BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

4 December 2024

10:00 GMT Europe/London

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

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Board Part 1 Agenda 04.12.2024 FINAL.pdf

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Wednesday 4 December 2024 at 10:00 – 12:15

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION **Perinatal Services** Emma Strivens, Director of Delivery and Partnership				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 2 October 2024	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Discussion
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Noting
8.2	Learning from Deaths – Quarterly Overview of Learning and Data Report Q1 2024/25	AS	Attached	Noting
9	**STRATEGIC INITIATIVES**			
9.1	Strategic Impact Report M6	ZT	Attached	Noting
10	**REGULATION AND COMPLIANCE**			

10.1	Annual Review of Governance Documents	DG	Attached	Approval
10.2	Emergency Preparedness, Resilience & Response (EPRR) National Core Standards Return 2024	NL	Attached	Discussion
10.3	Quarterly Report on Safe Working Hours for Resident Doctors	MK	Attached	Noting
11	**OTHER**			
11.1	Use of Corporate Seal	PS	Attached	Noting
11.2	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
11.3	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.4	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.5	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 5 February 2025 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 2 April 2025 at 10:00, The Lodge Training room 1 Wednesday 4 June 2025 at 10.00, The Lodge Training room 1 Wednesday 6 August 2025 at 10:00, The Lodge Training room 1 Wednesday 1 October 2025 at 10:00, The Lodge Training room 1 Wednesday 3 December 2025 at 10:00, The Lodge Training room 1			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Standing item | SS | 1

2. DECLARATIONS OF INTEREST

Standing item SS 1

PRESENTATION - PERINATAL SERVICES, EMMA STRIVENS

Information Item | Emma Strivens | 10

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 2 OCTOBER 2024

Decision Item SS 2

REFERENCES

Only PDFs are attached

2024 10 02 Board Part 1 Minutes.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 02 October 2024
Training Room 1, The Lodge, Lodge Approach, Runwell, SS11 7XX

MEMBERS PRESENT:

Professor Sheila Salmon	SS	Chair
Paul Scott	PS	Chief Executive Officer
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Denver Greenhalgh	DG	Senior Director of Corporate Governance
Dr Ruth Jackson	RJ	Non-Executive Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Non-Executive Director
Elena Lokteva	EL	Non-Executive Director
Jenny Raine	JR	Non-Executive Director

IN ATTENDANCE:

Janette Leonard	JL	Chief Information Officer (deputising for Zephan Trent)
Dr Feena Sebastian	FS	Deputy Medical Director for Community Delivery Mid and South Essex (deputising for Dr Milind Karale)
Dr Mateen Jiwani	MJ	Non-Executive Director – observing via MS Teams
Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Clare Sumner	CS	Trust Secretary's Office Administrator (for part)
Matt Sisto	MS	Director of Patient Experience and Participation
John Jones	JJ	Lead Governor
Pam Madison	PM	Deputy Lead Governor
Stuart Scrivener	SS	Public Governor
Kim Russell	KR	Head of Communications

There was one member of the Public / Staff Members present.

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

The meeting commenced at 10am.

99/24 APOLOGIES FOR ABSENCE

Zephan Trent	Executive Director of Digital, Strategy and Transformation
Dr Milind Karale	Executive Medical Director
Nigel Leonard	Executive Director of Major Projects & Programmes

100/24 **DECLARATIONS OF INTEREST**
There were no declarations of interest.

101/24 **PRESENTATION – PEER SUPPORT**
AG introduced the presentation, advising that peer support is a fundamental part of the Time to Care programme. The initiative had been piloted on some inpatient units and the presentation provided the outcome of the pilots.

MS delivered the presentation, highlighting the following:

- The initiative focused on people with their own lived experiences supporting individuals in similar situations. This brings people together based on their experiences and can help challenge stigma (including self-stigma) which can be a challenge to recovery.

- There are other organisations that use peer support, but EPUT has introduced Peer Support Workers to help improve patient experience. The Peer Support Worker can support someone during their stay on an inpatient unit, including advocating and helping during tribunals.

- The pilot was launched at The Linden Centre, working through initial challenges such as training and supervision. There were also challenges around people understanding the role of a Peer Support Worker.

- The overall feedback from the pilot was positive, with the following key findings:

  - The Peer Support Worker model had worked and added value to the existing multi-disciplinary and therapeutic offer.

  - There were fewer incidents where peer support workers were on the wards as they were able to de-escalate certain situations.

  - The use of language changed and there had been a shift in dialogue to be more empathetic and person centred.

- The key outcomes from the pilot was the establishment of substantive posts to recruit to and the development of an evidence-based costed model. The Trust had also been recognised nationally.

<u>Questions and Discussions</u>

- The Board thanked MS for the presentation and supported the outcome of the pilot and peer support worker model.

- There was a query around the reference to a comment regarding challenges with staff on the ward. The query was whether this was around the boundaries of the role or a cultural issue. MS advised the challenges were around staff understanding the role of the peer support worker in building relationships and breaking down barriers, rather than an active clinical role. Staff understanding the role helped them understand the value.

- There was a query as to whether there had been consideration to extend the initiative to community services. MS advised this was something that was currently being taken forward as there was value in peer support workers in the community. The pilot had allowed the role to be understood in relation to inpatient services and now needed to be considered as part of the community model.

- The Board discussed the initiative shifting the power dynamic towards the patient, which had been challenging as a different way of thinking. The initiative complimented Time to Care as it moved away from the traditional staffing model. There was a query in how the Trust is working with other organisations to share the success and adopt any learning from other organisations. MS advised the Trust was part of the national peer leader's network, which shared a good amount of learning across the network. There are some organisations that are further ahead in relation to community services and this would be a good source of learning for the Trust.

- The Board were advised of the positive feedback that had been received from patient partners. There had also been presentations to the Integrated Care Boards and Local Authority partners, which had included a person with lived experience which had enhanced the conversation around patient safety which was well-received. There was also a link with the Greater Manchester report on the agenda, with one of the key findings around the importance of listening to patients and carers.

- There was a query regarding the expected staff / peer worker / patient ratio. MS advised the recommendation was for two peer support workers per ward. The pilot had started with one per ward and it was found the individual could quickly become overwhelmed.

- The Board discussed the importance of thinking creatively about career progression and structures relating to the peer support roles. There was a suggestion regarding peer support workers being used in the education of staff to understand the importance of therapeutic engagement and activity.

102/24 MINUTES OF THE PREVIOUS MEETING HELD ON 07 AUGUST 2024

The Board of Directors reviewed the minutes of the meeting held on 7 August 2024.

- P5 – People and culture third bullet change wording to "Trust had taken the opportunity"

The Board of Directors agreed the minutes as an accurate record and noted the record of questions from Governors / public and the responses.

103/24 ACTION LOG AND MATTERS ARISING

No action log for this meeting as there were no actions to carry forward.

104/24 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

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

- The Chair had attended the Expo24 Power of Kindness event hosted by Suffolk and North East Essex Integrated Care Board. The event had been attended by a range of partners from Essex and Suffolk, focusing on the power of kindness and compassion.

- The pilot for Quality Assurance Visits had been completed and a review was held. The visits had been a positive learning experience.

- The Mental Health Urgent Care Department in Basildon had won an East of England regional award in the 2024 NHS Parliamentary Awards.

- The Early Intervention in Psychosis (EIP) had been accredited with the highest rating of Level 4 by the National Clinical Audit of Psychosis.

- Jenny Raine was stepping into the role of Associate Non-Executive Director.

The Board received and noted the report

105/24 **CEO REPORT**

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

- Board members had attended the Lampard Inquiry hearing where they had heard powerful and moving testimony given by families who had lost loved ones. The dignity and courage shown by families was recognised and reinforced the importance of the work to improve services and engage with patients and families in a different way.

- The Electronic Patient Record project was progressing and would be a fundamental change in improving consistency for patients, freeing up staff to provide a more therapeutic model of care.

- The NHS is facing challenging operational and financial circumstances, which creates pressures for the Trust. This is seen through levels of out of area placements and the continued work to deliver the financial plan for the year.

The Board received and noted the report

106/24 **QUALITY AND PERFORMANCE SCORECARD**

PS presented the report, in conjunction with a summary provided in the CEO report and invited Executive Directors to provide any updates in within their remits.

Finance (TS)

- Discussions had been held at the Finance & Performance Committee regarding the current mental health in-patient operational pressures, and the impact from temporary staffing and out of area placements on the financial plan. There was full organisational engagement with managing financial pressures and additional controls in place to support recovery of the position.

- Enhanced controls were in place for pay and non-pay expenditure.

- The Trust had proactively participated with PWC on the Investigate & Intervene programme, which included system and regional colleagues.

- The mid-year review was currently underway and a revised forecast position would be provided.

- There was engagement with external partners on staff rostering and further commercial support was being sought on estates matters.

- The Trust was actively working with the Mid & South Essex Integrated Care System to develop a medium term financial plan for the next three to five years.

Operations (AG)

- Details were provided of actions taken to address out of area placements, including a weekly report to Executive Team on flow and capacity, deep-dives undertaken at standing committee level and medical support for purposeful admission. There was also an escalation system with partners on any delays, which were predominantly around supported accommodation.

- Efficiency meetings had taken place reviewing the use of bank and agency staff on wards. The meetings focused on the better use of data and controls on staffing.

People and Culture (AM)

- There was a clear coordinated plan in terms of efficiencies, including relating to rostering.

- There had been a significant improvement in Health Care Assistant vacancies.

<u>Questions and Discussions</u>

- There was a query regarding the number of red key performance indicators relating to staffing, such as sickness and vacancy rates. Assurance was sought that this was a continued focus. AM advised there was a significant focus on recruitment to ensure there is a substantive workforce to the benefit of patients and staff. The challenge was around supporting more efficient rostering and reducing bank / agency spend to create a more substantive workforce. There was also the introduction of Peer Support Workers and the creation of career progression pathways, so the Trust is able to grow its own workforce.

- There was a query regarding the pace of cultural transformation whilst also improving safety and efficiency, asking how tension was managed to keep staff motivated. This included the external narrative regarding the pressures on the NHS as a whole. AG advised stakeholder sessions had identified the changes people wanted to take place and highlighted the importance of local conversations in managing change. AS advised work

was underway to develop a quality dashboard and there was an openness in the care units to understand data. TS advised there was good relationship building and communication with colleagues through accountability meetings. PS advised the Trust was moving in the right direction in terms of outcomes and the operational / financial pressures faced was not unique to EPUT.

The Board of Directors received and noted the report

107/24 COMMITTEE CHAIRS' REPORT

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

Finance and Performance Committee (LL)

- The Committee had considered the PWC Investigate & Intervene report, which had found good financial controls were in place at the Trust.
- The Committee had undertaken a deep dive into flow and capacity, which identified two key recommendations which were being implemented.
- The Committee had requested the Quality Committee review the safety of patients waiting for inpatient beds. This was agreed and noted.

People, Equality and Culture Committee (DL)

- The Committee had discussed the development of an Education Strategy, including a goal to effectively utilise the Trust apprenticeship levy.
- The Committee had discussed the people exemplar programme, which focused on the retention and on-boarding of staff.
- The national staff survey had launched the previous day, with a target response rate of 50 per cent.

Quality Committee (RJ – on behalf of MJ)

- The Committee had discussed the importance of patient experience in evaluating the impact of different initiatives.
- The Committee was discussing the development of a dashboard to quantify and track the progress of quality improvement.
- The Committee had discussed inpatient flow, looking at the challenges and highlighting the importance of working with partners to resolve issues.

The Board of Directors received and noted the contents of the report and the assurance provided

108/24 **CQC Assurance Report**

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

- The report from the CQC Inspection at Brockfield House in March 2024 was awaited.

- Feedback from the Quality Assurance Visits programme from external partners had been positive.

- The CQC had published guidance regarding improving culture in mental health inpatient services, which linked with the Time to Care programme.

- The Trust CQC Improvement Plan continued to progress, with 87 per cent of the Must Do actions completed and 21 closed actions moving through the external assurance programme. Discussions were being held with partners to increase the frequency of assurance meetings to increase the pace of closing actions.

- There were twelve sub-actions past timescale, with some actions relating to the Paris electronic patient record upgrade.

- The Trust was undertaking deep dives to proactively understand the root causes of sleeping on duty, noting the increased prevalence on wards with high patient acuity and use of bank / agency staff. Actions were already being implemented from the deep dive, including the completion of regular welfare checks for staff undertaking observations.

Questions and Discussions

- There was a query regarding the pace of actions moving through the assurance process, asking when it was anticipated the improvement plan would be fully closed. DG advised the External Assurance Group met monthly to review actions, which created a slow pace and discussions were under way to increase the number of meetings. AS advised that ICB partners had confirmed a willingness to visit services, which could also increase the pace of closure.

- The delay in the receipt of the feedback report for the CQC inspection of Brockfield House was noted and asked whether there were any key informal findings which could be considered in light of the delay. AS advised a meeting had been held with the CQC and a number of key areas of focus were provided. The Trust has regular meetings with the CQC and are able to provide feedback on progress with these key areas.

The Board of Directors received and noted the contents of the report for assurance of oversight of progress against the CQC improvement plan.

Action: Provide an update on the timescale for completion of the CQC Improvement Plan following discussions with the ICB to increase the frequency of assurance meetings. (AS)

109/24 WORKFORCE EQUALITY STANDARDS AND ACTION PLAN 2024 – 2025

AM presented a report providing a summary of key headlines and information associated to our obligations for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). AM provided details of the indicators that had improved from the previous year and the key areas of improvement identified.

Questions and Discussions

- There was a suggestion that the areas where progress had been made could be more detailed to provide specific details for each of the indicators. There was also a query regarding how leaders could help create a more positive culture. AM agreed more explicit detail would be provided around the progress made, noting the importance of being more transparent around measures and improvements, which would help leaders create a more positive culture.

- The role of the staff networks was highlighted, noting the shift in power to empower the staff networks. AM agreed and noted the positivity around Executive Directors committing time to supporting the networks.

The Board of Directors noted the contents of the report. Approved the proposed action plans for publication on 31 October 2024.

110/24 BOARD ASSURANCE FRAMEWORK

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

- **SR2 People & Workforce:** Work was under way to split the risk into three parts, organisation development, staff retention and workforce sustainability, which will help focus the risk. This would be presented to PECC and then Board in December.

- **CRR96:** The Trust now has sufficient loggists to provide a 24/7 rota, and this will be monitored ongoing as part of the EPRR Core Standards.

Questions & Discussions

- There was a query regarding SR1 Safety, noting the likelihood reducing from four to three since July 2023. The scorecard provided two actions, of which one had been completed, and queried whether there were sufficient actions to reduce the likelihood as noted in the report. DG advised the risk was in the process of being reviewed as it was developed when the Safety First, Safety Always Strategy was in place. The new risk would include the safety improvement plans and Quality of Care Strategy.

The Board of Directors received and noted the contents of the report. Noted the reduction in risk scores for CRR96 – Loggists.

111/24 HEALTH & SAFETY AND VAPR ANNUAL REPORT

DG presented the Annual Health, Safety and Security Report 2023 – 2024 which provided an update on the activity of the Health, Safety and Security Team from 01 March 2023 – 31 March 2024, giving assurance that there were satisfactory arrangements in place for managing Health, Safety and Security across the organisation. DG highlighted the following:

- There were some internal objectives that had not been met, which was due to challenges in recruitment to vacancies. The team had now been redesigned, with dual training meaning objectives could be achieved in the next year.

Questions and Discussions

- It was noted the objectives that had not been met had been deferred to this financial year and an update was requested on any progress to date. DG advised there had been good progress and changes to the incident reporting system would aid the delivery of these objectives.

The Board of Directors received and approved report, noting the prior review and recommendation to the Board from the Quality Committee.

112/24 SAFEGUARING ANNUAL REPORT

AS presented a report providing 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 report outlines how the Safeguarding Service is performing and promoting best practice. AS highlighted the following:

- Assurance was provided that the Trust has systems and processes in place to manage safeguarding, with positive feedback from partners.

- The report reflected innovations and challenges during the year, including embedding safeguarding processes in records, reframing section 75 arrangements and work around sexual safety.

The Board of Directors received and approved the report, the improvements made during 2023/24 and the quality improvement priority areas for implementation during 2024/25.

113/24 MENTAL HEALTH ACT ANNUAL REPORT 2023-24

AS presented a report providing assurance to the Board of Directors that risks that may affect the achievement of the organisation's objectives and impact on quality are being managed effectively and to provide assurance that the Group is discharging its terms of reference and delegated responsibilities effectively. AS highlighted the following:

- The report included details around civil and forensic sections, looking at discharge in relation to the Act.

- The report provided assurance the Trust had the right staff, with the right training in place. The report also reflected work undertaken with Associate Hospital Managers around how legislation is used in the Trust, with the focus on the least restrictive interventions.

The Board of Directors received and approved the report.

114/24 **TRUST RESPONSE TO THE GREATER MANCHESTER MENTAL HEALTH REVIEW**

AS presented a report providing the Board of Directors with a framework to review the recommendations received through the Greater Manchester Mental Health review, and the gap analysis undertaken against the organisation's strategic plans and enabling strategies to ensure a focus on relevant learning opportunities AS highlighted the following:

- The review had been undertaken following a BBC Panorama programme highlighting issues around quality of care across the Greater Manchester organisation.
- The review had highlighted issues around internal governance and how feedback was triangulated, including not listening to patients and carers.
- The Trust had looked at each recommendation and identified potential gaps in its own processes for the development of an improvement plan. This review had been completed with staff and external partners.

Questions and Discussions

- The Board noted the positivity in completing a self-assessment and providing this in a consolidated report. There was a query around the review identifying if any service needed a greater level of support. AG advised that services in the mid and south Essex areas were the most challenging, due to the complexity of the geography and the different approaches in different areas. The outcome of the review had provided a focus on internal structures and the strengthening of governance.

The Board of Directors received and noted the report.

115/24 **ESTATES STRATEGY**

S presented a report providing a strategic oversight of the Trust's estate and a framework to assist in developing future estate plans as part of the annual planning cycle. TS highlighted the following:

- The strategy had been developed following extensive collaboration and there would be continued engagement as the strategy moves into delivery.
- The Strategy has provided a baseline of the estate and the development of targets and ambitions for the future.
- The Strategy is a live document which will change as it is taken forward, with oversight from the Finance & Performance Committee.

The Board of Directors received and approved the Estate Strategy.

116/24 RESPONSIBLE OFFICERS AND REVALIDATION ANNUAL REPORT AND STATEMENT OF COMPLIANCE

FS presented a report providing information on the implementation of revalidation within the Trust for the 2023/24 appraisal year. This supports the Trust's annual statement of compliance which is sent to the higher level Responsible Officer at NHS England. FS highlighted key findings in the report and noted that it had been discussed at the PECC.

The Board of Directors received and approved the report for submission.

117/24 USE OF CORPORATE SEAL

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

- 117 – 119 Mollands Lane, South Ockendon, Lease Surrender and Re-grant.

The Board of Directors received and noted the report.

118/24 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

119/24 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

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

120/24 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

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

- The presentation at the start of the meeting had highlighted the importance of the patient perspective, and reflections from the CEO highlighted the importance of listening and hearing experiences.
- There were discussions in relation to equality around operational models and some challenges noted.
- The importance and empowerment of staff networks had been noted.

121/24 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIREMENT)

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

122/24 ANY OTHER BUSINESS

There was no other business.

SS highlighted:

- Coproduction conference on 10 October 2024
- Spirituality Faith Network Conference on 4 November 2024, to be held in Chelmsford Cathedral

123/24 QUESTION THE DIRECTORS SESSION

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

124/24 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 04 December 2024.

The meeting closed at 12:21

Appendix 1: Governors / Public / Members Query Tracker (Item 123/24)

Governor / Member of the Public	Query	Response
John Jones, Public Governor	**Safeguarding Annual Report (Page 9):** The report advised there had been 206 Section 17 enquiries. Could any context be provided to determine if these were particularly high or if these were increasing / decreasing?	There was an expectation that there would be a high number of Section 17 enquiries, as part of the work was helping people moving safely into the community. AS agreed to meet outside the meeting to provide analysis against other Trusts to provide further context.
	Board Assurance Framework CRR94: The commentary around this risk was queried as it was not clear if this related to the impact on safety or a CQC initiative. The narrative also noted that risk assessments had been revisited, but did not provide information on whether this was successful and the risk score has not improved. Page 101 CRR94 – don't understand commentary around it, is around impact on safety and CQC initiative. Statement that risk assessment been revisited – if been revisited is successful or not? Risk doesn't appear to have dropped.	The risk relates to the Strategic Risk 1: Safety which was in the process of being reviewed. The report for Board in December will provide a new detailed risk which would address the points raised.
	Board Assurance Framework SR7 Capital: The first action references the securing of £0.4m capital funding. What was this for?	This related to some Mental Health Urgent Care capital that was available, which had been secured through an application earlier in the year. The funding has been allocated to the Trust capital programme.
Member of Public	There was a lack of phone signal at Brockfield House which could potentially cause damage to relationships with friends and family members for the patient, is there anything that can be done? In addition, could there be supervised access to mobile devices and laptops for patients, to help provide a mechanism to allow patients to contact people?	There had been a meeting agreed with the individual to meet with staff at Brockfield House to discuss their concerns. This meeting would be rescheduled and the concerns raised taken forward with the individual.

Governor / Member of the Public	Query	Response
	Are staff asked questions relating to empathy and a caring attitude as part of recruitment? And is there training for existing staff? This was in relation to the individual experiences within services.	AS thanked the individual for sharing their experience and suggested a member of the nursing team join the meeting to provide further input into these issues and feed their experiences into overall quality of care improvements.

4. ACTION LOG AND MATTERS ARISING

Standing item | SS | 2

REFERENCES

Only PDFs are attached

Action Tracker CHECKED .pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 2 October 2024

Lead	Initials	Lead	Initials	Lead	Initials
Ann Sheridan	AS				

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
108/24 October	Provide an update on the timescale for completion of the CQC Improvement Plan following discussions with the ICB to increase the frequency of assurance meetings.	AS	December 2024	Included within the CQC Report for December 2024 meeting.	Closed	Green

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item SS 5

REFERENCES

Only PDFs are attached

Chairs Report CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

Report Title:	**Chairs Report (including Governance Update)**					
Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:	NA					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Chairs Report (Including Governance Update)

Non-Executive Lead:
[signature] **Professor Sheila Salmon** **Chair**

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Chair of EPUT

As my term of office draws to a close, recruitment for a successor is underway and updates will be shared as they become available.

2.2 Lampard Inquiry Hearings

Following the initial Lampard Inquiry hearings held earlier in the year, further hearings took place online from 25 – 27 November. The Hearings included additional opening statements from those that did not provide them in September. We fully realise that this will be a difficult time for colleagues, patients and families and continue to offer support to colleagues during the Inquiry. Patients, families and carers can also access support via PALS on 0800 0857935 or by email epunft.pals@nhs.net. As a Board, we are clear that we welcome the progress of the Inquiry in the hope that it can deliver the answers that families have been seeking. The Trust continues to engage openly with the Lampard Inquiry Team and would urge any staff member who feels they have experience or information they want to share to do so. Only by being open and transparent can we properly support Baroness Lampard and her team to deliver meaningful conclusions that will improve mental health care nationally.

2.3 Joint Board Seminar

The Board had a seminar session with our Council of Governors on 6 November. The session focused on our new Estates Strategy and an update on progress towards the development of a Unified Electronic Patient Record (EPR). The session was a great opportunity for our two governing bodies to discuss some key developments underway at EPUT.

In the afternoon, the Board met separately to plan our next steps for continuing to develop our leadership and governance. The Board also engaged in an excellent interactive session looking at the risk appetite for our Board in achieving our strategic objectives.

2.4 Our Friend and Colleague Mark Dale

Following the recent sad passing of our dear friend and respected colleague Mark Dale; on behalf of the Board of Directors and Council of Governors, I would like to put on record our deepest and heartfelt sympathies to Mark's family. Mark was a highly committed publicly elected governor, a proactive patient safety partner and lived experience lead for coproduction and participation, helping EPUT to place service user and family experience at the heart of everything we do. Everyone who had the privilege to know and work alongside Mark recognised his dedication and passion to helping improve healthcare services. Mark is very much missed by us all and leaves an enduring legacy.

2.5 Coproduction Conference

I was delighted to participate in the second EPUT Coproduction Conference on 10 October which was held in Southend. This was a truly inspirational day with notable keynote speakers representing national, regional and local voices on involvement and coproduction. The venue was filled to capacity and delegates have evaluated the event as highly positive and productive in terms of learning. Congratulations to the Patient Experience Team for their leadership and management of a complex event.

2.6 Spirituality, Faith & Mental Health Conference

I was likewise delighted to participate in EPUT's inaugural conference focussing on mental health and spirituality. This landmark event was supported by our multi faith network with the executive sponsorship of our Medical Director, Dr Milind Karale, led and organised by the EPUT Chaplaincy Team, being held in the beautiful surroundings of Chelmsford Cathedral. Service user involvement

was a central feature, with inspirational content. The conference was well attended, attracting delegates from multiple organisations. Our thanks and congratulations go to Helen Semoh, Lead Chaplain and her team.

2.7 Safeguarding Adults Week

To recognise Safeguarding Adults Week (18 – 22 November), the Safeguarding Team arranged a schedule of visits to Trust sites to talk to staff, patients and their families about safeguarding and sexual safety. The team were joined by the Violence and Abuse Prevention and Reduction (VAPR) and Staff Engagement Teams; Next Chapter, a specialist domestic abuse support service, were also able to join a number of these events.

2.8 Service visits

The NEDs and I continue with our visits to services across the Trust, to see and hear first-hand the experience of our patients and staff. These visits also include Quality Assurance Visits (QAV) with ICB and governor representation. Since the last Board meeting, visits have taken place to Woodlea Clinic, Chelmer Ward, Galleywood Ward, Tower Ward and Gloucester Ward.

2.9 Equality and Diversity at EPUT

It is important to recognise that our workforce is made up of many different types' people who come from a variety of professional and personal backgrounds. To celebrate our staff and the diversity of our workforce, I have shared below just some of the events that have taken place since the last Board meeting:

- **Support Worker Day**
  The HCA Academy held two drop in sessions for HCAs to celebrate Support Worker Day on 22 November. At these sessions there was an opportunity to hear from EPUT and MSEFT staff, covering many interesting topics such as apprenticeships, wellbeing and the upcoming initiatives being rolled out.

- **Transgender Awareness Week and Transgender Day of Remembrance**
  Transgender Day of Remembrance is an annual observance that honours the memory of transgender people whose lives have been lost due to acts of anti-transgender hate and violence. It was founded in 1999 to commemorate the life and death of Rita Hester, a trans woman murdered in Boston, Massachusetts. The day followed Transgender Awareness Week which took place from 12 to 19 November. Trans Awareness weeks provides an opportunity to foster an understanding of the lives of transgender and gender non confirming people. There is information available to staff on our intranet about how we can support the LGBTQ+ community. We also have a LGBTQ+ staff equality network that is open for all staff to join.

- **Disability History Month**
  Disability History Month runs from 14 November until 20 December. This year, the focus is on disability, livelihood and employment in the health and care sector. Our Staff Disability and Mental Health Equality Network hosted an event from EPUT staff on 22 November with speakers sharing thought provoking talks on the theme of community as well as a Q&A session, alongside the NHS England Disability History Month annual webinar.

- **Islamophobia Awareness Month**
  The NHSE Muslim Network marked Islamophobia Awareness Month in November by hosting sessions focussed on raising awareness of and challenging Islamophobia and outlining the impact it has on health outcomes.

- **International Men's Day**
  To mark International Men's Day, Zephan Trent, Executive Director of Digital, Strategy and Transformation, shared with staff a written piece reflecting on his personal thoughts and experiences as a man, husband and father. Having recently welcomed a new addition to his family, Zeph has recently returned from a period of parental leave and highlighted the flexible policies in place within the Trust to support families. Zeph reflected on the progression of family friendly policies, and encouraged all to complete the NHS Staff Survey, emphasising that only

by using a collective voice can we change attitudes and ultimately national policies that will make a difference for ourselves and future generations.

2.10 Partnership Working to Provide Therapeutic Programmes

EPUT are working closely with iCARP, a community interest company based in Great Oakley, to deliver a fishing programme to help change the lives of people experiencing mental health conditions including post-traumatic stress disorder and depression. iCARP uses fishing as a way to help people relax and learn a new skill, while providing a supportive and safe space for them to talk to qualified coaches and other participants about their mental health. The programme also breaks down barriers for people who may find it difficult to open up in traditional therapy sessions, and complements the work our clinical teams also provide. This programme has been designed with the north east Essex community mental health teams and our Colchester and Tendring community mental health teams and Op COURAGE, a specialist mental health service for armed forces veterans, are among the services who refer patients to iCARP.

3.0 Legal and Policy Update

3.1 Mental Health Bill long – awaited step towards tackling disparities in detentions

Please see the first link below for a copy of the report published on 6 November 2024. The second link is the press release outlining better care for mental health patients. The third link is a copy of an article – Modernisation of Mental Health Law that provides key changes to the Bill

For Information: Mental Health Bill long-awaited step towards tackling disparities in detentions | NHS Confederation; Better care for mental health patients under major reforms - GOV.UK; bevanbrittan.com/insights/articles/2024/modernisation-of-mental-health-law/

3.2 New National People Sexual Misconduct Policy Framework

Please see the first link below for a copy of the report published on 24 October 2024 that will support employers in meeting their new legal duty under the Worker Protection Act 2024 to prevent the sexual harassment of staff. The second link is a copy of Sexual Safety in healthcare – organisational charter.

For Information: New guidance around legal duty to prevent sexual harassment | NHS Employers
NHS England » Sexual safety in healthcare – organisational charter

3.3 The New Employment Rights Bill

Please see the link below for a copy of the factsheet published on 17 October 2024.

For Information: Employment Rights Bill: factsheets - GOV.UK

3.4 Maternal Mental Health Services

Please see the link below for a copy of the progress report. This report details how maternal mental health services are being delivered at the local level. It finds that there has been progress with the establishment of these services in most areas of England but that many of these small services are struggling to cope with levels of demand. The data shows wide variation between what care is provided for women, birthing people and their families, the criteria to access this care, and waiting times for assessment and treatment in different parts of the country.

For Information: mmha_progress_report_on_mmhs_final.pdf

Professor Sheila Salmon
Chair
December 2024

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item PS 5

REFERENCES

Only PDFs are attached

CEO Report December 2024 CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1				4 December 2024	
Report Title:	**Chief Executive Officer (CEO) Report**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report				
Summary of risks highlighted in this report				
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			X
	SR2 People (workforce)			X
	SR3 Finance and Resources Infrastructure			X
	SR4 Demand/ Capacity			X
	SR5 Lampard Inquiry			X
	SR6 Cyber Attack			X
	SR7 Capital			X
	SR8 Use of Resources			X
	SR9 Digital and Data Strategy			X
Does this report mitigate the Strategic risk(s)?	Yes/ No			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.				
Describe what measures will you use to monitor mitigation of the risk				
Are you requesting approval of financial / other resources within the paper?	Yes/No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Receive and note the content of the report.

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

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

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

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

Acronyms/Terms Used in the Report			

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

Non-Executive Lead:
[signature] **Paul Scott,** **Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Lampard Inquiry

The Lampard Inquiry process continues with three virtual hearings taking place from 25 – 27 November following on from hearings held in Chelmsford earlier this year. As a Trust we are committed to continuing to engage with the Inquiry and know that many of our staff and those that they care for will have been deeply impacted by the Inquiry. Recognising that different types of support will be needed by different people, options have been developed within a 'triangle of support' which includes wellbeing, psychological and legal support.

1.2 MP Engagement

As part of our ongoing programme of engagement with Essex MPs and other key stakeholders, we have been running a series of virtual and face to face briefings to update stakeholders on the progress of the Lampard Inquiry. These briefings have been a valuable opportunity to establish relationships with some of the MPs who were newly elected in July, as well as strengthening existing relationships. Stakeholders have found the updates helpful and we have been able to reassure them of the actions we continue to take to improve our services and provide safe care. More briefings are planned over the coming weeks. In November, we also issued regular written updates to stakeholders, which are sent to over 130 colleagues across local authorities, the NHS, HealthWatches and partner universities.

1.2 SOPHIA App for Standard Operating Procedures

A new digital app giving staff fast, easy access to Standard Operating Procedures (SOPs) is now live across the Trust. Clinical and Corporate SOPs are step by step, easy to follow guides to support staff in providing safe, high quality and consistent care across our services. Adhering to SOPs is vital to patient safety, SOPHIA stores SOPs in one place that can be accessed through various means including the Trust intranet, tablet or mobile phone.

1.3 NHS Staff Survey

EPUT staff were encouraged to complete the annual NHS Staff Survey to ensure we have an accurate picture of what it is like to work for EPUT and the NHS. As in previous years, the survey was confidential and anonymous, with responses handled by an external survey provider. The staff survey is a national statistic, and feedback can help inform improvements in staff experience and patient care across the NHS and locally at EPUT.

1.4 Racial Abuse Scrutiny Panel

The safety of our staff is extremely important to myself and the leadership team. Initiated by our Employee Programme Safety Lead, a Racial Abuse Scrutiny Panel, including staff from EPUT, Essex Police and The Crown Prosecution Service, recently convened to understand how the police could better support EPUT colleagues when they report incidents of violence or discrimination. Colleagues from the Basildon Mental Health Unit met with the Basildon Police Commander and Regional Hate Crime Lead for the Crown Prosecution Service. Together they reviewed anonymised cases of racial abuse reported by EPUT staff, identifying learning for both Essex Police and EPUT. With this initial event having a focus on Basildon, similar events are to be scheduled in other areas.

1.5 Trust Shortlisted for Three Awards

I am delighted to report that the Trust has been shortlisted in three categories in this year's Nursing Times Workforce Awards. Congratulations to Prince Adoe, who has been shortlisted for Overseas Nurse of the Year and Moriam Adekunle, Director of Patient Safety and Patient Safety Specialist, who has been shortlisted for Diversity and Inclusion Champion of the Year. We have also been shortlisted for Best Employer for Diversity and Inclusion for our RISE customised talent development programme for colleagues from Black, Asian and minority ethnic backgrounds.

1.6 NHSE East of England CEO and Chair Event

I recently attended the NHS East of England CEO and Chair's meeting with other Chairs and CEO's in the region, where we discussed the health of the population in the East of England, opportunities for improving population health outcomes and health equity and the role of hospitals in improving population health outcomes – The Healthy Hospitals Framework.

1.7 NHS Providers Annual Conference and Exhibition

I recently attended the NHS Providers annual conference and exhibition held in Liverpool, where I was invited to join a panel of speakers on "Leading and improvement Culture: people powered improvement cultures". The session explored how different relational aspects of leadership could drive an improvement culture with people at the heart of it. I, and the other panellists, spoke of the importance of focussing on the relational people focussed aspects of improvement, the different approaches we have adopted and the impact that had.

2. UPDATES

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

- Improving rates of cardio metabolic monitoring in the completion of full health checks for our inpatient and SMI community patients, with sustained month on month increases positioning these indicators at their highest for 18 months.

- Adult mental health inpatient capacity challenged with an increased average length of stay (ALOS). Older adult ALOS decreased. Delayed Transfers of Care for adults (8%) outside of the target threshold (5%), with some inconsistency between the recording of Expected Date of Discharge and the Clinically Ready for Discharge dates. Inappropriate Out of Area Placements reduced from 81 to 65 in October, with 50% fewer placed out of area in October (24) compared to September (49) and 40 patients repatriated to EPUT services.

- Three system MADE events completed, resulting in firm commitments to expected dates of discharged from system partners. Learning and recommendations following the events to be overseen by the Southend, Essex and Thurrock Strategy Implementation Group.

- 9% increase in crisis calls to 111 option 2; 80% of calls answered within the response 60 seconds, falling short of the 95% target. 4 hour face to face assessment performance fell below target at 92%, all breaches were in mid and south and being reviewed. 100% of assessments within 24 hours achieved.

- Wheelchair urgent assessments in 5 days steadily improving from a low in April (of 30%) to 96% in October.

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

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Tendable Digital Platform for Audits - As part of our Quality Assurance Framework, we undertook a review of our ward based quality control audits. The review highlighted a high volume of questions, inconsistency in deployment and a mistrust in the quality of the results. Therefore, a transformation of questions asked, deployment and reporting has taken place. This resulted in the Trust reviewing its Tendable contact to increase the scope to the whole Trust. New audit suite went live in the acute inpatient mental health wards in October 2024 using the Tendable digital platform capturing data, allowing action planning and data reporting with the eradication of paper audits. Roll out to Specialist services is in progress.

Director of Nursing, Rebecca Pulford presented this work at the Tendable Quality Excellence conference at the Royal Collage of Nursing in November 2024. Our Public Governor Paula Grayson

visited the Linden Centre In November 2024 to gain understanding and speak to the staff on the new audit programme.

Early Warning Signs Framework- The Trust is a pilot site of the NHS England work to establish a new national oversight and early warning signs framework for inpatient mental health, learning disability and autism inpatient settings. The aim is to help spot quality issues and address them by routine quality discussions including regional partners on the data and soft intel that 'matters most'.

This work also align with CQCs work on closed cultures, and draw on findings from serious quality failings in the sector. Our involvement in this work has allowed us to draw on additional expert support to help us better embed our existing quality measures with clinical leadership at a care unit level. Work will start in December 2024 with Inpatient and Urgent Care and West Care Units agreeing to focus on a smaller number of quality measures that have national focus and reflected through the Model Health System.

Safeguarding Roadshows - These in person events have started across all inpatient sites. The demand for support and education around safeguarding is on the rise. As the media and public spotlight focuses increasingly on this area of practice, it is essential that our frontline workforce and local leadership teams responsible for overseeing the delivery of care have the knowledge, skill and confidence to safeguard Adults at risks and children who have contact with our services.

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

National Workforce Report

Sexual Misconduct -NHS England has now published a new sexual misconduct national policy framework and e-learning module to support employers in meeting their legal duty under the Worker Protection Act 2023 to prevent the sexual harassment of staff. We are working with our staff side representatives to agree the policy into the Trust's policy framework.

Employment Rights Bill -The government has launched consultations in relation to the following four areas of its proposed Employment Rights Bill:

- Statutory Sick Pay – SSP to be available to employees from day one of sickness absence and increase to lower earnings limit.
- Zero Hours contracts for Agency Workers – how zero-hours contract measures can best be applied to agency workers.
- Industrial Relations – repeal the majority of the Trade Union Act 2016 with changes to current practices and provisions.
- Collective Redundancy and 'Fire and Rehire' – enhance and strengthen collective redundancy framework and protections for employees.

The Trust is part of a working group established by NHS Employers to provide a collective response to the government's consultation.

Workforce Performance

Mandatory Training - The current compliance rate is 85 % which demonstrates a flat line trajectory looking at the last 3 months. The reports for the organisation and Care units now highlight the specific detail associated with staff group and subject matter to provide areas of risk.

Recruitment_- The Trust has a vacancy rate of 12.8% which has reduced from 15.1% in the last reporting period, overall set target is 12%. Further consideration by staff group shows a vacancy rate for Nursing at 14% down from 22%, HCAs at 12% down from 13% and AHPs at 13% down from 17%. Time to hire averages out at 51 days from job approval to start date, inclusive of candidate notice period. This has come down from 82 days.

Staff in Post - The Trust is currently operating at 9% above planned workforce trajectories taking consideration of substantive, agency and bank workforce. This is predominantly due to high levels of

bank use which continues to operate significantly above plan. However, in terms of substantive staffing the Trust is ahead of target in October with 6,155,77 wte in post against an in month target of 6137,77 wte and therefore on trajectory to meet our end of year target of 6285.50 wte.

2.5 Medical – Dr Milind Karale, Executive Medical Director

A number of our consultant colleagues have been awarded the Fellowship of the Royal College of Psychiatrists (FRCPsych) in recognition of their contributions to mental health and patient care.

- Dr Anirban Bhowmick
- Dr Hooria Ahmad
- Dr Edwin Ugoh
- Dr Fiona McDowall

Various engagement sessions are also planned for clinical directors to attend, booked across Trust sites to meet with Paul Scott and Dr Milind Karale.

2.6 Finance – Trevor Smith, Executive Chief Finance Officer

- Income and Expenditure year to date deficit £6m, due to high levels of patient demand and acuity within Inpatient Mental Health services (£8.1m) leading to overspend in staffing and out of area placements. A range of measures and actions are being taken across the organisation and with system colleagues in order to deliver the planned deficit for the year.

- Capital expenditure totals £7m year to date with an opening planned programme £24.4m.

- Cash balances total £38.1m.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS 15

REFERENCES

Only PDFs are attached

Quality Performance Scorecard CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	dg

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

Risk Assessment of Report

Summary of risks highlighted in this report	All inadequate and requiring improvement indicators		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital & Data Strategy		
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Full Report

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

Summary of Key Issues

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

Mental Health Inpatient Capacity

- The average length of stay for adult patients increased in October, reporting an average of 81 against the national benchmark of <35. When monitoring this performance with assessment units included we see an average length of stay position of 59 days. There were 70 discharges (40 from assessment units), 26 of whom were long stays (60+ days). There were 5 discharges in October with a length of stay of 250+ days.

- Older adult average length of stay decreased in the month to 102 days, remaining outside the target of 74. There were 24 discharges, 13 of whom were long stays. The average length of stay for Older Adult current inpatients continues to increase with October's performance the highest average ever reported of 136 days. The implementation plan for the introduction of system escalation forum for Older Adults is making good progress.

- PICU average length of stay remains within the target threshold.

- MADE events took place in October, resulting in patient movement and firm commitment to expected dates of discharge in November.

- Learning from the MADE events is being taken forward by EPUT and system partners and is overseen by the SET Strategy Implementation Group.

Inappropriate Out of Area Placements

- October saw a reduction in the total number of patients in out-of-area beds, dropping to 65 from 81 in September. This is a positive trend and the reduction of around 50% in newly placed patients (24 in October compared to 49 in September) also shows improvement in performance.

- 40 patients were successfully repatriated back to EPUT wards in October.

- There is continued focus on front door reviews and gate keeping but there is increased work to reduce the length of stay and discharge delays.

NHS Talking Therapies

- North East Essex access rates continue to be the most challenged area. There has been an improvement in October, reporting 739 against the target of 844. North East Essex have consistently achieved 80% of the access target since 2021.

- Across other Talking Therapies KPIs; all areas consistently meet 100% for clients beginning treatment both within 6 weeks and 18 weeks. The percentage of clients moving to recovery also maintains consistent target attainment.

Physical Health Checks

- Sustained month on month improvement of cardio metabolic monitoring rates in the completion of full health checks for inpatient mental health and SMI community patients, with highest recorded performance for 18 months.

Temporary Staffing –

- The Trusts performance for agency staffing saw a slight increase in shifts being booked through agency in October. West Essex remains the care unit with the highest agency utilisation, however

work is on-going with HR to transition temporary staff to substantive roles, and there has been a further decline in their agency usage during the month.

- The number of booked shifts and hours for bank staff increased in October. Inpatient & Urgent Care remains the care unit with the highest bank utilisation.
- Reducing temporary staff continues to be a main theme of the Time to Care programme and focused work being carried out by the HR Business Partners. In addition, regular discussions and monitoring of this performance takes place within the Accountability Frameworks.
- There also continues to be proactive work on vacancies and substantive recruitment with particular emphasis on HCA, qualified nursing and AHP roles in order reduce dependency on temporary staffing. There is a forum taking place in January 2025 to discuss a strategy regarding the vacancies for consultants and understand immediate and longer term mitigations.
- There are also enhanced controls being implemented over the next few weeks including a cessation of agency bookings for HCA roles as a result of a reduction in the vacancy rate to under 10%.

Sickness Absence

- Sickness absence has seen a rise in September and October compared to previous years, indicating a cause for concern. September reported 8.5%, and the draft figures for October reports 9.7% against the benchmark of <5%. Both short and long term sickness saw an increase in September, and a further increase can be seen in short term sickness absence in the draft figures for October.
- Nationally, EPUT is reporting slightly higher than the England average which was reported at 4.5% in May. The most reported reason for absence across all areas remains to be anxiety/stress/depression/other psychiatric illness, and there has been a seasonal increase of cold/covid sickness.
- The care units with the highest sickness rates in October (subject to sign off) were Specialist at 10.6%, West at 10.9% and Inpatient & Urgent Care at 10.9%

Income and Expenditure

- Continued high demand and acuity for Mental Health Inpatient services driving staffing and Out of Area placement overspends. National non-recurrent deficit support funding has been received and the Trust's annual plan is now to deliver breakeven. Against this plan the year to date deficit is £6m.
- Month 7 results include the YTD impact of pay awards which has increased expenditure compared with month 6

Finance - Maximising Capital Resources

- Year to date capital expenditure £7m, £4.9m below plan. £2.6m relates to National re-profiling of EPR funding (deferred to 25/26), £1m relates to the reassessment exercise relating to IFRS 16 leases and £1.3m relates to timing of delivery of the local schemes.

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

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

3: We empower	✓

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

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

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

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Information Item | Chairs | 10

REFERENCES

Only PDFs are attached

Committee Chairs Report 04.12.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

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

Risk Assessment of Report				
Summary of risks highlighted in this report	N/A			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 Finance and Resources Infrastructure			✓
	SR4 Demand/ Capacity			✓
	SR5 Lampard Inquiry			✓
	SR6 Cyber Attack			✓
	SR7 Capital			✓
	SR8 Use of Resources			✓
	SR9 Digital and Data Strategy			✓
Does this report mitigate the Strategic risk(s)?	N/A			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

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

Recommendations/Action Required

The Board of Directors is asked to note the report and assurance provided.

Summary of Key Points

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

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

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

- Assurance – any key assurances to be provided to the Board.
- Information – any issues previously identified which have now been resolved, including lessons learned.

- Alert – any issues / hotspots for escalation to the Board.
- Action – any issues where the Standing Committee is requesting action from the Board.

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Committee Chairs Report
Appendix 1: Audit Committee Terms of Reference
Appendix 2: Audit Committee Annual Report and Effectiveness Review

Executive/ Non-Executive Lead / Committee Lead:

Chairs of Board of Director Standing Committees.

Committee Chairs Report

Board of Directors Part 1

December 2024

1. INTRODUCTION

Purpose of the report

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

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

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

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

2. AUDIT COMMITTEE

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

Committee meeting held: 15 October 2024

Assurance

Internal Audit Progress
- The Committee received an update on progress against the Internal Audit Plan for the period August-October 2024, noting it was on track in terms of field work, but the report finalisation needs further progression.
- Three audits had been completed since the last report:
  - Core Financial Assurance – Substantial Assurance.
  - Care Plans and Risk Assessments (Inpatient Acute and Mental Health Services) – Reasonable Assurance.
  - Recording and Monitoring of Therapeutic Observations - Reasonable Assurance.
- 17 of the 19 management actions had been completed, noting good progress, and two were past due date.
- 2 management actions with past due dates associated with the Risk Management Assurance Framework / Risk Appetite where extension had been agreed with the Board.

Waiver of Standing Orders
- The Committee received the Waivers report for the period 1 June-31 October 2024.
- The Executive Director of Digital, Strategy and Transformation provided an analysis of Waivers relating to the Digital, Strategy & Transformation directorate, noting in particular the clinical risk if we were to change systems as we work towards a new single EPR.

Claims Annual Scorecard 2024
- The Committee received an Annual Scorecard Report covering the 10-year period 1 April 2014-31 March 2024, noting the reduction in total value between this period and the last.

Risk Management Assurance Framework Annual Report 2023/24
- The Committee received and noted the Risk Management Assurance Framework Annual Report 2023/24 and the continued programme of work to enhance the Trust's risk management culture.

Information

Quality Assurance Audits Using Tendable
- The Committee received an update on the progress of Quality Control Audits using the Tendable platform as an enhancement to the annual clinical audit programme.
- Following the pilot of a new process, the Tendable platform went live across mental health inpatient services in October 2024, and was expected to be live within Specialist Services and Community & Physical Health Services by the end of 2024.
- Committee members felt assured about the alignment between Tendable and the main Audit portfolio.

Anti-Crime Progress
- There has been substantial progress with the rollout of the Counter Fraud, Bribery and Corruption Awareness e-learning module.

External Audit Progress
- Audit planning for 2024/25 will commence in January 2025, with the Annual Audit process commencing in April 2025.

AUDIT COMMITTEE

Action

Annual Review Scheme of Reservation & Delegation / Standing Orders for the Practice and Procedures of the Board of Directors

The Committee approved the onward reporting to the Board of Directors for ratification of:

- A revised *Scheme of Reservation & Delegation* and *Standing Orders for the Practice & Procedures of the Board of Directors*.
- Changes to the Trust's Governance Manual.
- And the prospective amendment to the *Standing Orders for the Practice and Procedures of the Board of Directors,* to be enacted from February 2025.

These are a substantive item for the next Board meeting.

Audit Committee Annual Report & Effectiveness Review

- The Committee approved the draft Audit Committee Annual Report & Effectiveness Review for onward reporting to the Board of Directors for ratification.

Alert

Audit Committee Terms of Reference

- The Chair of the Trust approved revised Terms of Reference for the Audit Committee. These are attached as Appendix A.

3. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 21 November 2024

Assurance

Performance Report
- The Committee received assurance on the Trust's performance during October 2024.
- Areas of performance discussed included: CPA 12 Month Reviews; Cardio Metabolic Inpatient and Community Health; Patients Clinically Ready for Discharge; Mental Health Inpatient Capacity; Inappropriate Out of Area Placements; NHS Talking Therapies; Crisis Call Response Times; Crisis Face to Face Assessments; Wheelchairs; Essex STaRS.

Financial Report Month 7
- The Committee received an update on the Trust's Revenue, Capital and Cash position for Month 7.
- Non-recurrent financial support of £11.1m has been confirmed by the National Team. This support means the Trust is to deliver a year-end break-even position.
- The Finance Team is analysing the projected impact of the Pay Awards.
- The Trust's Cash position currently exceeds planned forecasts.
- A mid-year financial review and forecast outturn exercise has been completed and will be reviewed by the relevant Committees.
- Projected costs for the Public Inquiry will be reassessed in line with the extended timelines.
- A new finance dashboard has been developed and will be launched shortly.

Assurance Reports
The following Assurance Reports were received by the Committee:
- Cyber & Information Governance Assurance Report – July-September 2024
- Board Assurance Framework – October 2024.

Information

Capital Deep Dive
- The Committee received a Deep Dive report on Capital, noting the Year to Date Capital position for Month 7
- Details of key achievements to date were provided to the Committee.
- The Trust awaits confirmation of 2025/26 capital allocations, with a three-year allocation expected in Spring 2025.
- The Trust has been asked to submit an initial view of 10-year capital requirements as part of an ICS return.

Action

Strategic Impact Report
- The Committee gave their approval for the Strategic Impact Report Month 6 2024/25 to be presented to the Board of Directors.
- This will be provided in a separate Agenda item.

Alert

No Alerts for the Board.

4. PEOPLE, EQUALITY & CULTURE COMMITTEE

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

Committee meeting held: 30 October 2024

Assurance

Time to Care
- One third of the new Time to Care posts have now been filled.
- Adverts for a range of roles are currently live.
- Roadshows at Rochford Hospital, The Linden Centre, The Lakes and Basildon MHU to roll out the model to staff were attended by 157 people including Executives and NEDs.

Staff Survey 2024
- At the time of the meeting the response rate was 25.6%, against a target of 50%.
- A range of enhanced staff engagement activities are planned to increase take-up.

Worker Protection Act (amendment of Equality Act 2010)
- This Act came into force on 26 October 2024, introducing a new legal duty on employers to take reasonable steps to prevent sexual harassment of their workers.
- The Committee received assurance that sexual safety principles issued by NHSE will be implemented across the Trust.
- Mandatory training will be revised and rolled out to all staff.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Annual Workforce Plan Progress Report – Quarters 1 and 2.
  - Workforce Performance Report – September 2024.
  - Lived Experience & Volunteers Update – Quarters 1 and 2.
  - Recruitment Strategy Assurance Report – September 2024.
  - Equality, Diversity & Inclusion Update – Quarter 2.
  - Independent Review Action Plan – September 2024.
  - Board Assurance Framework Report – September 2024.
  - Freedom to Speak Up Report – September 2024.
  - Employee Relations Case Management Assurance Report – September 2024.

Information

Equality & Inclusivity Events
- Several events were held to mark National Inclusion Week in September 2024.
- A range of activities were held throughout October to mark Black History Month.
- Events are organised during November and December to celebrate Disability History Month.

Research & Innovation Funding Opportunities
- Bids have been submitted to the University of Essex for innovation and research funding relating to increasing recruitment within local communities, and developing management competencies.

Leadership Development
- A review of the current leadership development training portfolio is underway, with three-year plans for care units and corporate services to be produced for implementation in the 2025/26 financial year.

Recruitment
- An HCA recruitment event was held October, where virtual reality headsets were used.
- The Recruitment Team attended the Essex Chamber of Commerce ‘Essex Has Talent’ event on 13 November 2024 to recruit for a range of roles across the Trust.

Hearing Managers
- A cohort of business unit and operational managers will be trained as investigation and hearing managers to increase the Trust’s capacity and competency to deal with employee cases.

PEOPLE, EQUALITY & CULTURE COMMITTEE

Action

Strategic Impact Report

- The Committee gave their approval for the Strategic Impact Report Month 6 2024/25 to be presented to the Board of Directors.
- This will be provided in a separate Agenda item.

Alert

Committee Work Plan 2024/25

- The Committee approved an updated Committee Work Plan 2024/25.

5. QUALITY COMMITTEE

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

Committee meeting held: 18 October & 18 November 2024

Assurance

Health Inequalities Deep Dive
- The Committee received assurance on initiatives relating to health inequalities within the areas of: Mental Health Act; Perinatal Services; Learning Disability Services Immunisation Services; and Sexual Safety.

Safety Improvement Plans (SIPs)
- Updates were received on four Safety Improvement Plans (SIPs): Embedding Gold Standard e-SOPs; Multi-Disciplinary Team; Transitioning of Children and Young Persons to Adult Mental Health Services; Clinical Handover.

Quality of Care Strategy Delivery
- Update on the Quality of Care Strategy - since its launch in April 2024 is proceeding well, noting the further development of metrics to aligned to the priorities.
- Governance arrangements are in place.
- Four Clinical Quality Senate meetings have been held year to date.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Mental Health Act Report – August 2024
  - Reducing Restrictive Practice – Quarter 2 2024/25
  - Sexual Safety – Quarter 2 2024/25
  - Learning from Deaths – Quarter 1 2024/25
  - Clinical Audit & NICE Progress Report – Quarter 2 2024/25
  - Pharmacy & Medicines Optimisation – Annual Report 2023/24
  - Senior Information Risk Owner (SIRO) – Annual Report 2023/24
  - Patient Safety Incident Response Framework (PSIRF) – Quarter 2 2024/25
  - Patient & Service User Experience – Quarter 2 2024/25
  - CQC Improvement Plan Bi-Monthly Progress Report – November 2024
  - Board Assurance Framework Bi-Monthly Report – November 2024

Information

Executive Chief Nurse/Executive Medical Director Emergent Issues
- The Trust is working with Prison services to ensure adequate arrangements are in place for people requiring mental health support following release from prison.
- Additional resource has been allocated to support an increase in looked after children moving to the area.
- A new Flow and Capacity system is being piloted.
- The Trust is working in collaboration with public sector providers to reduce delays to discharge.
- A Co-Production Conference held in October 2024 had been very successful, with more than 120 attendees including staff, volunteers and senior leaders from EPUT and across the System.

Quality Performance Dashboard
- Development and implementation of the new Quality Dashboard is progressing well.

Patient Led Assessments of the Care Environment (PLACE) 2024 Progress
- Work is on track to meet NHSE deadlines.
- Early results indicate improvements in comparison to 2023.

Senior Information Risk Owner (SIRO) Annual Report
- The Committee approved the Trust's continued commitment to supporting arrangements to attain compliance against Data Security & Protection Toolkit assertions during 2024/25.

Strategic Impact Report
- Committee members discussed how the Trust's Research activity could be incorporated into Trust services to improve the quality of care for service users.

QUALITY COMMITTEE

Action

Strategic Impact Report

- The Committee received and endorsed the Strategic Impact Report Month 6 2024/25 to be presented to the Board of Directors. This will be provided in a separate Agenda item.

Alert

Board Assurance Framework

- Received the BAF and CRR for those risks aligned with the Committee and noted that a number of risks were now being reassessed as a consequence of management actions being achieved and proposed positive risk score changes. These were due to be reviewed and approve by Executives.

APPENDIX 1

To the Board of Directors

I certify that I have taken Chairs action on 12 November 2024 on the item detailed below.

Signed

Professor Sheila Salmon
Chair
Date:

CHAIR AUTHORITY TO AGREE

Terms of Reference: Audit Committee

Amendment of the Audit Committee Terms of Reference to enable an associate non-executive director to form part of the quorum for the meeting. This will retain the experience and skills of the Committee to discharge its duties under its terms of reference.

Revised copy attached.

AUDIT COMMITTEE			
CHAIRED BY:	Elena Lokteva, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Committee Secretary	**FREQUENCY:**	Meetings shall be held not less than four times a year
AUTHORITY:	The Audit Committee (hereafter Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. The Committee is authorised by the Board of Directors to investigate any activity within the Trust. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board of Directors to instruct the in-house legal advisors and other professional advisors with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.		
PURPOSE- The duties of the Committee shall include the following:	**Governance, Risk Management and Internal Control:** 1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. 2 In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and Care Quality Commission essential standards of quality and care), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • Arrangements by which staff of the Trust may raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority • Proposals for tendering for both Internal or External Audit services and the Anti Crime Specialist services or for purchase of non-audit services from contractors who provide audit services. 3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness 4 The Committee will create an Annual Working Plan against which its performance is to be evaluated on an annual basis 5 To receive assurance that the Board Assurance Framework, Corporate Risk Register and the Directorate Risk Registers are properly utilised by the standing committees of the Board of Directors and by the Executive Directors to identify and adequately manage risk and identify mitigating actions. **Internal Audit:** 6 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal • Review and approval of the Internal Audit strategy, operational plan and more detailed program of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework		

- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimize audit
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annually reviewing of the effectiveness of internal audit.

External Audit:

7 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment of the External Auditor leading to an annual recommendation by the Audit Committee to the Council of Governors regarding the appointment/re-appointment of the External Auditor. This report will include reference to the performance of the external auditor including details such as the quality and value of the work and the timeliness of reporting and fees
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact of the audit fee
- review all External Audit reports before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is a current policy on the engagement of the external auditor to supply non-audit services which has been approved by the Council of Governors
- ensuring that there is a process in place so as to be able to report to the Council of Governors on any matters of significance
- ensuring that there is a process in place which delegates responsibility to the Audit Committee to review and monitor the independence and objectivity of the external auditor.

8 The Audit Committee has a responsibility to ensure that the Trust's appointed External Auditors are not compromised in terms of maintaining their integrity, objectivity and independence (as per section 1.8 of the Code of Audit Practice produced by the National Audit Office) or prohibited from undertaking such work. The Chair of the Audit Committee is required to be consulted with, and approve the use of the Trust External Auditors for any non-audit work prior to their appointment. This does not delegate the approval of expenditure to the Chair of the Committee.

Anti Crime (Fraud):

9 The Committee will:

- Review and approve the annual Anti Crime Specialist work plan
- Review the effectiveness of the Anti Crime strategy
- Monitor the implementation of Anti Crime reports
- Consider the annual report of the Local Anti Crime Specialist

Governance Manual:

10 The Committee will:

- Review annually the Governance Manual (consisting of the Standing Orders, Standing Financial Instructions and the Scheme of Delegations
- Review changes to the aforementioned documents
- Examine the circumstances associated with each occasion when SOs are waived and comment as necessary.

Other Assurance Functions:

11 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation

12 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

13 Where necessary, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee

Annual Accounts Review:

14 To review the annual statutory accounts for exchequer funds (which subject to an annual materiality test, are not consolidated), before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgement has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved

15 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy

16 To receive reports on the review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Value for Money (VFM):

17 The Committee will consider the appropriateness of value for money projects undertaken by the Trust and receive regular reviews of VFM progress

18 The Committee will also consider other topics as defined by the Board of Directors or Council of Governors arising from any sources that are considered by the Committee to be significant to the Trust.

Management:

19 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control, including but not limited to:

- Annual Counter Fraud Report
- Annual Report
- Financial Statements
- Annual Internal Audit Plan and reports
- External Audit Plan and reports
- Other reports as required

20 They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.

ATTENDANCE:	MEMBERSHIP:	IN ATTENDANCE:
	Three (3) Non-Executive Directors, one of whom must have relevant and recent financial experience and one being a member of the Quality Committee. One Associate NED attendance is permitted to form part of quorum.	Executive Chief Finance Officer / Director of Finance Head of Financial Accounts Senior Director of Corporate Governance Internal Audit Representative External Audit Representative Anti Crime Specialist Chief Executive (to present the Annual Governance Statement) Other Directors and Officers as requested by the members (Limited assurance reports)

<table>
<tr><td>QUORUM:</td><td colspan="2">Two (2) Non-Executive Directors / Associate NED.
It is expected that members will attend a minimum of 75% of meetings per year.</td></tr>
<tr><td></td><td>INPUTS:
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.</td><td>OUTPUTS:
Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval.

The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered.

The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.</td></tr>
<tr><td>Document Control:</td><td>Date Approved: November 2024</td><td>Date of Last Review: November 2024
Next Review: March 2025</td></tr>
</table>

ESSEX PARTNERSHIP UNIVERSITY NHS FT

SUMMARY REPORT	BOARD OF DIRECTORS	4 DECEMBER 2024			
Report Title:	Audit Committee Annual Report 2023/24				
Executive/ Non-Executive Lead / Committee Lead:	Elena Lokteva, Non-Executive Director				
Report Author(s):	Chris Jennings, Assistant Trust Secretary				
Report discussed previously at:	Audit Committee 15 November 2024				
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**

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

Risk Assessment of Report			
Summary of risks highlighted in this report	Maintaining a system of internal control.		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓	
	SR2 People (workforce)	✓	
	SR3 Finance and Resources Infrastructure	✓	
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry	✓	
	SR6 Cyber Attack	✓	
	SR7 Capital	✓	
	SR8 Use of Resources	✓	
	SR9 Digital and Data Strategy	✓	
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with the annual report bringing together the work of the Committee, review of its terms of reference and outcome of the annual effectiveness review.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Diretors is asked to:

1. Receive and approve the Audit Committee Annual Report .
2. Note the confirmation that the Committee discharged its responsibilities in line with its terms of reference in 2023/24
3. Note the revised terms of reference for the Committee to include

Summary of Key Points

The committee annual report provides confirmation to the Board of Directors of discharging its responsibilities under its terms of reference for 2023/24. It further details the output of the self-assessment of committee effectiveness undertake in June / July 2024.

An overall score of 84% was achieved in the self-assessed committee effectiveness review, providing reasonable assurance that the Committee is being effective, with some areas of improvement noted as priorities for the remainder of this year.

The report also, includes a revised terms of reference for the Committee, reference to the inclusion of an associate NED being permitted to form part of the quorum for the 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: No direct impact on finances as covered by NHS R insurance, however cumulative values of claims in preceding years do affect the annual contributions payable. **Capital £** **Revenue £** **Non Recurrent £**			✓
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
1. Audit Committee Annual Report 2023/24

Executive/ Non-Executive Lead / Committee Lead:
Elena Lokteva Non-Executive Director and Chair of the Audit Committee

Audit Committee Annual Report 2023/24

Audit Committee

Annual Report 2023/24

1. Background

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

The Committee oversees all aspects of internal control (including internal audit and external audit activity) and provides assurance to the Board of Directors on meeting its terms of reference.

2. Committee Membership

Elena Lokteva, Non-Executive Director, chaired the Committee from July 2023. Janet Wood chaired the Committee until June 2023 and remained a member of the Committee until September 2023.

Included within the current membership are two other Non-Executive Directors. And in attendance are the Executive Chief Finance Officer and the Senior Director of Corporate Governance. The Committee has a number of subject matter leads who attend e.g. Internal Audit, External Audit, Anti-Crime Specialist, Director of Finance and Head of Financial Accounts. Other members of the executive team may attend on an ad hoc basis and the Chief Executive attends annual for the review of the draft accounts and to present the Annual Governance Statement.

Administration relating to the Committee business was undertaken by the PA to the Executive Chief Finance Officer. In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

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

Table 1: Attendance at meetings held 2023/24:

		Attended	Total No. Meetings
Members			
Elena Lokteva	Chair	6	6
Janet Wood	Chair / Non-Executive Director (until September 2023)	4	4
Rufus Helm	Non-Executive Director	5	6
Dr Mateen Jiwani	Non-Executive Director	2	5

Jenny Raine	Non-Executive Director (from March 2024)	1	1
Diane Leacock	Non-Executive Director (from March 2024)	0	1
In Attendance			
Trevor Smith	Executive Chief Finance Officer	5	6
Denver Greenhalgh	Senior Director of Governance	4	6
Paul Scott	Chief Executive Officer	1	1
Simon Covill	Director of Finance	6	6
Clare Barley	Head of Financial Accounts	6	6

In addition, individuals from Internal Audit, External Audit and specialist staff attended at relevant meetings. A member of the Council of Governors also attended as observer.

3. Meetings

Meetings were held as per the schedule of business with six meetings taking place during the year.

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

4. Terms of Reference

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

5. Arrangements

The Committee provides internal assurance by reviewing the systems of control, including:

- Governance, Risk Management and Internal Control (excluding those managed by the Quality Committee)
- Internal Audit
- External Audit
- Anti-Crime (Fraud)
- Governance Manual
- Other Assurance Functions (such as reviews by the Department of Health Arm's Length Bodies)
- Annual Accounts Review

- Value for Money (VFM)

The Audit Committee receives reports and assurances from directors and managers on the overall arrangements for governance control, including, but not limited to the annual anti-crime report, financial statements, the annual report, the annual internal audit plan and reports, external audit plan and reports and any other required reports.

The minutes of the Audit Committee are made available to the Board of Directors. The Committee also reports to the Board via a Chairs Key Issues report, which highlights for the Board's attention where an item is for Board approval, alert for awareness, action to be taken or reporting on assurance received.

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

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

The Committee received reports on the following within the year:

- Annual Governance Statement
- Final Annual Report and Account 2022/23, incorporating the letter of representation (At the time of writing this report the Committee has also finalised and submitted the 2023/24 annual report and accounts)
- Audit Results Report for the year ending 31 March 2023
- External Audit progress reports
- Internal Audit updates, including the annual plan, progress report, update on recommendations, anti-crime, whistleblowing and governance functional standards
- Cyber Security alert monitoring and assurance until September 2023 (where after oversight transferred to the Finance and Performance Committee)
- Waiver of Standing Orders and an annual review of waivers
- Losses and Special Payments
- Write Offs

- Financial Policies & Procedures
- Annual Review of Governance Manual documents.
- Final Charity Report and annual accounts
- Claims Annual Scorecard
- Clinical Audit process and delivery assurance report
- Independent / Lampard Inquiry Update (Part 2)until January 2024 (transferred to the new Lampard Inquiry Oversight Committee established by the Board of Directors)
- Use of Consultants / Legal Services

The Committee delivered it annual work plan and therefore the members consider that it has discharged its duties as set out in its Terms of Reference.

6. Duties of the Audit Committee

Committee members carry out a self-assessment of the effectiveness of the Committee. The Trust Secretary’s Office manages this on an annual basis. The results enable the Committee to draw up a plan for improvement, which, for 2023/24 evaluation is on the agenda for its meeting in November 2024 alongside this annual report.

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

7. Control

During the past year, the Committee has considered any issues for escalation to the Board of Directors as part of the Committee Chairs Key Issues report. The Committee highlighted the following item to the Board of Directors at its meeting in March 2024:

- Based on the TIAA report and discussion at the meeting the Committee provides the Board with the partial level of assurance over IA plan progress and the acceptable level of assurance over recommendations implementation during the period.

8. Priorities (to be agreed by the Committee)

The following are priorities to focus on in the remainder of the year:

- To strengthen the reporting of the BAF and associated control assurance to the Committee from 2025/26 year.
- To continue to work (where appropriate) with other Committees of the Board through the sharing of IA reports for information.
- Continue to build relationships within the Committee and seek to put in place guidance for when executives are required to attend.
- To strengthen the reporting of clinical audit – assurance on process and delivery.

AUDIT COMMITTEE			
CHAIRED BY:	Elena Lokteva, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Committee Secretary	**FREQUENCY:**	Meetings shall be held not less than four times a year
AUTHORITY:	The Audit Committee (hereafter Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. The Committee is authorised by the Board of Directors to investigate any activity within the Trust. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board of Directors to instruct the in-house legal advisors and other professional advisors with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.		
PURPOSE- The duties of the Committee shall include the following:	**Governance, Risk Management and Internal Control:** 1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. 2 In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and Care Quality Commission essential standards of quality and care), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • Arrangements by which staff of the Trust may raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority • Proposals for tendering for both Internal or External Audit services and the Anti Crime Specialist services or for purchase of non-audit services from contractors who provide audit services. 3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness 4 The Committee will create an Annual Working Plan against which its performance is to be evaluated on an annual basis 5 To receive assurance that the Board Assurance Framework, Corporate Risk Register and the Directorate Risk Registers are properly utilised by the standing committees of the Board of Directors and by the Executive Directors to identify and adequately manage risk and identify mitigating actions. **Internal Audit:** 6 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal • Review and approval of the Internal Audit strategy, operational plan and more detailed program of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework		

- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimize audit
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annually reviewing of the effectiveness of internal audit.

External Audit:

7 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment of the External Auditor leading to an annual recommendation by the Audit Committee to the Council of Governors regarding the appointment/re-appointment of the External Auditor. This report will include reference to the performance of the external auditor including details such as the quality and value of the work and the timeliness of reporting and fees
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact of the audit fee
- review all External Audit reports before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is a current policy on the engagement of the external auditor to supply non-audit services which has been approved by the Council of Governors
- ensuring that there is a process in place so as to be able to report to the Council of Governors on any matters of significance
- ensuring that there is a process in place which delegates responsibility to the Audit Committee to review and monitor the independence and objectivity of the external auditor.

8 The Audit Committee has a responsibility to ensure that the Trust's appointed External Auditors are not compromised in terms of maintaining their integrity, objectivity and independence (as per section 1.8 of the Code of Audit Practice produced by the National Audit Office) or prohibited from undertaking such work. The Chair of the Audit Committee is required to be consulted with, and approve the use of the Trust External Auditors for any non-audit work prior to their appointment. This does not delegate the approval of expenditure to the Chair of the Committee.

Anti Crime (Fraud):

9 The Committee will:

- Review and approve the annual Anti Crime Specialist work plan
- Review the effectiveness of the Anti Crime strategy
- Monitor the implementation of Anti Crime reports
- Consider the annual report of the Local Anti Crime Specialist

Governance Manual:

10 The Committee will:

- Review annually the Governance Manual (consisting of the Standing Orders, Standing Financial Instructions and the Scheme of Delegations
- Review changes to the aforementioned documents
- Examine the circumstances associated with each occasion when SOs are waived and comment as necessary.

Other Assurance Functions:

11 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation

12 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

13 Where necessary, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee

Annual Accounts Review:

14 To review the annual statutory accounts for exchequer funds (which subject to an annual materiality test, are not consolidated), before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgement has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved

15 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy

16 To receive reports on the review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Value for Money (VFM):

17 The Committee will consider the appropriateness of value for money projects undertaken by the Trust and receive regular reviews of VFM progress

18 The Committee will also consider other topics as defined by the Board of Directors or Council of Governors arising from any sources that are considered by the Committee to be significant to the Trust.

Management:

19 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control, including but not limited to:

- Annual Counter Fraud Report
- Annual Report
- Financial Statements
- Annual Internal Audit Plan and reports
- External Audit Plan and reports
- Other reports as required

20 They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.

ATTENDANCE:	MEMBERSHIP:	IN ATTENDANCE:
	Three (3) Non-Executive Directors, one of whom must have relevant and recent financial experience and one being a member of the Quality Committee.	Executive Chief Finance Officer / Director of Finance Head of Financial Accounts Senior Director of Corporate Governance Internal Audit Representative External Audit Representative Anti Crime Specialist Chief Executive (to present the Annual Governance Statement) Other Directors and Officers as requested by the members (Limited assurance reports)

QUORUM:	Two (2) Non-Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Date Approved:** March 2024	**Date of Last Review:** March 2023 **Next Review:** March 2025

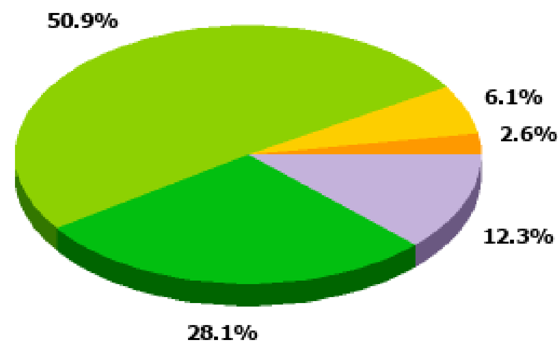
This summary report shows total scores, total percentage scores and a breakdown of responses by category and by individual statement.

Key and Scoring

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

Audit Committee Effectiveness Review 2024

Spread of Scores



Breakdown of report by category

Audit Committee Effectiveness Review 2024							Score	%age
General Questions	0	1	2	18	13	2	145/170	85%
Committee Focus	0	1	0	8	5	1	59/70	84%
Committee Team Working	0	0	1	15	8	0	103/120	86%
Committee Effectiveness	0	1	4	12	2	2	72/95	76%
Committee Engagement	0	0	0	5	4	0	40/45	89%
Strengths and Weaknesses	0	0	0	0	0	9	0/0	0%

Breakdown of report by individual statement

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

	Audit Committee Effectiveness Review 2024	Score	%age
	General Questions		
1	The terms of reference for the Committee are clear		87%
2	There is a set and agreed forward plan		93%

Comment: Significant review of ToR and work plan undertaken within last 12 months.

Comment: Terms of reference and forward plan for the Committee has been set for 2024/25.

***Response1**: The Committee should review the feedback from members and consider if new items need to be added and clearly commission the reports from the relevant executive / attendee.*

3	The committee meets frequently enough and with enough time to discharge its duties		87%

Comment: Reviewed and agreed with work plan, sequencing achieves national and local timescales and targets.

Comment: The Committee achieves its terms of reference within the scheduled meetings within the year.

4	The committee has a mechanism to keep it aware of topical, legal and regulatory issues		87%

Comment: Updates via Internal and external audit along with management updates.

Comment: There is no evidence of this being formalised through the agenda.

***Response2**: The Committee should consider how it could formalise updates on topical, legal and regulatory issues relevant to the committee business.*

5	The committee understands how it integrates with other committees		93%
6	There is no duplication or overlap with other committees		73%

Comment: I am not aware of the remits of other committees to be able to comment on whether there is any duplication or overlap with other committees.

Comment: The new ToR has eliminated overlaps

Comment: Where there is overlap, this is intentional so that topics for future audits can be identified in committees and taken back to be incorporated in the internal audit programme.

***Response3**: The Committee (with other Board Committees) should continue to check the correct alignment of assurance work across the Board Committees. Using the mechanism (via the Chairs Key Issues Report) to make requests of other committees.*

7	The committee has reviewed the robustness and effectiveness of the content of the Board Assurance Framework relevant to its area	67%

Comment: Whilst the Committee has received an annual review of the Board Assurance Framework, it is not submitted for review on a regular basis. Other similar organisations submit the Board Assurance Framework at each meeting.

Comment: With the new highly experienced members onboard, I would encourage more challenge on BAF effectiveness in FY24/25.

Comment: Robust framework with detailed reviews across Committees co-ordinated via Audit Committee.

Comment: The Committee receives an annual IA review of the robustness and effectiveness of the Board Assurance Framework (for 2023/24 this provided reasonable assurance).

***Response 4**: The Committee should consider what level of information it would like to see in regards to the BAF. As part of the BAF maturity process the oversight of controls assurance should be mapped against the 3 lines of defence to inform the IA programme for 2025/26.*

8	The committee considers the internal auditor's recommendations for those key controls within its assurance framework	87%

Comment: The Audit Committee oversees management actions in response to IA assurance reviews.

Response 5: The Committee should consider how it shares the outcomes of IA reports with other committees for information and inform their forward work plan to ensure sustainability of improvements following closure of management actions.

9	If the committee receives reports from programmes of work e.g. clinical audit , CIP and Transformation, the Committee: • Reviewed an annual plan, which is clearly linked to clinical risks and assurance needs • Received regular progress reports Monitored the implementation of management actions	90%
10	The committee ensures it receives explanations for variation in performance / achievement of objectives	87%
11	The committee receives and reviews the evidence required to demonstrate compliance with regulatory requirements	87%
12	The committee provides a meaningful summary report of its meetings to the next available Board meeting	90%

Comment: Whilst I understand a summary report is provided to the next Board meeting, I have not seen these to be able to confirm that it is a meaningful summary.

Comment: The Chair of the Committee provides a 'Chairs Key Issues Report' to each public meeting of the Board.

Committee Focus

13	The committee has set itself a series of objectives it wants to achieve this year.	87%
14	The committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.	87%
	Comment: The Committee continuously reviews the level of information that it receives for each of the items on its business planner. We should consciously confirm proportionality when setting new requests.	
15	Committee members contribute regularly across the range of issues discussed.	73%
	Comment: There is general discussion and contribution at the meeting. However, on occasion there has been a reluctance to contribute due to the tone of the meeting, this can stifle broader engagement rather than encourage. ***Response 6****: The Chair to consider how all contributions are encouraged and to challenge poor behaviours when observed.*	
16	The committee is fully aware of the key sources of assurance and who provides them in support if the controls mitigating the key risks to the organisation.	87%
17	The committee clearly understands and receives assurances from third parties the Trust uses to manage/operate key functions – for example, shared services, other NHS bodies or private contractors	90%
Committee Team Working		
18	The committee has the right balance of experience, knowledge and skills to fulfil its role as designed in the terms of reference.	80%
	Comment: Potential for further clinical management input Comment: The Committee has the right experience, knowledge and skills to fulfil its role. When discussing IA reports associated with clinical practices should consider inviting either the Chief Nurse of the Executive Medical Director to attend. ***Response 7****: The Committee should agree a set of rules for when clinical executives would be beneficial to attend (noting the cross over with the Quality Committee).*	
19	The committee has structured its agenda to cover its main duties in its terms of reference.	87%
	Comment: We organised and administered inside and outside of formal meetings	
20	The committee ensures that the relevant executive director/manager attends meetings to enable it to secure required level of understanding of the reports and information it receives (i.e. the right executive lead is there to discuss risk and internal matters in their area of responsibility rather than the committee having to rely on a single director to act as conduit to the executive).	93%
	Comment: Relevant Executive required for limited opinion reports and missed implementation dates or follow-up compliance ***Response 8****: The Committee should agree a set of rules for when executives would be beneficial to attend.*	

No.	Statement	Score
21	Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'.	80%
	Comment: The Board Assurance Framework only tends to be submitted annually to the Audit Committee.	
	Comment: The Committee no longer owns any of the BAF risks and therefore this function is carried out by other Board Committees.	
	Response 9: The Committee should consider what level of information it would like to see in regards to the BAF. As part of the BAF maturity process the oversight of controls assurance should be mapped against the 3 lines of defence to inform the IA programme for 2025/26.	
22	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	93%
	Comment: On occasions have reluctance to contribute due to the tone of the meeting, this can stifle broader engagement rather than encourage.	
	***Response 10**: The Chair to consider how all contributions are encouraged and to challenge poor behaviours when observed.*	
23	I understand the messages being given	87%
24	Members hold the reporting members to account for late or missing assurances.	87%
25	When action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.	80%
	Comment: Enhance by regular Audit agenda item on expanded ET with care units.	
	Committee Effectiveness	
26	The quality of the committee papers received allows me to perform my role effectively.	87%
	***Response 10**: Given the score the Chair should confirm if changes to papers received are required for future reporting cycles.*	
27	Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	73%
	Comment: We struggled with the continuity of membership in FY23/24. With new members onboard I expect there will be a strong improvement in FY24/25	
28	Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.	73%
	Comment: I would let members and attendees comment on this	
	Comment: Not conscious of any discussion being cut short due to time constraints.	
29	Each agenda item is 'closed off' appropriately, so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.	73%
	Comment: I would let members and attendees comment on this	

Comment: There is usually a summing up completed by the Chair at the end of each item.

30	At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.	73%

Comment: I would let members and attendees comment on this

Comment: This is completed at the end of the meeting.

31	The committee provides a written summary report of its Board	90%

Comment: Whilst I understand a summary report is provided to the next Board meeting, I have not seen these to be able to confirm that it is happening in practice.

Comment: The Chair provides a 'Chairs Key Issues Report' to each Board meeting.

32	The Board challenges and understands the reporting from this committee	60%

Comment: The Board rarely challenge sub-committees reports. I don't remember if I was ever asked any question after presenting AC report.

Comment: I do not attend the Board so am unable to answer this question.

Committee Engagement

33	The committee actively challenges management during the year to gain a clear understanding of their findings.	87%
34	The committee is clear about the complementary relationship it has with other Board assurance committees.	93%
35	I can provide two examples of where we as a committee have focused on improvements as a result of assurance gaps identified.	87%

Comment: All internal audit reports lead to some form of improvement. E.g. Medical Devices and DSPT

Strengths and Weaknesses

36 This is what the committee should do more of

Should consider whether they would like to undertake deep dives of specific risks at different Audit Committee meetings in order to obtain more assurance on management of risks.

Further development of links to Clinical Audit and associated activities

New ToR give us the right focus for FY24/25 work, nothing to add from my side.

37 This is what the committee should do less of

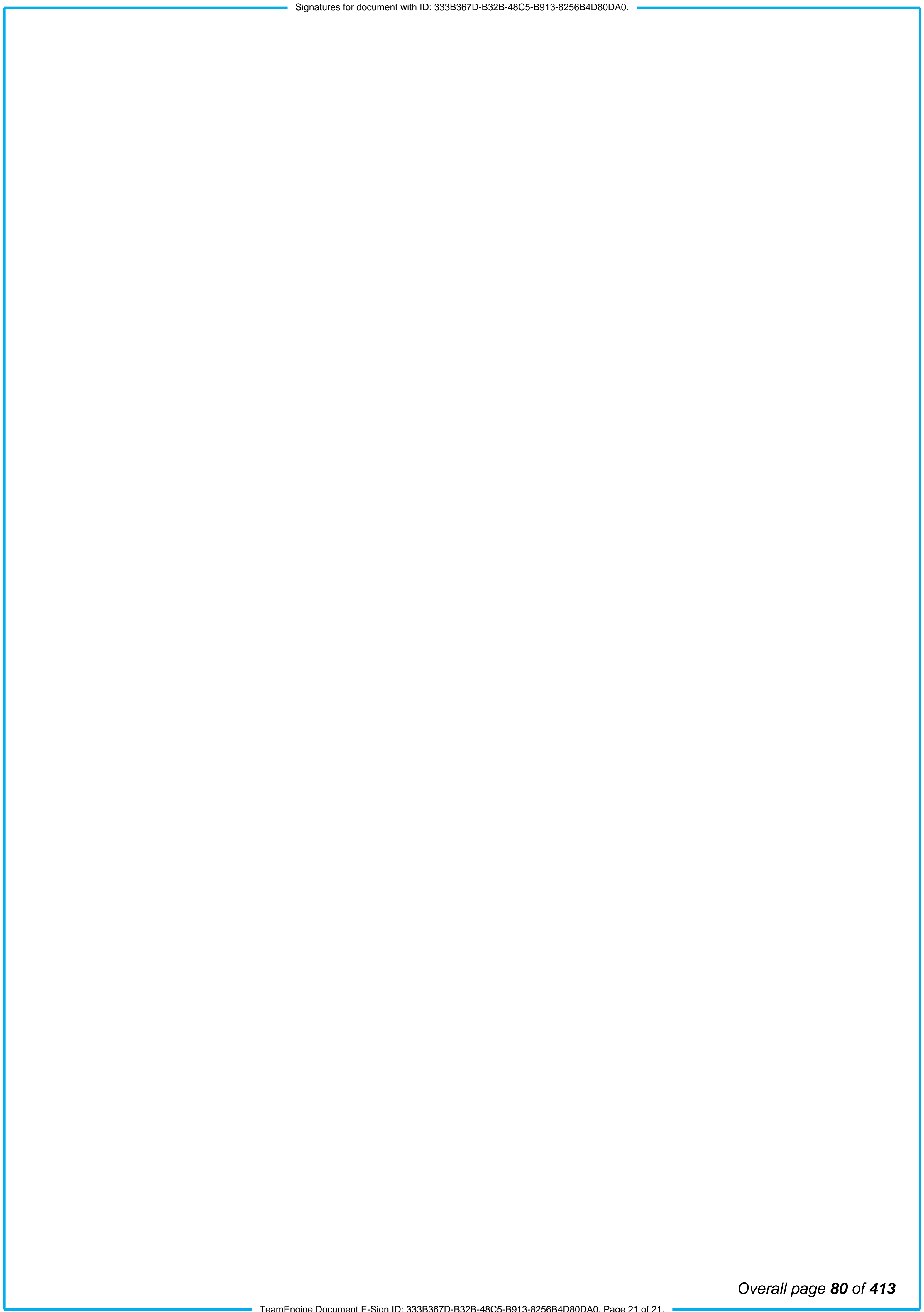
New ToR give us the right focus for FY24/25 work, nothing to add from my side.

38 Any other comments / observations:

None

General Comments

Strong leadership provided by Chair. The committee gets through the agenda efficiently. Good discussions.



7.3 CQC ASSURANCE REPORT

Discussion Item | AS | 10

REFERENCES

Only PDFs are attached

CQC Assurance Report CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

Report Title:	CQC Assurance Report					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Comfort Sithole, Head of Compliance and Emergency Planning.					
Report discussed previously at:	Quality Committee 18 November 2024					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

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

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

2. An update and escalations as required on progress made against the Trust CQC improvement plan. 3. Internal Assurance against the CQC Quality Statements 4. Details of CQC guidance/updates that have been received since the previous reporting in October 2024		

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Points

- EPUT continues to be fully registered with the Care Quality Commission.
- CQC undertaking unannounced focussed inspection.
- The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made with the implementation of actions with 91% of actions reported completed by action owners and 32% having been agreed for closure through the Evidence Assurance Group.
- The Trust awaits the CQC inspection report of our Forensic / Secure Services at Brockfield House in March 2024.
- The revised joint quality visits framework continue with early feedback being positive.
- There was one CQC enquiry raised during this reporting period.

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

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
ICB	Integrated Care Board	EAG	Evidence Assurance Group

Supporting Reports and/or Appendices
CQC Assurance Report Appendix 1 - CQC Improvement Plan Update November 24

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Assurance Report

1. Purpose of the report

This report provides the Board of Directors with:

- An update on CQC related activities that are being undertaken within the Trust.
- An update and escalations as required on progress made against the Trust CQC action plan.
- Internal assurance of CQC Quality Statements.
- Details of CQC guidance / updates that have been received since the previous reporting in October 2024.

2. CQC Registration Requirements

2.1. Registration

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

2.2. Forward View

The Trust is expecting to receive the routine CQC request for an Adult Social Care Provider Information Return (PIR) for Rawreth Court nursing home, in November 2024, with a one month period for responding and work has commenced in preparation.

3. CQC Inspections and Improvement Plans

3.1. Unannounced CQC Inspection

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

3.2. CQC Improvement Plan

The Trust has continued to focus on implementation of the CQC improvement plan.

As at 13 November 2024:

- 71 (91%) of the Must do / Should do actions have been reported as completed by action owners. Of these, 25 (32%) have been closed following review at the Evidence Assurance Group.
- 335 sub-actions complete
- 11 sub-actions past timescale (Nb. Associated with 6 overall actions status) weekly monitoring is in place.

The EAG meeting held on the 31 October 2024 was chaired by the MSE ICB Deputy Director of Nursing with EPUT operational and corporate staff in attendance. 3 actions and their relevant

evidence, were discussed and all approved for closure. The next EAG is scheduled for 25 November 2024.

3.3. CQC Enquiries

The CQC raised one query on 16 August 2024 seeking assurance via a response to the outlined concerns raised and information on current staffing on the Colchester MH wards, including establishment versus vacancies for occupational therapy and psychological therapy staff. Concerns were investigated by the Care Unit leadership, with support from the Executive Nurse. A response was provided with assurance on actions taken to address the concern.

4. Annual Programme 2024-25

4.1. Internal Assurance

The Trust annual compliance team assurance visit programme to promote and monitor adherence to the CQC quality statements for 2024-25 continues. In the period, the Compliance Team focused on the following Core Services:

- Community Health Services

Following the visits, feedback was provided to the core service capturing the good practice and any areas for improvement. This is shared with the Service and Care Unit Leadership for review and implementation of change. These in turn are monitored through the Accountability Framework meetings.

Note: The recommendations are based on limited assurance testing gained through the internal Compliance Team reviews and applied across the service for shared learning and checks.

4.2. Quality Assurance Visits (QAVs)

To bring in line with the Trust Quality Assurance Framework, the Quality Assurance Visits have been re-developed and a pilot undertaken. Key progress includes the conclusion of the pilot for inpatient QAVs and a feedback session facilitated to effectively evaluate the pilot. The session included internal and external partners that have been involved in the pilot and the feedback is currently being collated and adjustments implemented as appropriate.

5. CQC Guidance / Updates

5.1. Priorities for rebuilding trust in CQC

The CQC Interim Chief Executive shared some of the steps the CQC have taken following the DASH report. This is the first of a series of regular updates on the progress they are making in delivering these priorities.

Over the last few weeks, they have been working hard to develop implementation plans for the priority areas of improvement:

- Updating their approach to relationship management - NHS trust relationships pilot (govdelivery.com)
- Having the right expertise in place
- Frequency of assessments
- A regulatory handbook and the provider portal

5.2. Death certification reforms

The CQC National Medical Examiner's guidance supports the roll-out of the statutory medical examiner system and death certification reforms. From Monday 9 September all deaths in any health setting that are not investigated by a Coroner will be reviewed by NHS medical examiners.

The changes form part of DHSC's Death Certification Reforms which include a new medical certificate of cause of death.

5.3. Sir Julian Hartley will be appointed as the Care Quality Commission's (CQC's) new Chief Executive.

Sir Julian has been the Chief Executive of NHS Providers since February 2023, prior to which he had a distinguished career as Chief Executive of several organisations, most recently 10 years as Chief Executive of Leeds Teaching Hospitals NHS Trust.

Sir Julian's start date is yet to be confirmed. The selection process for Sir Julian's recruitment was led by CQC's Chair with the involvement of the non-executive members of CQC's Board, following open competition.

6. Recommendation

The Board of Directors is asked to:

1. Receive and note the content of the report

2. Note the assurance on progress against the improvement plan

Report Prepared by:

Comfort Sithole
Head of Compliance and Emergency Planning

On behalf of

Ann Sheridan
Executive Chief Nurse

Appendix 1:

CQC Improvement Plan Update 13 November ‘24

CONTENTS

01 Introduction

02 Action Progress Update

03 Risk Management

04 Assurance Metrics

05 Next Steps

Introduction

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

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

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

- Initial S29 plan (Willow and Galleywood Wards – Oct ‘22)
- Intra-inspection feedback of acute wards for adults and PICU (Nov ‘22)
- Internal report for 2 Adult Acute Wards (Jan ‘23)
- CQC report Acute Wards for Adults and PICU (published Apr ‘23)
- CQC report Core Services and Well Led (published July 23)
- CQC report Rawreth Court (published Nov ‘23)
- CQC Inspection Forensic and Secure Services (March ‘24 report pending)

OUR STRATEGIC OBJECTIVES

We will deliver **safe,** high quality **integrated** care services.

We will **enable** each other to be the **best** that we can.

We will work together with our **partners** to make our services **better.**

We will help our communities **thrive.**

Level of Assurance: Level 1

Key Messages

There are currently 78 ‘must do’ / ‘should do’ actions being taken forward (Note: combination of some actions into one), with 348 sub-actions (as at 13 November’24) associated with CQC activity.

Overview as of the 13 November 2024:

- 71 (91%) of the Must do / Should do actions have been completed.
- 25 (32%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 335 sub-actions complete

11 sub-actions past timescale as at 13 November’24 (Nb. Associated with 6 overall actions status) recovery plans are in place.

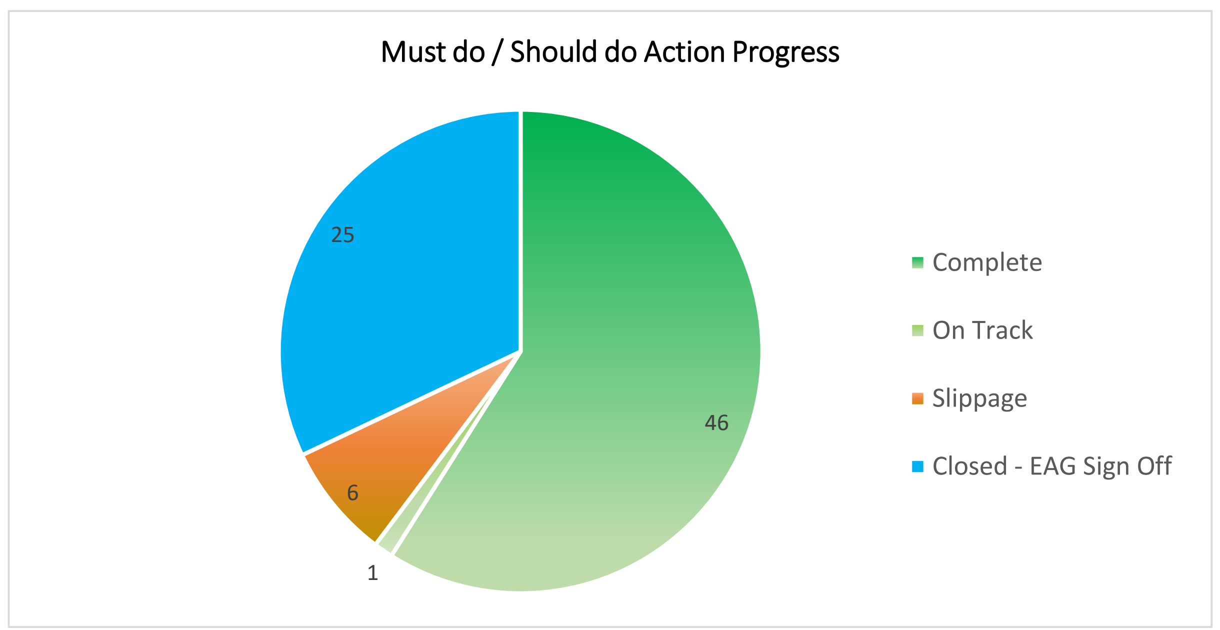
The CQC Action Leads meeting continues to hold action owners to account for delivery. The meeting is chaired by the Senior Director of Corporate Governance and attended by Executive Chief Nurse and Executive Chief Operating Officer.

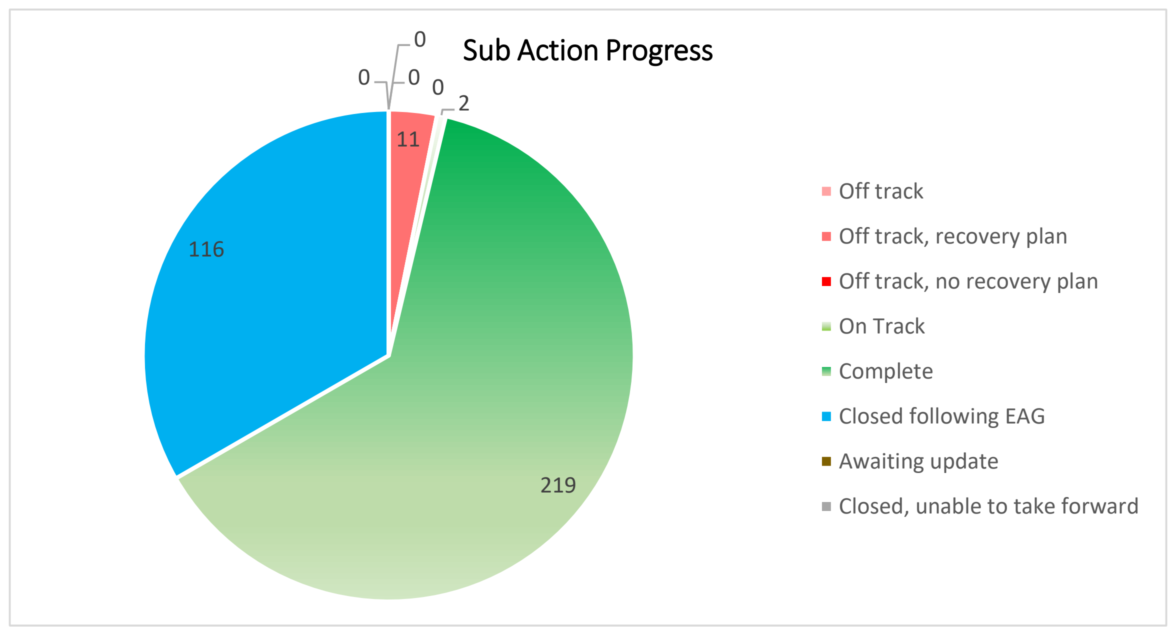
Next EAG arranged for 25 November ‘24 with the following to be presented: S16 (Meaningful Activities: Older Adults); S13 (Care Plans; Community MH); M34 (EPR systems; Community MH)

Action Progress Update

Summary of implementation status

- 78 Must do / Should do actions as at 13 November '24 and 348 Sub-Actions identified as at 13 November '24
- 25 (32%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 71 (91%) of the Must do / Should do actions have been completed. (next step is for the evidence to be presented to the CQC Leads Meeting and Evidence Assurance Group)
- 335 sub-actions complete
- 11 sub-actions past timescale as at 13 November '24 (Nb. Associated with 6 overall actions status) recovery plans are in place





Summary of activities and highlights

Summary of key activities completed in the last month:

- M3 (Trust side) – Resolution of bug, with Paris upgrade now complete. Next steps are to enable Paris connect on each site with a timeline for full roll out set.
- M32 (MH Community) – 2nd Audit undertaken and results collated
- S9 (Crisis & HBPoS) – Action closed following review of comparison between vacancy rate rates at point of CQC inspection and current levels. Improvement was evident.

Actions Closed

3 Actions closed by EAG in the reporting period (25 closed in total)

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

Summary of activities and highlights

Key Slippages (11 Sub-actions are past timescale)				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M3: The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. M5: The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (4/11 actions complete / 2 on track)	M3.4.1 Complete Paris upgrade which will include waiting list management	Supplier (Civica) is actively supporting the trust for the upgrade of Paris following setbacks in the testing of the new version. Upgrade to undergo Dry Run and short spell of UAT. A further bug has been found therefore further slippage.	Paris upgrade is now complete. Next steps are to enable Paris connect on each site with a timeline for full role out set. **Timeline: 25 November 2024**.	Jan Leonard
	M3.5.1 Enhancement of the Shared Care Record (SCR)	ICS Programme re-baselined project go live date 8th July technology go-live and 12 July service go-live. Testing continues. Data validation and UAT dates to be moved out post sign-off of technical testing. Shared care record went live 27/08/24 although reserved some time to meet actual commitment /requirement to be met	Orion health/ Cerner (Suppliers) negotiations for resolution to share care record access between ICS's See update above. **Timeline: 25 November 2024.**	Jan Leonard
M6: M1 (April 2023) and M6 (May 2023) The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts' policies and procedures for the recording and reporting of incidents	M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning	Work continues for remote access can be uploaded to current ward IT equipment. New software identified and has passed cyber security processes. Identifying funding options to take forward. Current mitigation of access at current location in place.	New software identified and passed as Cyber Compliant. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona
S19 The trust should ensure that care plans are easy to use and understand. (2/3 actions complete)	S19.2 New smart care plan to be launched later this year late Q3 (key principles of SMART, Simple and uncluttered, short and to the point, includes primary outcome measure and secondary outcome measure)	Care plan signed off at Project Board. System now being aligned with new care plan Go live extended to January 2025	**Continue training in preparation for go live** Impacted by the Paris upgrade delay. **Weekly touchpoint to review**	Tendai Ruwona

Summary of activities and highlights

Key Slippages (11 Sub-actions are past timescale)				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M8: The trust must ensure that staff do not fall asleep when undertaking patient observations. (Regulation 12 (2).	M8.6 Address Sleeping on duty action plan following further review	New action incorporated following concerns identified during the evidencing of the embedding and sustainability of the original action. Formulation of risk register completed. Action Plan to address audit findings to be presented to Safety of Care.	Continuing to monitor as still no sustainability. Reviewing improvement implementations and benefit: Breaks / Welfare Checks / Supporting induction Criteria for closure to be identified (Exit Plan) to move to BAU **Weekly touchpoint to review**	Angela Wade
M32: The trust must ensure that all patients have fully completed discharge plans and that there are systems and processes in place to secure timely discharge for patients using the recovery and wellbeing part of the service as part of their recovery.	M32.1 Change care plans to prompt clinicians to set discharge date M32.2 Create clear identification for cases where there are factors that limits the patients from being discharged and extends length of time on caseload M32.3 Benchmark workforce establishment to understand resourcing and availability to complete discharge M32.4 Training needed to identify when and how to have goal setting and discharge conversations and also the tactical preparation for discharge planning. Connect this in with the work already on the safety improvement planning work.	The action was put on hold to consider a re-frame. Discussion held at Executive Team and with COO. Agreed to revert back to original actions. Work continues to embed discharge and transfer planning. Care Unit Director to worked with teams to ensure discharge plans are clearly articulated and for the people who remain with the services for extended period legitimately (such as Depo injections, S117 after care, CTO etc) this is clearly documented within the record. Questions added to care note audit to test these are in place moving forward	Initial Audit results collated and presented. The audit is complete, results collated and being presented at Action leads on 13 November'24 **Timescale: December 2024**	Lynnbritt Gale

Summary of activities and highlights

Key Slippages (11 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	CQC Lead
S22 The trust should ensure all wards follow its governance systems and processes to maintain patient safety, in particular for clinical equipment monitoring, assessment and management of patient risk, and medicines management (2/3 actions complete)	S22.3 Tendable data to be made available on safety dashboards to ease accessibility of data.	Explored how to use automation and funding. Contract reviewed and expanded.	Dashboard in place. DPIA completed and approval received. Identifying access **Timescale: End of November'24**	Rebecca Pulford
RC10: Queries – Nursing Home admission criteria	RC10.3: To review home admission criteria	Review underway. Requires wider discussion with ICB partners	Meeting held with ICB. Service Specification and CQC Registration to be reviewed. Identify impact prior to any changes being made **Touchpoint end December 2024**	Tendai Ruwona

CQC Evidence Assurance Sign off Timeline

Actions with EAG sign off to date	Actions Awaiting Evidence Assurance	Actions On track	Actions In Recovery
25	46*	1 (March 26)	6 (3 due to complete Jan, 1 march and 2 TBC)

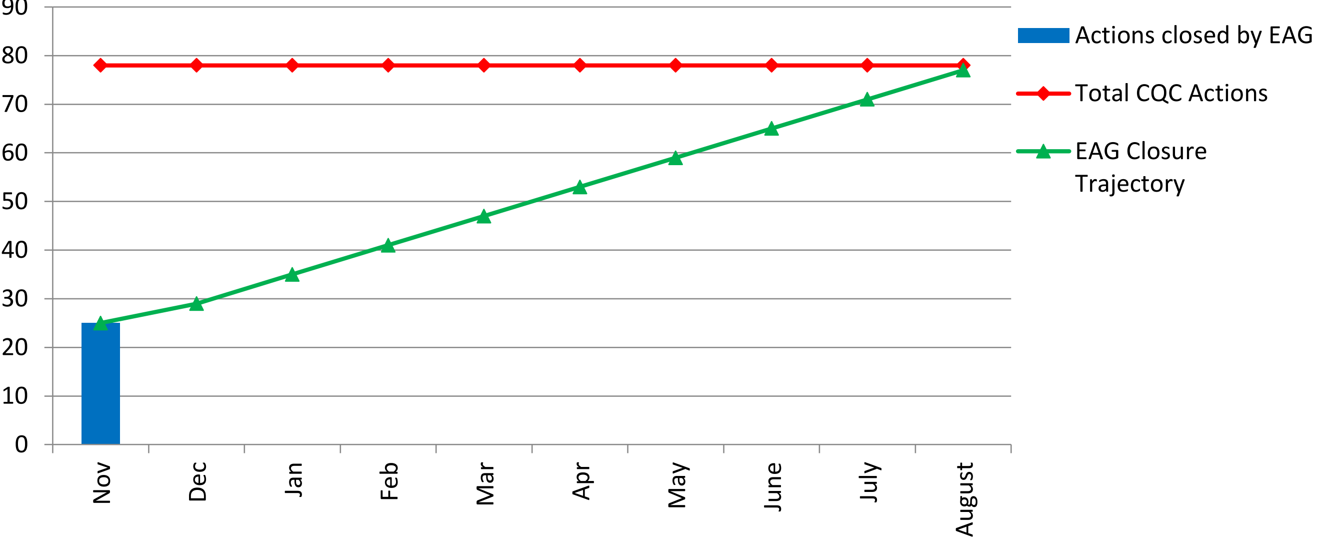
**** 5 previously presented to EAG with request for more evidence and 19 previously presented to CQC leads with request for more evidence***

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

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

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

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



Next steps

Areas of focus for the next month

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

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Information Item | PS | 5

REFERENCES

Only PDFs are attached

Board Assurance Framework Report December 2024 CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

2. Note the reduction in risk scores for:

   - SR5 Lampard Inquiry
   - CRR94 Engagement and Supportive Observation
   - CRR77 Medical Devices
   - CRR81 Ligature (Fixed)
   - CRR93 Continuous Learning

3. Request any further information or action

Summary of Key Issues

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

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

The Board is asked to note:

- Board Assurance Framework dashboard providing an oversight.

  Note there are a number of risks following reassessed have been reduced in risk score.

  SR2 People has been formally closed and superseded by the three new risks SR10 – Organisational Development; SR11 – Staff Retention; and SR12 Workforce Sustainability, which are reporting for the first time to Board.

  SR1Safety is being reviewed to reframe to align with the Quality of Care Strategy. The new risk descriptor has been reviewed at the Executive BAF meeting in Nov '24 and the controls assurance and actions being assessed for future reporting cycles. Noting that we will formally close risk SR1 and carry forward the outstanding actions 1 and 7. The risk descriptor being:

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

- Risks that have changed in risk score

  SR5 Lampard Inquiry - following review the risk score has been reduced in regards to our ability to service the inquiry having now responded in a timely manner to requests from the Inquiry secretariat and having full site of the revised terms of reference.

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

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

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

  CRR93 Continuous Learning - Risk rating reviewed following discussion with Executive Nurse. Agreed risk rating target score has been achieved. Continuous learning mechanisms / structure within EPUT, developed through the Culture of Learning Programme will form controls with the new SR1 risk going forward from the next reporting cycle.

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

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

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

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

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

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

Board Assurance Framework

4 December 2024

Denver Greenhalgh,
Senior Director of Corporate Governance

Risk Dashboard

November 2024

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	3	1	1-SR2
Risk Score Increase	**Risk Score Decrease**	**Risk Score No Change**	**On Risk Register >12 months**
0	0	1	7

RISK RATING

Likelihood	Consequence 1	2	3	4	5
1					
2				SR5	
3					SR1 SR4 SR3 SR6 SR9
4				SR10 SR11 SR12	SR7 SR8
5					

% Risks with Controls Identified	% Risks with Assurance Identified	Actions Overdue	Risk Reviewed by Risk Owner
100%	100%	4	11

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR2	2	People	MR		Closed	Closed	National challenge for recruitment and retention	SR2 formally closed and replaced by SR10, 11 and 12.
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	4x2=8	16 > 16 > 8	Government led public inquiry in to Mental Health services in Essex	The internal governance is now well established and functioning as an oversight Committee, on behalf of the Board. Continue to have a good relationship with the Inquiry secretariat and have to date manage any requests for information within agreed timelines. Continue to plan resources to be able to respond appropriately. Following review risk score has been reduced in regards to our ability to service the inquiry.
SR7	All	Capital	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 > 20 > 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	F&P Committee received a deep dive into capacity resource and utilisation at its meeting in November '24. We have been successful to date in securing an additional 0.4 million pounds following mental health applications.
SR8	All	Use of Resources	TS	Safety, Compliance, Service Delivery, Experience, Reputation	5x4=20	20 > 20 > 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Deficit funding received (£11.1m), revised plan is breakeven. And, progressing with the Investigate & Intervention Programme activity
SR4	All	Demand and Capacity	AG	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	15 > 15 > 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The new Operating Model which has been approved by the Board. Implementation has commenced. The 3 ICBs and Trust have appointed external consultant to support Out of Area risk share review and unified management. Revised timeline for the action has been set March '25 (but anticipate resolution may be sooner). Whilst we continue to focus on the long term management of demand and capacity, we continue (as reported to F&P Committee) to experience current issue with our inpatient capacity with significant focus on discharge arrangements and unblocking internal and external system delays (to de-escalation from OPEL 4 status).
SR1	1	Safety	AS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 > 15 > 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	SR1 is being reviewed to reframe to align with the Quality of Care Strategy. The new risk descriptor has been reviewed at the Executive BAF meeting in Nov '24 and the controls assurance and actions being assessed for future reporting cycles. Noting that we formally close risk SR1 and carry forward the outstanding actions 1 and 7.
SR3	All	Infrastructure	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 > 15 > 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	F&P Committee received a deep dive into use of capital resource which detailed the improvements in the Estate achieved. Estate Strategy approved by Board October 2024, and discussed at the November '24 Joint Council of Governors and Board meeting. Premises Assurance (PAM) data submitted Sept '24 and ERIC data to be published in December '24.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	All actions to mitigate the risk to its target score of 12 have been completed. A reassessment is being undertaken to assess if target score has been met and awaiting the output of IA review.
SR9	1	Digital and Data Strategy	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation.	The Digital transformation plan is undergoing further review to ensure it reflects the Trust efficiency targets and prioritises areas of greatest need for lifetime of the strategy. Target operating model approved May '24 with implementation commencing July '24 and will be fully implemented by the end of the 2024/25 year. Action timeline amended to align with the programme of work. New service desk management system is now live.
SR10	ALL	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of the People and Education Strategy and accompanying implementation plan has commenced. The newly appointed People Promise Manager has developed a 1 year retention strategy. Consultation paper completed for workforce leadership team and approved by the Executive Team (being implemented).
SR11	ALL	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of strategy and accompanying implementation plan commenced. The new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority. People Promise exemplar status has been implemented and completed. The review of workforce KPIs has commenced alongside the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs. There is also a set of extended KPIs that have been developed in draft for quarterly publication that are associated to better understanding trends in staff turnover and retention.
SR12	ALL	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16	The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Review of Strategy and accompanying implementation plan commenced. The implementation plan has been updated to represent the additional activities on OD

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
8	0	3	0
Risk Score Increase	**Risk Score Decrease**	**Risk Score No Change**	**On Risk Register >12 months**
0	3	5	8

Likelihood \ Consequence	1	2	3	4	5
1					
2				CRR71	CRR94 CRR93
3				CRR11 CRR45 CRR92 CRR81 CRR98	
4					
5					

% Risks with Controls Identified	% Risks with Assurance Identified	Extended Actions	Risk Reviewed by Risk Owner
100%	100%	2	100%

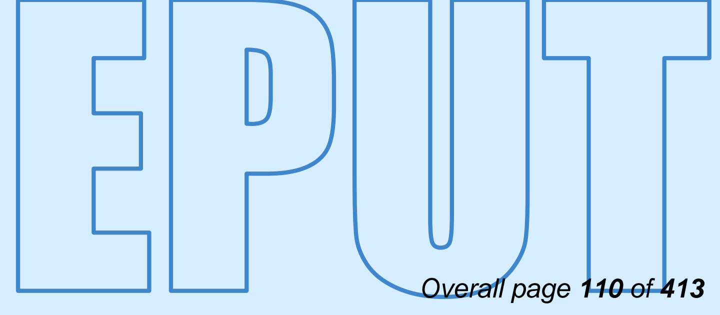
ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement & Supportive Observation	AS	Safety Regulatory	5x2=10	20 > 20 > 10	CQC found observation learning not embedded	Safe wards implementation continues, with learning events scheduled in diaries with all inpatients teams to review safewards implementation and will support skills and knowledge of Safe Wards interventions (linking with international lead for safewards who has agreed to support our continued implementation). Programme of work being tracked via Reducing Restrictive Practice Group and reporting to the Safety of Care Group (chaired by the Executive Chief Nurse). Engagement and Supportive Observation training compliance (97% substantive / 84% bank staff) Internal Audit (Recording and Monitoring of Therapeutic Observation) received a reasonable assurance opinion. Risk assessment has been reviewed and following the review of latest tendable audit / IA review (Recording and monitoring of therapeutic observations) it is assessed that the risk score be reduced to 10. To confirm the de-escalation of the risk from the CRR, having met the target score, a review of the controls assurance is being undertaken. Ongoing review through Nursing and Quality Risk Register.
CRR98	Pharmacy Resource	FB	Safety	4x3=12	12 > 12 > 12	Continuous state of business continuity plan	Recruitment campaign will continue on an ongoing basis.
CRR11	Suicide Prevention	MK	Safety	4x3=12	12 > 12 > 12	Implementation of suicide prevention strategy	STORM (Effective self-harm and suicide prevention) now in place. Working with our Lived Experience Ambassadors and our communities to take forward actions. Oversight of this programme of work is through the new Effectiveness of Care Group chaired by the Executive Medical Director. Linking with the reduction in fixed ligature incidents assessing the risk from non-secure ligatures to add to CR11 or as a stand alone risk entry, linking with the work of the Ligature Risk Reduction Group and therapeutic engagement as we launch our new inpatient operating model.
CRR45	Mandatory Training	MR	Safety Regulatory	4x3=12	12 > 12 > 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Transition to yearly update period complete. All New starters successfully completed 5 day Induction training within 12 week allocation, as per policy. Continue with programme to provide TASI training to bank staff (revised timeline March '25).
CRR77	Medical Devices	AS	Safety Financial Service Delivery	4x2=16	16 > 16 > 8	Number of missing medical devices compared to Trust inventory	Reassessment of the risk is that the risk score is reduced to target of 8. To confirm the de-escalation of the risk from the CRR, having met the target score, a review of the controls assurance is being undertaken. Ongoing review through Nursing and Quality Risk Register. Continue to work in partnership with MSE FT to put in place a new point of care testing quality assurance.
CRR81	Ligature	AG/TS	Safety Regulatory Reputation	4x3=15	12 > 12 > 12	Patient safety incidents	This risk is associated with 'fixed' ligature and following review of data it is proposed that the risk has reached its target risk score. Awaiting confirmation through LRRG to enact de-escalated from the CRR. Note that a new risk associated with 'unsecured' ligatures is proposed or to be incorporated into CR11.
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 > 12 > 12	Staff Experience	Designing a OD and Engagement Strategy which will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evaluation and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR93	Continuous Learning	FB	Safety Regulatory	5x2=10	15 15 10	HSE and CQC findings highlighting learning not fully embedded across all Trust services	Risk rating reviewed following discussion with Executive Nurse. Agreed risk rating target score has been achieved. Continuous learning mechanisms / structure within EPUT will form controls with the new SR1 risk going forward from the next reporting cycle.

NHS
Essex Partnership University
NHS Foundation Trust

Strategic Risk Register

November 2024



SR1- Safety (At a Glance)

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

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

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

Initial Risk Score C5x 4L = 20	*Current Risk Score C5 x L3 =15*	*Target Score C5 x L2 = 10*	**Note 1:** Completed Action 3 - 6 removed as previously reported on. **Note 2:** SR1 is being reviewed to reframe to align with the Quality of Care Strategy. The new risk descriptor has been reviewed at the Executive BAF meeting in Nov '24 and the controls assurance and actions being assessed for future reporting cycles. Noting that we formally close risk SR1 and carry forward the outstanding actions 1 and 7.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. The Trust SIPs are managed through the SIP Oversight Group which reports monthly into the Safety of Care Group
7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	Extended Jan '25	NJ	Assurance	PSIRF Oversight Groups established. Further work added to this action to enhance some aspects of Datix system to improved reporting functionality of the incident management module within the care units. We have established the process and care units are making good progress in reviewing incidents on Datix. Ongoing until Jan 25 with touch point reviews. Note RAG rated amber as action extended.

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previous reported completed actions 1, 3, 4 and have been removed from the report. **Note 2:** Completed action 2 will be removed from the report next cycle. **Note 3:** New actions 5 and 6 associated with assurance through ERIC and Premises Assurance Model assessments. **Note4 :** F&P Committee received a deep dive into use of capital resource which detailed the improvements in the Estate achieved in year.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
2	Develop Estates Strategy & Development Plan (as informed by the 6-facet survey)	Complete	MM	Roadmap	Estate Strategy approved by Board October 2024, and discussed at the November '24 Joint Council of Governors and Board meeting.
5	Review ERIC data submission against Peer groups and determine efficiencies	Jan-25	MM	Control	Trust have evaluated and submitted the ERIC return for 2023-24 in August 2024. Data to be published in December 2024
6	Develop action plan for Premises Assurance Model (PAM) outstanding tasks	Dec-24	MM	Control	PAM data to be submitted September 2024.

Actions (to modify risks)		By When	By Who	Gap	Update
7	New Action: Capital programme to be established for Estates	Mar '25	MM/JD	Roadmap	New action following the approval of the Estates Strategy.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score C5x 4L = 20	*Current Risk Score C5 x L3 =15*	*Target Score C5 x L3 = 15*	**Note1:** Previous reported completed actions 1, 2, 3, 4, 4.1,4.2, 4.3, 4.4, 4.5, 4.8 and 5 have been removed from the report.

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

Actions (to modify risks)		By When	By Who	Gap	Update
4.6	Reducing variations across wards	Complete	LW	Control	This is the new Operating Model which has been approved by the Board. Implementation has commenced. This action to be closed as implementation to reduce variation across wards is addressed in action 8 below.
6	Demand and Capacity module to be procured and fully implement	Extended Mar '25	JL	Control	The launch of the new Demand & Capacity model is reliant of the completion of other works (ingestion of clinical data into the new data platform). Competing strategic and BAU priorities (Flagged in the Digital/data strategy update report) - Data ingestion is now a prioritised project.
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Extended Mar '25	AG	Control	The system has appointed external consultant to support the risk share review and conclusion. Revised timeline for the action has been set March '25 (but anticipate resolution may be sooner).
8	Implementation of new operating model	Mar-25	SB	Control	The new Operational Model for Inpatient Services has been agreed and the launch events will commence in October 2024.

SR5 - Lampard Inquiry (At a Glance)

Risk Description: If EPUT does not have the correct governance arrangements in place to openly and transparently serve the Lampard Inquiry this may result in a lack of confidence from the public and reputational damage for the organisation.

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

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

Initial Risk Score *C5x 4L = 20*	*Current Risk Score* *C4 x L2 =8*	*Target Score* *C4 x L1 = 4*	**Note 1:** Previous reported complete actions 1, 2, 3 and 5 have been removed from the Board report. **Note 2:** Review of risk score has been completed with NED colleagues from the Lampard Inquiry Oversight Committee in the period noting a reduction to 8.

Executive Responsible Office: Executive Director Major Projects Board Committee: Lampard Inquiry Oversight Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (70% Inquiry, 20% FTSU) Project Director (100%) Browne Jacobson (100%) Essex Chambers (100%) Independent Advisors (as required):	Trust Board of Directors Lampard Inquiry Oversight Committee	Internal Audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director.	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board.	External audit of provision for the Inquiry
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel. Relativity	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal Audit
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal Audit
Support for Staff	Resources from GW. Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal Audit
Support for Families	Report from HPT to Project Working Group IWGC Report to Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal Audit
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee, BOD	Internal Audit

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
4	Schedule meetings for Care Units and Wards in place (C5, 7)	Ongoing	GW	N/a.	Ongoing schedule in place to attend Care Unit Meetings and completing staff visits.

	Actions (to modify risks)	By When	By Who	Gap	Update
6.	Reviewing resources to ensure (C2) Best value for money; Right skills and resources in place; Operational planning.	Jan-25	GB	Awaiting evidence session schedule from the Inquiry to be able to plan potential operational issues linked with attendance at hearings.	Reviewing legal framework undertaken to ensure best value for money. Reviewing the service areas potentially affected by the Inquiry who may need to release staff to complete statements and /or evidence sessions.
7	Info system procured and in place (C3).	Extended Jan 2025	GB/AW	Awaiting decision from the Lampard Inquiry on the system to be used for disclosure. No longer a gap in assurance as we now have the decision from the Lampard inquiry	Update: Lampard inquiry have now made the decision to purchase the relativity system but will not fund licences for other core participants. EPUT to order licences for the system and implement
8	Rule 9 progress (C1 and 4) R9 (1) Draft Statement R9 (4) Draft Statement Other Rule 9s received (2-6) submitted in draft to the Inquiry.	 Ongoing Ongoing	 GB GB	Awaiting decision on whether Assessment criteria will be expanded by the Inquiry. Awaiting response to concerns raised over personal identifiable information.	Rule 9 (1) original deadline of 28.05.24 met and two extensions provided by the Inquiry to allow for assessment information to be extracted also met (11.06.24 and 11.07.24). Finalise the data set for Rule 9 (1). 0.1% cells to be completed. Rule 9 (4) draft statement completed awaiting lawyers review of personal identifiable information.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score *C5x 4L = 20*	*Current Risk Score* *C5 x L3 =15*	*Target Score* *C4 x L3= 12*	**Note 1:** Previous reported completed actions 1, 2, 3 and 4 have been removed from the report. **Note 2**: Completed action 6 will be removed from the report in the next cycle. **Note 3:** All actions to mitigate the risk to its target score of 12 have been completed. A reassessment is being undertaken to assess if target score has been met and awaiting the output of IA review.

Executive Responsible Office: Executive Director Strategy Transformation and Digital
Board Committee: F&P Committee

Key Controls	Controls Assurance Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail	Penetration tests - no clinical vulnerabilities identified.	Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Audit
Business Continuity Plans and National Cyber Team processes	BCP plans	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DPST BDO audit completed, recommendations accepted and in plan

	Actions (to modify risks)	By When	By Who	Gap	Update
5	Systems that are running unsupported software identified by the latest penetration test and internal cyber audit require upgrade or replacement.	Complete	AW	Control	All of the high-risk security remediation activities identified by the penetration test within EPUTs control have been completed. There are outstanding medium and low risk actions identified by the pen test that are tracked on the local cyber risk/action log and are progress reported as part of the routine cyber assurance report to F&P.

SR7- Capital (At a Glance)

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

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

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

Initial Risk Score C5x 4L = 20	*Current Risk Score C5 x L4 = 20*	*Target Score C5 x L3 = 15*	**Note 1:** Previous reported completed action 2 has been removed from the report. **Note 2**: F&P Committee received a deep dive into capacity resource and utilisation at its meeting in November '24.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£0.4m resources secured 2024/25 YTD	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2024/25 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	FBC approved NHSE

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Currently over committed the programme which is planned to be covered by system resources. We have been successful to date in securing an additional 0.4 million pounds following mental health applications.
3	Track key strategic investments i.e. EPR to be monitored for impact on Capital Programme	Mar '25	JD	Control	Electronic Patient Record Full Business Case approved by Board and approved by NHSE.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score C5x 4L = 20	*Current Risk Score C5 x L4 =20*	*Target Score C5 x L3 =15*	**Note 1:** Previous reported completed action 1,3,4, and 5 has been removed from the report.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023). Reasonable opinion Core Financial Assurance (excluding payroll)(2023/24)
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24	Transformation and Efficiency Group oversight and reporting Executive Team (Enhanced assurance)	Transformation and Efficiency Group Report to Executive Team Finance Report	System Finanical Sustainability Programme Board (Chaired by ICB)
Finance reporting	Finance Reports AF Reports	EA of Accounts	NOF3 Rating
Budget setting	To complete mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2024/25			
Discretionary Non Pay Expenditure Control (Enhanced control)	Discretionary Non Pay Expenditure Control Panel and Procedures	Procurement and Contracts Report to Executive Team	Monthly Regional and ICB Review Meetings
Vacancy Control (Enhanced Control)	Vacancies Control Panels (Care Unit / Corporate / Executive)	Temporary Staffing Report to Executive Team	Monthly Regional and ICB Review Meetings
Forecast Outturn and risk/ opportunities assessments 24/25			

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
2	Deliver Financial Efficiency Target	31 Mar '25	TS	Control	£28.6m (5.2%) by 31 March 2025 - schemes identified but with high risk of full delivery. YTD delivery £11.6m
6	Deliver Financial plan for 24/25	Mar '25	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Deficit funding received (£11.1m), revised plan is breakeven.

	Actions (to modify risks)	By When	By Who	Gap	Update
7	Investigate & Intervention Programme Activity: Rostering and scheduling with Total Mobile and Health Trust Europe.	Mar '25	AM	Control	Progressing
8	Investigate & Intervention Programme Activity: Estates commercials review i.e. leases, PFI, PropCo and Valuation options.	Mar '25	TS	Control	Estates specialist being sort to support the programme activity.
9	Investigate & Intervention Programme Activity: Out of Area Placements (scope provided to PwC and Regional Colleagues)	Mar '25	AG	Control	Progressing
10	Investigate & Intervention Programme Activity: VAT advice relating to a single contract (details provided to PwC)	Mar '25	TS	Control	Progressing
11	Investigate & Intervention Programme Activity: Property Top-Up Insurance (details provided to PwC).	Mar '25	DG	Control	Action subject to Estates Specialist being identified to be progressed.

SR9- Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score C5x 3L = 15	*Current Risk Score C5 x L3 =15*	*Target Score C5 x L2 =10*	**Note 1:** Previously reported complete action 2,3, 6,7 and 8 have been removed from the report. **Note 2**: Completed actions 1 and 9 will be removed from the reporting future cycles.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Digital Transformation programme Plan	Complete	JL	Road Map	Digital transformation programme plan is in place, with constant ongoing review of priorities to align with overall Trust delivery of efficiency savings and the delivery of this plan.
4	Digital target operating model implementation	Mar-25	AW	Control	Digital target on plan for Phase 1. Timing for Phase 2 will be set on completion of Phase1.

Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**

9	Implementation of the new service desk management system.	Complete	AW	Control	New service desk platform (Hornbill) launched 19 November 2024.

SR10: Workforce Sustainability

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

Likelihood based on: Staff turnover, temporary staff usage and EPUT ability to provide career pathways

Consequence based on: Staff morale (staff survey results), skills gaps and identified quality of care risks associated with workforce sustainability.

Initial Risk Score C4 x L4= 16	*Current Risk Score C4 x L4= 16*	*Target Score C4 x L3 = 12*	**Note 1:** New risk formed from the disaggregation of SR2 People.

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review the People & Education Strategy and associated implementation plan with emphasis in staff retention.	Nov '24	Chief People Officer	Road Map	Review of Strategy and accompanying implementation plan commenced and has been updated to represent the additional activities on People Promise (retention). It is expected that the wider review of the strategy will take place between January and March 2025.
2	To develop a supporting Staff retention strategy alongside relevant internal and external stakeholders.	Nov '24	Director of OD & Culture	Road Map	The newly appointed People Promise Manager has developed a 1 year strategy. However, this will be developed further with potential for changes throughout the next 12 months.
3	To review the leadership and wider workforce structure with clear objectives that align to supporting the staff retention strategy.	Dec '24	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team (being implemented). Progress: the consultation and subsequent change management has been completed and the new structure, taking consideration of notice, will be effective from 1 January 2025.
4	To establish training for the workforce modelling team and associated stakeholders in finance and care unit management teams.	Jan '25	Associate Director of People - Operational HR	Control	This will be sourced following the implementation of the new team. The new leadership team have commenced considering the objectives and structure of the wider People & Culture teams going forward to meet expectations. Therefore consultation is expected to be commenced in January 2025.

Actions (to modify risks)		By When	By Who	Gap	Update
5	To establish workforce modelling frameworks that link with the operational plan and support the Trust and Care Units to have credible 1-5 year plans.	Mar '25 (Implementation from Apr '25)	Associate Director of People - Operational HR	Control	These will be developed alongside the introduction of the new team. The new Associate Director has been appointed with plans in place to create a defined workforce modelling team for the Trust.

SR11: Staff Retention

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

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

Initial Risk Score *C4 x L4= 16*	*Current Risk Score* *C4 x L4= 16*	*Target Score* *C4 x L3 = 12*	**Note 1:** New risk formed from the disaggregation of SR2 People.

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review People Strategy and associated implementation plan with emphasis on staff retention.	Nov-24	Chief People Officer	Control	Review of strategy and accompanying implementation plan commenced. The new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority.
2	To develop a supporting Staff retention strategy alongside relevant internal and external stakeholders	Nov-24	Director of OD & Culture	Control	The newly appointed People Promise Manager has developed a 1 year strategy. However, this will be developed further with potential for changes throughout the next 12 months. The new People Promise Manager has been working with colleagues in the region and nationally to enhance the strategy and operational actions to support staff retention. This will be reviewed by PECC and also by the NHS England team associated to People Promise.
3	To review the leadership and wider workforce structure with clear objectives that align to supporting the staff retention strategy.	Dec-24	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team (being implemented). Since November the new Director of OD & Culture has been appointed with greater emphasis on retention as a strategic priority.
4	To implement the investment of People Promise exemplar status with new People Promise Manager.	Complete	Director of OD & Culture	Assurance	People Promise exemplar status has been implemented and completed.

Actions (to modify risks)		By When	By Who	Gap	Update
5	To review workforce core and extended key performance indicators with emphasis on turnover related analysis	Dec-24	Associate Director of People – Resourcing	Assurance	The review of workforce KPIs has commenced alongside the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs. There is also a set of extended KPIs that have been developed in draft for quarterly publication that are associated to better understanding trends in staff turnover and retention.

SR12: Organisational Development

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

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

Initial Risk Score C4 x L4= 16	*Current Risk Score C4 x L4= 16*	*Target Score C4 x L3 = 12*	**Note 1:** New risk formed from the disaggregation of SR2 People. Note current controls assurance will flow through in future reports following assessment .

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

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

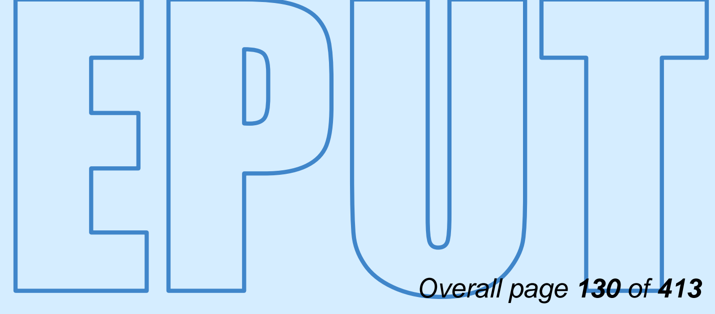
	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review People Strategy and associated implementation plan with emphasis on OD interventions.	Nov-24	Chief People Officer	Control	Review of Strategy and accompanying implementation plan commenced. The implementation plan has been updated to represent the additional activities on OD. It is expected that the wider review of the strategy will take place between January and March 2025.
2	To review the leadership and wider workforce structure with clear objectives that align to supporting a future OD strategy.	Dec-24	Chief People Officer	Control	Consultation paper completed for workforce leadership team and approved by the Executive Team (being implemented). The new Director of OD & Culture has been appointed with revised objectives to take forward and develop an OD strategy for EPUT.
3	To review workforce core and extended key performance indicators with emphasis on staff experience and OD interventions	Dec-24	Director of OD & Culture	Assurance	The review of workforce KPIs has commenced alongside the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. Extended KPIs that include those that can measure OD interventions have been drafted for consideration.
4	To undertake a gap analysis of OD skills to determine what is required to be effective	Jan-25	Director of OD & Culture	Control	To be undertaken prior to finalising the revised OD team in conjunction with wider workforce team changes. The new objectives have been published for the Director of OD & Culture in order that this can inform the review of the service and advise the nature of the new structure, skills required and the consultation process.

Actions (to modify risks)		By When	By Who	Gap	Update
5	To source partnership arrangements with effective and established OD practitioners alongside an effective development plan that supports OD skills at the Trust	Jan-25	Director of OD & Culture	Assurance	To be undertaken prior to finalising the revised OD team in conjunction with wider workforce team changes. The new Director of OD & Culture has developed partnership arrangements with system partners and regional partners on OD best practice.
5	To review workforce core and extended key performance indicators with emphasis on turnover related analysis	Dec-24	Associate Director of People – Resourcing	Assurance	The review of workforce KPIs has commenced alongside the business intelligence team with introduction of additional KPIs to be incorporated into the IPR and accountability framework. The IPR is to be updated to reflect the new KPIs. There is also a set of extended KPIs that have been developed in draft for quarterly publication that are associated to better understanding trends in staff turnover and retention.

Essex Partnership University
NHS Foundation Trust

Corporate Risk Register

November 2024



CRR94 - Observation and Engagement

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

Initial Risk Score C5x 4L = 20	*Target Score C5 x L2= 10*	*Target Score C5 x L2= 10*	**Note 1**: Previous reported completed actions 1-11 have been removed from the report. **Note 2**: Completed action 12 will be removed in future reporting. **Note 2**: Risk assessment has been reviewed and following the review of latest tendable audit / IA review (Recording and monitoring of therapeutic observations) it is assessed that the risk score be reduced to 10. To confirm the de-escalation of the risk from the CRR, having met the target score, a review of the controls assurance is being undertaken. Ongoing review through Nursing and Quality Risk Register.

Executive Responsible Office: Executive Nurse Director Lead: Director of Nursing and IPC Leads: Deputy Directors of Quality & Safety (Inpatients and Specialist Services) Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		IA Recording and Monitoring of Therapeutic Observation (Reasonable Assurance Opinion received 2024)
Weekly Ward Huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks		
Electronic observations recording tool	e-observations in wards (with exception of 7 wards)		IA Recording and Monitoring of Therapeutic Observation (Reasonable Assurance Opinion received 2024)
Tendable Audits (quality control)	Audit results reviewed at weekly huddles		
Observation and Engagement e-learning and training videos	Engagement and Supportive Observation training compliance (97% substantive / 84% bank staff)		
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		
Deep dive into unexpected deaths in inpatient services or within 3 months of inpatient admission between 2000 - 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise and assurance report to ET Apr '23	
Ward Improvements	Planning supported by patients Grab Therapy Resources available		

Actions (to modify risks)		By When	By Who	Gap	Update
12	Thematic review into incidents across all units	Complete	LJ	Assurance	Review completed and linked to work programme of the Reducing Restrictive Practice Group and the Ligature Risk Reduction Group,
13	Monitor Safe Wards Interventions	Extended Dec '24	LJ	Assurance	Baseline planned to be complete over next quarter of safe wards implementation. Learning events are scheduled in diaries with all inpatients teams to review safewards implementation and will support skills and knowledge of Safe Wards interventions (linking with international lead for safewards who has agreed to support our continued implementation). Programme of work being tracked via Reducing Restrictive Practice Group and reporting to the Safety of Care Group (chaired by the Executive Chief Nurse).

CRR11 - Suicide Prevention

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

Initial Risk Score *C4x 4L = 16*	*Current Risk Score* *C4 x L3 = 12*	*Target Score* *C4 x L2= 8*	**Note 1:** CRR34 Suicide Prevention Training has been amalgamated into this risk as part of delivery of overall Suicide Prevention Framework, with CRR34 being closed on the risk register. **Note 2:** Previous reported completed actions 1, 2, 3 and 4 have removed from the report for CRR11. **Note 3:** Previous reported completed actions 1, 2 and 3 have been removed from the report for CRR34.

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

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

Actions (to modify risks)		By When	By Who	Gap	Update
5	Review approach to ligature risk management training (through the introduction of effective self-harm and suicide prevention training).	Complete	GW	Control	STORM (Effective self-harm and suicide prevention) now in place.
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Next steps following approval of the framework (action 1) is to work with our Lived Experience Ambassadors and our communities to take forward actions. Oversight of this programme of work is through the new Effectiveness of Care Group chaired by the Executive Medical Director.

CRR45: Mandatory Training

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

Initial Risk Score C4 x L4= 16	*Current Risk Score C4 x L3 = 12*	*Target Score C4 x L2 = 8*	**Note 1:** Previously reported completed actions 1, 2 and 3 have been removed from the report.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
4	New Action: Monitor transition of TASI training back to yearly update arrangements and that all new starters have successfully completed the full suite of mandatory training.	Complete	PT	Assurance	Transition to yearly update period complete. All New starters successfully completed 5 day Induction training within 12 week allocation, as per policy.
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Extended March '25	PT	Control	Bank staff 63%. There is work to validate the tracker data with the workforce systems team, which will materially change the denominator as some bank staff do not need the training. An initial review of this data supports 183 names being removed which will take compliance to 70% with the remaining 327 bank staff to be booked onto TASI by 1st December. This supports a projected trajectory of 90% compliance by end of March 2025.

CRR71: Medical Devices

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

Initial Risk Score C4 x L4 = 16	*Target Score C4 x L2 = 8*	*Target Score C4 x L2 = 8*	**Note 1:** Previous reported completed actions 1,2 6-8 have been removed from the report. **Note 2:** Reassessment of the risk is that the risk score is reduced to target of 8. To confirm the de-escalation of the risk from the CRR, having met the target score, a review of the controls assurance is being undertaken. Ongoing review through Nursing and Quality Risk Register.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
1a	Implement the solutions from the outcomes of the deep dive	Closed	NA	Control	Management actions concluding. Remaining action associated with actions detailed below, therefore action 1a closed by Executive BAF Group.
4	Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Complete	NA	Control	Responsibilities of staff groups on training will be stated in new Medical Devices Training Policy (CLP88) approved and now operational.
5	Introduce point of care testing quality assurance process to avoid use of equipment that is not calibrated or serviced	Extended Dec '24	NA	Control	Exploring working in partnership with MSEFT for the provision for quality assurance programme. In process of procuring new devices to support the programme. Delay in obtaining costings from MSEFT - now expected October '24 (extended timelines as a consequence).
9	Tender contract for medical devices programme.	Complete	NA	Control	Tender for contract complete - now progressing through contract award through F&P Committee and Board.
10	To enhance the Medical Devices Policy with detail of risk assessment for equipment marked as 'end of life' to support continued use in a clinical area.	Complete	AB	Control	CLP17 Medical Devices Policy has been reviewed and approved and now operational.

Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
11	To deliver management actions from the IA of medical devices management at ward / service level (2023/24)	Jan '25	NA	Control	Management actions being progressed and on track.

CRR81: Ligature

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

Initial Risk Score	*Current Risk Score*	*Target Score*	Notes
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note 1:** Previous reported completed actions 1 - 7 have been removed for the report. **Note 2**: This risk is associated with 'fixed' ligature and following review of data it is proposed that the risk has reached its target risk score. Awaiting confirmation through LRRG to enact de-escalated from the CRR. Note that a new risk associated with 'unsecured' ligatures is proposed or to be incorporated into CR11.

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

Controls Assurance

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17/01/24**
8	Roll out new ligature training	Extended March 25	Project Group	Control	Roll out of new training programme commenced in May 2024 (face to face sessions) Additional training dates added to continue delivery through to March'25. Drills established in all inpatient areas from Sept'24 OLM provision review being finalised to launch Sept'24

CRR92: Addressing Inequalities

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

Initial Risk Score C5 x L4 = 20	*Current Risk Score C4 x L3 = 12*	*Target Score C3 x L2 = 6*	**Note 1:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report.

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

Actions (to modify risks)		By When	By Who	Gap	Update
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	Designing a OD and Engagement Strategy which will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evaluation and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	LH	Control	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. The Leadership Behaviour Toolkit continues to be socialised and will be further strengthened through the OD and Engagement Strategy. With a plan to include a targeted approach for leaders and a timeline with monthly activity to engage all staff around behaviours including discrimination, code of conduct, policies, and behaviours in meetings

CRR93: Continuous Learning

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

Initial Risk Score *C5 x L3 = 15*	*Target Score* *C5 x L2 = 10*	*Target Score* *C5 x L2 = 10*	**Note 1:** Previous reported completed actions1,- 6 have been removed from the report. **Note 2:** Risk rating reviewed following discussion with Executive Nurse. Agreed risk rating target score has been achieved. Continuous learning mechanisms / structure within EPUT will form controls with the new SR1 risk going forward from the next reporting cycle.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
7	Assessment of the current Risk	Complete	MA	Assurance	Risk rating reviewed following discussion with Executive Nurse. Agreed risk rating target score has been achieved. Continuous learning mechanisms / structure within EPUT will form controls with the new SR1 risk going forward from the next reporting cycle.

CRR98: Pharmacy Resource

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note 1:** Following a review of business continuity plan as a consequence of new starters in February '24 , the likelihood score driving the change from a 4 (likely) to a 3 (possible) with a revised risk score of 12.

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
1	Continue with recruitment campaign	Ongoing	HS	Control	Recruitment campaign will continue on an ongoing basis.

Risk Movement and Milestones

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

Risk ID	Initial Score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	
SR1	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**
SR2	20	Closed																										**C**
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**
SR4	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**
SR5	20	15	15	15	15	15	15	15	15	15	15	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**
SR6	12	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**
SR7	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**
SR8	15	15	15	15	15	15	15	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**
SR9	20																New	20	15	15	15	15	15	15	15	15	15	**15**
SR10	16																									New	16	**16**
SR11	16																									New	16	**16**
SR12	16																									New	16	**16**

Risk Movement and Milestones

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

Risk ID	Initial Score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	**12**
CRR34	9	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	Closed (Amalgamated with CR11										**C**
CRR45	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	12
CRR77	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	8	**8**
CRR81	12	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	**12**
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	**12**
CRR93	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10	**10**
CRR94	16	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	10	**10**
CRR95	20	15	15	15	15	12	12	Close																					**C**
CRR96	16			New	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	De-escalated		**C**
CRR98	20				New	20	20	20	20	20	20	20	20	20	20	20	20	20	12	12	12	12	12	12	12	12	12	12	**4**
CRR99	16			New	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	8	8	8	8	De-escalated				**C**

8.2 LEARNING FROM DEATHS ? QUARTERLY OVERVIEW OF LEARNING AND DATA REPORT Q1 2024/25

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Learning from Deaths Q1 Report CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1					4 December 2024
Report Title:	Learning from Deaths – Quarterly Overview of Learning and Data Report Q1 2024/25					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, (Learning from Deaths Co-ordinator)					
Report discussed previously at:	Learning from Deaths Oversight Group (17th September 2024) Learning Oversight Sub-Committee (25th September 2024) Safety of Care Group (26th September 2024) Quality Committee (18th October 2024)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report				
Summary of risks highlighted in this report	On-going risk relating to the resourcing capacity within the learning from deaths workstream being addressed Data processes currently in place continue to be reviewed to further strengthen the Trust's ability to undertake mortality surveillance			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 Finance and Resources Infrastructure			
	SR4 Demand / Capacity			
	SR5 Lampard Inquiry			✓
	SR6 Cyber Attack			
	SR7 Capital			
	SR8 Use of Resources			
	SR9 Digital and Data Strategy			✓
Does this report mitigate the Strategic risk(s)?	N/A			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

Purpose of the Report		
This report presents to the Board of Directors the *Learning from Deaths – Quarterly Overview of Learning (Q1 2024/25)* report, which includes the following:	**Approval**	
	Discussion	
	Information	✓

• An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result; • Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements;		

Recommendations/Action Required

The Board of Directors is asked to:

1. Received and note the content of the report; and
2. Request any further information or action

Summary of Key Points

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

2. The Learning from Deaths – Quarterly Overview of Learning and Data report for Q1 2024/25 is attached. This provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. This learning is presented on a monthly basis to the Trust's Learning from Deaths Oversight Group, Learning Collaborative Partnership and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

3. The report also presents data that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. The Q1 2024/25 data was extracted and analysed as at 09/08/24. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q1 data, which is broadly in line with that of previous quarters.

4. Key points of note for Q1 data are (as at 09/08/24):
   - There were a total of 128 deaths reported on Datix for Q1 2024/25 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 141 Datix reports made in respect of the 128 deaths.
   - A total of 35 of these deaths had, as at 09/08/24, been deemed in scope.
   - Of these deaths 6 were inpatient deaths and 8 were EPUT nursing homes deaths. All these deaths, with the exception of one for which confirmed cause of death is awaited at the time of writing this report, have been confirmed as natural causes.
   - 13 deaths in Q1 had been closed at Stage 1 via Care Unit scrutiny and assurance processes as requiring no further level of review. 6 deaths had been identified as requiring a Stage 3 PSIRF review via Care Unit Patient Safety Oversight Groups and 3 had been identified as requiring a Stage 2 clinical case note / thematic review in line with the Trust's mandated criteria for Stage 2 reviews.
   - A total of 26 deaths were awaiting completion of a Stage 1 review.
   - All deaths requiring report to LeDeR, the national review programme for LD deaths, have been confirmed as reported to the programme.

5. At the point of extracting the data for Q1, a total of 75 Stage 1 reviews had been undertaken by local service managers in relation to deaths occurring between 01/04/24 – 30/06/24 to ascertain learning and identify those for further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally.

6. The processes by which mortality data is collated and analysed have been developed and refined over the past year. There continues to be scope to further refine and strengthen those processes, utilising improving technologies available to the Trust. Work is to be undertaken with the Trust's systems teams to strengthen the Trust's death notification and initial screening processes and this work is being progressed as a priority for the Trust.

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

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

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

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

Supporting Reports and/or Appendices

Attached:

- Report: Learning from Deaths – Quarterly Overview of Learning and Data (Q1 2024/25)

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

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

"Using the Care Review Tool for mortality reviews in Mental Health Trusts" Royal College of Psychiatrists November 2017:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Nurse

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

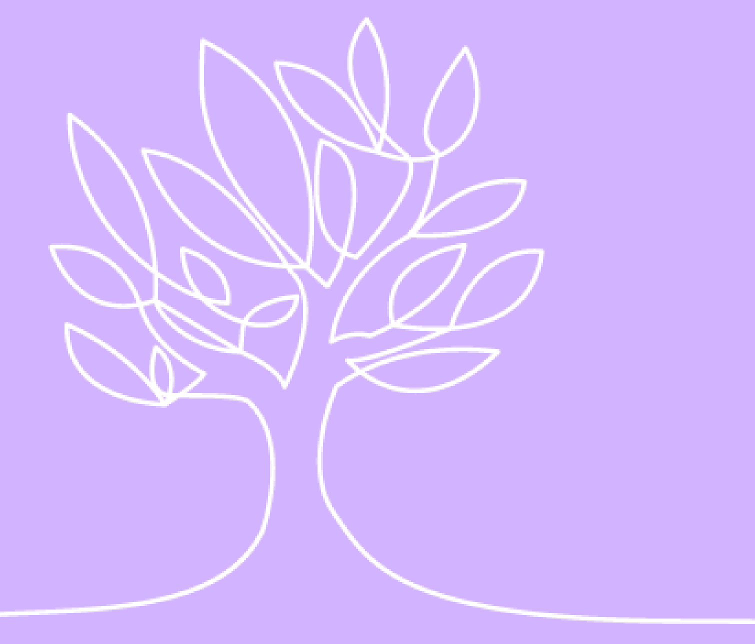
QUARTER 1 - 2024/25

PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (August 2024) – i.e. learning identified between June 2024 – August 2024 (pages 4 – 16);
- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1 April 2022 (pages 17 – 20);
- An update on changes to reporting and review processes being made from 1 October 2024 (page 21);
- Data relating to deaths recorded on Datix for Q1 2024/25 (1 April – 30 June 2024) (pages 22 –24); and
- Updated data for deaths relating to 2023/24 and 2022/23; and for previous years under the previous mortality review arrangements (page 25)

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT



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

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

The Trust sets out to achieve these aims by:

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

LEARNING FROM REVIEWS OF DEATHS

June – August 2024

This section on learning details:

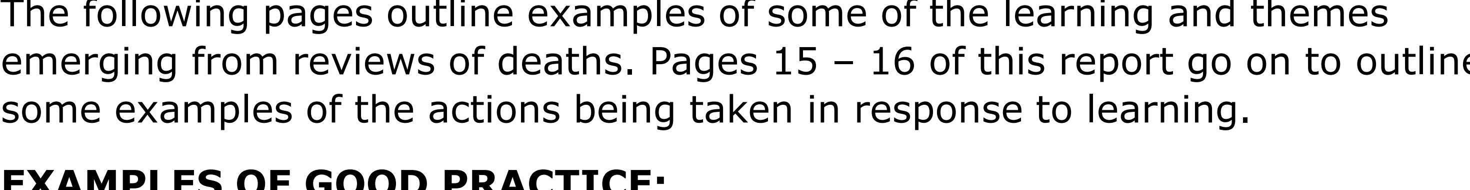
- Sources of learning (page 4)
- Examples of good practice identified (page 5)
- Learning emerging from Stage 1 reviews (pages 6 - 7)
- Learning emerging from Stage 2 reviews (pages 8 - 9)
- Learning emerging from various other review processes (pages 10-13)
- Learning emerging from Stage 3 PSIRF reviews (page 14)
- Examples of actions being taken to address and action learning from learning from deaths reviews (pages 15 - 16)

Sources of learning:

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

Examples of good practice emerging from Stage 1 reviews

June – August 2024


The following pages outline examples of some of the learning and themes emerging from reviews of deaths. Pages 15 – 16 of this report go on to outline some examples of the actions being taken in response to learning.

EXAMPLES OF GOOD PRACTICE:

- Evidence of joint working between different agencies in the care of the patient (e.g. EPUT, acute Trust, Essex County Council, care home)
- Team responsive to the needs of the patient with a full Multi-Disciplinary Team working around the patient with involvement from Community Psychiatric Nurse, Senior Occupational Therapist, Support Worker, Psychology - and the Care Coordinator was liaising with social care and the patients' family. All plans made were agreed upon by all, including the patient and their family.
- Patient was well supported by Hospice and GP surgery with support from the Frailty Virtual Ward.
- Staff had been trained to be able to support the patient whilst on End of Life care pathway in the ward.
- Investigation completed indicating very detailed and robust care was offered leading up to and around time of patient death.
- PEACE document and Do Not Attempt Resuscitation document in place and family involved in the care.
- A review of all clinical documentation informs that appropriate steps had been taken to support service user and the death could not have been anticipated.

Learning themes emerging from Stage 1 reviews

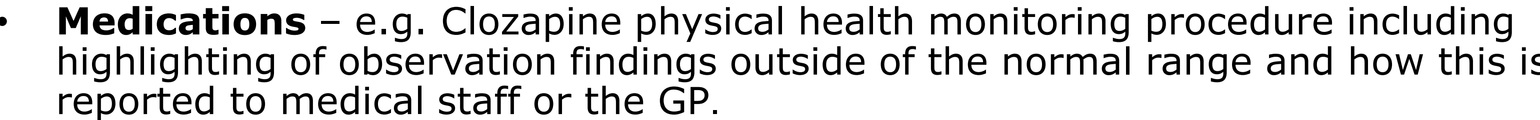
June – August 2024 [1]

CONTINUING THEMES:

- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues for timing of Stage 3 PSIRF / Stage 2 reviews)
- Majority of the deaths reviewed are from **physical health causes** (eg long term conditions, multiple co-morbidities, expected deaths of patients receiving end of life care, physical health crisis, deaths in Acute Trust hospitals) – importance of integrated working between mental and physical healthcare services and awareness of impact of mental health medications on physical health
- **Disengagement –** e.g. exploring in more detail when patients cancel appointments
- **Clients not open to services at time of death –** e.g. Coroner Do You Know? enquiries
- **Record keeping** – e.g. ensuring records provide a full account of care given and document all contacts made; documenting involvement of family; documenting in EPUT records if patient under care of joint local authority / health team for which main records are held on local authority system; updating records to denote if patient deceased)
- **Communication and information sharing** – e.g. between Trust teams and with GP
- **Internal reporting and review processes** – e.g. team responsibility for reporting, commissioning investigations

Learning themes emerging from Stage 1 reviews

June – August 2024 [2]



- **Medications** – e.g. Clozapine physical health monitoring procedure including highlighting of observation findings outside of the normal range and how this is reported to medical staff or the GP.
- **End of life care related –** e.g. putting in place anticipatory medications on a timely basis; engaging continuing health care and ensuring safe accommodation for end of life care.

EXAMPLES OF NEW LEARNING:

- Clarity of **responsibilities between health and local authority** in situations of e.g. Care Act assessments and care package funding.

Learning themes emerging from Stage 2 Clinical Case Note Reviews

June – August 2024

STAGE 2 CLINICAL CASE NOTE REVIEWS:

Since the last report to the Board of Directors, there has been one Stage 2 review approved. Learning was as follows:

“Overall care was good. Regular input from care co-ordinator. Regular DBT therapy sessions were also provided and appropriate escalation to request emergency intervention and support at times of crisis.”

Learning themes emerging from Stage 2 Thematic Reviews

June – August 2024

EPUT THEMATIC REVIEWS:

- As reported in the last report to the Board of Directors, a thematic review of n.36 **non-Patient Safety Incident related deaths of patients with Severe Mental Illness** (2022-23) has been completed by the Trust's Nurse Consultant in Physical Health.
- Key recommendations related to closer integration and stronger communication between primary care (i.e. GP) and secondary mental health services; ensuring physical health reviews and recording of such as part of specific mental health interventions and for those with SMI; allowing clinical time for health promoting interventions and encouraging direct referral to appropriate agencies for specialist health promotion / screening; and exploring the possibility of EPUT clinicians intervening and prescribing physical health medications perhaps with shared care arrangements in place.
- The recommendations have been considered internally within a number of EPUT forums and have also been presented for discussion with partner agencies, via various Integrated Care Board multi-agency forums.
- The outcomes of these various discussions are now being considered within the Learning from Deaths Oversight Group and specific next steps are in the process of being agreed.

Learning themes emerging from End of Life care reviews

June – August 2024

END OF LIFE CARE REVIEWS:

Examples of learning identified via reviews of end of life care in the period include:

- Redesign of SystmOne (electronic patient record system) end of life care templates, care plans and data sharing in response to learning identified.

- Awareness raising across partner agencies including ambulance service and hospital transport of validity of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documents when signed by senior clinical nurses with competencies. The agencies have taken action to ensure staff are updated. Clinical nurse, GP and care home have also been updated on outcome of the incident leading to learning identification.

Learning themes emerging from EDAP multi-agency collaborative reviews

June – August 2024 [1]

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

Good practice examples included:

- Evidence of good practice and good joint working to support client.
- Examples of good working with family members (some of whom were also service users) in a number of reviews – e.g. in relation to Duty of Candour, support following death
- Multiple attempts to engage client with services.
- Case was escalated to System Partnership Meeting and reviewed by Service Manager, Consultant and Coroner's Office - multiple evidence of good practice identified.
- Client felt safe enough to disclose pertinent information.
- Harm minimisation discussions well documented.
- Followed up appointments with other NHS services on behalf of client.

Learning themes emerging from EDAP multi-agency collaborative reviews

June – August 2024 [2]

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

Learning examples included:

- Identified training gap in terms of hidden behaviours in older client base – organised training for team as a result regarding groin injecting / harm reduction.
- Ensuring timeliness of contact following allocation of clients to team member.
- Opportunities to strengthen communication between EDAP and mental health services such as holding joint appointments with clients.
- Need to consider support that can be offered to clients placed in temporary accommodation in relation to securing permanent accommodation.
- Risk assessments to be more responsive and clearly documented.
- Importance of documenting capacity clearly in patient record, including decision making process.
- Importance of documenting resolutions to issues raised in patient record.
- Ensuring Care Plans are in place and updated.
- Importance of face to face appointments – staff capacity impacted ability to offer this.

Good practice and learning themes emerging from local LeDeR reviews (national Learning Disability review programme)

June – August 2024

Good practice examples included:

- Agencies worked collaboratively to ensure appropriate health investigations were carried out and that was effective discharge planning from the hospital to ensure safe discharge.
- Hospital passport in place.
- Virtual weekly ward rounds undertaken by GP.

Learning examples included:

- Ensuring full records are kept by all agencies involved in care.
- Ensuring timely access to specialist healthcare.
- Importance of putting in place a Health Action Plan as a result of Annual Health Checks; and of undertaking regular structured medication reviews.
- Ensuring discharges from hospital are made at times of the day when appropriate support can be in place at home for patient's safe and comfortable return.
- Exploring appropriate methods of sharing information (with consent) with more than one family member where all are not able to attend meetings / appointments in person.

Learning themes emerging from PSIRF reviews

June – August 2024

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

- Medications
- Record keeping
- Clinical care
- Policies and procedures
- Communication
- Staffing
- Family and carer involvement
- Physical health

Examples of actions being taken in response to learning from deaths – Stage 1 and 2 reviews

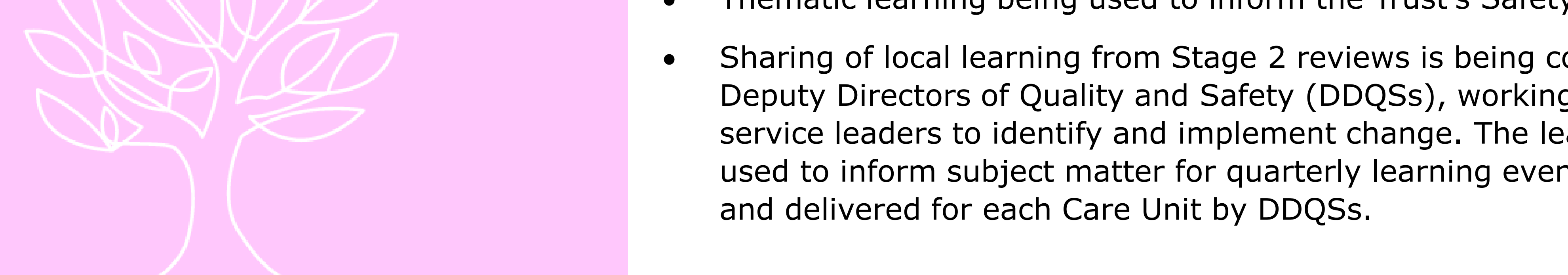
- Local immediate actions by services – e.g. changes to Duty of Candour processes to follow up with family / carers – rather than only making contact in the initial stages of grief now scheduling additional calls for weeks later when further support might be needed/taken up; changes made to practice in relation to documenting / undertaking risk assessments; training delivered in response to identified training needs; improved communication between hospital, community and family resulting in more cohesive care planning and execution).

- Learning presented to and considered monthly by Learning Collaborative Partnership – included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate.

- Learning used to inform topic areas for "Learning Matters" MST development sessions – eg lessons learned from specific deaths.

- Thematic learning being used to inform the Trust's Safety Improvement Plans.

- Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. The learning is also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.



Actions being taken in response to learning from deaths – PSIRF example

Learning identified:

- Listening to family concerns.
- Holistic risk assessment, considering known community risks in forward planning care.
- Therapeutic benefits of In patient care versus Community Care.
- Individual practitioners to use their professional judgement about individual risk, especially when the patients are new to the service.
- Consideration of the use of pharmacology in EUPD diagnosis and reduction of medications used during crisis against measured outcomes of reduction in symptoms.
- Discharge medications to be reviewed by subject matters experts before discharge.

Actions taken:

- Review report and Safety Action Plan shared with the teams involved.
- Review report shared with family for feedback and any questions.
- System wide approach to locality intelligence to reduce the risk of suicide in the community implemented.
- Corroborative approach with the complaints team implemented.
- North East Essex Suicide Prevention Operational Group established.
- Review completed across all ward areas of 'as required' (PRN) medications - Quality Improvement project focussed on appropriate use of PRN during admission and at discharge followed by audit.
- In-patient services 'PRN Focus Week'.

Mortality Data – Context (1)

- From 1 April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust and thus report on Datix. This definition was based on the categories defined in the National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf and Royal College of Psychiatrists mortality review guidance https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf and is outlined on the following page.

- Regardless of the mandatory requirements for report on Datix, services are also encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data from Q1 2022/23 onwards.
- It should be noted that data in this report was extracted as at 09/08/24. Any updates to information after this date will be included in future reports.
- Mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee monthly and quarterly for review and approval.
- Summary mortality data for Q1 2024/25 is detailed in the following section.

Mortality Data – Context [2]

Deaths in scope consideration for **mandatory** individual mortality review in the Trust and thus report on Datix are as follows:

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

Mortality Data – Context (3)

- Regardless of the above mandatory requirements for a formal review, services are encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data from Q1 2022/23 onwards. It should be noted that this will not reflect negatively on the Trust in terms of potential to appear as an "outlier" set against other Trusts mortality figures. The national guidance was clear that, given there is no standard national definition for deaths that should be included in Trust mortality data, no comparison or benchmarking should take place between Trusts – the data should be used solely internally to the organisation to support mortality surveillance and quality development. We are however exploring with other local mental health trusts their approach to reporting deaths and data provision to establish whether it is possible to locally determine a defined scope for reporting and benchmarks etc.

- This report includes mortality data mandated for report under the National Guidance on Learning from Deaths - i.e.:
  - the number of deaths in scope;
  - the number of these deaths subjected to review;
  - the level of review to which the deaths are being subjected; and
  - the determination of whether or not the deaths were more likely than not to have been due to problems in care.

- As the scope of deaths included has changed from the previous mortality review arrangements, there was no historic data prior to Q1 2022/23 against which to make comparisons. As a result, as well as analysing the data under the new arrangements, the data for 2022/23 and for Q1 – Q3 2023/24 was also analysed using previous scope arrangements in order to provide assurances that the Trust was not experiencing increases in death numbers across key services against historic data. Sufficient data had been collated under the current arrangements by the end of Q4 2023/24 to produce Statistical Process Control analysis under the current arrangements from Q4 2023/24 onwards.

Mortality Data – Context (4)

- Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. Deaths reviewed under the Patient Safety Incident Response Framework (PSIRF) from 01/05/21 were not subject to this determination as the methodology encourages focus on quality learning outcomes. A local methodology was initially put in place to make this determination for deaths reviewed under PSIRF from 01/04/22; however this has been paused whilst further research is undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination for deaths reviewed under PSIRF given that the PSIRF methodology has not been designed for this purpose. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will be reassessed.

- The Trust's established mortality data dashboard was amended from 1st April 2022 to enable recording of data in line with the new arrangements, whilst still retaining the ability to use the process as a validation exercise to ensure deaths are reported on both Datix and clinical information systems and that learning disability deaths have been reported to the national LeDeR mortality review programme. A validation exercise between Datix and Clinical Information Systems is undertaken each quarter to ensure deaths are reported appropriately on both systems. At the time of writing this report, this process is still underway for Q1 2024/25 – any updates to Q1 data as a result of this process will be reflected in the Q2 report.

- As detailed in previous quarterly reports, refinements to data processes were put in place last year to streamline and automate some previously manual processes, utilising more advanced technologies available to the Trust. The refinements made were intended to strengthen efficiency, accuracy and resilience in the production of meaningful data. These new processes have been utilised for the production of Q1 2023/24 data onwards. Data processes continue to be reviewed to establish opportunities for further strengthening of the Trust's approaches – please see following page for further information.

Mortality Data – Update on future developments outlined in Q3/Q4 2023/24 Learning from Deaths report

- In order to further strengthen the Trust's ability to report and provide assurance on the deaths of patients under its care into the future, the Trust continues to work on system enhancements whereby all patient deaths identified from the "National Spine", a central record essentially fed by GP clinical systems, will be automatically notified by the central Trust information team to the relevant service lead. The service lead will then undertake the initial screening of the death onto a newly built section of the relevant Electronic Patient Record for the patient which will identify and record whether the death falls within the scope of the Trust's Policy for report onto Datix and, even if not, any learning identified.
- This will enhance the ability for the Trust to be able to report data on all deaths of patients, not just those within the scope of the Policy for review, and provide documented assurance that all have been subject to an initial screening review. The timescale for completion of these system enhancement works and implementation of the new arrangements is now anticipated to be January 2025, enabling such reporting and data to be included in the Q4 2024/25 quarterly report onwards.
- The Trust is also continuing to liaise with local Medical Examiners Offices to explore opportunities for automatic data flows to the Trust on all confirmed causes of deaths for all patients under the care of the Trust. At the time of writing this report, the new statutory arrangements for death certification and Medical Examiner scrutiny of all deaths - including those occurring in a community setting – have very recently been implemented nationally (from 9 September 2024). The Trust has worked closely with all Medical Examiner Offices to ensure readiness for implementation.
- Following implementation of the above processes, the Trust's intention is to move onto exploring possible enhancements to sophistication of analysis of the data by demographic factors to strengthen the ability to use the data to improve public health outcomes.

Summary of Quarter 1 2024/25 mortality data (as at 09/08/24)

- **Total number of deaths reported:** There were a total of 128 deaths reported on Datix for Q1 2024/25 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 141 Datix reports made in respect of the 128 deaths. This is lower than previous quarters and reporting levels will be kept under review.

- **Total number of deaths in scope for mandated reporting:** To date, a total of 35 deaths in Q1 2024/25 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 26 deaths which is required to determine whether they are in scope for mandated reporting and this total is therefore expected to increase). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 (Q1 – 65 Q2 – 63 Q3 – 60 Q4 – 61) and in 2023/24 (Q1 - 67 Q2 - 60 Q3 - 59 Q4 - 57). The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

- **Inpatient / Nursing Homes deaths:** Of the 128 deaths reported in Q1, 6 were inpatient deaths and 8 were nursing home deaths. This is broadly in line with previous quarters. Five of the 6 inpatient deaths and all of the nursing homes deaths have been confirmed as due to natural causes. The confirmed cause of death for one inpatient death is awaited.

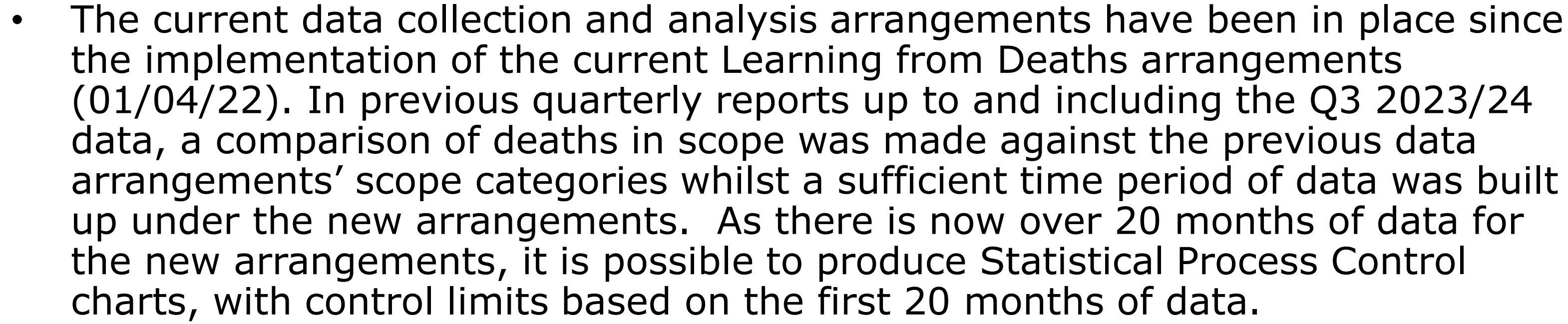
- **LeDeR reporting validation:** All 3 reported Learning Disability deaths in Q1 2024/25 have been confirmed as reported to the national LeDeR programme.

- **Level of review:** Thus far, 9% of deaths in Q1 2024/25 have been closed at Stage 1; 2% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 4% have been referred for Stage 3 full PSIRF review. Obviously, these figures are expected to increase as deaths are progressed through the review consideration processes.

Summary of Quarter 1 2024/25 mortality data (2) [as at 09/08/24]

- **Stage 1 reviews:** A total of 75 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the 141 Datix death reports in Q1. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 26 outstanding Stage 1 reviews for Q1 deaths. This is lower than in previous quarterly reports.
- **Stage 2 (clinical case note) reviews:** A total of 3 deaths in Q1 have been identified to date for Stage 2 mortality clinical case note review / thematic review, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 6 deaths in Q1 have been identified to date for PSIRF review.
- **Completion of Stage 2 (Clinical Case Note Review) and Stage 3 (PSIRF) reviews:** Given the point of reporting, no Stage 2 and Stage 3 reviews for deaths occurring in Q1 have yet been completed. However, since the last quarterly report to the Board of Directors, 3 x Stage 2 reviews and 16 x Stage 3 reviews have been approved for deaths occurring in previous periods. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews. This is monitored by the Learning from Deaths Oversight Group and mitigating actions to ensure timeliness of review and learning identification are being pursued.
- **Problems in care assessment –** There are 0 deaths for Q1 thus far that have been assessed as being more likely than not due to problems in care by EPUT; and the assessment is still to be determined for 117 deaths. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 66 out of the total of 520 deaths for that year and for 265 out of 697 total deaths for 2023/24. This includes deaths closed following PSIRF review as the assessment of problems in care has been paused whilst further research continues to be undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination given that the PSIRF methodology has not been designed for this purpose. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will be reassessed. This data will be updated in future reports as reviews are completed and the likelihood is determined.

Statistical process control charts for Datix reported deaths (for mortality surveillance)



- The current data collection and analysis arrangements have been in place since the implementation of the current Learning from Deaths arrangements (01/04/22). In previous quarterly reports up to and including the Q3 2023/24 data, a comparison of deaths in scope was made against the previous data arrangements' scope categories whilst a sufficient time period of data was built up under the new arrangements. As there is now over 20 months of data for the new arrangements, it is possible to produce Statistical Process Control charts, with control limits based on the first 20 months of data.

Summary of previous years' mortality data (2017/18 – 2023/24)

- In summary:
  - 2022/23 and 2023/24 data is presented in the new format and indicates that, since the last report to the Board of Directors:
    - **2022/23:**
      - 2 x Stage 2 reviews have been approved
      - 2 x Stage 3 (PSIRF) reviews have been approved
    - **2023/24**
      - 57 x Stage 1 reviews have been completed
      - 24 x deaths have been closed at Stage 1
      - 1 x Stage 2 review has been approved
      - 13 x Stage 3 (PSIRF) reviews have been approved
      - 9 x additional deaths have been identified via the end of year audit for report onto Datix – these have been reported and are reflected in the data
  - 2 reviews for deaths in **2021/22** remain open (1 x PSIRF review and 1 x under determination). These continue to be actively progressed, with the latter now being ready for approval of closure at Stage 1.
  - The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

CONCLUSIONS AND ACTIONS REQUIRED

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

- It also provides assurance that the learning is being acted upon, with examples provided of actions taken in response to learning identified.

- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q1 2024/25.

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

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

9. STRATEGIC INITIATIVES

9.1 STRATEGIC IMPACT REPORT

Information Item ZT 10

REFERENCES

Only PDFs are attached

Strategic Impact Report M6 CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

Report Title:	**Strategic Impact Report M6**					
Executive/ Non-Executive Lead / Committee Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy Richard James, Director of Transformation					
Report discussed previously at:	Executive Operational Committee 15 October 2024 People, Education and Culture Committee 30 October 2024 Quality Committee 18 November 2024 Finance & Performance Committee 21 November 2024					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board with an update on the implementation of the Trust's Strategic Plan as at M6 of the second of five years. It also provides updates on the Transformation portfolio. Finally, the report summarises the proposed approach to Operational Planning for 2025/26.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board is asked to:

1. Note and take assurance from the report.

Summary of Key Points

A strategic impact report is prepared and presented to the Board twice per year. Its purpose is to monitor and assess delivery of the Trust's Strategic Plan and identify further action where required.

This report has been developed through a combination of:

- Analysis of available performance data by the Business Information team aligned with the measures agreed for each of the Trust's four strategic objectives;
- Thematic review and distillation of Accountability Framework papers for M1-6 2024/25;
- Supplementing Accountability Framework discussions, informal meetings with some care unit leadership teams to review progress against operational plans for 2024/25 and five-year care unit strategies, as well as any risks to operational delivery;
- Updates presented to the Strategy Steering Group, Executive Operational Committee and Board committees on the delivery of EPUT's suite of enabling strategies.

At M6 of Year 2 of its Strategic Plan, EPUT can evidence steady progress against each of its strategic objectives within each care unit.

- **We will deliver safe, high-quality integrated care:** Since the launch of EPUT's new Quality of Care strategy in April 2024, Trust oversight and governance processes have been adjusted to reflect the focus on driving improvements in patient experience, effectiveness and safety of care. EPUT's Quality Senate is now established, the Trust's Quality Impact Assessment framework has been updated and metrics for new Quality Power BI dashboards have been agreed to support ward to Board oversight and assurance. EPUT continues to enforce a zero tolerance approach to unwanted or inappropriate sexual behaviour at work and in the last six months held its first Sexual Safety Conference attended by 150 people and developed and delivered active bystander training. EPUT's new Pharmacy & Medicines Optimisation strategy was published in August 2024 and the new electronic prescribing and medicines administration system went live on pilot wards in May, replacing paper based drug charts with a digital record and linking together the different teams and individuals involved in medication related activities for safer and more effective care. The Estates strategy was approved by the Board in October and will now move into implementation. Safe, high quality and integrated care will progressively be underpinned by a modern and unified Electronic Patient Record (EPR), for which work continues to progress.
- **We will enable each other to be the best we can be:** The review and redesign phase of the Time to Care (TTC) Inpatients Operating Model has been completed and approved by the Board. Mobilisation planning is underway to align with workforce and operational priorities. EPUT has been granted exemplar status for the NHS People Promise by NHS England which will increase capacity to focus on retention rates alongside the other aspects of the People Promise. EPUT's new People & Education strategy was launched in February 2024 and progress has been made against each of the three themes of train, retain and reform in the last six months. Delivery highlights include development of a plan to eliminate HCA vacancies by December 2024, contracting with a new Occupational Health provider in summer 2024 and launch of a new Leadership Development hub on the Trust intranet.
- **We will work together with our partners to make our services better:** Relationships across our four Integrated Care Systems (ICS) continue to strengthen with a particular focus in recent months on the continued development of local community collaboratives, both formal and informal. The Board has recently implemented a framework for management of strategic stakeholder relationships to ensure consistency and internal coherence of key messages to our partners. Implementation of the Southend, Essex and Thurrock All Age Mental Health Strategy continues to progress well, with delivery highlights including: a medical monitoring standard operating procedure agreed for Eating Disorders; implementation of a new supported accommodation pathway by Essex County Council; commitment to an equitable pan-Essex provision of smoking cessation services and increased capacity created in Children and Adolescent Mental Health Services (CAMHS) through implementation of the Thrive model (an integrated, person-centred and needs led approach to improve coherent and resource-efficient support communities). EPUT hosted its

second annual co-production conference on 10 October 2024, attended by more than 120 people, and celebrating the power of partnerships. Significant progress has been achieved in the delivery of EPUT's Research & Innovation strategies, including increasing the number of Principal Investigators actively leading studies by five, strengthening our partnership with University College Health Partners and running a third joint annual conference with Anglia Ruskin University in September on the theme of Neuropsychiatry and Neurodiversity.

- **We will help our communities thrive:** EPUT published its new Social Impact Charter in September 2024, publicly outlining the building blocks of its approach to positively impacting the social determinants of health across the communities it serves. Across the three tiers of the Social Impact strategy, EPUT continues to make good progress in adapting business as usual processes to maximise social impact (tier 1), and in tier 2 Enable East has successfully expanded its Multiply (numeracy skills) offering into its own inpatient services and local prisons in recent months, thereby continuing to drive up the grant funding coming into the Trust and the number of Essex residents benefiting from Multiply. The Social Impact Leadership Group has now turned its attention to generation and prioritisation of tier 3 interventions, for which a proposal for a multi-year, externally funded, collaborative programme will be developed by the end of 2024. In August, NHS partners including EPUT became members of the Essex Chambers of Commerce, creating a new opportunity to collaborate for social value with local businesses. At July 2024, EPUT had completed 77% of the actions outlined in its Green Plan 2021-2025, which is due for refresh in the next year.

The report then summarises the high level approach proposed for the 2025/26 operational planning round, which commenced at the end of August 2024 at EPUT. The approach builds on the integrated approach to planning that we took last year so that we are able to articulate the same story about the organisation and services from whichever lens we look through, be it quality & safety, activity, workforce and finance.

The senior planning triangulation group is currently working through a process of mid-year reviews of delivery against 2024/25 plans to planning for 2025/26, focusing in turn on:

- Activity data
- Workforce modelling
- Financial planning
- Transformation priorities
- Quality and safety and service developments
- Digital and data transformation
- Estates and capital planning

The senior operational planning triangulation group is continuously working to strengthen the planning process by:

- Clarifying priorities
- Positioning senior planning triangulation group as collective voice of operational and corporate to inform and support executive decision making
- Building on robustness of planning in absolute terms to drive more focus on profiling through the year
- Considering course correction for alignment with enabling strategies and Trust strategic plan where needed
- Ensuring the planning process has to proactively work alongside Inquiry process and take account of impact on colleagues

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
M6 Strategic Impact Report v6 final

Executive/ Non-Executive Lead / Committee Lead:
Zephan Trent **Executive Director of Strategy, Transformation & Digital**

Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT REPORT

M6 2024/25

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INTRODUCTION

Essex Partnership University
NHS Foundation Trust

EPUT'S STRATEGIC PLAN 2023/24-2027/28

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

WE EMPOWER.

Strategic objectives

We have four strategic objectives to achieve our vision:

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

Delivered through our target operating model

Our Year 2 commitments to deliver the strategic plan

Trust overall	• Implement digital and data strategic priorities and continue progress in developing the unified EPR • Complete development of Estates Strategy • Start implementing Research, Innovation and Commercial Strategies • Continue work towards becoming a trauma-informed and psychologically-informed organisation
We will deliver safe, high quality, integrated care services	• Start implementation of Quality of Care Strategy • Phased implementation of Time to Care model • Continue to actively engage with the Lampard Inquiry and respond to recommendations once concluded • Implement principles of NHS England Sexual Safety Charter/ take zero tolerance approach to unwanted sexual behaviour
We will enable each other to be the best we can be	• Implement People and Education strategy, including developing behavioural framework as part of creating a psychologically safe culture • Continue to collaborate with local and regional partners on long term workforce development plan • Improve staff development offer and extend offer to lived experience and volunteer roles
We will work together with our partners to make our services better	• Implement Working in Partnership with People and Communities Strategy to drive cultural change • Build on work with system partners, building on relationships (including voluntary sector) to support pathway transformation and improved outcomes • Secure research programmes and infrastructure funding through strategic partnerships for direct patient benefit
We will support our communities to thrive	• Continue delivery of Social impact strategy with focus on parity for people with serious mental illness, learning disability or autism • Refresh the Green Plan for 2025 onwards to ensure services are environmentally sustainable • Form local commercial and innovation partnerships • Consolidate local and inclusive recruitment plans • Continue to take a lead role in improving awareness of suicide risk

DELIVERY HIGHLIGHTS

M6 2024/25

At the mid-year point of Year 2 of the Strategic Plan, we continue to evidence steady progress against each strategic objective within each care unit

Strategic objective	Progress on key deliverables
We will deliver safe, high-quality integrated care	**Focus on high quality care** • Trust Quality Senate established • Quality Impact Assessment framework updated • Power BI quality dashboard metrics agreed • New EPMA now live on all inpatient wards • New Pharmacy and Medicines Optimisation Strategy launched in August • Estates Strategy approved by Trust Board in October; now proceeding to implementation **Focus on safety** • Continued work towards implementation of unified Electronic Patient Record • Continued zero tolerance towards unwanted/inappropriate sexual behaviour • First sexual safety conference held
We will enable each other to be the best we can be	**Remodelling our inpatient offer** • Review and redesign of Time to Care operating model completed, approved and being mobilised **Supporting our staff** • EPUT granted exemplar status for NHS People Promise - extra capacity to focus on retention rates • New People and Education Strategy launched in February with three themes – train, retain, reform • Plan in place to eliminate Health Care Assistant vacancies by December 2024 • New occupational health provider started in summer 2024 • New leadership development hub now live on InPut (staff intranet)

At the mid-year point of Year 2 of the Strategic Plan, we continue to evidence steady progress against each strategic objective within each care unit

Strategic objective	Progress on key deliverables
We will work together with our partners to make our services better	**Developing strategic relationships** • Relationships across all four Integrated Care Systems continue to develop; focus on development of local collaboratives • Board implemented strategic stakeholder relations framework, ensuring consistent messages/approach **Delivering care in partnership** • Continued progress in implementing Southend, Essex and Thurrock all-age mental health strategy • Standard procedure in place for medical monitoring of eating disorders • New supported accommodation pathway implemented with Essex County Council • Commitment to smoking cessation services and increased capacity in child & adolescent mental health services (CAMHS) using Thrive model • Strengthened university partnerships in research and innovation and trained new clinicians to lead research

We will help our communities thrive	**Publication of new social impact charter in September**
	• Demonstrates Trust commitment to positively impact social determinants of health in communities served, including adapting business as usual processes to maximise social impact
	• Delivery in M1 to M6 includes:
	    • Expanding Enable East's Multiply numeracy skills programme into inpatient wards and local prisons, benefitting these communities with increased grant income
	    • Delivering majority of actions in Trust Green Plan for 2021-2025, ahead of refresh in 2025
	    • New membership of Essex Chambers of Commerce to enable collaboration with local businesses

DELIVERY AGAINST STRATEGIC OBJECTIVES

M6 2024/25

Delivery against strategic objective 1 – we will deliver safe, high quality integrated care

Trust overall

- Consistency in patient safety incident reporting rates
- Increasing trend in total incidents reported as evidence of a learning culture
- Consistent numbers of low/no harm reports maintained
- Average monthly increase of 80 patient reported experience measures
- More people report feeling safe in EPUT's care
- Further integration with primary care services
- Care Closer to Home programme in West Essex helping to address variations in health outcomes for community health services

Care group specific

Urgent Care and Inpatients

- Quarter 2 reduction in self-harm, restraints, seclusion and long term segregation

Specialist Services

- Capital upgrade programmes at Wood Lea Clinic and Brockfield House completed, including installation of Oxevision and Power BI self-service data
- Significant reduction of almost two thirds in restrictive practice in CAMHS wards

Psychological Services

- New assistant psychologist reviewing compliance against NICE guidelines and standards
- Early Intervention in Psychosis service exceeding national targets

North East Essex

- Increase in physical health checks for people with severe mental illness

West Essex

- Backlogs in both dementia patient letters and incident sign-offs significantly reduced

Mid and South Essex

- Corringham Integrated Medical and Wellbeing Centre shortlisted for the Place-based Partnership & Integrated Care Award at the 2024 HSJ awards
- Launched first neighbourhood health and wellbeing hub as part of Thurrock Alliance
- Continued improvements in waiting times at Lighthouse Centre child and adolescent service, now the lowest since service transferred to EPUT in 2022

STRATEGIC OBJECTIVE 1:
WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

Metric		Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Narrative/ Trend Graph
Patient Safety incident rates (PSIM)	Incident Reporting Rates	>44.33	68.6	66.1	70	72.8	57.9	58.6	56.6	57.8	67.5	64.1	65.6	51.4	
	Reduction in PSIs	<3	3	2	1	2	0	1	2	2	0	0	1	0	
Patient Safety Events rated by Harm (not including incidents that have yet to be reviewed)	No/low harm incident rates (mental health)	>93.9%	91%	91%	92%	90%	91%	90%	89%	85%	87%	83%	81%	77%	
	No/low harm incident rates physical health)	>94.6%	74%	82%	80%	76%	77%	79%	78%	80%	74%	70%	66%	63%	
	Total incidents reported	<3	1755	1809	1848	1732	1794	1521	1344	1625	1736	2113	1844	1426	
Live Integrated Network Teams	West Essex	6												6	
	MSE (SEE)	6												4	
	NEE	8												8	
PREMS	No. reviews		369	367	367	463	471	388	548	572	569	538	354	326	
	5 star score		4.71	4.72	4.84	4.7	4.75	4.77	4.77	4.82	4.73	4.64	4.81	4.7	
	% Positive experience		90.4%	92.6%	96.2%	93.3%	84.3%	93.30%	77.40%	94.20%	89.50%	86.20%	92.70%	94.20%	
	% Negative experience		4.5%	3.0%	2.2%	4.1%	2.8%	3.40%	3.10%	1.40%	3.20%	5.60%	2.00%	4.30%	

Note: Any data variance from the Integrated Performance Report is driven by live updates from Datix on incidents reported retrospectively

Delivery against strategic objective 2 – we will enable each other to be the best we can be

Trust overall

- Maintained staff turnover rates at 9.3% average against target of 12%
- Using Time to Care programme recruitment as an opportunity to consolidate vacancy recruitment
- 78% increase in staff participating in latest national quarterly pulse survey, with improved scores in 8 of the 9 questions
- More staff have taken up professional development opportunities in M1 to M6
- 50 new volunteers recruited
- Around 30% increase in time given by Lived Experience Ambassadors
- New social work apprenticeship scheme launched with Anglia Ruskin University
- Virtual reality training event showcased ability of immersive technology to better equip staff with vital skills
- Trust won two awards at the Zenith Global Health Awards

Care group specific

Urgent Care and Inpatients

- Reduction in temporary staffing is on target
- Recruitment progressing for Time to Care roles

Specialist Services

- Scheduled programme of senior leadership visits to clinical sites to support provision of safe spaces for all teams

Psychological Services

- Inpatient teams now staffed to establishment
- Marketing plan developed to focus on hard-to-recruit areas including CAMHS

North East Essex

- Reduction in sickness absence and increase in appraisal rates
- Reduction in temporary staffing; recruitment progressing for perinatal mental health teams

West Essex

- Programme of rotations in place to support development and retention of occupational therapists; intention to roll out same approach for healthcare assistants

Mid and South Essex

- Vacancy rate reduced from 8% to 6.6%
- Trust is leading MSE Healthcare Assistant Academy, including shared induction programme
- Over 50 new healthcare assistants have already passed through the academy

STRATEGIC OBJECTIVE 2: WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Metric		Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Narrative
Retention rate	Staff Turnover (Target 12%)	9.2%	9.1%	9.3%	9.1%	9.2%	9.1%	9.6%	9.4%	9.3%	9.3%	9.5%	9.5%	
Range and update of learning & development opportunities (inc. volunteers and lives exp. roles)s		APRIL 2023-MARCH 2024 inclusive (EPUT and SHARED DELIVERY) Leadership Programme: 63 Management Development Programme: 111 Edward Jenner Programme: 14 STORM Training: 45 PSIRF (Systems Approach to Learning from Patient Incidents): 40 Time Management: 1 Minute Taking: 9 VDT MOCA Training: 2 ACT Training: 30 RISE: 45 APRIL 2023-MARCH 2024 inclusive (DELIVERED BY EXTERNAL PROVIDERS) Leadership Programmes: 7 Managers Programme: 1 ACT Training: 6 APPRENTICESHIPS: 3 currently on a Leadership Programme						APRIL 2024-SEPT 2024 inclusive (EPUT and SHARED DELIVERY) Leadership Programme: 42 Management Development Programme: 83 Edward Jenner Programme: 5 STORM Training: 53 PSIRF (Systems Approach to Learning from Patient Incidents): 0 Time Management: 1 Minute Taking: 0 VDT MOCA Training: 0 ACT Training: 28 RISE: 0 APRIL 2024-SEPT 2024 inclusive (DELIVERED BY EXTERNAL PROVIDERS) Leadership Programmes: 9 Managers Programme: 1 ACT Training: 3 APPRENTICESHIPS (Leadership/Management Programmes): No new starts for this period						
Number of PSE and Lived Experience role	Total No. LEAs	156	158	211	214	214	214	217	220	221	221	222	225	
	Total No. Volunteers inc LEA	311	317	330	332	394	455	411	424	439	451	466	487	
	Total New Registrations inc LEA	11	8	10	14	35	23	15	13	15	12	15	19	
	Hours LEA (per month)	645	47	607	610	584	371.5	728.5	885.9	525.1	764.1	478	532	
	No of LEA's involved in activities	92	51	75	72	88	78	117	132	87	77	87	69	
	No of activities Per month	21	20	21	30	23	27	42	41	36	25	40	49	

Delivery against strategic objective 3 – we will work together with our partners to make our services better

Trust overall

- *Quality Together* governance structures in place with ICBs are supporting delivery of Trust quality improvements
- Increase in peer support workers on inpatient wards from 5 to 21
- Working collaboratively to introduce *Right Care, Right Person* initiative with Essex Police
- Review of Greater Manchester Mental Health report includes improvement actions with system partners
- Sustained focus with university partners on health and care system workforce development
- New research strategy is starting to bring benefits in research output, monitoring and recruitment to studies
- Second annual co-production conference celebrated the power of partnerships

Care group specific

Urgent Care and Inpatients

- Expansion of peer support team to cover The Lakes (Colchester) and Basildon Mental Health Unit
- System flow improvement project under way to reduce inappropriate out of area placements

Specialist Services

- East of England Provider Specialist Mental Health, Learning & Autism Provider Collaborative reconfigured bed base to provide increased capacity/ facilitate more repatriations to the region
- New CAMHS eating disorders pathway launched to reduce out of area placements

Psychological Services

- Innovative exhibition held to showcase artwork produced by Early Intervention in Psychosis service users, bringing better awareness and understanding to local communities
- Expanded coproduction and service user network model into more services

North East Essex

- By Your Side perinatal service expansion and transformation programme now completed with county-wide system partners; service shortlisted in 2024 HSJ Awards

West Essex

- Core participation in HWE ICB Care Closer to Home programme, including transformed approach to end of life care

Mid and South Essex

- Coproduced and launched *MyCareBridge* online platform for partners supporting young people with Autistic Spectrum Disorder
- Thurrock partnership completed detailed review of 30 long term care packages to ensure people are receiving appropriate care and partners are making best use of shared resources

STRATEGIC OBJECTIVE 3: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Metric	Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Narrative
Lived experience survey					28 responses received. Of the 28 received; overall 19 were positive, 3 were neutral and 6 were negative			Survey will be repeated annually in Q4						
Number of all open studies in a month (cumulative)	22	19	19	18	18	18	19	15	17	18	18	19	19	
Proportion (%) of research studies open non-commercial : commercial	(18:4)	(18:1)	(18:1)	(17:1)	(17:1)	(17:1)	(18:1)	(14:1)	(16:1)	(17:1)	(17:1)	(18:1)	(18:1)	
Raw NIHR non-commercial research studies recruitment numbers across all study types in the month	-	43	50	21	27	45	37	14	21	33	30	24	30	
LSS(x1):Obs (x3.5): IV (x11)	09:53:38	05:47:48	04:53:43	04:55:41	04:57:39	04:60:36	04:62:34	03:38:59	02:39:59	03:22:75	02:21:77	03:20:77	03:18:79	
Cumulative combined study types weighted NIHR non-commercial research studies recruitment	5500	1249	1426.5	1495	1577	1734.5	1866.5	74	187.5	425.5	645.5	769.5	967	
		-22.70%	-25.90%	-27.20%	-28.70%	-31.50%	-33.90%	1.35%	3.41%	7.74%	11.74%	13.99%	17.58%	

Delivery against strategic objective 4 – we will help our communities to thrive

Trust overall

- Increase in BAME colleagues in posts at band 7 and above continued to grow
- 40 BAME staff graduated from the RISE professional development programme
- 30% of purchase order value was placed with suppliers in Essex, Bedfordshire or Suffolk (30% increase); ongoing work with anchor partners on options to increase this percentage
- Continuing to work on evaluation of social value of procurement contracts with anchor partners
- Over 85% of Trust staff now trained in clinical risk
- Fall in suicide rates in north East Essex, one of only four areas nationally to report a reduction
- Enable East delivery of Multiply numeracy skills programme via grant funding to Southend, Essex County and Thurrock councils for >330 adults without a mathematics GCSE

Care group specific

Urgent Care and Inpatients

- Hubs developed in south sites to collocate community services including housing and employment support
- Thurrock Food Bank continues to support local people as demand increases

Specialist Services

- Extension of offer to marginalised and vulnerable adults in Suffolk extended for 10 years; new provision for North East Essex commissioned on a one year pilot
- Strengthened partnership with St Luke's Primary School in Runwell with appointment of Trust senior manager from Brockfield House to the school's Governing Body

Psychological Services

- Launch of new employment advisory service with Mind in North East Essex and with Mental Health Matters in South East Essex

North East Essex

- Participation in secondary school careers event, with plans for primary school engagement

West Essex

- Project Search partnership in place with local colleges to attract students into apprenticeships within the Trust as part of inclusive employment plans

Mid and South Essex

- MSE Community Collaborative working with NHS Providers and the Health Foundation to improve cardiovascular disease pathway and maximise impact of community services and primary prevention
- Evaluation of Thurrock Partnership Complex Housing Intervention Programme showed qualitative evidence of positive impact on access, effectiveness and experience of people supported and average system saving of £54k per client multiplied across a caseload of 17 people

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STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Metric		Target	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Narrative
% of workforce employed from local communities			Snapshot as atMar24: 5484 out of 6750 (81%) employed and live in same county											88.90%	Data provided as a snap shot as not many changes month on month
% BAME staff in roles >B7			20.6%	20.7%	20.73%	20.98%	21.05%	21.37%	22.06%	22.18%	22.34%	22.63%	22.57%	22.62%	Figures do not include Medical staff
% procurement spend with local suppliers			13.6%	51.5%	72.6%	18.7%	12.1%	14.4%	30.1%	2.7%	9.1%	42.1%	12.1%	19.7%	
Uptake and evaluation of suicide awareness training	Preventing Suicide by Ligature	85%	90.0%	90.0%	88.0%	89.0%	91.0%	91.0%	81.8%	80.9%	80.6%	79.0%	87.4%	80.3%	
	Clinical Risk for Registered Staff	85%	86.6%	87.3%	88.2%	88.8%	87.2%	87.2%	89.5%	88.9%	87.3%	87.4%	92.1%	89.5%	
	Clinical Risk for Non-Registered Staff.	85%	90.0%	90.3%	89.4%	89.5%	88.7%	88.7%	89.4%	89.8%	89.7%	89.6%	95.3%	90.3%	
	Suicide Prevention & Self-harm Mitigation (Storm):		From 1st January 2023 -1st December 2023:- 31 courses offered, 248 delegates could have been trained. 4 courses were cancelled due to facilitator unavailability, 3 were not released on the mandatory training calendar due to an error/oversight, therefore out of the potential 248 available places, only 192 were offered for training. 151 delegates were trained (79%)			1st Jan 2024 - 31st March 2024 9 courses were offered and 72 delegates could have been trained. 4 courses were cancelled; 2 due to facilitators unavailable (sickness) and 2 due to insufficient amount of delegates enrolled (3 only enrolled, minimum is 4/5 – maximum 8) Therefore out of the potential 72 available places only 31 received training (43%) as some delegates cancelled and others did not turn up and on two occasions there were insufficient amount of delegates and the course was cancelled.			1st April 2024 – 30th September 2024 • 18 courses were offered and 144 delegates could have attended • We ran 15 courses and should have had 120 delegates but only 88 attended. • 3 courses were cancelled , one was due to unavailability of facilitators and two were due to insufficient amount of delegates enrolled (2 only enrolled for each course, minimum is 4 – maximum 8). • Therefore out of the potential 144 available places only 88 received the training (73.3%) as some delegates did not turn up and others cancelled.						

TRANSFORMATION DELIVERY FRAMEWORK UPDATE

MONTH 6 2024/25

INTRODUCTION

The Transformation Team continues to work with colleagues across EPUT and System Partners to improve services for patients, service users, families and staff. Using a diverse set of skills and abilities, they work closely with internal, local, regional and national colleagues in health, social care and the voluntary sector to support each other with challenges, such as service redesign, rising costs and changes in regulations.

There are three key functions of the team – delivery of projects & programmes, assurance & oversight of the overall portfolio of change alongside providing coaching & support to staff to resolve operational issues and to deliver change.

Team members bring experience in project & programme management, quality improvement, portfolio management & assurance and data analytics. This experience comes from a variety of backgrounds in both the public and private sectors. Demand on team resources is high and through secondments they are supporting other Trusts, NHSE and the Lampard Inquiry.

The portfolio management office has continued to manage and provide assurance on an extensive portfolio of projects & programmes, efficiency schemes and strategies being delivered by the Trust.

In the last six months the team has continued to support several key programmes including Community Mental Health Transformation, Reducing Length of Stay, Redesign of the Inpatient Operating Model (part of our Time to Care programme), and the Electronic Prescribing of Medicines programme. Most recently the team have supported the launch of a new digital platform that allows the Trust to standardise and optimise its Standard Operating Procedures making them more accessible and useable for staff.

The team is driven by a set of principles which were collaboratively designed and agreed. These represent the values and behaviours that each member believes are important in their work and in supporting and constructively challenging one another.

Executive Portfolios and Key Performance Indicator Dashboard

Every large-scale change project or programme is assigned an Executive Director to hold accountability for its delivery. These form Executive Portfolios which are monitored regularly and the current dashboard is included later in this report.

Identified Efficiency Schemes

The team support the Care and Corporate units to identify and manage projects that provide financial savings without compromising the quality and safety of care.

Adoption & Implementation of Aspyre

Full adoption of Aspyre, our portfolio management software, has enabled us to manage and report on the work we do. In the coming months we will further deploy Aspyre throughout the organisation and support colleagues to be consistent in project management delivery and reporting.

Quality Improvement, Training & Development

Six team members have completed Quality Service Improvement and Redesign (QSIR) training devised by NHS England. QSIR tools help us to make smaller changes and deliver continuous improvements that have long-term, positive impacts on the quality of the services we provide.

Skills Matrix & Service Catalogue

The team is developing a skills matrix and service catalogue to help colleagues better understand the capabilities we have within the team and how we can support their work. Once published, the documents will be shared with external partners and accessible to all staff on the intranet.

Translation & delivery of operational plans for 2024/25

The team continue to support care unit and corporate service leads to fully establish and embed their portfolios of change, ensuring delivery of their strategic priorities.

USING PORTFOLIO MANAGEMENT SOFTWARE FOR BETTER OUTCOMES

Our new Portfolio Management software has enabled us to work more efficiently. Some of the key benefits are:

Comprehensive Portfolio Management

Advanced Analysis of Key Data

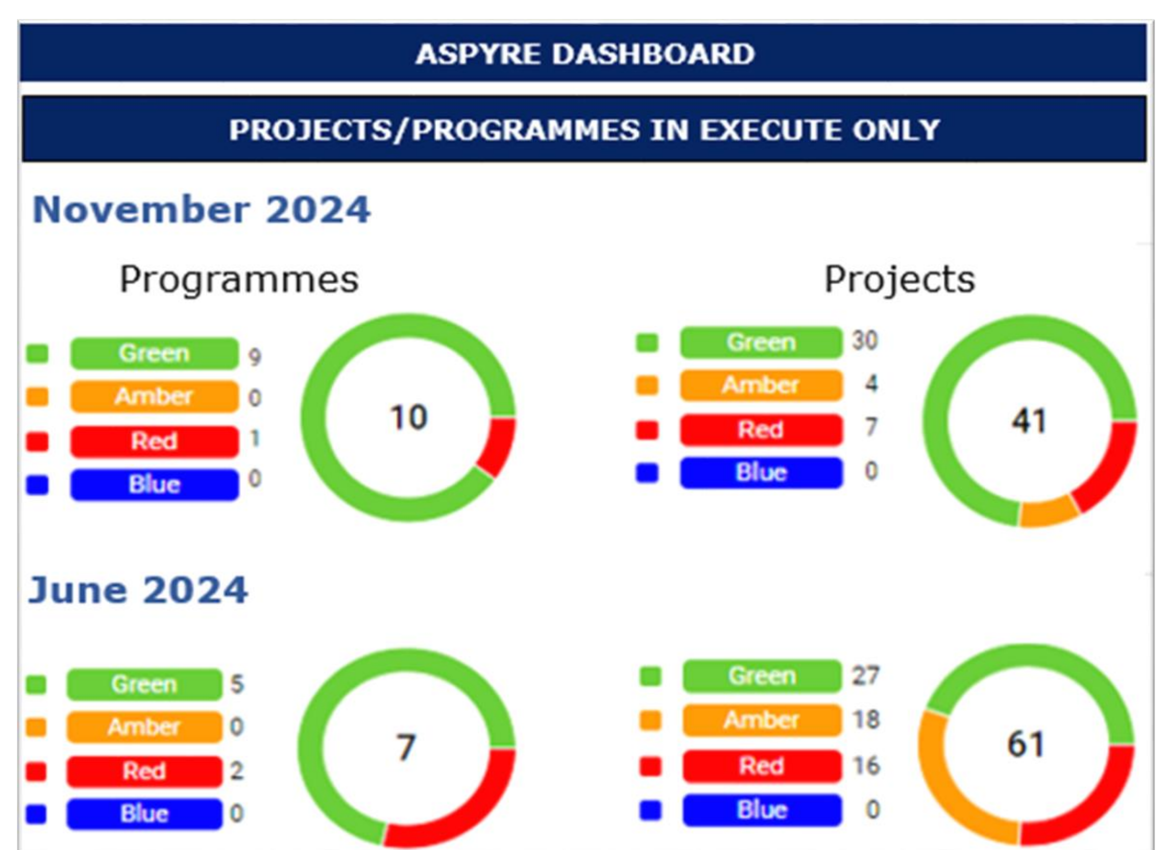
Real-Time Reporting & Dashboards

Aspyre is used to provide real-time data to monitor the overall portfolio. It enables the portfolio management office to manage, track and report on projects & programmes, strategies and efficiency schemes. Aspyre tracks these from being an initial concept or idea, all the way through to achieving and realising the benefits to our services.

This software enables early recognition of projects or programmes that may not be on track to deliver the desired outcomes and those that may require intervention.

The team are notified when a red status has been flagged and have implemented an **assurance process** for when a project has been reporting behind plan for an extended period. This process has **improved the delivery success** of projects & programmes, and we have seen a steady reduction in the number which fall short of our standards and require extra support.

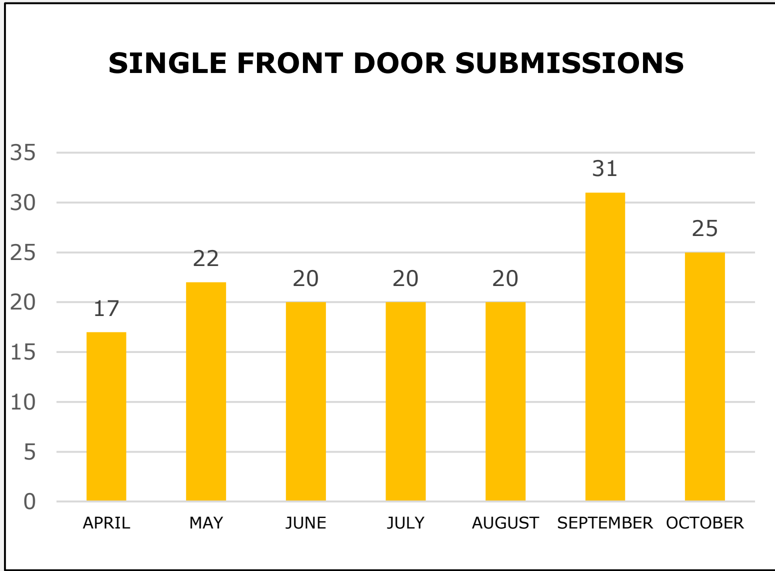
The dashboard shows that over the last six months the team have been able to manage a reduction of the number of projects and programmes in red and amber.



TRANSFORMATION PORTFOLIO ACTIVITY

The **Portfolio Management Office** manage processes and reporting alongside a log of potential ideas that could help the Trust to deliver its strategic objectives in the future when the opportunity allows.

The team also monitors delivery of benefits and captures learning which is then used to drive continuous improvement.



All requests for change are captured through our Single Front Door (SFD) process.

There have been **155 SFD requests** for change or suggested ideas between April and October 2024. This is an average of 22 per month.

The team make sure they get the balance right between starting a new initiative against effectively closing an existing project or programme. This helps to prioritise discussions and any actions which will support successful delivery.

Good governance allows projects to only move through the agreed lifecycle stages, ensuring that plans are credible, and benefits are captured.

Benefits and Lessons are consistent and more readily available for sharing. This has a positive impact on future change activity throughout the Trust, which results in better service improvements.

Tracked benefits include:

ü Patient safety
ü Service user experience
ü Impact of co-production
ü Quality of Care
ü Staff morale
ü Value for money

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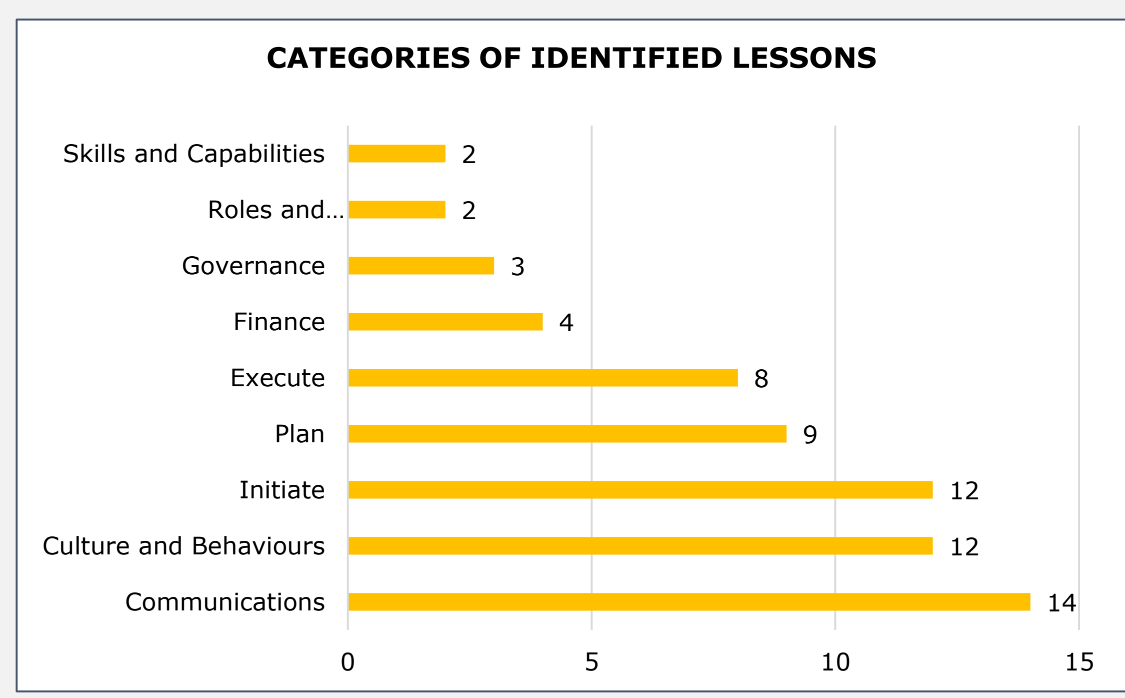
EMBEDDING OUR CULTURE OF LEARNING



Since April 2024 **67 lessons have been identified**. The above graph highlights the categories in which lessons have been captured.

Alongside Digital colleagues the team have been recording lessons that are identified throughout the lifecycle of the project or programme.

Continuous improvement & next steps

In order to support and embed a lessons learning culture for all change activity throughout the organisation we:

1. Undertake thematic analysis
2. Use insights from our analysis to provide guidance on lessons learnt in order to drive quality
3. Encourage a buddy scheme between project managers throughout the organisation in order to embed lesson learning
4. Cascade lessons learnt throughout the organisation

COLLABORATING AND WORKING WITH THE SYSTEM

The team has developed good working relationships with other health and care organisations across Essex. We work closely with both them and people who have lived experience of our services to ensure projects and programmes are co-produced and that we remain involved in system change.

County Wide Collaborative Working

The Strategic Implementation Group works across Southend, Essex and Thurrock and has a clear, system-wide collaborative programme. The group implements elements of the Southend, Essex and Thurrock (SET) Mental Health and Wellbeing Strategy that have a county wide approach. The benefits of working like this are already being recognised:

- The SET Specialist Perinatal Mental Health Service transformation has been recognised nationally by the HSJ awards in the *"Place Based Partnership and Integrated Care*" award category. We were instrumental in designing and supporting the start up of this service.

- We are working with colleagues in operational services to make improvements to the flow of patients. Using county wide approaches which improve the admission and safe discharge of patients and service users, whether they are supported by health, social care or the voluntary sector lowers the reliance on out of area beds.

Place Based Collaborative Working

Transformation is needed at a local level to address inequalities and local population health outcomes. We have developed required relationships and we support system change alongside sharing lessons from other work. This assists other organisations with insight and consistency.

- We ensure people with lived experience of services are equal partners in projects and programmes to make sure that they are part of the continuous improvement cycle.

- We supported the movement of secondary care into a collaborative approach with other organisations and GPs. North-East Essex were supported to use this approach and have been recognised for *"Mental Health Clinical Improvement"* in The General Practice Awards 2024.

- We coordinated multi agency workshops and events for service design. This help clinical teams work together and create seamless pathways for people (e.g. Specialist Community Mental Health Transformation).

- Our Portfolio Leads regularly meet system partners to share learning, collaborate and support one another in the delivery of community services. This helps to improve existing services instead of starting again.

TRANSFORMATION DASHBOARD – OCTOBER 2024

Time To Care	Workforce & Culture	QI, Safety and Learning	Clinical Model	People & Community	Digital & Data	Finance, Estates and Commercial
Executive Sponsor Alex Green	**Executive Sponsor** Andrew McMenemy	**Executive Sponsor** Ann Sheridan	**Executive Sponsor** Milind Karale	**Executive Sponsor** Nigel Leonard	**Executive Sponsor** Zephan Trent	**Executive Sponsor** Trevor Smith
Overview - Staffing model; process improvement	**Overview -** Changing culture; staff development & leadership	**Overview -** Safety; learning; independent inquiry; QI	**Overview -** Clinical strategy; clinical pathways	**Overview -** Community engagement; lived exp. & participation	**Overview -** Modernisation of digital and data systems and processes	**Overview -** Financial efficiencies, Modernisation & optimisation of estates
Projects 1 project in Execute, of which • 0 Green • 1 Amber • 0 Red 1 Pipeline project	**Projects** 1 project in Execute, of which • 1 Green • 0 Amber • 0 Red 1 Pipeline project	**Projects** 6 projects in Execute, of which • 4 Green • 1 Amber • 1 Red 2 Pipeline projects/ 7 Strategies	**Projects** 20 projects in Execute, of which • 17 Green • 2 Amber • 1 Red 6 Pipeline projects	**Projects** 4 projects in Execute, of which • 4 Green • 0 Amber • 0 Red 2 Pipeline projects	**Projects** 13 projects in Execute, of which • 8 Green • 0 Amber • 7 Red 63 Pipeline projects/1 Strategy	**Projects** 8 projects in Execute, of which • 7 Green • 1 Amber • 0 Red 4 Pipeline projects
Transformation team Resource Committed • 2 WTE	**Transformation team Resource Committed** • 0.2 WTE	**Transformation team Resource Committed** • 0.4 WTE	**Transformation team Resource Committed** • 4 WTE	**Transformation team Resource Committed** • 0.2 WTE	**Transformation team Resource Committed** • 1 WTE	**Transformation team Resource Committed** • 3 WTE
Example of key projects & programmes • TTC – Building our Workforce • TTC – Clinical Inpatient Operating Model • TTC - Oxevision EPR Integration Proof of Concept (POC)	**Example of key projects & programmes** • Health Care Support Worker Academy • Re-build Intranet Business Case Production • Combined Steering Group for Patient Pathways	**Example of key projects & programmes** • Embedding Gold Standard SOPs • Lampard Inquiry • Embed Quality Improvement Methodologies • PSIRF Improvement	**Example of key projects & programmes** • Integrated Mental Health Primary Care Transformation Programme • Outcome Measures Programme • Specialist Community Mental Health Transformation • Specialist Perinatal MH Transformation • MSE Community Collaborative Adult SLT Transformation • Eating Disorders Transformation	**Example of key projects & programmes** • West Essex Care Coordination Centre • West Essex Virtual Hospital	**Example of key projects & programmes** • ePMA • MaST • Patient Record Sharing Programme	**Example of key projects & programmes** • Brockfield House Safety Improvement Works • Woodlea Clinic Refurbishment • Efficiency Programme
Projects & Programmes moved to BAU or Closed	**Projects & Programmes moved to BAU or Closed**	**Projects & Programmes moved to BAU or Closed**	**Projects & Programmes moved to BAU or Closed** • Pan Essex Treating Tobacco Dependency Service • Mental Health Crisis Transformation NEE • Dementia NEE	**Projects & Programmes moved to BAU or Closed**	**Projects & Programmes moved to BAU or Closed** • Electronic Prescribing in SystmOne for Perinatal MH Service • Manchester Triage Template	**Projects & Programmes moved to BAU or Closed** • Rapid Response - Coombewood • Woodlea Clinic Refurb • The Lakes Garden Phase 2 Works

OUR KEY PROJECTS AND PROGRAMMES

PROJECT/PROGRAMME	AIM	KEY DELIVERABLES	BENEFITS	END DATE
Time To Care	Increasing the variety of professionals in each inpatient team to support the implementation of a new operating model for acute mental health inpatient services. This ensures patients receive better, personalised, quality care and integrate with place-based community and the system	• Recruiting Allied Health Professionals, Psychologists, Pharmacy staff, Mental Health Nurses, Registered Care Practitioners and Activity Co-ordinators • Rolled out SMART bed management system	• Staff are trained on better admission practices • Staff can now deliver more therapeutic care • Patients are involved in conversations about their discharge plans right from their admission	March 2025
Embedding Gold Standard Operating Procedures	Increase patient safety by ensuring that there are accurate, easy-to-follow and accessible Standard Operating Procedures (SOPs) in place for clinical staff	• All staff have access to a new app called SOPHIA which holds the procedures • When existing SOPs need to be reviewed they will be moved to SOPHIA	• Patients receive safer and more consistent care • Staff are equipped with the tools to make sound clinical decisions • SOPs an interactive process and shows audit trails of access – managers are able to see that their teams are accessing SOPs regularly	March 2025
Embed Quality Improvement Methodologies	The use of systematic tools and methods to continuously improve the quality of care and outcomes for patients.	• QI will be used to support community teams, patients and families to look back at work that has already been done and see what further improvements can be made	• Patients and carers are involved in the design of services to ensure they are fit for purpose and hold the patient at the centre	March 2026
Integrated Mental Health Primary Care Transformation Programme	Creation of a new integrated Mental Health capability between health, social care and the voluntary sector	• Mental Health staff including doctors, specialist pharmacists, nurses, social workers and occupational therapists now work in or support GP surgeries with triaging, assessing and treating of people with a Mental Health condition • Staff carry out physical health care checks for people with a serious mental illness	• Social Care staff within the GP surgeries are able to support people earlier with Care Act assessments and support to access funded care • Access to Mental Health support is reduced (currently from 28 days to 5 days on average)	March 2025

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OUR KEY PROJECTS AND PROGRAMMES – CONTINUED

PROJECT/PROGRAMME	AIM	KEY DELIVERABLES	BENEFITS	END DATE
Outcomes Measures Programme	Introduce a new care plan and 'Outcome Measures Tool' to support more personalised care, shared decision making and empowerment of people that use our services	• A new care plan to be used across Essex which has built-in outcome measures that capture significant clinical change	• Gives clinicians, supervisors, managers, the Trust, commissioners, and most importantly patients and carers feedback on the effectiveness of care • Contains an outcome measure providing the opportunity for staff delivering care and people receiving care to check their progress • The care plan is built for use with all local providers in health, social care and the voluntary sector	March 2026
Specialist Community Mental Health Transformation	Review and redesign the Community Mental Health model to incorporate the care of people with complex mental health needs	• An understanding of how we can fully integrate our services in health and social care • West Essex, as a national implementer, already uses an advanced whole systems model for comprehensive care delivery and management	• Patients will have a seamless model of care, with input from the right people at the right time • Access to care will be quicker	March 2025
MSE Community Collaborative Adult SLT Transformation	Create a single, high quality Speech and Language Therapy service in Mid and South Essex that addresses health inequalities and meets the needs of its population	• Launching a new, single service across the Mid and South Essex area • Reduction of waiting times	• Patients will have quicker access to the service • Implement a single point of access into the service	March 2025
Mental Health Rehabilitation	Collaborate with other organisations and improve the provision of mental health rehabilitation to ensure that it gives patients the best experience and outcome	• Create new pathways into and out of the rehabilitation service • Ensure that the service is based on good outcomes and evidence from other similar services and research	• Patients are able to access the right treatment and support at the right time • Patients are given the right amount of support to build the skills they need to go home	March 2026

OUR KEY PROJECTS AND PROGRAMMES – CONTINUED

PROJECT/PROGRAMME	AIM	KEY DELIVERABLES	BENEFITS	END DATE
Eating Disorders Transformation	Standardise access to community adult eating disorders services (CAEDS) across Essex	• Provide equitable, consistent, and personalised care • Introducing new pathways, standardised operating procedures, and digital improvements. Additionally, early intervention services for 18-25 year olds are being rolled out to ensure a unified service	• People with eating disorders experience safer and more consistent care • Faster access to services • Better communication with other services	November 2024
Maternal Mental Health	Create a new service across Essex supporting mothers and birthing parents with their mental health during pregnancy after loss	• Launch a specialist service accessible for mothers and birthing parents that have a moderate to severe mental health response following a perinatal loss	• Improved mental health for mothers and birthing parents • Safer outcomes for babies and families • Lower reliance on social care • Lower rates of severe mental illness (SMI) and suicide	January 2025
ePMA (Electronic Prescribing Medicines Management Administration)	Move to a digital system that manages prescribing and medicines administration	• All prescription to be digitised • Easy for staff to access prescribing records	• Reduce waiting times for discharge medicines • Improved patient experience • Reduce waiting times for beds • Better information for patients on medication Improved availability of prescriptions via remote access • Reduction in staff time as no transcription required for charts • Improved availability of relevant patient information, e.g. allergy, patient preferences • Improved medicine recording	June 2025

OUR KEY PROJECTS AND PROGRAMMES – CONTINUED

PROJECT/PROGRAMME	AIM	KEY DELIVERABLES	BENEFITS	END DATE
Patient Flow	Understand and rectify process issues that make discharge difficult for people who have stayed in an adult mental health ward of longer than 60 days	• Review of patient electronic records to find common process issues • Hold multi agency discharge events (MADE) enabling multiple organisations to provide intensive process support to get people home	• Provide a more positive experience for patients from admission, treatment through to discharge • Stabilise patients and support them back into community settings to enhance recovery outcomes	March 2026
Point of Care Testing Pilot	Use specialist blood testing machines in patients' homes to give them an immediate result in seeing the effect of medication on their bodies.	• Successful use of POCT machines in community visits • Reduction in phlebotomy clinic appointments • Reduction in staff journeys to hospital labs	• Patients have access to immediate information about their health • Staff are able to reduce the delivery journeys to laboratories in local hospitals, saving time and enabling them to see more patients • Rapid changes in care can be made, if needed, to improve patient outcomes and experience	May 2025
Community Accommodation	Working with county wide partners to co-ordinate all community bed accommodation (residential, nursing and supported housing). This will support system flow and capacity by co-ordinating all community bed-based accommodation	• Supported Accommodation review • Residential and Nursing bed review • Independent Living • Admission avoidance for those in supported accommodation • Development of Complex Housing Interventions Team Pilot • Development of Enhanced Housing First Model • Improve the pathway between Mental Health Rehab & Community accommodation	• People receive as much support as possible to enter and retain independent housing, avoid relapse and consequent accommodation instability • Improve overall patient flow across Essex	March 2026

SIX MONTH FORWARD PLAN

Resource Utilisation	Service Catalogue	Updated Intranet	Continuous Improvement	Operating Model Review	Integration of Portfolio Management Offices

1-3 months ***3-6 months***

Resource Utilisation	Service Catalogue	Updated Intranet	Continuous Improvement	Operating Model Review	Integration of Portfolio Management Offices
Through further prioritisation, utilise team resources and capabilities in the right way all of time to support the overall priorities of the Trust	Create a catalogue, which outlines the skills and capabilities available from the Transformation Team and enables wider colleagues across EPUT to understand how we can support them	Relaunch of the Transformation Team intranet page incorporating the new service catalogue. Sharing best practice, lessons learned, tools and templates for starting, managing and closing projects	Continuous development of Aspyre to ensure gold standard project reporting, promote best practice and support decision making on priorities. Provide further assurance on delivery of projects & programmes	Regular evaluation of the team purpose and function to ensure it continues to meet the needs of the Trust today and in the future	Integrate the Digital, Efficiency and Transformation Portfolio Management Offices into one to streamline the use of resource, tools and processes and ensure consistent delivery of services

OPERATIONAL PLANNING UPDATE 2025/26

EPUT IS CONTINUING TO EVOLVE ITS ANNUAL OPERATIONAL PLANNING PROCESS

Reflections on 2024/25 planning process

- Trust began planning process early ahead of publication of national guidance
- Senior planning triangulation group created environment for healthy debate and challenge, including valuable peer challenge between care units
- Improved engagement from care unit leadership teams over previous year
- Development of Estates strategy drove improved accuracy and completeness of baseline
- Challenge of reconciling commitments in operational plans to those in corporate strategies
- Lack of Trust-wide clinical/model of care strategy can make decision making difficult - will partially be enabled by unified EPR in future years, but acknowledge challenge of different models specified in different ICBs and requirements of integration at place level
- Improved co-ordination, more robust triangulation and harmonisation between care units via triangulation group
- Heightened profile of efficiency requirement early in the process
- Cost pressure long list helped inform contracting discussions
- Updated costing of overheads to better reflect actual costs

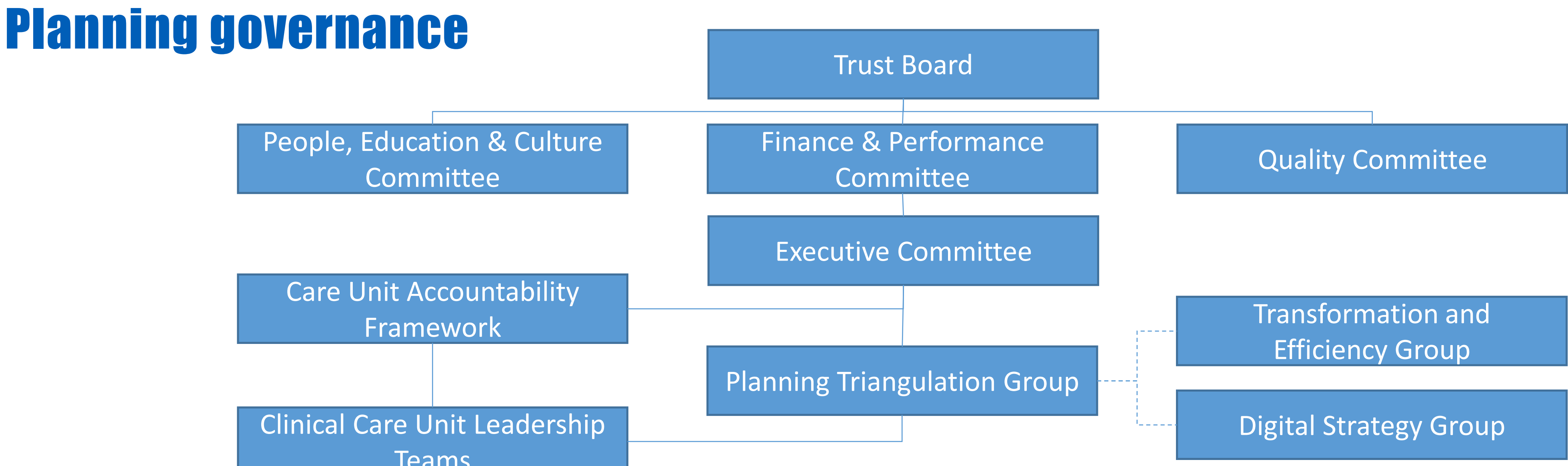
Planned ways to strengthen the operational planning process for 2025/26

- Review of operational priorities
- Position senior planning triangulation group as collective voice to inform executive decision making
- Even stronger triangulation so that financial plans are directly informed by activity and workforce plans
- Clearer translation of plans to reporting/monitoring in year via Accountability Framework, with appropriate balance between empowerment and oversight
- Benefit from more operational support for contract discussions in some areas
- Build on robustness of planning in absolute terms to drive more focus on profiling through the year
- Estates - consolidation and improved utilisation, disposal through estates strategy
- Course correction for alignment with enabling strategies and Trust strategic plan where needed
- Agree approach to co-production of ops plan with Lived Experience Ambassadors
- Planning process has to proactively work alongside Inquiry process and take account of impact on colleagues

Approach for 2025/26 operational planning process

- Build on the integrated approach to planning taken in 2023/24
- Recognise key role of budget setting in articulating same service story when viewed through quality and safety, activity, workforce and finance
- In context of exceptionally challenging financial context, retain commitment to planning driven by quality, safety, improvement and population need
- Position finance as an enabler alongside workforce transformation, digital solutions, data and estates

Planning governance



Planning Triangulation Group

- Detailed working group to build the approach and timetable
- Accountable to Executive Team and recommends actions
- To hold organisation to account for delivering against milestones
- To resolve core issues being raised by Clinical and Corporate Care Units relating to operational planning
- Responsible for coordination of centrally provided templates & dataset on completely and accurately
- Receive decisions taken by TEG and DSG to contextualize within operational plan
- Provides operational planning context to TEG and DSG
- Membership: corporate planning leads & clinical care group reps
- Reps have responsibility to ensure planning activities and deadlines are timetabled into Care Group / SLT governance and disseminated appropriately
- All work shared and circulated via Teams channel

Care Groups / Corporate Directorates are responsible for:

- Sign-off of local plan
- Mobilisation of their teams to meet deadlines completely and accurately
- Engagement with stakeholders within and external to Trust relevant to their areas

Board committees

- Scrutinise relevant recommended drafts of operating plans from Executive Committee
- Finance & Performance Committee receives and approves triangulated finance, workforce, activity and narrative plans
- Recommend drafts of operating plans to Trust Board for approval

10. REGULATION & COMPLIANCE

10.1 ANNUAL REVIEW OF GOVERNANCE DOCUMENTS

Decision Item | DG | 5

REFERENCES

Only PDFs are attached

Annual Review of Governance Documents 04.12.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

Report Title:	**Annual review of Governance Documents**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary Clare Barley, Head of Financial Accounts					
Report discussed previously at:	Executive Management Committee 31 October 2024 Audit Committee 15 November 2024					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand / Capacity	
	SR5 Lampard Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data Strategy	
Does this report mitigate the Strategic risk(s)?	The Documents provide the governance that underpins the use of resources and decision making by the Board of Directors and for the management.	
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 revised Standing Orders for the Board of Directors, the Scheme of Reservation & Delegation, Standing Financial Instructions and Detailed Scheme of Delegation for approval by the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board is asked to:

1. Note the annual review of the Standing Orders and the Scheme of Reservation and Delegation for 2024.
2. Receive the recommendation from the Audit Committee for approval
3. Approve the Standing Orders, the Scheme of Reservation and Delegation, the Standing Financial Instructions and Detailed Scheme of Delegation.

Summary of Key Issues

Scheme of Reservation & Delegation

The annual review of the Scheme of Reservation and Delegation (SoRD) was undertaken with the Audit Committee approving the following amendments:

Ref.	Amendment
Ref. 4.6	The addition of the Lampard Inquiry Oversight Committee
Ref.5.8 and Ref. 7.6	Amendment to appointment of Deputy CEO to allow for more than one individual to be designated as such.
Ref. 6.2 (6.1.2)	Amendment of his/her to gender inclusive language
Ref.6.5 (6.5.1)	
Ref.6.8 (6.8.1)	
Ref.6.8 (6.8.2)	
Ref. 7.24 (7.24.3)	
Ref. 7.30 (7.30.2)	Removal of reference to NHS Improvement.
Ref.7.33 (7.33.6)	Correction of year to latest guidance 'Procure 23'

Standing Orders for the Practice and Procedure of the Board of Directors / Scheme of Reservation & Delegation

The annual review of Standing Orders for the Practice and Procedures of the Board of Directors was undertaken with the Audit Committee approving the following amendments

Ref.	Amendment
2.7.5	Amendment of process for reappointment after a second term of office for the Chair and NEDs to align with Code of Governance for NHS Provider Trusts and reflect the requirements to have any extensions agreed with NHS England.
2.7.6	Additional provision for the role of Associate Non-Executive Director.
2.11	Amendment to appointment of Deputy CEO to allow for more than one individual to be designated as such.
9.2.1 / 9.4.2 / 9.6.1	Addition of reference to The Health Care Services (Provider Selection Regime) Regulations 2023
Appendix A	Inclusion of the Lampard Inquiry Oversight Committee

The Board of Directors are asked to note and approve the prospective amendment to the Standing Orders for the Practice and Procedures of the Board of Directors to be enacted from February 2025 where the Public Contract Regulations are replaced by the Procurement Act 2023 for clauses 9.2.1 / 9.8.1

Standing Financial Instructions (SFI's)

The annual review of Standing Financial Instructions (SFI's) was undertaken with the Audit Committee approving the following amendments

Section	Proposed Change
Foreword	Annual requirement for Budget Holders to confirm they have read the Governance Manual now included.
1.1.2	Approval route for finance policies and procedures updated to Policy and Oversight

	Ratification Group rather than Audit Committee.
7.3.2	Budget Holders responsibilities expanded to include requirement for staff change forms to be completed at earliest opportunity to remove risk of incorrect payments being made to staff, and to review and return staff lists on a monthly basis.
11	Expanded to confirm that all staff can report criminal offences made against them to the police
12.2.1b	Expanded to include compliance with any establishment control panel in operation at the time.
13.2.1	Expanded to include compliance with any non-pay control panel in operation at the time.
13.2.6c	Requirement to ensure contracts only signed in agreement with procurement / contracts department expanded to confirm this includes electronic signing (eg docusign)

Detailed Scheme of Delegation:

The annual review of Detailed Scheme of Delegation was undertaken with the Audit Committee approving the following amendments:

Section	Proposed Change
2.1a (v)	Approving of drug-related requisitions / invoices up to £99,999 is proposed to be delegated to Director of Pharmacy. All other Directors would retain a financial limit of £49,999.
2.1a (viii)	Following Board approval in October, authority to approve payments relating to Mid and South Essex community collaborative (EPUT is lead Provider) in excess of £1m is delegated to the CEO and ECFO rather than requiring individual Board approval.
2.1a (viii)	The Provider Selection Regime (PSR) came into force on 1 January 2024 and provides a set of rules for any health care or public health service procured by NHS Trusts, NHS England and ICB's requiring greater transparency around contracts that have been entered into. Those PSR contract awards that are linked to commissioned activity will be exempt from the thresholds in the DSoD and would not need to go to Board for approval. Any PSR contracts not linked to commissioned activity will not be exempt.
2.1a (xi)	Amended to include reference to electronic signing of contracts (e.g. docu sign) and a requirement these documents must only be signed in accordance with delegated limits.
2.2	Updated to reference Care Groups and Directorates
15	Approval route for finance policies and procedures updated to Policy and Oversight Ratification Group rather than Audit Committee.
17e	All additional staff to agreed establishment now need to go to Establishment Control Panel for approval.
17d (iii)	Authority to approve overtime now restricted to Assistant Directors and above (previously included Budget Managers) and the relevant Establishment Control Panel.
17f	Following approval at EOC, the level of annual leave able to be carried forward is now restricted to one week (of contractual hours) rather than 7 days previously allowed. All leave carried forward in excess of this (except for long term absence) now requires approval of ECPO.
18	Financial limits for the authorisation of new drugs with additional cost implications (compared to existing therapy) updated from £4,999 per annum to £9,999 reflecting increases in drug

	costs. Approval for those over £9,999 per annum updated to Effectiveness of Care Group rather than EOC.
24	Updated for Communications on-call arrangements

The adoption of the Procurement Act 2023 by the NHS has been deferred from October 2024 to an anticipated go-live date of February 2025. This will necessitate a number of changes to section 4 of the detailed scheme of delegation which the Board are asked to consider as part of this review rather than seeking further approval mid-year. In the event changes are not as currently anticipated below, further amendments will be required:

- Reference to EU terms be replaced with Procurement Act
- Reference to opportunities being advertised on Contract Finder to be replaced with the Central Digital Platform in line with limits detailed in the Procurement 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.	**YES/NO**	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			
SO	Standing Orders	NAO	National Audit Office
SoRD	Scheme of Reservation and Delegation	SFI's	Standing Financial Instructions
SFI	Standing Financial Instructions	DSoD	Detailed Scheme of Delegation

Supporting Documents and/or Further Reading
Scheme of Reservation and Delegation Standing Orders for the Practice and Procedures of the Board of Directors Standing Financial Instructions Detailed Scheme of Delegation

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

Document title:	**SCHEME OF RESERVATION & DELEGATION (SoRD)**		
Document reference number:	FP12	**Version number:**	8.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Senior Director of Corporate Governance		
Approval group/ committee(s):	Executive Team, Audit Committee & Board of Directors		15 November 2024
Professionally approved by: (Director)	Audit Committee		
Executive Director:	Chief Executive		
Ratification group(s):	Board of Directors		04 December 2024
CQC Quality Statement	Well Led – Governance		
Key word(s) to search for document on Intranet / TAGs:	Reservation, Delegation	**Distribution method:**	☐Intranet

Initial issue date:	01 April 2017	**Last Review date:**	27 September 2023	**Next Review date:**	01 January 2025	**Expiry Date:**	01 January 2025

Controlled Document

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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

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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 Senior Director of Corporate Governance Senior Director of Corporate Governance.

Services	Applicable	Comments
Trust wide	✓	

The Director responsible for monitoring and reviewing this policy is Chief Executive Officer

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
001	Trust Secretary	Replaces SEPFP12, Replaces NEP Scheme of Delegation, Minor – reflects new constitution and revised SFIs	01 April 2017
002	Trust Secretary	Minor – typographical amendments	01 August 2018
003	Trust Secretary	Not Documented	01 September 2019
004	Trust Secretary	New template used. Tables made consistent resulting in changes to document references. Addition of section delegating authority as part of the Major Incident Plan.	01 September 2020
005	Trust Secretary	Section 2.6: This section has been amended to provide for the new process agreed by the BoD Remuneration & Nomination Committee to allow the CEO to identify an Executive Director to act as Deputy CEO in their absence. The statement has also been amended to provide for formal acting-up status to an Executive Director should it be required for the CEO / CFO to approve income or expenditure and the CFO is acting as the CEO. Section 2.8: Section added to provide a general statement to allow the Board to delegate authority to Executive Directors to make decisions on behalf of the Board for any community collaborative board to ensure it functions effectively. Clarity has been made that this must be in-	01 September 2021

		line with any limitations provided by the DSoD.	
006	Trust Secretary	Updated to include People, Equality and Culture Committee, in place of People, Innovation and Transformation Committee	01 September 2022
6.1	Trust Secretary	References to LCFS amended to CF / ACS (Counter Fraud / Anti-Crime Specialist(s))	01 September 2022
007	Trust Secretary	Updated in line with the Health & Care Act 2022.	27 September 2023
7.1	Trust Secretary	Updated in line with the Health & Care Act 2022. 7.1 – Extended to January 2025	27 September 2023
8.0	Trust Secretary's Office	Updated to include the Lampard Inquiry Oversight Committee, amended to allow for more than one individual to be designated as Deputy CEO and correction of five reference to be gender inclusive.	05 December 2024

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Scheme of Reservation & Delegation (SoRD)

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8.0 SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFI'S)

9.0 MAJOR INCIDENT PLAN

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Scheme of Reservation & Delegation (SoRD)

1 INTRODUCTION

1.1 The Code of Governance for NHS Provider Trusts (2023) *requires* that responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations.

1.2 The schedule of matters reserved for decision by the Board of Directors (the Board) and those the Board has delegated are set out in this document.

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.

1.3 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 (including arrangements for functions to be exercised by or jointly with another relevant body) will be exercised on behalf of the Board by the Chief Executive (CEO).

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 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 without proper authority. 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 Executive Directors or officers. All powers delegated by the CEO can be reassumed by them should the need arise.

2.5 The SoRD shows only the ‘top level’ of delegation within the Trust. The Scheme should be read 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 them may be exercised by an Executive Director 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 Executive Chief Finance and Resources Officer (ECFO) is appointed to act up as the CEO, a further executive shall be named to act up with the ECFO for the purposes of approving expenditure and income up to an amount delegated by the DSoD a responsibility normally conferred to the CEO and ECFO. 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 them 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 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 England, 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, joint arrangements with other relevant bodies, 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

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Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				the extent to which a member of the Board may remain involved with the matter under consideration
			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 of the Board or joint arrangements with other relevant bodies 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

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Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				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 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
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

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Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				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 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

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Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				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 ECFO for losses and special payments previously approved by the Board
			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 the 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 as corporate trustee
			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 NHS England
			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

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Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				order to continually appraise the affairs of the Trust
			3.8.2	All returns required by NHS England 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 NHS England, and the Director with the portfolio for other areas of performance
			3.8.4	Approve the making of declarations in accordance with statutory requirements and /or at the request of NHSE
			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 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 Senior Director of Corporate Governance.

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

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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
4.7	Lampard Inquiry Oversight Committee	Terms of Reference

5 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~~Executive Director
13. Annual Members Meeting	Senior Director of Corporate Governance	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	Senior Director of Corporate Governance	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 Senior Director of Corporate Governance	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	Senior Director of Corporate Governance	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

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Constitution Ref.	Delegated To	SoRD Ref.		Duties Derived from the Constitution
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~~individual Executive Directors to be the Deputy Chief Executive in line with agreed procedure
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 Council
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)	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
34.1. Board of Directors Meetings (Exclusion)				
34.2. Board of Directors Meetings	Senior Director of Corporate Governance	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)

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Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
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	Senior Director of Corporate Governance	5.14	5.14.1	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
			5.14.2	Make the above registers available to the public in line with the conditions in the constitution
41. Documents Available for Public Inspection	Senior Director of Corporate Governance	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 NHS England and laying before Parliament
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

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Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
47. Instruments	Board of Directors	5.20	5.20.1 Authorise the procedure for the 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 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~~their 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

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
			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	6.4	6.4.1	Responsible for the overall organisation and management
	Chief People Officer		6.4.2	Responsible for staffing of the Trust
	ECFO		6.4.3	Responsible for the Trust's procedures in financial and other matters
	ECFO		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
			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~~they are ~~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

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				prescribed by NHS England 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 NHS England
	CEO		6.5.12	ensure that conflicts of interest are avoided, whether in the 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

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				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 Public Sector Internal Audit Standards.
12 – 15: Advice to the Board	CEO ECFO	6.6	6.6.1	Ensure that appropriate advice is tendered to the Board and the 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

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				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 NHS England 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 NHs England. 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 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. NHS England /I should be informed of such an instruction, if possible before the decision is

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				implemented. It will then be for NHS England 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 they are 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 can act on ~~his/her~~their 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~~they 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

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Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which ~~he or she~~they 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 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 Senior Director of Corporate Governance)
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 the Council of Governors
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	Chair	7.4	7.4.1	Appoint (and remove) the CEO subject to approval by Council of

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
appointment	Non-Executive Directors		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~~individual 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 of Governors
2.15 Senior Director of Corporate Governance appointment	Chair CEO	7.8	7.8.1 Appoint a Senior Director of Corporate Governance
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 NHS England 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

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			7.11.3	Lead on setting agenda for meetings and ensure that adequate 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 Senior Director of Corporate Governance to call a meeting by giving written notice
			7.13.4	If the Senior Director of Corporate Governance 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 Senior Director of Corporate Governance 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		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 Senior

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
Meetings	Senior Director of Corporate Governance		Director of Corporate Governance 7.14.2 Issue notice of meetings 7.14.3 Issue notice of and calling of extraordinary meetings and urgent 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 of Governors 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

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			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
3.12 / 3.15 Minutes	Senior Director of Corporate Governance	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	CEO	7.24	7.24.1	Prepare a detailed Scheme of Reservation & Delegation

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
functions by 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~~their absence, the Deputy CEO, provided that prior to taking such action, the CEO has consulted with and gained the agreement of the Chair
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

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
			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
	Senior Director of Corporate Governance		7.27.3 Ensure Register(s) of Interests is maintained
	Senior Director of Corporate Governance		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
6.3 Register of gifts and hospitality	Senior Director of Corporate Governance	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 NHS England *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

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
			~~NHSI~~ NHSE 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
			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		7.33.3 Competitive quotations should be obtained. Where this is not

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	ECFO			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/Procure23 scheme represents value for money and genuinely transfers risk to the private sector
	Board of Directors		7.33.6	Approve PFI/~~Procure22~~ Procure23 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 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	Senior Director of Corporate Governance CEO ECFO	7.34	7.34.1	Keep the common seal of the Trust in a secure place and maintain a register of sealing in line with Trust procedure.
	CEO ECFO		7.34.3	Approve and sign all building, engineering, property or capital documents

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
	Executive Directors (not within the originating directorate)		
	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
	Senior Director of Corporate Governance		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 of Governors 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

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SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
			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 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.
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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			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
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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				Meetings. Exceptionally, refer to NHS England any matters of concern, having raised it with the Chief Executive Accounting Officer and Executive Chief Finance Officer
2.2.1	ECFO	8.15	8.15.1	Ensure an adequate internal audit service, for which they are accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed)
2.2.2	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
2.3.9	Audit Committee	8.23	8.23.1	Ensure external auditors appointed by the Council meet the criteria included by the NAO Code of Audit Practice and the Local Audit and Accountability Act 2014
2.3.13	ECFO	8.24	8.24.1	Forward to NHS England within 30 days any public Interest report issued by auditors
2.4	CEO	8.25	8.25.1	Ensure compliance with the Counter Fraud Functional Standards

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
	ECFO			including the appointment of the Local Counter Fraud Specialist
2.5	CEO	8.26	8.26.1	Ensure compliance with NHS violence prevention and reduction standard
3.1.2	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 NHS England. 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
3.1.3 3.1.4	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
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	8.32	8.32.1	Must not exceed the budgetary total or virement limits set by the

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
	Budget Holders		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 are only undertaken in line with the Detailed Scheme of Delegation 8.34.5
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 NHS England as per the Single 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 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. NHS England

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				and ICBs).
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
6.2.3	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 portfolios of Finance,	8.45	8.45.1	Ensure that regular reports are provided to the Board detailing actual performance against signed LBCs

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
	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.	CEO delegated to Executive Directors	8.49	8.49.1 Approval of variation to funded establishment of any department
8.2.1	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 Chief People Officer	8.51	Payroll: 8.51.1 specifying timetables for submission of properly authorised time records and other notifications 8.51.2 final determination of pay and allowances 8.51.3 making payments on agreed dates 8.51.4 agreeing method of payment 8.51.5 issuing instructions (as listed in SFI 8.3.2)
8.3.3	Nominated Managers*	8.52	8.52.1 Submit time records in line with timetable 8.52.2 Complete time records and other notifications in required form 8.52.3 Submitting termination forms in prescribed form and on time
8.3.4	Chief People Officer	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		8.54	8.54.1 Ensure that all employees are issued with a Contract of

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
	Executive Director with Portfolio of People Management Nominated Managers*		Employment in a form approved by the Board of Directors and 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 9.1.2c	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 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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 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	8.60	8.60.1 Make a written case to support the need for a prepayment
	ECFO		8.60.2 Approve proposed prepayment arrangements
	Budget Holder		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 best practice. 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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 8.65.3 The ECFO will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by NHS England 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 NHS England 8.66.2 The ECFO is responsible for advising the Finance and Performance Committee on investment strategy and shall report periodically on 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			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
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 23 represents value for money
	Board of Directors		8.72.2 Proposal to use PFI/Procure 23 must be specifically agreed by the Board

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
11.4.1	CEO	8.73	8.73.1	Maintenance of asset registers including right of use assets (on advice from ECFO)
11.4.3	ECFO	8.74	8.74.1	Responsibility for ensuring that commissioner requested property is not disposed (unless agreed with main commissioner and informed to (NHS England
11.4.4	ECFO	8.75	8.75.1	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
11.4.7	ECFO	8.76	8.76,1	Calculate capital charges in accordance with NHS England requirements.
11.4.8	Board of Directors	8.77	8.77.1	Approve the use of non-commissioner requested assets for the 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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
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 Counter Fraud Authority 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
13.2.5	ECFO	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 & IT	6.99	6.99.1 Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define 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 of Strategy, Transformation and Digital, in conjunction with ECFO	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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
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
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	Senior Director of Corporate Governance	8.106	8.106.1	Review Register of Interests on an annual basis to link in with disclosures of annual report
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	Senior Director of Corporate Governance ECFO	8.110	8.110.1	Consult NHS Resolution in case of doubt as to the power to use commercial insurers
19.6	Senior Director of Corporate Governance 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

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SFI Ref.	Delegated To	SoRD Ref.		Duties Derived from the Standing Financial Instructions (SFI's)
				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. The ECFO shall ensure that the arrangements entered into for commercial or fleet are appropriate.
19.7	ECFO	8.112	8.112.1	Ensure documented procedures cover management of claims and payments below the excess amount 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 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 NHS England's 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

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SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
20.5	Finance and Performance 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 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 / Deputy CEO or Director on call should this be out of core business hours.

END

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Related Trust documents (to be read in conjunction with)
None

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001	Trust Secretary	Reflects New Constitution	01 April 2017
002	Trust Secretary	Some typographical and factual amendments	01 September 2018
003	Trust Secretary	Recommendations following legal advice	01 September 2019
004	Trust Secretary	Minor Amendments	01 September 2020
4	Trust Secretary	Addition of section to provide delegated authority to Executive Directors as part of a collaborative board (4.6.4) Amendments to formal competitive tendering and where competitive tendering is not required. (9.4, 9.6)	01 September 2021
5	Trust Secretary's Office	Removal of references to "Monitor". Amendment of statements using the "he" pronoun.	01 September 2022
6	Trust Secretary's Office	Alignment with the Code of Governance for NHS Provider Trusts (2023) and amendments through the Health and Care Act 2022 Slight amendments to procurement section to align with latest arrangements.	01 September 2023
6.1	Trust Secretary's Office	Extension applied until January 2025	01 March 2024
7.0	Trust Secretary's Office	New template and minor updates. Inclusion of definition of Associate NED	04 December 2024

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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).

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. These are covered by the Scheme of Reservation & Delegation of Powers of the Board. (SoRD).

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 that 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 and the Health and Care Act 2022)

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 **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.

2.6 **Appointment and Removal of the Chair and other Non-Executive Directors**

In accordance with paragraph 28 of the constitution and guidance issued by NHS England, the Chair and the other Non-Executive Directors are appointed (and removed) by the Council at a general meeting of the Council

2.7 **Terms of Office of the Chair and other Non-Executive Directors**

2.7.1 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 Foundation Trust governance guidance

2.7.2 The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years

2.7.3 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

2.7.4 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

2.7.5 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. Any extensions need to be clearly explained and agreed with NHS England.

2.7.6 The role of Associate Non-Executive Director is to bring capacity to work of the Board committees where additional skills and expertise would be beneficial in the achievement of organisational objectives. An Associate Non-Executive Director is non-voting and in attendance only at Board meetings.

2.8 Appointment and Powers of Vice-Chair

2.8.1 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

2.8.2 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

2.8.3 In the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust

2.8.4 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

2.8.5 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

2.9 Appointment and Removal of the Chief Executive

2.9.1 In accordance with the constitution paragraph 31.1, the Non-Executive Directors of the Trust will appoint (and remove) the Chief Executive

2.9.2 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

2.10 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.

2.11 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 identified Executive Directors to be the Deputy Chief Executive.

2.12 Joint Executive Directors

2.12.1 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

2.12.2 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

2.12.3 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

2.12.4 The presence of either or both persons shall count as the presence of one person for the purposes of SO 30.17 (Quorum)

2.13 Appointment and Removal of the Senior Independent Director

2.13.1 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

2.13.2 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.

2.14 **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.

2.15 **Role of the Chief Executive**

2.15.1 The Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business

2.15.2 The Chief Executive reports to the Chair and the Board

2.15.3 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 NHSE or any other relevant body

2.16 **Role of the Executive Chief Finance and Resources Officer**

2.16.1 The Executive Chief Finance and Resources 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

2.16.2 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 NHSE or any other relevant body.

2.17 **Role of Executive Directors**

Executive Directors shall exercise their authority within the terms of these SOs, SFIs and the SoRD

2.18 **Role of the Chair**

2.18.1 The Chair shall be responsible for the leadership of the Board (and Council), and chair all Board (and Council) meetings when present

2.18.2 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

2.18.3 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.

2.18.4 The Chair is responsible for ensuring that the Board and the Council work effectively together

2.19 **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

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:

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceed to the next business*
- the appointment of an ad hoc committee to deal with a specific item of business; or
- 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:

- 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
- 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 notice of motion under SO 3.9.1 (Notices of Motion) has been given
- not fewer than half of the total number of Non-Executive Directors vote in favour of the amendment
- at least two-thirds of Directors are present
- the amendment proposed does not contravene a statutory provision or direction made by NHS England

3.14.2 For the avoidance of doubt, SO 3.16 (Quorum) shall not apply to the variation of the SOs and the higher quorum required in this SO 3.14 (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:

- the Chief Executive has waived the requirement for the Chief Executive or the Deputy Chief Executive to be present; and
- 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, to an Executive Director or arrangements for functions to be exercised by or jointly with another relevant body.

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, an Executive Director, another relevant body or a joint committee with another relevant body.

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 NHS England. 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 and Resources 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

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 NHS England, 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 NHS England. 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 NHS England 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 NHS England 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 they are 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 Interest

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 Trust’s Counter Fraud Policy and Procedure and any such guidance issued by NHS England 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, and The Health Care Services (Provider Selection Regime) Regulations 2023, 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:

- 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;
- policies and procedures in place for the control of all tendering activity, and
- 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 (i) 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, 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)

(j) requirements under the Health Care Services (Provider Selection Regime) Regulations 2023 permit the use of a procedure that does not require a competitive process.

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 (h) 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)

(c) Salary recharges – including seconded staff, staff provided by another authority, and Graduate Management Trainees

(d) Where requirements under the Health Care Services (Provider Selection Regime) Regulations 2023 permit the use of a procedure that does not require a competitive process.

A waiver form does not need to be completed if either 9.6.1 (a), 9.6.1 (b), or 9.6.1 (c) 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, the Chief Executive, or the Executive Chief Operations Officer. This decision then needs to be reported to the next available meeting of the Audit Committee

Reasons for waivers may include:

(e) 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

(f) 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

(g) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source only

(h) 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

(i) 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)

(j) 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 23**

The Trust may consider using PFI/ProCure 23 when considering a capital procurement. When the Board proposes that PFI/ProCure 23 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 NHS England 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 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 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 two executive directors.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Executive Chief Finance and Resources Officer (or an officer nominated by them 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 the Code of Governance for NHS Provider Trusts (February 2023) the roles and responsibilities of the Council of Governors are set out in Appendix C.

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 NHS England and any other relevant body

16.1.5 the SoRD approved by the Board

16.1.6 The Detailed Scheme of Delegation

16.1.7 Tendering and Quotations Procedure

16.1.8 the Trust's Counter Fraud Policy

16.2 **Specific Guidance and Legislation**

These SOs must be read in conjunction with any directions and guidance issued by NHS England, 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
- Data Protection and Security Toolkit (April 2018) (and any subsequent versions)
- Bribery Act 2010
- Data Protection Act 2018 and relevant guidance from the Information Commissioner's Office
- Code of Governance for NHS Provider Trusts (February 2023) (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
7. Lampard Inquiry Oversight Committee

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Appendix B: Standards of Business Conduct for NHS Staff

Prevention of Corruption – Bribery Act 2010

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:

- bribing, or offering to bribe, another person (section 1);
- requesting, agreeing to receive, or accepting a bribe (section 2);
- bribing, or offering to bribe, a foreign public official (section 6);
- failing to prevent bribery (section 7)

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 £6) 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 / Anti-Crime

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.

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Appendix C: 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 NHS England, 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

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Related Trust documents (to be read in conjunction with)
Trust Constitution Schedule of Reservation and Delegation Detailed Scheme of Delegations Supporting Finance Procedures

What we do together matters

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Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1.0	Associate Chief Finance Officer (SEPT)	Replaces NEP Standing Financial Instructions	01 April 2017
1.0	Associate Chief Finance Officer (SEPT)	GDPR	01 August 2018
2.0	Head of Financial Accounts	Replaces SEPTFP10 and NEP Standing Financial Instructions. No Key changes documented	26 September 2018
3.0	Head of Financial Accounts	Not Documented	01 September 2019
4.0	Head of Financial Accounts	Annual Review	01 September 2020
4.0	Head of Financial Accounts	Annual Review	01 September 2021
5.0	Head of Financial Accounts	Not Documented	01 September 2022
5.1	Head of Financial Accounts	LCFS changed to Counter Fraud / Anti-Crime Specialist(s) throughout	01 September 2022
6.0	Head of Financial Accounts	Annual review 2.3.10 – Removal of external audit formal responsibility with respect to Quality Report 2.4.9 – References to Standards of Conduct for both temporary staff and BoD have been included in addition to those references for substantive staff 8.5.2 – New section which reminds staff of the need to ensure any compliance checks around use of individuals who are not employees of the Trust are completed ahead of any work commencing 9.2.6(c) – Amended to provide confirmation that contracts should only be signed with the prior approval of the procurement / contracts department and then be in line with delegated authority limits 11.3 – References to Procure 22 replaced with Procure 23 11.4.1 – Section updated to confirm that registers for right of use assets will also be maintained (following implementation of new accounting standard on leases in 22/23) 19 – Section updated to clarify that responsibility for NHS Resolution and Risk Management lies with the Senior Director of Corporate Governance, and that commercial insurances lies with the ECFO.	01 September 2023
6.1	Head of Financial Accounts	Extension of review until January 2025	01 March 2024

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7.0	Head of Financial Accounts		Date
			Date

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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. On an annual basis, Budget Holders will be asked to confirm that they have read the documents and understand that failure to comply is a disciplinary matter.

In addition to the Standing Orders and SFIs, there is a Detailed Scheme of Delegation and a Schedule of Reservation and Delegation which are referred to as the 'Governance Manual'. These are further supported by 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 Head of Finance or Finance Business Partner responsible for your area.

Executive Chief Finance Officer

December 2024

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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. **The supporting finance policies and procedures must be approved by the Policy and Oversight Ratification Group on the recommendation of the Finance Policy Group.**

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 Trust's Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation, and Detailed Scheme of Delegation will take precedence.

2 Principles

2.1 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.

2.2 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. On an annual basis, Budget Holders will be asked to confirm that they have read the documents and understand that failure to comply is a disciplinary matter.

3 Scope

3.1 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust.

4 Definitions / Glossary

4.1 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

Term	Definition / Meaning
Accounting Officer	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.
Board of Directors / **Board / Board Member / Member of the Board**	The Chair, Executive and Non-Executive directors of the Trust collectively as a body in accordance with the constitution. This consists of both voting and non-voting members.
Budget	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.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Term	Definition / Meaning
Budget Holder	The Director or employee with delegated authority to manage finances (including income, pay, non-pay expenditure and capital where relevant) for a specific area of the organisation.
Chair of the Board / Chair of the Trust / Chair	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 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 otherwise unavailable.
Chief Executive	The person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	A committee appointed by the Board of Directors.
Constitution	The Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.
Council of Governors / Council	The Council of Governors of the Trust as described in paragraphs 14 and 18 the constitution.
Deputy Chief Executive	The Officer of the Trust nominated by the Chief Executive to act as their Deputy.
Director / Senior Director	A Director (as appointed by a Senior Director or an Executive Director respectively) of a service who does not hold Executive Director status, and therefore is not a member of the Board of Directors.
Executive Director	A member of the Board of Directors appointed under paragraph 31 of the constitution.
Funds held on trust	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.
Legal Adviser	The properly qualified person or legal firm appointed by the Trust to provide legal advice.
NHSE	The office or an officer of NHS England.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks under the Scheme of Reservation and Delegation.

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Term	Definition / Meaning
Non-Executive Director	A member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.
NHS Act	The National Health Service Act 2006 as amended by the Health and Social Care Act 2012, and Health and Care Act 2022.
Officer	An employee of the Trust or any other person holding a paid employment or office with the Trust. This also includes employees of third parties contracted and seconded from other organisations when acting on behalf of the Trust.
Principle Purpose	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.

4.2 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.

4.3 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.

5 Responsibilities and Delegation

5.1 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.

5.2 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.

5.3 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.

5.4 The Chief Executive and the Executive Chief Finance Officer will delegate specific responsibilities, but they remain accountable for financial control.

5.5 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.

5.6 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.

5.7 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.

5.8 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.

5.9 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.

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6 Audit

6.1 AUDIT COMMITTEE

The National Health Service Act 2006 specifies that auditors of NHSFTs shall comply with the directions of NHS England under paragraph 24 (5) of Schedule 1 to the Act with respect to the standards, procedures and techniques to be adopted.

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.1.4 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.

6.1.5 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.

6.1.6 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.

6.2 EXECUTIVE CHIEF FINANCE OFFICER

6.2.1 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 Counter Fraud / Anti-Crime Specialists, 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.

6.2.2 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.

6.3 AUDIT

(A) ROLE OF INTERNAL AUDIT

6.3.1 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, or 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

6.3.2 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).

6.3.3 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.

6.3.4 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.

6.3.5 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.

6.3.6 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:

6.3.7 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 6.1.4 above).

6.3.8 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.

6.3.9 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).

6.3.10 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 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
5. 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.
6. to consider the issue of a public interest report
7. to certify the completion of the audit
8. to express an opinion on the accounts
9. 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.

10. to read the monthly / quarterly reports required under NHS Oversight Framework, annual report and comparing the information to ensure there are no material inconsistences;

11. to review reports arising from Care Quality Commission planned and responsive reviews of the NHSFT and any consequent action plans developed by the NHSFT.

6.3.11 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

6.3.12 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

6.3.13 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.

6.4 FRAUD, BRIBERY AND CORRUPTION

6.4.1 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.

6.4.2 The Executive Chief Finance Officer shall nominate a suitable person to carry out the duties of the Counter Fraud / Anti-Crime Specialists

6.4.3 The Counter Fraud / Anti-Crime Specialists shall report to the Trust's Executive Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

6.4.4 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 (CP11) which sets out action to be taken by persons detecting a suspected fraud and responsibilities for investigating it.

6.4.5 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.

6.4.6 Proven instances of fraud, theft and corruption shall normally be dealt with as gross misconduct under the NHSFT's disciplinary policies and procedures.

6.4.7 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 Budget Managers who should in turn ensure that all staff have access to these.

6.4.8 The Executive Chief People Officer 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.

6.4.9 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 for substantive staff, HRPG59 Appendix 1 for temporary workers and the Code of Conduct CP15 for the Board of Directors).

6.4.10 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.

6.4.11 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.

6.4.12 The Counter Fraud / Anti-Crime Specialists 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.

6.4.13 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 Freedom to Speak Up (Whistle Blowing) Policy CP53). They can do this through:

1. Their line manager;
2. Internal Audit;
3. The Executive Chief Finance Officer;
4. The NHSFT's Counter Fraud / Anti-Crime Specialists; or,
5. The NHS National Fraud and Corruption Reporting Line.

6.4.14 Any abuse of the procedures, such as unfounded or malicious allegations, will also be subject to full investigation and appropriate disciplinary action where appropriate.

6.5 SECURITY MANAGEMENT

6.5.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with best practice on NHS security management.

6.5.2 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.

6.5.3 The Trust shall consider the need for a nomination of a Non-Executive Director to be responsible to the Board for NHS security management.

6.5.4 The Trust shall prepare a Security Policy that sets out measures to protect staff, visitors, premises and assets.

6.5.5 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).

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

7 Annual Planning, Budgets, Budgetary Control, And Monitoring

7.1 PREPARATION AND APPROVAL OF ANNUAL PLANS AND BUDGETS

7.1.1 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.

7.1.2 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.

7.1.3 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.

7.1.4 All budget holders must provide information as required by the Executive Chief Finance Officer to enable budgets, plans, estimates and forecasts to be compiled.

7.1.5 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.

7.1.6 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.

7.2 BUDGETARY DELEGATION

7.2.1 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.

7.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

7.2.3 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.

7.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

7.3 BUDGETARY CONTROL AND REPORTING

7.3.1 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 detail 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:

ix. 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.

7.3.2 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

f) staff change forms (including staff leavers / terminations / change of base / entitlements) are actioned at the earliest opportunity to remove the risk of incorrect payments being made to staff

g) staff lists are reviewed and returned to finance on a monthly basis.

7.3.3 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.

7.4 CAPITAL EXPENDITURE

7.4.1 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.)

7.5 FINANCIAL PERFORMANCE AND MONITORING:

7.5.1 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 (e.g. NHSE and ICB’s).

8 Annual Accounts and Reports

8.1 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.

8.2 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.

9 Bank Accounts – Also Refer to SFI 10: External Borrowing and Investments

9.1 **GENERAL**

9.1.1 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.

9.1.2 The Board of Directors shall approve the banking arrangements, financing and working capital facilities.

9.2 BANK ACCOUNTS AND WORKING CAPITAL FACILITIES

9.2.1 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;

9.3 BANKING PROCEDURES

9.3.1 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;

9.3.2 The Executive Chief Finance Officer must advise the NHSFT’s bankers in writing of the conditions under which each account will be operated.

9.3.3 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.

9.4 TENDERING AND REVIEW

9.4.1 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.

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10 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

10.1 INCOME SYSTEMS

10.1.1 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.

10.1.2 The Executive Chief Finance Officer is also responsible for the prompt banking of all monies received.

10.2 FEES AND CHARGES

10.2.1 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.

10.2.2 In receiving cash payments, the Trust should adhere to the maximum value for a single transaction as specified in the Money Laundering Regulations.

10.2.3 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.

10.3 DEBT RECOVERY

10.3.1 The Executive Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

10.3.2 Income not received should be dealt with in accordance with losses procedures.

10.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

10.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

10.4.1 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.

10.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor "IOUs."

10.4.3 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.

10.4.4 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.

10.5 INCOME FROM NON-PRINCIPAL PURPOSES

10.5.1 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.

10.5.2 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.

11 Contracts with Commissioners

11.1 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.

11.2 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.

11.3 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.

11.4 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.

11.5 As required by the NHSFT's Terms of Authorisation, the NHSFT will maintain a public and up-to-date schedule of Commissioner Requested Services.

12 Terms of Service, Allowances and Payment of Executive Directors and Employees

12.1 REMUNERATION AND TERMS OF SERVICE

12.1.1 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.

12.1.2 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

12.2 STAFF APPOINTMENTS

12.2.1 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

b) unless approved by any establishment control panels in operation at the time; and

c) within the limit of their approved budget and funded establishment.

12.2.2 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.

12.3 PROCESSING PAYROLL

12.3.1 The Executive Chief People Officer, 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.

12.3.2 The Executive Chief People Officer, 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.

12.3.3 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 Chief People Officer; 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.

12.3.4 Regardless of the arrangements for providing the payroll service, the Executive Chief People Officer 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.

12.4 CONTRACTS OF EMPLOYMENT

12.4.1 The Board of Directors shall delegate responsibility to the Executive Chief People Officer 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.

12.5 PAYMENTS TO INDIVIDUALS WHO ARE NOT EMPLOYEES OF THE TRUST

12.5.1 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.

12.5.2 Staff must ensure that all compliance checks in respect of the use of individuals who are not employees of the Trust are completed ahead of any work commencing.

13 Non Pay Expenditure

13.1 DELEGATION OF AUTHORITY

13.1.1 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.

13.1.2 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.

13.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

13.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

13.2.1 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 including compliance with any non-pay control panels (if in operation). Where this advice is not acceptable to the requisitioner, the Executive Chief Finance Officer (and/or the Chief Executive) shall be consulted.

13.2.2 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.

13.2.3 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).

13.2.4 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.

13.2.5 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;

d) Only be issued to, used by or electronic access granted, to those duly authorised by the Chief Executive.

13.2.6 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;

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) contracts (including electronic forms of signing e.g. docusign) must only be signed with the prior approval of the procurement / contracts department, and be in line with delegated limits

d) 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

e) no requisition/order is placed for any item or items which cannot be accommodated within total available resources;

f) 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 and agency payment, .or where 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;

g) 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";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Executive Chief Finance Officer;

k) 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

l) petty cash records are maintained in a form as determined by the Executive Chief Finance Officer.

13.2.7 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.

14 External Borrowing and Investments

14.1 The Executive Chief Finance Officer will be responsible for the management of the NHSFT's cashflow.

14.2 **EXTERNAL BORROWING**

14.2.1 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.

14.2.2 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.

14.2.3 The Executive Chief Finance Officer will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by NHS England.

14.2.4 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.

14.3 INVESTMENTS

14.3.1 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.

14.3.2 The Executive Chief Finance Officer is responsible for advising the Finance and Performance Committee on investment strategy and shall report periodically on the performance of investments held.

14.3.3 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.

15 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

15.1 CAPITAL INVESTMENT

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 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.

15.1.5 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.

15.2 PRIVATE FINANCE

15.2.1 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.

15.3 PROCURE 23

15.3.1 NHS ProCure 23 has been developed by the Department of Health with the objective of promoting better capital procurement in the NHS.

15.3.2 The Trust may consider P23 as a possible procurement route when considering building projects above the amount specified in the detailed scheme of delegation.

15.3.3 When the Board proposed, or is required, to use the P23 procurement route, the following should apply:

a) The Chief Executive and Executive Chief Finance Officer shall demonstrate that the use of P23 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.

15.4 **ASSET REGISTERS**

15.4.1 The Chief Executive is responsible for the maintenance of registers of assets (including Right of Use 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.

15.4.2 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.

15.4.3 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).

15.4.4 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.

15.4.5 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.

15.4.6 The value of each asset shall be depreciated using agreed methods and asset lives.

15.4.7 The Executive Chief Finance Officer of the Trust shall calculate and expense 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.

15.4.8 The Board of Directors may approve the disposal of non-CRS assets to raise funds for the development of services

15.5 SECURITY OF ASSETS

15.5.1 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.

15.5.2 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.

15.5.3 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.

15.5.4 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.

15.5.5 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.

15.5.6 Where practical, assets should be marked as NHSFT property.

16 Stores and Receipts of Goods

16.1 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.

16.2 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.

16.3 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.

16.4 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.

16.5 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.

16.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Chief Finance Officer.

16.7 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.

16.8 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 charge.

17 Disposals, Condemning, Losses and Special Payments

17.1 DISPOSALS AND CONDEMNING

17.1.1 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 property that supports Commissioner Requested Services (CRS) 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.

17.1.2 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

17.1.3 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.

17.1.4 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.

17.2 LOSSES AND SPECIAL PAYMENTS

17.2.1 The Executive Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

17.2.2 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 Counter Fraud / Anti-Crime Specialists.

17.2.3 The Executive Chief Finance Officer must notify the NHS Counter Fraud Authority (via the appointed Counter Fraud / Anti-Crime Specialist) and the External Auditor of all frauds.

17.2.4 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.

17.2.5 The approval of the writing-off of losses is as per the limits set out in the detailed scheme of delegation.

17.2.6 The Executive Chief Finance Officer shall be authorised to take any necessary steps to safeguard the NHSFT’s interests in bankruptcies and company liquidations.

17.2.7 For any loss, the Executive Chief Finance Officer should consider whether any insurance claim could be made.

17.2.8 The Executive Chief Finance Officer shall maintain a Losses and Special Payments Register.

18 Information Technology

18.1 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.

18.2 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.

18.3 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.

18.4 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.

18.5 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.

18.6 Where computer systems have an impact on corporate financial systems the Executive Chief Finance Officer in conjunction with Executive Director with portfolio for ITT, 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.

19 Patients' Property

19.1 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.

19.2 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.

19.3 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.

19.4 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.

19.5 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.

19.6 Staff should be informed, on appointment, by the appropriate senior manager of their responsibilities and duties for the administration of the property of patients.

19.7 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.

20 Funds Held on Trust (Charitable Funds)

20.1 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.

20.2 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.

20.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

20.4 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.

20.5 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.

21 Acceptance of Gifts by Staff and Declaration of Interest

21.1 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 Trust Secretary's Office), must be followed, and the Chief Executive notified immediately so that appropriate action can be taken.

21.2 The Chief Executive shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff.

21.3 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.

21.4 The Register of Interests should also be referred to, prior to any major contracts in excess of £500,000 being awarded.

22 Retention of Documents

22.1 The Chief Executive, and the relevant Executive Director, shall be responsible for maintaining archives for all documents required to be retained.

22.2 The documents held in archives shall be capable of retrieval by authorised persons.

22.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

23 Insurance and Risk Management

23.1 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.

23.2 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.

23.3 The Board of Directors shall decide if the NHSFT will insure through the risk pooling schemes administered by NHS Resolution) 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.

23.4 The Executive Chief Finance Officer is required to consider and make proposals to the Board of Directors regarding commercial 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.

23.5 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Senior Director for Corporate Governance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Senior Director for Corporate Governance shall ensure that documented procedures cover these arrangements.

23.6 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 Senior Director for Corporate Governance 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 Senior Director for Corporate Governance 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.

23.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Senior Director for Corporate Governance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

24 New Business/ Income Opportunities

24.1 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 practice guidance including Risk Evaluation for Investment Decisions (REID) or any subsequent guidance that may be issued by NHSE.

24.2 The Board of Directors will ensure there is a governance framework in place to scrutinise and consider any new initiatives 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.

24.3 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.

24.4 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.

24.5 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.

24.6 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.

24.7 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.

25 Training requirements

All Budget Holders are required to adhere to this document with queries directed to their relevant Finance Business Partner in the first instance.

26 Monitoring and audit

Monitoring of compliance with this document is undertaken by senior Trust staff and Trust auditors. Non-compliance can lead to disciplinary action being taken.

27 Approval and implementation

27.1 The Standing Financial Instructions will be approved by the Board of Directors based on recommendation from the Audit Committee.

28 Preliminary equality analysis

28.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 1)

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 1: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

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Date (DD/MM/YYYY)	10/10/2024	
Directorate / locality / department	Finance	
Name of new policy / service / function	Annual review	
Is this a new policy / service / function or a change / review to an existing one?	Annual review	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: Clare Barley	Role: Head of Financial Accounts
	Name:	Role:
	Name:	Role:
Name of relevant director of services	Simon Covill	
Contact email address of lead assessor	c.barley@nhs.net	

Actions as a result of this EIA:
Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

	E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)	**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:		**Role:**	
Date:			

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Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	N	
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	N	
Age	N	
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	N	
People who are/were Married or are/were in a Civil Partnership	N	
People who are Pregnant or are on Maternity / Paternity Leave	N	
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	N	
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	N	
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	N	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	N	

Document title:	**DETAILED SCHEME OF DELEGATION**		
Document reference number:	FP11	**Version number:**	8.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Head of Financial Accounts		
Approval group/ committee(s):	Audit Committee		15 November 2024
Professionally approved by: (Director)	Director of Finance		
Executive Director:	Executive Chief Finance Officer		
Ratification group(s):	Board of Directors		04 December 2024
CQC Quality Statement	Well-Led - Governance		
Key word(s) to search for document on Intranet / TAGs:	Scheme of Delegation, DSoD, limits	**Distribution method:**	☐Intranet

Initial issue date:	01 April 2017	**Last Review date:**	01 September 2023	**Next Review date:**	01 January 2025	**Expiry Date:**	01 January 2025

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The Director responsible for monitoring and reviewing this policy is Executive Chief Finance Officer

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1.0	Associate Chief Finance Officer (SEPT)		01 April 2017
2.0	Head of Financial Accounts	Not documented	26 September 2018
3.0	Head of Financial Accounts	Not Documented	26 September 2018

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4.0	Head of Financial Accounts	Not Documented	01 September 2019
4.0	Head of Financial Accounts	Annual Review	01 September 2020
5.0	Head of Financial Accounts	Not Documented	01 September 2021
6.0	Head of Financial Accounts	Not Documented	01 September 2022
6.1	Head of Financial Accounts	LCFS changed to CF / ACS (Counter Fraud / Anti-Crime Specialist(s)) throughout	01 September 2022
7	Head of Financial Accounts	Annual review 2(w) – Change relates to SFI 9.2.6c to provide clarity that contracts should not be signed without the prior approval of the procurement / contracts department, and then once approval has been obtained, this needs to be in line with delegated authority limits 17e(ii) – Further clarity provided to confirm that travel expenses in excess of 3 months need to be approved by the ECFO and Director of HR / Associate Director of HR / HR Business Partner 22 – Updated to reflect responsibility for insurance 38 – Use of seal has been updated from requiring Chair / Chief Executive to any two Executive Directors following amendment to Standing Orders	01 September 2023
7.1	Head of Financial Accounts	Extension Approved for review – January 2025	Date
8.0	Head of Financial Accounts	Annual review – updates include need for timely completion of staff change forms and Budget Holder approval of staff lists, reference to establishment and non pay control panels, and introduction of Provider Selection Regime.	Date
			Date

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DETAILED SCHEME OF DELEGATION

BM	Budget Managers
HoE	Head of Estates / Property Management
CE	Chief Executive
ECFO	Executive Chief Finance Officer
ECPO	Executive Chief People Officer
DoF	Director of Finance
HoF	Heads of Finance
HoFA	Head of Financial Accounts
DHoFA	Deputy Head of Financial Accounts
HoP	Head of Procurement
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
PORG	Policy Oversight and Ratification Group
ECP	Establishment Control Panel

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.

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	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 / HoF / 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 E.G., NHS SUPPLY CHAIN ~~AND OFFICE DEPOT~~) AND SIGNING OF CONTRACTS		
Requisitions / invoices must not be raised in such a way to bypass financial limits stated in the Governance Manual.		

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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 / Director of Pharmacy (drugs only)	
	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 / HoF / DHoFA	
	• All NHS and independent sector transactions relating to the East of England provider collaborative and the Mid and South Essex community collaborative arrangements	CFO and CE	
	• NHS Commissioned Contracts and sub contracts that flow from them and for Provider Selection Regime (PSR) awards	CFO and CE	

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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 / HoF / HoFA	
xi) Signing of contracts (including electronic signing eg Docusign)	Subject to limits above in (a) to (viii) post procurement / contracts approval	
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) to (viii).	Dir, ED or CE	
2.2 BUDGET VIREMENTS		
a **Virements within a cost centre / care group / 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 care groups / 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		

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	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	
	b	Approval of any new capital allocations not included in Operational Plan, and any requests which exceed total capital allocated in Operational Plan	FPC	
	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 leases for equipment and other assets, where there is a pre-negotiated framework agreement lease and no Right of Use Asset arising (e.g. 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 quotations ~~tenders~~, each competitive quotation exercise ~~tender~~ should, where possible, provide for the opportunity for at least one contractor to bid that has not quoted ~~tendered~~ within the preceding 12 months. Contract opportunities 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.		SFI Section 11 / Standing Orders Section 9

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Goods / services must not be ordered in such a way as to bypass financial limits stated in the Governance Manual.		
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		**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	
7		**ENGAGEMENT OF CONSULTANCY SERVICES (as defined by prevailing NHSE guidance and applicable to revenue expenditure only)**		

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	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)	
8	**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	
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)	

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	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	

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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 (e.g. 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 (e.g. 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) In exceptional circumstances, over £75 can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
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	

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	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 COUNTER FRAUD / ANTI-CRIME RECOMMENDATIONS**	Directors	SFI Section 2
15	**MAINTENANCE AND UPDATE OF TRUST FINANCIAL PROCEDURES**		
	a Approval of finance policies and procedures	~~Audit Committee~~ PORG	
16	**INVESTMENT OF FUNDS**		
		DoF	SFI Section 5

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			Delegated to	Reference
a		Investment of Exchequer Funds (day to day)		
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** 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	ECPO	Job Matching and Evaluation Policy and Procedure HR15 / HRPG15
c		**Establishments**		
	i)	Additional staff to the agreed establishment with specifically allocated finance	~~AD~~ Care Group ECP	
	ii)	Additional staff to the agreed establishment without specifically allocated finance	~~CEO and ECFO~~ Care Group ECP	
d		**Pay**		
	i)	Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director or AD of HR ~~or nominated deputy /~~ Directors / BM or Manager with delegated authority	

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	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 / ECP ~~/ 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 / Associate Director for HR / HR Business Partner	
f		**Leave**		
	i)	Approval of annual leave	Line / Departmental Manager	
	ii)	Approval of carry forward of annual leave up to a maximum of one week (of contractual hours) ~~57 days~~	Line / Departmental Manager	
	iii)	~~Approval of carry forward of annual leave up to a maximum of 10 days~~	~~HR Director~~	
	iv)	Approval of carry forward of more than ~~10~~ one week (of contractual hours) ~~days~~ of annual leave where there has been no long term absence in the year	ECPO	
	v)	Approval of carry forward of more than ~~7~~ one week (of contractual hours) ~~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	Special Leave Procedure HRPG24c
	viii)	Leave without pay	Director	Special Leave Procedure HRPG24c
	ix)	Medical staff leave of absence	Medical Director / Deputy Medical Director & CEO	
	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

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				Policy / Procedure HR26 / HRPG26b
	ii)	Return to work part time on full pay to assist recovery	Line Manager in accordance with Equality 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 AD 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**		HR57 / HRPG57

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		Authorisation of payment of relocation expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		
	i)	Up to £8,000	Director	
	ii)	Over £8,000	CEO / ECPO	
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.	AD 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 / ECPO & ECFO	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 and in conjunction with Occupational Health	HR26 / HRPG26b / HRPRG27a

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			and HR Department	
	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 £9,999 ~~£4,999~~ per annum (compared with existing therapy)	Medicines Management Group	
	b	With additional implications of over £9,999 ~~£5,000~~ per annum (compared with existing therapy)	~~ET~~ Effectiveness of Care Group	
19	**AUTHORISATION OF SPONSORSHIP DEALS**			
	a	Authorisation of clinical sponsorship deals	Medicines Management Group, Medical Director, CEO	CLP51
	b	Authorisation of other sponsorship deals	Director / ED / CEO	
20	**AUTHORISATION OF RESEARCH PROJECTS**		Research Governance Group	
21	**AUTHORISATION OF CLINICAL TRIALS**		Research Governance Group	
22	**INSURANCE POLICIES AND RISK MANAGEMENT**			
	a	Risk Management and NHS Resolution	Senior Director for Corporate Governance	SFI 19
	b	Commercial Insurance (e.g. property, fleet)	ECFO	SFI 19

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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	Director of Communications / Communications Team	
	ii)	Outside hours	~~Director on Call~~ On Call Press Officer / Senior Communications Rota	
b		Emergency enquiries		
	i)	Within hours	Director of Communications / Communications Team	
	ii)	Outside hours	~~Director on Call~~ On Call Press Officer / Senior Communications Rota	
25		**INFECTIOUS DISEASES AND NOTIFIABLE OUTBREAKS**	Duty Officer / Director on Call / ED for Operations	

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26	**EXTENDED ROLE ACTIVITIES**		
	Approval of nurses to undertaken duties / procedures which can properly be described as beyond the normal scope of Nursing Practice	CEO, Medical Director and Executive Nurse	
27	**PATIENT SERVICES**		
	a Variation of operating and clinic sessions within existing numbers, i) Outpatients ii) Other	EDs in consultation with Medical Director 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 Work experience students	Director 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	

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31	**REVIEW MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AUTHORITY (MHRA) AND DRUG ALERTS ISSUED BY THE CENTRAL ALERTING SCHEME**	~~Chief Pharmacist~~ Director of Pharmacy / 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 TRUST'S 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 TRUST'S COMPLIANCE WITH ACCESS TO RECORDS ACT**	Lead Director for Information	
36	**REVIEW OF THE TRUST'S 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**	Any two Executive Directors	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**	CEO and Directors for their respective services	

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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**		Counter Fraud / Anti-Crime 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**			

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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 / HoF / DHoFA	
c	Payment of invoices and signing of contracts	DoF / HoFA / HoF / DHoFA	
47	**LEGAL SERVICES**		
	Authority to engage any of the Trust's panel law firms	Persons authorised in legal protocol	

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Appendix 1: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the

initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

Date (DD/MM/YYYY)	10/10/2024	
Directorate / locality / department	Finance	
Name of new policy / service / function	Review of existing	
Is this a new policy / service / function or a change / review to an existing one?	Review of existing	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: Clare Barley	Role: Head of Financial Accounts
	Name:	Role:
	Name:	Role:
Name of relevant director of services	Simon Covill	
Contact email address of lead assessor	Trevor Smith	

Actions as a result of this EIA:

Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

	E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)	**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:		**Role:**	
Date:			

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Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	**Yes / No**	**What / where is the evidence / reasoning to suggest this?**
Race, Ethnic Origins, Nationality (including traveling communities)	N	
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	N	
Age	N	
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	N	
People who are/were Married or are/were in a Civil Partnership	N	
People who are Pregnant or are on Maternity / Paternity Leave	N	
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	N	
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	N	
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	N	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	N	

10.2 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR)

NATIONAL CORE STANDARDS RETURN 2024

Discussion Item | NL | 10

REFERENCES

Only PDFs are attached

EPRR Core Standards 2024-25 Final Position CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

Report Title:	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2023					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director of Major Projects & Programmes (EPRR AEO)					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Purpose of the Report		
This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2024-25 completion of which is a requirement for all NHS organisations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Trust Board of Directors are asked to:

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

Summary of Key Issues

The NHSE 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. Following submission a core standards peer review confirm and challenge meeting is held, at which there is an opportunity to revise submission.

On 17 July 2024, the Trust received communication from the regional EPRR team at NHSE (East) informing the Trust of the newly published national EPRR core standards and the process for the national annual assurance process for 2024.

The Standards are split into two sections, the main Core Standards and a Deep Dive which changes each year. For 2024, the deep dive is in relation to ‘cyber security.

The following process was used within the Trust to complete the Core Standards self-assessment:

1. Review of all standards by EPRR Team to complete initial self-assessment identifying how the Trust meets the standards, any gaps and actions required
2. Review of initial self-assessment by the EPRR Accountable Executive Officer, Director of Risk and Compliance, Associate Director of Risk & Compliance and the Head of Compliance and Emergency Planning.
3. Review and challenge of self-assessment by Health Safety and Security Committee (HSSC)
4. Review of Self-Assessment by Executive Operational Committee

As part of the national process, the Trust attended a “confirm and challenge” meeting with the Regional EPRR team on 17 October 2024. Following which, the position reported by the LHRP is that EPUT are substantially compliant with 94.8%. 55 out of the 58 standards assessed as compliant, 3 assessed as partially compliant (meaning aims to achieve compliance within 12 months) and the deep dive has been assessed as fully compliant. The following standards were assessed as partially met:

Ref.	Domain	Action to be taken
21	Command & Control – Trained On Call Staff	Continue to work towards improvements regarding on-call (particularly at a GOLD level) training compliance.
37	Cooperation – LHRP Engagement	Representation at LHRP Meetings
44	Business Continuity – BC Policy Statement	Business Continuity Management System (BCMS) /Policy to be reviewed moving away from an annual review for all plans.

The core standards assessment outcome informs our annual EPRR programme.

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

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

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

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	LHRP	Local Health Resilience Partnership
NHSE	NHS England	AEO	Accountable Emergency Officer
BCMS	Business Continuity Management System		

Supporting Documents and/or Recommended Further Reading

Lead
[signature] Nigel Leonard, Executive Director of Major Projects & Programmes (EPRR AEO)

10.3 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Information Item MK 5

REFERENCES

Only PDFs are attached

Safe Working of Resident Doctors Report 04.12.2024 CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 December 2024

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

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital		
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Resident Doctors Forum, any unresolved issues is further escalated to Dr Karale. Medical Staffing ensures that the Resident doctors working hours are in line with the Junior Doctors contract 2016.		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.	**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

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

2. Gaps in the rota are managed by existing doctors within the Trust and no agency locums were used.

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

4. Two Exception reports were raised in this quarter, one trainee received time off in lieu and the other trainee will receive extra payment and the Trust has been fined as the trainee breached the contractual working hours during their on call.

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

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

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

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

Acronyms/Terms Used in the Report			
LAS	Locum Appointed Service	RDF	Resident Doctors Forum
MTI	Medical Training Initiative		
DME	Director of Medical Education		

Supporting Reports/ Appendices /or further reading

Lead

Dr Milind Karale
Executive Medical Director

QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

1 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 EXECUTIVE SUMMARY

This is the quarterly report for the period 1 July to the 30 September 2024. The Trust has established robust processes to monitor safe working of resident doctors and report any exceptions to their terms and conditions.

Exception Reports:

A total of 2 exception reports were raised in this quarter

1. 30 August 2024: Core trainee worked extra 1 hour during on-call shift due to managing an emergency situation on the ward. This is considered as a breach in contractual hours and Trust is fined.

2. 11 September 2024: A higher trainee raised an exception report for working extra 1 hour and 30 minutes on the ward due to excessive workload. Time off in lieu was given.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 7 August 2024.

Doctors in Training Data

Total number of posts EPUT Training Scheme inclusive of foundation and GP	**160**
Total number of psychiatry training posts	**103**
Total number of doctors in psychiatry training on 2016 Terms and Conditions	**88**
Total number of foundation posts	**38**
Total number of GP posts	**19**
Total number of vacancies across all grades	**20**
Total vacancies covered LAS/ MTI/Agency	**14**
Total gaps	**6**

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick	150	150	0	1800	1800
Total	150	150	0	1800	1800

Resident Doctor Industrial Action

Resident doctors took part in the industrial action held from 27 June 2024 until 2 July 2024. The Trust ensured that patient safety was not compromised and a shadow rota was set up to cover both day and night shift across all five areas of the Trust.

In total 534.5 hours were covered by internal locums plus 5 consultants were stood down on each of the evenings so a total of £65,920 was spent on the shadow rota.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website. Few International doctors who were appointed have started their posts.

2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.

Fines:

Trust is fined at £110.32 of which trainee receives £41.38 and Guardian receives £68.94.

This is following an exception report raised by a core trainee during their on-call due to breach of contractual hours.

Issues Arising:

1. Trainees raised concerns on the excess workload during on-call shifts especially in the North east part of the Trust, this was due to covering several wards which are geographically distanced and trainees struggle to manage time to travel and to provide effective patient care.

   Hence on-call monitoring is in place for all grades of doctors throughout the Trust.

3 ACTION REQUIRED

The Board of Directors is asked to receive and note the report.

Report prepared by
Dr P Sethi, MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

11. OTHER

11.1 USE OF CORPORATE SEAL

Information Item | PS | 2

REFERENCES

Only PDFs are attached

Use of Corporate Seal Report 04.12.2024 CHECKED.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1				04 December 2024
Report Title:	**Use of Corporate Seal**				
Executive Lead:	Paul Scott, Chief Executive Officer				
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors				
Report discussed previously at:					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A – Information item confirming use of corporate seal		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides a summary of when the corporate seal has been used.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report

Summary of Key Points
The EPUT Corporate Seal has been used on the following occasions: • 05.11.24 Lease Renewal, Ground Floor and Second Floor rear, Western House, 2 Cambridge Road, Stansted, CM24 8AG

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
None

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

11.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item SS 1

Verbal

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

Decision Item   ALL   1

Verbal

11.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item | ALL | 5

Verbal

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

Information Item ALL 1

12. ANY OTHER BUSINESS

Information Item   ALL   5

Verbal

13. QUESTION THE DIRECTORS SESSION

10

14. DATE AND TIME OF NEXT MEETING

1

Wednesday 5 February 2025 at 10am, The Lodge, Training Room 1