** staff have their self-reported status recorded in ESR as disabled (a little under **4.31%** of the organisation and higher than the NHS wide reported figure of 3.7% in 2021).

Within the senior non-clinical workforce, disabled staff are under-represented in the most senior clinical roles (8b+).There are also low numbers of recorded disabled staff in the Medical Workforce too (8c+), a picture which is consistent with National data trends.

Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

Performance against this Metric has improved. Non-disabled applicants are 0.81 times (down from 1.17) more likely to be appointed from shortlisting relative to disabled applicants, where 1 would indicate exactly the same relative likelihood, disabled applicants are more likely to be approved from EPUT's shortlisting process in comparison. This is significant as it shows that our hiring practices as a disability confident employer and our guaranteed interview scheme for those declaring a disability appear to be effective.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

This Metric suggests that staff with disabilities are not disproportionally represented in capability proceedings. With a likelihood ratio of 0.00 caused by a very low number of staff being entered into the formal capability process (capability process in this context refers solely to performance grounds, not ill health grounds).

As this metric is averaged across two years, only one member of staff with a disability or LTC has been subject to entering this process on the grounds of ill health.

Metrics 4 – 9: Staff Experience metrics drawn from the 2021 Staff Survey

Out of six Metrics based on Staff Survey data (with Metric 4 consisting of 4a, 4aii, 4aiii and 4b) EPUT have improved upon five (with the progress in 4 being counted as a positive). In comparison to national 2021 benchmarks, EPUT are performing better than average on four.

A number of staff survey measures are included, comparing the experience of disabled, non-disabled and staff with LTC's, across areas including experience of bullying and harassment; staff engagement and being valued, workplace pressure and reasonable adjustments at work. A full data breakdown is presented in **Appendix A**

Staff Survey Metrics (data taken from Staff Survey 2021)		EPUT Progress			National Comparison	
		EPUT 2020	EPUT 2021	EPUT 21 / 22 Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
4ai	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 26.2%	Non-Dis 26.8%	+0.6%	Non-Dis 24.7%	-2.1%
		Dis / LTC 38.7%	Dis / LTC 37.8%	**-0.9%**	Dis / LTC 32.2%	**+5.6%**
4aii	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 9.6%	Non-Dis 8.9%	-0.7%	Non-Dis 7.1%	-1.8%
		Dis / LTC 18.4%	Dis / LTC 17.0%	**-1.4%**	Dis / LTC 13.4%	**+3.6%**
4aiii	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	Non-Dis 15.5%	Non-Dis 15.2%	-0.3%	Non-Dis 12.3%	-2.9%
		Dis / LTC 22.4%	Dis / LTC 23.4%	**+1%**	Dis / LTC 20.2%	**+3.2%**

Staff Survey Metrics (data taken from Staff Survey 2021)		EPUT Progress			National Comparison	
		EPUT 2020	EPUT 2021	EPUT 21 / 22 Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Average***	Non-Dis 55.5%	Non-Dis 59.0%	-3.5%	Non-Dis 61.0%	+2%
		Dis / LTC 52.4%	Dis / LTC 56.5%	**+4.1%**	Dis / LTC 59.4%	**-2.9%**
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 58.6%	Non-Dis 61.4%	+4.1%	Non-Dis 60.2%	-1.2%
		Dis / LTC 53.0%	Dis / LTC 56.2%	**+3.2%**	Dis / LTC 54.4%	**+2.2%**
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 18.9%	Non-Dis 17.1%	-1.8%	Non-Dis 14.7%	-2.4%
		Dis / LTC 31.5%	Dis / LTC 22.3%	**-9.2%**	Dis / LTC 20.8%	**+1.5%**
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 55.2%	Non-Dis 49.9%	-5.3%	Non-Dis 51.5%	-1.6%
		Dis / LTC 43.3%	Dis / LTC 45.9%	**+2.6%**	Dis / LTC 43.6%	**+2.3%**
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	77.5%	80%	**+2.5%**	78.8%	**+1.2%**
9a	The staff engagement score for Disabled staff, compared to non-disabled staff. *Higher % = Improvement* ***EPUT 2021 – 22 = No Change*** ***Higher than 2021 National Average***	Non-Dis 7.3	Non-Dis 7.2	- 0.1	Non-Dis 7.2	0
		Dis / LTC 6.8	Dis / LTC 6.8	**0**	Dis / LTC 6.7	**+0.1%**

Metric 9b: What actions have you taken action to facilitate the voices of Disabled staff in your organisation to be heard?

The Trust has taken action to ensure the voices of Disabled staff are heard, with key examples including:

- **Disability Confident Employer:** In addition to our ongoing Disability Confident Employer accreditation through Job Centre Plus, this year we are applying to for Leader Employer accredited
- **Supporting Neurodiversity:** EPUT Disability and Mental Health Staff Network supports staff with Mental Health conditions, LTCs as well as staff with neurodiversity.

Metric 10: Board Composition:

In 2022, the differential in disabled workforce composition between board and the organisation as a whole is 8.19% (12.5 Board; 4.31% Organisation). In 2022, the differential in disabled workforce composition between the executive membership of the board and the organisation as a whole is 8.19% (12.5 Board; 4.31% Organisation)

5.0 CONCLUSION

The in-year trend in WDES Metrics in 2022 relative to 2021 shows positive improvements reported in a range of staff experience Metrics. Whilst continuing to support staff across the Trust with their disability and LTC's, the focus for 2022/23 will be Bullying and Harassment faced by staff with disabilities and long term conditions. It was also observed through our wider work and staff feedback that there should be a focus on how we as an organisation support those with invisible conditions (disabilities or long term conditions that aren't visually noticeable).

6.0 NEXT STEPS

Our WDES Action Plan 2022-2023 will be fully refreshed to address the key themes, maintain delivery on priority actions and will include recommendations from our Disability and Mental Health Network, key stakeholders as well as feedback from staff across the Trust who attended the WDES Stakeholder engagement session. The plan will be submitted to the Executive Team for approval and implementation across the Trust and progress will be overseen by the People, Equality and Culture Committee (PECC).

7.0 ACTION REQUIRED

Trust Board are asked to:

- Receive and note the content of the report
- To note that the People, Equality and Culture Committee have reviewed the detail and recommend the report to the Board of Directors.
- To approve of the data for publication in line with National requirements

Report prepared by:

Lorraine Hammond
Director of Employee Experience | 22.09.2022

On behalf of:

Sean Leahy
Executive Director of People and Culture

Appendix A: Breakdown and Results of WDES Metrics 1 - 10

Key	
Symbol	Meaning
▲ ▼	An Improvement from EPUT's WDES 2021 Data
▼ ▲	A Decline from EPUT's WDES 2021 Data
-	No Increase / Decrease from EPUT's WDES 2021 Data

METRIC 1 – PERCENTAGE OF DISABLED / LTC (LONG TERM CONDITON) STAFF IN EACH BAND COMPARED TO THE OVERALL WORKFORCE 2022.

This metric shows staff across all pay bands and grades by cluster.

Fig 1 – NON-CLINICAL POSTS

Cluster (Bandings)	Disabled / LTC Staff		Trend
	2021	2022	
C1 (1-4)	70 (3.5%)	85 (4.6%)	▲
C2 (5-7)	11 (3%)	16 (4.0%)	▲
C3 (8a / 8b)	3 (3.9%)	5 (6.0%)	▲
C4 (8c +)	2 (3.3%)	4 (6.0%)	▲

Fig 2 - CLINICAL POSTS

Cluster (Bandings)	Disabled / LTC Staff		Trend
	2021	2022	
C1 (1-4)	108 (3.3%)	91 (3.4%)	▼
C2 (5-7)	124 (4.1%)	153 (4.8%)	▲
C3 (8a / 8b)	12 (2.7%)	22 (6.1%)	▲
C4 (8c +)	2 (4.8%)	2 (4.4%)	-
C5 (Consultants)	1 (1%)	1 (0.98%)	-
C6 (Career Grade)	0	0	-
C7 (Trainees)	1 (1%)	3 (2.9%)	▲

NB: In regards to the lower staff numbers in Metric 1 (Cluster 1-4) EPUT's overall bank workforce figures have decreased due to a reduced number of Mass Vaccination Programme bank staff in these bands compared to last year.

Workforce Metrics (Data taken from April 2021 – March 2022)		EPUT Progress			National Comparison	
		EPUT 2021	EPUT 2022	EPUT Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
1	Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	3.58%	4.31%	**+0.73%**	3.7%	**+0.6%**
2	Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. *Lower Ratio = Better, with "1" being equal likelihood.* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Ratio***	1.17	0.81	**-0.36**	1.94	**-1.13**
3	Relative likelihood of non-disabled staff compared to disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. *Lower Ratio = Better, Data taken as an average across two years. With "1" being equal likelihood.* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Ratio***	2.61	0.00	**-2.61**	1.94	**-1.94**
9b	Have you taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes, See Below				
10i	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the board. *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis -8.94% Dis / LTC 8.90%	Non-Dis -4% Dis / LTC 8.19%	+4.94% **-0.71%**	Non-Dis -1.6% Dis / LTC 0%	+3.34% **+8.19%**
10ii	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Executive membership of the board. *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	Non-Dis 8.02% Dis / LTC -3.58%	Non-Dis 21% Dis / LTC -4.31%	+13% **+0.73**	Non-Dis 0.7% Dis / LTC 0.1%	+12.3% **+4.21**

Staff Survey Metrics (data taken from Staff Survey 2021)		EPUT Progress			National Comparison	
		EPUT 2020	EPUT 2021	EPUT 21 / 22 Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
4ai	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 26.2%	Non-Dis 26.8%	+0.6%	Non-Dis 24.7%	-2.1%
		Dis / LTC 38.7%	Dis / LTC 37.8%	**-0.9%**	Dis / LTC 32.2%	**+5.6%**
4aii	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 9.6%	Non-Dis 8.9%	-0.7%	Non-Dis 7.1%	-1.8%
		Dis / LTC 18.4%	Dis / LTC 17.0%	**-1.4%**	Dis / LTC 13.4%	**+3.6%**
4aiii	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in last 12 months *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	Non-Dis 15.5%	Non-Dis 15.2%	-0.3%	Non-Dis 12.3%	-2.9%
		Dis / LTC 22.4%	Dis / LTC 23.4%	**+1%**	Dis / LTC 20.2%	**+3.2%**
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Average***	Non-Dis 55.5%	Non-Dis 59.0%	-3.5%	Non-Dis 61.0%	+2%
		Dis / LTC 52.4%	Dis / LTC 56.5%	**+4.1%**	Dis / LTC 59.4%	**-2.9%**
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 58.6%	Non-Dis 61.4%	+4.1%	Non-Dis 60.2%	-1.2%
		Dis / LTC 53.0%	Dis / LTC 56.2%	**+3.2%**	Dis / LTC 54.4%	**+2.2%**
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 18.9%	Non-Dis 17.1%	-1.8%	Non-Dis 14.7%	-2.4%
		Dis / LTC 31.5%	Dis / LTC 22.3%	**-9.2%**	Dis / LTC 20.8%	**+1.5%**

Staff Survey Indicators (data taken from Staff Survey 2021)		EPUT Progress			National Comparison	
		EPUT 2020	EPUT 2021	EPUT 21 / 22 Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	Non-Dis 55.2%	Non-Dis 49.9%	-5.3%	Non-Dis 51.5%	-1.6%
		Dis / LTC 43.3%	Dis / LTC 45.9%	**+2.6%**	Dis / LTC 43.6%	**+2.3%**
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	77.5%	80%	**+2.5%**	78.8%	**+1.2%**
9a	The staff engagement score for Disabled staff, compared to non-disabled staff. *Higher % = Improvement* ***EPUT 2021 – 22 = No Change*** ***Higher than 2021 National Average***	Non-Dis 7.3	Non-Dis 7.2	- 0.1	Non-Dis 7.2	0
		Dis / LTC 6.8	Dis / LTC 6.8	**0**	Dis / LTC 6.7	**+0.1%**

METRIC 9b HAS YOUR TRUST TAKEN ACTION TO FACILITATE THE VOICES OF DISABLED / LTC STAFF IN YOUR ORGANISATION?

Trusts that answer YES to this question must provide at least one practical example within this report. For EPUT these examples are as follows:-

- EPUT Endorsed as a Disability Confident Employer, and currently applying for Leader status.
- A Disability and Mental Health Staff Network which specifically has Mental Health within its title to ensure mental health conditions and disabilities are given equal weighting when providing support. This Network also supports neurodiversity as well as any Long Term Condition.
- Implementation of Reasonable Adjustments Policy into Trust Policy and Procedure, as well as promotion of this through Trust and guidance materials to facilitate manager and employee conversations.
- Lived experience videos and articles share staff lived experience and how colleagues can support these conditions (including Neurodiversity and Long Term Conditions.)
- Staff Inductions now contain guidance on supporting disability and mental health in the workplace, including reasonable adjustments and managing discrimination against those with disabilities and mental health conditions
- Easy to read guide on how to update disability status on ESR
- Equality and Inclusion intranet pages advising how staff can make sure that their accessibility needs are supported by the Trust (including in an emergency) as well as micro-aggressions against disability and mental health. Online resources supporting those with disabilities who feel pressured to come into work.
- Regular articles encouraging staff to update their ESR status.
- Promotion and intranet articles for disability and mental health events across the year.

*CHANGES TO DATA CALCULATION FOR METRIC 5

- For 2021, the way in which data for Staff Survey Q15 is reported has changed, with the inclusion of "don't know" responses in the base of the calculation.

- All these changes have been applied retrospectively so all historical results for Q15 and data shown in the average calculations are comparable across years. However, the figures shown may not be directly comparable to the results reported in previous years.

- Full details of how the data are calculated are included in the Technical Document below

Staff Survey Data
Technical Guidance.pc

QUERY FROM WDES TEAM

Metric 1 was queried by the WDES Team due to a reduction in overall staff numbers, a response was provided by EPUT via our ESR team, confirming our datasets and explaining this was due to the reduction in Mass Vaccination program bank staff since the last report.

- *"In 2021 the MVP bank figure was 2157 but it was reduced to 1413 in 2022."*

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Workforce Race Equality Standard Report 2022**					
Executive/ Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Lorraine Hammond, Director of Employee Experience					
Report discussed previously at:	People, Equality and Culture Committee on the 22 September 2022.					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

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

Purpose of the Report		
This report provides the Board of Directors: • Oversight of Trust performance relative to the 9 indicators within the Workforce Race Equality Standard (WRES) as reviewed by the People, Equality and Culture Committee • Seek approval for the publication of the data set in line with National reporting requirements	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Receive and note the content of the report
- To note that the People, Equality and Culture Committee have reviewed the detail and recommend the report to the Board of Directors.
- To approve of the data for publication in line with National requirements

Summary of Key Issues

The report shows progress against a number of indicators of workforce equality and to understand the experience of staff as well as the nature of the challenges.

The in-year trend in WRES indicators shows a broadly improving picture with improvements both within the Trust as well as nationally.

Whilst there has been progress, there are significant improvements to be made in the following areas:

- Relative likelihood of BME staff entering the formal disciplinary process compared to white staff, as measured by entry into a formal disciplinary investigation. (**Indicator 3**)
- Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months. (**Indicator 5**)
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (**Indicator 6**)

The WRES Action Plan 2022-2023 will be fully refreshed to address the key themes and maintain delivery on priority actions. The plan will be submitted to the Executive Team for approval and implementation across the Trust and progress will be overseen by the People, Equality and Culture Committee (PECC).

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

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard		

BWRES	Bank Workforce Race Equality Standard		
ESR	Electronic Staff Record		

Supporting Reports/ Appendices /or further reading

WRES Breakdown and Indicators – Appendix 1
BAME Staff Appointment Trajectory Chart and Ambition Modelling – Appendix 2

Lead

Sean Leahy
Executive Director of People and Culture

Agenda Item: 7e
Board of Directors Part 1
28 September 2022

WORKFORCE RACE EQUALITY STANDARD 2022

1.0 PURPOSE

In 2015, the WRES was created to provide an impetus to the race equality agenda and to challenge organisations to improve their performance in relation to race equality and diversity as well as to ensure employees from black, Asian and minority ethnic (**BME**) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Whilst we as an organisation use "BAME" when reporting this data, the WRES report uses BME, but this does not omit those of Asian heritage.

2.0 INTRODUCTION

The NHS Workforce Race Equality Standard 2021 data analysis report for NHS Trusts has found:

- As at 31 March 2021, **22.4%** (309,532) of staff working in NHS trusts in England were from a black and minority ethnic (**BME**) background **(+3.3%)**
- **36.2%** of staff from an "other" Asian background (i.e., other than Bangladeshi, Chinese, Indian, or Pakistani) **experienced harassment, bullying or abuse from patients, relatives or the public** in the last 12 months.
- **16.7%** of **BME** staff had personally experienced **discrimination at work from a manager**, team leader or other colleagues

3.0 EXECUTIVE SUMMARY

The percentage of BME staff in EPUT is **22.7%**, which has **declined by 2%** since the previous WRES report. As such, the key thrust of the WRES remains a priority to the Trust as we seek to maintain and further develop our organisational culture.

EPUT has seen **modest improvement** in their scores in comparison to 2021. Improvements has been made in **six out of the nine WRES indicators in 2022** (below), whereas in 2021, we only saw improvement in three out of nine. Nationally, of the nine indicators, five are trending positively and three are showing deterioration.

In other areas, however, there is still a need for **significant improvement in EPUT** to enhance the experience of our BME workforce in the following areas.

4.0 EPUT WRES PERFORMANCE

A summary of the EPUT's position for 21/22, with trend indicators and benchmarked performance is presented in the table in Appendix A. This data is taken from both our Electronic Staff Record (April 2021 – March 2022) and our Staff Survey (2021) and this data has been shared with NHS England's WRES Team via a Data Collection Framework on August 31st 2022. Progress against these indicators has been measured against the previous WRES 2021 report and the 2021 national averages. The detail of each indicator is presented below:

Indicator 1: Overall percentage of BME staff in Bands 1-9 and VSM.

Performance against this indicator has slightly improved. The **BME non-clinical workforce** in Bands 4, 5 and 6 **continues to grow on a positive, but slow trajectory** and now stands at **1.15%.** Whilst this is a marginal increase since 2021, it offers a positive signal for the development pipeline into more senior roles. The number of **BME Clinical Workforce** (of which is non-medical) has seen positive growth in Bands 7, 8a

and 8d which an increase of **1.5%** since 2021.Whilst clinical staff disparity ratios are available for the previous year's report on Model Health System, these are expected for release for 2022 in December (End Q3).

The **BME Clinical (medical and dental) Workforce** shows a steady in year growth with an increase of **2.24%** and at continue to be a diverse and representative group. There will be a more specific focus on Medical and Dental Roles in the MWRES (Medical WRES)

It is important to note: NHS England has developed a separate WRES for Bank Staff which will be known as (**BWRES**), therefore **figures for 2022 no longer include Bank Staff like they did in 2021**. This change has had a significant impact on Indicators 1-4 and 9 due to staff from Black, Asian and Minority Ethnicity (BME) groups working in bank roles not being accounted for in this report. EPUT's overall bank workforce figures have also decreased in these bands due to a reduced number of Mass Vaccination Programme bank staff in these bands compared to last year.

Indicator 2: Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts:

Performance against this indicator has seen marginal improvement. With White staff only being 1.44 times more likely to be appointed from shortlisting. In EPUT we have seen a **decrease of 0.15** in likelihood and are slightly **below the National average by 0.17.**

Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff. As measured by entry into a formal disciplinary investigation

At EPUT, the relative likelihood of BME staff entering the formal disciplinary process has marginally decreased this year. There is still need for further improvement as based on these figures, **BME staff were approximately three times more likely to enter a formal disciplinary process than their white counterparts**, performance has deteriorated when compared to the National average with our ratio 1.97 points higher.

In 21/22 of the 33 formal disciplinary cases, 16 related to BME staff members. In total, disciplinary cases have reduced by nearly 67.3% for BME Staff and 69.4% for staff overall in 21/22 compared to 20/21

Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

Performance against this indicator has improved with a likelihood ratio below one meaning that BME Staff are more likely to access these types of career development than their White counterparts. This is a **great achievement** for EPUT as the Trust was considered one of the lowest performing Trusts in this indicator in the **NHS Workforce Race Equality Standard 2021 data analysis report for NHS Trusts**

Indicator 9 – Percentage difference between the organisations' Board voting membership and its overall workforce

BME Board representation currently stands at **25%** which has deteriorated since 2021, however, we are significantly performing above the National average by **7.5%.** With **22.7%** organisational BME representation, the differential between BME workforce composition and BME board composition is **2.3%**.

When comparing the Board Executive BME membership (1 member or **12.5%**) and our overall BME workforce (**22.7%**). The representation difference is **10.2%**; this is **2.4%** lower than the national average.

Indicators 5-8: Staff Experience.

These indicators are directly drawn from the EPUT's 2021 NHS Staff Survey Results. Comparative data from 2020 is also shown and this year the Staff Survey are now measured against seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale).

Performance against two of these indicators have improved, whilst two have deteriorated.

Indicator 5 (*staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months*) is trending negatively and has increased significantly within EPUT by **6.1%**, as well as the national average by **7.8%**.

	Staff Survey Indicators (data taken from Staff Survey 2021)	**EPUT 2020**	**EPUT 2021**	**EPUT 21 / 22 Diff.**	**National 2021 Bench.**	**EPUT 2021 Diff. (National)**
5	Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	White: 28.2%	White: 27.7%	**-0.5%**	White: 26.2%	+1.5%
		BME: 33.5%	BME: 39.6%	**+6.1%**	BME: 31.8%	**+7.8%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	White: 22.2%	White: 21.1%	**-1.1%**	White: 18.1%	+3%
		BME: 26.7%	BME: 28.0%	**+1.3%**	BME: 22.9%	**+5.1%**
7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Same as National Average***	White: 60.9%	White: 62.6%	**+1.7%**	White: 61.0%	+1.6%
		BME: 41.2%	BME: 48.9%	**+7.7%**	BME: 48.9%	**0%**
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	White: 6.6%	White: 7.0%	**+0.4%**	White: 6.0%	+1%
		BME: 17.7%	BME: 16.6%	**-1.1%**	BME: 14.4%	**-3.3%**

5.0 CONCLUSION

The in-year trend in WRES indicators shows a broadly improving picture with improvements both within the Trust as well as nationally.

Whilst there has been progress, there are significant improvements to be made in the following areas:

- Relative likelihood of BME staff entering the formal disciplinary process compared to white staff, as measured by entry into a formal disciplinary investigation. (**Indicator 3**)
- Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months. (**Indicator 5**)
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (**Indicator 6**)

6.0 NEXT STEPS

Our WRES Action Plan 2022-2023 will be fully refreshed to address the key themes, maintain delivery on priority actions and will include recommendations from our Ethnic Minority and Race Equality Staff Network (EMREN), key stakeholders as well as feedback from staff across the Trust who attended the WRES Stakeholder engagement session. The Action Plan will be submitted to the Executive Team for approval and implementation across the Trust and regular updates on progress will be overseen by the People, Equality and Culture Committee (PECC).

7.0 ACTION REQUIRED

Board are asked to:

- Receive and note the content of the report
- To note that the People, Equality and Culture Committee have reviewed the detail and recommend the report to the Board of Directors.
- To approve of the data for publication in line with National requirements

Report prepared by:

Lorraine Hammond
Director of Employee Experience | 22.09.2022

On behalf of:

Sean Leahy
Executive Director of People and Culture

Appendix 1: Breakdown and Results of WRES Indicators

Key	
Symbol	**Meaning**
▲ ▼	An Improvement from EPUT's WRES 2021 Data
▼ ▲	A Decline from EPUT's WRES 2021 Data
-	No Change from EPUT's WRES 2021 Data

Indicator 1: Percentage of BME staff in each of the AfC Bands 1 - 9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
(Percentage rounded to 2dp)

1a) Non-Clinical Workforce					
	2021	**2021 %**	**2022**	**2022 %**	**Trend**
Band 1	**Band 1 Removed from Grading System**				
Band 2	98	1.05%	54	0.89%	▼
Band 3	119	1.27%	48	0.79%	▼
Band 4	36	0.38%	39	0.64%	▲
Band 5	12	0.13%	15	0.25%	▲
Band 6	15	0.16%	16	0.26%	▲
Band 7	8	0.09%	8	0.13%	-
Band 8a	8	0.09%	7	0.12%	▼
Band 8b	5	0.05%	5	0.08%	-
Band 8c	3	0.03%	3	0.05%	-
Band 8d	1	0.01%	1	0.02%	-
Band 9	0	-	0	-	-
VSM	2	0.02%	3	0.05%	▲

1b) Clinical Workforce (of which non-medical)					
	2021	**2021 %**	**2022**	**2022%**	**Trend**
Band 1	0	-	0	-	-
Band 2	611	6.53%	5	0.08%	▼
Band 3	335	3.58%	253	4.17%	▼
Band 4	133	1.42%	79	1.30%	▼
Band 5	324	3.46%	184	3.03%	▼
Band 6	286	3.06%	281	4.63%	▼
Band 7	115	1.23%	136	2.24%	▲
Band 8a	33	0.35%	49	0.81%	▲
Band 8b	19	0.20%	19	0.31%	-
Band 8c	5	0.05%	4	0.07%	-
Band 8d	0	-	2	0.03%	▲
Band 9	0	-	0	0.00%	-
VSM	1	0.01%	1	0.02%	-
Clinical Workforce (of which Medical and Dental)					
Consultants	63	0.67%	66	1.09%	▲
Of which, Senior Medical Manager	1	0.01%	1	0.02%	-
Non Consultant, Career Grade	33	0.35%	33	0.54%	-
Trainee Grades	48	0.51%	62	1.02%	▲
Other	1	0.01%	2	0.03%	▲

NB: NHS England has developed a separate WRES for Bank Staff which will be known as (BWRES), therefore figures for 2022 no longer include Bank Staff like they did in 2021. This change has had a significant impact on Indicators 1-4 and 9 due to staff from Black, Asian and Minority Ethnicity (BAME) groups working in bank roles not being accounted for in this report. EPUT's overall bank workforce figures have also decreased in these bands due to a reduced number of Mass Vaccination Programme bank staff in these bands compared to last year.

Workforce Indicators (Data taken from April 2021 – March 2022)		EPUT 2021	EPUT 2022	EPUT Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce *Higher % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	BME 24.7%	BME 22.7%	**-2%**	BME 22.4%	**+0.3%**
2	Relative likelihood of white staff being appointed from shortlisting compared to BME staff *Lower Ratio = Better, with "1" being equal likelihood.* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Ratio***	1.59	1.44	**-0.15**	1.61	**-0.17**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff, as measured by entry into a formal disciplinary investigation. *Lower Ratio = Better, with "1" being equal likelihood.* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Ratio***	3.40	3.11	**-0.29**	1.14	**-1.97**
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff *Lower Ratio = Better, with "1" being equal likelihood. Figure below 1 means that White Staff are less likely than BME Staff.* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Ratio***	1.64	0.84	**-0.80**	1.14	**-0.30**
9i	Percentage difference between the organisations' Board voting membership and its overall workforce *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce* ***EPUT 2021 – 22 = Decline*** ***Lower than 2021 National Average***	White 2.9%	White -6.1%	-3.2%	White 13.1%	19.2%
		BME 0.3%	BME 2.3%	**+2.0%**	BME -9.8%	**-7.5%**
9ii	Percentage difference between the organisations' Board Executive membership and its overall workforce *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce* ***EPUT 2021 – 22 = Improvement*** ***Lower than 2021 National Average***	White 13.6%	White 12.7%	-0.9%	White 8.2%	+4.5%
		BME -10.4%	BME -10.2%	**-0.2%**	BME -12.6%	**-2.4%**

Staff Survey Indicators (data taken from Staff Survey 2021)		EPUT 2020	EPUT 2021	EPUT 21 / 22 Diff.	National 2021 Bench.	EPUT 2021 Diff (National)
5	Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	White: 28.2%	White: 27.7%	-0.5%	White: 26.2%	+1.5%
		BME: 33.5%	BME: 39.6%	**+6.1%**	BME: 31.8%	**+7.8%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Decline*** ***Higher than 2021 National Average***	White: 22.2%	White: 21.1%	-1.1%	White: 18.1%	+3%
		BME: 26.7%	BME: 28.0%	**+1.3%**	BME: 22.9%	**+5.1%**
7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. *Higher % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Same as National Average***	White: 60.9%	White: 62.6%	+1.7%	White: 61.0%	+1.6%
		BME: 41.2%	BME: 48.9%	**+7.7%**	BME: 48.9%	**0%**
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months. *Lower % = Improvement* ***EPUT 2021 – 22 = Improvement*** ***Higher than 2021 National Average***	White: 6.6%	White: 7.0%	+0.4%	White: 6.0%	+1%
		BME: 17.7%	BME: 16.6%	**-1.1%**	BME: 14.4%	**+3.3%**

***CHANGES TO DATA CALCULATION FOR INDICATOR 7**

- For 2021, the way in which data for Staff Survey Q15 is reported has changed, with the inclusion of "don't know" responses in the base of the calculation.

- All these changes have been applied retrospectively so all historical results for Q15 and data shown in the average calculations are comparable across years. However, the figures shown may not be directly comparable to the results reported in previous years.

- Full details of how the data are calculated are included in the Technical Document available on request.

Appendix 2: BAME Staff Appointment Trajectory Chart and Ambition Modelling

	Fig 1. Trajectory of Black, Asian and Minority Ethnicity Staff being appointed into Band 8a+ Roles									2028	
	2020			2021			2022			Ambition	Appt's required
	Ambition	Actual	Diff.	Ambition	Needed	Diff.	Ambition	Actual	Diff.		
Band 8a	37	37	**0**	39	41	**+2**	41	49	**+2**	51	+2
Band 8b	16	18	**+2**	17	24	**+7**	17	19	**+2**	21	+2
Band 8c	7	3	**-4**	7	8	**+1**	8	4	**-4**	13	+ 9
Band 8d	2	1	**-1**	3	1	**-2**	3	2	**-1**	4	+ 2
Band 9	0	0	**0**	0	0	**0**	0	0	**0**	1	+1
VSM	1	1	**0**	1	3	**+2**	2	1	**-1**	3	+2

How do we calculate our WRES Ambition Modelling goals?

These Model Employer figures are based on the 2019 Trajectory Goals (attached at bottom of appendix) set by NHS Improvement. Our ambition goals are based on the 10 Year Plan proposed by NHS England to ensure that these bandings have equitable representation by 2028.

How are we performing?

The above table shows how far away we are from achieving the overall 2028 goals in the next 6 years and the figures are mixed, with steady increases in appointments into lower Band 8 roles, but decreases in higher Band 8 positions. Further work is needed to continue the programme of increasing the proportion of ethnic minority staff in these positions to meet the 2028 targets, in particular Band 8c.

		Agenda Item No: 7f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr.Gladvine Mundempilly, Director for Medical Appraisal and Revalidation					
Report discussed previously at:	People, Equality and Culture Committee 22 September 2022					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors information with on the implementation of revalidation within the Trust for 2021/22 appraisal year in order to provide annual statement of compliance provided to the higher level Responsible Officer at NHS England	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report and approve the compliance statement
2 The Designated Body (EPUT) through its Chair or Chief Executive Officer to submit the compliance statement to the Higher Responsible Officer at NHS England
3 Request any further information or action.

Summary of Key Issues

The Board of Directors of the Essex Partnership University NHS Foundation Trust as a designated body has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act.

The report is expected in the format stipulated by NHS England and includes details about the quality assurance, clinical governance, Trust's performance on revalidation, action plans to strengthen the revalidation process, audits on concerns of doctors' practice and audits on the appraisals input and output.

Since the appraisal process was reinstated by NHS England, there has been an increase in the compliance during the last year. The compliance rate for 2021-22 was 86% compared to 78.4% last year

As of 31st March 2022 there were 165 doctors with a prescribed connection to EPUT. Of the 165 doctors, 142 had an annual appraisal (86%). Out of the remaining 23, doctors 8 was authorised delays for valid reasons. A plan is progressing for the completion of the appraisals with a view to achieving the target 90% by the end of next appraisal year.

EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation.

There are some areas to be improved upon regarding appraisal rates, namely improving the completion rate to get it back up to the expected 90%.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Appendix 1: Annex D – Annual Board Report and Statement of Compliance Appendix 2: Annual Report Template Appendix A – Audit of all missed or incomplete appraisals.

Lead

Dr Milind Karale
Executive Medical Director
Responsible Officer (Revalidation)

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Essex Partnership University NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: EPUT has an appropriately trained medical practitioner. Dr Milind Karale, who was appointed as Responsible Officer in 2012 Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: The Board to continue its support for annual appraisal and revalidation processes. Comments: The Designated Body currently provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act Action for next year: The Board to continue its support for annual appraisal and revalidation processes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to carry out process and amend the prescribed connection list as appropriate Comments: There is an established process to ensure the accuracy of the list of doctors with prescribed connections to the Trust. In addition to the information gathered prior to and at the time of a job offer to a doctor, the Workforce Department provides a monthly report of new starters and leavers to the Appraisal and Revalidation Support Manager. Triangulation of this information is carried out with Human Resources – Medical Staffing department and the clinician concerned. This is cross checked with the list on Prescribed Connection list with the GMC and is amended as appropriate.

Action for next year: Continue to carry out process and amend the prescribed connection list as appropriate

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Continue to monitor and review the policies in place to support medical revalidation

Comments: All new national guidance and amendments to existing documentation is read, shared appropriately and implemented where possible. EPUT's Medical Appraisal and Development policy and procedure was last updated in 2021.

Action for next year: Continue to monitor and review the policies in place to ensure that these support medical revalidation.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Organise a peer review of our appraisal and revalidation processes.

Comments: A peer review was not undertaken last year due to pressures from the post pandemic period and the measures to get the appraisal processes back on track. The Trust has relied on internal Quality Assurance processes. The processes have been regularly reviewed by the RO and the Director of Medical Appraisals and Revalidation along with Human Resources. The information relating to appraisal and revalidation has been shared with the CQC as part of their inspection of the organisation

Action for next year: Organise a peer review of our appraisal and revalidation processes.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.

Comments: All doctors are supported in their continuing professional development, appraisal, revalidation and governance. The medical education department has regular internal CPD activities and all the doctors are encouraged to attend. The doctors are also assisted with their external CPD requirements both in terms study leave and financial support.

The revalidation office provides regular support for the doctors on appraisal and revalidation, including timely reminders of appraisals, appraisal training and support in developing appraisal portfolios.

Where the doctor does not have a prescribed connection to the Organisation, such as agency locums, they are provided with the necessary supporting information to pass on to their Designated Body and include at their appraisal.

Action for next year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.

Section 2a – Effective Appraisal

6. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

Comments: All doctors with prescribed connection to EPUT are required to have a whole practice annual appraisal, which includes any necessary information on complaints and/or significant events that they have been named in for each appraisal year so that lessons learnt and reflections can be drawn upon. The Trust has a process in place to assist the doctor to collate this information held internally. Where the appraiser is not the line manager of the doctor, the latter provides a medical managers report covering specific issues if any, to be discussed during the appraisal. Where EPUT is not the doctors' sole employer within their appraisal year, the doctor is required to provide a fitness to practice statement from all places where they were employed in a medical capacity.

Trust have adopted Appraisal 2020 model whilst allowing our doctors to choose the standard appraisal template if they wish to. Majority of the doctors used the 2020 model.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Action for next year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

7. Where in Question 6 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.

Comments: Where a doctor does not have a whole practice annual appraisal, the reasons are explored and a plan put in place for its completion. These are further analysed to improve the process and ensure that the doctor is supported to complete these in a timely manner. The Responsible Officer and the Director of Medical Appraisal and Revalidation review the report on delayed appraisals on a monthly basis

Action for next year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete an audit on missed or incomplete appraisals.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Continue to review national policy and update the Medical Appraisal policy and procedure accordingly

Comments: EPUT has a Medical Appraisal policy in place, which is in line with national policy. This was updated and ratified in 2021.

Action for next year: Continue to review national policy and update the Medical Appraisal policy and procedure accordingly

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Organise new and appraiser refresher training

Comments: As of 31st March 2021, there were 34 formally trained and approved medical appraisers across EPUT which is a sufficient number to carry out timely annual medical appraisals for all its licensed medical practitioners. The new and refresher training for appraisers were not organised last year as the resources were directed at improving the appraisal compliance rates from last year.

Action for next year: Organise new and appraiser refresher training.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.

Comments: There is on-going support for the medical appraisers by way of regular updates. The Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is also made available to the appraisers periodically.

Each appraise is expected to complete an anonymised feedback of their experience, which is summated annually and provided to individual appraisers for their reflection. The individual appraisers include their appraiser role within their own annual appraisal for discussion and reflection

Action for next year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue to complete annual audits and submit to Board.

Comments: Annual audits of our appraisal system are completed and submitted to Board with the Board Report. The report is shared with the Executive Team and discussed at the Quality Committee. Please see attached Appendix A for 2021/22 findings.

Action for next year: Continue to complete annual audits and submit to Board.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	165
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	142
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	15
Total number of agreed exceptions	8

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

Comments: The GMC Connect is reviewed regularly and recommendations are made in a timely manner.

Action for next year: To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue to ensure that revalidation recommendations are communicated promptly.

Comments: Revalidation recommendations are communicated to the doctor at the point of the recommendation being made, if not sooner. Where the recommendation of deferral or non-engagement is made, the reasons are discussed with the doctor in advance and a plan is put in place to ensure a subsequent positive recommendation.

Action for next year: Continue to ensure that revalidation recommendations are communicated promptly

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue to create an environment which delivers effective clinical governance for doctors

Comments: The organisation has effective clinical governance processes for doctors in place. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. This is in the form of regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet and relevant reminders are sent to the doctors by the Medical Director. The doctors are also encouraged to contribute to the clinical governance process by undertaking investigations and reviewing the incidents.

Action for next year: Continue to provide an environment which delivers effective clinical governance for doctors

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal.

Comments: Monitoring the performance of all doctors working within the Trust is carried out regularly in a variety of ways. Some examples include monitoring adherence to Trust policies and procedures, recording data on complaints, significant events and service provision, compliance with mandatory training and revalidation requirements and feedback from trainees. The Clinical Directors have a monthly meeting with the doctors under their line management to discuss the performance of doctors.

Corporate data such as information on complaints, significant events, audits and attendance at internal weekly teaching sessions are provided to the doctor to include in their annual appraisal.

In the appraisal, the doctors include their updated job plan, mandatory training record, probity declaration and issues relating to any suspensions/investigations that they are subjected to. This is triangulated with Trust and GMC Connect data.

Action for next year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue with established process and update the policy and procedure as and when required

Comments: The organisation has a process in place for responding to concerns and has a Maintaining High Professional Standards – Conduct and Capability policy and procedure for Medical and Dental staff, which is in line with national guidance and was last updated in 2022. The Trust has an adequate number of trained Case Managers and Case Investigators

Action for next year: Continue with established process and update the policy and procedure as and when required.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Continue to complete annual audit and submit to Board.

Comments: Annual audit of responding to concerns about a doctor in our organisation is completed and submitted to Board with the board Report

Action for next year: Continue to complete annual audit and submit to Board.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary. Comments: Medical Practice Information Transfer forms are used to transfer information and concerns between responsible officers where necessary. This is a nationally approved form. The doctors are required to declare to the organisation, all the places where they are employed in a medical capacity and to provide a fitness to practice statement from them to include in their annual appraisal. Action for next year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to ensure the appropriate policies and procedures in place are followed and updated to ensure that those involved in investigations are adequately trained. Comments: The organisation has a Maintaining High Professional Standards policy and procedure which has been ratified and which is in line with national guidance. Those involved in investigations are appropriately trained for the role. There is also an appeal and remediation policy and procedure, which are followed when required. Action for next year: Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are adequately trained.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue with new starter processes

Comments: EPUT has systems in place to ensure that we are compliant with the Responsible Officer Regulations Act with regards to recruitment and employment checks. Medical HR carries out the necessary pre-employment checks prior to any doctor joining the Trust. Once the doctor is in the post the Appraisal and Revalidation Team carries out further assurance checks, which include name of last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form. The Medical staffing department follows an agreed process for recruiting agency locums ensuring that they meet the expected standards for their role.

Action for next year: Continue with new starter processes

Section 6 – Summary of comments, and overall conclusion

Since the last Board report, considerable action and resources were put in place to ensure that the appraisal process is back on track since the GMC mandate came back in force. This has been successful and most of the delays were due to unavoidable reasons.

As of 31st March 2022, there were 165 doctors with a prescribed connection to EPUT. Of the 165 doctors, 142 had an annual appraisal (86 %) during the appraisal year from 1st April 2021 to 31st March 2022. Out of the 23 incomplete appraisals, 8 were approved delays. Although this is an improvement compared to last year, a plan has been put in place to ensure that the appraisal compliance rate is above the expected 90% for next year.

During the next year, there are plans to recruit more appraisers and provide regular updates on training for those already in place. EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _ _

Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

	Totals
Number of doctors on GMC Connect as of 31 March 2022	165
Number of doctors who were not due for an appraisal by 31 March 2022 (new starters after April 2021)	19
Number of doctors who were due for an appraisal by 31 March 2022. (Excluding new starters i.e.; after April 2021)	146
Number of appraisal completed for 2021-22 including leavers during this period.	142
Approved Incomplete/Missed Appraisals for 2021-22	8
Unapproved Incomplete/Missed Appraisals for 2021-22	15 (Out of these 6 are now completed)

Annual Report Template Appendix B – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[5]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2021 – Mar 2022) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	4	3	9
Capability concerns (as the primary category) in the last 12 months	1	3		4
Conduct concerns (as the primary category) in the last 12 months	1	1	1	3
Health concerns (as the primary category) in the last 12 months			2	2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2022 who have undergone formal remediation				1

[5] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

between 1 April 2021 and 31 March 2022. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year	
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)	7
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)	1
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)	0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2021 and 31 March 2022: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months	 1 (4 months)

6 - 12 months	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	4
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	1
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

	Totals
Number of doctors on GMC Connect as of 31 March 2022	165
Number of doctors who were not due for an appraisal by 31 March 2022 (new starters after April 2021)	19
Number of doctors who were due for an appraisal by 31 March 2022. (Excluding new starters ie; after April 2021)	146
Number of appraisal completed for 2021-22 including leavers during this period.	142
Approved Incomplete/Missed Appraisals for 2021-22	8
Unapproved Incomplete/Missed Appraisals for 2021-22	15 (Out of these 6 are now completed)

Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2021 – Mar 2022) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	4	3	9
Capability concerns (as the primary category) in the last 12 months	1	3		4
Conduct concerns (as the primary category) in the last 12 months	1	1	1	3
Health concerns (as the primary category) in the last 12 months			2	2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2022 who have undergone formal remediation between 1 April 2021 and 31 March 2022. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				7
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2021 and 31 March 2022: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	4 months
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	4
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	1
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	

Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

28 September 2022
Trust Board of Directors
Agenda Item 8a

EPUT

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TBOD 28 September 2022

Essex Partnership University NHS Foundation Trust

Introduction

The purpose of the Board Assurance Framework (BAF) is to assure the organisation that we are on track to achieve strategic and annual objectives for the current year and describe any risks to delivery that have been identified and the actions being taken to control such risks.

The Board has overall responsibility for ensuring systems and controls are in place and are sufficient to mitigate any significant risks, which may threaten the achievement of the Strategic Objectives.

The Board Assurance Framework is now the overarching report relating to Strategic risks and Corporate risks.

The BAF outlines key strategic risks, linked to the strategic objectives. The risks (where appropriate) have a strategy underpinning them and will have longer-term actions with deliverables, and expectation on movement is slow burn.

The Board of Directors may wish to undertake deep dives on individual strategic risks. The Executive Team may assign Strategic risks to a specific Committee for overview and scrutiny.

EPUT Board of Directors is asked to:

- Approve the full BAF summary report for September 2022
- Note one new Corporate Risk: (Loggists, with a risk score 16)
- Note change in risk score (CRR94 Engagement and Supportive Observation)
- Consider effectiveness of controls and assurances

Level of Assurance: Level 1

Corporate Impact Assessment	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications:	Nil
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	

02 - BAF Dashboard

September 2022

EPUT

Strategic Risks

Essex Partnership University NHS Foundation Trust

Existing Risks	Recommended New Risks	Recommended for Downgrading	Recommended for Closure
8	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	8	8	2

% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	100%

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x4= 20	20 → 20 → 20	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• Patient Safety dashboard drafted and shared with ECOL Steering Group utilising PowerBI • Lessons Identified Management System (ELMIS) concept and PID approved by ET • Learning Collaborative Partnership Group second meeting held
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4= 20	20 → 20 → 20	Replaced BAF50 Skills, Resource and Capacity National challenge for recruitment and retention	• Workforce plan approved by ET and MSE • Ofsted inspection on 27th-29th July 2022 scoring good in all domains • International recruitment, achieved 88 nurses so far • Bank to permanent conversion, achieved 150 people since Nov 2021 • Time to care launched and started working with operational services. Produced a first draft of the current status, future vision and long list of solutions report
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4= 20	20 → 20 → 20	Covid-19. Long-term plan. White Paper. Transformation and innovation National increase in demand on services	• Additional work is ongoing working with Flow & Capacity leads to ensure recording of Delayed Transfers of Care are being recorded on both EPR's. • Monthly review continues to indicate clients with an extended LOS are in active treatment and extended inpatient admission is clinically appropriate.
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4= 20	20 → 20	The need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Capital Project process for safety prioritisation action complete. • Monthly monitoring by Capital Planning Group to Executive Team.

Strategic Risks

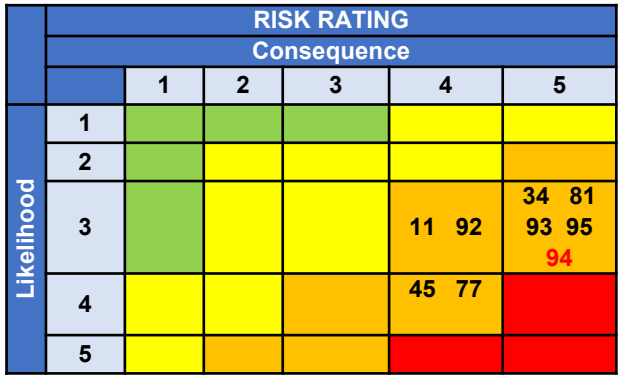
NHS Essex Partnership University NHS Foundation Trust

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score <20 (Existing risks)								
SR3	All	Systems and Processes/ Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	ZT/TS	5x3=15	15 15 15	Capacity and adaptability of the support service infrastructure including Estates & Facilities, ITT /Digital Systems, Estates, Finance, Procurement and Business Development/ Contracting to support frontline services. Recovery from HSE and Covid-19. Need to release clinical time.	• BCPs updated following Cyber Incident
SR5	1	Independent Inquiry	Compliance, Reputation	NL	5x3=15	15 15 15	Government led independent inquiry into Mental Health services in Essex	• Draft memorandum of understanding in progress • 1 page methodology in place • Reviewing wording of risk
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.	• Managed Cyber incident with Finance & Procurement system resumption September. • Business Continuity plans invoked and tested. • IGSC are recommending to Executive Team reducing score to 12
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15	The need to devolve financial management and ensure EPUT makes effective and efficient use of its resources.	• Pay award funding agreed with Integrated Care System colleagues. • Internal Audit of Budgetary Management, Substantial assurance. • HFMA financial checklist completed.

Corporate Risks

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
9	1	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	1	8	9	8



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	• Working with Human Engine to further review strategy to bring in SMART principles. • Review of Suicide Prevention Group underway. • Have identified 4 key priorities which are being monitored. • Self Harm pilot project underway at a number of wards with enhanced funding to support utilisation of sensory approaches and increased activity coordinators. Positive initial feedback • Preparing comms for suicide prevention awareness day
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	• Trainers recruited • Continuing communications to encourage staff to complete training • Linking with Francis Stevens to develop training trajectory
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	• New training days created and • New process checking capacity meets need for courses • Attendance maximisation for f2f including booking reminders and advertising spaces via Wednesday weekly • August 2022 mandatory training performance reported 91%
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• Concerns around resource available, seeking project team support. • Medical device asset register currently being cleansed

Corporate Risks

NHS
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NHS Foundation Trust

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	15 → 15 → 15	Patient safety incidents	• New process established for mitigation statements, currently being evaluated • Local ligature forum gaining good attendance
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 → 12 → 12	Risk was escalated from Corporate Risk Register to the BAF in March 2021 – de-escalated November 21	• Engagement champion re-launch • Utilising Champions toolkit, monthly newsletter and monthly Grill session with Executive Team • Staff positive feedback re RISE programme • WRES/WDES data 2021/22 shows improvement in 7 areas, however continues to be areas for EPUT improvement and action plan developed
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 → 15 → 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Patient Safety dashboard drafted and shared with ECOL Steering Group utilising PowerBI • Lessons Identified Management System (ELMIS) concept and PID approved by ET • Learning Collaborative Partnership Group second meeting held
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x3=15	20 → 20 → 15	CQC found observation learning not embedded in last inspections	• Score reduced to 15 due to completion of observation project. Working now on embedding controls including new policy. • E'Observation pilot continuing • 78% wards scored above 90% in June Tendable Audits (7% below 90% and 15% did not complete audit)
CRR95	Delivery of new vaccination programme	Service Delivery, Financial	NL	5x3=15	15 → 15 → 15	Focus has changed around delivery of the new autumn programme of mass vaccinations	• The autumn vaccination programme is underway. All vaccination centres and other delivery models are open. • The Trust has been requested to also support care homes and the housebound. • At this stage the project team are confident of achieving the activity target for the number of vaccines.

03 - New Risks

Sept 2022

EPUT

Executive Director – Major Projects

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Summary	Potential Risk	Context	Key Controls that mitigate the risk	Gaps in Controls	Key Assurances	Gaps in Assurance
CRRTBC Loggists Initial and current score 4 x 4 = 16 Target score 4 x1 = 4 Jan 2023	If EPUT is unable to increase number of trained loggists and increase hours of availability for 24/7 then there may not be sufficient loggists available to log a Major Incident resulting in poor decision / action audit trail in the event of a major incident occurring.	Low number of loggists currently available No training available currently from the region	Pool of trained loggists including EPRR team and Executive Director PAs	Not enough loggists to cover significant period and none available out of hours No training currently available from region	All EPRR incidents have been logged to date	Some logging has been undertaken by staff who are not trained

04 – Strategic Risks

September 2022

EPUT

SR1: Safety

NHS
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At a Glance:

If EPUT does not invest in safety or effectively learn lessons from the past
(***Cause***), Then we may not meet our safety ambitions (***Effect***), Resulting in a possibility of experiencing avoidable harm, loss of confidence and regulatory requirements (***Impact***).

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

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10 (Mar '23)

Risk Appetite:
Risk Tolerance:

Progress since last report:

- Patient Safety dashboard drafted and shared with ECOL Steering Group utilising PowerBI
- Lessons Identified Management System (ELMIS) concept and PID approved by ET
- Learning Collaborative Partnership Group second meeting held

Key Gaps in Assurance

- Reduction in Patient Safety Incidents (Aug 22 remains below reduction target)
- No Harm / Low Harm incidents >93% (Aug 22 - 83.7% MH and 67.5% CHS

Executive Responsible Officer:
Natalie Hammond, Executive Nurse

Executive Committee: ESOG
Board Committee: BSOG, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Refresh deliver Patient Safety Incident Response Plan	TBC (When data Available)	Moriam Adekunle Director of Safety and Patient Safety Specialist	Road Map
2. Deliver the Patient Safety Incident Response Plan	March 2023	Moriam Adekunle Director of Safety and Patient Safety Specialist	Controls
3. Deliver the Patient Safety Strategy (Safety First Safety Always)	End March 2023	Natalie Hammond Executive Chief Nurse	Road Map / Control
4. Culture of Learning Programme	Ongoing	Moriam Adekunle Director of Safety and Patient Safety Specialist	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Team and Corporate Nursing Team (inc PSI)	Team in place		
Safety First Safety Always Strategy	ESOG Reporting	Annual Report to TB 0 Never events YTD 0 safety alert breaches YTD Positive incident reporting rate	
PSIRF; Complaints; Claims; Safety First Safety Always Strategy	Policy Register	PSIRF reports/ risk management reports/ complaints reports/ ESOG reporting cycle / Clinical Audits	IA Reviews inc PSIRF May 22 and Medical Devices Feb 22
Thematic analysis	Service improvement plans	Learning collaborative partnership Group	
EPUT Lab/ Quality Academy/ Lunchtime Learning/ Key messages / Quality and Safety Champions Network	Have been running and scheduled for future		
Intensive Support Groups			
Nurse Advocates/ RISE leadership	12 nurses completed advocate training		
PMO Support	Overall portfolio status		
Capital investment in patient safety	Progress on delivery of essential safety improvements		CQC CAMHS inspection safety improvements
Insight into wellbeing	Reports to ESOG and QC Culture of Learning progress report		

SR2: People

Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate. [add some statistics)

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L3 = 15 (Mar '23) C5 x L2 = 10 (Mar '24)

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Workforce plan approved by ET and MSE
- Ofsted inspection on 27th-29th July 2022 scoring good in all domains
- International recruitment, achieved 88 nurses so far
- Bank to permanent conversion, achieved 137 people since Nov 2021
- Time to care launched and started working with operational services. Produced a first draft of the current status, future vision and long list of solutions report

Key Gaps in Assurance

- Employee experience team not fully established
- Fill rates remain below Trust targets
- Vacancy and Sickness rates above target in Aug 22
- Supervision and Appraisal rates below target in Aug 22

Executive Responsible Officer:
Sean Leahy, Executive Chief People Officer

Executive Committee: Executive Team
Board Committee: People, Equality and Culture Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Rolling recruitment programme	Ongoing	Matt Gall Associate Director Resourcing	Control
Deliver International Recruitment Programme	December 2022 / Ongoing	Marcus Riddell Senior Director of OD	Control
Bank/Agency Conversion Programme	Ongoing	Matt Gall Associate Director Resourcing	Control
Student Recruitment	Ongoing	Annette Thomas-Gregory Director of Education & Learning	Control
Apprenticeship Programme Relaunch	October 2022	Annette Thomas-Gregory Director of Education & Learning	Control
Time to Care Programme	December 2023	Paul Scott Chief Executive	Control
Refresh and Deliver Recruitment and Retention Strategy	December 2022	Matt Gall Associate Director Resourcing	Road Map / Control
Develop People Commitments (strategic plan)	December 2022	Marcus Riddell Senior Director of OD	Road Map
Employee experience road map	October 2022	Lorraine Hammond Director Employee Experience	Road Map

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
HR Team (e.g. Engagement / Resourcing and OH)	Team in place		
HR Policies	Policy Register	IA Reviews Workforce Reports to PECC	Ofsted inspection on 27th-29th July 2022 scoring good in all domains
Workforce Plans	Workforce Safeguards Workforce Establishment Reviews	Workforce Safeguards Workforce Establishment Reviews Workforce Reports to PECC	CQC inspections NHSE Workforce Returns System Workforce Returns / benchmarks
Sit Rep Meetings	Staffing Sit-Rep / Dial thing?		CQC inspections
Use of Bank and Agenda Staff (when needed)	Staffing Sit-Rep	Workforce Reports to PECC	CQC inspection reports Use of Resources Assessment
Recruitment Branding	Branding in place from March '22	Direct Hire Numbers within the Workforce reporting to PECC	
Staff wellbeing	Engagement Champions	0 bullying and harassment incidents Aug 22 Turnover rate below target and starters above target	Plus Survey

SR3: Systems and Processes/ Infrastructure

Essex Partnership University NHS Foundation Trust

At a Glance:

If our systems, processes and infrastructure do not continue to adapt to support clinical services(***Cause***), Then we may not have the right facilities/ resources to deliver safe, high quality care (***Effect***), Resulting in not attaining our safety, quality/ experience and compliance ambitions(***Impact***).

Likelihood based on:
Consequence based on:

Initial risk score	Current risk score	Target risk score
C4 x 4L = 16	C4 x L4 = 16	C4 x L2 = 8 (Mar '23)

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- BCPs reviewed following Advanced cyber incident
- Roadmap and action plan for implementation of interim digital strategy
- Review of people systems underway and new roles filled within People and Culture Team

Key Gaps

- Teams not fully established

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance and Resources Director
Zephan Trent, Executive Director Strategy Transformation and Digital

Executive Committee: Executive Team, ESOG
Board Committee: BSOG, Finance and Performance Committee, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Fully recruit to all finance, resources, strategy, transformation and digital systems teams including agreeing portfolios and jointly funded posts	September 2022	Trevor Smith, Executive Chief Finance and Resources Director& Zephan Trent, Executive Director Strategy Transformation Digital	Control - Full establishment
Develop EPUT Strategy	October 2022	Zephan Trent, Executive Director Strategy Transformation Digital	Roadmap
Develop Commercial Strategy	December 2022	Liz Brogan, Director of Contracting & Service Development Lauren Gable, Director of Finance Commercial	Roadmap
Develop Estates Strategy	December 2022	Charles Hanford Director of Estates and Facilities	Roadmap
Deliver Interim Digital Strategy	March 2027	Zephan Trent, Executive Director Strategy Transformation Digital	Control
Deliver on the Target Operating Model	End March 20223	All Executives	Control
Fully recruit to all finance, resources, strategy, transformation and digital systems teams including agreeing portfolios and jointly funded posts	September 2022	Trevor Smith, Executive Chief Finance and Resources Director& Zephan Trent, Executive Director Strategy Transformation Digital	Control - Full establishment
Develop EPUT Strategy	October 2022	Zephan Trent, Executive Director Strategy Transformation Digital	Roadmap

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Digital Systems, Estates and Facilities, Contracting and Business Development, Finance Teams	Establishment Support services		
Interim Digital Strategy Range of corporate, finance and IG policies Information Governance Framework		EOSC, Information Governance Sub-Committee, Digital Strategy Group Capital Group and PMO	NHS Digital Information Governance Toolkit
Information Governance Training		IG Training compliance reporting via Accountability Framework	
Investment in PMO, Capital Programme, E-expenses system, HIE		Weekly PMO/ ITT integration meetings Capital Planning Group	Access to data and services across system
Audit programme/ ISO in place		Audit Committee Internal Audit	CQC CAMHS inspection highlighted effectiveness of HIE BSI data external assessment

SR4: Demand and Capacity

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If we do not effectively address demands (***Cause***), Then our resources may be over-stretched(***Effect***), Resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions (***Impact***).

Likelihood based on:
Consequence based on: Mismanagement of patient care and length of the effects.

Initial risk score	Current risk score	Target risk score and timescale
C5 x 4L = 20	C5 x L4 = 20	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Additional work is ongoing working with Flow & Capacity leads to ensure recording of Delayed Transfers of Care are being recorded on both EPR's.
- Monthly review continues to indicate clients with an extended LOS are in active treatment and extended inpatient admission is clinically appropriate.
- MH UEC Project continues to be taken forward including development of flow and capacity team, reinforced community provision, B&B and discharge funds, working towards establishment of a MH ED

Key Gaps:

- OPEL 4 / Black alert declared in August 2022
- August 2022 ALOS increased slightly and remains outside benchmark
- August 2022 Bed Occupancy remains above target
- August 2022 seen an increase in OAA

Executive Responsible Officer:
Alex Green, Executive Chief Operating Officer

Executive Committee: SMT
Board Committee: BSOG, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Recruitment and Development of the Care Unit leadership structures.	December 2022	Milind Karale Executive Medical Director Natalie Hammond Executive Chief Nurse	Control
Embedding of Care Units (Operational and governance structures)	September 2022	Alex Green, Executive Chief Operating Officer	
Development of individual Care Unit Service Strategies	September 2022	Zephan Trent Executive Director Strategy Transformation & Digital	Road Map
Implement Service Delivery Strategy	March 2023	Alex Green, Executive Chief Operating Officer	Control
Model service need (population health / bed model)	TBC	Zephan Trent Executive Director Strategy Transformation & Digital (Supported by KPMG)	Control
Time to Care Programme	December 2023	Paul Scott Chief Executive	Control

Controls Assurance

Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
Operational staff	Establishment		
Integrated Director posts covering Mental Health and physical health	Establishment		
Target operating model/ care unit development, Accountability Framework, Safety First, Safety Always Strategy, Flow and Capacity Policy, MAST roll out	Dedicated discharge coordinator	Accountability meetings	
MH UEC Project, MSE Connect Programme, Partnerships, Time to Care initiative, New ways of working and new digital solutions	Flow and Capacity Project	Purposeful admission steering group Mthly inpatient quality and safety group	Provider Collaborative EoE Provider Collaborative MH Collaborative Whole Essex system flow and capacity group
Service dashboards Daily sit reps	Updated OPEL framework DTOC 2.8% in Aug 22	Performance and Quality Report to Accountability Meetings and Finance and Performance Committee	
Skilled temporary workforce via Trust Bank	Bank establishment		
Business Continuity Plans	Emergency Planning		

SR5: Independent Inquiry

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT is not open, transparent and has the correct governance arrangements in place (Cause)
Then it may not embed the learning from past failings (Effect)
Resulting in undermining our Safety First, Safety Always Strategy (Impact)

Likelihood based on:
Consequence based on:

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	C4 x L2 = 8 Target dependent on length of Inquiry

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Draft memorandum of understanding in progress
- 1 page methodology in place
- Reviewing wording of risk

Key Gaps:
MOU and ISP in draft

Executive Responsible Officer:
Nigel Leonard, Executive Director, Major Projects

Executive Committee: SMT
Board Committee: BSOG, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Carry out internal audit on learning	March 23	BDO	Assurance
Respond to information requests	Ongoing	Gill Brice Project Director	Control
Learning log in place	Ongoing	Gill Brice Project Director	Assurance
Project Plan in place	Ongoing	Jade Line Project Manager	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Project Team Independent Director and Clinical Advisor	Establishment	EOC and Audit Committee oversight	
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group overseeing	
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	In place and used for reporting to ET Audit Committee and BOD	

SR6: Cyber Security

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If we experience a cyber-attack (***Cause***), Then we may encounter system failures and downtime(***Effect***), Resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage (***Impact***).

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.
Consequence based on: assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C4 x L3 = 12 Inherent ongoing risk

Risk Appetite:
Risk Tolerance:

Progress since last report:

- Successfully managed Cyber incident via third party supplier, instigated Business Continuity Plans, system testing and system re-instatement.
- Cyber Essentials documentation submitted for accreditation
- Cyber security Operations manager recruited and in post
- Yearly Penetration test (Aug 22) highlighted no high risk vulnerabilities
- High risk audit recommendations mitigated
- Advanced hosted systems cyber threat control managed – new firewall limitations and rules imposed on network for Advanced hosted applications.
- Business Continuity plans updated.
- Recommendation from IGSSC that risk rating be reduced to 4x3=12 as a result of the above mitigations.

Key Gaps:

- Audit recommendations to be completed

Executive Responsible Officer:
Zephan Trent, Executive Director Strategy Transformation and Digital

Executive Committee: IG Steering Group, Digital Strategy Group
Board Committee: Finance and Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Appoint to Cyber Governance Manager	March 23	BDO	Assurance
Complete recommendations from internal audit	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
Develop business continuity plan and disaster recovery for each system	TBC	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
Take actions to meet gaps identified in Cyber Essentials Accreditation	October 22	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place – two appointments to be made	New Cyber Governance Manager post to act in independent policing type role Existing Cyber Security Manager role	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	IGSSC BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual)
Investment in prioritisation of projects to ensure support for operating systems and licenses			
IG & Cyber risk log	Risk working group 2022 complete – highlighted no risks vulnerabilities	IGSSC and Digital Strategy Group	DSPT
Business Continuity Plans and National Cyber Team processes		Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+

SR7: CAPITAL RESOURCE

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: percentage of capital programme unable to deliver / deferred
Consequence based on: what not delivered and the impact on the strategic plans.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress :
- Capital Project process for safety prioritisation action complete and moved into BAU

Key Gaps
- Key strategies to be developed

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance and Resources Officer

Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
Develop Estates Strategy (co-dependent on Clinical Strategy)	End Dec 2022	Charles Hanford – Director of Estates & Facilities	Road Map
Develop Digital Strategy (co-dependent on Clinical Strategy)	Ongoing	Jan Leonard – Director of IMT	Road Map
Develop a medical devices replacement programme	Ongoing	Natalie Hammond – Executive Chief Nurse	Road Map
Horizon scan to maximise opportunities both regional and national to source capital investment	Ongoing	Simon Covill – Director of Finance	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Purchasing / tendering policies	Policy Register	IA reviews	
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23	Capital Project Group Reporting - £14.3m	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	ECFO or Deputy Attendance at ICS Meetings		
	CEO or Deputy membership of ICB		

SR8: USE OF RESOURCES

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources(***Cause***), Then it may not meet its financial controls total
(***Effect***), Resulting in potential failure to sustain and improve services(***Impact***).

Likelihood based on: EPUT financial risk and opportunities profile
Consequence based on: assessed impact on long financial model for EPUT and the System

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:
- Pay award funding agreed with Integrated Care System colleagues.
- Internal Audit of Budgetary Management, Substantial assurance.
- HFMA financial checklist completed.

Gaps:
- Improve financial maturity

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance and Resources Officer

Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
Improve financial maturity (Training and development for budget holders and business partners)	End March 2023	*Lauren Gable Finance Director*	*Control*
Efficiency workshops to identify remaining efficiency savings	End May 2022 (delayed due to additional national planning activities now Sept '22)	*Simon Covill Director of Operational Finance*	*Control*
Deliver Financial Efficiency Target (All Budget Holders)	End Mar 2023	*Trevor Smith Executive Chief Finance Officer*	*Control*
In year forecast outturn (FOT) and risk and opportunities assessments	End Sept 2023 (monthly thereafter)	Simon Covill	Assurance
Deliver Operational Plan 2022/23	End March 2023	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Policy Register	IA reviews	Budgetary Management Internal Audit substantial assurance
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23		Capital Plan and Group	
Fully identified efficiency target		Reporting to ET, F&PC and BOD	
Finance reporting	ECFO or Deputy Attendance at ICS Meetings	Capital Group, EOSC, F&PC Accountability Meetings	Nationally mandated controls
	CEO or Deputy membership of ICB		

05 – Corporate Risks

September 2022

EPUT

CRR94: Engagement and Supportive Observation

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L2 = 8

Progress since last report:

- Reduced risk score to 15 due to completion of observation project. Working now on embedding controls including new policy.
- E'Observation pilot continuing
- 78% wards scored above 90% in June Tendable Audits (7% below 90% and 15% did not complete audit)

Key Gaps:

- Some wards do not have Oxehealth for electronic recording
- Tendable audits not routinely reported on

Executive Responsible Officer: Chief Operational Officer

Executive Committee: Executive Operational Committee
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
E'Observation Pilot, outcome to be reported to ET	Ongoing	Jan Leonard	Control
Undertake annual audit using data from Tendable Follow up clinical audit in Q2	December 22	Jo Paul	Audit recommendations
Enhance with planned staffing improvements enabled by digital tools, engagement with AHPs and improved oversight through the Accountability Framework	Ongoing	Jan Leonard / Jo Paul	Assurance
Review on line training	September 22	Jo Paul	Control
Collation of learning	Ongoing	Jo Paul	
Development of KPIs	September 22	Richard James / Jo Paul	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Engagement and Observation Project	Project Group	Plan Complete and Group Closed	
Revised Observation and Engagement Policy		CG&QC Accountability Meetings	
Weekly ward huddles		Tendable Audits	
Electronic observation recording tool	In trail stage		
Comprehensive audits using Tendable	Audit Results via weekly huddles	June 2022 – 25 wards scored 100%	
Observation and Engagement E'Learning and Training Videos			

CRR11: Suicide Prevention

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:

- Working with Human Engine to further review strategy to bring in SMART principles.
- Review of Suicide Prevention Group underway.
- Have identified 4 key priorities which are being monitored.
- Self Harm pilot project underway at a number of wards with enhanced funding to support utilisation of sensory approaches and increased activity coordinators. Positive initial feedback
- Preparing comms for suicide prevention awareness day

Key Gaps:

- Strategy requires refresh

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Implementation of revised strategy, work plan and dashboard	March 2023	Nuruz Zaman	Roadmap
Align with Safety First Safety Always Strategy	March 2023	Nuruz Zaman	Clear strategic direction
Focus groups with patients and families and Research into family involvement in suicide	March 2023	Nuruz Zaman	Control
Implement outcome measures	March 2023	Nuruz Zaman	Assurance
Review approach to Safer Wards and Ligature risk	March 2023	Angie Butcher	Control
Introduce self-harm reduction pilot project	March 2023	Diane Lucky	Control
Comms and Engagement over September / October to mark Suicide Awareness Day and MH Awareness Day	Sept / Oct 2022	Nuruz Zaman / Comms	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Identified Medical Lead			
Suicide Prevention Strategy 2021-23	Suicide prevention group	Overseen by Mortality Sub-Committee	
Ongoing communication and engagement with staff	Examples: Breaking the Silence Safety Plans		
Local reflective sessions			
Oxehealth digital monitoring			
Suicide prevention training			
Suicide prevention outcomes			

CRR34: Suicide Prevention - Training

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT does not train and support staff effectively in suicide prevention; then staff may not have the necessary skills or confidence to support suicidal patients; resulting in self-harm or death and a failure to achieve our safety first, safety always strategy

Initial risk score	Current risk score	Target risk score
C3 x L3 = 9	C5 x L3 = 15	C3 x L2 = 6

Progress since last report:
- Trainers recruited
- Continuing comms to encourage staff to complete training
- Linking with Francis Stevens to develop training trajectory

Key Gaps:
Training attendance

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: .Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Refresher course required due to attrition	Ongoing	Nuruz Zaman	Control
Move to STORM training	Ongoing	Nuruz Zaman	Control
Explore training offers and frequency	Ongoing	Nuruz Zaman	Control
Develop improvement trajectory and report on suicide prevention training	Ongoing	Nuruz Zaman	Assurance
Develop a quality improvement project to address the barriers on completing the suicide prevention training	Ongoing	Nuruz Zaman	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trainers	Recruited		
Suicide prevention strategy	Sets out training requirements overseen by Suicide Prevention Group	Reporting to Mortality Sub-Group Annual Report	
Virtual training offer			

CRR45: Mandatory Training

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x 3L = 12	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:

- New training days created
- New process checking capacity meets need for courses
- Attendance maximisation for f2f including booking reminders and advertising spaces via Wednesday weekly
- August 2022 mandatory training performance reported 91%

Key Gaps:

IG Training 81.9% against 95% target
Face to face course attendance

Executive Responsible Officer: Director of People and Culture

Executive Committee: Executive Operational Team.
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Implement recovery plan	Ongoing	Training Team	Assurance
Review mandatory training policy	October 22	Annette Thomas-Gregory	Control
Work to give flexible workers equal priority on mandatory training	TBC	Training Team	Control
Managers reminded to check training trackers and prompt staff whose training is overdue	Ongoing	Comms	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Training Team	Established		
Induction and Training Policy	Policy system		
Managers reminded to check trackers			
Training recovery plan			
Training days created for staff			
Monthly reporting to ET		Accountability. F&PC and PECC August 2022 – Mandatory Training reported at 91%	

CRR77: Medical Devices

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway; then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use; resulting in a failure to achieve our safety first, safety always strategy

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8

Progress since last report:

- Concerns around resource available and seeking addition project team support.
- Medical device asset register currently being cleansed

Key Gaps:
Resource and capacity
No capital replacement programme in place

Executive Responsible Officer: Executive Chief Nursing Officer

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Complete actions from recommendations in internal audit report	March 2023	Nick Archer	Assurance
Options appraisal for Capital replacement programme and Medical device replacement strategy	March 2023	Nick Archer / TBC	Control (Resource)
Options appraisal EPUT management of Medical Devices inc resource needed	March 2023	Nick Archer / TBC	Control (Clear resource)
Review Althea contract reporting	March 2023	Nick Archer / TBC	Assurance
Trailing process of reminder email to services before Althea visits	March 2023	Nick Archer / TBC	Control (Innovation)
Review of Policy and Procedure to ensure clear process and monitoring set out	March 2023	Nick Archer / TBC	Control (Policy)
Medical Device Management training	March 2023	Nick Archer / TBC	Control (training)

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance	Established		
Medical Devices Group	Established and meets regularly	Overseen by Medical Devices Group	
Althea contract for device maintenance	Monthly KPI Report	Overseen by Medical Devices Group	
Procurement process in place Medical Devices Policy	Asset Register	Medical Devices Group oversee	Internal Audit Report Q4 2021/22 (Moderate / Limited Assurance)
Asset Register			
Incident Reporting			
BCPs in place			

CRR81: Ligature

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L3 = 12	C5 x L3 = 15	C4 x L2 = 8

Progress since last report:

- Recommending combined Executive Leads with Trevor and Alex to reflect holistic focus.
- New process established for mitigation statements, currently being evaluated
- Local ligature forum gaining good attendance

Key Gaps:

- DTAs not in place in Brockfield House
- Ligature actions on 2 systems

Executive Responsible Officer: Chief Finance Officer / Chief Operating Officer

Executive Committee: Executive Safety Oversight Group
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Completion of ELFT Independent review Action Plan	March 2023	Jane Cheeseman/ Comfort Sithole	Assurance
Identify right system for recording ligature actions (overseen by Project Group)	March 2023	Project Group	Control
Ensure EPUT environments meet environmental standards and Review environmental risk stratification document	Ongoing	Charles Hanford	Control
Review standards on outdoor garden furniture to avoid raised fittings ligature risk		Charles Hanford	Control
Further roll out of DTA to bedroom doors	March 23	Charles Hanford Anthony Flaherty	Control
Increase awareness and ownership of ligature reduction work	March 2023		Control
Review of Tidal training to see if this could be brought in-house	March 2023	Jane Cheeseman/ Comfort Sithole	Control
Develop robust and systemic processes for disseminating learning related to ligature reduction. Link to Culture of learning project	December 22	Jane Cheeseman/ Comfort Sithole	Assurance
Develop KPIs and dashboard to highlight progress on ligature reduction	September 22	Nicola Jones Richard James	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Ligature / Patient Safety Leads in Estates, H&S and Compliance Team	Established		
Ligature Project Group	Established		
Ligature Policy and Procedure	Ligature wallet audits	Overseen by LRRG ESOG and BSOG top priority	Internal Audit 2021 (all actions complete) ELFT Review (actions open)
Ligature Training	71 staff trained via TIDAL (as at July 2022)		
Trend analysis		Incident Rate below benchmark of 42 (39.42 for Aug 2022)	

CRR92: Addressing Inequalities

NHS
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NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C4 x L3 = 12	C3 x L2 = 6

Progress since last report:

- Engagement champion re-launch
- Utalising Champions toolkit, monthly newsletter and monthly Grill session with Executive Team
- Staff positive feedback re RISE programme
- WRES/WDES data 2021/22 shows improvement in 7 areas, however continues to be areas for EPUT improvement and action plan developed

Key Gaps:
EDI Team gap in resource

Executive Responsible Officer: Executive Director of People and Culture

Executive Committee: Equality and Inclusion Sub-Committee
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Establishment of EDI and Employee experience team	Dec 2022	Loraine Hammond	Control
Improve EDI learning offer for EPUT	June 2023	Lorraine Hammond	Control
Working on staff safety and closer alignment with LSMS	March 2023	Lorraine Hammond / Nicola Jones	Control
Develop culture which brings EDI into all Trust workstreams	Ongoing	Lorraine Hammond	Control
Complete WDRES Action Plan	June 2023	Lorraine Hammond	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Employee Team including Director	Established		
Equality and Inclusion Policies	Policy System		
Range of equality networks and staff engagement methods	Established	Equality and Inclusion Sub-Committee	WRES and WDES (actions identified)
RISE Programme			Positive staff feedback
Champions Toolkit and monthly newsletter			
The Grill			

CRR93: Continuous Learning

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT does not continuously learn and improve
then patient safety incidents will occur
resulting in failure to achieve our safety strategy ambitions
and maintain or improve CQC Good ratings

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Patient Safety dashboard drafted and shared with ECOL Steering Group utalising PowerBI
- Lessons Identified Management System (ELMIS) concept and PID approved by ET
- Learning Collaborative Partnership Group second meeting held

Key Gaps:
Embedding new processes

Executive Responsible Officer:
Executive Chief Nursing Officer

Executive Committee: Executive Safety Oversight Group.
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Stakeholder communications plan and series of workshops scheduled and developing	Ongoing	Moriam Adekunle	Control
Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Ongoing	Moriam Adekunle	Control
Review and explore learning from other organisations including non-NHS	March 23	Moriam Adekunle	Control
Develop new safety dashboard to go live status	Dec 2022	Moriam Adekunle	Control
Develop Lessons Identified Management System (ELIMS)	TBA	Moriam Adekunle	Control and Assurance
Review PSIRF process	March 23	Moriam Adekunle	Control
Establish Governance structure for Learning Lessons	March 23	Moriam Adekunle	Control
Develop and embed Quality and Safety Champions Network	Dec 2022	Moriam Adekunle	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Team	Established		
Quality and Safety Champion Network			
Learning Collaborative partnership meeting and Learning Oversight Committee		Reporting to Quality Committee	
Adverse incident policy inc PSIRF SOP	Policy system		
Range of initiatives via culture of learning project			Internal audit completed – awaiting results

CRR95: Delivery of new vaccination programme

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT is uncertain of its role and available budget to deliver the autumn vaccination programme
then then there may be significant cost and workforce shortfalls resulting in a challenge to delivering future programmes and potential reputational damage

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:
- Mobilising for Autumn programme

Key Gaps:
Awaiting guidance from JCVI on autumn programme

Executive Responsible Officer:
Executive Director of Special Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
Work with each system to develop system plans and joint vaccination programme	September 2022	Nigel Leonard	Roadmap
Review delivery models and associated costs	September 2022	Nigel Leonard	Delivery model and costings

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Mass Vaccination Team		Project Board	
Internal plan to reduce direct and in-direct costs			

06 – Risk Movement

Sept 2022

EPUT

Risk Movement and Milestones

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Strategic Risk Movement – 18 month period (April 21 – Sept 22)

Risk ID		Initial Score	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Risk ID
SR1	Safety	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR1
SR2	People	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3	Infrastructure	15							New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4	Demand	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5	Independent Inquiry	20	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6	Cyber	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR6
SR7	Capital																	New	20↔	20↔	SR7
SR8	Resources																	New	15↔	15↔	SR8

Strategic Risk Milestones

Risk ID		Initial Score	Time on SR/ old BAF	Nov 20	Dec 20	May 21	Oct 21	Nov 21	Dec 21	Jan 22	Jul 22	Aug 22	Sep 22
SR1	Safety	20	>1 year				New	20					
SR2	People	20	>1 year				New	20					
SR3	Infrastructure	15	>1 year				New	15					
SR4	Demand	20	>1 year				New	20					
SR5 (BAF54)	Independent Inquiry	20	>2 years	New	20	15↓		SR					
SR6 (CRR40)	Cyber	12	>2 years						CRR	15			
SR7	Capital	20	> 6 months								New	20	
SR8	Resources	15	> 6 months								New	15	

Risk Movement and Milestones

NHS
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NHS Foundation Trust

Corporate Risk Movement – 18 month period (April 21 – Sept 22)

Risk ID		Initial Score	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May22	Jun 22	Jul 22	Aug 22	Sep22
CRR11	Suicide Prevention	16	12↔	12↔	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔
CRR34	Training – Suicide	9	9↔	9↔	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
CRR45	Mandatory Training	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔
CRR77	Medical Device	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔
CRR81	Ligature	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
CRR92	Inequalities	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔
CRR93	Continuous Learning	15	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
CRR94	Observation	16				New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓
CRR95	Mass Vaccination	20																15	15↔	15↔

Risk Movement and Milestones

NHS
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NHS Foundation Trust

Corporate Risk Milestones

Risk ID		Initial Score	Time on CRR or old BAF	Oct 20	Feb 21	Mar 21	Apr 21	May 21	Jul 21	Aug21	Dec 21	Jan 22	Jul 22	Sep 22
CRR11	Suicide Prevention	16	> 2 years						8	12				
CRR34	Training – Suicide	9	> 2 years							15				
CRR45	Mandatory Training	12	> 2 years	**16**										
CRR77	Medical Device	16	>1 year					16						
CRR81	Ligature	12	> 2 years											
CRR92	Inequalities	20	>1 year		New	20		16				12		
CRR93	Continuous Learning	15	>1 year			New 15	15							
CRR94	Observation	16	>6 months						New 16	16	20			15
CRR95	Mass Vaccination	20	>6 months										New 15	

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07 – Useful Information

Sept 2022

EPUT

Acronyms

Essex Partnership University NHS Foundation Trust

BAF	**Board Assurance Framework**	**SR**	**Strategic Risk**
SO	Strategic Objective	**CRR**	Corporate Risk Register
RR	Risk Register	**DRR**	Directorate Risk Register
ICS	Integrated Care System	**F&PC**	Finance & Performance Committee
QC	Quality Committee	**PECC**	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	**EOSC**	Executive Operational Sub Committee
BOD	Board of Directors	**ESOG**	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	**LRRG**	Ligature Reduction Group
MHA	Mental Health Act	**HSSC**	Health Safety Security Committee
ECC	Essex County Council	**CQC**	Care Quality Commission
CxL	Consequence x Likelihood	**CRS**	Current Risk Score
SMT	Senior Management Team	**HSE**	Health & Safety Executive
CAS	Central Alert System	**NHSE/I**	NHS England/ Improvement
PMO	Project Management Office	**ESR**	Electronic Staff Record
EFIN	Electronic Finance Record	**TBA**	To be advised or agreed
PFI	Private Finance Initiative	**NHSPS**	NHS property services
CMO	Chief Medical Officer	**EDS**	Equality and Diversity Standards
BAU	Business as Usual		

NHS
Essex Partnership University
NHS Foundation Trust

THANK YOU

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 8bii

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	28 September 2022

Report Title:	Charitable Funds Committee Report					
Executive/ Non-Executive Lead:	Amanda Sherlock, Non-Executive Director					
Report Author(s):	Carol Riley, Personal Assistant to Executive Chief Finance Officer					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the Charitable Funds Committee. It is designed to provide assurance to the Board of Directors that the duties of the Charitable Funds Committee have been appropriately complied with and risks that may affect the achievement of the organisations objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified

Summary of Key Issues

The Charitable Funds Committee met on the 28 July 2022 and the report provides details of the following:

- Report of the Financial Trustee
- Terms of Reference and Workplan
- General Bidding Round 2022/23

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Main Report

Lead
Amanda Sherlock **Non-Executive Director and Chair of Charitable Funds Committee**

Agenda Item: 8bii
Board of Directors Part 1
28 September 2022

REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

1.0 PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the Charitable Funds Committee. It is designed to provide assurance to the Board of Directors that the duties of the Charitable Funds Committee have been appropriately complied with and risks that may affect the achievement of the organisations objectives are being managed effectively.

2.0 EXECUTIVE SUMMARY

The Charitable Funds Committee met on the 28 July 2022 and approved the minutes of the meeting held on the 30 November 2021. These are available to Board members via Content Locker.

At the meeting held on 28 July 2022 the following matters were discussed:

Report of the Financial Trustee
As at the end of October 2021 the financial position was £1,152,150 this has reduced by a net amount of £83,484 to £1,068,666 as at the end of June 2022. It was noted that this is largely in respect of fund expenditure and changes in investment values.

Terms of Reference and Workplan

The above were approved by the Committee.

General Bidding Round 2022/23

The Committee reviewed the available general funds and agreed to commence the annual general bidding round with a closing date for bids to be received the end of September 2022. It was noted that any bids in excess of the Committee's delegated authority of £10,000 will be recommended to the Board for approval.

Management of Risk
This Committee is not responsible for managing any of the Trusts' significant risks (as identified in the Board Assurance Framework).

New Risks
There are no new risks that the committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

3. Action Required

The Board of Directors is asked to:

1. Note the summary of the meeting held on the 28 July 2022.
2. Confirm acceptance of assurance given in respect of risks and actions identified
3. Request any further information or action.

Report produced by:

Amanda Sherlock
Non-Executive Director
Chair of Charitable Funds Committee

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/ Non-Executive Lead:	Loy Lobo Chair of the Finance & Performance Committee					
Report Author(s):	Amy Tucker Senior Performance Manager					
Report discussed previously at:	Finance & Performance Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Listed in BAF report	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	Yes	
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 the Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action

Summary of Key Issues

Contracting
The Director of Commercial Finance advised the committee that the Op Courage Integrated Veterans Mental Health Service bid and the Essex Sexual Health Services bid have both been submitted.
The School Aged Immunisation Service remains in the due diligence phase with key principals set and the Bridging service bid was successful.

The Chair of the committee thanked the Director of Commercial Finance for their update on these bids.

Lighthouse Service
The Director of Commercial Finance provided an update on the Lighthouse service which the Trust had taken on in March 2022. Lessons learnt, achievements, and next steps were a key focus during this update. The Director of Commercial Finance sought recommendation approval from the committee to take forward an investment proposal for the MSE ICS. The Chair of the committee gave approval for the proposal to go forward through further governance, with agreement that modelling work will be undertaken once final approval is granted.

MH Urgent Care Business Case
The Director of Commercial Finance outlined this proposal is for a 24/7 service based in Basildon, using a collaborative approach with Acute, Ambulance, Police, and Voluntary sector colleagues.

The information given by the Director of Commercial Finance, with further input from the Executive Chief Operations Officer outlined costings, risks, and benefits we hope to see from this business case.

The business case was approved by the committee with a further action to review benefits realisation.

Finance M6
The Director of Finance gave an update as to the month 5 financial position for the Trust.

The YTD actual deficit is £2.3m, £0.3m favourable to plan. A risks and opportunities assessment was performed and forecast outturn remains on plan. The Capital annual plan is £12.3m. Year to date spend is £2.5m; £3.4m behind plan. Key drivers include Estates and ICT initiatives; ICT schemes impacted to an extent as some resources were diverted to the Cyber incident. The Capital group has tasked all programme managers to produce forecast outturn / review of 5 yr plan by the end of September.

Committee members asked for Care Unit specific pressure points to be included in the next update, the Director of Finance agreed to bring this next month.

Quality & Performance
The Executive Chief Operations Officer advised of the current contractual performance, in which there are six contracts with inadequate measures.
Updates were provided on the topics of Safer Staffing, CPA Reviews, Inpatient Capacity, & Psychology, as well as the escalation of two new requiring improvement measures; restraints and complaints.

The Executive Chief Operations Officer reported that August had been a challenging month with staffing and capacity pressures, however gave reassurance that there are processes in place to manage and monitor this.
The committee asked for assurance that work continues to progress in the utilisation of the accountability frameworks to set core metrics and measures, to which the Executive Chief Operations Officer advised members that this is still the aim and the project is almost ready for that step.

BAF Report
The Director of Risk and Compliance provided an update on risks as at the end of August.
There are currently four risks overseen by the Finance & Performance Committee, all of which are strategic risks. Assurances have been identified and there is no slippage on actions.

The Chair of the committee thanked the Director of Risk and Compliance for the update on risks and positively noted the new report.

National Cost Collection

The Director of Commercial Finance advised the committee this report has been provided to the agenda for information and that the submission was made on time and there has been no requirement to resubmit, as well as this the Trust has improved this year on comparison metrics.

Committee members praised this work and are keen to see how this moves forward.

Any Risks or Issues

There were no risks identified as requiring addition to the risk register in August.

Any Other Business

There was no other business.

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
Main Report

Lead
Loy Lobo   **Non-Executive Director**   **Chair of the Finance and Performance Committee**

Agenda Item 8biii
Board of Directors Meeting Part 1
28th September 2022

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Finance and Performance Committee, Loy Lobo to provide assurance to Board members that the performance operational, financial and governance as at month 5 August 2022 was subject to appropriate and robust scrutiny.

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

2.0 CONTRACTING

The August contracting update began with acknowledgement from the Executive Chief Finance Officer that there had been a high number of bids submitted recently and many were time intensive. In addition, it was noted positively that the Bridging service bid was successful.

The Director of Commercial Finance advised the committee that the Op Courage Integrated Veterans Mental Health Service bid has been submitted, the Essex Sexual Health Services bid has also been submitted with no significant changes and the Trust hopes to hear the outcome shortly.
The School Aged Immunisation Service remains in the due diligence phase with key principals set.

The Chair of the committee thanked the Director of Commercial Finance for their update on these bids.

3.0 LIGHTHOUSE SERVICE

The Director of Commercial Finance provided an update on the Lighthouse service which the Trust had taken on in March 2022.

Lessons learnt, achievements, and next steps were a key focus during this update, with many committee members noting the challenges the Trust has faced with this service and how we are looking collaboratively to find solutions.

The Director of Commercial Finance sought recommendation approval from the committee to take forward an investment proposal for the MSE ICS. The Chair of the committee gave approval for the proposal to go forward through further governance, with agreement that modelling work will be undertaken once final approval is granted.

Members of the committee praised the lessons learnt report and gave their praise for a well constructed paper and update.

4.0 MH URGENT CARE BUSINESS CASE

The Director of Commercial Finance provided a brief background on this business case and advised this was the product of searching for solutions to flow and access for patients in mental health crisis across all services.

The proposal is for a 24/7 service based in Basildon, using a collaborative approach with Acute, Ambulance, Police, and Voluntary sector colleagues.

The information given by the Director of Commercial Finance, with further input from the Executive Chief Operations Officer outlined costings, risks, and benefits we hope to see from this business case. As well as practical steps to introduce a new 136 suite, how patients will present to the service, and what success measures and data sharing may look like.

The business case was approved by the committee with a further action to review benefits realisation.

5.0 FINANCIAL UPDATE M5

The Director of Finance gave an update as to the month 5 financial position for the Trust.

The YTD actual deficit is £2.3m, £0.3m favourable to plan. A risks and opportunities assessment was performed and forecast outturn remains on plan. The Capital annual plan is £12.3m. Year to date spend is £2.5m; £3.4m behind plan. Key drivers include Estates and ICT initiatives; ICT schemes impacted to an extent as some resources were diverted to the Cyber incident. The Capital group has tasked all programme managers to produce forecast outturn / review of 5 yr plan by the end of September.

The Trust is will receive a block contract (with marginal rate tolerances) for activity between September and December. The Trust has now agreed pay award funding of £4.2m.

The Trust was impact by the National Cyber incident with the finance system unavailable between 9 Aug – 2 Sept. Business continuity plans were successfully deployed, and adapted during the incident with no operationally impacts.

Committee members asked for Care Unit specific pressure points to be included in the next update, the Director of Finance agreed to bring this next month.

6.0 QUALITY AND PERFORMANCE REPORT

This report covers the position for month 5 (August-22).

In August 2022 there were 5 areas of inadequate performance, with the new addition of Safer Staffing (4 in July):

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity (Adults)
- Out of Area Placements
- Psychology

The Executive Chief Operations Officer advised of the current contractual performance, in which there are six contracts with inadequate measures. Assurance was provided that contractual approval will be sought to remove one inadequate measure for which any breaches are pre-approved by the CCG's.

Updates were provided on the topics of all five inadequate measures listed above, as well as the escalation of two new requiring improvement measures; restraints and complaints.

The Executive Chief Operations Officer reported that August had been a challenging month with staffing and capacity pressures, however gave reassurance that there are processes in place to manage and monitor this.

The committee asked for assurance that work continues to progress in the utilisation of the accountability frameworks to set core metrics and measures, to which the Executive Chief Operations Officer advised members that this is still the aim and the project is almost ready for that step.

7.0 BAF REPORT

The Director of Risk and Compliance provided an update on risks as at the end of August, advising that the report is in its new format to align with Board reports and committee members have had the opportunity to review this.

There are currently four risks overseen by the Finance & Performance Committee, all of which are strategic risks. Assurances have been identified and there is no slippage on actions.

The Chair of the committee thanked the Director of Risk and Compliance for the update on risks and positively noted the new report.

8.0 NATIONAL COST COLLECTION

The Director of Commercial Finance advised the committee this report has been provided to the agenda for information and that the Costing Steering Group is now chaired by the Director for Health and Care Delivery in West Essex.

The committee were advised that the submission was made on time and there has been no requirement to resubmit, as well as this the Trust has improved this year on comparison metrics.

Committee members praised this work and are keen to see how this moves forward.

9.0 ANY RISKS OR ISSUES

There were no risks identified as requiring addition to the risk register in August.

10.0 ANY OTHER BUSINESS

There was no other business.

10.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action

Report prepared by:

Amy Tucker
Senior Performance Manager

On behalf of:

Loy Lobo
Non-Executive Director
Chair of the Finance and Performance Committee

		Agenda Item No: 8biv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Quality Committee Report**					
Executive/ Non-Executive Lead:	Rufus Helm, Chair of the Quality Committee					
Report Author(s):	Matt Rangué, Quality Project Lead					
Report discussed previously at:						
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 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with assurance on actions taken by the Quality Committee, to progress key aspects of the quality agenda.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.

Summary of Key Issues
The Quality Committee has reviewed the work of the sub-committees and all performance and quality dashboards accountable to the Committee. This report is presented to the Board of Directors as assurance of the review and challenge initiated. This report confirms that the Quality Committee has received assurance that all work streams are in place and actions are being taken to mitigate risks.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Rufus Helm **Chair of the Quality Committee** **Non-Executive Director**

Agenda Item: 8biv
Board of Directors Meeting Part 1
28 September 2022

QUALITY COMMITTEE ASSURANCE REPORT

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with assurance on actions taken by the Quality Committee, to progress key aspects of the quality agenda.

2.0 EXECUTIVE SUMMARY

Summary of discussions and issues identified as well as assurances provided at the August and September meetings:

2.1 COMMITTEE MEETING HELD ON 11 AUGUST 2022

2.1.1 Quality Performance Report

The Committee received the Quality Performance Report identifying that 15 indicators continue performing within target parameters with 3 indicators currently performing outside of target. These areas are recorded as underperforming for a number of months and have been discussed at previous meetings. The areas concerned are:

- Care Plan Approach
- Inpatient Mental Health Capacity
- Psychology Waiting Times

It was noted that the 3 indicators are also discussed at the Finance & Performance Committee with progress and outcomes being reported, and Committee members raised the challenge that rather than repeating discussions at this Committee on the interventions being made to improve performance, consideration should be given to whether the Committee is looking at the right indicators. Assurance was received that the Trust Secretary is currently reviewing the information reported to each Committee with the aim to provide more relevant information and avoid duplication.

The Committee also noted that the Care Unit structure has been developed and that the Quality and Safety Groups within each Care Unit will give additional assurance to this Committee.

2.1.2 CQC Exception Report

The Committee received an update report outlining assurance on the key CQC related activities that are being undertaken within the Trust, particularly noting the following areas:

- An overview of the new CQC regulatory model is now available which brings significant change, removing the Key Lines of Enquiry and replacing these with Quality Statements and introducing 6 evidence categories. It was noted that the current Trust CQC Assurance Framework will require amendment to take account of these changes and staff will need to be updated

- Receipt of the final CAMHS CQC report which shows improvement in all areas previously rated as 'inadequate'
- New IPC Tool for nursing homes has been reviewed and tested with excellent results

It was noted that significant challenge for the Trust is providing evidence for service user involvement and capturing what people say about their care. Assurance was however given that a variety of methods already available to the Trust will be employed to gather user engagement information including the 'I Want Great Care' Tool.

2.1.3 Non PSI Deaths Presentation

The Committee received a presentation on learning from non PSI deaths following a review to:

- Access the extent to which physical health risks or conditions contributed to premature death
- Explore a whole system approach, reflect on avoidable mortality and look at how we can contribute to the 'parity of esteem' agenda
- Gain an understanding of initiatives that may help to improve health and manage health conditions for people with server and enduring mental illness

It was noted that cardio indicators have been challenging to gather, largely due not having access to GP information. However, progress is, and continues to be, made and is also being taken forward with the Digital Strategy.

Committee members agreed for the presentation to be shared with our system partners for an opportunity to work together.

2.1.4 Ligature Risk Quarterly Report

The report identified the continued downward trend in ligature incidents associated with fixed points and that the Intensive Support Team continues to work with Trust staff to reduce suicide in older adults.

Committee members noted the reduction in fixed point ligature incidents and commended the work of Trust staff in improving patient safety.

2.1.5 Emergency Preparedness, Resilience and Response (EPPR)

The report brought to the attention of the Committee that there are insufficient loggists within the Trust to sustain support in the event of a major incident. There are currently seven. Committee members noted the risk and recommended that it be escalated to the Corporate Risk Register.

2.1.6 Information Governance Framework

Committee members noted and approved the Information Governance Framework.

2.2 <u>COMMITTEE MEETING HELD ON 08 SEPTEMBER 2022</u>

2.2.1 Combined Sub-Committees Assurance Report

The Committee received assurance reports from all relevant sub-committees:

- Mortality Review Sub-Committee
- Health, Safety and Security Sub-Committee
- Mental Health Act & Safeguarding Sub-Committee
- End of Life Group
- Information Governance Sub-Committee
- Multi-Professional Education Group
- Restrictive Practice Group
- Research & Innovation Group
- Learning Oversight Sub-Committee
- Equality & Inclusion Sub-Committee
- Patient Experience and Carer Sub-Committee
- Physical Health Sub-Committee
- Clinical Governance & Quality Sub-Committee

There were no issues reported for further escalation and key points of discussion included:

- Mental Health Act and Safeguarding Sub-Committee - continued capacity to meet response deadlines
- Health, Safety and Security Sub-Committee - hotspots being actioned include ligature risk from new door closures and improvements to deep cleaning
- End of Life Group - tackling disparities between protocols for EOL between the Integrated Care Board providers
- Information Governance Sub-Committee - following a significant cyber incident affecting mental health providers it was noted how potentially vulnerable clinical systems are to attack and the need for staff to remain vigilant
- Mortality Review Sub-Committee - working with the Coroner to prevent methadone overdose being recorded as an issue when prescribing within therapeutic levels. It was also noted that capacity within the Patient Safety Incident Team is improving with the appointment of experienced recruits and, as an early adopter, the Trust is now in the position of presenting the organisation's work in the national arena. Committee members commended the work and evidence of success as the Trust is performing considerably better than peer organisations
- Learning and Oversight Sub-Committee – Committee members commended the team in developing the approach to safety and learning across the organisation following the introduction of the Patient Safety Incident Review Framework (PSIRF). It was also noted that the new Care Unit approach will further improve local action and ownership of incidents, while also ensuring escalation and shared learning across the Trust. Committee members also debated how the use of quantitative data, soft qualitative case studies and Power Business Intelligence will contribute to a more meaningful dashboard for quality and safety, and emphasised the importance of the Quality Committee involvement in the validation and inclusion of new measures of quality performance

Going forward, this report will include a summary of key quality and safety hotspots identified by the sub-committees/groups to ensure good use of Committee time, and to ensure all relevant issues are discussed, challenged and escalated as appropriate. A dashboard of key quality markers will also be developed to support the narrative

2.2.2 CQC Assurance Report

The Committee received, discussed and noted the CQC Assurance Report. Key discussion centered on the escalation of the Children and Adolescents Mental Health Services (CAMHS) rating to 'good' in the domain of caring, and recorded that this is an excellent reflection on the work undertaken by Trust colleagues to act on the CQC findings and make the necessary improvements to services and patient experience.

Committee members commended the new style report, stating it is easy to read and that it should be a format adopted by other services within the Trust.

2.2.3 Safeguarding Annual Report

The Committee received the Safeguarding Annual Report, particularly noting the additional demand being placed on the service and how the Safeguarding Team have responded well to demand for training, and how this has been well received by staff.

Committee members commended the new style report stating it is easy to read and that it should be a format adopted by other services within the Trust.

2.2.4 Cardio-Metabolic Key Performance Indicator Update

The report was received and discussed by members of the Committee who noted the pan-Essex work being undertaken to ensure that there is a common set of KPIs within the Integrated Care Board. This will make data collection and comparative data analysis easier in the future.

2.2.5 Mental Health Act Procedure Quarterly Review

The Committee received the review which provided assurance that any impact on quality and safety is being managed effectively through the Mental Health Act Operational Procedure.

Discussions took place regarding the status of the procedure in terms of approval and Committee members agreed that good governance of the document would be achieved through formal approval via the Mental Health Act & Safeguarding Sub-Committee.

2.2.6 Emergency Preparedness Resilience and Response (EPPR) Core Standards

Approval of the standards were sought at this Committee as they had not been presented to the Board of Directors due to time scheduling. Committee members approved.

2.2.7 Board Assurance Framework Action Plan

The Board Assurance Framework was presented and Committee members commended the new format, although it was noted that further action is required to ensure the 'by when' and 'by whom' sections are completed.

2.2.8 Patient Story

The Committee received a video presentation from a service user on her experience of using Trust services, transitioning from adolescent to adult services.

2.2.9 Flow and Capacity Deep Dive

The Flow and Capacity Deep Dive report was presented in response to concern expressed by Committee members regarding the issues raised by the care plan approach, length of stay and access to psychology metric performance.

Committee Members were assured that an After Action Review is being undertaken to identify what worked well and what could be improved following the OPEL 3 incident, and noted the joint work with the Mid and South Essex Hospitals Group establishing a Mental Health Urgent Care Unit at the Basildon Hospital Site, where work is ongoing with partners to agree the optimum pathway to ensure the facility is used effectively. If successful, the model could potentially be adopted across five sites in Essex.

Challenge was made on whether the Trust has evidence of harm following the impact of recent capacity issues and debated the impact of not admitting less acute patients on inpatient acuity, and the potential delay to admission of patients until their mental health deteriorates further.

Committee members noted that there is good evidence that all patients occupying inpatient beds are doing so appropriately and that the current national bench mark for length of stay (LOS) remains a useful rule of thumb for peer comparison, which encourages investigation as to whether a protracted LOS impacts on recovery and reintegration on discharge from hospital.

The Committee concluded discussions by recommending that 'Getting It Right First Time' (GIRFT) should be involved as an expert resource when developing new measures of performance for flow and capacity.

2.2.10 Infection Prevention and Control Board Assurance Framework

The Committee received, discussed and noted the Infection Prevention and Control Board Assurance Framework.

2.2.11 Reflections on Risks, Issues and Concerns

The Committee identified:

Risks for escalation:

- Insufficient Loggists to support the EPPR Process
- Significant capacity issues affecting mental health services

Risks for other Committees:

- The requirement for better communication between Finance & Performance Committee and Quality Committee

Reflections on good practice:

- The trial and review of the Infection Prevention and Control Tool for care homes
- The effectiveness of the Student Trainee 'Buddy Scheme'
- Learning from incidents process

2.2.12 Quality Committee Annual Evaluation

The Committee noted the comments from the review on timeliness and clear information and discussing outcomes and formalising decisions.

Committee members agreed to reflect on the Committee's performance at the end of each meeting going forward. Reflections on performance from today's meeting were:

What went well:

- Patient story – impactful
- New style approach to the Safeguarding Annual Report

What did not go well:

- Combined Sub-Committees Assurance Report – this needs to include a summary of the key issues raised and the inclusion of a performance dashboard

2.2.13 Any Other Business

The Committee noted and thanked the work, input and challenge undertaken by Amanda Sherlock as her tenure comes to an end, and members expressed profound gratitude for her insight and support.

3.0 POLICIES

3.1 Policies approved at the August meeting:

The following policies were approved by the Committee:

- RM12 and RM12.1 Appendix 2 Assured Safe Catering Policy and Procedures
- RM21 and RMPG21 Appendix 3 Operational and Maintenance Policy and Procedure for the Management and Control of Asbestos
- CP28 and CPG28 Appendix 4 Surveillance Systems Policy and Procedures

It should be noted that during this part of the agenda, due to the Executive Director present having to leave to attend another appointment, the meeting was not quorate. It was therefore agreed by Committee members for Chairs Action in approving the policies.

Please note that no policies were presented for approval at the September meeting.

3.2 Policy extension requests approved at the August Meeting:

The Committee received requests to extend the review dates for the following policies:

- IPCG1.5 Infection Control Procedure Section 5 – Management of MRSA – MH and CHS
- MHA1 Administration of MHA Policy
- MHA21 Pan-Essex Mental Health Act Section 117 Protocol
- CLP28 Clinical Risk Assessment & Safety Policy and Procedures
- CLP30 CPA Policy and Procedures
- CLP82 (Essex) Repetitive Transcranial Magnetic Stimulation (rTMS) Policy and Procedure
- CP36 Communicating Patient Safety Incidents 'Being Open' Policy
- CPG50B Email Internet Intranet Access & Use Procedure
- CPG50H NHS Mail Usage Procedure
- CP82 Reward and Recognition for People with Lived Experience

It was noted that at a previous meeting it had been agreed by Committee members that this Committee would no longer support policy extension requests going forward. Assurance was however given that a strategy is in place to ensure policies are approved on time following the establishment of the Policy Reference Group, therefore Committee members agreed that the position of no-longer approving policy extensions would be delayed until the Policy Reference Group is in place.

Based on there being no risks identified with the proposed extension of the above policies review dates, Committee members gave their approval.

4.0 RECOMMENDATIONS/ACTION REQUIRED

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.

Report prepared by:
Matt Rangué, Quality Project Lead

On behalf of:
Rufus Helm, Non-Executive Director
Chair of the Quality Committee

		Agenda Item No: 8bv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**People, Equality and Culture Committee**					
Executive/Non-Executive Lead:	Manny Lewis, Chair of the People Equalities and Culture Committee					
Report Author(s):	Denver Greenhalgh Senior Director of Corporate Governance					
Report discussed previously at:	Not previously discussed.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber-Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	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.	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 details that the People Equality and Culture Committee (PECC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Receive and note the contents of the report 2 Accept the Assurance provided

Summary of Key Issues

The People, Equality and Culture Committee (PECC) met on the 22 September 2022, the meeting was quorate by means of delegated membership and the minutes of the meeting held on 21 July 2022 were approved as an accurate reflection of the meeting.

The Committee received reports on the following:

- **Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES)** – a measure of equal opportunities,populated from workforce information and results of the staff survey 2021. Whilst the reports highlighted a good and improving picture for EPUT the following areas were discussed in terms of focused work programmes:
  Bullying and harassment both from services user and staff; relative number of BAME staff being subject to disciplinary action (remaining above the national average) and effective management of reasonable adjustments (particularly with non-visible disabilities). The Committee triangulated this with current employee relation cases, feedback from the Freedom to Speak Up Guardian and the Time to Care programme which will look to tackle abuse from services users within our inpatient areas. The Committee welcomed and look forward to receiving an action plan to address areas for further improvement and acknowledged continued focus and progress that collectively we will make a difference. The action plan will be reviewed by the Executive Team as it was agreed that senior leadership was key to addressing the cultural and behavioural issues. The full reports are provided to the Board of Directors.

- **International Recruitment Update** – The Committee heard that the Trust was on track to deliver against its target for 195 nurses recruited by the end of December 2022, with 88 new colleagues already here. The Committee heard of the benefits from pausing the service to undertake reflection, engage, learn and adapt the programme. There continued to be complexity associated with visas, OSCE testing and accommodation which were being proactively worked through on individual basis. The Committee noted the high quality of the pastoral care that our new colleagues had received and received assurance that the wider issues were being addressed with stronger corporate engagement

  The Committee received feedback from Alex Green (Executive Director of Operations) that there was a sense of hope in the organisation, with the wards welcoming new colleagues and that they were able to make best use of the resources whilst awaiting completion of OSCE exams and being in a position to be included within the rostered numbers.

- **Time to Care Programme** – Following the mobilisation of the programme Paul Scott (Chief Executive) presented the first report from the Time to Care Programme Steering Group, noting that there continues to be a focus on engagement with all staff as we move to finalising a long list of opportunities to inform the final plan in October 2022. The Committee welcomed the clear programme presented. The Committee raised the challenge of funding likely investment requirements and was advised tat there would be a concerted strategy with commissioners, partners and through the Trust's own funding to secure what was required. The Committee looked forward to receiving the delivery plan in due course.

- **Focus on Education and Development** - The Committee welcomed Annette Thomas-Gregory (Director of Education and Learning Development) to her first meeting and to the

Trust, provided an overview of the following areas: Road map to the development of the EPUT Education Strategy with clear links to the other agenda items at the meeting: Digital transformation; Apprenticeship Programme; Mandatory Training; Student Clinical Placements. The Committee welcomed the vision and ambition.

- **Apprenticeship Programme OFSTED Inspection** – The Committee received an update from the latest inspection and the good outcome (appendix to this report for Board colleagues). As with all inspections there are improvements that the Trust can make and one particular focus will be on understanding the attrition rate. The Committee was apprised that OFSTED was one aspect of the regulatory landscape for the programme and were reminded of the registration requirements to be a provider under the Department of Education. The Committee congratulated the team on the very positive inspection outcome.

- **Mandatory Training Update** – The Committee heard that compliance had recovered to the pre-pandemic levels and work continued to drive improvement and offering including for NEDs

- **Annual Quality Assurance Framework for Responsible Officer and Revalidation** – The Committee welcome Alesia Waterman (Director of HR – Medical) to her first meeting who presented the annual report for 2021/22. The reported noted that of the 165 doctors connected to EPUT, 142 had completed their appraisal and revalidation. There were 8 deferrals. The report gave assurance that the governance was in place in respect of responsible officer, revalidation lead and having in place 34 trained appraisers. The Committee received and endorsed the report. The full report is a full agenda item at the meeting of the Board of Directors for approval of the annual submission to NHS England.

- **Meeting feedback** – This was the first of the new style Committee meeting with a focus of one aspect of the people plan (Learning & Development). It was felt that there was a strong set of papers and good to have dedicated time to focus on one area. The size and complexity of the education and learning portfolio was acknowledged, along with the progress.

The focus for the next Committee meeting is Staff Experience.

The Board is asked to note that there were no significant risks to report from this meeting.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
None

Lead
Manny Lewis **Non-Executive Director** **Chair of the People, Equality and Culture Committee**

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Board Safety Oversight Group Report – September 2022**					
Executive/ Non-Executive Lead:	Alison Rose-Quirie, Chair of Board Safety Oversight Group and Non-Executive Director					
Report Author(s):	Richard James, Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with an update on the progress of projects and programmes 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

Summary of Key Issues

This report is provided an update on the continued progress of projects, programmes and other activity that are linked to the safety priorities within the safety strategy, including:

- EPUT Culture of Learning
- Ligature Risk Reduction
- Mental Health Emergency Department
- International Recruitment
- Safety Strategy Update

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		**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
 **Alison Rose-Quirie** **Non-Executive Director** **Chair of the Board Safety Oversight Group**

Agenda Item: 8c
Board of Directors Meeting Part 1
28 September 2022

BOARD OVERSIGHT SAFETY GROUP

This report is provided as assurance to the Trust Board on the continued progress of projects, programmes and other activity that are linked to the safety priorities within the safety strategy.

1.0 LIGATURE RISK REDUCTION

We have had early sight of the new nationally developed draft ligature harm minimisation standards and guidance. The recommendations in the guidance document will be aligned to the Safety Improvement Plan for Self-Harm reduction as a basis for monitoring medium and long term goals. Our implementation of the new proposed standards affords us an opportunity to be part of the testing of the guidance.

The questions in the guidance are key for future analysis of ligature incidents and will sit well within the Safety First, Safety Always strategy.

The oversight for implementation will be monitored through both the Ligature Risk Reduction Group (LLRG) and the Learning Oversight subcommittee meetings. This will be tabled as an agenda item in both of these in October 2022.

Following the recent re-scoping of the project, we have continued our focus in four key areas:

Training

The Ligature Risk Reduction Training working group held two sessions in July, inviting clinical and operational colleagues to comment on the proposal to bring Ligature Risk Awareness and Management training in-house. The feedback from these sessions included; consideration around duration, frequency, location, requirements and attendees. The proposal was approved in principle at the Ligature Risk Reduction Group on the 14 September 2022. However, consideration needs to take place around capacity of our Education Team and the liaison with Psychology colleagues.

Systems

The plan to move to version 10 of 3i (facilities management system) has been paused due to technical issues impacting EPUT and other NHS Trusts. This has delayed the development of the robotic process automation (RPA) link between 3i and Datix (risk management system). When complete this RPA solution will remove the current manual process of updating both systems.

An RPA platform has however been built to enable the synchronisation between 3i and Datix in version 8 (the previous version of 3i). The EPUT & SNEE joint development team are meeting on the 22/09 to finalise the design and following this meeting they will confirm a “go live” date.

Policy

Together with the wider review of all EPUT policies, the review of any ligature related policies is taking place. This will provide a sense-check and ensure they remain accurate

and reflect the current position. The policy group have also developed and had approval for a 'policy on a page' template which will now be trialled using the ligature risk assessment and management policy before moving to the pilot stage.

Environment

Updated completed environmental issues is included in Part 2 of this report.

2.0 EPUT CULTURE OF LEARNING (ECOL)

ECOL is now being delivered through seven work streams: Learning Lessons Documentation and Management, PSIRF Process Review, Safety Dashboard, Learning Lessons Governance, Quality and Safety Champion Network, Information Sharing and Learning Lessons & Wider Team upskilling.

Following approval at the Digital Strategy Meeting at the end of July, in collaboration with Trustmark we have developed a prototype safety dashboard that can streamline and interrogate data. The work will be delivered over 3 phases.

- Phase 1 of this prototype is progressing with test users to further refine the user interface options and allow the data cleanse to be completed. An outstanding action with Trustmarque is to refine data queries and adjust user interface options
- Phase 2 will be to develop a detailed Safety report which allows for a far more in-depth analysis of the Trust's safety data and the ability to flag areas of concern dynamically to improve interpretation.
- Phase 3 will be a simplified report specifically for Matrons and Service Managers for them to access and understand any issues within their responsibility area.

The newly formed Learning Lessons Team have completed all their required training and development and have successfully delivered an EPUT Lessons training package and an eLearning tool for OLM (online learning system).

The inaugural Learning Collaborative Partnership meeting took place on the 9 August 2022. Following this meeting, the group produced the first edition of the lessons identified newsletter and a "5 key message" poster. The group has gone onto produce a further edition of both of these, all of which can be found on Input.

We have continued to recruit a number of Quality and Safety Champions and work to expand this team will continue throughout the rest of 2022. These champions act as advocates for quality and safety by disseminating information, preparing and delivering communications and supporting/training teams around new and existing policies and practices to improve awareness and compliance.

It has been agreed by the ECOL Steering Group that the People and Culture directorate will now lead and provide updates on the progress of the Just Caring and Learning Culture elements via People, Equality and Culture Committee.

3.0 MENTAL HEALTH URGENT CARE DEPARTMENT

We continue to progress the implementation of the full mental health urgent care department (MHUCD) with a target launch date of the end of February 2023.

In order to successfully develop this, we have created a brief which provides detail on our service offering. This was created following a review of other UK MHUCD models and

research into EPUT/Mid & South Essex (MSE) system structures, requirements and current urgent care pathways.

We have instigated a system led project group which includes senior leaders from EPUT and the Acute MSE, MSE Integrated Care System (ICS), ambulance service, police and the voluntary sector. This group has agreed the design of the MHUCD and Mental Health Assessment Unit (MHAU) site in the Basildon mental health building. We completed and received approval from NHS England for a capital BID for £1.2m, completed and received approval of a SOC for system allocation of £2.7m revenue and £1.3m of capital funding. Finally, we have developed the required project structures, timelines and governance processes including operations, staffing, estates, data, IT and lived experience coproduction.

Alongside the above, we completed a review of the MHUCD together with the urgent care patient pathways to determine service specifics. We also reviewed the MHUCD staffing requirements, combined with other services within the MHUCD pathways to plan best use of revenue funding and Multi-Disciplinary Team (MDT) resource.

4.0 INTERNATIONAL RECRUITMENT

The project team has worked hard to resolve a number of issues that were impacting the project and to plan the remaining cohorts. Throughout this time we have also continued the on-boarding of nurses that had visas in place, as a delay would have caused these to expire. We have now welcomed a further 23 nurses in July and August, taking our overall total to 88.

One of the key issues has been delays for nurses being deployed to our wards due to occupational health (OH) clearances. This is now being managed on a daily basis by the Associate Directors of both Transformation and Recruitment. Through this mitigation, we have now had OH clearances for 57 of the 88 on-boarded nurses, with the remaining nurses requiring the results of their TB test.

The following processes have been implemented in order to apply the learning from our initial cohorts:

- An overall cohort delivery plan and readiness tracker
- The creation and population of a master database designed to track each nurse through the recruitment to substantive post process. This includes all associated required data e.g. flights, exam dates, accommodation, ward allocation, VISAs and related costs
- Implementation of a training tracker tool to ensure we have sufficient capacity of practice education facilitators and training space for all nurses

5.0 SAFETY STRATEGY

An update on the continued work to demonstrate our progress against the safety strategy is included in the Chief Executive Board Report under Performance and Operational Issues.

Report prepared by:
Richard James – Director of Transformation

On behalf of:
Alison Rose-Quirie, Non-Executive Director
Chair of Board Oversight Safety Group

Agenda Item No: 8d

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	28 September 2022

Report Title:	**Policy Oversight and Ratification Group**					
Executive/ Non-Executive Lead:	Denver Greenhalgh Senior Director of Governance and Corporate Affairs					
Report Author(s):	Nicola Jones Director of Risk and Compliance					
Report discussed previously at:	Executive Operational Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
The report puts forward a proposal to stand up a new forum to oversee the quality assurance, approval and maintenance of trust-wide policies and procedures.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

Trust Board of Directors is asked to:

1 Approve the stand up of a Policy Oversight & Ratification Group and its terms of reference.

2 Approve changes to the Trust Policy for the Development Review and Control of Trust Approved Documents to reflect the new Policy Oversight & Ratification Group

3 Note the phased programme of work associated with the quality assurance, approval and maintenance of trust-wide policies and procedures.

Summary of Key Issues

Background

This paper builds on a report provided to the Executive which signalled the start of piece of work to optimise the policy oversight systems used within the Trust. As a consequence of COVID-19 a number of documents are behind the original review dates (albeit extensions to their use were assessed and agreed through the Executive and Board Committees). This has now culminated in a 'rising tide' of reviews which without a coordinated approach will not make best use of resources.

The current oversight and approval governance underpinning the system is at best duplicative and time consuming, with the risk that the volume of workflow associate with the management of policies detracts from the other responsibilities of the Board Committees.

Following discussion with both executive team and non-executive directors it is proposed that the Board support a programme of work to redefine the governance with the aim to enhance the quality assurance underpinning the development of policies and procedures and put in place robust maintenance business rhythm.

Phase one of this programme is to establish a Policy Oversight & Ratification Group, to be chaired by the Senior Director of Corporate Governance. The role of the Policy Oversight & Ratification Group will be to provide quality assurance and final ratification of trust-wide policies and procedures in line with the Policy for Development, Review and Control of Trust Approved Documents (reference CP1).

Establishment of this group will divert all oversight and ratification through one group and remove this work flow from both the Executive Operational Sub-Committee and the Board Committees. The exception to the rule being those documents that are classed as 'matters reserved for the board'. The draft terms of reference for approval are outlined in attachment 1.

To ensure the Board has assurance it is proposed that a policy management key controls report will be developed and provided to the Executive Operational Sub-Committee on a quarterly basis going forward. This can then be shared with the Audit Committee as an assurance on the system of control.

The Trust Policy for the Development Review and Control of Trust Approved Documents (as a matter reserved for the Board) has been revised to reflect the establishment of a new Policy Oversight & Ratification Group and is attached in attachment 2 for 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
Appendix 1 Terms of Reference Appendix 2 Revised Policy for the Development Review and Control of Trust Approved Documents

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

Policy Oversight & Ratification Group
TERMS OF REFERENCE

NHS
Essex Partnership University
NHS Foundation Trust

CHAIRED BY:	Denver Greenhalgh, Senior Director of Corporate Governance	**SECRETARIAT:**	[name] Assurance and Policy Lead	**FREQUENCY/DURATION:**	Monthly
PURPOSE:	The role of the Policy Oversight & Ratification Group is to provide quality assurance and final ratification of trust-wide policies and procedures in line with the Policy for Development, Review and Control of Trust Approved Documents.				
PROPOSED AGENDA:	▪ To manage the policy and procedure document register to ensure all documents remain reflective of best practice, current and aligned to organisational structure. ▪ To undertake quality assurance of all policies and procedural document put forward for ratification (checking updates reflective of latest guidance, appropriate consultation, consistency with other trust documents and alignment with the Policy for Development, Review and Control of Trust Approved Documents). ▪ To agree any new additions and removal of items from the policy and procedure register. ▪ To approve (with the exception of those items under 'matters reserved for the Board') policies and procedures following the appropriate review process. ▪ Recommend policies under 'matters reserved for the Board' to the Board for ratification. ▪ To in exceptional circumstances, approve review extensions, following an impact assessment. ▪ To maintain an action and decisions log. ▪ To provide a policies and procedures management key controls report to the Executive and to the Audit Committee.				
ATTENDANCE:	Membership will consist of: • Senior Director of Corporate Governance • Executive Medical Director • Director of Risk and Compliance • Finance Representative • Estates Representative • Nursing & Quality Representative • People & Culture Representative • Operations Representative • Assurance and Policy Lead • Policy Author (as required)		The Chair of the Committee will be the Senior Director of Corporate Governance , in their absence another Director from the membership will be asked to chair. The quorum will be all members (or their nominated alternate) Group Chair will keep under review attendance at Group meetings and take any necessary action to ensure that meetings are held in accordance with these terms of reference. When members cannot attend it is expected an alternate will be nominated.		
AUTHORITY:	The Group has delegated authority to oversee, review and ratify (or refuse the same)for all trust policies and procedures (with the exception of those 'matters reserved for the Board).		**OUTPUTS:**	Key controls report to Executive Operational Sub-Committee (Quarterly) To be shared with the Audit Committee.	

Essex Partnership University
NHS Foundation Trust

POLICY FOR THE DEVELOPMENT, REVIEW, MONITORING AND CONTROL OF TRUST APPROVED DOCUMENTS

POLICY REFERENCE NUMBER	CP1
VERSION NUMBER	4
KEY CHANGES FROM PREVIOUS VERSION	Review of approval process to streamline and introduce the new Trust Policy Oversight and Ratification Group
AUTHOR	Head of Assurance
CONSULTATION GROUPS	HSSC, CGQSC, IGSSC, EISC
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	November 2018; November 2020: September 2022
LAST REVIEW DATE	March 2021
NEXT REVIEW DATE	March 2024
APPROVAL BY EXECUTIVE OPERATIONAL SUB-COMMITTEE	July 2022
RATIFIED BY TRUST BOARD OF DIRECTORS	
COPYRIGHT	

The Director responsible for monitoring and reviewing this policy is Chief Executive Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Structured Summary

Policy Title: CP1 Policy for Development, Review, Monitoring and Control of Trust Approved Documents

This policy should be implemented by: All Policy authors

The 5 core things you must remember / consider / do:

1 – Authors must ensure that robust consultation has taken place as part of policy creation / review

2 – Authors must ensure that Policies, Procedures & Appendices are presented to the relevant specialist committee/s and approved prior to sending to the Policy Controller for inclusion in the next Policy Oversight and Ratification Group meeting.

3 – All Policies must adhere to the structure and formatting guidelines outlined in Appendix 1 of the Procedure.

4 – All proposed new policies must address the criteria for new approved documents outlined in section 5.1 of the policy

5 – Authors are expected to liaise with the Policy Administrator ~~Controller~~ when amendments are made to a policy, to ensure that due consultation takes place and approval is sought as necessary

Why do we need this policy?
To ensure consistency of approach to the development, review, approval, monitoring and control of all Trust approved documents to ensure good governance, and compliance with regulations and requirements. It provides guidance and protection for policy authors.

The Trust monitors the implementation of and compliance with this policy in the following ways:
Through the Trust Assurance Team

Relationship to Trust Strategic Objectives (please tick):
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 ✓

If you have any comments or would like to be involved in a future revision of this policy, please email epunft.ask.policies@nhs.net

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR THE DEVELOPMENT, REVIEW, MONITORING AND CONTROL OF TRUST APPROVED DOCUMENTS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR THE DEVELOPMENT, REVIEW, MONITORING AND CONTROL OF TRUST APPROVED DOCUMENTS

1.0 INTRODUCTION

1.1 The purpose of this policy is to set out the Trust policy for the development, review, monitoring and control of all Trust approved documents to ensure good governance and compliance with all requirements.

1.2 This policy is self-governing and is subject to all the checks and balances applied to other Trust policies.

1.3 In an organisation the size and complexity of Essex Partnership University NHS Foundation Trust (EPUT), it is essential that all approved documents are clear, functional and consistent, and that the systems for developing, reviewing, approving, implementing and monitoring approved documents are robust.

1.4 Policies and procedural guidelines are necessary in many different contexts and may be led by legislation (i.e. the Trust's Complaints Policy), or a need to have clear thinking on a particular issue, i.e. the Forensic Service 'Key Suiting Policy'. Consequently, there will be a range of policy and procedural guidelines, which will operate at Trust/Corporate, Directorate and Service levels.

1.5 The aim of this policy is to describe the process for development, approval, management and review of new and existing policies, procedures, strategies, frameworks, local policies and procedures and clinical guidelines. It outlines:

- What policies should look like
- How to carry out effective consultation
- How to ensure that you have covered all of the relevant points
- What you need to do and when
- Equality, Diversity, and Inclusion issues – in particular responsibilities related to carrying out equality impact assessments
- Approval processes

1.6 For the purpose of this policy and related procedural guideline the term approved document applies to:

- Trustwide Policies and Procedural Guidelines
- Trust Strategies and Implementation Frameworks
- Operational Policies/Standard Operational Procedures
- Local Policies/Procedures
- Clinical Guidelines

1.7 The Policy for Development, Review, and Control of Trust Approved Documents may be referred to as the 'Policy on Policies' to provide a shortened reference.

2.0 SCOPE

2.1 This policy and its accompanying procedural guidelines apply equally to all staff employed by the Trust, as well as bank workers, agency workers and contractors, where appropriate

3.0 DEFINITIONS

3.1 Policy
Policies are a statement of Trust intent. Policy statement documents will outline the Trust's stated aims and/or objectives on a given issue.

3.2 Procedures
Procedural guidelines will detail how the aims and/or objectives stated in the policy are to be put into practice. These are also a consistent way of conducting a task/practice. For more complex processes multiple procedural guidelines may be developed.

3.3 Local policies and procedures
These apply to only one or two Trust services or one Trust speciality.

3.4 Strategy
A Strategy is a long term plan of action designed to achieve a particular goal. Trust Strategies are divided into three categories the Five Year Strategic Plan and Operational Plan, Support/Enabling Strategies and Implementation Frameworks.

3.5 Operational Policy/Standard Operating Procedures / Protocol
Operational Policies/Standard Operating Procedures are documents that outline an agreed process to be followed in only one or two specific areas or specialities within the Trust. Any process developed that is applicable Trustwide will be developed into or included in a Trustwide policy and procedure.

3.6 Clinical Guidelines
EPUT has adopted the Royal Marsden Manual of Clinical and Cancer Nursing Procedures and Great Ormond Street Hospital (GOSH) Manual of Children's Nursing Practices for all relevant staff to follow. In addition EPUT specific Clinical Guidelines are developed where the Royal Marsden Manual and the Great Ormond Street Manual do not cover a required topic. Clinical Guidelines make recommendations on the appropriate treatment and care of people with specific diseases and conditions. Clinical Guidelines are applicable to all clinical staff within EPUT and must be followed.

3.7 Ratification
Ratification is to approve and give formal sanction.

4.0 DUTIES

4.1 The Chief Executive Officer is responsible for:

- Overseeing the document control system in the Trust
- Co-ordinating the development, approval and distribution of all Trust approved documents.
- Ensuring that all Trust approved documents are communicated to all staff via Trust communication processes

4.2 Trust Executive Directors are responsible for:

- Nominating policy/procedure/clinical guidelines authors responsible for the development or review of any Trustwide policies, procedures or clinical guidelines
- Nominating an author responsible for development of any new or reviewed Trust strategies or implementation frameworks
- Nominating an author responsible for development or review of any operational/local policies
- Ensuring that all new/reviewed operational policies and local protocols are distributed to all relevant staff

4.3 Service/Operational Directors are responsible for:

- Signing off all revised local documents and approval records to ensure appropriate consultation has been undertaken / documents and approval reports are in the correct format
- Uploading all new/reviewed local documents onto the Trust Intranet as appropriate
- Maintaining the local policy/local procedure control system ensuring local documents are managed effectively and reviewed in line with policy
- Maintaining an archive system for their local policies and procedures

4.4 Operational Managers are responsible for:

- Ensuring staff are aware and have read and understood all relevant corporate (e.g. HR) policies, operational policies and local procedures for their service

4.5 Policy authors/reviewers are responsible for:

- Ensuring all policies, procedures and clinical guidelines are in line with best practice and legal requirements
- Ensuring robust consultation has been undertaken and is recorded appropriately
- Ensuring they liaise with the policy controller throughout the policy development & approval process
- Ensuring that policies are approved by an appropriate and relevant specialist Committee (or Committies) prior to submission for ratification by the Trust Policy Oversight and Ratification Group.
- Providing revised documents (policy/procedure/clinical guideline and all appendices) with approval report(s) to the policy controller for checking before submission to the Policy Oversight and Ratification Group.

- Providing a Structured Summary and Equality Impact Assessment where required

4.6 Approval committees are responsible for:

- Ensuring that appropriate consultation has been undertaken involving all interested parties
- Providing specialist guidance and feedback to authors where it is considered that further work is required on a policy prior to approval
- Approving policies for issue which fall under their specialist responsibility and ensuring that they are then sent to the Policy Oversight and Ratification Group for final ratification and issue

4.7 Policy Oversight and Ratification Group is responsible for:

- Providing quality assurance and final ratification of trust-wide policies and procedures in line with the Policy for Development, Review and Control of Trust Approved Documents.

4.8 Facilitators of Approval Committees are responsible for:

- Informing the Policy ~~Controller~~ authors of the outcome of approval requests
- Accurately documenting approval outcomes in Committee minutes as an audit trail
- Informing the Policy Controller of any policies approved

4.9 The Policy Controller is responsible for:

- Co-ordination of the Trustwide Policy and Procedure approval and ratification process
- Ensuring that all approved policies are sent to the next available Policy Oversight and Ratification Group meeting for ratification
- Maintaining the policy control system and notifying authors of review dates
- Maintaining the policy database of all current policies
- Maintaining an archive system for all Trust Policies
- Uploading all new/reviewed Trust Ratified Documents onto the Trust Intranet
- Maintaining and implementing the policy control workplan and schedule of policy approval
- Developing and maintaining a flow chart for guidance to staff on policy control and approval process
- The Policy Controller is not responsible for developing or writing policies – such responsibilities lie with the relevant Directorate, as identified by the Executive Director

4.10 This policy should be followed by any member of staff who is required to be involved in the development or review of a Trust approved document.

5.0 POLICY PRINCIPLES

5.1 The Trust has adopted the approach to separate policies and procedures to enable multiple corporate and operational procedures to sit behind one policy, i.e. records management.

5.2 All Trust approved documents must be reviewed at the appropriate interval, as outlined in the accompanying procedural guidelines. Review may be more frequent if necessary.

5.3 A review will include appropriateness and accuracy and take account of all available best practice guidelines.

~~5.4~~ All new and revised Trust approved documents will undergo a formal consultation period as part of the specialist committee recommendation for approval process, prior to submission to the Trust Policy Oversight and Ratification Group for formal ratification.

5.5 All relevant policies will be drafted to enable the development of appropriate audit/monitoring tools to measure compliance against standards and incorporate a systematic review of their effectiveness.

5.6 All policies must follow sequential (numeric) version control. Full review will result in a full number change i.e. 1 to 2; minor amendments will maintain the original number with increments i.e. 1 to 1.1.

5.7 All policies must have a completed initial Equality Impact screening (Equality Impact Assessment), as part of the Trust's commitments under the Public Sector Equality Duty (PSED) and the Equality Act 2010. This should be in a written format as set out in the procedural document. Where necessary full Equality Impact Assessments must be conducted, based upon the findings of the initial screening.

5.8 The Trust will provide policies in accessible formats to staff where required, such as Braille.

5.9 All Trust approved documents will be presented to the appropriate Trust ~~sub~~-specialist committees and the Policy Oversight and Ratification Group for formal approval, ratification and extensions, as outlined in the accompanying procedural guidelines, CPG1. Local and Operational Policies will be presented to the appropriate SMT for approval.

5.10 Where appropriate and in line with the Trust Scheme of Delegation some Policy documents will be presented to the Trust Board of Directors for final ratification.

5.11 All Trust policies and procedures and Trust strategies and implementation frameworks will be added to the Trust intranet and approval communicated to all Trust staff via Trust communication methods.

6.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

6.1 Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Policy Controller in conjunction with the compliance function and Finance and Performance Committee as outlined in the associated procedural guideline. The policy control process may also be subject to internal audit review.

7.0 ASSOCIATED DOCUMENTATION AND REFERENCES

7.1 References

Health and Social Care Act 2012
Equality Act 2010
The Equality Act 2010 (Statutory duties) Regulations 2011
Promoting Equality and Human Rights in the NHS – A Guide for Non-Executive Directors of NHS Boards (2005) Department of Health
NHS Constitution
NHS Audit committee handbook

END

		Agenda Item No: 9i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	**Ligature Risk Management Q1 Report**					
Executive/Non-Executive Lead:	Alex Green, Executive Chief Operating Officer					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Ligature Risk Reduction Group (LRRG) Health, Safety and Security Committee (HSSC) Executive Operational Committee (EOC) Quality Committee (QC)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of Risks highlighted in this report	CRR81 - 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	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The purpose of this report is to: 1. Provide an update and assurance on the key risks associated with ligature from a fixed point within the Trust's in-patient estate and activities that were undertaken within the Trust for Q1. 2. Outline activities planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in-patient estate.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks

Summary of Key Issues

Independent Assurance

- Recommendations from the East London NHS Foundation Trust (ELFT) peer report continue to be taken forward.
- Testing against the Care Quality Commission (CQC) briefing guide for inspection teams continues to be taken forward.

Governance

- A review of the Ligature Risk Reduction Group (LRRG) Terms of Reference was undertaken to ensure the group remains effective, has correct membership and reporting structures. The revised Terms of Reference were agreed by LRRG in April 2022. The reviewed and agreed Terms of Reference along with a review of the agenda has ensured a move in the groups focus towards clinical assessment and management of ligature risks and away from the environmental focus, which is undertaken by the Estates Expert Reference Group.
- All Mental Health and Learning Disability wards have received a Ligature Environmental Risk Assessment in the last 12 months and received a 6-month follow up review which focuses on clinical risk management and staff coaching.
- Action required following a ligature risk assessment is recorded and monitored. Any extreme and high risk overdue actions are discussed in detail monthly and followed up by members of LRRG.
- No changes required to Policy and Procedure in Q1
- There remains an open risk around ligature risk reduction in the corporate risk register (CRR81). The action plan continues to be monitored and has been revised to reflect the changes in focus of the Ligature Risk Reduction Group.

Continuous Learning

- A networking forum with other Trusts has been successfully established. To date the group has met twice and has set out the aims to provide an opportunity for Mental Health Trusts risk management and clinical teams to work collaboratively in the reduction, response and learning from ligature risk incidents.
- A monthly EPUT staff ligature forum has been successfully established with the first meeting held on the 21st June 2022 with over 140 staff members taking part in the forum.
- Throughout Q1, LRRG continues to receive incidents analysis and identifies learning in conjunction with national and local safety alerts.

Enhancing Environments

- The LRRG continues to develop the agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme
- The trust Ligature risk reduction project is continuing with a clear project plan monitored by the Executive Safety Oversight Group.

Culture - Staff Training

- TIDAL ligature risk assessment training: The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff.
- E-learning "Preventing Suicide by Ligature": This is the mandatory online training that all staff have to undertake. Compliance with the training is monitored monthly at LRRG.

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			
BAF	Board Assurance Framework	LRRG	Ligature Risk Reduction Group
CQC	Care Quality Commission	ELFT	East London Foundation Trust
EERG	Estate Expert Reference Group	CRR	Corporate Risk Register
MH	Mental Health	LD	Learning Disability

Supporting Documents and/or Further Reading
Ligature Q1 Report

Lead
Nicola Jones **Director of Risk and Compliance**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Agenda Item: 9i
Board of Directors Part 1
28 September 2022

LIGATURE RISK MANAGEMENT – Quarter 1

1.0 INTRODUCTION

This report provides an update of the work that has been undertaken and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management; carrying out patient safety improvement works to create safer physical environments; and to creating a risk aware culture.

The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Corporate Risk Register (CRR81). A robust action plan is in place to mitigate this potential risk. Reports on the action that has been taken are provided regularly to the Board of Directors.

This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and that progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning.

It also has to be recognised that the Trust's inpatient environments, consistent with many providers of mental health services, will rarely be entirely free of fixed ligature points. This is because most physical environments were not designed to mitigate the potential risks being identified currently, and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 INDEPENDENT ASSURANCE

2.1 East London NHS Foundation Trust (ELFT) Review

As previously reported, EPUT undertook peer reviews with East London Foundation Trust (ELFT). The purpose was to identify improvements that could be made to the EPUT ligature processes through shared learning with ELFT. The draft report was received and checked for factual accuracy, however, the final report was not received.

An action plan was developed to address the findings/recommendations highlighted in the draft report. This action plan covers the following aspects:

1. Governance and working practice
2. Environment
3. Workforce and
4. Training and Learning.

Work on the actions outlined in the plan is currently ongoing and is monitored bimonthly by the Ligature Risk Reduction Group (LRRG).

2.2 Care Quality Committee (CQC) New Inspection Criteria

Work is continue to undertake self-assessments against the revised CQC inspection criteria. The next step is to provide information sheets for Non-Executive Directors to aid their understanding of the CQC criteria and how the Trust meets this.

3.0 GOVERNANCE

3.1 Ligature Risk Reduction Group

A review of the LRRG Terms of Reference was undertaken in April 2022 to ensure the group remains effective with the correct membership and reporting structures. The review of the agenda has also been undertaken to ensure a move in the group's focus towards clinical management of ligature risk rather than environmental focus which is undertaken by the Estates Expert Reference Group.

The Estates Expert Reference Group (EERG), chaired by the Executive Chief Finance Officer, continues to meet monthly to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessments and setting of agreed standards by the Ligature Risk Reduction Group.

The ligature project supported by the Performance Management Office is continuing with updates reported to EERG, LRRG and Executive Safety Group. The chart below outlines the current Governance arrangements for the project group feeding into Trust committees:

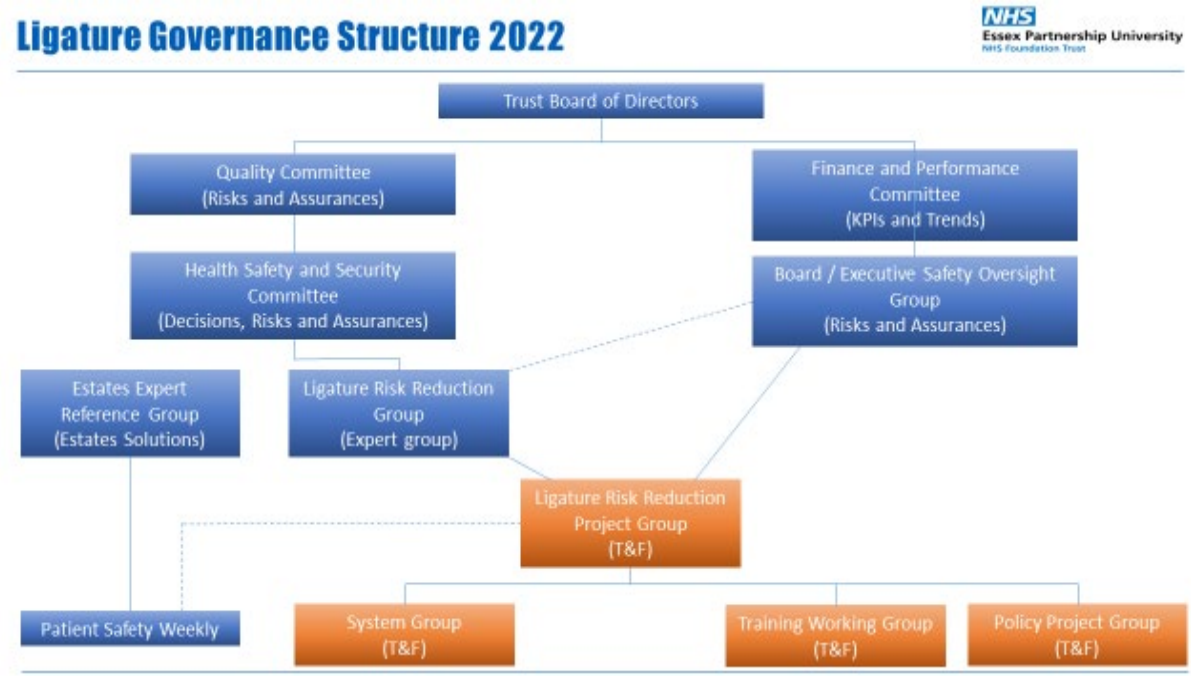

Figure 1: Governance Structure

Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation

3.2 Policy and Procedure

There have been no changes to the Ligature Risk Assessment and Management Policy and Procedure in Q1. Work is underway with the Project Management Team to further review the policy and building a 'policy on a page' template with the aim to make the policy easily accessible to staff.

3.3 Ligature Environmental Risk Assessment

All Mental Health and Learning Disability wards have received a Ligature Environmental Risk Assessment in the last 12 months and received a 6 month follow up review which focuses on clinical risk management and staff coaching.

Compliance checks within the Risk Team continue to ensure all ligature risk assessment tools and reports are completed correctly and in line with policy.

Action required following a ligature risk inspection is recorded and monitored on a database held by the Risk Team through to completion. Each month any extreme and high risk overdue actions are discussed in detail and followed up by members of LRRG.

Work continues within the Risk and Estates teams to understand the increasing trend and disparity of overdue actions.

3.4 Co-production

A protocol remains in place to safely include a person with lived experience (PWLE) as part of the inspection team. As previously reported, there had been limited progress with the initiative to include a PWLE on the ligature inspections due to the pandemic. This is currently being reviewed, along with the current protocol, with the Patient Experience team, to ensure effective involvement going forward.

3.5 Corporate Risk Register, (CRR81)

The Trust continues to have an open risk on the corporate risk register around Ligature risk reduction, CRR81. The action plan continues to be monitored and work is underway to review this plan to reflect the changes in focus and within the terms of reference of the Ligature Risk Reduction Group. Resultantly, the focus of the action plan will not just be on the physical environment, but also on risk awareness and clinical risk management.

4.0 CONTINUOUS LEARNING

4.1 Estates and Facilities/National Patient Safety Alerts (NatPSA)

There have not been any NatPSA or Estates and Facilities Patient Safety Alerts directly relating to ligature risks issued in Q1.

4.2 Learning Forums

The Trust's approach to identifying and mitigating potential risk is constantly subject to reflection and review, informed by independent review (as detailed above), incident data and internal scrutiny. The Compliance Team have set up a local networking ligature forum with leads from neighbouring trusts to enable wider learning and sharing of ligature awareness. To date the group has meet twice and has set out aims to provide an opportunity for Mental Health Trusts risk management and clinical teams to work collaboratively in the reduction, response and learning from ligature risk incidents

LRRG approved an internal monthly EPUT Ligature Forum that is aimed at providing a platform to share learning and deliver coaching, covering any gaps in knowledge identified. These gaps are identified through the annual Ligature Inspections, the 6-Month Ligature Reviews, Datix reporting, feedback from Tidal training and/or Operational staff. The first forum was held on the 21st of June 2022 and had over 140 members of staff attend. The next forum is due on 19th July 2022.

Each session is recorded for staff to access and a review of the forum in increasing awareness of ligature risk management will be undertaken in the autumn and reported to LRRG.

4.3 Ligature Incident Data

A bi-monthly report is presented to LRRG detailing ligature incidents involving a fixed anchor point within EPUT's inpatient wards. This report facilitates discussion with the wider Multi-Disciplinary Team represented within the group to identify learning.

To compliment this, a quarterly incident report is presented to LRRG providing an overview of ligature incidents in which a mental health inpatient has attempted/succeeded self-harm. The report details incidents using both a secured point to fix a ligature and an unsecured ligature. This increases understanding of incidents and any emerging trends in order to increase learning and adopt safer practices.

Lessons were identified for the incidents with a common theme pertaining to the following

- The effective use of clinical engagement with patients
- Risk assessments and
- Staff vigilance.

Learning has been shared at LRRG.

5.0 Enhancing Environments

Setting Environmental Standards
The LRRG has, and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme and these are appended to the Ligature Risk Management Policy and Procedure. The environmental standards have been updated to take into account all known safety alerts and ligature learning. No changes we added in Q1.

Ligature Risk Reduction Project
The trust Ligature risk reduction management project continues with a clear project plan monitored by the Executive Safety Oversight Group.

Over the past 12 months, the primary focus of the Ligature Risk Reduction management project has been addressing environmental concerns, which has seen significant progress. As the project progresses, focus must now also be given to both the Training offer and needs of staff and the Policies in place to support staff. In order to drive this work forward, leads have been identified for each area and Short Life Working Groups have been established.

6.0 CULTURE – STAFF TRAINING

We continue with the aim to develop a culture of risk awareness and continuous learning when incidents happen. An essential part of developing this culture is having robust training programmes for staff. As such all staff working within a mental health/ Learning Disability inpatient setting are required to complete the ligature awareness on-line training package "Preventing Suicide by Ligature" on an annual basis.

Overall trust compliance with training as of the end of June 2022 has slightly decreased to 84% broken down as follows:

- Bedford Mental Health – 85%
- West Essex – 100%
- South East Essex – 88%
- South Essex MH – 85%
- North Essex – 83%

The compliance of staff training is monitored monthly by the LRRG and any potential risk is escalated should the figures be below the Trust's target.

The trust continues to offer staff the bespoke TIDAL ligature risk assessment training. From May 2022, this training was extended to now include those of a Band 4 and above to increase ligature awareness of our staff across the inpatient mental health wards. The training is delivered over 2 full days by TIDAL Training; attendees include clinical staff, members of the risk team and estates staff who undertake ligature risk assessments. To date 86 staff have been trained as follows:

- 61 Clinical staff
- 13 Estates staff
- 12 Corporate/Risk Staff

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

The uptake of this training is also monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training. The next TIDAL training session is booked for July 2022.

The Ligature Risk Reduction Project Management Group is currently working on a proposal to bring the externally commissioned Tidal Training in-house, in anticipation of capturing a larger audience within Trust staff to increase ligature risk management awareness.

7.0 CONCLUSION

The summary of information provided in this report is by its nature only a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

The focus on mitigating ligature risks continues to be strong and progress continues. However, it should be recognised that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning

It is intended that the information provides sufficient assurance that the Trust continues to take action and mitigating the risk of ligature seriously.

8.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the contents of this report
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks

Report Prepared By:

Nicola Jones
Director of Risk and Compliance

On behalf of:
Alex Green,
Executive Chief Operating Officer

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Affairs					
Report Author(s):	Nicola Jones, Director of Risk and Compliance Alison Buckland, Compliance Officer					
Report discussed previously at:	Executive Operational Team Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
The purpose of this report is to: 1. Provide an update on the key CQC related activities being undertaken within the Trust. 2. Provide details of CQC guidance/updates received. 3. Provide an update on progress with actions agreed in response to the CQC inspection report for CAMHS	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to 1. Receive and note the content of the report.

Summary of Key Issues
The report summarises the key activities

- EPUT is registered with the CQC.
- CQC undertook an inspection of our CAMHS Wards in March and April 2022 resulting in an improved rating for the service.
- An improvement plan to address the 'must do' actions resulting from the inspection of CAMHS has been developed and submitted to the CQC. A CAMHS Improvement Planning Group has been set up to oversee the delivery of the plan. As of reporting 44% (11/25) of actions to address the 'must do' recommendations are reported as complete.
- There has been 1 CQC enquiry received in this period from the CQC in relation to specific services following their receipt of a concern. This was reviewed in full and a formal response returned following approval by the Chief Operating Officer /Executive Chief Nurse.
- The CQC has develop a new regulatory model, with the publication of a new Single Assessment Framework, Quality Statements (to replace the current Key Lines of Enquiry) and 6 evidence categories that the CQC will use to organise their findings.
- Progress continues with the annual plan to promote and monitor adherence to the fundamental standards of care (CQC registration requirements).
- Site visits by the Compliance Team continue to support services to sustain high standards and to take action where improvements are required.
- The Pharmacy Team have review the CQC recently published report on the safer management of controlled drugs.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Service	KLOE's	Key Lines of Enquiry
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
BAU	Business As Usual	ESOG	Executive Safety Oversight Group
MHA	Mental Health Act	CICC	Cumberlege Intermediate Care Centre

Supporting Documents and/or Further Reading
Compliance Update Report Appendix 1 CAMHS CQC Action plan Appendix 2 CQC information sheet

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1.0 INTRODUCTION

The purpose of this report is to provide an update on the key Care Quality Commission (CQC) registration requirements and related activities within the Trust. The report provides details of guidance/updates that have been received since the previous report.

2.0 CQC REGISTRATION REQUIREMENTS

2.1 Registration

EPUT is fully registered with the CQC.

3.0 CQC INSPECTIONS

3.1 CAMHS March 2022

As previously reported the CQC undertook an inspection of our CAMHS Wards in March and April 2022, resulting in an improve rating for the service from 'inadequate' to 'requires improvement'. In line with the requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A the Trust has updated the rating posters displayed across our sites.

The inspection report made 6 'must do' recommendations to address observed breaches of regulation and 7 'should do' recommendations to prevent a future breaches.

An improvement planning group has been established, and having reviewed the report recommendations the Group have developed an improvement plan. The approved plan was submitted to the CQC on 25 August 2022 (Appendix 1).

As of 2 September 2022, 11 (44%) individual 'must do' actions are reported as being complete.

Action Type	Must Do Actions				Specific Actions That Address Must Do Actions			
	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale
Must Do	6	0	6	0	25	11	14	0
TOTAL	**6**	**0**	**6**	**0**	**25**	**44%**	**56%**	**0**

The Group will continue to meet monthly to provide oversight and support to the delivery of the plan.

3.2 CQC Enquiries

The CQC raised one enquiry in the month of August 2022 with regards to the North East Urgent Care Services (MH Liaison, Crisis, and Home treatment). The enquiry was associated with high levels of staffing pressures through the sustained COVID-19 pandemic and service pressures which lead to the declaration of OPEL 4 Black Alert in August 2022. The enquiry was reviewed with the Operational

Director and service leads and a response was submitted to the CQC within the deadline set, following executive sign off. The review has identified learning which is being taken forward by the service manager. Learning includes roll out of the restorative resilience model of supervision which specifically aims to support staff following high pressure time periods and a recruitment drive with a focus on Urgent Care Services. In addition an Urgent Care Service Away Day is due to be held to further support staff following the pressure of the COVID-19 pandemic.

Please note safeguarding inquiries are submitted directly to the Trust safeguarding team and are not included in this report. Safeguarding is reported via the Trust MH and Safeguarding Committee.

4.0 ANNUAL PROGRAMME 2022

The Trust annual plan to promote and monitor adherence to the fundamental standards of care (CQC registration requirements) has been developed for 2022/23. The following key activity has taken place in August 2022:

4.1 Themes for Focus

The Compliance Team have continued to use analysis from a range of data sources to identify key themes to be focused on in this period. There were no new themes identified in this period.

4.2 Ward / Service Focus

The internal ward heat map document used to identify key wards/services for focused support demonstrates the following against the 4 scoring categories:

Level	Descriptor	Map
Level 1 (score 0-11)	Review for good practice	24 wards scoring at level 1
Level 2 (score 12-15)	Ward Review via Accountability Meetings	22 wards scoring at level 2
Level 3 (score 16-19)	Compliance Team to visit and consider deep dive	4 wards scoring at level 3 which will be visited by the Compliance Team.
Level 4 (score 20+)	Compliance Team to visit and consider Rapid Response	0 (zero) wards scoring at level 4

The Compliance Team have a visit schedule to review all identified areas; with wards receiving an onsite visit and community areas having a mix of site visits and virtual (desktop) review.

The visits are focused on what the data is telling us alongside the current CQC key lines of enquiry (KLOE's) and an action plan is agreed with the area to address any gaps found.

For wards identified as potentially benefiting from additional support an intensive support group or deep dive is established to identify key improvement areas. There are currently 3 services receiving additional support.

A review of the metrics in the heat map is underway with a plan to incorporate more qualitative information from Tendable and greater analysis of incident data. Further to this a full review to align the heat map with the new CQC Quality Assurance Statements.

5.0 TRUST COMPLIANCE PROGRAMME

5.1 New CQC Approach to Regulation

The CQC has been working with key stakeholders to develop their new regulatory model, with the publication of a new Single Assessment Framework, Quality Statements (to replace the Key Lines of Enquiry) and the introduction of 6 evidence categories that the CQC will use to organise their findings.

This represents a significant change to how the CQC will regulate and as such the Trust is considering current compliance function with a view to aligning with the new approach.

This piece of work will include:

- Phase 1: a detailed review of the changes to ensure robust understanding by the Compliance Team as the trust CQC subject matter experts.

- Phase 2: undertake a gap analysis of each Quality Statement, this work will be completed with key Trust subject matter experts and allocation of senior responsible officer status for each Quality Statement.

- Phase 3: an assurance framework developed to provide oversight of compliance and associated risk / escalation procedure.

- Phase 4: a service handbook developed for each service type to support self-assessment and link with the existing Quality Star.

- Communication: A communication plan has been developed to raise awareness of the new standards and programme of work.

Further information on the CQC new regulatory model is provided in Appendix 2 for information.

5.2 Ongoing programme of ward/service visits to test compliance with the fundamental standards of care

In August 2022 the Compliance Team undertook 7 visits and supported services to highlight good practice found and set plans to address areas for improvement.

Information from the visits is analysed to identify any key themes emerging and this feeds into the preparation plan and inform areas for focus and shared learning.

Some examples of good practice seen were:

<u>Safe</u>

- All staff wear pin point alarms, lighting is good and high wall mirrors highlight corners/blind spots and CCTV is also in use.
- SBARD tool in use

<u>Effective</u>

- Evidence of Multiagency meetings
- Evidence seen of team meetings being held in July 2022. Evidence of lessons learnt within minutes of team meetings

<u>Caring</u>

- Staff were all engaged with patients during our visits undertaking offering drinks, lunches and completing physical observations with patients.

Responsive

- A range of information leaflets were available for patients and Carers
- An open day is booked for September 2022 for carers and families to attend.

Well Led

- A daily health check of the unit staff was undertaken by the Matron
- Matron undertakes daily welfare checks for the ward staff

The Compliance Team continue to carry out action plan testing. Where insufficient evidence of the embedding of actions is found support is provided to take corrective action.

6.0 CQC GUIDANCE / UPDATES

6.1 The Safer Management of Controlled Drugs

The safer management of controlled drugs - Care Quality Commission (cqc.org.uk)

The annual report from the CQC on the safer use of controlled drugs highlights their regulatory oversight activities and inspection findings in 2021 and has been reviewed by the Pharmacy team to identify any learning for the Trust.

7.0 ACTION REQUIRED

The Board of Directors is asked to:

1. Receive and note the content of the report.

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of:

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

		Agenda Item No: 10b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	Annual review of: • Standing Orders for the Board of Directors • Scheme of Reservation and Delegation (SoRD) • Detailed Scheme of Delegation • Standing Financial Instructions					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Chris Jennings, Assistant Trust Secretary Clare Barley, Head of Financial Accounts					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	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.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the revised documents for approval following review and recommendation to the Board of Directors by the Audit Committee: • Standing Orders • Scheme of Reservation and Delegation (SoRD) • Scheme of Delegation • Standing Financial Instructions	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked:

- Received and note the four documents following review by the Audit Committee
- Approval of the four documents

Summary of Key Issues

These documents provide the Trust with a business and financial framework within which all officers are expected to work, with the Detailed Scheme of Delegation confirming who within the Trust has delegated responsibility for specific items, including financial limits where relevant.

The changes to the documents are described below for ease of reference:

Standing Orders (Appendix 1): Minor amendment to move to a gender neutral pronoun and removal of references to Monitor which has been dissolved by the enactment of the Health and Care Bill 2022.

Scheme of Reservation and Delegation (SoRD) (Appendix 2): No amendments made and provided to the Board of Directors for completeness of the suite of documents.

Detailed Scheme of Delegation (Appendix 3):

Section	Change
2.1	Further clarity provided around delegated limits also applying to stand-alone approval systems including NHS Supply Chain and Office Depot. This was highlighted in a recent internal audit report. Reiterated that requisitions / invoices must not be raised in such a way to bypass financial limits.
3.2a to d	New section included to reflect requirements arising from IFRS16 and delegate approval of leases with 'Right of Use Assets' with whole lease term revenue or capital impact of up to £100k to CPPG, up to £999k to CE or ECFO and over £1m to FPC. Similarly, all terminations of leases containing a Right of Use Asset to be approved by the CPPG. Those leases where a Right of Use Asset does not exist is delegated as per existing limits detailed in section 2.1.
3.2e to g 3.2h	Section 8 has also been incorporated within section 3.2 (re 3.2e to 3.2g). This section now also includes confirmation that all variations to PFI contracts are to be approved by CPPG if up to £100k, CE or ECFO if up to £999k and Board if over £1m. PFI is also now included as a standard agenda item at CPPG.
4	Reiterated that requisitions / invoices must not be raised in such a way to bypass financial limits.
6.1	Amended to note that approval for breaching of agency cap and thresholds is delegated to Executive Director or the On-Call Director.
6.2	New section included for engagement of consultancy services. NHSE requirements relate to NHSFT's who are in receipt of interim support or in breach of license due to financial issues and all NHS Trusts and ICB's. Other NHSFT's are encouraged to comply but guidance is not mandatory, with restrictions relating to revenue expenditure only. The Trust will adhere to this best practice guidance. Proposal included for all consultancy spend (including irrecoverable VAT and costs / expenses) up to £50k to be delegated for approval to Director / Executive Director and over £50k to NHSE via EOC on submission of Consultancy template.
17 17f	Updated for delegated authority of number of HR processes including approval of leave, renewal of fixed term contracts, ill-health retirement and special leave, and removal of reference to Deputy Director of HR post. Carry forward of leave with Line / Departmental Manager is set at 7 days rather than 10 days in line with associated HR guidance. Approval for carry forward in excess of this (with no absence due to maternity or sickness in year) now requires approval of Director of HR for up to 10 days and the Executive Director of People and Culture and the Executive Chief Finance Officer for over 10 days.

Standing Financial Instructions (Appendix 4):

Section	Change
All	References to NHS Improvement and Monitor, aligned to NHS England.
1.1.2	Amended to confirm that finance policies and procedure need to go to Executive Team prior to formal approval by the Audit Committee.
1.2b	Confirmation that Board can consist of both voting and non-voting members.
1.2m and 1.2z	Updated to include new post of Senior Director.
2.2.1c, 2.5.2, 2.5.5 and13.2.2	Reference to Local Security Management Service (LSMS) replaced with Violence and Abuse Prevention and Reduction Advisor (VAPR).
3.1.3	Confirmation that approval of budgets for the financial year is by Board following presentation to Finance and Performance Committee.
11.1.4	Confirmation that approval of a detailed capital programme at the start of the financial year is approval for schemes to commence in line with required governance. Any new bids in year, or requests to vire money between schemes needs to be approved in line with the detailed scheme of delegation.
11.4.2	Updated to include lease asset register for Right of Use Assets arising from implementation of IFRS16 in April 2022.
20.4 and 20.6	Section updated to delegate authority to the Finance and Performance Committee in respect of new business / income opportunities following the demise of the People, Innovation and Transformation Committee.

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			
SOs	Standing Orders	SoRD	Scheme of Reservation and Delegation

Supporting Reports/ Appendices /or further reading

- Appendix 1 - Standing Orders for the Board of Directors
- Appendix 2 - Scheme of Reservation and Delegation (SoRD)
- Appendix 3 - Detailed Scheme of Delegation
- Appendix 4 - Standing Financial Instructions

Lead

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

Trevor Smith
Executive Chief Finance Officer

Essex Partnership University
NHS Foundation Trust

STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE BOARD OF DIRECTORS

POLICY REFERENCE NUMBER:	TB01
VERSION NUMBER:	5
KEY CHANGES FROM PREVIOUS VERSION	Removal of references to "Monitor". Amendment of statements using the "he" pronoun.
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Board of Directors Audit Committee Executive Team Council of Governors
IMPLEMENTATION DATE:	01 April 2017
AMENDMENT DATE(S):	08 November 2017 (Chair's action) August/September 2018 September 2019, September 2020, September 2021, September 2022
LAST REVIEW DATE:	September 2022
NEXT REVIEW DATE:	September 2023
APPROVAL BY BOARD OF DIRECTORS	September 2022
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POLICY SUMMARY

The purpose of the Standing Orders for the Board of Directors is to set out the practice and procedures of the Board in order to maintain good standards of governance.

The Trust monitors the implementation of and compliance with this policy in the following ways:

Monitoring of implementation and compliance with the Standing Orders for the Board of Directors will be undertaken by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	

The Chief Executive is responsible for monitoring and reviewing this policy

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INTRODUCTION

Regulatory Framework

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1 April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act) by Monitor - Independent Regulator of NHS Foundation Trusts.

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no 120163) and all relevant legislation and guidance.

These Standing Orders add clarity and detail where appropriate. Nothing in these Standing Orders shall override the Trust's constitution, the National Health Service Act 2006 and the Health & Social Care Act 2012.

The Trust's Standing Orders and wider governance arrangements are further supported by various policies and procedures and for financial matters, by the Standing Financial Instructions (SFIs), Detailed Scheme of Delegation (DSoD), and associated finance procedures. Certain powers are reserved to be exercised by the Board only, others are delegated to individual Executive Directors and/or committees of the Board. These are covered by the Scheme of Reservation & Delegation of Powers of the Board. (SoRD).

The principal place of business of the Trust is at The Lodge, Lodge Approach, , Wickford SS11 7XX.

As a public benefit corporation the Trust has the power to act as a corporate Trustee of charitable funds. Under section 11 of the Trustee Act 2000 the Trust can appoint a Charitable Funds Committee and delegate its functions to it. This power includes appointing a committee whose members are not members of the Board of Directors. The Trust has appointed a Charitable Funds Committee which operates in accordance with these Standing Orders and its terms of reference (as approved by the Board of Directors) and the relevant guidance from the Charity Commission.

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair of the Trust shall be the final authority on the interpretation of these Standing Orders (on which they should be advised by the Chief Executive and the Trust Secretary)

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 and regulations made under it shall have the same meaning in these Standing Orders and in addition:

1.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012)

1.2.2 **2012 Act** means the Health & Social Care Act 2012

1.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

1.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**

1.2.5 **Budget** means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust

1.2.6 **Chair of the Board** or **Chair of the Trust** or **Chair** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable

1.2.7 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution

1.2.8 **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources

1.2.9 **Committee** means a committee appointed by the Board of Directors

1.2.10 **Committee members** means persons formally appointed by the Board of Directors to sit on or to chair specific committees

1.2.11 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act

1.2.12 **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

1.2.13 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution

1.2.14 **Deputy Chief Executive** means the officer of the Trust appointed under paragraph 30 of the constitution

1.2.15 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.2.16 **Executive Chief Finance Officer** means the Chief Finance Officer of the Trust

1.2.17 **Executive Director** means a member of the Board of Directors appointed under paragraph 31 of the constitution

1.2.18 **Licence** means the Trust's provider licence (no 120163) issued by NHS England on 1 April 2017 (and reissued on 11 October 2017)

1.2.19 **Member** means a person registered as a member of one of the constituencies as set out in paragraph 5 of the constitution

1.2.20 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting

1.2.21 **Nominated Officer** means an officer charged with the responsibility for discharging specific task under the Scheme of Reservation & Delegation

1.2.22 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution

1.2.23 **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust

1.2.24 **SFIs** means the Standing Financial Instructions of the Trust

1.2.25 **Scheme of Reservation & Delegation** is the Trust's scheme of reservation and delegation of powers approved by the Board of Directors

1.2.26 **SOs** means these Standing Orders (for the Board of Directors)

1.2.27 **Trust** means Essex Partnership University NHS Foundation Trust

1.2.28 **Trust headquarters** means The Lodge, Lodge Approach, , Wickford SS11 7XX

1.2.29 **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.2.30 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution

1.2.31 **Working days** means a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday

1.3 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

2. THE BOARD OF DIRECTORS

2.1 The general duty of the Board and of each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate Trustee

2.3 The powers of the Trust shall be exercisable by the Board. The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the SoRD and have effect as if incorporated into these SOs

2.5 **Patients Forum Representatives**
The Trust will continue to be subject to the general duty to involve patients, and to seek assurance that the appropriate process has been adhered to in line with national guidance

2.6 **Composition of the Board**
In accordance with paragraph 25 of the constitution, the composition of the Board of the Trust shall be:

- A Non-Executive Chair
- Not less than five and not more than eight other Non-Executive Directors
- Not less than four and not more than eight Executive Directors

so that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive in a voting capacity.

2.7 **Appointment and Removal of the Chair and other Non-Executive Directors**
In accordance with paragraph 28 of the constitution and guidance issued by Monitor, the Chair and the other Non-Executive Directors are appointed (and removed) by the Council at a general meeting of the Council

2.8 **Terms of Office of the Chair and other Non-Executive Directors**

2.8.1 The Chair and Non-Executive Directors shall be appointed with terms and conditions of office as decided by the Council at a general meeting taking account of Monitor's governance guidance

2.8.2 The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years

2.8.3 The Chair and Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory

performance) and subject to the provisions of the 2006 Act in respect of removal of a Director

2.8.4 The Chair and Non-Executive Directors may in exceptional circumstances serve longer than six years subject to annual re-appointment and subject to external competition if recommended by the Board and approved by the Council. In establishing that the Non-Executive Director continues to be independent, the Chair will take into account guidance and conduct an evidence-based evaluation

2.8.5 Any reappointment after the second term of office for the Chair and Non-Executive Directors shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence

2.9 **Appointment and Powers of Vice-Chair**

2.9.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place

2.9.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision

2.9.3 In the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust

2.9.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 2.9

2.9.5 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair and be entitled to exercise all the rights and powers conferred upon the Chair by the constitution including but without limit those set out in these SOs and in the SOs of the Council until a new Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair

2.10 **Appointment and Removal of the Chief Executive**

2.10.1 In accordance with the constitution paragraph 31.1, the Non-Executive Directors of the Trust will appoint (and remove) the Chief Executive

2.10.2 The appointment of the Chief Executive requires the approval of the majority of the Council at a meeting of the Council in accordance with paragraph 31.2 of the constitution

2.11 **Appointment and Removal of Executive Directors**
In accordance with the constitution paragraph 31.3, all Executive Directors (excluding the Chief Executive) are to be appointed (and removed) by a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors.

2.12 **Appointment of the Deputy Chief Executive**
In accordance with paragraph 30.4 of the constitution, the Board of Directors Nominations Committee, which shall comprise all of the Non-Executive Directors, may nominate one of the Executive Directors to be the Deputy Chief Executive.

2.13 **Joint Executive Directors**

2.13.1 Where more than one person is appointed jointly to an Executive Director post, those persons shall count for the purpose of SO 2.6 (composition of the Board) as one person (save that the Executive positions of registered Medical Practitioner or registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions) in accordance with paragraph of 31.4 of the constitution

2.13.2 Where such an arrangement is in force, both individuals shall be able to attend a meeting of the Board provided that at any meeting of the Board they may only count as one individual for the purposes of the quorum and may only exercise one vote between them

2.13.3 Where the two individuals disagree as to how to vote at a Board meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both

2.13.4 The presence of either or both persons shall count as the presence of one person for the purposes of SO 30.17 (Quorum)

2.14 **Appointment and Removal of the Senior Independent Director**

2.14.1 The Board shall (following consultation with the Council) appoint one of the Non-Executive Directors as the Senior Independent Director in accordance with paragraph 30.3 of the constitution, for such period not exceeding the remainder of the individual's term of office as a Non-Executive Director

2.14.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board (following consultation with the

Council) may thereupon appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of this Standing Order.

2.15 **Trust Secretary**

The Chair and Chief Executive shall appoint a Trust Secretary to act independently of the Board, to provide advice on corporate governance issues to the Chair and the Board, and to monitor the Trust's compliance with the regulatory framework, the constitution and the SOs.

2.16 **Role of the Chief Executive**

2.16.1 The Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business

2.16.2 The Chief Executive reports to the Chair and the Board

2.16.3 The Chief Executive is the Accounting Officer and shall be responsible for ensuring the discharge of obligations under all relevant financial directions and guidance issued by NHS FT regulators or any other relevant body

2.17 **Role of the Executive Chief Finance Officer**

2.17.1 The Executive Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems

2.17.2 The individual shall be responsible, along with the Chief Executive, for ensuring the discharge of obligations under all relevant financial requirements, conditions or notices issued by NHS FT regulators or any other relevant body.

2.18 **Role of Executive Directors**

Executive Directors shall exercise their authority within the terms of these SOs, SFIs and the SoRD

2.19 **Role of the Chair**

2.19.1 The Chair shall be responsible for the leadership of the Board (and Council), and chair all Board (and Council) meetings when present

2.19.2 The Chair must ensure effectiveness in all aspects of the Board's role and lead on setting the agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues

2.19.3 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board (and Council) in a timely manner with all the necessary information and advice being made available to the Board (and Council) to inform the debate and ultimate decisions.

2.19.4 The Chair is responsible for ensuring that the Board and the Council work effectively together

2.20 **Role of Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

3. MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press**

3.1.1 The meetings of the Board shall be open to members of the public and the press in accordance with paragraph 34.1 of the constitution

3.1.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Board will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 18E of Schedule 7 of the 2006 Act, the Board of Directors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed"

3.1.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as detailed in SO 3.1.2 above

3.1.4 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board and such agreement not to be unreasonably withheld

3.1.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Board and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting

3.2 **Calling Meetings**

3.2.1 Ordinary meetings of the Board shall be held at such times and places as the Board may determine

3.2.2 Meetings of the Board are convened by the Trust Secretary, by order of the Chair. Not less than one-third of the Directors can requisition

the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary

3.2.3 The Trust shall hold meetings of the Board at least six times in each calendar year

3.3 **Notice of Ordinary Meetings**

3.3.1 The Trust Secretary shall give to all Directors at least ten (10) working days written notice of the date and place of every ordinary meeting of the Board

3.3.2 Agendas will be sent to Directors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent or extraordinary business under SO 3.4 or SO 3.5.

3.3.3 A notice or other document(s) to be served upon a Director under these SOs shall be manually delivered or sent by post to the Director at their usual place of residence which he shall have last notified to the Trust, or where sent by email, to the address which they shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means

3.3.4 A notice or other document(s) where manually delivered or sent by post shall be presumed to have been served on the next working day following the day of delivery and where sent by email at the time at which the email is sent

3.3.5 Failure to serve notice and supporting papers on any Director shall not affect the validity of an ordinary meeting

3.3.6 Save in the case of urgent meetings, for each meeting of the Board a public notice of the date, time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's head office and on the Trust's internet site for general access at least three working days before the meeting

3.3.7 Before holding a meeting, the Board must send a copy of the agenda of the meeting to the Council

3.4 **Notice of Extraordinary Meetings**

3.4.1 At the request of the Chair or by at least one-third of the whole number of members of the Board, the Trust Secretary shall send a written notice to all Directors within 10 (ten) working days of receipt of such a request specifying the date and place to discuss the specified business

3.4.2 If the Trust Secretary does not send notice a meeting of the Board within ten (10) working days of receiving a request from the Chair or a requisition from not less than one-third of the Directors pursuant to SO 3.4.1, the Directors who made the requisition may convene the

meeting themselves by giving written notice to all Directors; this notice must be signed by all of the Directors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

3.5 **Notice of Urgent Meetings**

3.5.1 At the request of the Chair or not less than one-third of Directors, the Trust Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Trust Secretary shall give Board members as much notice as is possible in light of the urgency of the request

3.5.2 If the Trust Secretary fails to call such a meeting, then the Chair or at least one-third of the whole number of Board members shall call such a meeting

3.5.3 In the case of a meeting called under SOs 3.4 and 3.5, the notice shall be signed by the Chair or at least one-third of the whole number of Board members

3.5.4 No business shall be transacted at the meeting called under SOs 3.4 and 3.5 other than that specified in the notice. Agendas will be sent to Board members three working days before the meeting and supporting papers shall accompany the agenda, save in the case of urgent meetings

3.5.5 In the case of a meeting called under SOs 3.4 and 3.5 failure to serve such a notice on more than three Directors will invalidate the meeting

3.6 **Setting the Agenda**

3.6.1 The Board may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted

3.6.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 (ten) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven (7) working days before a meeting may be included on the agenda at the discretion of the Chair

3.6.3 Before holding a meeting, the Trust Secretary must send a copy of the agenda of the Board meeting to the members of the Council and may be sent in any manner permitted under SO 3.3.5 and 3.3.6

3.7 **Petitions**

Where a petition has been received by the Trust not less than ten (10) working days before a meeting of the Board, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting

0=3.8 **Chair of Meeting**

3.8.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent (and provided the Chair has waived the requirement for the Chair or Vice-Chair to be present under SO 3.17), the Non-Executive Directors present shall nominate a Chair for the meeting from their number and who has no conflict of interest

3.8.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Non-Executive Directors present shall nominate, shall preside

3.9 **Motions**

3.9.1 **Notices of Motion:** A Director desiring to move or amend a motion shall send a written notice thereof at least ten (10) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda

3.9.2 **Withdrawal of motion or amendment:** A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair

3.9.3 **Motion to Rescind a Resolution:** Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Board member who gives it and also the signature of four other Board members, to include at least one non-executive director and one executive director. Such notice shall be sent at least ten (10) working days before the meeting to the Chair, who shall insert in the agenda for the meeting. When any such motion has been disposed of by the Board, it shall not be possible for any Board member other than the Chair to propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate

3.9.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto

3.9.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Director to move:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*

(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate

3.9.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion

3.10 **Chair's Ruling**

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final

3.11 **Voting**

3.11.1 Subject to the following provisions of this clause, questions arising at a meeting of the Board shall be decided by a majority of votes. Each Director shall have one vote:

(a) in the event of joint Executive Directors, SO 2.13 shall apply. In case of an equality of votes the Chair shall have a second casting vote
(b) no resolution of the Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present

3.11.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands

3.11.3 A paper ballot may also be used if a majority of the Directors present so request in which case any person attending by telephone, teleconference, video or computer link shall cast their vote verbally (such verbal vote to be recorded in the minutes)

3.11.4 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained

3.11.5 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot)

3.11.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote

3.11.7 Directors may participate (and vote) in Board meetings by telephone, teleconference, video or computer link with the prior agreement of

the Chair; participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting

3.11.8 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director and has a responsibility to consult with the Executive Director if available. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director, but has a responsibility to consult with the Executive Director if possible and to ensure their views are included within the debate, prior to the vote taking place. An officer's status when attending a meeting shall be recorded in the minutes

3.12 **Minutes**

3.12.1 The minutes of the proceedings of a meeting shall be drawn up by the Trust Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it

3.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting

3.12.3 Minutes shall be retained in the Trust Secretary's office

3.12.4 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by any applicable guidance

3.12.5 As soon as practicable after holding a Board meeting, the Trust Secretary must send a copy of the approved minutes of the meeting to the members of the Council of Governors

3.12.6 Where Directors have concerns that cannot be resolved about the running of the Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes. On resignation, a Director should provide a written statement to the Chair for circulation to the Board, if they have any such concerns

3.13 **Informal Meetings and Meetings as a Committee**

3.13.1 The Chair should hold meetings with the Non-Executive Directors without the Executives Directors present

3.13.2 Led by the Senior Independent Director, the Non-Executive Directors should meet without the Chair present, at least annually, to appraise the Chair's performance, and on other such occasions as are deemed appropriate

3.13.3 Notwithstanding anything in these SOs, the Directors may meet informally or as a committee of the Board at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation

3.14 **Amendment of Standing Orders**

3.14.1 These SOs may be amended without the need to amend the constitution. These SOs may be amended only if:

(a) a notice of motion under SO 3.9.1 (Notices of Motion) has been given
(b) not fewer than half of the total number of Non-Executive Directors vote in favour of the amendment
(c) at least two-thirds of Directors are present
(d) the amendment proposed does not contravene a statutory provision or direction made by Monitor

3.14.2 For the avoidance of doubt, SO 3.17 (Quorum) shall not apply to the variation of the SOs and the higher quorum required in SO 3.15 (Variation and Amendment of Standing Orders) shall be reached

3.15 **Record of Attendance**

3.15.1 The names of the Chair, Directors and all others present at the meeting (other than members of the public and media) who are present at a meeting of the Board shall be recorded in the minutes

3.15.2 A meeting of the Board refers to officers being physically present and officers being present via the use of technology, as defined in SO 3.17.5 and 3.18

3.16 **Quorum**

3.16.1 Seven (7) Directors including not less than two (2) Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive) and not less than two (2) Non-Executive Directors (one of whom must be the Chair or the Vice-Chair) shall form a quorum provided that a meeting shall be quorate if:

(a) the Chief Executive has waived the requirement for the Chief Executive or the Deputy Chief Executive to be present; and
(b) the Chair has waived the requirement for the Chair or the Vice-Chair to be present

3.16.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum

3.16.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that

matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business

3.16.4 The above requirement for at least two (2) Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee)

3.16.5 Board Directors may participate (and vote) in its meetings by telephone, teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

3.17 **Meetings: Electronic Communication**

3.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof

3.17.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board or of a standing committee or sub-committee of the Board shall be regarded for all purposes as being present and personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication

3.17.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair is physically present

3.17.4 Meetings held in accordance with this SO are subject to SO 3.16 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting

3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 The NHS Act 2006 provides for all the powers of the Trust to be exercised by the Board on its behalf. It also states that the Board may delegate any of its powers to a committee of Directors or to an Executive Director

4.2 Subject to such requirements, conditions, notices or guidance as may be given by NHS England, the Board may make arrangements in these SOs for the exercise, on behalf of the Board, of any of its functions by either a committee or an Executive Director

4.3 In each case subject to such restrictions and conditions as the Trust thinks fit

4.4 Where a function is delegated (as detailed in the Trust's SoRD, i.e. delegation to committees or officers) the Trust retains full responsibility

4.5 **Emergency Powers**

The powers which the Board has retained to itself within these SOs may in emergency situations be exercised by the Chief Executive or in their absence, the Deputy Chief Executive, provided that prior to taking such action, the Chief Executive has consulted with and gained the agreement of the Chair or in their absence, the Vice-Chair. Where time permits the Chair should contact all Board members in writing to allow the opportunity for objection. The exercise of such powers by the Chief Executive shall be reported to the next formal meeting of the Board held in public for ratification

4.6 **Delegation to Committees and Officers**

4.6.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with statute and such requirements, conditions, notices or guidance as may be given by Monitor. The constitution and terms of reference of these committees and their specific executive powers shall be approved by the Board

4.6.2 The Board may delegate certain functions of the Trust to an Executive Director

4.6.3 The Chief Executive shall prepare a detailed SoRD identifying the functions to be delegated to either an Executive Director or a committee of the Board. The proposals shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the detailed SoRD that shall be considered and approved by the Board as indicated above

4.6.4 The Board may delegate executive powers to an Executive Director to make decisions on behalf of the Board of Directors as part of a Collaborative Board. However, this must be in line with limitations set by the DSoD and SoRD.

4.6.5 Nothing in the SoRD shall restrict or limit the responsibility of the Executive Chief Finance Officer to provide information and advice to the Board in accordance with any statutory requirements, but subject to his discharge of these statutory requirements, the Executive Chief Finance Officer shall be accountable to the Chief Executive for the performance of his role

4.6.6 The arrangements made by the Board as set out in the SoRD shall have effect as if incorporated in these SOs

4.7 **Non-compliance with the Standing Orders**

Full details of any non-compliance with these SOs together with the circumstances around the non-compliance shall be reported by the relevant Executive Director immediately to the Chair and the Chief Executive and to the next formal meeting of the Board for action and ratification. All staff have a duty to disclose any potential or impending non-compliance to their Executive Director, who in turn has a duty to report to the Chief Executive and the Chair as soon as possible.

5. COMMITTEES

5.1 The National Health Service Act 2006 states that:

5.1.1 The Board shall appoint an Audit Committee of Non-Executive Directors to perform such monitoring, reviewing and other functions as appropriate in accordance with this SO and the constitution paragraph 43

5.1.2 The Board shall appoint a Remuneration Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors in accordance with SO 2.10 and 2.11 and the constitution paragraph 37

5.2 Subject to the NHS Act 2006 and the regulatory framework and any such guidance as may be issued by Monitor, the Board may appoint standing committees of the Board (ref SO 4.6 Delegation to Committees and Officers)

5.3 The SOs of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits

5.4 There is no requirement to hold meetings of committees in public

5.5 Each such standing committee (including their sub-committees and working groups) shall have terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by Monitor. Such terms of reference shall have effect as if incorporated into the SOs.

5.6 Committees are authorised to establish sub-committees which shall operate as working groups and shall have no delegated executive powers from the Board or a committee of the Board

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted

5.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by Monitor and/or the law, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the regulations and directions made by Monitor and/or the law

5.9 The committees established by the Board are attached at Appendix A of the SOs

5.10 The Board may change the committees, without requirement to amend these SOs

5.11 A Board member or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board shall resolve that it is confidential

5.12 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 All Board members have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with interests of the Trust. Any Director who has an interest in a matter that he/she is required to declare in accordance with paragraph 36 of the Trust's constitution shall declare such interest to the Board and:

(a) shall withdraw from the meeting and play no part in the relevant discussion or decision; and
(b) shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

6.1.2 Details of any such interest shall be recorded in the Register of Interests of Board members. At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes. Any changes in interests should be declared in accordance with the requirements of paragraph of the Trust's constitution

6.1.3 Any Board member who fails to disclose any interest required to be disclosed under the preceding clause must permanently vacate their office if required to do so by a majority of the remaining Board members and (in the case of a Non-Executive Director) by the requisite majority of the Council

6.1.4 Board members' directorships of companies which may conflict with their management responsibilities should be published in the Trust's annual report. As the Trust maintains a Register of Interests which is open to the public, the disclosure in the annual report may at the discretion of the Board, be limited to a comment on how access to the information in that Register may be obtained

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision

6.1.6 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Trust Secretary

6.2 **Register of Interests**

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members. In particular the Register will include details of all Directorships and other interests which have been declared by both Executive and Non-Executive Board members in accordance with paragraphs 36 and 40 of the Trust's constitution

6.2.2 The Trust Secretary will keep these details up to date by means of an annual review of the Register in which any changes to the interests declared during the preceding 12 (twelve) months will be incorporated. It is the responsibility of each member of the Board to provide an update to the Trust Secretary of their register entry if their interest changes

6.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it

6.3 **Register of Gifts and Hospitality**

6.3.1 A Register of Gifts and Hospitality will be maintained by the Trust Secretary for Board members and staff

6.3.2 The Register will be published on the Trust's website in line with regulatory requirements.

7. CONFLICT OF INTEREST AND PECUNIARY INTEREST

7.1 **Disclosure of Interest**
Subject to the following provisions of this SO, if a Board member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall disclose that interest to the Board and/or meeting as soon as he becomes aware of it

7.2 **Conflict of Interest**
During the course of a Board meeting (or other meeting) if a conflict of interest is disclosed, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision

7.3 The Board may exclude the Director from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration

7.4 Any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director shall not be treated as a pecuniary interest by the Trust for the purpose of this SO

7.5 For the purpose of this SO, a Board member shall be treated, subject to SO 7.7, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.5.1 they, or a nominee of theirs, are a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.5.2 they are a partner of, or are in the employment of a person with whom the contract was made or are proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and, in the case of sibling, parent, child, cohabiting spouse or civil partner or person living together with them as partner, the interest of one shall, if known to the other, be deemed for the purposes of this SO to also be an interest of the other.

7.6 A Board member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.6.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body

7.6.2 of an interest in any company, body or person with which they are connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter

7.7 In the event that the Board member having an indirect pecuniary interest in a contract (including a proposed contract or other matter) by virtue of holding securities of the company concerned, then for the Board member to be able to participate in the consideration or discussion of the contract (or other matter), and vote on any question with respect to it, the following requirements need to be met:

7.7.1 If one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total nominal value of issued share capital of the company concerned; or

7.7.2 If more than one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total issued share capital of that class

However, it remains the responsibility of the individual to disclose their interest

7.8 This SO applies to a committee or sub-committee or a joint committee of the Board as it applies to the Board and applies to any such committee or sub-committee as it applies to a Director.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 All Board members must comply with the Trust's standards of business conduct policy as amended from time to time.

8.2 All Board members should comply with this SO 8, Appendix B national guidance contained in HSG 1993/5 *Standards of Business Conduct for NHS Staff*, the S*tandards for members of NHS boards and Clinical Commissioning Group governing bodies in England (November 2013)* included in Appendix C, the Trust's Counter Fraud Policy and Procedure and any such guidance issued by Monitor or the Department of Health and Social Care from time to time

8.3 **Interest of Officers in Contracts**

8.3.1 If it comes to the knowledge of an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein

8.3.2 An Officer should also declare to the Chief Executive in accordance with Trust procedure, any other employment, business or other relationship of theirs, or of a spouse/partner/other family member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust

8.3.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff, in accordance with Trust procedure

8.4 **Canvassing of, and Recommendations by, Board Members in Relation to Appointments**

8.4.1 Canvassing of Board members of the Trust or of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the contractor for such appointment. The contents of this provision of the SO shall be included in application forms or otherwise brought to the attention of contractors

8.4.2 A Board member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this clause of this SO shall not preclude a Board member from giving written testimonial of a contractor's ability, experience or character for submission to the Trust

8.4.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.5 **Relatives of Board Members or Officers**

8.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Board member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal

8.5.2 Every Board member and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Board member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made

8.5.3 On appointment, Board members (and prior to acceptance of an appointment in the case of officer Board members) should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust

8.5.4 Where the relationship to a Board member of the Trust is disclosed, SO 7 applies.

9. TENDERING AND CONTRACT PROCEDURE

9.1 **Duty to comply with Standing Orders and Standing Financial Instructions**

The procedures to be followed by the Trust in relation to all contract opportunities with the Trust and for awarding all contracts with the Trust shall comply with the SOs, SFIs, the financial limits specified in the detailed SoRD, and the Trust's Tendering & Quotation Policy and Procedure.

9.2 **Legislation Governing Public Procurement**

9.2.1 The Trust shall comply with the Public Contracts Regulations 2015 (the "Regulations") as applicable and any European Union (EU) Directives

relating to EU procurement law having direct effect in England (the "Directives") and any other duties derived from EU Treaty ("Treaty Obligations") and any other duties derived from the UK common law ("Common Law Duties") and where applicable The National Health Service (Procurement, Patient Choice and Competition)(No.2) Regulations 2013 (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in those SOs as "Procurement Legislation"). The Procurement Legislation as from time to time amended shall have effect as if incorporated in these SOs and the Trust's Standing Financial Instructions

9.2.2 The Trust should consider obtaining support from the NHS Supply Chain and/or the Cabinet Office where relevant and/or any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures)

9.2.3 The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity

9.2.4 When procuring services, the Trust should have regard to the requirements of the Public Services (Social Value) Act 2012 and its supporting regulations and guidance, as amended.

9.3 **Guidance on Procurement and Commissioning**

9.3.1 The Trust should have regard to all relevant guidance issued in relation to the conduct of procurement practice, including but not limited to:

(a) the Department of Health's "*Capital Investment Manual*" and "Estate Code" in respect of capital investment and estate and property transactions save where either has been superseded by later published guidance;
(b) policies and procedures in place for the control of all tendering activity, and
(c) in the case of management consultancy contracts the Department of Health guidance "*The Procurement and Management of Consultants within the NHS*" or any successor guidance issued by the Department of Health and Social Care;

or any successor to such guidance issued from time to time.

9.4 **Formal Competitive Tendering**

9.4.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any Procurement

Legislation or as otherwise set out in the Trust's Tendering and Quotation Policy and Procedure and/or the DSoD

9.4.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive (except in (c) to (h) below) where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the minimum procurement threshold for the purposes of the Regulations or any figures set by the Board, (this figure to be reviewed annually); or
(b) the supply is proposed under special arrangements negotiated by the DHSC or NHS England and Improvement (NHSE/I) , to the extent that these arrangements comply with the Regulations and utilising them will not cause the Trust to breach any of its obligations arising pursuant to any Procurement Legislation, in which event the said special arrangements must be complied with; or
(c) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members
(d) Where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender
(e) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source
(f) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor for the new task would be inappropriate
(g) There is clear benefit to be gained from maintaining continuity with an earlier project. (The benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering)
(h) Sole/single source supplier; or
(i) the supply of goods or services is covered by an NHS Framework Agreement or other Public Sector framework available to the trust and the price is certain (i.e. quoted)

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure

Where it is decided that competitive tendering is not applicable and should be waived by virtue of (c) to (f) above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Executive Operational Committee. All such waivers should also be reported at the next available meeting of the Audit Committee

9.4.3 Except where SO 9.4.2, or a requirement under SO 9.2, applies, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required

9.4.4 Tendering procedures are set out in the Trust's Tendering & Quotation Procedure.

9.5 **Quotations**

9.5.1 Quotations are required where formal tendering procedures are waived under SO 9.4.2 (a) or (c) and where the intended expenditure is reasonably expected to exceed the financial limit specified in the DSoD

9.5.2 Where quotations are required under SO 9.5.1 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board

9.5.3 Quotations should normally be in writing, (subject to limits specified in SFIs and occasions when verbal quotes can be obtained)

9.5.4 All quotations should be treated as confidential and should be retained for inspection. A written record of verbal quotations should also be retained

9.5.5 The Chief Executive or the nominated officer (via the DSoD) should select the quotations which gives the best quality and value for money. If this is not the lowest cost then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record

9.5.6 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or the nominated officer, possible or desirable to obtain competitive quotations
(b) the goods/services are required urgently.

9.6 Where tendering or competitive quotation is not required

9.6.1 The Trust shall use NHS Supply Chain and other NHS Frameworks for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

Competitive quotations should be sought for all expenditure in excess of the limit specified in the DSoD. However, there are a number of approved instances when three competitive quotes need not be sought as follows:

(a) Part order of locally tendered contract.
(b) NHS/National Framework Agreement – if the supply of goods or services is on a national framework agreement, and the price is certain (i.e. quoted)

A waiver form does not need to be completed if either 9.6.1 (a), or 9.6.1 (b) applies.

In all other circumstances where three competitive quotations cannot be obtained, then a formal waiving of competitive quotations needs to occur and section C of the waiver form needs to be completed and authorised by either the Executive Chief Finance Officer or the Chief Executive. This decision then needs to be reported to the next available meeting of the Audit Committee

Reasons for waivers may include:

(c) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members
(d) Where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender
(e) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source **only**
(f) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor for the new task would be inappropriate
(g) There is clear benefit to be gained from maintaining continuity with an earlier project. (The benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering)
(h) Sole/single source supplier

9.6.2 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11).

9.7 **Private Finance/Procure 22**

The Trust may consider using PFI/Procure 22 when considering a capital procurement. When the Board proposes that PFI/Procure 22 be considered:

9.7.1 The Chief Executive shall demonstrate that the scheme represents value for money and genuinely transfers risk to the private sector

9.7.2 The proposal must be specifically agreed by the Board

9.7.3 Trust competitive tendering/quotations procedures should apply where necessary.

9.8 **Contracts**

9.8.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

(a) these SOs;
(b) the Trust's SFIs;
(c) EU Directives and other statutory provisions;
(d) any relevant and mandatory directions including Monitor's guidance on Risk Evaluation for Investment Decisions, the DoH's Capital Investment Manual, Estate Code and guidance on the Procurement and Management of Consultants;
(e) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.8.2 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.9 **Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

9.10 **Legally Binding Contracts (LBC) for the Provision of Healthcare**

Legally binding contracts for the supply of healthcare services shall be drawn up in accordance with legal advice, best practice and where possible use the NHS Standard model contract. These legally binding contracts will be administered by the Trust.

9.11 **Cancellation of Contracts**

Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

9.11.1 if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or

9.11.2 if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

9.11.3 if in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916, the Bribery Act 2010 and any other appropriate legislation.

9.12 **Determination of Contracts for Failure to Deliver Goods or Material** There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

9.12.1 such default; or

9.12.2 in the event of the contract being wholly determined the goods or materials remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.13 **Contracts involving Funds Held on Trust** shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

10. DISPOSALS

10.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

10.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer

10.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust

10.1.3 items to be disposed of with an estimated sale value of less than £5,000

10.1.4 items arising from works of construction, demolition or site working, which should be dealt with in accordance with the relevant contract

10.1.5 land or buildings concerning which DoH or other statutory body guidance has been issued but subject to compliance with such guidance.

11. IN-HOUSE SERVICES

11.1 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

11.1.1 Specification group, comprising the Chief Executive or nominated officer/s and specialist

11.1.2 In-house tender group, comprising a nominee of the Chief Executive and technical support

11.1.3 Evaluation team, comprising normally a specialist officer, a supplies officer and the Executive Chief Finance Officer or their nominated representative. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team

11.2 All groups should work independently of each other. No officer is able to sit on both the in-house tender group and the evaluation group

11.3 The evaluation team shall make recommendations to the Executive Operational Sub-Committee and/or the Board, in accordance with the Trust's DSoD.

12. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal**
The common seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents**

12.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Chief Executive or Executive Chief Finance Officer

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Executive Chief Finance Officer (or an officer nominated by him and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Directorate).

12.3 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. The report shall detail the description of the document, the date of sealing and the names of persons who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

13. SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee with delegated authority.

14. MISCELLANEOUS

14.1 **Standing Orders to be given to Board Members and Officers**
It is the duty of the Chief Executive to ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

14.2 **Documents having the standing of Standing Orders**
SFIs, DSoD and the SoRD shall have effect as if incorporated into SOs.

14.3 **Review of Standing Orders**
SOs shall be reviewed annually by the Board. The requirement for review extends to all documents having the effect as if incorporated in SOs.

14.4 **Dispute Resolution**

14.4.1 Where there is a dispute between the Board of Directors and the Council of Governors, the procedure set out in the *Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance* should be referred to and followed

14.4.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that

dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible

14.4.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute

14.4.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

15. RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

15.1 The Council has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its Licence. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the Trust. The Council is responsible for representing the interests of Trust members and the public and staff in the governance of the Trust. Governors must act in the best interests of the Trust and should adhere to its values and code of conduct. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty

15.2 Governors should discuss and agree with the Board how they will undertake these 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. Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan

15.3 Board members are to present to the Council at a general meeting the annual accounts, any report of the auditor on them, and the annual report

15.4 The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). The Trust will comply with the NHS Foundation Trust

Annual Reporting Manual. The Council may request that a matter which relates to the annual accounts or forward planning for the Trust is included on the agenda for a meeting of the Board

15.5 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.

15.6 The annual report should include a statement from the Board on how performance evaluation of the Board, its committees and its Directors is conducted and the reason why the Trust adopted a particular method of performance evaluation

15.7 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing

15.8 If the Council does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position

15.9 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors

15.10 In accordance with section A 1.1 of Monitor's *Code of Governance* (February 2014) the roles and responsibilities of the Council of Governors are set out in Appendix D.

16. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, THE STANDING FINANCIAL INSTRUCTIONS, THE PROVIDER LICENCE AND THE NATIONAL HEALTH SERVICE ACT 2006

16.1 **Specific Policy Statements**

These SOs must be read in conjunction with the following policy statements and documents which shall have effect as if incorporated in these SOs:

16.1.1 the Standards of Business Conduct and Conflicts of Interest Policy for Trust staff

16.1.2 the Code of Conduct for Board Members

16.1.3 the Staff Disciplinary and Appeals Procedures

16.1.4 the SFIs adopted by the Board in accordance with all financial regulations, directions and guidance issued by Monitor and any other relevant body

16.1.5 the SoRD approved by the Board

16.1.6 Tendering and Quotations Procedure

16.1.7 the Trust's Counter Fraud Policy and Procedure

16.2 **Specific Guidance and Legislation**

These SOs must be read in conjunction with any directions and guidance issued by Monitor, the Department of Health and Social Care and any other relevant body and in accordance with the following:

- National Health Service Act 2006
- Health and Social Care Act 2012
- DH Caldicott Guardian Manual 2010 (and any subsequent versions)
- Human Rights Act 1998
- Freedom of Information Act 2000 and relevant guidance from the Information Commissioner Office
- Equality Act 2010
- Information Governance Toolkit July 2010 (and any subsequent versions)
- Bribery Act 2010
- Data Protection Act 2018 and relevant guidance from the Information Commissioner's Office
- Monitor's Code of Governance (December 2013) (and any subsequent versions)
- any other relevant legislation and guidance as applicable from time to time.

16.3 **Potential Inconsistency**

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in SO 16.2 above (the Legislation), the Legislation shall prevail.

In the event of any conflict or inconsistency between these SOs and the Licence and/or the constitution, the Licence and/or the constitution shall prevail.

Appendix A

COMMITTEES OF THE BOARD OF DIRECTORS

1. **Audit Committee**
2. **Charitable Funds Committee**
3. **Finance & Performance Committee**
4. **People, Equality and Culture Committee**
5. **Remuneration and Nominations Committee**
6. **Quality Committee**

Appendix B

STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF

1. Prevention of Corruption – Bribery Act 2010

1.1 The Trust has a responsibility to ensure that all Directors (and staff) are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

(a) bribing, or offering to bribe, another person (section 1);
(b) requesting, agreeing to receive, or accepting a bribe (section 2);
(c) bribing, or offering to bribe, a foreign public official (section 6);
(d) failing to prevent bribery (section 7)

1.2 All Directors (and staff) are required to be aware of the Bribery Act 2010 and should also refer to the remaining provisions in this Appendix B for further guidance in relation to this duty as well as any other national guidance.

2. NHS staff are expected to abide by the seven principles of public life (Nolan) at all times:

2.1 **SELFLESSNESS**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends

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

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

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

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

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

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

3.0 IMPLEMENTING THE GUIDING PRINCIPLES ABOVE:

Gifts

3.1 With the exception of items of little value (less than £50) such as diaries, calendars, flowers and small tokens of appreciation (including seasonal gifts), which may be accepted, all offers of gifts should be declined. In cases of doubt, advice should be sought from your line manager. A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value. Any personal gift of cash or cash equivalents (e.g. tokens) must be declined whatever its value. All Directors (and staff) should report immediately all offers of unreasonably generous gifts to the Trust Secretary and return promptly any unacceptable gifts, with a letter politely explaining the terms of this policy and stating that you are not allowed to accept them.

Hospitality

3.2 Hospitality will be in accordance with Trust's policy on hospitality and sponsorship.

Raising concerns

3.3 It is the duty of every member of the Board (and staff) to speak up about genuine concerns in relation to criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and the cover up of any of these in the workplace. The Trust has a whistle-blowing policy that sets out the arrangements for raising and handling staff concerns. The procedure for reporting specific concerns relating to fraud are described below at 3.5.

Freedom to Speak Up

3.4 The Trust's Freedom to Speak Up Guardian is contactable by email and telephone and contact details are available on the Trust's intranet for all staff needing to raise a concern about patient or staff safety. For example, matters may be raised such as unsafe patient care; unsafe working conditions; inadequate induction or training for staff; lack of, or poor, response to a reported patient safety incident or a bullying culture across a team.

Counter fraud

3.5 All Directors (and staff) are required not to use their position to gain financial advantage. The Trust is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. The Trust's Directors (and staff) should inform the Executive Chief Finance Officer immediately, unless the Executive Chief Finance Officer is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken

3.6 The Trust's Directors (and staff) can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

3.7 Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The Executive Chief Finance Officer will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised

3.8 The Trust's Directors (and staff) should not ignore their suspicions, investigate themselves or tell colleagues or others about their suspicions.

Preferential treatment in private transactions

3.9 Individual Directors must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. (This does not apply to concessionary agreements negotiated with companies by the Directors, or by recognised staff interests on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts

3.10 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to the standards set out in Appendix B and are encouraged to also follow the professional standards set out in the Ethical Code of the Chartered Institute of Purchasing and Supply.

Favouritism in awarding contracts

3.11 Fair and open competition between prospective contractors or suppliers for all contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

3.11.1 no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.

3.11.2 each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

3.11.3 the Trust should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

3.12 The Trust will wish to ensure that all invitations to potential contractors to tender for NHS and non-NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

3.13 No Directors should engage in outside employment that may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area; the Trust will be responsible for judging whether the interests of patients could be harmed.

Intellectual property

3.14 The Board of Directors should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by the Trust's employees in the course of their duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Directors should build appropriate specifications and provisions into the contractual arrangements that they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases

3.15 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles

3.16 In the case of collaborative research and evaluative exercises with manufacturers, the Trust should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under their contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Standards of business

3.17 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to these standards; and

3.17.1 maintain the highest standard of integrity in all business relationships

3.17.2 reject any business practice which might reasonably be deemed improper

3.17.3 never use their authority or position for their own personal gain

3.17.4 enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way

3.17.5 foster the highest standards of professional competence amongst those for whom they are responsible

3.17.6 optimise the use of resources which they have influence over for the benefit of the organisation

3.17.7 comply with both the letter and the intent of: - the law of countries where the contracts are executed or as otherwise stated in the contracts - Chartered Institute of Purchasing and Supply guidance on professional practice

3.17.8 declare any personal interest that might affect, or be seen by others to affect, their impartiality or decision making

3.17.9 ensure that the information they give in the course of the work is accurate

3.17.10 respect the confidentiality of information they receive and never use it for personal gain

3.17.11 strive for genuine, fair and transparent competition

3.17.12 not accept inducements or gifts, other than items of small value such as business diaries or calendars

3.17.13 always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision

3.17.14 remain impartial in all business dealing and not be influenced by those with vested interests.

Appendix C

STANDARDS FOR MEMBERS OF NHS BOARDS AND CLINICAL COMMISSIONING GROUP GOVERNING BODIES IN ENGLAND

standards-for-memb
ers-of-nhs-boards-an

Appendix D

ROLES AND RESPONSIBILITIES OF THE COUNCIL OF GOVERNORS

The roles and responsibilities of the Council which are to be carried out in accordance with the constitution and the Trust's licence include:

General Duties

1. To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

2. To represent the interests of the members of the Trust and the interests of the public.

Non-Executive Directors, Chief Executive and Auditor

3. To approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council

4. To approve the appointment and removal of the Chair and the Non-Executive Directors. The Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board

5. To approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the Remuneration Committee of the Council. All Non-Executive Directors and elected Governors should be submitted for re-appointment or re-election at regular intervals. The performance of Executive Directors should be subject to regular appraisal and review. The Council should ensure planned and progressive refreshing of the Non-Executive Directors

6. To set the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors on the recommendations of the Remuneration Committee of the Council. The Council should consult external professional advisers to market-test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive Director

7. To approve the appointment of a candidate as Chief Executive of the Trust recommended by the Non-Executive Directors

8. To approve the criteria for the appointment, removal and re-appointment of the auditor

9. To approve the appointment, removal and re-appointment of the auditor on the recommendation of the Audit Committee

Strategy Planning

10. To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate

11. To collaborate with the Board in the development of the forward plan

12. Where the forward plan contains a proposal that the Trust will carry out activity other than the provision of goods and services for the purpose of the NHS in England, to determine whether the proposal will interfere in the fulfilment by the Trust of its principal purpose and notify its determination to the Board

13. To approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the Trust

14. To approve entering into any significant transactions (as defined by the Board from time to time) in accordance with the 2006 Act and the constitution

15. To approve proposals from the Board for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

16. When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

17. To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council

Representing Members and the Public

18. To prepare and from time to time review the Trust's membership engagement strategy and policy

19. To notify Monitor, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, if these concerns cannot be resolved at local level

20. To report to the members annually on the performance of the Council

21. To promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy

22. To seek the views of stakeholders and feed back to the Board.

Essex Partnership University
NHS Foundation Trust

SCHEME OF RESERVATION & DELEGATION (SoRD)

POLICY REFERENCE NUMBER	FP12
VERSION NUMBER	006
KEY CHANGES FROM PREVIOUS VERSION	Updated to include People, Equality and Culture Committee, in place of People, Innovation and Transformation Committee.
AUTHOR	Trust Secretary
CONSULTATION GROUPS	Executive Team Audit Committee Board of Directors
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 2018, September 2019, September 2020, September 2021, September 2022
LAST REVIEW DATE	September 2022
NEXT REVIEW DATE	September 2023
APPROVAL BY AUDIT COMMITTEE	September 2022
RATIFICATION BY BOARD OF DIRECTORS	September 2022
COPYRIGHT	

POLICY SUMMARY
The purpose of the Scheme of Reservation & Delegation (SoRD) is to set out the powers reserved to the Board of Directors and those that the Board has delegated. It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply. The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust

The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the SoRD will be undertaken by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Chief Executive Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

1.0 INTRODUCTION

1.1 NHSE/I *NHS Foundation Trust: Code of Governance* requires that there should be a formal schedule of matters reserved for decision by the Board of Directors (Board).

1.2 This document sets out the powers reserved to the Board and those that the Board has delegated.

1.3 The Board remains accountable for all of its functions, including those which have been delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to perform its monitoring role.

1.4 All powers of the NHS Foundation Trust (Trust), which have not been retained as reserved by the Board or delegated to a committee of the Board, will be exercised on behalf of the Board by the Chief Executive (CEO) or another Executive Director (ED).

1.5 The National Health Service Act 2006 (the Act) designates the CEO of the Trust as the Accounting Officer. The Act states that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. The Accounting Officer has the personal duty of signing the Trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

1.6 The CEO is ultimately accountable to the Board and has overall executive responsibility for the Trust's activities

2.0 PURPOSE

2.1 The purpose of this document is to set out the powers reserved to the Board and those that the Board has delegated. It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply.

2.2 The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.3 The Board reserves certain matters to itself which are set out in the SoRD which is the schedule of matters reserved to the Board.

2.4 The Detailed Scheme of Delegation (DSoD) identifies any functions which the CEO will perform personally and those delegated to other EDs or officers. All powers delegated by the CEO can be reassumed by him/her should the need arise.

2.5 The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.6 If the CEO is absent, powers delegated to him/her may be exercised by the ED who is formally acting up as CEO. Formal acting-up status shall be confirmed in writing by either the CEO or the Chair.

Where the CFO is appointed to act up as the CEO, a further executive shall be named to act up with the CFO for the purposes of approving expenditure and income up to an amount delegated by the DSoD a responsibility normally conferred to the CEO and CFO. Formal acting-up status shall be confirmed in writing by either the Chair, CEO, or the CFO.

If the ECFO is absent powers delegated to him/her may be exercised by a Director of Finance.

2.7 The key documents in the corporate governance framework include:

- Standing Financial Instructions (SFIs)
- Detailed Scheme of Delegation (DSoD)
- Constitution
- Standing Orders (SOs) for the Board of Directors

2.8 The Board has delegated to any Executive Director who is a member of a collaborative board, such authority as agreed to be necessary in order for the collaborative board to function effectively in discharging its responsibilities as set out in any agreement. For the avoidance of doubt, this cannot exceed financial limits set-out in the Trust Detailed Scheme of Delegation (DSoD)

3.0 DECISIONS RESERVED TO THE BOARD OF DIRECTORS

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
Constitution	General Enabling Provision	3.1	3.1.1	The Board is responsible for ensuring on-going compliance by the Trust with its licence, its Constitution, mandatory guidance issued by NHS Improvement (NHSI), the Independent Regulator for Foundation Trusts, relevant statutory requirements and contractual obligation
			3.1.2	The Board may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors
			3.1.3	Any functions of the Trust that have been reserved to the Board shall be exercised by the Board on behalf of the Trust or may be delegated by the Board to a committee of Directors or to an Executive Director
			3.1.4	All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual standing committees, sub-committees, Directors or officers
N/A	Regulation & Control	3.2	3.2.1	Approve Standing Orders For The Practice and Procedures of the Board of Directors (SOs) and a schedule of matters reserved to the Board (Scheme of Reservation & Delegation – SoRD), Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business, including the ability to suspend, vary or amend SOs
			3.2.2	Ratify any urgent decisions taken by the Chair and/or CEO
			3.2.3	Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which a member of the Board may remain involved with the matter under consideration

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			3.2.4 Approve the corporate structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity, this will comprise of details of the structure of the Board and its committees and sub-committees. Organisational structures below ED are the responsibility of the CEO who may delegate this function as appropriate 3.2.5 Delegate executive powers to be exercised by committees or sub-committees or joint committees of the Board and approve the committee structure of the Board including associated terms of reference and the required accountability arrangements 3.2.6 Receive and consider reports from committees of the Board and, where relevant, approve any recommendations made by the committees 3.2.7 Approve governance arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust 3.2.8 Approve the Trust's banking arrangements 3.2.9 Ratify any urgent or emergency decisions taken by the Chair and/or CEO in accordance with SO (Emergency Powers) of the SOs 3.2.10 Consider instances of failure to comply with SOs and take action where appropriate 3.2.11 Approve the disciplinary procedures for officers of the Trust 3.2.12 Approve the systems and processes for escalating and resolving quality issues, including the escalation of such issues to the Board where appropriate 3.2.13 Ensure there are adequate systems and processes maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery (including

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			systems and processes to ensure effective financial decision-making, management and control)
			3.2.14 Establish standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
			3.2.15 Call meetings of the Board
			3.2.16 Approve the minutes of the proceedings of Board meetings
			3.2.17 Review the Constitution and SOs annually
N/A	**Committees**	3.3	3.3.1 Appoint and disestablish committees that are directly accountable to the Board
			3.3.2 Establish terms of reference and reporting arrangements for all Board committees
			3.3.3 Ratify the appointment/removal of Board committee members
			3.3.4 Receive reports from committees including those which the Trust is required by its constitution, or by the regulator or by the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action thereon
			3.3.5 Confirm the recommendations of the Board's committees where the committees do have executive powers
N/A	**Strategy, Business Plans and Budgets**	3.4	3.4.1 Define the strategic aims of the Trust with due regard to the views of the Council of Governors (Council)
			3.4.2 Approve proposals for ensuring the quality and safety and for applying the principles and standards of clinical governance as set out by relevant bodies (including the Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions) of services provided by the Trust.
			3.4.3 Approve and monitor the Trust's programme of risk management

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			which must identify risks and liabilities, evaluate them and ensure adequate responses/actions are in place and monitored
			3.4.4 Approve outline and final business cases for Capital Investment over the agreed thresholds detailed in the SFIs
			3.4.5 Approve annual budgets.
			3.4.6 Ensure plans take timely and appropriate account of quality of care considerations.
			3.4.7 Approve the annual plan and forward plan (also known as the Trust's Five Year Plan)
			3.4.8 Consider a merger, acquisition, separation or dissolution of the Trust (such an application may only be made with the approval of more than half the members of the Council of Governors (CoG)).
			3.4.9 Consider a significant transaction as defined in the constitution. A significant transaction may only be entered into if approved by more than half of the Governors voting at a meeting of the Council
			3.4.10 Approve proposals for acquisition, disposal or change of use of land and/or buildings over the agreed thresholds detailed in the SFIs
			3.4.11 Approve PFI proposals
			3.4.12 Approve the appointment of bankers and the opening of bank accounts
			3.4.13 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature as set out in the Detailed Scheme of Delegation
			3.4.14 Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the CEO and Executive Chief Finance Officer (ECFO) for losses and special payments previously approved by the Board

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
			3.4.15	Approve individual compensation payments in accordance with Trust Detailed Scheme of Delegation (DSoD)
			3.4.16	Approve proposals for action on litigation against or on behalf of the Trust as per the financial limits set out in the Detailed Scheme of Delegation/
			3.4.17	Review the use of NHS Resolution risk pooling schemes.
			3.4.18	Approve proposals for ensuring equality and diversity in both employment and the delivery of services
Constitution	Audit	3.6	3.6.1	Approve the appointment (and where necessary dismissal) of internal auditor (the recommendation in respect of the external auditors is made by the Audit Committee to the Council)
Audit Committee			3.6.2	Receive an annual report from the Audit Committee
Constitution	Annual Reports and Accounts	3.7	3.7.1	Approve the Annual Report and Accounts for the Trust
			3.7.2	Approve the Charity Accounts for the Trust
			3.7.3	With regard to the views of the Council, prepare the information as to the Trust's forward plan in respect of each financial year to be given to NHSE/I
			3.7.4	Present to the Council at a general meeting, the annual accounts, any reports of the auditors on them and the annual report
N/A	Monitoring	3.8	3.8.1	Receive such reports, as the Board sees appropriate from committees in respect of their exercise of powers delegated as well as from members of the Board and officers of the Trust in order to continually appraise the affairs of the Trust
			3.8.2	All returns required by NHSE/I and the Charity Commission will be reported, at least in summary, either in a specific report to the Board or by a committee report
			3.8.3	Receive reports from the ECFO on financial performance and requirements of NHSE/I, and the Director with the portfolio for other areas of performance

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors
			3.8.4 Approve the making of declarations in accordance with statutory requirements and /or at the request of NHSI 3.8.5 Monitor the delivery of business plans (including any changes to such plans) and receive internal and where appropriate external assurance on such plans and their delivery

4.0 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

The Board may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board from time to time taking into account where necessary the requirements of the regulator and/or the Charity Commission (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with the SOs, Board committees may not delegate executive powers to sub-committees.

A list of committees together with their terms of reference shall be maintained by the Trust Secretary.

The Board has delegated decisions/duties to the following committees:

SoRD Ref	Committee	Decisions / Duties Delegated by the Board to Committees
4.1	Audit Committee	Terms of Reference
4.2	Charitable Funds Committee	Terms of Reference
4.3	Finance & Performance Committee	Terms of Reference
4.4	People, Equality and Culture Committee	Terms of Reference
4.5	Remuneration & Nominations Committee	Terms of Reference
4.6	Quality Committee	Terms of Reference

5.0 SCHEME OF DELEGATION DERIVED FROM THE CONSTITUTION

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
4. Powers	Board of Directors	5.1	5.1.1	All the powers of the Trust shall be exercised by the Board on behalf of the Trust
			5.1.2	Any of these powers may be delegated to a committee of Directors or to an ED
13. Annual Members Meeting	Trust Secretary	5.2	5.2.1	The Trust shall hold an annual meeting of its members which shall also be open to members of the public
14. Council of Governors	Trust Secretary	5.3	5.3.1	The Trust is to have a Council of Governors that will comprise of both elected and appointed Governors
18.3. Council of Governors Skills & Knowledge	Chair Trust Secretary	5.4	5.4.1	The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such
23.1. Council of Governors Travelling Expenses	Trust Secretary	5.5	5.5.1	The Trust may pay travelling expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust.
30.1. Appointment of the Vice Chair	Chair Council of Governors	5.6	5.6.1	The Chair shall be entitled to advise the Council of the NED who is recommended by the Board for appointment as the Vice-Chair
30.2. Appointment of the Acting Chair				
30.4. Appointment of the Senior Independent Director	Board of Directors	5.7	5.7.1	The Board shall, following consultation with the Council, appoint one of the NEDs as the SID
30.5. Appointment of Deputy CEO	Remuneration & Nomination Committee	5.8	5.8.1	Appoint one of the EDs to be the Deputy Chief Executive in line with agreed procedure

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
31.1. Appointment and Removal of CEO	Chair Non-Executive Directors	5,9	5.9.1	The NEDs shall appoint or remove the CEO. The appointment shall require the approval of a majority of the COG present at a meeting of the COG
31.3. Appointment and Removal of Other Executive Directors	Remuneration & Nomination Committee	5.10	5.10.1	A Committee consisting of the Chair, CEO and the other NEDs shall appoint or remove other EDs
19.2. Council of Governors Meetings (Exclusion) 34.1. Board of Directors Meetings (Exclusion)	Chair	5.11	5.11.1	The Chair may exclude any person from a meeting of the Council/Board if that person is interfering with or preventing the proper conduct of the meeting
34.2. Board of Directors Meetings	Trust Secretary	5.12	5.12.1 5.12.2	Send a copy of the agenda to the Council prior to holding a Board meeting Send a copy of the minutes of a Board meeting to the Council (as soon as reasonably practicable)
37.2. Remuneration & Terms of Office	Remuneration & Nomination Committee	5.13	5.13.1	Decide the remuneration and allowances and other terms and conditions of office of the CEO and other EDs
38 / 39 / 40. Registers	Trust Secretary	5.14	5.14.1 5.14.2	Compile and maintain including admission/removal from registers including: • Register of members • Register of members of the Council of Governors • Register of interests of Governors • Register of Directors • Register of interests of Directors Make the above registers available to the public in line with the conditions in the constitution

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
41. Documents Available for Public Inspection	Trust Secretary	5.15	5.15.1	The Trust shall make the following documents available for inspection by members of the Trust/members of the public free of charge at all reasonable times: • Constitution • Latest annual accounts, including any report of the auditor on them • Latest annual report • Documents relating to a special administration of the Trust
43. Audit Committee	Audit Committee	5.16	5.16.1	Perform such monitoring, reviewing and other functions for an Audit Committee as are appropriate
44. Accounts	CEO (Accounting Officer)	5.17	5.17.1	The Trust shall prepare in respect of each financial year annual accounts in line with regulatory requirements
45.1. Annual Report	Board of Directors	5.18	5.18.1	Prepare an annual report for submission to NHSE/I
45.2 – 45.7. Forward Plan	Board of Directors	5.19	5.19.1	Prepare the forward plan having regard to the views of the Council
47. Instruments	Board of Directors	5.20	5.20.1	Authorise use of the seal
48.1. Constitution Amendments	Board of Directors	5.21	5.21.1	Make amendments to the constitution (subject to more than half the Council and Board approving amendments)
Annex 5. Model Election Rules	Board of Directors	5.22	5.22.1	Retention and public inspection of election documents (para 57.1) – these will be destroyed after one year unless otherwise directed by the Board
			5.22.2	Consent (or not) to the application for inspection of certain documents relating to an election (para 58)
Annex 9. Significant Transactions	Strategy & Planning Committee	5.23	5.23.1	Assess the significance of the overall risk of a transaction that exceeds the definition as detailed in section 1 of Annex 9 Significant Transactions of the constitution

6.0 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM (AUGUST 2015)

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
1.	CEO	6.1	6.1.1 The National Health Service Act 2006 (the 2006 Act) designates the CEO of an NHS FT as the Accounting Officer 6.1.2 The Board has agreed that to support the Accounting Officer to discharge his/her duties the following functions will be delegated as identified below
3.	CEO	6.2	6.2.1 The Accounting Officer has the duty to prepare the accounts in accordance with the 2006 Act 6.2.2 An Accounting Officer has the personal duty of signing the NHS FT's accounts 6.2.3 By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.
5.	CEO	6.3	6.3.1 Regardless of the source of the funding, the Accounting Officer is responsible to Parliament for the resources under their control.
7. General Responsibilities of the Accounting Officer	CEO Director with Portfolio for People Management ECFO	6.4	6.4.1 Responsible for the overall organisation and management 6.4.2 Responsible for staffing of the Trust 6.4.3 Responsible for the Trust's procedures in financial and other matters 6.4.4 Ensure there is a high standard of financial management in the Trust as a whole 6.4.5 Ensure the financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
			6.4.6	Ensure financial considerations are fully taken into account in decisions on Trust policy proposals
8-11: Specific Responsibilities of the Accounting Officer	ECFO	6.5	Responsible for ensuring:	
			6.5.1	the propriety and regularity of the public finances for which he/she is answerable
			6.5.2	the keeping of proper accounts
			6.5.3	prudent and economical administration
			6.5.4	the avoidance of waste and extravagance
			6.5.5	the efficient and effective use of all the resources in their charge
	CEO		6.5.6	personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content as prescribed by NHSE/I in accordance with the Act
	ECFO		6.5.7	comply with the financial requirements of the Trust's provider licence
			6.5.8	ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the Trust)
			6.5.9	ensure that the resources for which the Accounting Officer is responsible are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
	ECFO or Director with Portfolio for Estates		6.5.10	ensure that assets for which the Accounting Officer is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
	ECFO		6.5.11	ensure that any protected property (or interest in) is not disposed of without the consent of NHSE/I
	CEO		6.5.12	ensure that conflicts of interest are avoided, whether in the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
			proceedings of the Board, Council or in the actions or advice of the Trust's staff, including the Accounting Officer
	ECFO		6.5.13 ensure that in the consideration of policy proposals relating to the expenditure for which the Accounting Officer is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board
	CEO		6.5.14 ensure that there are effective management systems appropriate for the achievement of the Trust's objectives, including financial monitoring and control systems, have been put in place 6.5.15 ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the Trust), including a critical scrutiny of output and value for money • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively
	CEO ECFO		6.5.16 ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the Government Internal Audit Standards
12 – 15: Advice to	CEO ECFO	6.6	6.6.1 Ensure that appropriate advice is tendered to the Board and the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
the Board				Council on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the PAC, transactions for which they are accountable
	CEO		6.6.2	The Board and the Council of an NHS FT should act in accordance with the requirements of propriety or regularity. If the Board, Council or the Chair is contemplating a course of action involving a transaction which the Accounting Officer considers would infringe these requirements, the Accounting Officer should set out in writing his/her objection to the proposal and the reasons for this objection. If the Board, Council or Chair decides to proceed, the Accounting Officer should seek a written instruction to take the action in question. The Accounting Officer should also inform NHSE/I of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHS England, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that the Accounting Officer is overruled, the instruction must be complied with, but the Accounting Officer's objection and the instruction itself should be communicated without undue delay to the Trust's external auditors and to NHSE/I. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction
			6.6.3	If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to the Accounting Officer's wider responsibilities for economy, efficiency and effectiveness, it is the Accounting Officer's duty to draw the relevant factors to the

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				attention of the Board and the Council and to advise them in whatever way he/ she deems appropriate. If the advice is overruled, and the proposal is one which the Accounting Officer would not feel able to defend to the PAC as representing value for money, the Accounting Officer should seek a written instruction before proceeding. NHSE/I should be informed of such an instruction, if possible before the decision is implemented. It will then be for Monitor to consider the matter, and decide whether or not to intervene
			6.6.4	If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 2 and 3 above before the decision is taken, the Accounting Officer must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards
16 -20: Appearance before the Public Accounts Committee	CEO	6.7	6.7.1	Appear before the PAC furnishing the PAC with an explanation of any indications of weaknesses in the matters covered by the paragraphs of the Accounting Officer Memorandum headed *The Specific Responsibilities of an NHS FT accounting Officer* to which the PAC's attention may have been drawn/ about which it may wish to question the Accounting Officer and ensuring the accuracy of evidence furnished. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence. In practice, the Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his/her accountability
21 -23: Absence of an Accounting Officer	CEO	6.8	6.8.1	The Accounting Officer should ensure that he/she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the Trust who

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				can act on his/her behalf if required
	Board of Directors		6.8.2	If it becomes clear to the Board that the Accounting Officer is so incapacitated that he/she will be unable to discharge these responsibilities over a period of four weeks or more, the Board should appoint an acting Accounting Officer, usually the Deputy CEO, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted
	Acting Accounting Officer		6.8.3	The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time to submit them to the Minister, the NHS FT may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

7.0 SCHEME OF DELEGATION FROM THE STANDING ORDERS FOR THE BOARD OF DIRECTORS

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
1.1.	Chair	7.1	7.1.1	Save as otherwise permitted by law, the Chair has the final authority in interpretation of SOs (as advised by the CEO and the Trust Secretary)
2.4. Board of Directors	Board of Directors	7.2	7.2.1	The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Scheme of Reservation & Delegation (SoRD) and have effect as if incorporated into the SOs
2.9 Vice-Chair appointment	Board of Directors	7.3	7.3.1	Recommend the appointment of the Vice-Chair / Acting Chair to

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				the Council
2.9.5. Acting Chair appointment			7.3.2	In the absence of the Chair, the Vice-Chair / Acting Chair will act as the Chair of the Trust
2.10 CEO appointment	Chair Non-Executive Directors	7.4	7.4.1	Appoint (and remove) the CEO subject to approval by Council of Governors
2.11 Executive Directors appointment	Remuneration & Nomination Committee	7.5	7.5.1	All EDs (excluding the CEO) to be appointed (and removed) by a Committee consisting of the Chair, CEO and other NEDs
2.12 Deputy CEO appointment	Remuneration & Nomination Committee	7.6	7.6.1	Appoint one of the EDs to be the Deputy Chief Executive in line with agreed procedure
2.14 Senior Independent Director appointment	Board of Directors	7.7	7.7.1	Appoint one of the NEDs as the SID in consultation with the Council
2.15 Trust Secretary appointment	Chair CEO	7.8	7.8.1	Appoint a Trust Secretary
2.16 Role of the Chief Executive Officer	Chair CEO	7.9	7.9.1	Implement the decisions of the Board in the running of the Trust's business. The CEO is the Accounting Officer (see dedicated section in terms of specific delegated responsibilities)
2.17 Role of the Executive Chief Finance Officer	ECFO	7.10	7.10.1	Responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems
	ECFO CEO		7.10.2	Responsible for the discharge of obligations under all relevant financial directions and guidance issued by Monitor or any other relevant body
2.19. Role of the Chair	Chair	7.11	7.11.1	Responsible for the leadership of the Board (and Council) and chair all Board (and Council) meetings when present
			7.11.2	Ensure effectiveness in all aspects of the Board's role
			7.11.3	Lead on setting agenda for meetings and ensure that adequate

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				time is available for discussion of agenda items and strategic issues
			7.11.4	Ensure key and appropriate issues are discussed by the Board in a timely manner with all necessary advice being available to inform debate and decisions
			7.11.5	Responsible for ensuring that the Board and Council work effectively together
2.20. Role of the Non-Executive Directors	Non-Executive Directors	7,12	7,12,1	May exercise collective authority when acting as members of or when chairing a committee of the Board which has delegated powers
3.1 / 3.2 / 3.3 / 3.4.2 / 3.5 Board meetings	Board of Directors	7.13	7.13.1	For special reasons including commercial confidentiality, may exclude members of the public and press
			7.13.2	Determine times and places for ordinary meetings of the Board
			7.13.3	Not less than one-third of Directors (or the Chair) can requisition the Trust Secretary to call a meeting by giving written notice
			7.13.4	If the Trust Secretary does not send a notice of a meeting of the Board within ten working days of receiving an order from the Chair or a requisition from more than one-third of Directors, the Directors who made the requisition may convene the meeting
			7.13.5	The Chair or at least one-third of the Board may call an extraordinary or urgent meeting if the Trust Secretary fails to call such a meeting
	Chair or Board of Directors		7.13.6	Request in writing to the Chair a matter to be included on the agenda at least ten working days before the meeting
3.2.2 / 3.3 / 3.4 / 3.5 Meetings	Trust Secretary	7.14	7.14.1	Meetings of the Board are convened by order of the Chair, or more than one-third of Directors who give written notice to the Trust Secretary
			7.14.2	Issue notice of meetings
			7.14.3	Issue notice of and calling of extraordinary meetings and urgent

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				meetings
			7.14.4	Send agendas to Directors not later than three working days before the meeting; supporting papers, wherever possible, will accompany the agenda save in the case of the need to conduct urgent business
			7.14.5	Display at the Trust's head office and website a public notice of the date, time and place of the meeting including the public part of the agenda at least three working days before the meeting (save in the case of an urgent meeting)
			7.14.6	Send a copy of the agenda to the Council before the Board meeting
3.6 / 15.1 Setting the agenda	Chair or Board of Directors	7.15	7.15.1	Can determine certain matters to be included on every agenda for an ordinary meeting
			7.15.2	Include petition if received not less than 10 working days before a meeting
3.8 Chair of meeting	Chair Vice Chair / Acting Chair Non-Executive Directors	7.16	7.16.1	Chair all Board meetings and associated responsibilities
			7.16.2	Chair meeting if the Chair of the Trust is absent from a meeting
			7.16.3	If the Chair and Deputy Chair are absent (or disqualified from participating) a NED as nominated by other NEDs, will preside
3.9 Motions	Directors	7.17	7.17.1	Move or amend or withdraw or rescind a motion
3.10 Chair's Ruling	Chair	7.18	7.18.1	Give final ruling on questions of order, relevancy, and regularity and other matters of meetings
3.11 Voting	Directors	7.19	7.19.1	Have one vote (with the exception of joint EDs)
	Chair		7.19.2	Determine voting method (oral/show of hands)
	Directors		7.19.3	A majority of Directors present can request a paper ballot
			7.19.4	Request voting (other than by paper ballot) to be recorded to show how each Director present voted/abstained
	Officer		7.19.5	Entitled to vote if appointed formally by the Board to act up for an ED during a period of incapacity/vacancy
	Chair		7.19.6	Has a second or casting vote in the event of equality of votes

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
3.12 / 3.15 Minutes	Trust Secretary	7.20	7.20.1	Ensure meetings are minuted and submitted for agreement at the next meeting where they will be signed by the person presiding at it
			7.20.2	Record the names of the Chair, Directors and all others present at the meeting (other than members of the public and media)
			7.20.3	Retain minutes
			7.20.4	Circulate minutes including sending approved minutes to Council of Governors and make public
	Directors		7.20.5	Ensure minutes record any concerns that cannot be resolved about the running of the Trust or a proposed action
3.13 Informal and committee meetings	Chair	7.21	7.21.1	Hold meetings with NEDs without EDs present
	Senior Independent Director		7.21.2	Meet with the NEDs without the Chair present at least annually to appraise the Chair's performance and on other such occasions as deemed appropriate
	Board of Directors		7.21.3	May meet informally or as a Board committee at any time
3.14. Amendments of Standing Orders	Board of Directors	7.22	7.22.1	May amend SOs without the need to amend the constitution
3.16 Quorum	CEO	7.23	7.23.1	Waive requirement for CEO or Deputy CEO to be present at a meeting
	Chair		7.23.2	Waive requirement for Chair or Vice-Chair to be present at a meeting
4. Exercise of functions by delegation	CEO	7.24	7.24.1	Prepare a detailed Scheme of Reservation & Delegation identifying the functions to be delegated to either an ED or a committee of the Board for approval by the Board
	Board / Directors		7.24.2	Formal delegation of executive powers to committees which it has formally constituted; however, the Trust retains full responsibility
	CEO / Deputy CEO		7.24.3	The powers which the Board has retained to itself within the SOs may in emergency situations be exercised by the CEO or in his/her absence, the Deputy CEO, provided that prior to taking such action, the CEO has consulted with and gained the agreement of the Chair

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
4.7 Non-compliance with Standing Orders	All Executive Directors	7.25	7.25.1	Disclosure of full details of any non-compliance with SOs shall be reported to the Chair and CEO as soon as possible and to the next formal meeting of the Board for action and ratification
	All Staff		7.25.2	Duty to disclose any potential or impending non-compliance with the SOs to their ED who in turn has a duty to report to the CEO and the Chair as soon as possible
5 Committees	Board of Directors	7.26	7.26.1	Appoint an Audit Committee of Non-Executive Directors.
			7.26.2	Appoint a Remuneration Committee of Non-Executive Directors
			7.26.3	Appoint standing committees of the Board
			7.26.4	Approve the appointments to each committee formally constituted
			7.26.5	Standing committees to have terms of reference and powers, and be subject to such conditions, such as reporting back to the Board, as the Board decides
	Standing Committees		7.26.6	Standing committees may establish sub-committees that do not have delegated executive powers from the Board or committee of the Board
6 Declarations / Register of Interest	Directors	7.27	7.27.1	Statutory duty to avoid a situation in which they have a direct or indirect interest that conflicts (or may conflict) with the interests of the Trust
			7.27.2	Declare interests to the Board that are required to be declared (under constitution) and ensure an update is provided if their interests change
	Trust Secretary		7.27.3	Ensure Register(s) of Interests is maintained
	Trust Secretary		7.27.4	Take reasonable steps to bring the existence of the Register to the attention of the local population and publicise arrangements for viewing it
			7.27.5	Keep the Register of Interests up-to-date by means of an annual review in which any changes to interests declared in the preceding 12 months will be incorporated

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
6.3 Register of gifts and hospitality	Trust Secretary	7.28	7.28.1	Maintain a register of gifts and hospitality for Board members and staff
			7.28.2	Publish on Trust's website in line with regulatory requirements
7 Conflict of interest and pecuniary interest	Directors Standing Committees	7.29	7.29.1	Disclose any pecuniary interest (as defined in SOs) in any contract/proposed contract/other matter and is present at a meeting at which the contract/other matter is being considered
			7.29.2	Withdraw from a meeting if a conflict of interest is disclosed
			7.29.3	SO also applies to a committee/sub-committee/joint committee of the Board
8 Standards of Business Conduct Policy	Staff Directors	7.30	7.30.1	Comply with the Trust's Standards of Business Conduct Policy at all times
			7.30.2	Comply with national guidance contained in *NHSE/I Standards of Business Conduct policy* (ref Appendix B of SOs), *the Standards for Members of NHS Boards and CCG Governing Bodies in England (Nov 2013)* (ref Appendix C of SOs), Trust's Policy for Fraud and Bribery, and any such guidance issued by NHSI or the DHSC from time to time.
8.3 Interests of officers in contracts	Staff	7.31	7.31.1	Disclose any pecuniary interest in a contract to which they are a party (or has been or is proposed to be)
	Staff Directors		7.31.2	Disclose to the CEO any other employment, business or other relationship of theirs or of a spouse/partner/other family member that conflicts or might reasonably be predicted that could conflict with the interests of the Trust
	Staff		7.31.3	Declare interests/employment/relationships on a Register of Interests for staff
8.5 Relatives of Board members or officers	Staff Directors	7.32	7.32.1	Disclose whether they are related to any other Board member or holder of any office in the Trust
			7.32.2	Disclose to the CEO any relationship between themselves and a candidate for staff appointment of whose candidature the Board member or staff member is aware

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			7.32.3	On appointment Board members should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust
	CEO		7.32.4	CEO to report any disclosures under 7.32.2 to the Board of Directors
9 Tendering and contract procedure	CEO	7.33	7.33.1	Where it is decided that competitive tendering is not applicable and should be waived, the reasons should be documented and reported by the CEO to the Executive Operational Sub-Committee and to the next available meeting of the Audit Committee
	CEO or Nominated Officer		7.33.2	Responsible for selecting quotations which gives the best quality and value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record
	CEO ECFO		7.33.3	Competitive quotations should be obtained. Where this is not possible and none of the reasons apply (under SO 9.6.1), the CEO and ECFO can waive this requirement. The decision needs to be reported to the Audit Committee
	CEO		7.33.4	Responsible for ensuring best value for money can be demonstrated for all services provided under contract or in-house
	CEO Board of Directors		7.33.5	Demonstrate that a PFI/Procure22 scheme represents value for money and genuinely transfers risk to the private sector
	Board of Directors		7.33.6	Approve PFI/Procure22 proposal
	CEO Nominated Officer		7.33.7	Endeavour to obtain best value for money in relation to contracts
			7.33.8	CEO will nominate an officer to oversee and manage each contract on behalf of the Trust
			7.33.9	CEO will nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts
			7.33.10	Competitive tendering or quotation procedures will not apply to the disposal of any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				pre-determined in a reserve) by the CEO or nominated officer
	Evaluation Panel		7.33.11	Make a recommendation to the Executive Operational Sub-Committee and/or Board of Directors in relation to in-house services and in accordance with the DSoD
12. Custody of Seal and Sealing of Documents	Trust Secretary CEO ECFO	7.34	7.34.1	Keep the common seal of the Trust in a secure place and maintain a register of sealing
	CEO ECFO		7.34.2	Authorise the fixing of the Trust Seal to documents
	CEO ECFO Executive Directors (not within the originating directorate)		7.34.3	Approve and sign all building, engineering, property or capital documents
	Board of Directors		7.34.4	Receive a report of all sealings at least quarterly
13. Signature of Documents	CEO or Nominated Executive Director	7.35	7.35.1	Approve and sign all documents which will be necessary in legal proceedings involving the Trust, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to another executive director for the purpose of such proceedings
			7.35.2	Sign where authorised by resolution of the Board on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub- committee or standing committee with delegated authority
14. Standing Orders	CEO	7.36	7.36.1	Ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs
14.4. Dispute Resolution	SID	7.37	7.37.1	Make all reasonable efforts to mediate a settlement to a dispute that involves the Chair

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	Trust Secretary		7.37.2	Deal with any membership queries and other similar questions including any voting or legislation issues in the first instance
15. Council of Governors	Board of Directors	7.38	7.38.1	Present to the Council at a general meeting the annual accounts, any report of the auditor on them, and the annual report
			7.38.2	Explain in the annual report their responsibility for preparing the annual report and accounts and the approach to quality governance
			7.38.3	Comply with Annual Reporting Manual including stating they consider the annual report and accounts as fair, balanced and understandable and provide the necessary information so that the Trust's performance, business model and strategy can be assessed; as well as approach to quality governance.
	External Auditor		7.38.4	Statement about reporting responsibilities
	Audit Committee		7.38.5	Agree with the Council the criteria for appointing, reappointing and/or removing external auditors

8.0 SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFI'S)

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
1.1.2	Audit Committee	8.1	8.1.1	Approval of all Trust wide financial procedures and financial control procedures
1.1.3	ECFO	8.2	8.2.1	Advice on interpretation or application of SFIs
1.1.5	Board of Directors Staff	8.3	8.3.1	Disclosure of non-compliance with SFIs as soon as possible to the ECFO; ECFO to report to the Audit Committee
1.3.3	CEO	8.4	8.4.1	Responsible as the accounting officer to ensure financial targets and obligations are met and have overall responsibility for the system of internal control.

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
1.3.4	CEO ECFO	8.5	8.5.1 Accountable for financial control but will, as far as possible, delegate their detailed responsibilities
1.3.5	CEO	8.6	8.6.1 To ensure systems and processes in place so that all Board members, officers and employees, present and future, are notified of and understand SFIs
1.3.6	ECFO	8.7	Responsible for: 8.7.1 Implementing the Trust's financial policies and co-ordinating corrective action 8.7.2 Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented 8.7.3 Ensuring that sufficient records are maintained to explain Trust's transactions and financial position 8.7.4 Providing financial advice to members of Board and staff 8.7.5 Design, implement and supervise systems of internal financial control 8.7.6 Maintaining such accounts, working papers, etc., as are required for the auditors to carry out their statutory duties
1.3.7	All Board Members & Employees	8.8	8.8.1 Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions, and Financial Procedures. and Schemes of Delegation
1.3.8	CEO	8.9	8.9.1 Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply
2.1.1	Audit Committee	8.10	8.10.1 Provide independent and objective view on Governance and assurance processes and arrangements
2.1.2	Board of Directors	8.11	8.11.1 Members of the Audit Committee have recent and relevant financial experience or have appropriate training

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
2.1.3	Audit Committee	8.12	8.12.1	Assess the work and fees of external audit on an annual basis to ensure that the work is of a high standard and that fees are reasonable
2.1.4	Audit Committee	8.13	8.13.1	Recommend to the Council of Governors re: the appointment/re-appointment of external auditors
2.1.5	Chair of Audit Committee	8.14	8.14.1	Where there is evidence of ultra vires transactions, improper acts and other important matters these should be raised at Board Meetings. Exceptionally, refer to Monitor any matters of concern, having raised it with the Chief Executive Accounting Officer and Executive Chief Finance Officer
2.1.6 2.2.1	ECFO	8.15	8.15.1	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed)
2.2.1	ECFO	8.16	8.16.1	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption, in consultation with Local Counter Fraud Specialist
2.3.1	Chief Internal Auditor	8.17	8.17.1	Review, appraise and report in accordance with best practice
2.3.1 2.3.2	Chief Internal Auditor	8.18	8.18.1 8.18.2	Produce an annual audit opinion on the effectiveness of the systems of internal control Raise with the ECFO immediately any matter which involves or thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity
2.3.3	Chief Internal Auditor	8.19	8.19.1	Attend audit committee meetings
2.3.4	Chief Internal Auditor	8.20	8.20.1	Report directly to the ECFO and refer audit reports to Auditees as appropriate
2.3.6 2.3.12	ECFO	8.21	8.21.1	Provide Internal Auditors and External Auditors with information
2.3.7	Council of Governors	8.22	8.22.1	Appoint external auditors

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
2.3.9	Audit Committee	8.23	8.23.1	Ensure external auditors appointed by the Council meet the criteria set by Monitor) NHSE/I
2.3.13	ECFO	8.24	8.24.1	Forward to (Monitor) NHSE/I within 30 days any public Interest report issued by auditors
2.4	CEO ECFO	8.25	8.25.1	(Monitor) NHSE/I and ensure compliance with on fraud and corruption including the appointment of the Local Counter Fraud Specialist
2.5	CEO	8.26	8.26.1	(Monitor) NHSE/I and ensure compliance with best practice on NHS security management, including the appointment of the Local Security Management Specialist
3.12	CEO	8.27	8.27.1	Compile and submit to the Board an Operational Plan which takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans and in the format specified by (Monitor) NHSE/I. The annual business plan will contain: • a statement of the significant assumptions on which the plan is based • details of major changes in workload, delivery of services or resources required to achieve the plan • and have due regard to the views of the Council, including confirmation by the Council that they are satisfied that any activities undertaken by the Trust for non-primary purposes will not to any significant extent interfere with the fulfilment of their principle purpose or other functions
3.13 3.14	ECFO	8.28	8.28.1 8.28.2	Submit budgets to the Board for approval Monitor performance against budget, submit to the Board financial estimates and forecasts
3.1.6	ECFO	8.29	8.29.1	Ensure adequate training is delivered on an on-going basis to budget holders

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
3.1.7	Board of Directors	8.30	8.30.1 Take appropriate action to manage and overcome any potential operational deficit and decide on the appropriate use of any forecast operational surplus
3.2.1	CEO	8.31	8.31.1 Delegate budget to budget holders
3.2.2	CEO Budget Holders	8.32	8.32.1 Must not exceed the budgetary total or virement limits set by the Board
3.3.1	ECFO	8.33	8.33.1 Devise and maintain systems of budgetary control and reporting
3.3.2	Budget Holders	8.34	Ensure that: 8.34.1 no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board 8.34.2 approved budget is not used for any other than specified purpose subject to rules of virement no permanent employees are appointed in excess of available resources as approved by Board or Director without the approval of the CEO 8.34.3 ensure that there is compliance with the system of budgetary control established by the ECFO 8.34.4 budgetary virements between divisions are only undertaken in line with the Detailed Scheme of Delegation 8.34.5 budgetary virements between commissioning contracts should not be undertaken
3.3.3	CEO	8.35	8.35.1 Identify and implement cost improvements and income generation activities in line with the Operational Plan
3.5.1	CEO	8.36	Submit to (Monitor) NHSE/I, as per the Oversight Framework: 8.36.1 financial performance measures have been defined and are monitored 8.36.2 reasonable targets have been identified for these measures 8.36.3 a robust system is in place for managing performance against targets 8.36.4 reporting lines are in place to ensure overall performance is managed

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			8.36.5 arrangements are in place to manage/respond to adverse performance 8.36.6 relevant financial information is submitted to the statutory authorities and other relevant organisations (e.g. STP's).
4.1	ECFO	8.37	8.37.1 Preparation of annual accounts.
5.1.1	ECFO	8.38	8.38.1 Managing banking arrangements, including provision of banking services, financing, working capital facilities, reporting on accounts and working capital facilities, operation of accounts, preparation of instructions for operating accounts and list of cheque signatories
5.1.2	Board of Directors	8.39	8.39.1 Approve banking arrangements, financing and working capital facilities
5.4	ECFO	8.40	8.40.1 Commercial banking arrangements reviewed at regular intervals
6.	ECFO	8.41	8.41.1 Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash
6.2.2	All Employees	8.42	8.42.1 Duty to inform ECFO of money due from transactions which they initiate/deal with
6.5	ECFO	8.43	8.43.1 Monitoring and reporting to the Board of Directors that the Trust is complying with its obligation under the Health and Social Care Act 2012 that the total income derived from its principal purpose is greater than its total income from the provision of goods and services for 'any other purpose' and seeking Council of Governors approval when it is proposed to increase by 5% or more the proportion of income received from non-primary purposes
7.1 7.2	CEO	8.44	8.44.1 Ensure the Trust enters into suitable Legally Binding Contracts (LBC) with service commissioners for the provision of NHS services, devised to minimise risk
7.4	CEO Directors holding	8.45	8.45.1 Ensure that regular reports are provided to the Board detailing actual performance against signed LBCs

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
	portfolios of Finance, Integrated Clinical Services and Contracting			
7.5	ECFO	8.46	8.46.1	Maintain a public and up-to-date schedule of Commissioner Requested Services as required by the Trust's Terms of Authorisation
8.1.1	Board of Directors	8.47	8.47.1	Establish a NEDs' Remuneration Committee for EDs
8.1.3	Board Remuneration and Nomination Committee	8.48	8.48.1	Report in writing to the Board of Directors its advice and its bases about remuneration and terms of service of directors
8.2.1	CEO delegated to Executive Directors	8.49	8.49.1	Approval of variation to funded establishment of any department
8.2.2	CEO delegated to Executive Directors	8.50	8.50.1	Appointment of staff, including agency staff
8.3.1 8.3.2	CEO delegated to Executive Directors	8.51	Payroll: 8.51.1 8.51.2 8.51.3 8.51.4 8.51.5	 specifying timetables for submission of properly authorised time records and other notifications final determination of pay and allowances making payments on agreed dates agreeing method of payment issuing instructions (as listed in SFI 8.3.2)
8.3.3	Nominated Managers*	8.52	8.52.1 8.52.2 8.52.3	Submit time records in line with timetable Complete time records and other notifications in required form Submitting termination forms in prescribed form and on time
8.3.4	ECFO	8.53	8.53.1	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies
8.4	Executive Director with Portfolio of People	8.54	8.54.1	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
	Management Nominated Managers*			which complies with employment legislation
			8.54.2	Deal with variations to, or termination of, contracts of employment
8.5	ECFO	8.55	8.55.1	Issue instructions to staff regarding procedures to be followed when payments are to be made to individuals who are not employees of the Trust
9.1	CEO	8.56	8.56.1	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. (Please see attached Detailed Scheme of Delegation)
9.1.3	CEO	8.57	8.57.1	Set out procedures on the seeking of professional advice regarding the supply of goods and services
9.2.1	Requisitioners*	8.58	8.58.1	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought
9.2.3	ECFO	8.59	8.59.1	Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed
			8.59.2	Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds
			8.59.3	Be responsible for the prompt payment of all properly authorised accounts and claims
			8.59.4	Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable
			8.59.5	A timetable and system for submission to the ECFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			payment 8.59.6 Instructions to employees regarding the handling and payment of accounts within the Finance Department 8.59.7 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
9.2.4	Appropriate Executive Director ECFO Budget Holder	8.60	8.60.1 Make a written case to support the need for a prepayment 8.60.2 Approve proposed prepayment arrangements 8.60.3 Ensure that all items due under a prepayment contract are received (and immediately inform ECFO if problems are encountered)
9.2.5	CEO	8.61	8.61.1 Authorise who may use and be issued with official orders.
9.2.6	Managers Officers	8.62	8.62.1 Ensure that they comply fully with the guidance and limits specified by the ECFO
9.2.7	CEO ECFO	8.63	8.63.1 Ensure that Standing Orders are compatible with Department of Health requirements re building and engineering contracts. 8.63.2 Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with any relevant guidance published by the Department of Health and / or NHSE/I. The technical audit of these contracts shall be the responsibility of the relevant Director.
10.1	ECFO	8.64	8.64.1 Trust's cash flow management
10.2	ECFO	8.65	External borrowing: 8.65.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The ECFO is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest 8.65.2 Any application for new borrowing will only be made by the ECFO or by an officer so delegated by him/her

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			8.65.3 The ECFO will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by (Monitor) NHSE/I 8.65.4 Assets supporting Commissioner Requested Services shall not be used as collateral for borrowing. Non Commissioner Requested assets will be eligible as security for a loan
10.3	ECFO	8.66	Investments 8.66.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by (Monitor) NHSE/I 8.66.2 The ECFO is responsible for advising the Board on investment strategy and shall report periodically to the Board concerning the performance of investments held 8.66.3 The ECFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained as specified in the Trust Operating Cash Management Policy
11.1.1 11.1.2	CEO	8.67	Capital investment programme: 8.67.1 ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans 8.67.2 responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost 8.67.3 ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences 8.67.4 ensure that a business case is produced for each proposal in line with limits approved by the Board of Directors
11.1.2	ECFO	8.68	8.68.1 Certify professionally the costs and revenue consequences detailed in the business case for capital investment

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
11.1.3	CEO ECFO	8.69	8.69.1	Issue procedures for management of contracts involving stage payments
	ECFO		8.69.2	Assess the requirement for the operation of the construction industry taxation deduction scheme
			8.69.3	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure
11.1.4	Executive Operational Committee CEO ECFO Finance & Performance Committee Capital Projects Program Group (CPPG)	8.70	8.70.1	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Approval will be granted in line with limits in detailed scheme of delegation.
11.1.5	ECFO	8.71	8.71.1	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes
11.2 11.3	ECFO	8.72	8.72.1	If required, demonstrate that the use of private finance/Procure 22 represents value for money
	Board of Directors		8.72.2	Proposal to use PFI/Procure 22 must be specifically agreed by the Board
11.4.1	CEO	8.73	8.73.1	Maintenance of asset registers (on advice from ECFO)
11.4.4	ECFO	8.74	8.74.1	Responsibility for ensuring that commissioner requested property is not disposed (unless agreed with main commissioner and informed to (Monitor) NHSE/I)
11.4.5	ECFO	8.75	8.75.1	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
11.4.9	ECFO	8.76	8.76,1	Calculate capital charges in accordance with Monitor requirements.
11.4.10	Board of Directors	8.77	8.77.1	Approve the use of non-commissioner requested assets for the

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				development of services
11.5.1	CEO	8.78	8.78.1	Overall responsibility for fixed assets
11.5.2	ECFO	8.79	8.79.1	Approval of fixed asset control procedures
11.5.4	All Senior Staff	8.80	8.80.1	Responsibility for security of Trust assets including notifying discrepancies to ECFO, and reporting losses in accordance with Trust procedure
12.2	CEO	8.81	8.81.1	Delegate overall responsibility for control of stores (subject to ECFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Please see attached Detailed Scheme of Delegation)
	ECFO		8.81.2	Responsible for systems of control over stores and receipt of goods
	Designated Pharmaceutical Officer		8.81.3	Responsible for controls of pharmaceutical stocks
	Designated Estates Officer		8.81.4	Responsible for control of stocks of fuel oil and coal
12.3	Nominated Officers*	8.82	8.82.1	Security arrangements and custody of keys
12.4	ECFO	8.83	8.83.1	Set out procedures and systems to regulate the stores
12.5	ECFO	8.84	8.84.1	Agree stocktaking arrangements
12.6	ECFO	8.85	8.85.1	Approve alternative arrangements where a complete system of stores control is not justified
12.7	ECFO	8.86	8.86.1	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items
	Nominated Officers*		8.86.2	Operate system for slow moving and obsolete stock, and report to ECFO evidence of significant overstocking
12.8	CEO	8.87	8.87.1	Identify persons authorised to requisition and accept goods from NHS Supplies
13.1.1	ECFO	6.88	8.88.1	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
13.2.1	ECFO	6.89	8.89.1	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft
13.2.2	All Staff	6.90	8.90.1	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CEO and ECFO
	ECFO		8.90.2	Where a criminal offence is suspected ECFO must inform the police if theft or arson is involved, following consultation with LSMS. In cases of fraud and corruption ECFO must inform the relevant Operational Fraud Team in line with SoS directions and consult with the Counter Fraud Specialist where appropriate.
13.2.3	ECFO	6.91	8.91.1	Notify NHS Protect and External Audit of all frauds
13.2.4	ECFO	6.92	8.92.1	Unless trivial, notify Board of Directors, Local Security Management Specialist & External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness
13.2.5	Board of Directors	6.93	8.93.1	Approve write off of losses (within limits delegated by Trust)
13.2.7	ECFO	6.94	8.94.1	Consider whether any insurance claim can be made
13.2.8	ECFO	6.95	8.95.1	Maintain losses and special payments register
14.1	Executive Director with Portfolio of Information & IT	6.96	8.96.1	Responsible for accuracy and security of computerised data
14.2	ECFO in conjunction with Executive Director with Portfolio of Information & IT	6.97	8.97.1	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation
14.3	Relevant Officers	6.98	8.98.1	Send proposals for general computer systems to ED with portfolio of IT
14.4 14.5	Executive Director with Portfolio of Information &	6.99	6.99.1	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
	IT		responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review 6.99.2 Seek periodic assurances from the provider that adequate controls are in operation
14.6	Executive Director with Portfolio of Information & IT	6.100	Where computer systems have an impact on corporate financial systems satisfy themselves that: 6.100.1 systems acquisition, development and maintenance are in line with corporate policies 6.100.2 data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists 6.100.3 ECFO and staff have access to such data 6.100.4 Such computer audit reviews are being carried out as are considered necessary
15.2	CEO	6.101	6.101.1 Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
15.3	ECFO	8.102	8.102.1 Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients
15.6	Departmental Managers	8.103	8.103.1 Inform staff of their responsibilities and duties for the administration of the property of patients
16.5	ECFO	8.104	8.104.1 Primary responsibility to the Board of Directors for Charitable Funds as Financial Trustee
17.2	CEO	8.105	8.105.1 Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
17,3	Trust Secretary	8.106	8.106.1 Review Register of Interests on an annual basis to link in with disclosures of annual report

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
18.1	CEO	8.107	8.107.1	Maintaining archives for all documents required to be returned
19.1	CEO	8.108	8.108.1	Risk management programme
	Boards of Directors		8.108.2	Approve and monitor risk management programme
19.3	Board of Directors	8.109	8.109.1	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self- insure should be reviewed annually
19.4	ECFO	8.110	8.110.1	Consult NHS Resolution in case of doubt as to the power to use commercial insurers
19.6	Director with Portfolio of Insurance & Risk Management ECFO	8.111	8.111.1	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution, the Director holding the portfolio of Insurance and Risk Management shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ECFO shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the ECFO shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The ECFO will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed
19.7	ECFO	8.112	8.112.1	Ensure documented procedures cover management of claims and payments below the excess amount (currently £10K for LTPS and £3K for PES claims) as defined by NHSR
20.1	CEO	8.113	8.113.1	Ensure there are processes in place to oversee the management of new business development and income generation opportunities, and ensuring compliance with the Terms of Authorisation, Risk

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				Assessment Framework and available best practice guidance
20.2	Board of Directors	8.114	8.114.1	Ensure there is a governance framework in place to scrutinise and consider new initiatives as necessary
20.3	Council of Governors	8.115	8.115.1	Ensure involvement in the approval process of all 'significant transactions' as per Monitors definition in the Risk Assessment Framework, any transactions in excess of £10m and a significant overall risk rating based on the Trust's risk management framework
20.5	Strategy & Planning Committee	8.116	8.116.1	Consideration of investment, initiatives or opportunities where a change to the Trust's corporate structure is required or potential significant risk

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Detailed Scheme of Delegation document.

9.0 MAJOR INCIDENT PLAN

In the event of a Business Continuity, Critical or Major Incident being declared leading to the activation of the Major Incident Plan (RM14) a Major Incident Response Team (MIRT) will be established consisting of a Gold Command. Delegated powers will be given to the Gold Commander who will be the CEO or Deputy CEO.

END

DETAILED SCHEME OF DELEGATION

POLICY NUMBER:	FP11
VERSION NUMBER:	6
AUTHOR:	Head of Financial Accounts
CONSULTATION GROUPS:	Audit Committee
IMPLEMENTATION DATE:	April 2017
AMENDMENT DATE(S):	September 2020
LAST REVIEW DATE:	April 2017, September 2018, November 2018, September 2019, September 2020, September 2021, September 2022
NEXT REVIEW DATE:	September 2023
APPROVAL BY AUDIT COMMITTEE:	September 2022
RATIFICATION BY BoD:	September 2022

POLICY SUMMARY
THIS DOCUMENT PROVIDES A BUSINESS AND FINANCIAL FRAMEWORK WITHIN WHICH ALL OFFICERS OF THE TRUST ARE EXPECTED TO WORK. THIS DOCUMENT SHOULD BE READ IN CONJUNCTION WITH THE TRUST'S CONSTITUTION, STANDING FINANCIAL INSTRUCTIONS, SCHEME OF DELEGATIONS AND SUPPORTING FINANCE PROCEDURES. FAILURE TO COMPLY CAN RESULT IN DISCIPLINARY ACTION.
The Trust monitors the implementation of an compliance with this policy in the following ways:
INTERNAL AUDIT WORKPLAN EXTERNAL AUDIT WORKPLAN LOCAL COUNTER FRAUD SPECIALIST AUDIT COMMITTEE

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DETAILED SCHEME OF DELEGATION

BM	Budget Managers
HoE	Head of Estates / Property Management
CE	Chief Executive
ECFO	Executive Chief Finance Officer
DoF	Director of Finance
HoFM	Head of Financial Management
HoFA	Head of Financial Accounts
DHoFA	Deputy Head of Financial Accounts
HoP	Head of Purchasing
AD	Assistant / Deputy Directors or direct report to a Director
Dir	Director / Senior Director (but not a formal member of the BoD)
ED	Executive Director
EoC	Executive Operational Committee
BoD	Board of Directors
FPC	Finance and Performance Committee
CPPG	Capital Projects Programme Group

The above titles may change as restructures are undertaken. Equivalent job titles may need to apply in terms of the authority being delegated and where this is uncertain, approval from the finance department should be sought.

In the event that staff to which authority has been delegated are absent, then approval / authority reverts to line manager or equivalent (and related) post.

All limits quoted are assumed to include VAT irrespective of whether this is reclaimable or not.

		AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.1	**MANAGEMENT OF BUDGETS (PAY, NON PAY AND INCOME) IN LINE WITH GOVERNANCE MANUAL**		
a	At individual budget level	BM	SFI Section 3 / FP03-01 Budgetary Control
b	At service level	AD, Dir or ED	
c	For the totality of services covered by the Assistant Director (or equivalent) or Service Director	Dir, ED or CE	
d	For all other areas (including, but not limited to, utility bills, phone bills, inter-NHS invoices, lease car invoices, which may be charged to a delegated budget or control account.	DoF / HoFM / HoFA / DHoFA	
e	Approval of authorised signatory forms (revenue or capital)	AD / Director / ED	
f	Approving expenditure (revenue or capital) up to an increase of 10% on the tender price or £20k whichever is the lower.	Director	
g	Approving expenditure as above, but up to a maximum of £100k.	ED	
h	Approving expenditure as above, but over £100k	BoD	
2.1	**NON-PAY REVENUE AND CAPITAL EXPENDITURE – REQUISITIONING, ORDERING AND PAYMENTS OF GOODS AND SERVICES (INCLUDING STAND-ALONE SYSTEMS EG, NHS SUPPLY CHAIN AND OFFICE DEPOT)**		
	Requisitions / invoices must not be raised in such a way to bypass financial limits stated in the Governance Manual.		

DETAILED SCHEMEOF DELEGATION

a	i)	Up to an individuals authorised signatory limit but not exceeding £4,999	Other Authorised Staff	SFI Section 9 / FP01-03 Requisitioning of Goods and Services
	ii)	Requisitions / invoices up to £9,999	Budget Manager	
	iii)	Requisitions / invoices up to £24,999 or up to individuals authorisation limit (whichever is lowest)	Assistant Director	
	iv)	All requisitions / invoices from £25,000 to £49,999	Director / ED	
	v)	All requisitions / invoices from £50,000 to £99,999	Executive Director	
	vi)	All requisitions / invoices from £100,000 to £249,999	CFO or CE	
	vii)	All requisitions / invoices from £250,000 to £999,999	CFO and CE	
	viii)	All requisitions / invoices over £1 million with exception of agreed exemptions:	Reserved for Board and verification against Register of Interest	
		• All payroll related transactions including HMRC, pensions and deductions via payroll provider / direct engagement supplier	DoF / HoFA / HoFM / DHoFA	
		• All NHS and independent sector transactions relating to the East of England provider collaborative arrangements	CFO and CE	
	ix)	Placing official orders on receipt of a signed valid requisition up to £249,999	HoP	
	x)	Placing official orders on receipt of a signed valid requisition over £250,000	HoP and CE / ECFO / DoF / HoFM / HoFA	
b				

	Non-pay expenditure in excess of allocated resources and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a).	Dir, ED or CE	
2.2	**BUDGET VIREMENTS**		
	a **Virements within a cost centre / directorate**		SFI Section 3 / FP03-01 Budgetary Control
	i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	
	ii) Within pay / non-pay lines above £100,000 and all transfers between pay and non-pay lines	Dir or ED	
	b **Virements between directorates**		
	i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	
	ii) Within pay / non-pay lines above £100,000 and all transfers between pay and non-pay lines	Dir or ED	
3.1	**CAPITAL EXPENDITURE**		
	a Approval of the release of funds to individual capital schemes and ability to vire between capital allocations,		SFI Section 11
	i) Up to £100,000	CPPG (with noting to FPC)	
	i) Up to £999,999	CE or ECFO (with noting to FPC)	
	ii) Over £1,000,000	FPC FPC	

b	Approval of any new capital allocations not included in Operational Plan, and any requests which exceed total capital allocated in Operational Plan		
c	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations.	Director for Estates / HoE	
d	Financial monitoring and reporting on all capital scheme expenditure.	ECFO / DoF	
3.2	**LEASES / LICENSES / PFI**		
a	Extension of existing or new leasesfor equipment and other assets, where there is a pre-negotiated framework agreement lease and no Right of Use Asset arising (eg photocopier)	As per 2.1	FP05-01 Leasing Procedure
b	Termination of lease relating to pre-negotiated framework agreement lease and no right of use asset	BH in conjunction with Purchasing Department	
c	Extension of existing or new leases containing a Right of Use Asset (equipment or property) and with whole lease term revenue or capital impact of,		
	i) Up to £100,000	CPPG	
	ii) Up to £999,999	CE or ECFO	
	iii) Over £1,000,000	FPC	
d	Termination of lease containing a Right of Use Asset	CPPG	
e	Letting of premises to outside organisations	CPPG on recommendation of Director of Estates	

f Approval of rent based on professional assessment	CPPG on recommendation of Director of Estates	
g Preparation and signature of all tenancy agreements / licences for all staff subject to Trust Policy on accommodation to staff	HoE / Director of Estates	
h Capital and revenue variations to PFI contract	Limits as per 3a	
4 REQUIREMENTS FOR QUOTATION, TENDERING AND CONTRACT PROCEDURES FOR EXPENDITURE / INCOME PROPOSALS, WHETHER CAPITAL OR REVENUE, PURCHASES OR DISPOSALS		
In line with EU terms, limits are based on the value for the length of the contract. In the interest of ensuring that a wide range of contractors have the opportunity to submit competitive tenders, each competitive tender should, where possible, provide for the opportunity for at least one contractor to bid that has not tendered within the preceding 12 months. Contracts will be advertised on the 'Contract Finder' website in line with current DH limits. The use of framework agreements should be considered where appropriate. All quotes and Bid Request/Option Appraisal/FBC should be appended to order when raised. Goods / services must not be ordered in such a way as to bypass financial limits stated in the Governance Manual.		SFI Section 11 / Standing Orders Section 9
a Obtaining a minimum of 3 written quotations for all goods/services over £10,000 and up to £24,999.		
b Obtaining a minimum of **3 written quotations** for goods/services from £25,000 to £99,999 including a clear auditable selection process and Bid Request form recommended by CPPG where applicable		

c	i) Invite a minimum of 5 bidders (where available) to submit written competitive tenders for goods/services from £100,000 to £999,999 (in line with EU limits) and Options Appraisal form recommended by CPPG where applicable		
	ii) Invite a minimum of 5 bidders (where available) to submit competitive tenders for goods / services above £1,000,000 (in line with EU limits) and Full Business Case recommended by CPPG where applicable		
d	New business developments and Income Generation opportunities. The ability to approve tender submissions where;		SFI Section 20
	i) Annual Tender price up to £10m.	EOC	
	ii) Annual Tender price above £10m	BoD	
	iii) Annual Tender price on Sole Supplier cumulatively on a number of different projects above £10m.	BoD	
	iv) All transactions deemed to be significant in terms of a deminimus limit of £10m (per annum) and the Trusts risk management framework (and in addition to above delegated approval) require involvement of Council of Governors		
e	Approval of contract in reference to new business ventures	BoD	
5	**SETTING OF FEES AND CHARGES** (subject to 4e for new business / tender opportunities)		
a	Overseas visitors, income generation and other ad-hoc patient related services	ECFO and Operational ED's	SFI Section 6 and 7
b	Price of NHS Contract Charges for all NHS legally binding contracts be they block, cost per case, cost and volume or spare capacity	CE and ECFO	

6.1	**ENGAGEMENT OF STAFF NOT ON THE ESTABISHMENT**		
	a Booking of medical locums	Medical Director / Deputy Medical Director	HR40 Deployment of Temporary Workers Policy
	b Booking of nursing agency staff	Executive Nurse / ED Operations / Operational Directors	
	c Booking of AHP (including psychologists) and other clinical agency staff	ED Operations / Operational Directors	
	d Booking of all other agency staff	Corporate ED's / Directors	
	e Breaching of agency cap and thresholds	ED / On Call Director	
6.2	**ENGAGEMENT OF CONSULTANCY SERVICES CHARGEABLE (as defined by prevailing NHSE guidance and applicable to revenue expenditure only)**		
	a Up to £49,999 (including irrecoverable VAT and costs / expenses)	Dir / ED (and noting to Audit Committee)	
	b Over £50,000 (including irrecoverable VAT and costs / expenses)	NHSE via EOC using Consultancy Template (and noting to Audit Committee)	
7	**EXPENDITURE ON CHARITABLE AND ENDOWMENT FUNDS**		
	a Up to £5,000 per request or up to individuals charitable fund authorised limit	Fund Manager or nominated deputy	SFI Section 16 / FP09/03 Charitable Funds
	b Up to £5,000 per request	Fund / Service Director	

c	Up to £10,000 per request	Charitable Fund Committee	
d	Above £10,000 per request or above authorisation limit	BoD	
e	Overall financial management of Charitable Funds	Financial Trustee	
f	Overall management of Charitable Funds	BoD	
~~8~~	**~~AGREEMENT / LICENSES OF TRUST OWNED PROPERTIES~~**		
~~c~~	~~Approval of rent based on professional assessment~~	~~ECFO~~	
~~d~~	~~Preparation and signature of all tenancy agreements / licences for all staff subject to Trust Policy on accommodation to staff~~	~~HoE / Lead Director for Estates~~	
9	**CONDEMNING AND DISPOSAL**		
a	Items of equipment which are obsolete, obsolescent, redundant, irrepairable or cannot be repaired cost effectively:		SFI Section 13 / FP05/02 / RMPG13c
	i) Individual items not on the asset register	BM / Facilities	
	ii) Individual items on the asset register up to £10,000	DoF (& noting to Audit Committee)	
	iii) Individual items on the asset register up to £100,000	ECFO (& noting to Audit Committee)	
	iv) Individual items on the asset register above £100,000	Audit Committee (& noting to BoD)	
b	Land and buildings which are surplus to Trust requirements or held for sale		

		BoD (as detailed in Operational / Annual Plan)	
10	**DEBTOR WRITE OFFS / OTHER WRITE OFFS / LOSSES AND SPECIAL PAYMENTS**		
	a Up to £10,000 per item	DoF (& noting to Audit Committee)	SFI Section 13 / FP09/01
	b Between £10,000 and £99,999	ECFO (& noting to Audit Committee)	
	c Over £100,000 per item	Audit Committee (& noting to BoD)	
	d Special Severance Payments (irrespective of value)	HM Treasury	
	e Financial remedy to a complaint:		CPG2 (Appendix 2)
	i) A direct quantifiable loss of up to £50	Director	
	ii) A direct quantifiable loss of over £50 / All non-quantifiable losses	ECFO, NED & Lead Director for Complaints	
	iii) All financial remedies approved by the Ombudsman	Director / ED for relevant service	
11	**REPORTING OF INCIDENTS TO THE POLICE**		
	Where a criminal offence is suspected of a non-fraud nature	Dir / AD / Managers, ECFO, DoF or nominated deputy	SFI Sections 2 and 13
12	**PETTY CASH DISBURSEMENTS**		
	a Expenditure up to £100	Petty Cash Holder	

b Expenditure in excess of £100	Approval of CE / ECFO / DoF	
c Reimbursement of clients money	Welfare & Cashier Officer	
13.1 RECEIVING GIFTS		
a Gifts from current or potential suppliers / contractors:		
i) Low cost branded promotional items (eg pens / post-its) up the value of £6 can be accepted and do not need to be declared	All staff	
ii) Anything else should be declined whatever their value	All staff	
b Gifts from other sources (eg patients, families, service users):		
i) All cash and vouchers to individuals to be declined	All staff	
ii) Modest gifts of less than £50 can be accepted and need not be declared	All staff	
iii) Gifts over £50 can be accepted on behalf of the Trust (not by individual) with the approval of the Service Director and must be declared	Director & Declaration Form	
13.2 ACCEPTING HOSPITALITY		
a Meals and Refreshments:		
i) Under £25 can be accepted and need not be declared	All staff	
ii) Between £25 and £75 can be accepted and must be declared	All staff & Declaration Form	
iii) Over £75 are to be routinely declined	All staff	
Iv)	Director (in writing) & Declaration Form	

	In exceptional circumstances, over £75 can be accepted with the approval of the Service Director and must be declared		
b	Travel and Accommodation:		
i)	Modest offers related to attendance at events can be accepted and must be declared	All staff & Declaration Form	
ii)	In exceptional circumstances, other offers which go beyond modest or are of the type the Trust would not usually offer can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
13.3	**OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)**		
a	Outside employment	All staff & Declaration	
b	Shareholdings and other ownership issues	All staff & Declaration	
c	Patents / intellectual property rights	All staff & Declaration	
d	Loyalty interests	All staff & Declaration	
e	Accepting sponsorship	Director in conjunction with Trust Secretary	
f	Sponsored research	Research & Innovations Department	CPL19
g	Sponsored posts	HR Department	
h	Clinical private practice	All staff & Declaration	CP48 / CPG48
13.4	**DONATIONS TO EPUT CHARITY**		
a	From current / potential suppliers should be declined	All staff	Charitable Funds Policy & Procedure

	b In exceptional circumstances, such donations can be accepted with the approval of the Service Director and must be declared	Director & Declaration Form	
	c Other donations / legacies can be accepted	All staff	
13.5	**OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)**		
	At every stage of procurement, steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. Records will be kept that show a clear audit trail of how conflicts have been identified and managed. Conflicts of interest must be declared.	All staff & Declaration	CP8 / CPG8
14	**IMPLEMENTATION OF INTERNAL / EXTERNAL AUDIT AND LCFS RECOMMENDATIONS**	Directors	SFI Section 2
15	**MAINTENANCE AND UPDATE OF TRUST FINANCIAL PROCEDURES**		
	a Approval of finance policies and procedures	Audit Committee	
16	**INVESTMENT OF FUNDS**		
	a Investment of Exchequer Funds (day to day)	DoF	SFI Section 5
	b Investment of Charitable Funds	Charitable Funds Committee	SFI Section 16 / FP09/03a (appendix 1)
17	**PERSONNEL AND PAY**		SFI Section 8
	a **Additional Increments** The granting of additional increments to staff within budget	Director of HR / Remuneration Committee	HR57 / HRPG57
	b **Upgrading and Regrading**	ED for People and Culture	Job Matching and Evaluation Policy

		All requests for upgrading / regrading shall be dealt with in accordance with Trust Procedure and there shall be no provision beyond this for regrading of posts		and Procedure HR15 / HRPG15
c		**Establishments**		
	i)	Additional staff to the agreed establishment with specifically allocated finance	AD	
	ii)	Additional staff to the agreed establishment without specifically allocated finance	CE and ECFO	
d		**Pay**		
	i)	Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director for HR or nominated deputy / Directors / BM or Manager with delegated authority	
	ii)	Authority to complete and authorise positive reporting forms / finalise rotas in Health Roster	AD / Directors / BM or Manager with delegated authority	
	iii)	Authority to authorise overtime	AD / Directors / BM or Manager with delegated authority	
e		**Travel and Subsistence Expenses**		
	i)	Authority to approve up to three months following month in which expense was incurred	AD / BM or Manager with delegated authority	
	ii)	Authority to approve if over three months following month in which expense was incurred	ECFO and Director for HR (or nominated deputy)	

f		**Leave**		
	i)	Approval of annual leave	Line / Departmental Manager	
	ii)	Approval of carry forward of annual leave up to a maximum of 7 days	Line / Departmental Manager	
	iii)	Approval of carry forward of between 7 and 10 days of annual leave where there has been no long term absence in the yeas	Director of HR	
	iv)	Approval of carry forward of more than 10 days of annual leave where there has been no long term absence in the year	ED for People & Culture and ECFO	
	v)	Approval of carry forward of more than 7 days of annual leave where there has been absence due to maternity / long term sickness	Line Manager in accordance with Disability Act	Employee Wellbeing & Management of Sickness Absence (HR26 / HRPG26b), Maternity & Adoption, Paternity, Parental Leave & Shared Leave Procedure (HRPG24b)
	vi)	Compassionate leave (see HR Policy for limits)	Line / Departmental Manager	Leave Policy HR24 / Special Leave Procedure HRPG24c
	vii)	Special leave arrangements including paternity and carers leave (see HR Policy for limits)	Line / Departmental Manager Director	Special Leave Procedure HRPG24c

	viii)	Leave without pay		Special Leave Procedure HRPG24c
	ix)	Medical staff leave of absence	Medical Director / Deputy Medical Director & CE	
	x)	Time off in lieu	Approval in line with departmental guidance	
	xi)	Maternity leave – paid and unpaid	Automatic approval with guidance	Leave Policy HR24 / HRPG24b
g		**Sick Leave**		
	i)	Reinstatement of half pay in accordance with S14.9 of AfC terms and conditions of service	Director	Employee Wellbeing & Management of Sickness Absence Policy / Procedure HR26 / HRPG26b
	ii)	Return to work part time on full pay to assist recovery	Line Manager in accordance with Disability Act	
	iii)	Extension of sick leave on full pay or half pay in accordance with Section 14.12 of AfC terms and conditions	Director in conjunction with Head of Employee Relations and Executive Director	
h		**Extended Study Leave or Study Leave Outside the UK**		
	i)	Study leave outside the UK	Relevant Remuneration Committee & Workforce Development Approval Panel	Whitley Council / NHS T&Cs (AFC) & CE / Study Leave Policy HR18
	ii)	Medical staff study leave (UK)	Workforce Development Approval Panel	Trainee & Trust Grade Doctors

				Procedure HRPG18c
	iii)	All other study leave (UK)	Workforce Development Approval Panel	Study Leave Policy & Procedure HR18 / HRPG18a/b
	iv)	General study leave	Line Manager	
i		**Relocation Expenses**		
		Authorisation of payment of relocation expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		HR57 / HRPG57
	i)	Up to £8,000	Director	
	ii)	Over £8,000	CE	
j		**Grievance Procedure**		
		All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Senior HR Advisor must be sought when the grievance reaches the level of a Director.	Head of Employee Relations	HR2 / HRPG2a / HRPG2b
k		**Authorised Mobile Phone Users**		
	i)	Requests for new posts to be authorised as mobile telephone users	Director (plus Director for IT)	
l		**Renewal of Fixed Term Contract**	Line / Departmental Manager in accordance with Recruitment & Retention Policy (HR57)	HR57 / HRPG57
m		**Redundancy**		

			Director responsible for People Management & ET	Organisational Change Policy and Procedure HR1 / HRPG1a
	n	**Ill-Health Retirement** Decisions to pursue retirement on the grounds of ill-health	Line / Departmental Manager in accordance with Trust Procedure andin conjunction with Occupational Health and HR Department	HR26 / HRPG26b / HRPRG27a
	o	**Dismissal**	In accordance with Trust Procedure	HR1 / HR27 / HRPG27a/ HRPG27b/ HR26/ HRPG26b
18	**AUTHORISATION OF NEW DRUGS**			
	a	With additional implications of up to £4,999 per annum (compared with existing therapy)	Medicines Management Group	
	b	With additional implications of over £5,000 per annum (compared with existing therapy)	ET	
19	**AUTHORISATION OF SPONSORSHIP DEALS**			
	a	Authorisation of clinical sponsorship deals	CE, Medical Director, Medicines Management Group	CLP51
	b	Authorisation of other sponsorship deals	Director / ED / CE	
20	**AUTHORISATION OF RESEARCH PROJECTS**		Research Governance Group	

21	**AUTHORISATION OF CLINICAL TRIALS**	Research Governance Group	
22	**INSURANCE POLICIES AND RISK MANAGEMENT**	CE and ECFO	
23	**PATIENTS AND RELATIVES COMPLAINTS**		
a	Overall responsibility for ensuring that all complaints are dealt with effectively	Lead Director for Complaints	CP2
b	Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	AD	
c	Medico-legal complaints – co-ordination of their management	Lead Director for Clinical Negligence / Insurance	
24	**RELATIONSHIPS WITH PRESS**		
a	Non-emergency general enquiries		CP51
i)	Within hours	Head of Communications	
ii)	Outside hours	Director on Call	
b	Emergency enquiries		
i)	Within hours	Head of Communications	
ii)	Outside hours	Director on Call	
25	**INFECTIOUS DISEASES AND NOTIFIABLE OUTBREAKS**	Duty Officer / Director on Call / ED for Operations	

26	**EXTENDED ROLE ACTIVITIES**		
	Approval of nurses to undertaken duties / procedures which can properly be described as beyond the normal scope of Nursing Practice	CE, Medical Director and Executive Nurse	
27	**PATIENT SERVICES**		
	a Variation of operating and clinic sessions within existing numbers,		
	i) Outpatients	EDs in consultation with Medical Director	
	ii) Other	EDs in consultation with Medical Director	
28	**FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE**		
	Professional recognition, honorary contracts and insurance of medical staff	Director	
	Work experience students	Director	
29	**REVIEW OF FIRE PRECAUTIONS**	Fire Safety Officer	
30	**REVIEW OF ALL STATUTORY COMPLIANCE LEGISLATION AND HEALTH AND SAFETY REQUIREMENTS, INCLUDING CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH**	Health and Safety Manager	
31	**REVIEW MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AUTHORITY (MHRA) AND DRUG ALERTS ISSUED BY THE CENTRAL ALERTING SCHEME**	Chief Pharmacist / Accountable Officer for Controlled Drugs	
32	**REVIEW COMPLIANCE WITH ENVIRONMENTAL REGULATIONS (EG THOSE RELATING TO CLEAN AIR AND WASTE DISPOSAL)**	HoE and AD's	

33	**REVIEW OF TRUSTS COMPLIANCE WITH THE DATA PROTECTION AND FREEDOM OF INFORMATION ACTS**	Lead AD / Lead Director for Data Protection & FOI	
34	**MONITOR PROPOSALS FOR CONTRACTURAL ARRANGEMENTS BETWEEN THE TRUST AND OUTSIDE BODIES**	Lead Director for Contracting	
35	**REVIEW THE TRUSTS COMPLIANCE WITH ACCESS TO RECORDS ACT**	Lead Director for Information	
36	**REVIEW OF THE TRUSTS COMPLIANCE CODE OF PRACTICE FOR HANDLING CONFIDENTIAL INFORMATION IN THE CONTRACTING ENVIRONMENT AND THE COMPLIANCE WITH SAFE HAVEN PER EL(92)60**	Lead Director for Information	
37	**THE KEEPING OF A DECLARATION OF INTERESTS REGISTER**	Trust Secretary / ED	SO Section 6
38	**ATTESTATION OF SEALINGS IN ACCORDANCE WITH STANDING ORDERS AND USE OF SEAL**	Trust Chair & CE	SO Section 12
39	**THE KEEPING OF A REGISTER OF THE USE OF THE TRUST SEAL**	Trust Secretary	SO Section 12
40	**THE KEEPING OF THE HOSPITALITY REGISTER**	CE and Directors for their respective services	
41	**RETENTION OF RECORDS**	Lead Director for Information	SFI Section 18
42	**CLINICAL AUDIT**	Quality Committee	
43	**OPENING OF TENDERS**		SO Section 9
	a Responsibility for ensuring conflict of interest forms are completed	Contracts Department	
	b Responsibility for reviewing audit trail of current and closed tenders	Contracts Department	

44	**CARRY OUT DUTIES RELATING TO FRAUD AND CORRUPTION**	Local Counter Fraud Specialist / ECFO	
45	**AUTHORISING, MANAGING AND PROCESSING CLINICAL NEGLIGENCE AND INSURANCE CLAIMS**		
a	Day to day management of clinical negligence and insurance claims	Lead Director for Clinical Negligence / Insurance	
b	Authorisation of payments for clinical negligence and insurance claims,		
i)	Up to £10,000	Lead AD	
ii)	Up to £50,000	Lead Director for Clinical Negligence / Insurance	
iii)	Above £50,000	As per limits in section 2.1	
46	**LEASE / SALARY SACRIFICE CARS**		
a	Authority to designate posts eligible for lease cars involving a Trust contribution (Standard or Senior Manager schemes)	Director	
b	Requisitions and ordering of leased vehicles on receipt of authorisation from manager	DoF / HoFA / HoFM / DHoFA	
c	Payment of invoices and signing of contracts	DoF / HoFA / HoFM / DHoFA	
47	**LEGAL SERVICES**		
	Authority to engage any of the Trust's panel law firms	Persons authorised in legal protocol	

DETAILED SCHEMEOF DELEGATION

Essex Partnership University
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

POLICY REFERENCE NUMBER	FP10
VERSION NUMBER	5
KEY CHANGES FROM PREVIOUS VERSION	Not applicable
AUTHOR	Head of Financial Accounts
CONSULTATION GROUPS	Audit Committee Executive Operational Committee Senior Finance Staff
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	August 18 (GDPR), September 2018, September 2019, September 2020, September 2021, September 2022
LAST REVIEW DATE	September 2022
NEXT REVIEW DATE	September 2023
APPROVAL BY	Audit Committee
RATIFIED BY	Not applicable
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POLICY SUMMARY
THIS DOCUMENT PROVIDES A BUSINESS AND FINANCIAL FRAMEWORK WITHIN WHICH ALL OFFICERS OF THE TRUST ARE EXPECTED TO WORK. THIS DOCUMENT SHOULD BE READ IN CONJUNCTION WITH THE TRUST'S CONSTITUTION, SCHEDULE OF RESERVATION AND DELEGATION, DETAILED SCHEME OF DELEGATIONS AND SUPPORTING FINANCE PROCEDURES. FAILURE TO COMPLY CAN RESULT IN DISCIPLINARY ACTION.
The Trust monitors the implementation of an compliance with this policy in the following ways:
INTERNAL AUDIT WORKPLAN EXTERNAL AUDIT WORKPLAN LOCAL COUNTER FRAUD SPECIALIST AUDIT COMMITTEE

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

FOREWORD:

These Standing Financial Instructions (SFIs) together with the Essex Partnership University NHS Foundation Trust's (the NHSFT) Constitution, and Standing Orders, provide a business and financial framework within which all Executive Directors, Directors, Non-Executive Directors and officers of the NHS Foundation Trust will be expected to work. All Executive Directors, Non-Executive Directors, Directors and other members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These documents fulfil the dual role of protecting the interests of the NHSFT and protecting staff from any possible accusation that they have acted less than properly.

In addition to the Standing Orders and SFIs, there is a Detailed Scheme of Delegation, a Schedule of Reservation and Delegation, Finance Procedures and locally generated rules and instructions. Existing Finance Procedures, Procedure Notes and locally generated rules and instructions shall apply until these are revised (except where specifically overruled by these SFIs).

The SFIs have been formally adopted by the Board of Directors, and shall have effect as if incorporated in the standing orders.

Any queries regarding the contents of this document should in the first instance be raised with the Finance Business Partner responsible for your area.

Executive Chief Finance Officer
September 2022

1 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the NHSFT. They are designed to ensure that financial transactions are carried out in accordance with the law, Government policy and the requirements of NHS England (NHSE) in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders, Schedule of Reservation and Delegation and the Detailed Scheme of Delegation adopted by the Board of Directors.

1.1.2 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They are not intended to provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All Trust wide financial policies and procedures must first be reviewed by the Executive Team, ahead of formal approval by the Audit Committee on the recommendation of the Executive Chief Finance Officer.**

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Executive Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar and comply with the provisions of all associated documents.

1.1.4 FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER THAT COULD RESULT IN DISMISSAL.

1.1.5 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Chief Finance Officer at the earliest opportunity.

1.1.6 The NHSFT may be responsible for providing shared financial and other corporate services to other NHS organisations.

The specific services to be provided will be defined in legally binding contracts between the NHSFT and the receiving organisation. Where these contracts do not cover a specific matter, the NHSFT's Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation and Detailed Scheme of Delegation will take precedence.

1.1.7 The Trust has entered into collaborative arrangements in respect of the provision of core services. The specific arrangements will be defined in

legally binding contracts between all parties and where these contracts do not cover a specific matter, the Trusts Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation, and Detailed Scheme of Delegation will take precedence.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in Financial Directions made under the Acts shall have the same meaning in these instructions; and

(a) **"Accounting Officer"** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For the Trust, this is the Chief Executive;

(b) **"Board of Directors" or "Board"** means the Trust Chair, Executive and Non-Executive directors of the NHSFT collectively as a body in accordance with the constitution. This consists of both voting and non-voting members;

(c) **"Board Member"** means Executive or Non-Executive Director including the Trust Chair and Chief Executive.

(d) **"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the NHSFT;

(e) **"Budget Holder**" means the Director or employee with delegated authority to manage finances (including income, expenditure and capital where relevant) for a specific area of the organisation;

(f) "**Chairman / Chair of the Board / Trust Chair"** is the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the NHSFT as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or otherwise unavailable;

(g) **"Chief Executive"** is the person appointed as the Chief Executive officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution;

(h) **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the NHSFT within available resources;

(i) **"Committee"** means a committee appointed by the Board of Directors;

(j) **"Constitution"** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act;

(k) **"Council of Governors"** or **"Council"** means the Council of Governors of the NHSFT as described in paragraphs 14 and 18 the constitution;

(l) **"Deputy Chief Executive"** means the Officer of the Trust nominated by the Chief Executive to act as their Deputy;

(m) **"Director"** means a Director (as appointed by a Senior Director or an Executive Director) of a service who does not hold Executive Director status, and therefore is not a member of the Board of Directors.

(n) **"Executive Chief Finance Officer"** means the chief financial officer of the Trust;

(o) **"Executive Director"** means a member of the Board of Directors who holds an executive office of the NHSFT;

(p) **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable;

(q) **"Legal Adviser"** means the properly qualified person or legal firm appointed by the NHSFT to provide legal advice;

(s) **"NHSE"** means the office or an officer of NHS England

(t) **"Nominated Officer"** means an officer charged with the responsibility of discharging specific tasks under the Scheme of Reservation and Delegation;

(u) **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the NHSFT and is appointed by the Council of Governors;

(v) **"NHS Act"** means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

(w) **"NHSFT" or "Corporation"** means the Essex Partnership University NHS Foundation Trust constituted as a public benefit corporation in accordance with the National Health Service Act 2006;

(x) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust. This also includes employees of third parties contracted and seconded from other organisations when acting on behalf of the NHSFT;

(y) **"Principle Purpose"** means the delivery of goods and services for the purposes of the health service in England, as per Section 164 of the Health and Social Care Act 2012;

(z) **"Senior Director"** means a Director (as appointed by an Executive Director) of a service who does not hold Executive Director status, and therefore is not a member of the Board of Directors.

(aa) **.**

1.2.2 Wherever the title Chief Executive, Executive Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them or act on their behalf.

1.2.3 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Schedule of Reservation and Delegation.

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Schedule of Reservation and Delegation adopted by the Board of Directors.

1.3.3 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accounting Officer accountable to Parliament, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Trust Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.4 The Chief Executive and the Executive Chief Finance Officer will delegate specific responsibilities, but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that systems and processes are in place so that the Board of Directors and other employees are notified and understand their responsibilities within these Instructions.

1.3.6 The Executive Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

(d) advising the Board of Directors regarding the financial performance, legality and vitality of the Trust

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Chief Finance Officer include:

(e) the provision of financial advice to other members of the Board of Directors and employees;

(f) the design, implementation and supervision of systems of internal financial control; and

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the NHSFT may require for the purpose of carrying out its statutory duties.

1.3.7 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the NHSFT;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Finance Procedures and the Schemes of Delegation.

1.3.8 Any contractor or employee of a contractor who is empowered by the NHSFT to commit the NHSFT to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Executive Chief Finance Officer.

2 AUDIT

2.1 AUDIT COMMITTEE

The National Health Service Act 2006 specifies that auditors of NHSFTs shall comply with the directions of Monitor under paragraph 24 (5) of Schedule 1 to the Act with respect to the standards, procedures and techniques to be adopted.

2.1.1 In accordance with Standing Orders (and as set out in the National Health Service Act 2006) the Board of Directors shall formally establish an Audit Committee, comprising of Non-Executive Directors, with clearly defined formal terms of reference. The role of the Audit Committee will be to provide an independent and objective review of governance and assurance processes and arrangements.

2.1.2 The Board of Directors shall satisfy itself that the Chairman and members of the Audit Committee have recent and relevant financial experience or have appropriate training.

2.1.3 The Audit Committee must assess the work and fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable.

2.1.4 The Audit Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the external auditors. If the work has been satisfactory and the charges reasonable, the Council of Governors may re-appoint the auditors for the following year without the need for a formal selection process. However, in line with National Audit Office Audit Code and the Local Audit and Accountability Act 2014 (LAAA), the NHSFT will undertake a market-testing exercise for the appointment of the external auditors at least once every 5 years.

2.1.5 Where the Audit Committee considers there is evidence of ultra vires transactions, improper acts, or other important matters that the committee feel it is justified to escalate, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS England having been raised with the Executive Chief Finance Officer and Accounting Officer.

2.1.6 The Executive Chief Finance Officer, Audit Committee and Trust Governor shall be involved in the selection process when/if an audit service provider is changed.

2.2 EXECUTIVE CHIEF FINANCE OFFICER

2.2.1 The Executive Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the purpose, authority and responsibility of internal audit is formally defined by the NSHFT in the Terms of Engagement with regard to professional best practice;

(c) deciding at what stage to involve the police in cases of misappropriation, in consultation with the Violence and Abuse Prevention and Reduction Advisor(VAPR), and other irregularities not involving fraud or corruption. Where fraud and corruption is suspected and in consultation with the Local Counter Fraud Specialist, any irregularities should be investigated as appropriate.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear opinion on the effectiveness of internal financial control, risk management and organisational controls;
(ii) major internal control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

(e) Ensuring that the Chief Internal Auditor delivers an annual audit opinion on the effectiveness of the system of internal control.

2.2.2 The Executive Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the NHSFT;

(c) the production of any cash, stores or other property of the NHSFT under a member of the Board and employee's control; and

(d) explanations concerning any matter under investigation.

2.3 AUDIT

(A) ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will, in accordance with recognised professional best practice and as included in the agreed plan for the year, review, appraise and report upon:

(a) the extent to which the achievement of the NHSFTs objectives are monitored;

(b) the extent of compliance with, and the financial effect of risk associated with, relevant established policies, plans and procedures;

(c) the adequacy, efficiency and application of financial and other related management controls;

(d) the suitability and effective usage of financial and other related management data;

(e) the extent to which the NHSFT's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

(f) Internal Audit will produce an annual audit opinion on the effectiveness of the systems of internal control

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Chief Finance Officer must be notified immediately. (See also SFI 13 – Disposals and Condemnations, Losses and Special Payments).

2.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the NHSFT.

2.3.4 The Chief Internal Auditor shall report directly to the Executive Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take the necessary remedial action within a reasonable period shall be reported to the Executive Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit the Chief Internal Auditor shall have access to report directly to the Audit Committee.

2.3.5 The Chief Internal Auditor shall co-ordinate internal audit plans and activities with line managers of the function being audited, external audit and other review agencies to ensure the most effective audit coverage is achieved and publication of effort is minimised.

2.3.6 The NHSFT will provide the Chief Internal Auditor with every facility and information which is reasonably required for the purposes of the functions under the terms of engagement.

(B) EXTERNAL AUDIT:

2.3.7 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors (also refer to 2.1.4 above).

2.3.8 The initial appointment must be made as soon as possible and no later than the end of the first period for which the NHSFT will be preparing accounts.

2.3.9 The NHSFT must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the NAO Code of Audit Practice and the Local Audit and Accountability Act 2014 (LAAA).

2.3.10 The external audit responsibilities (in compliance with the requirements of DHSC and NHS England) are as follows:

1. to assess if they are satisfied that the accounts comply with the directions provided including compliance with the NHS Foundation Trust Annual Reporting Manual and the DH Group Accounting Manual (where relevant)
2. to assess if they are satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts
3. to assess if they are satisfied that proper practices have been observed in compiling the accounts
4. to assess if they are satisfied the quality report has been prepared in accordance with the detailed guidance issued by NHSE
5. to assess if they are satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources and to provide commentary in line with the reporting criteria stated in the Code of Audit Practice 2020
6. to comply with any directions given by NHSE as to the standards, procedures and techniques to be adopted, i.e. to comply with the NAO Code of Audit Practice and LAAA 2014.
7. to consider the issue of a public interest report
8. to certify the completion of the audit
9. to express an opinion on the accounts
10. to refer the matter to NHSE if the NHSFT, or an officer or Board Director of the NHSFT, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.
11. to read the monthly / quarterly reports required under NHS Oversight Framework, the quality report, annual report and comparing the information to ensure there are no material inconsistences;
12. to review reports arising from Care Quality Commission planned and responsive reviews of the NHSFT and any consequent action plans developed by the NHSFT.

2.3.11 External auditors will ensure that there is a minimum of duplication of effort between themselves and relevant regulators. The auditors will discharge this responsibility by:

1. reviewing the statement made by the Chief Executive as part of the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the NHSFT
2. reviewing the results of the work of relevant assurors, for example the Care Quality Commission, to determine if the results of the work have an impact on their responsibilities
3. undertake any other work that they feel necessary to discharge their responsibilities

2.3.12 The NHSFT will provide the external auditor with every facility and all information which they may reasonably require for the purposes of their functions under Part 1 of the 2006 Act

2.3.13 The NHSFT shall forward a report to NHSE within 30 days (or such shorter period as may be specified) of the external auditor issuing a public interest report in terms of Schedule 5 paragraph 3 of the Act. The report shall include details of the NHSFT's response to the issues raised within the public interest report.

2.4 FRAUD, BRIBERY AND CORRUPTION

2.4.1 In line with their responsibilities, the Trust's Chief Executive and Executive Chief Finance Officer shall monitor and ensure compliance with best practice on prevention of fraud, bribery and corruption.

2.4.2 The Executive Chief Finance Officer shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust's Executive Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

2.4.4 The Executive Chief Finance Officer is responsible for providing detailed procedures to enable the NHSFT to minimise and where possible, eliminate fraud and corruption. These procedures are included in the NHSFT's Fraud and Bribery Policy which sets out action to be taken by persons detecting a suspected fraud and responsibilities for investigating it.

2.4.5 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the NHSFT is accountable to, through:

1. encouraging prevention;
2. promoting detection; and,
3. ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

2.4.6 Proven instances of fraud, theft and corruption shall normally be dealt with as gross misconduct under the NHSFT's disciplinary policies and procedures.

2.4.7 It is expected that all officers shall act with utmost integrity, ensuring adherence to all relevant regulations and procedures. This responsibility has been delegated to the Executive Chief Finance Officer who will produce and issue these to the appropriate Directors and managers who should in turn ensure that all staff have access to these.

2.4.8 The Executive Director for People and Culture is responsible for ensuring that steps are taken at recruitment stage to establish, as far as possible, the previous record of potential officers in terms of their propriety and integrity.

2.4.9 Staff are expected to act in accordance with the NHSFT's Standing Orders, Standing Financial Instructions and the Standards of Conduct (outlined in HRPG27a Appendix 2).

2.4.10 The Bribery Act 2010 replaced the "Prevention of Corruption Acts 1906 and 1916" with new corporate and individual offences of bribery. The Executive Chief Finance Officer is responsible for ensuring that all staff and contractors are made aware of the Act and implementing procedures designed to ensure compliance with the Act by the Trust and staff. Any breach of the Act may result in criminal proceedings being commenced.

2.4.11 Non-Executive Directors are subject to the same standards of accountability and are required to declare and register any interest which might potentially conflict with those of the NHSFT.

2.4.12 The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls, and evaluate the implication of fraud on the system of risk management, control and governance, reported to the Audit Committee.

2.4.13 Staff employed by the NHSFT are encouraged to raise any concerns they may have regarding suspected fraud and/or corruption (Please refer to the Fraud and Bribery Policy and the NHSFT's Raising Concerns (Whistle Blowing) Policy). They can do this through:

1. their line manager;
2. Internal Audit;
3. the Executive Chief Finance Officer;
4. The NHSFT's Local Counter Fraud Specialist; or,
5. the NHS National Fraud Hotline.

2.4.14 Any abuse of the procedures, such as unfounded or malicious allegations, will also be subject to full investigation and appropriate disciplinary action where appropriate.

2.5 SECURITY MANAGEMENT

2.5.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with best practice on NHS security management.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Violence and Abuse Prevention and Reduction Advisor (VAPR) as specified by the Secretary of State for Health guidance on NHS security management.

2.5.3 The Trust shall consider the need for a nomination of a Non-Executive Director to be responsible to the Board for NHS security management.

2.5.4 The Trust shall prepare a Security Policy that sets out measures to protect staff, visitors, premises and assets.

2.5.5 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Executive Director with the lead for Security Management and the appointed Violence and Abuse Prevention and Reduction Advisor (VAPR).

3 ANNUAL PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 PREPARATION AND APPROVAL OF ANNUAL PLANS AND BUDGETS

3.1.2 The Chief Executive will compile and submit to the Board of Directors an Operational Plan in a format prescribed by NHSE which takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans. The Operational Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan;

(c) and, have due regard to the views of the Council of Governors, including confirmation by the Council of Governors that they are satisfied that any activities undertaken by the NHSFT for non-primary purposes will not to any significant extent, interfere with the fulfilment of their principle purpose or other functions.

3.1.3 Prior to the start of the financial year the Executive Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets to the Finance and Performance Committee, ahead of formal Board of Directors approval. These budgets may subsequently be amended as a result of the preparation of the Operational Plan, and any such changes should be reported to the Board at the earliest opportunity. Such budgets will:

(a) include income, revenue operational expenditure and capital expenditure which will:

(i) be in accordance with the aims and objectives set out in the Operational Plan;
(ii) accord with workload and manpower plans;
(iii) align with the wider system financial plan.

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the limits of available funds; and

(d) identify potential risks, and mitigating strategies.

3.1.4 The Executive Chief Finance Officer shall monitor financial performance against budget and the operational plan, including activity, workforce and other targets. These shall be periodically reviewed, and reported to the Finance and Performance Committee, ahead of assurance being provided to the Board of Directors at every ordinary meeting of the Board.

3.1.5 All budget holders must provide information as required by the Executive Chief Finance Officer to enable budgets, plans, estimates and forecasts to be compiled.

3.1.6 The Executive Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage resources successfully.

3.1.7 The Board of Directors must take appropriate action to manage and overcome, where possible, any potential operational deficit and decide on the appropriate use of any forecast operational surplus.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and will normally form part of individual job descriptions. Through the annual budget setting and approval process, budget holders will be set:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Executive Chief Finance Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) Detailed monthly financial reports to the Executive Operational Committee and Finance and Performance Committee, and monthly financial assurance reports to the Board of Directors. Finance reports to the Executive Operational Committee and Finance and Performance Committee will be in a format agreed with the Executive Chief Finance Officer and may include the following:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) summary cash flow and forecast year-end position;

(iii) capital project spend, projected outturn against plan and fixed asset disposals;
(iv) explanations of any material variances that explain any movement from the plan at the end of the current month position;
(v) performance against NHSE monitoring ratings currently in force;
(vi) Any changes to key financial assumptions underpinning the operational and strategic plans;
(vii) The use of working capital facilities and the management of working capital (if applicable);
(viii) Key balance sheet performance including cash, debtors and creditors:
(x) Details of any corrective action where necessary and the Chief Executive's and/or Executive Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed in excess of available resources as approved by the Board of Directors, without the approval of the Chief Executive and,

(d) ensuring compliance with the systems of budgetary control established by the Executive Chief Finance Officer.

(e) budgetary virements are only undertaken in line with the Detailed Scheme of Delegation

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operational Plan and the Strategic Plan as authorised by the Board of Directors.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 11.)

3.5 FINANCIAL PERFORMANCE AND MONITORING:

3.5.1 The Chief Executive is responsible for ensuring that:

1. financial performance measures have been defined and are monitored;
2. reasonable targets have been identified for these measures;
3. a robust system is in place for managing performance against targets;
4. reporting lines are in place to ensure overall performance is managed;
5. arrangements are in place to manage/respond to adverse performance; and,
6. relevant financial information is submitted to the statutory authorities and other relevant organisations (eg NHSE and ICB's).

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Executive Chief Finance Officer, on behalf of the NHSFT, will:

(a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSE may, with the approval of the Treasury direct;

(b) ensure that, in preparing annual accounts, the NHSFT complies with any directions given by NHSE with the approval of the Treasury as to:

1. the methods and principles according to which the accounts are to be prepared; and
2. the information to be given in the accounts.

(c) ensure that a copy of the annual accounts and annual report and any report of the external auditor on them, are laid before Parliament and that copies of these documents are sent to NHSE as required in the Annual Reporting Manual for Foundation Trusts.

4.2 The NHSFT will prepare a combined annual report and accounts as required by paragraph 26 of Schedule 1 of the Act. This will be presented to the Board of Directors for approval and received by the Council of Governors at a public meeting. A copy will be forwarded to NHSE. The report will give:

(a) Information on any steps taken by the NHSFT to ensure (taken as a whole) the actual membership of its public constituency is representative of those eligible for such membership;
(b) Information explaining the impact of any non-primary purpose income on the delivery of goods and services for their principle purpose (i.e. the delivery of goods and services for purposes of health services in England); and
(c) Any other information required by NHSE.

5 BANK ACCOUNTS – ALSO REFER TO SFI 10: EXTERNAL BORROWING AND INVESTMENTS.

5.1 GENERAL

5.1.1 The Executive Chief Finance Officer is responsible for managing the NHSFT's banking arrangements and for advising the NHSFT on the provision of banking services, operation of accounts, financing and working capital facilities.

5.1.2 The Board of Directors shall approve the banking arrangements, financing and working capital facilities.

5.2 BANK ACCOUNTS AND WORKING CAPITAL FACILITIES

5.2.1 The Executive Chief Finance Officer is responsible for:

(a) bank accounts, financing and working capital facilities;

(b) establishing separate bank accounts for the NHSFT's non-exchequer funds;

(c) reporting to the Board of Directors when working capital facilities are committed, liquidity headroom calculations, details of potential drawdown's and when accounts are overdrawn;

5.3 BANKING PROCEDURES

5.3.1 The Executive Chief Finance Officer will prepare detailed instructions on the operation of bank accounts that must include:

(a) the conditions under which each bank account is to be operated;
(b) those authorised to sign cheques or other orders drawn on the NHSFT's accounts and limitations on single signatory payments; and
(c) the committed working capital facility (where relevant) approved by the Board of Directors to be operated under the terms and conditions agreed with the bank and approved by the Board of Directors;

5.3.2 The Executive Chief Finance Officer must advise the NHSFT's bankers in writing of the conditions under which each account will be operated.

5.3.3 All funds shall be held in accounts in the name of the NHSFT. No officer other than the Executive Chief Finance Officer shall open any bank account in the name of the NHSFT.

5.4 TENDERING AND REVIEW

5.4.1 The commercial banking arrangements of the Trust should be reviewed at regular intervals by the Executive Chief Finance Officer to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business, where appropriate.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Executive Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The Executive Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Executive Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in-kind such as subsidised goods or loans of equipment) is considered, the NHSFT's policies on these matters shall be followed.

6.2.2 In receiving cash payments, the Trust should adhere to the maximum value for a single transaction as specified in the Money Laundering Regulations.

6.2.3 All employees must inform the Executive Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Executive Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Executive Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of

safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the NHSFT.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor “IOUs.”

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Chief Finance Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the NHSFT is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the NHSFT from responsibility for any loss. A senior officer within each area responsible for holding cash, in discussion with the finance department, should ensure there are suitably secure arrangements in place to minimise the risk of loss.

6.5 INCOME FROM NON-PRINCIPAL PURPOSES

6.5.1 The Executive Chief Finance Officer is responsible for monitoring and reporting to the Board of Directors that the NHSFT is complying with its obligation under that the Health and Social Care Act 2012 that the total income derived from its principal purpose (i.e. the delivery of goods and services for the purposes of the health service in England) is greater than its total income from the provision of goods and services for "any other purposes" including the provision of private healthcare.

6.5.2 The Executive Chief Finance Officer is responsible for ensuring that the approval of the Council of Governors is obtained when it is proposed to increase by 5% or more the proportion of income derived from the provision of goods and services for non-primary purposes.

7 CONTRACTS WITH COMMISSIONERS:

7.1 The Chief Executive supported by the Executive Directors holding the portfolios of Finance, Operational Services and Contracting, are responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the Operational and Strategic Plans.

7.2 Contracts with commissioners shall be devised to minimise risk. The contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract should be considered.

7.3 In carrying out these functions, the following should be taken into account:

1. activity (e.g. bed days, attendances, etc. attached to the legally binding contracts);
2. payment terms and conditions;
3. billing systems and cash flow management;
4. any other matters of a financial nature;
5. the contract negotiation process and timetable;
6. the provision of contract data;
7. monitoring arrangements;
8. amendments to contracts;
9. discretion to use spare capacity; and
10. any other matter relating to contracts such as joint responsibility for the delivery and achievement of CIPs, QIPPs etc.
11. any requirements of the NHS Constitution.

7.4 Regular reports detailing actual performance against signed contracts should be provided to the Board of Directors by the Directors holding the portfolios of Finance and Performance.

7.5 As required by the NHSFT's Terms of Authorisation, the NHSFT will maintain a public and up-to-date schedule of Commissioner Requested Services.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

8.1 REMUNERATION AND TERMS OF SERVICE

8.1.1 In accordance with Standing Orders, the Board of Directors shall establish a Remuneration Committee for Executive Directors with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will:

a) advise the Board of Directors of their decisions in relation to the remuneration and terms of service for the Chief Executive and Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms;

b) monitor and evaluate the performance of the Chief Executive and Executive Directors

8.2 STAFF APPOINTMENTS

8.2.1 No Executive Director or employee may engage, or re-engage employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

8.2.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees covered under the national Agenda for Change pay rates.

8.3 PROCESSING PAYROLL

8.3.1 The Executive Director for People and Culture , together with support from the Executive Chief Finance Officer where appropriate, is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.3.2 The Executive Director for People and Culture , together with support from the Executive Chief Finance Officer where appropriate, will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque (by exception) or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the NHSFT.

8.3.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the relevant Executive Directors instructions and in the form prescribed by the Executive Director for People and Culture ; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement.

(d) Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Head of Employee Relations must be informed immediately.

8.3.4 Regardless of the arrangements for providing the payroll service, the Executive Director for People and Culture shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4 CONTRACTS OF EMPLOYMENT

8.4.1 The Board of Directors shall delegate responsibility to the Executive Director for People and Culture for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

8.5 PAYMENTS TO INDIVIDUALS WHO ARE NOT EMPLOYEES OF THE TRUST

8.5.1 The Executive Chief Finance Officer is responsible for issuing instructions to managers concerning:

(a) Making payments of agency invoices
(b) Making payments to self-employed individuals

(c) Making payments to limited companies
(d) Additional compliance requirements to be followed in assessing the employment status of individuals who are not employees of the Trust.

9 NON PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum approval value for each manager and the system for authorisation above that level; and

(c) delegate approval for establishing new or amending existing authorised signatories (via associated processes / forms) to the relevant Assistant Director, Director or Executive Director.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the NHSFT. In so doing, the advice of the NHSFT's adviser on supply shall be sought, and policies and procedures on procurement are to be followed at all times. Where this advice is not acceptable to the requisitioner, the Executive Chief Finance Officer (and/or the Chief Executive) shall be consulted.

9.2.2 The Executive Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

9.2.3 The Executive Chief Finance Officer will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions (where not already provided in the Detailed Scheme of Delegation or procedure notes for budget holders)

on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees authorised to certify invoices

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment;

- VAT is appropriately accounted for.

(iii) A timetable and system for submission to the Executive Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Where material (and not agreed under the terms of the contract or licensing arrangements), prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages i.e. cashflows must be discounted to NPV using the base rate specified by the Executive Chief Finance Officer.-

(b) the appropriate Executive Director must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the NHSFT if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(c) the Executive Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Executive Chief Finance Officer;

(c) state the NHSFT's terms and conditions of trade; and

(d) only be issued to, used by or electronic access granted, to those duly authorised by the Chief Executive,

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Executive Chief Finance Officer and that:

(a) all contracts (other than for a simple purchase permitted within the Detailed Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are actioned as per the NHSFT's procedures on Losses;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement and comply with the

latest Public Sector Procurement Directives. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(c) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) hospitality as per the Trust's policy

(d) no requisition/order is placed for any item or items which cannot be accommodated within total available resources;

(e) all goods, services, or works are ordered on an official order except those detailed on the 'PO Exceptions List' which is maintained by the Purchasing Department. This includes for example: purchases from petty cash, agency payments for staff and utility invoices where it is deemed that alternative control mechanisms are in place. The Executive Chief Finance Officer or their nominated Deputy should review the 'PO Exceptions List' on an annual basis and ensure, where possible, these are minimised;

(f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Executive Chief Finance Officer;

(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Chief Finance Officer ; and

(k) petty cash records are maintained in a form as determined by the Executive Chief Finance Officer.

9.2.7 The Chief Executive and Executive Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

10 EXTERNAL BORROWING AND INVESTMENTS

10.1 The Executive Chief Finance Officer will be responsible for the management of the NHSFT's cashflow.

10.2 EXTERNAL BORROWING

10.2.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the NHSFT's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The Executive Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest.

10.2.3 Any application for new borrowing will only be made by the Executive Chief Finance Officer or by an officer so delegated by them. The Board of Directors is required to approve the acceptance of all external borrowing agreements.

10.2.4 The Executive Chief Finance Officer will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by Monitor.

10.2.5 Assets supporting Commissioner Requested Services (CRS) shall not be used as collateral for borrowing. Non-Commissioner Requested assets will be eligible as security for a loan.

10.3 INVESTMENTS

10.3.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by NHSE in accordance with the NHSFT's Operating Cash Management Policy.

10.3.2 The Executive Chief Finance Officer is responsible for advising the Board of Directors on investment strategy and shall report periodically to the Board of Directors concerning the performance of investments held.

10.3.3 The Executive Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained as specified in the NHSFT Operating Cash Management Policy.

11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The Chief Executive, supported by the Executive Chief Finance Officer:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is prepared in accordance with the detailed scheme of delegation issued by the Chief Executive on the advice of the Executive Chief Finance Officer and approved by the Board of Directors. Where the financial value outlined in the detailed scheme of delegation is met, the Chief Executive supported by the Executive Chief Finance Officer shall ensure that a business case) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(b) that the Executive Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and where required is submitted to the Board of Directors in accordance with the detailed scheme of delegation;

(c) business cases requiring legal and tax expertise have been subjected to appraisal by the NHSFTs legal and tax advisor or the most appropriate legal and tax advice obtained.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Executive Chief Finance Officer will ensure there are processes in place for their management.

The Executive Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Executive Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.4 The approval of a detailed capital programme by the Finance and Performance Committee and Board of Directors at the start of the financial year shall constitute approval for the initiation of expenditure on any scheme, subject to any further approvals required by the Digital Strategy Group (for ICT schemes) and associated governance being undertaken. Any new bids made in year or requests to vire money between schemes, need to be presented to the Capital Projects Programme Group and approved in line with the detailed scheme of delegation.

11.1.5 The Executive Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 PRIVATE FINANCE

11.2.1 The Trust may test for PFI when considering capital procurement. When the Trust proposes to use finance that is to be provided other than through its contracts, the following procedures shall apply:

(a) The Executive Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board.

11.3 PROCURE 22

11.3.1 NHS ProCure 22 has been developed by the Department of Health with the objective of promoting better capital procurement in the NHS.

11.3.2 The Trust may consider P22 as a possible procurement route when considering building projects above the amount specified in the detailed scheme of delegation.

11.3.3 When the Board proposed, or is required, to use the P22 procurement route, the following should apply:

(a) The Chief Executive and Executive Chief Finance Officer shall demonstrate that the use of P22 represents the best combination of value for money, project delivery time, and build quality, when compared with alternative procurement routes.

(b) The proposal must be specifically agreed by the Board.

The selection of a Principle Supply Chairman Partner (PSCP) must be carried out in accordance with Department of Health guidelines

11.4 ASSET REGISTERS

11.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.4.2 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets falling within the boundaries of IFRS16 and to be capitalised.

11.4.3 The NHSFT must not dispose of any property that supports a Commissioner Requested Service (CRS) without the agreement of the Trust's main commissioner and notification to NHSE, where notice has been given in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. This includes the disposal of part of the property or granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.4.4 The Executive Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in the statement of financial position against balances on fixed asset registers.

11.4.5 All land and buildings should undergo an interim revaluation every third year, and a formal revaluation every five years, in accordance with HM Treasury guidance. Investment properties are revalued on an annual basis.

11.4.6 The value of each asset shall be depreciated using agreed methods and asset lives.

11.4.7 The Executive Chief Finance Officer of the Trust shall calculate and charge capital charges in the form of depreciation and PDC dividends, to the Trust's expenditure budget each month. The Executive Chief Finance Officer shall ensure PDC dividends are paid to HM Treasury in accordance with guidance.

11.4.8 The Board of Directors may approve the disposal of non-CRS assets to raise funds for the development of services.

11.5 SECURITY OF ASSETS

11.5.1 The overall control of fixed assets is the responsibility of the Chief Executive, as advised by the Executive Chief Finance Officer for the accounting aspects and for the physical management and control

11.5.2 Asset control procedures must be approved by the Executive Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to / approved by the Director of Finance or Executive Chief Finance Officer and noted to / approved by the Audit Committee as per the Detailed Scheme of Delegation.

11.5.4 Whilst each employee and officer has a responsibility for the security of property of the NHSFT, it is the responsibility of the Board of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to the property of the NHSFT as may be determined by

the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5 Any damage to the NHSFT's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.5.6 Where practical, assets should be marked as NHSFT property.

12 STORES AND RECEIPT OF GOODS

12.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2 Subject to the responsibility of the Executive Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to employees by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees, subject to such delegation being entered in a record available and approved by the Chief Executive and the Executive Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer

12.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

12.4 The Executive Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.5 Stocktaking arrangements shall be agreed with the Executive Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Chief Finance Officer.

12.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Executive Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Executive Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.8 For goods supplied via NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

13 DISPOSALS, CONDEMNING, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNING

13.1.1 The Executive Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemning, and ensure that these are notified to managers. The NHSFT must not dispose of CRS property without the approval of the Trust's commissioners and without informing NHSE, if NHSE has given notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. These procedures shall comply with all appropriate Standing Orders and SFI's in addition to the requirements specified in the NHSFTs Policies and Procedures manual.

13.1.2 When it is decided to dispose of an NHSFT asset, the head of department or authorised deputy will determine and advise the Executive Chief Finance Officer of the estimated market value of the item, taking account of professional advice valuations where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Executive Chief Finance Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Chief Finance Officer.

13.1.4 Officers shall satisfy themselves as to whether or not to condemn, where evidence of negligence and shall report such evidence to the Executive Chief Finance Officer who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Executive Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Executive Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Executive Chief Finance Officer must immediately inform the

police, following consultation with the Violence and Abuse Prevention and Reduction Advisor (VAPR), if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Chief Finance Officer must inform the Local Counter Fraud Specialist.

13.2.3 The Executive Chief Finance Officer must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

13.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Chief Finance Officer must immediately notify:

(a) the Board of Directors

(b) the Local Security Management Specialist; and

(c) the External Auditor.

13.2.5 The approval of the writing-off of losses is as per the limits set out in the detailed scheme of delegation.

13.2.6 The Executive Chief Finance Officer shall be authorised to take any necessary steps to safeguard the NHSFT's interests in bankruptcies and company liquidations.

13.2.7 For any loss, the Executive Chief Finance Officer should consider whether any insurance claim could be made.

13.2.8 The Executive Chief Finance Officer shall maintain a Losses and Special Payments Register.

14 INFORMATION TECHNOLOGY

14.1 The Executive Director with the portfolio for ITT, and who is responsible for the accuracy and security of the computerised data of the NHSFT, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the NHSFT's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation 2016;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system (including those obtained by external agency arrangements) and that such computer audit reviews as they may consider necessary are being carried out.

14.2 The Executive Chief Finance Officer, in conjunction with the ITT department, shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible NHS bodies, directors and employees will send to the Executive Director with the portfolio for ITT:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.4 The Executive Director with the portfolio for ITT shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the

security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.5 Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director with the portfolio for ITT shall periodically seek assurances that adequate controls are in operation.

14.6 Where computer systems have an impact on corporate financial systems the Executive Chief Finance Officer, shall satisfy themselves that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) finance staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

15 PATIENTS' PROPERTY

15.1 The NHSFT has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Executive Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.4 The NHSFT will maintain a separate account for patients' money, which will be opened and operated under arrangements agreed by the Executive Chief Finance Officer. Any income relating to patients money which may temporarily be included within exchequer funds, will be reconciled and reported separately on a regular basis.

15.5 In all cases where property of a deceased patient is of a total value in excess of £10,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £10,000 or less, forms of indemnity shall be obtained.

15.6 Staff should be informed, on appointment, by the appropriate senior manager of their responsibilities and duties for the administration of the property of patients.

15.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16 FUNDS HELD ON TRUST (CHARITABLE FUNDS)

16.1 Standing Orders state the NHSFT'S responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the NHSFT, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust.

16.2 The Schedule of Reservation and Delegation and the Detailed Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom.

16.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

16.4 The over-riding principle is that the integrity of each fund must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.5 The Board of Directors hereby nominates the Executive Chief Finance Officer to have primary responsibility to the Board of Directors for ensuring that Funds Held On Trust (Charitable Funds) are administered in line with our Standing Orders, Charity Commission guidance and other statutory provisions. The Executive Chief Finance Officer will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of all Trust Funds for the discharge of the Board of Directors responsibilities as Corporate Trustees.

17 ACCEPTANCE OF GIFTS BY STAFF AND DECLARATIONS OF INTEREST

17.1 The acceptance of gifts, hospitality or consideration of any kind from contractors or other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The NHSFT's standards of business conduct guidance, (copy available from the Executive Chief Finance Officer), must be followed, and the Chief Executive notified immediately so that appropriate action can be taken.

17.2 The Executive Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff.

17.3 The Trust Secretary should review the Register of Interests for the Trust on an annual basis to tie in with the disclosures within the annual accounts.

17.4 The Register of Interests should also be referred to, prior to any major contracts in excess of £500,000 being awarded.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive, and the relevant Executive Director, shall be responsible for maintaining archives for all documents required to be retained.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

19 INSURANCE AND RISK MANAGEMENT

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured; and

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing the Annual Governance Statement within the Annual Report and Accounts.

19.3 The Board of Directors shall decide if the NHSFT will insure through the risk pooling schemes administered by NHS Resolution (formerly the NHS Litigation Authority) or self insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decide not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.4 The Executive Chief Finance Officer is required to consider and make proposals to the Board of Directors regarding insurance. In addition, the Executive Chief Finance Officer will consider the use of top-up building insurance to the NHS Resolution risk pooling scheme where appropriate.

19.5 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Executive Directors holding the portfolios of Insurance and Risk Management shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The

Executive Chief Finance Officer shall ensure that documented procedures cover these arrangements.

19.6 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Executive Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Executive Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

19.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Executive Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. NEW BUSINESS / INCOME OPPORTUNITIES

20.1 The Chief Executive will ensure that there are processes in place to oversee the management of New Business Development and Income Generation opportunities. Such processes must ensure compliance with the Trust's terms of authorisation and adherence to NHS Oversight Framework and mandatory reporting requirements. The Trust's processes will also adhere to best pratice guidance including Risk Evaluation for Investment Decisions (REID) or any subsequent guidance that may be issued by NHSI.

20.2 The Board of Directors will ensure there is a governance framework in place to scrutinise and consider any new iniatitives which contain one or more of the following characteristics:

- an equity component;
- significant reputational risk;
- potential to destabilise the Trust's core business;
- the inclusion of material contingent liabilities.

20.3 In the event a 'significant transaction' is being considered, then the Council of Governors also need to be involved in the approval process. The term 'significant transaction' is as per NHS definition detailed in the Oversight Framework, plus any other transaction in excess of a £10 million threshold and which has an overall risk rating (based on the Trust's risk management framework) which in the reasonable opinion of the Board of Directors, is considered to be significant.

20.4 The Finance and Performance Committee shall be chaired by a Non-Executive Director and comprise both Executive and Non-Executive Directors. The remit of this Committee will include:

- to establish the overall methodology, processes and controls of the Trust's investments and marketing initiatives/opportunities;
- to ensure that robust processes are followed;
- to ensure that Council of Governors approval has been obtained for any investment that would increase the proportion of income from non-principle purposes by 5% or more;
- to evaluate, scrutinise and monitor significant investments and marketing initiatives / opportunities.
- to ensure appropriate safeguards are in place for the investment of exchequer funds and review treasury management activities and performance.

20.5 The committee will also be responsible for consideration of investments or marketing initiatives / opportunities:

- where a change to the Trust's corporate structure is required (for example establishment of subsidiary vehicle);
- there is potential significant risk associated with the project in accordance with REID or established best practice guidelines.

20.6 The initial evaluation of any initial marketing opportunities and to engage in any tender processes may be delegated by the Board of Directors to the Executive Operational Committee, and / or the Finance and Performance Committee in accordance with approved limits.

20.7 Approval of new contracts in relation to new business opportunities will be the responsibility of the Board of Directors unless delegated to the Executive Operational Committee within approved limits.

		Agenda Item No: 10c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 September 2022**

Report Title:	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2022					
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:	HSSC, EOT, Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2022-23 completion of which is a requirement for all NHS organisations.	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Trust Board of Directors are asked to:

- Ratify approval of the Emergency Preparedness, Resilience and Response national core standards self-assessment 2022-23 for EPUT

Summary of Key Issues

The NHS England / Improvement NHSE/I 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 NHSE/I. Following submission a core standards peer review confirm and challenge meeting is held, at which there is an opportunity to revise submission.

On 1st August 2022, the Trust received communication from the regional EPRR team at NHSE/I (East) informing the Trust of the newly published national EPRR core standards and the process for the national annual assurance process for 2022. All organisations were required to submit completed self-assessments by 9th September 2022.

It should be noted that there is a requirement for organisational submissions to be approved by Boards of Directors, however to meet the submission timescale of 9th September 2022 the Quality Committee was asked to approve on behalf of the Trust Board of Directors. Ratification of approval is sought from the Trust Board of Directors and any changes requested by the Board will be made and resubmitted before the EPUT Core Standards Peer Review on 6th October 2022.

The Standards are split into two sections, the main EPRR Core Standards and a Deep Dive which changes each year. For 2022 the deep dive is in relation to 'Shelter & Evacuation'. It should be noted that there are an additional 20 standards within the Core Standards compared to 2021.

The following process was used in the Trust for completing 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 Associate Director of Risk and Compliance
3. Review and challenge of self-assessment by extraordinary Health Safety and Security Committee (HSSC)
4. Review of Self Assessment by Executive Operational Team
5. Self-Assessment approved by Quality Committee on behalf of the Trust Board of Directors

Following the self-assessment process 51 out of the 55 EPRR Core Standards have been assessed as compliant, with 4 being 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 full self-assessment is attached as appendix 1.

The following standards were assessed as partially met:

- Std 15 Mass Casualty – Trust policy requires to be strengthened to fully meet the Standard. Policy has been revised and will be presented to HSSC for approval in September.
- Std 16 and Deep Dive: Evacuation and Shelter - Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy, this has been completed and will be presented to HSSC for approval in September.
- Std 24: Responder Trainer - It was agreed by HSSC that this cannot be assessed as compliant due to the current lack of available training. The EPRR Team envisage that once Region identify what training is available, this will be undertaken as a priority.
- Std 26: Incident Co-Ordination Centre (ICC) - New ICC SOP has been developed and this will be presented to HSSC for approval in September.

As part of the national process, the next step following submission of the Core Standards is for the Trust to attend a "confirm and challenge" meeting with the Regional EPRR team. This is scheduled to take place in October 2022, date to be arranged. At this meeting, the Trust will be required to present the evidence available to demonstrate compliance with standards and to agree the final overall rating as a result. If NHSE/I do not agree with the Trust self-assessment an action plan will be required to be put in place and submitted to NHSE/I and

the Board of Directors.

The NHS England Core Standards inform the Trusts annual EPRR work programme which is overseen by the Health Safety and Security Committee.

The NHS Core Standards for EPRR 2022 submission is attached to this report as Appendix 1. The excel template is provided by NHSE/I and populated by EPUT with its response and evidence and the excel version of the template is available on request.

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans

Supporting Reports / Appendices /or further Reading
Appendix 1 NHS core standards for EPRR 2022

Lead

Nigel Leonard,
Executive Director of Major Projects & Programmes (EPRR AEO)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	<u>Evidence</u> • Name and role of appointed individual • AEO responsibilities included in role/job description	N/A	Fully compliant				AEO = Nigel Leonard, Executive Director of Projects NED = Janet Wood
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. <u>Evidence</u> Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	RM14 Major Incident Plan June 2021 RM22 EPRR Policy June 2021	Fully compliant			EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021)
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. <u>Evidence</u> • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities	EPRR Annual Report 2021 - 22	Fully compliant			EPRR Annual Report 2021/22 approved at HSSC & Quality Committee (standing committee of the Board of Directors) May 2022 and Trust Board July 2021
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<u>Evidence</u> • Reporting process explicitly described within the EPRR policy statement • Annual work plan	RM22 EPRR Policy June 2021 Section 5.7	Fully compliant			An annual work plan is in place as identified in the EPRR Policy, The work plan is submitted to HSCC / Quality Committee and Trust Board quarterly to be monitored

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group		Fully compliant				Nigel Leonard, Executive Director of Projects - AEO Janet Wood - NED Nicola Jones - Director Lara Brooks - Associate Director Jane Cheeseman - Head Amanda Webb - EPRR Lead Alison Buckland - Officer Vasanti Patel - Admin (maternity) Zuned Ussen - Admin (maternity cover)
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	RM14 Major Incident Plan June 2021 Section 20 Quarterly Reports Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) EPRR quarterly report records learning from all incidents / potential incidents
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Risk Management & Assurance Framework 2020-23	Fully compliant				Risk Management & Assurance Framework 2020-23 Risk management framework in place. Evidence that Major Incident Plan takes account of risks identified in local community risk registers. Involvement in LHRP (and thus LRFs). Organisational risk register risk framework reflects EPRR risk.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management & Assurance Framework 2020-23	Fully compliant				Risk Management & Assurance Framework 2020-23 Risk management framework in place and risk management processes referenced in EPRR Policy and Major Incident Plan.
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded		Fully compliant				Annual EPRR exercise (at both Gold and Silver command level) held in October 2019 including local partners. Collaboration groups MH MSE 2021-22/23 Live event during COVID tested collaboration. Current incidents - Learning from Debriefs Covid-19 Fuel disruption High winds Monkey pox Heatwave Ride London Major Incident and EPRR review in collaboration with NELFT and Provide

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	RM14 Major Incident Plan June 2021 RM22 EPRR Policy June 2021 Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021)
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	RMPG14d Heatwave Plan June 2022 RMPG14e Cold Weather Plan June 2021	Fully compliant				Heatwave Plan in place - reviewed and approved by HSSC June 2021. Available on intranet and prompting emails advising action required also sent out to distribution list when alert levels change. MET Office weather warning circulated as appropriate alongside Heatwave Level Prep Beat the heat poster updated 2022 Cold Weather Plan in place - reviewed and approved by HSSC June 2021. Available on intranet and prompting emails advising action required also sent out to distribution list when plan activated. MET Office weather warning circulated as appropriate.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	RM14 Major Incident Plan June 2021 Section 28 Communicable Diseases and Outbreak Control (ICPG1 Section 4)	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) RM14 major Incident Plan directs to ICPG1 Section 4 Communicable Diseases and Outbreak Control
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Communicable Diseases and Outbreak Control (ICPG1 Section 4)	Fully compliant				Communicable Diseases and Outbreak Control (ICPG1 Section 4)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution	RM14 Major Incident Plan June 2021 Section 2 Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Fully compliant				EPUT has no specific plan in place due to nature of Trust however do note in RM14 Major Incident Plan that it may be necessary to develop specific plans in response to a particular situation arising at a point in time (e.g. development of mass countermeasures distribution arrangements). These will be developed by the Major Incident Response Team in conjunction with multi-agency partners where appropriate.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	RM14 Major Incident Plan June 2021 Section 2 Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Partially compliant				Major Incident Plan includes reference to and framework to be followed should it be necessary to increase capacity in community / mental health services to facilitate acute hospitals in their ability to meet mass casualty surge demand. Trust has engaged and assisted in mass casualty plans for Mid and West Essex.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Individual Service BCP identifies Shelter Development: Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				Internal arrangements in place to set up an internal rest centre dependent on size and scale of incident. Larger rest centres would be established in partnership with local authorities and health support provided as appropriate.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	RM09 Security Policy Quarterly Reports	Fully compliant				Schedule of lockdown plans across the Trust are up to date/planned. Reviewed and tested every 2 years. RM09 Security Policy reviewed December 2021 Lockdown update provided to committee Bi-monthly

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	CPG43b VIP Visits Procedure	Fully compliant				CPG43b - VIP Visits Procedure in place to manage high profile visitors to the Trust and arrangements included and cross-referenced in Major Incident Plan.
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Y	Y	Y			Y					Y		Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	RM14 Major Incident Plan June 2021 Section 2 Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021)
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners		Fully compliant				24/7 senior manager and director on-call systems in place across organisation which would address any EPRR issues. Arrangements detailed in Major Incident Plan. Tested regularly through daily use for all operational matters. During COVID on call rota increased to provide resilience.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	RM14 Major Incident Plan June 2021 Appendix 2	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) EPRR hold training records

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	RM14 Major Incident Plan June 2021 Appendix 2 Quarterly EPRR Report	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Training evidenced in Quarterly EPRR Reports
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	EPRR Annual Report 2021 - 22	Fully compliant				EPRR Annual Report 2021/22 approved at HSSC & Quality Committee (standing committee of the Board of Directors) May 2022 and Trust Board July 2021
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Exercising Schedule which Evidence • Training records • Evidence of personal training and exercising portfolios for key staff		Partially compliant				Training Records within EPRR Need to identify what training is available in order to meet the MOS so that a can be put in place - Providing courses available can meet within the next 12 months
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	As part of mandatory training Exercise and Training attendance records reported to Board		Fully compliant				Quarterly reports Relevant plans shared as and when required on indication of a potential incident EPRR Command stood up

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26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	RM14 Major Incident Plan June 2021 Section 8 Development: New ICC SOP due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Incident Co-ordination Centre arrangements in place. Fall-back location identified (Hawthorn Centre, Rochford). Comms tested frequently as it is a location in use constantly. Documented scheduled testing to be implemented to provide audit trail. Fall back would be mobile communications. On-call directors and key responders to a major incident are on priority mobile network. Major Incident Boxes in place in both locations. During COVID ICC command has been held virtually via Microsoft Teams.
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Planning arrangements are easily accessible - both electronically and local copies		Fully compliant				Approved policies and procedures are held on internal input for all staff to access Available on encrypted Memory stick within the Major Incident Box in ICC in the event access to internet not available Printed copies held within Major Incident Box in ICC in the event of computer access not being available
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	RMPG14a Business Continuity Management Guidance and Procedures June 2021	Fully compliant				Business continuity plan arrangements in place - procedural guidance updated and approved by HSSC in June 2021 and ratified by Quality Committee in July 2021. Corporate and Services BCPs in place.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained Loggist(s) to ensure support to the decision maker	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for accessing and utilising Loggists • Training records	RM14 Major Incident Plan June 2021 Loggist Action Card Loggist SOP	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Training Records within EPRR
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	RM14 Major Incident Plan June 2021 Appendix 5 Development: Updated EPRR and Major Incident Policy due for review / approval and ratification October 2022 prior to embedding within Trust. Updated Policies incorporated strengthened detail relating to the Core Standard	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Established internal processes in place for SitRep reporting which would be utilised in the event of a major incident. SitRep reporting processes to regional office included in Major Incident Plan. During COVID EPUT has complied with daily SITREP reporting for an extended number of months.

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33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained Comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	RM14 Major Incident Plan Section 15	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Communications processes detailed in Major Incident Plan including multi-agency involvement / leadership. During COVID regular contact has been made with patients via co-ordinators, via a number of means and EPUT website is regularly providing up to date information.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	RM14 Major Incident Plan June 2021 Section 15	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Communications processes detailed in Major Incident Plan including multi-agency involvement / leadership. During COVID regular contact has been made with patients via co-ordinators, via a number of means and EPUT website is regularly providing up to date information.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7	RM14 Major Incident Plan June 2021 Section 15	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Communications processes detailed in Major Incident Plan including multi-agency involvement / leadership. Social Media Policy CP58 in place and referenced in Major Incident Plan. Information unit to support Major Incident Response Team would be established if deemed appropriate.

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36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	RM14 Major Incident Plan June 2021 Section 15	Fully compliant				Details of communications included in Major Incident Plan - in line with regional arrangements for communication co-ordination etc. Media Strategy / Policy in place and trained media spokespersons.
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	Y	Y	Y			Y	Y		Y			Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.		Fully compliant				Attendance at all meetings, either in person or by telephone.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	Y	Y	Y			Y	Y		Y			Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system		Fully compliant				Attendance at all meetings, either in person or by telephone.
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	RM14 Major Incident Plan June 2021 Section 29	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Mutual Aid Arrangements in place and appended to Major Incident Plan. EPUT have provided (and continue to provide) mutual aid during recent COVID pandemic with IPC training, FFP3 fit testing and staff .
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldecott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	RM14 Major Incident Plan June 2021 Section 6	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Section on information sharing and principles included in Major Incident Plan. No formal information sharing agreements in place specifically relating to major incidents but a number of general information sharing arrangements in place with key partner organisations which could be used in a major incident. Full list of Information Sharing Agreements collated and copy in Major Incident Boxes.

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44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and	RMPG14a Business Continuity Management Guidance and Procedures June 2021	Fully compliant				Detailed in Business Continuity Planning Procedure (RMPG14) - reviewed and approved by HSSC June 2021 and ratified by Quality Committee July 2021 Procedure written in line with ISO23001
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		RMPG14a Business Continuity Management Guidance and Procedures June 2021	Fully compliant				As above

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46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be	BCP00 Corporate BCP	Fully compliant				BCPs will be reviewed every 2 years or sooner should there be any significant changes to staff or services
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties		Fully compliant				Service BCP's
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	EPRR Annual Report 2021 - 22	Fully compliant				EPRR Annual Report 2021/22 approved at HSSC & Quality Committee (standing committee of the Board of Directors) May 2022 and Trust Board July 2021
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved		Fully compliant				Trust Information Governance Toolkit return made and achieved 'Standards met'
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business continuity policy • BCMS • performance reporting • Board papers	RMPG14a Business Continuity Management Guidance and Procedures June 2021 EPRR Annual Report 2021 - 22	Fully compliant				EPRR Annual Report 2021/22 approved at HSSC & Quality Committee (standing committee of the Board of Directors) May 2022 and Trust Board July 2021

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51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme		Fully compliant			Internal Audit commenced 20th June 2022 Feedback meeting held 29th July 2022 Audit complete Draft Report received
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or	RMPG14a Business Continuity Management Guidance and Procedures June 2021	Fully compliant			Detailed in Business Continuity Planning Procedure (RMPG14) - reviewed and approved by HSSC June 2021 and ratified by Quality Committee July 2021 Procedure written in line with ISO23001 BCP Procedure sets out requirement to review templates 2 yearly - pro - forma reviewed based on experience (e.g. local Comms cascade in event of loss of communication). BCPs updated following EU Exit planning and COVID pandemic.
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers		Fully compliant			3rd party suppliers required to demonstrate to contracts team that they have business continuity plans in place to continue services to the Trust. A number of suppliers BCP's are held by the EPRR team.

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55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	RM14 Major Incident Plan June 2021 Appendix 6	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Role card for CBRN incident included in Major Incident Plan and national guidance available on internet for staff - includes national telephone help line numbers on page 22/23. Reception staff also have hard copy to hand.
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	RM14 Major Incident Plan June 2021 Appendix 6	Fully compliant	2022 policy updates due to review and approval by Health, Safety and Security Committee HSSC - end of September 2022 and ratified by Quality Committee beginning October 2022			EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Initial role card in place, national guidance on internet and incidents referenced in Major Incident Response Plan and to be managed via Major Incident Plan framework
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities		Fully compliant				Trust Risk Framework in place, encompassing all EPRR risks.
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							Completed equipment inventories; including completion date		Fully compliant				Specialist equipment not required for mental health and community health provider. Trust will communicate with multi agencies if required for support

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Y		Y			Y							Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Input training tracker	Fully compliant				IPC Training
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	RM14 Major Incident Plan June 2021 Appendix 6	Fully compliant				EPRR Policy, Major Incident Plan and underpinning documents (reviewed and approved by Health, Safety and Security Committee - HSSC - June 2021 and ratified by Quality Committee July 2021) Role card in Major Incident Plan details this requirement.
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y									Fully compliant				FFP3 face masks would currently be sourced from NHS Supplies. During COVID a large number of staff have been Fit tested trained and EPUT have a supply of FFP3 for use when required.

Over arching changes:	Column previously titled "Standard" has been renamed as "Standard name" Column previously titled "Detail" has been renamed "Standard Detail" Column previously titled "Evidence" has been renamed "Supporting information" Organisation type previously "Clinical Commissioning Group" has been changed to "Integrated Care Board" Remove reference to "effective" arrangements/planning across all standards on the basis that all arrangements should be considered effective in nature. Domain 7 - Warning and Informing - has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Domain 9 - Business Continuity - was reviewed in collaboration with project team undertaking the review of the Business Continuity toolkit and their associated stakeholder group. The review includes development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Domain 10 - CBRN - to be reviewed as part of national CBRN work programme 2022-23. Core standards to be updated as part of interim review 2023.

Previous standard detail					New standard detail			
Ref	**Domain**	**Standard**	**Detail**	**2022 Changes**	**Ref**	**Domain**	**Standard name**	**Standard Detail**
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Standard amended to clarify that AEO should be a board level director "within their individual organisation" Removed reference to Non-Executive board member in light of national review of NED Champions. EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.	**1**	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Previously referred to as EPRR Policy statement, this has been amended to reflect the requirement that an organisation has an "EPRR Policy or statement of intent" Third bullet point under "The policy should" has been updated to include that arrangements are also "exercised" Standard now applicable to Clinical Support Unit and Primary Care Services Moved content requirements of policy to supporting information	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Removed reference to "Clinical Commissioning Group Accountable Officer" as no longer applicable Removed requirement for EPRR reports to go to "Governing Body" as no longer applicable Added "The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements" Moved content requirements of reports to supporting information	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Added a new first bullet point to include "Current guidance and good practice" Added: "The work programme should be regularly reported and shared with partners where appropriate"	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Removed "proportionate to is size" as this is not the only factor for consideration	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Standard detail wording amended to expand on what is implied by development of EPRR arrangements and specifically reference undertaking a "review and embed" learning into future arrangements	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Broadened standard detail to include consideration of all relevant risk registers including community and national risk registers Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**7**	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Added reference to "communicating and escalating EPRR risks internally and externally"	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Standard description amended to encourage greater collaborative working on broader EPRR arrangements and wider stakeholder engagement.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Previously separate standards relating to Critical Incident and Major Incident plans have been incorporated into a single standard which requires organisations to have effective plans in place to "define" and respond to "Critical and Major Incidents" as defined in the EPRR Framework	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Removed this standard as incorporated into the Incident Response standard				
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Previously separate standards relating to Heatwave and Cold Weather Plans have been incorporated into a single standard which requires organisations to have effective arrangements "in place for adverse weather events." Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Removed standalone standard as it is incorporated in to the redefined Adverse Weather standard				

15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Sub-section has been renamed "new and emerging pandemic" and reworded to reflect generic pandemic arrangements rather than disease specific (i.e. Influenza) planning, and differentiate separately form current arrangements in place to respond to the COVID-19 pandemic. The revised standard does however include reference to "reflecting recent lessons identified" recognising lessons likely to have been identified during the COVID-19 response and incorporated in to future planning. Revised standard has also been reordered to follow Infectious Diseases standard as these arrangements may be considered as a foundation for Pandemic response.	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Reference to specific diseases (i.e. VHF) and specific arrangements (i.e. IPC) removed to ensure broader planning considerations are taken in to account. Supporting information updated to include reference to DHSC FFP3 resilience in Acute setting guidance Revised standard has also been reordered to precede New and Emerging Pandemic standard as Infectious Disease arrangements may be considered as a foundation for pandemic response.	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Standard has been revised and renamed so not to be specific to Mass Countermeasures but to reflect an incident requiring "countermeasures or a mass countermeasure deployment". All other wording specifically referencing Mass Countermeasures has been removed and moved to supporting information column until national guidance published. Standard is now applicable to Integrated Care Boards and Primary Care Services	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Standard reworded to reference response to "incidents with mass casualties" rather than "responding to mass casualties". Specific references to freeing up of bed base in acute settings removed as these requirements are included in national guidance. Supporting information updated to reflect that arrangements should include safe patient identification system for unidentified patients in an mass casualty incident.	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Standard removed and incorporated as a consideration as part of broader Mass Casualty planning.				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Minor changes to standard name to reflect national guidance title i.e. "Evacuation and Shelter" rather than "Shelter and Evacuation" Removed reference to shelter and evacuation of whole buildings and sites etc. and working with other site users as this is incorporated in national guidance.	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Standard reworded to reflect different organisations types and any specific regulatory requirements	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Standard renamed No change to wording of standard	**19**	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Standard reworded to move away from reference to EPRR specific on call, to more broader mechanisms for escalating and responding to incidents 24/7.	**20**	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Standard reworded to reflect that those staff supporting the 24/7 on call mechanism to respond to incidents (as described above) are appropriately trained in EPRR.	**21**	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Reference to training records removed from the standard description, as it is included as evidence.	**22**	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.

27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Reference to "minimum standards in line with national guidance" included. Reference to specific exercise and testing requirements moved to supporting information and is included in national guidance. Addition to reiterate that exercise and testing should be undertaken "safely: no undue risk to exercise players or participants, or those patients in your care" "Lessons identified" removed from standard description but incorporated in to supporting information of post exercise	**23**	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Standard renamed "Responder Training" and reworded to include all responders, and reflect shared responsibility to maintain personal development portfolios with the host organisation. National occupational standards updated to reflect new "Minimum Occupational Standards"	**24**	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
				New standard	**25**	**Training and exercising**	**Staff Awareness and Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	Moved to Domain 9 - Business Continuity	**54**	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 6 - Response								
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include physical in addition to virtual arrangements but requires ICC arrangements to be resilient with dedicated BC arrangements. Requirement for equipment testing in line with EPRR Framework.	**26**	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include easily access to digital response plans but requires dedicated business continuity arrangements in place.	**27**	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No Change	**28**	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Standard description amended in order that there is focus on the importance of maintaining personal records and decision logs and the utilisation of loggists to support this	**29**	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Standard description revised	**30**	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	**31**	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Removed PHE branding from guidance title as this will likely change over time but recognise this has formally been published by PHE previously.	**32**	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing								
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Domain 7 - Warning and informing has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Supporting information has been added to support development of arrangements and future planning	**33**	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.		**34**	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Additional standard with specific requirement for organisations to have incident communication plans in place which can be enacted.	**35**	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
					36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation								
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Standard name changed to "LHRP engagement". Further clarification of requirement for suitable representation of AEO included in line with EPRR framework. Minimum attendance requirement removed to ensure all efforts are made for organisations to send representation to all meetings.	**37**	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Standard name changed to "LRF/BRF engagement"	**38**	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.

42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Added in requirement to adhere to national NHS guidance around MACA etc	**39**	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Changed to reflect that there may be a requirement to plan for *and* respond to multi LHRP/LRF boundary incidents and the resource requirements for this Applicable to ICB	**40**	**Cooperation**	**Arrangements for multi-area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	Changed PHE To UKHSA to reflect organisational change	**41**	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
45	**Cooperation**	**LHRP**	Arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	Changed subheading to include Secretariat. Standard applicable ICB to reflect the new statutory responsibilities.	**42**	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Added into supporting evidence additional legislative requirements	**43**	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	**44**	**Business Continuity**	**Business Continuity (BC) policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Standard description developed to provide further context regarding the requirement to define scope of the programme. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard.	**45**	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	**46**	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	**47**	**Business Continuity**	**Data Protection and Security Toolkit (DPST)**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Standard separated into two separate standards to reflect the requirement for a) Business Continuity Plans for the management of incidents and b) testing and exercising of BC Plans. This is extant for the requirement for testing and exercising of other non-BC EPRR and Incident response arrangements	**48**	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
					49	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	**50**	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Standard description developed to better define audit cycle and internal and external requirement. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	**51**	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Supporting information encompasses Monitoring, evaluating, lessons identified and audit cycle findings	**52**	**Business Continuity**	**BCMS continuous improvement process**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change to standard description. Supporting information developed to include support from Procurement and commercial teams at tender stage.	**53**	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
Domain 10 - CBRN								
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	No substantive change to standard content. Domain 10 - CBRN due to be reviewed as part of national CRBRN work programme and core standards updated as part of interim review.	**55**	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.		**56**	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.		**57**	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		**58**	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/		**59**	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.		**60**	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.

61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.

Standards renumbered as necessary

61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks
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67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Boards	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Evacuation and Shelter																							
Domain: Evacuation and Shelter																							
DD1	**Evacuation and Shelter**	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD2	**Evacuation and Shelter**	**Activation**	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD3	**Evacuation and Shelter**	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD4	**Evacuation and Shelter**	**Evacuation patient triage**	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	Y	Y	Y			Y						Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD5	**Evacuation and Shelter**	**Patient movement**	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	Y	Y	Y			Y					Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD6	**Evacuation and Shelter**	**Patient transportation**	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	Y	Y	Y	Y		Y						Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	Y	Y	Y	Y		Y						Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD8	**Evacuation and Shelter**	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	Y		Y			Y						Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD9	**Evacuation and Shelter**	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD10	**Evacuation and Shelter**	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD11	**Evacuation and Shelter**	**Communications-Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD12	**Evacuation and Shelter**	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				
DD13	**Evacuation and Shelter**	**Exercising**	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy which is due for review / approval and ratification October 2022 prior to embedding within Trust.	Partially compliant				Live Incident - Ipwich Road Ceiling Collapse Fire Drills

Board of Directors 28 September 2022