Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

4 June 2025

10:00 GMT+1 Europe/London

Microsoft Teams

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda June 2025.pdf

Meeting of the Board of Directors held in Public
Wednesday 4 June 2025 at 10:00

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

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	HLD	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	HLD	Verbal	Noting
	PRESENTATION Quality Improvement Project – Ligature Reduction – Longview ward Scott Huckle, Service Development and Assurance Lead, Specialist Care Unit			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 2 April 2025	HLD	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	HLD	Attached	Noting
5	Chairs Report (including Governance Update)	HLD	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 (inc. PLACE Results & Action Plan & EPR Update)	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	Safer Staffing Report for Inpatient Nursing (Bi-Annual)	AS	Attached	Approval
	Questions taken from the General Public			
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Complaints & Compliments Annual Report	AS	Attached	Approval
8.3	Patient Experience and Volunteers Annual Report	AS	Attached	Noting
8.4	End of Year Governance Reviews	DG	Attached	Approval

8.5	Emergency Preparedness, Resilience & Response (EPRR)	NL	Attached	Approval
Questions taken from the General Public				
9	**STRATEGIC INITIATIVES**			
9.1	Time to Care	AG	Attached	Noting
9.2	Strategic Impact Report	ZT	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
10.1	Duty of Candour Annual Review	AS	Attached	Noting
Questions taken from the General Public				
11	**OTHER**			
11.1	Use of Corporate Seal	PS	Attached	Approval
11.2	Correspondence circulated to Board members since the last meeting.	HLD	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
12.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	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 6 August 2025 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 1 October 2025 at 10:00, The Lodge Training room 1 Wednesday 3 December 2025 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item | HLD | 1

2. DECLARATIONS OF INTEREST

Standing item | HLD | 1

PRESENTATION: QUALITY IMPROVEMENT PROJECT ? LIGATURE REDUCTION ? LONGVIEW WARD

Information Item | SH | 10

Scott Huckle, Service Development and Assurance Lead, Specialist Care Unit

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 2 APRIL 2025

Decision Item HLD 2

REFERENCES

Only PDFs are attached

BoD Minutes Part 1 02.04.2025 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 02 April 2025
Training Room 1, The Lodge, Lodge Approach, Runwell, SS11 7XX

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Trust Chair
Paul Scott	PS	Chief Executive Officer
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Denver Greenhalgh	DG	Senior Director of Corporate Governance
Dr Mateen Jiwani	MJ	Non-Executive Director
Dr Milind Karale	MK	Executive Medical Director
Diane Leacock	DL	Non-Executive Director
Nigel Leonard	NL	Executive Director of Major Projects and Programmes
Loy Lobo	LL	Non-Executive Director / Vice Chair
Elena Lokteva	EL	Non-Executive Director
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Zephan Trent	ZT	Executive Director of Digital, Strategy and Transformation

IN ATTENDANCE:

Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary

There were nine members of the public/staff members present.

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

The meeting commenced at 12:59pm.

025/25 APOLOGIES FOR ABSENCE
Dr Ruth Jackson, Non-Executive Director

026/25 DECLARATIONS OF INTEREST
There were no declarations of interest.

027/25 PRESENTATION: INDIVIDUAL PLACEMENT AND SUPPORT
NL introduced James Sawtell (Associate Director Social Care) and Sharif Al Ani (Vocational Manager) to present on the Individual Placement and Support programme. The programme was an important support for service users and linked with Strategic Risk 4 helping our communities to thrive.

JS / SA delivered a presentation, highlighting the following:

- The programme focused on employment services to support individuals with mental health concerns to gain and sustain good quality employment. There was evidence that employment provides structure and purpose; providing the opportunity to meet people and provide stimulus / new skills to individuals.
- The employment service focused on helping those who are unemployed to gain paid work and helping those in work to retain their existing job or achieve a planned exit. The programme focuses on helping individuals to gain paid work.
- The service uses an internationally recognised model, based on eight evidence-based principles to support people with severe and enduring mental health into work.
- The programme is open to all, with zero exclusion and aims to help find jobs consistent with people's preferences. The aim is to work quickly through a rapid job search.
- The programme works with both employers and clinical teams, as this approach leads to better outcomes
- The programme also provides counselling, money management courses, CV design, job application support, interview preparation support and support in relation to health disclosures and managing personal information.

The programme aims to change the lives of individuals, improve health and wellbeing and to have a positive impact on the community, through family, friends and colleagues.

Questions & Discussions

- In response to a query regarding what has been learnt as an employer to support the principles set-out in the presentation, JS advised the programme was involved with Essex Cares, an initiative to help employers be more inclusive. In addition, there had been positive feedback, including the hiring manager's contact details on the advert, which allows individuals or their support worker to speak with someone about the role.
- AG highlighted the positivity of the service and had met some service users who had accessed the programme. AG advised the next step was to see how the programme could be scaled-up in the future, with discussion under way with Essex County Council
- The Board reflected on the similarities with previous initiatives through the Recovery College and asked what action can be taken by the organisation as part of recovery in health support, in line with the programme. SA suggested promoting the programme with clinical teams to help it to be seen as part of an overall healthcare package. There is also an opportunity to provide further training for clinicians so the approach to employment becomes a natural part of the recovery journey.
- In response to a query, JS advised there was more work to do around improving general care planning and to ensure employment is considered as part of the overall care plan. Employment service workers were integrated within teams, but more work was required to ensure they were embedded within patient care.

HLD thanked JS and SA for the presentation and extended her thanks to service users who were involved with the presentation.

028/25 MINUTES OF THE PREVIOUS MEETING HELD ON 05 FEBRUARY 2025

The Board of Directors reviewed the minutes of the meeting held on 5 February 2025 and agreed these as an accurate record.

The Board of Directors noted the responses to the questions raised by Governors and members of the public. AS provided an update in relation to the length of stay query, advising that a meeting had been held with the Lead and Deputy Lead Governor to

discuss the initiatives and opportunities in this area. A further meeting was planned for June update.

029/25 ACTION LOG AND MATTERS ARISING

The action log was reviewed, noting there were no outstanding actions.

030/25 CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

HLD presented the report which provided the Board of Directors with a summary of key headlines and shared information on governance developments within the Trust since the last Board meeting.

The Board of Directors:

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

031/25 CEO'S REPORT

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

- PS welcomed HLD to the EPUT Board of Directors and thanked Professor Sheila Salmon for her leadership, specifically around her commitment to EPUT, patients and service users.
- The Lampard Inquiry hearings were due to recommence in April, with public hearings taking place from 28 April to 15 May. The hearings will set context for the Inquiry, with significant gathering and sharing of information taking place ahead of the hearings. The Inquiry will hear from subject matter experts, as well as EPUT Board members.
- PS highlighted the need to ensure the Trust continues to drive forward improvements to services, noting the recent CQC inspection report providing a "Good" rating for services at Brockfield House.
- The Trust continued to proactively engage with MPs, including new MPs following the general election in 2024.
- There were significant pressures across the NHS, including operational and financial challenges around demand for beds and increased out of area placements and levels of temporary staffing. This reinforced the importance of Time To Care and the Electronic Patient Record, which will deliver benefits in terms of patient outcomes and experiences of staff. The Community First programme will translate the principles of Time To Care into the community.

<u>Questions & Discussions</u>

- The Board discussed the Lampard Inquiry hearings and asked whether there was an easy to understand summary on the Inquiry which could be provided to staff. PS advised significant work continued to take place to engage with staff and explain the Inquiry to everyone. NL advised there were a number of regular meetings held with teams, including online sessions with the Legal Team. This will continue and support is available for staff, including legal advice, psychological support and pastoral support.

The Board of Directors:

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

032/25 QUALITY AND PERFORMANCE SCORECARD

PS presented the report in conjunction with the CEO Report.

<u>Questions & Discussions</u>

- LL noted the use of the Power BI dashboard, which was positive in making information more accessible to the public. LL suggested providing a link to a

support page to explain how to drill down further into the metrics. ZT agreed to explore this, including the potential for developing a training video.

- EL commented that the Board had good visibility around out of area placements. EL highlighted the challenges around long length of stay for some Psychiatric Intensive Care Units (PICUs) and asked how the Board could be assured it was the correct setting for patients with a long length of stay. AG advised the long length of stay was usually caused by someone who had complex discharge needs, such as the sustainability of housing and supported accommodation. However, there is an expectation that patients would be stepped down from PICU during that time. AG confirmed she would look into this outside of the Board.

The Board of Directors:

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

Action:

1. **Provide an update on the development of a support guide function for the Power BI dashboard and / or the development of a training video. (ZT)**
2. **Provide an update in relation to long lengths of stay for PICU services and patients being stepped down from the service. (AG)**

033/25 COMMITTEE CHAIRS' REPORT

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

Audit Committee (EL)

- The Committee had reviewed progress with Internal Audits and had seen a number of audits finalised.
- The management of the workforce was a clear area of focus for the organisation and the Executive Chief People Officer had attended the Committee for the audit of roster management.

Finance & Performance (DL)

- There had been a reduction of out of area placements in February which was encouraging
- There was a discussion at the Committee regarding NHS Talking Therapies access rates, which were below target and the Committee was reviewing the detail.
- The Committee continued to consider the reported deficit, driven by demand on services as noted in the CEO Report.

<u>Questions & Discussions</u>

- LL asked whether there was any insight into the dropping of the virtual ward occupancy rate. AG advised it was unusual to see the occupancy rates dip at the same time for both areas where the service is provided. There were a range of schemes in place for people to step down to the service or to avoid admission. Both community areas providing the service are working with acute colleagues and system partners to drive the occupancy rate up and ensure use of the resource.
- MK highlighted a parliamentary update published by NHS Providers which noted an increase in admissions under the Mental Health Act. This helped provide context around demand against the national picture.

People, Equality and Culture Committee (DL – on behalf of RJ)

- The Committee focused on areas such as temporary staffing, where there had been a significant improvement, staff appraisals, progress with the people directorate structure consultation, the planned cultural review and progress for the development of the leadership programme.
- The Committee proposed to the Board to be renamed the 'People Committee'.

Questions & Discussions

- MK noted a cultural review had been completed at the point of merger to create EPUT in 2017, and suggested this is revisited to reflect on what had changed and any trends or lessons identified.

Quality Committee (MJ)

- Because of the significance of the Time to Care programme, the Chief Operating Officer has been asked to join the committee

HLD noted that the standing committees had reviewed their Terms of Reference and agreed work plans for the year. These would be presented to the Board meeting in June as part of the annual report and effectiveness reviews.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**
2. **Approved the change of name to People Committee.**

034/25 CQC Assurance Report

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

- Positive feedback had been received from the unannounced visits to Clifton Lodge and Brockfield House. The CQC had provided verbal feedback from the visit to acute mental health and intensive care wards and a draft report was now awaited.
- The CQC Improvement Plan was at 95% completion. There were two outstanding areas of action relating to the registration of care homes (work was being undertaken with ICB colleagues) and changes to how staff access CCTV.
- Details were provided of the notifications of serious incidents to the CQC and these would be addressed through the patient safety investigation process.
- Details were provided of the Quality Assurance Visits pilot which had recently concluded and feedback would be incorporated into the process going forward.

The Board of Directors:

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

035/25 NATIONAL STAFF SURVEY (2024): BENCHMARKED RESULTS, ANALYSIS AND TRUST WIDE PRIORITIES

AM presented the report which provided the Board with an updated set of results following the staff survey completed in 2024. The report included benchmarked data and national average comparisons. AM highlighted the following:

- There had been a small reduction in the level of engagement with the survey from the previous year.
- The results had identified five priority areas:
    1. Leadership and Accountability: compassionate and inclusive leadership and management
    2. Teamwork and Recognition: celebrating collaboration
    3. Workload and Well-Being: addressing burnout

4. Inclusive and safe working culture: creating psychological safety
5. Career Development and Growth: enhancing appraisals and clinical supervision

- The plan developed for the priority areas was part of a "You Said, We Did" campaign to provide staff with details of action taken following feedback and potentially increase engagement going forward.

Questions & Discussions

- LL noted the discussions around staff participating in the survey and queried whether there could be further work to understand why staff do not participate to identify action that could be taken to encourage participation. LL highlighted the importance of the feedback to create a better organisation and culture. AM advised there had been positive engagement with care units to create ownership at a local level for the feedback and actions. There was lower engagement in some areas, especially in clinical services, and local engagement combined with protected time would be used to try to drive up engagement.
- AG suggested reviewing messaging to change the perception of staff engagement and focusing on local ownership.
- AM advised it was important to consider the results in the strategic context of the wider NHS and the transformation work that will be taking place over the next few years to improve patient care and staff experience.
- DL thanked AM and team for the report which provided a succinct and meaningful insight into the results.

The Board of Directors:

1. **Noted and discussed the benchmarked results, analysis and priority areas of the National Staff Survey (2024) and NQPS results.**

036/25 BOARD ASSURANCE FRAMEWORK

DG presented a report which provided 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. DG highlighted the following:

- The information in the report was the position as at February and provided updates on the risks from Executive colleagues.
- There were a number of Internal Audit reports which provided independent assurance on the internal controls. Strategic Risk 6 Cyber Security had received reasonable assurance, but the risk had also been rebased due to the context of the wider cyber threats now in existence.
- E-rostering had received limited assurance and there was a need to ensure greater internal control in this area.
- Quality Governance had received reasonable assurance for the learning from deaths process, which provided confidence the process was working well.
- Strategic Risk 5 Lampard Inquiry had been temporarily increased by the Lampard Inquiry Oversight Committee in response to data requests received. This was during a time of increased demand, during which the project team had delivered everything required, but a significant amount of information was still required. The risk would be kept under review.

Questions & Discussions

- EL welcomed the improvement in reporting and could see the clear connections to strategic risks and standing committees. EL queried whether the strategic risks should be reviewed in line with the operational and financial plan for the next financial year. DG advised the report was as at February and further amendments

would be made in the next few months, but that it was unlikely scores would significantly change. TS also confirmed there would be a further refresh of control measures and management actions, and that there were no identified key changes to the risks at this time.

- LL highlighted that the Board Assurance Framework had been developed over the last three years, during which time it had evolved and become more robust. The current version provided clearly defined programmes of work to mitigate risks and a target date for when each risk should come into the agreed target score.
- PS advised there had been discussions on raising the profile of the BAF on the agenda and consideration would be given for how to use the BAF to set the tone for the performance of the organisation and wider discussions.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the increase in risk scores for SR5 Lampard Inquiry and SR6 Cyber Security.**
3. **Noted new controls assurance provided through the internal audit function.**
4. **Did not request any further information or action.**

037/25 LEARINNG FROM DEATHS Q3 2024/25 REPORT

AS presented a report providing details of the Learning from Deaths report , which included data relating to Q3 2024/25, an overview of learning resulting from the reviews undertaken under the Trust's arrangements and actions being taken as a result. AS highlighted the following:

- There were no issues in care highlighted in reviews completed in Quarter 3.
- There was work under way to enhance systems and build a dashboard to allow care units to respond in a timely way. There was also a triage system to help share learning and provide a greater learning across acute partners and other areas such as PSIRF.
- The report included a case study which provided details of actions identified and how these had been implemented to make improvements.

<u>Questions and Discussions</u>

- MJ welcomed the data collaboration to understand themes and provide greater emphasis on duty of candour, to help understand the impact represented by the data and the action being taken.
- AS advised there was subjectivity in the scoring as there was not currently a clear methodology.

The Board of Directors:

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

038/25 ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST CONSTITUTION

DG presented the report which provided the output of the annual review of the EPUT Trust Constitution. DG highlighted the following:

- The Bedfordshire, Milton Keynes, Luton and Rest of England constituency was proposed to be incorporated into the West Essex and Hertfordshire constituency.
- Revision to include Lived Experience Ambassadors into the Third Sector / Voluntary Sector constituency to potentially resolve issues with identifying an Appointed Governor for this area.
- Proposed addition to Section 2.1.7 to allow the Trust to terminate membership where there is sustained non-engagement, which helped keep the register of members live.
- The proposed changes had been approved by the Council of Governors.

The Board of Directors:

1. **Received and noted that the annual review of the EPUT Constitution has been completed and received agreement from the Council of Governors at their meeting on 19 March 2025.**
2. **Approved the EPUT Constitution as amended.**

039/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

040/25 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.

041/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

AG reflected that the presentation at the beginning of the Board meeting was a great example of addressing inequality to support our service users.

042/25 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.

043/25 ANY OTHER BUSINESS

There was no other business.

On behalf of the Board of Directors, HLD extended thanks to former Chair Professor Sheila Salmon for her leadership during her tenure as Chair.

044/25 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.

045/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 4 June 2025.

The meeting closed at 14:26.

Signed: Date: 2025

Hattie Llewelyn-Davies, Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 044/25)

Governor / Member of the Public	Query	Response
John Jones	**Quality and Performance Scorecard:** The Year to Date efficiency delivery was noted as being £5.1m behind plan, although this had improved due to temporary staff reduction. If it is the shortfall at the end of the year, what burden does this carry forward?	The shortfall in delivery of efficiency related to those efficiencies that were not found recurrently and these would carry forward to the following year and are part of the financial plan. The efficiency savings for 2024/25 would be 5% including the current shortfall.
	Board Assurance Framework: SR7 Capital and SR8 Use of Resources has been rated as red for a significant period of time - is there any way this can be addressed? Is the target unrealistic?	In relation to SR7 Capital, this reflected the national position of the NHS remaining capitally constrained and the actions taken were around what is within the Trust's gift, such as the estate programme and other internal programmes. The red rating indicated the scale of the Trusts capital requirements, like many providers, including backlog maintenance, facilities improvement and innovation in both Estates and Digital. In relation to SR8 Use of Resources, there was a difficult settlement last year with a planned deficit of £11.1m. This year there was agreed central support of £25m and there has been improvement in areas such as temporary staffing in recent months. Along with some reductions in out of area placements, the Trust was in a better position and hoped to see improvement going forward. It is anticipated that the work through the estates strategy may make the score for SR7 worse, but may also make the position more easily quantifiable.
	Staff Survey: To what extent are staff experiencing bullying at work, as previously there had been a figure on staff experiencing bullying from managers?	The question relating to staff experiencing bullying from colleagues (where a higher score is better) had improved from 82% in 2022 to 84% in 2024. Whilst this was still lower than the national average of 85% it showed a year-on-year increase.

Governor / Member of the Public	Query	Response
		One of the five priority areas was around supporting managers and developing a compassionate culture. It was important the Trust supported managers during challenging times to manage teams effectively.

4. ACTION LOG AND MATTERS ARISING

Standing item | HLD | 2

REFERENCES

Only PDFs are attached

Action Log Part 1 04.06.2025.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 2 April 2025

Lead	Initials	Lead	Initials	Lead	Initials
Zephan Trent	ZT	Alex Green	AG		

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
033/25 April	Provide an update on the development of a support guide function for the Power BI dashboard and / or the development of a training video.	ZT	August 2025	This is currently in progress.	In progress	
	Provide an update in relation to long lengths of stay for PICU services and patients being stepped down from the service.	AG	June 2025	The long stay patients on PICU are attributed to acuity and complex discharge needs. Further detail will be provided as part of the operational update on the agenda.	In progress	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | HLD | 5

REFERENCES

Only PDFs are attached

Chair Board Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Chair's Report**					
Executive/ Non-Executive Lead:	Hattie Llewelyn-Davies, Chair					
Report Author(s):	Angela Laverick, EA to Chair, Chief Executive and Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report				
Summary of risks highlighted in this report				
Which of the Strategic risk(s) does this report relates to:	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	✓		
	SR10 Workforce Sustainability	✓		
	SR11 Staff Retention	✓		
	SR12 Organisational Development	✓		
	SR13 Quality Governance	✓		
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 a summary of key headlines and shares information on governance developments within the Trust.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
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**	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Chair's Report

Lead
Hattie Llewelyn-Davies. Hattie Llewelyn-Davies Chair

CHAIR'S REPORT

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

Lampard Inquiry

Public hearings for the Lampard Inquiry took place from 28 April until 15 May. The Inquiry heard opening statements and viewed the Dispatches documentary, as well as taking a deeper look into some of the regulators' evidence and Health and Safety Executive prosecutions, Parliamentary Health Service Ombudsman reports and wards and services. Members of the EPUT Board have also been called as witnesses during the hearings.

Changes to the Board of Directors

Following the conclusion of the recruitment process for two new Non-Executive Directors, I would like to formally welcome to the EPUT Board of Directors Richard Spencer and Sarah Teather who joined us at the end of April and beginning of May respectively. Richard and Sarah are now both in the process of meeting with other Board members and visiting services as part of their induction process.

Brockfield House

I was delighted to receive the news that the CQC has rated the forensic inpatient and secure wards at Brockfield House as *Good* in all areas. This follows an unannounced inspection in April 2024, when inspectors visited Alpine, Forest, Aurora, Fuji and Causeway wards. The positive rating is a testament to the continued drive to improve care for all our patients.

EPUT Public Governor Workshops

Governors act as ambassadors for the Trust and influence how decisions are made and services are developed by making their voice heard and representing the views of others. EPUT public governor elections are taking place this summer and a series of workshops were held during April and May for members of the public to find out more about the role.

Service and Quality Assurance Visits

I have visited a number of EPUT sites with more visits scheduled since joining EPUT in April. The NEDs also continue to visit services across the geography of the Trust, including Quality Assurance Visits with Governors. This is a welcome opportunity to visit our staff on the front line to see and hear first-hand the challenges they face as well as their continuing dedication to supporting our patients. Recent visits have included: Brockfield House, The Lakes, The Linden Centre, Knightswick Clinic, Chelmer Ward, King's Wood Centre, Beech Ward.

International Nurses Day

12th May marked International Nurses Day, an important day in our calendar to recognise the work of our amazing nurses and health care assistants and the vital care they provide every day and the difference they make to the lives of so many.

Memorial Tree Campaign

As part of a national Memorial Tree Campaign, led by Doctors in Distress – a charity committed to protecting the mental health and wellbeing of healthcare workers - a memorial tree is to be planted

at the Lodge in memory of colleagues who have lost their lives to suicide. A tree planting ceremony will be held in the gardens at the front of the Lodge at 11.30am on Thursday 5 June.

3.0 Legal and Policy Update

3.1 The Provider Selection Regime (PSR) Statutory Guidance has been updated

Please see the link below for a copy of the updated statutory guidance.
Amendments have been made to the guidance to reflect changes to the PSR resulting from the Procurement Act 2023. This includes the replacement of references to the Public Contracts Regulations 2015 and an explanation of how the PSR will incorporate the provisions of the Procurement Act related to the exclusion and debarment of providers.
For Information: NHS England » The Provider Selection Regime: statutory guidance

3.2 New protocol on communications between Judges in Scotland, England and Wales and Northern Ireland in cases involving adults who lack capacity, and accompanying handbook

Please see the first link below for a copy of the new protocol regulating to communications between judges in Scotland, England & Wales and Northern Ireland for cases involving adults who lack capacity; the second link is a copy of the form and the third link is a copy of the handbook on adult capacity law.
For Information: JUDICIAL PROTOCOL REGULATING DIRECT JUDICIAL COMMUNICATIONS BETWEEN SCOTLAND, ENGLAND & WALES, AND NORTHERN IRELAND IN CASES OF ADULTS WHO LACK CAPACITY.pdf
Request-Form-Capacity-Cases-Protocol-Scotland-EW-and-NI.docx
A handbook on adult capacity law in Scotland, England & Wales, and in Northern Ireland - April 2025

3.3 NHS Confederation says capital funding boost for primary and community care is vital for government's three shifts

Please see the link below for a copy of the report published on 30 April which outlines that detainees being held in prison cells are being denied drugs for mental illnesses.
For Information: People detained by police denied insulin, cancer and epilepsy drugs, report claims | The Independent

3.4 Investment Priorities for Mental Health 2025

Please see the link below for a copy of the report published on 7 May, which states that, at a time of rising demand for mental health care and years of declining mental wellbeing in society, mental health services in England are under enormous pressure. The upcoming ten-year health plan and Spending Review present the government with the chance to deliver on its manifesto commitment to address the disparities between mental and physical health in the NHS and elsewhere.

The report goes on to state that this is an opportunity for the government to ensure public money is spent wisely, on services that will meet people's needs effectively, equitably and in a timely manner, while boosting economic activity, increasing living standards and improving health, in support of its core missions.
For Information: Investment-priorities-for-mental-health-2025.pdf

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

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REFERENCES

Only PDFs are attached

CEO Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Chief Executive Officer (CEO) Report**					
Executive/ Non-Executive Lead / Committee Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, EA to Chair, Chief Executive and Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	~~Yes/~~No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

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

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

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Lampard Inquiry

During April, the Lampard Hearing held a series of public hearings. During the three weeks, the Lampard Inquiry heard evidence from several public bodies, regulators and expert witnesses, who gave an overview of national and local mental health services. The charity INQUEST highlighted some of the issues they have experienced in mental health provision, however the planned sessions around Oevision were postponed to allow time to review updated material EPUT provided about our use of Oxevision.

Dr Milind Karale, our Executive Medical Director, gave statements about assessments and inpatient pathways, and I gave evidence on EPUT's position statement, which included the background to the issues that the Lampard Inquiry is considering. I also mentioned the significant progress EPUT has made in improving patient safety and increasing the involvement of patients and their families, while acknowledging that there was still much more to do.

The Board and I remain committed to serving the Inquiry, and encourage our staff to engage with the Inquiry, to share any experiences or information, both positive and negative. By being open and transparent, we can support Baroness Lampard and her team to provide the answers that patients, families and carers are seeking.

1.2 Not Part of My Job – New Anti-Discrimination Campaign

During the NHS Equality, Diversity and Human Rights week, the Trust launched a new anti-discrimination campaign – "Not Part of My Job".

Our staff work tirelessly to care for patients and deliver essential services across the Trust and deserve to do so in an environment free from racism, homophobia, ableism and all other forms of discrimination. Discrimination of any kind is not part of anyone's job, and it will not be tolerated.

This powerful campaign was co-created with input from our staff networks and dedicated volunteers, who shared their experiences and ideas to shape the message. The result is a series of four impactful posters to be displayed by our services that reinforce our commitment to a safe, respectful and inclusive workplace

1.3 Unified Electronic Patient Record System (NOVA)

As part of 'NOVA Week', the Trust welcomed over 500 members of staff to virtual sessions and spoke to nearly 2000 colleagues across various departments and professional groups. The questions, insights and suggestions heard have given invaluable guidance as we design our new EPR, Nova. Honest feedback was shared about what works and what doesn't with our current systems, and this input is shaping Nova's development. Speciality Reference Groups will be established across both EPUT and MSEFT with members representing their services to help shape how the new Nova system will work. Nova will be the first of its type for the NHS in England and in the UK, allowing us to transform patient care, f4rom physical to mental wellbeing. By working together we can create something that supports better care for our patients and makes our staff working lives easier. In addition, leading the way for the future of patient care for the communities we serve and beyond.

1.4 EPUT Awards Nominations

Two members of the Rough Sleepers Mental Health Team (RSMHT) in Southend have been highly commended for their innovative work with people who are homeless or at risk of homelessness. They were highly commended for the creative and innovative practice category in the UK Advancing Healthcare Awards 2025 which were held on 23 May.

The Essex Perinatal Mental Health Service has been shortlisted in the Positive Practice in Mental Health Awards. The team who provide one of the largest specialist perinatal mental health community

services in the country, have been shortlisted in the categories for Perinatal and Maternal Mental Health and Quality Improvement and / or Service Transformation. The Positive Practice in Mental Health Awards recognises the work of mental health services across England, Wales and Scotland and is open to organisations in the NHS, social care, third sector and independent sector.

2. UPDATES

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

Adult mental health bed occupancy is over the target threshold at 98% with older adults now reporting at 94% following a steady increase since January 2025. PICU occupancy has increased in April to 78% (against <88% target), following increasing trend over the past 12 months. Specialist ward occupancy reporting little variation month to month, with April reporting in line with the historical average at 75% against the 95% target.

Improved oversight of current mental health inpatient stays through the devolvement of flow and capacity management to localities, supported by the development of a Power BI dashboard to clearly show the length of stay by patient and by ward. This includes a profiling of the ranges of days that patients have been admitted real time.

Patients with a delayed transfer of care on Adult mental health wards have returned back within target thresholds, reporting 3% for April against the 5% target.

Small increase in the number of Out of Area placements (OOA) (17 Adult and two Older Adult and one PICU). However, following the repatriation of 22 patients (16 Adult and 6 PICU), there was still a reduction in the number of patients (45) remaining OOA at the end of the month (41 Adult, 2 Older Adult and 2 PICU). This is the fewest number of patients in an inappropriate out of area bed since June-24.

Routine referrals to the First Response Team (FRT) to be seen within 28 days is an ongoing challenge with performance reporting at 33% in April against a 95% target for the south Essex teams. FRT Basildon has been added to the internal risk register as demand exceeds capacity, the service is currently running with 2.68FTE vacancies and have seen an increase in demand, they are also triaging ADHD referrals which is impacting capacity.

Increase in virtual ward occupancy in West Essex and Mid and South Essex With West at 64% this represents a highest position since August 2024 and Mid and South have reported above target (80%) at 82% this month. In West Essex, EPUT medics are supporting Princess Alexandra Hospital Emergency Department with alternatives to admission.

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

- 25/26 operating plan finalised - balanced financial plan.
- M1 results :
    - Revenue position £0.7m deficit, £0.1m better than plan.
    - Capital expenditure of £0.6m, £0.2m ahead of plan. Annual capital programme £36.1m inclusive of £19m of proposed external funded schemes.
    - Cash balances £33m.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

International Nurses Day

The Trust celebrated International Nurse's Day on 12 May 2025. The Director of Nursing and CNIO and Director of Safety and Patient Safety Specialist attended the Florence Nightingale Commemoration Service at the Westminster Abbey on 12 May 2025, alongside key leaders in the nursing profession. The Nursing Leadership team and Executive Nurse also visited a number of services across the Trust to celebrate and express gratitude for the commitment and contributions of nurses across our services.

Coproduction Conference
This year's Coproduction Conference will be held jointly with Essex County Council on 10th October 2025 (world mental health day), with a dual theme of 'workplace mental health' and 'health equity'. This is the 3rd year we have held this conference and will accommodate 150 delegates from across Essex, coming together to celebrate and learn about coproduction in mental health services.

AHP
EPUT Allied Health Professional clinical teams met with the EOE Regional Chief Allied Health Professional and her team. EPUT Chief AHP, Mobolaji Lewis and Associate Director of AHP Mental Health and LD, Sharon Rautenbach led a group of AHPs and students in presenting good practice examples.

EPUT participated in an AHP educational face to face Health and Care Professional Council (HCPC) event that discussed standards, working in UK healthcare, raising concerns, everyday ethical dilemmas and record keeping.

EPUT's Quarterly Learning Together Event
The inaugural EPUT Quarterly 'Learning Together' event, took place on Thursday 10 April 2025 at Anglia Ruskin University in Chelmsford. The event explored the question 'what are we learning?' and brought together experience and expertise from healthcare staff from across the Trust, including key partners, with a focus on patient safety within inpatients settings, and co-production.

The important links between physical and mental health, and the Trust Quality of Care Strategy was also part of the discussion. The event also heard from staff drawing on safety improvement plans who shared case studies on improvement areas such as falls reduction, self-harm reduction, and improving patient care plans.

The presence and contributions of Lived Experience Ambassador's, Patient Safety Partners and clinical teams generated valuable and insightful conversations on further work required on the Trust safety improvement plans. The event prompted some really interesting discussions, and the learning shared will help us continue to improve our care.

The next quarterly learning event is scheduled for the afternoon of 10 July 2025 at Anglia Ruskin University in Chelmsford.

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

Workforce Performance

Workforce Plan - The Trust has submitted 25/26 Workforce plan. This year's planning cycle was undertaken in conjunction with the Operating Plan. Therefore including and aligning activity, finance and workforce. Key objectives of the plan include:

- Continued growth of staff in post for clinical substantive staff.
- Reduction of Infrastructure in line with Sir Jim MacKay letter NHS England - Working together in 2025/26 to lay the foundations for reform.
- Flat lining of Bank and agency target which are aligned to deliver 25% reduction on bank and 20% agency reduction in line with NHS operating plan delivering a £17.5m saving.

Substantive Staffing – Substantive staff in post growth continues with the on boarding of 124 new starters and 26 internal promotions in April, against leaver headcount of 51, Trust vacancy rate has reduced to 11%.

Temporary Staffing – The Trust has seen significant reduction of temporary staffing use in M1 reporting a 249.5 whole time equivalent (wte) reduction when compared to M12 figures The use of agency staff has continued to decline with 29 wte reduction between M12 and M1. The use of bank staff continues to fall with a 221 wte reduction between M12 and M1.

Absence Management – The absence rate at the Trust has reduced to 5% in March/April and is now in line with Trust Key Performance Indicator (KPI) target.

Staff Turnover –Trust turnover rate has seen a slight increase from 7.3% in February to 8.7%. Despite the increase the Trust continues to be under target and reports one of the lowest turnover rates across NHS Trusts in the East of England region.

Staff Appraisals – The appraisal rate has remained static at 83%. The appraisal window for 25/26 is now open and closes on 31st October. Care Groups are identifying plans via accountability framework meetings to improve compliance and reporting position.

Mandatory Training Compliance – Overall mandatory training compliance for substantive staff is at 87% (target 85%). However courses requiring 90% compliance currently sits at 85%.

Marketing & Brand

The new EPUT Public facing website went live at the end of April and has shown some great results so far. It is easier to use, more in line with NHS branding, more intuitive and most importantly, gives the user a better journey when finding the information they need, first time around. We will continuously update and improve the website in line with the ever changing digital landscape.

Operational HR

Job Evaluation - The NHS Staff Council and its job evaluation subgroup (JEG) have recently completed a review of the national job matching profiles for nursing and midwifery. It is anticipated that the updated profiles will be published the week commencing 2 June 2025, alongside technical guidance from the Job Evaluation Group (JEG) to detail the changes and guide matching panels in their use.

It is anticipated that there will be a significant 'surge' in the request for job evaluation reviews of existing job descriptions for nursing and midwifery staff following publication of the new national profiles. Within EPUT we have assessed our current position in relation to job documentation, job evaluation capacity. HR and Nursing colleagues together with staff side representatives are working collaboratively to agree a local action plan to understand timelines and realistic milestones for reporting and oversight.

Mutually Agreed Resignation Scheme (MARS) - At the end of April 2025, with support from NHS England the ICB, EPUT has launched a local MARS programme which will be open until 6 June 2025. The purpose of the MARS is to create job vacancies, which can be filled by redeployment of staff from other jobs or as a suitable alternative for those facing redundancy.

MARS has been designed to support the flexibility of the organisation to address periods of rapid change and service re-design. MARS is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment with EPUT in return for a severance payment.

A Mutually Agreed Resignation (MAR) is not a redundancy or a voluntary redundancy. A programme of engagement events; Q&A drop in sessions, suite of FAQ's and socialisation through team meetings continues. Panels have been scheduled to review and approve applications during June 2025.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

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REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 04.06.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 June 2025

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

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

Purpose of the Report		
This report provides the Board of Directors with: • 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 Points

Mental Health Inpatient Capacity:
Bed occupancy on Adult wards reports beyond the target threshold of 93% at 98%.

PICU occupancy reports an increase in April to 78% (against <88% target) There is an increasing trend over the past 12 months, the past several months evidencing this with concerning variation identified in the SPC chart.

Specialist ward occupancy continues to report little variation month to month, with April reporting in-line with the historical average at 75% against the 95% target.

Older Adult wards have seen an increase since January and April now reports 94% (against <86% target), this sharp increase is noted via the SPC flagging April as a data point of concern.

Analysis into the data has highlighted an ongoing issue with recording discharges where dates cannot be backdated if there are documents that require sign off post discharge, the MH Information Team is working with Wards, Operational Productivity and Systems to correct these issues.

The average length of stay for discharged Adult inpatients reduced in April to 74 days (from 90 in March), this remains outside the national benchmark of 35 days, the average length of stay reduces to 51 days when including the assessment units. There were 81 patients discharged 29 of these had stays over 60 days, 5 of these were 200+ days.

In April, Older Adult inpatients reported an average length of stay on discharge of 123 days against the target threshold of 74 days. There were 36 discharges of which 24 were long stays, with 3 of these being 200+ days.

For inpatients currently still on Older Adult wards the average length of stay reports at 120 days against a target of 80 days.

PICU average length of stay in April reports outside of the 50 day target at 129 days. There were 4 patients discharged, with 2 being long stays (1 at 78 days and the other 384 days).

To provide increased operational oversight of current mental health inpatient stays, a new dashboard has been developed in Power BI to clearly show the length of stay by patient and by ward. This includes a profiling of the ranges of days that patients have been admitted real time and has been BRAG rated. As at 1st of May our Mental Health inpatient wards average length of stay profile was:-

- Green: 150
- Amber: 72
- Red: 114
- Black: 78

Ward Fill Rates:
We are seeing an increase in the number of wards with less than 90% staff fill rate, April reported 25 wards against the target of 13 or fewer. An increasing trend has been observed since December, with month on month increases reported since.

The overall performance for staff fill rates continues to achieve target (for day/night un/qualified) but the margin of target attainment is reducing, with the Day/Night Qualified staff both reporting 91% for April (against 90% target).

Rates of Patients Clinically Ready for Discharge:
Patients with a delayed transfer of care on Adult mental health wards have returned back within target thresholds, reporting 3% for April against the 5% target.

PICU, Older Adults and Specialist wards all continue to maintain delays well within the targets limits

Inappropriate Out of Area Placements:
April has seen a small increase in the number of placements, with 20 (17 Adult and two Older Adult and one PICU). However, following the repatriation of 22 patients (16 Adult and 6 PICU), there was still a reduction in the number of patients (45) remaining OOA at the end of the month (41 Adult, 2 Older Adult and 2 PICU). This is the fewest number of patients in an inappropriate out of area bed since June-24 (40).

All out of area cases are reviewed and the majority now have estimated discharge dates and repatriation plans. Director level sign off is in place prior to any out of area placement decision

OPEL Status:
There were 11 days at OPEL 4 status in April. This was driven by demand on Adult Wards continuing to be an issue, all other days were at OPEL 3.

Cardio Metabolic
The indicator for health checks for SMI patients in Early Intervention Psychosis services maintains high levels of performance, with the last 8 months reporting over 95% against the 90% target, with April reporting at 96%.

Inpatient areas continue to report below the 90% target with April at 70%, the gradual progress that had been made appears to have stalled. 11 wards were fully compliant last month.

For SMI patients in the Community Teams the upward trajectories towards the target (65%) have slowed with April holding the same performance of March, reporting 52% for those on caseload over 12 months and 59% for those on caseload under 12 months.

NHS Talking Therapies:
The Talking Therapies services in the South East are currently reporting against historical Access Rates until these are replaced by commissioners with a greater focus on reliable improvement, recovery and 2nd appointments.

The Castle Point and Rochford and Southend teams are reporting access rates back above the quarterly target (following a reduction in Q4). North East Essex reports at 73% of its target, the service continues to see high numbers of referrals through Limbic, with 39% of referrals being received through this channel.

All three Talking Therapy teams report 100% for treatment within 6wks and Recovery Rates are reporting at 55% against the 50% target.

Workforce:
Staff turnover, sickness absence and Long Term sickness absence are all reporting within the target thresholds for the second month running, driven through the improvements in sickness. Turnover has reported consistently below threshold for several months.

Temporary Staffing:
The number of booked Agency shifts continues to reduce. The North and West Care Units have made significant progress in reducing their agency numbers, Mid and South are also improving but at a lesser rate and book the most agency shifts of all the care units. Inpatient and Urgent Care unit reported a small increase in the numbers booked in April.

Income & Expenditure:

The month 1 deficit of £0.7m is slightly better than planned, this includes efficiency in-month delivery of £1.7m.

Capital & Cash:
M1 Capital spend of £0.6m, £0.2m above plan. The cash balance is £33.4m.

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 - (INC. PLACE RESULTS & ACTION PLAN & EPR UPDATE)

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REFERENCES

Only PDFs are attached

Committee Chairs Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 June 2025

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

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A		
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
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 1. Note the report and assurance provided. 2. Approve the annual reports and Terms of Reference for the Standing Committees

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 (Diane Leacock)
3. People Committee (Ruth Jackson)
4. Quality Committee (Dr Mateen Jiwani)

The Standing Committees each considered an annual report and effectiveness review at their last meetings. The annual reports provided assurance that the Committees had been meeting their Terms of Reference for 2024/25 and identified new objectives for 2025/26 based on the outcome of the committee effectiveness review. The annual reports and revised Terms of References are attached to this report for approval.

In addition, the PLACE 2024 report considered by the Quality Committee and Council of Governors is attached to this report for information.

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. Audit Committee Annual Report and Terms of Reference Finance & Performance Committee Annual Report and Terms of Reference People Committee Annual Report and Terms of Reference Quality Committee Annual Report and Terms of Reference PLACE 2024 Report

Executive/ Non-Executive Lead / Committee Lead:
Chairs of Board of Director Standing Committees.

NHS
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Committee Chairs Report

Board of Directors

4 JUNE 2025

EPUT

INTRODUCTION

Purpose of the report

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

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

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

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

1. AUDIT COMMITTEE

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

Committee meeting held: 16 May 2025

Assurance

Internal Audit Progress
- Five audits have been finalised:
  - Consultant Job Plans: Limited Assurance.
  - Falls Management: Reasonable Assurance.
  - Payroll and Salary Overpayments: Reasonable Assurance.
  - Patient Safety Incidents Process: Reasonable Assurance.
  - Board Assurance and Risk Management: Substantial Assurance.
- A further audit is at the fieldwork stage, and a draft report will be issued imminently.
- Fieldwork for one audit is scheduled to commence in May 2025.
- One recommendation, relating to ICT-Cyber Security, is overdue.

External Audit Progress
- There has been no significant change since the last meeting.
- Auditors have commenced the annual audit of Accounts and are reassessing materiality levels. *Post meeting update: EY has since confirmed that materiality levels remain unchanged.*

Waiver of Standing Orders
- The Committee received a report on Waiver activity during February-March 2025; and an annual review of Waivers for 2024/25.
- The Committee was satisfied that Waivers were being used by exception, noting a sustained downward trend – particularly within the Digital, Strategy and Transformation Directorate.

Losses and Special Payments 2024/25
- All Losses and Special Payments in 2024/25 were in line with the Scheme of Delegation.

Information

Anti-Crime Progress
- The Trust received an overall Green rating in the 2024/25 Functional Fraud Assessment Standards, with an improvement in the number of Green ratings. Green ratings were received for all components other than Risk Assessments and NHSE Case Management System which were Amber.

Salary Overpayments
- The Committee received an update on salary overpayments and actions taken.

Annual Accounts and Annual Report 2024/25
- A page-turning exercise has been undertaken to review the Draft Accounts 2024/25.
- The draft Annual Report 2024/25 has been circulated for comment.
- These will be presented to the Board in separate agenda items.

Directors' Expenses 2024/25
- The Committee received a breakdown of Directors' Expenses during 2024/25.
- The total was similar to 2023/24, and there were no exceptional items to note.

1. AUDIT COMMITTEE *cont.*

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

Committee meeting held: 16 May 2025

Assurance

Internal Audit Annual Report 2024/25
- The Trust received a Reasonable Internal Audit Opinion for 2024/25.
- 12 of 15 planned Audits were completed, with three carried forward to 2025/26.

Conflicts of Interest 2024/25
- The Trust was compliant with NHSE Conflicts of Interest guidance during 2024/25.

Counter Fraud Services Annual Report 2024/25
- The Committee received the Counter Fraud Services Annual Report and draft Counter Fraud Functional Standard Return for 2024/25.

Risk Management Assurance Framework 2024/25
- The Trust received Substantial Assurance for its risk management arrangements during 2024/25.

Action

No Actions for the Board.

Alert

Annual Report & Committee Effectiveness Review
- The Committee endorsed the Committee Annual Report & Effectiveness Review 2024/25.
- This is attached, along with 2025/26 Committee Terms of Reference, for the Board's approval.

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2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 22 May 2025

Assurance

Performance Report
- Assurance on the Trust's performance during April 2025 included the following areas:
  - Crisis Call Response Times
  - Mental Health Inpatient Capacity
  - CHS Inpatient Capacity
  - Rates of Patients Clinically Ready for Discharge
  - Inappropriate Out of Area Placements
  - Admissions Under the Mental Health Act
  - OPEL Status
  - NHS Talking Therapies
  - Cardio Metabolic
  - Virtual Ward Occupancy
  - Community Health Services

Flow & Capacity
- An update on inappropriate Out of Area Placement performance, delayed discharges and length of stay across adult acute and older adult inpatient services was discussed.
- A new report included a map illustrating the locations of current Out of Area placements, and efforts were being focussed on repatriating patients to EPUT beds.

Financial Report
- The Committee received an update on the Trust's final 2025/26 annual plan submission and Month 1 results.
- The revenue position is on plan, with continued improvement in temporary staffing utilisation.
- Capital spend was £0.6m, with cash balances of £33.4m.

Board Assurance Framework Deep Dive: Pharmacy
- A review of the work of the Pharmacy and Medicines Optimisation Team was discussed.
- Committee members congratulated the Team for improved recruitment and efficiency achievements.

Board Assurance Framework Report
- The Committee Received the BAF risks aligned with the Committee.

Information

Strategic Impact Report
- The Committee received an update and assurance on the Trust's Strategic Plan.
- This will be presented to the Board in a separate Agenda item.

Provider Licence Self Certification
- A review undertaken against the Provider Licence and Code of Governance for NHS Providers indicates that the Trust is fully compliant with the provisions of its licence.
- The full paper will be presented to the Board in a separate Agenda item.

Action

No Actions for the Board.

Alert

Annual Report & Committee Effectiveness Review
- The Committee endorsed the Committee Annual Report & Effectiveness Review 2024/25.
- This is attached, along with 2025/26 Committee Terms of Reference, for the Board's approval.

3. PEOPLE COMMITTEE

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

Committee meeting held: 24 April 2025

Assurance

Macintyre Independent Review - Action Plan
- Following recommendations from the Board, the Review Action Plan associated to employee relations investigations has now been categorised and presented within the remit of the following three headings:
  - What was the learning?
  - How do we measure improvements and oversee impact?
  - Links to Board Assurance Framework (BAF) and Corporate workforce related risks.
- The Committee was assured by the actions and information presented, and therefore wishes to provide assurance to the Board.
- In addition, the actions will be considered by Internal Audit and linked to the BAF to provide further assurance and oversight.

Strategic Impact Report
- The Committee received an update and assurance on the Trust's Strategic Plan.
- This will be presented to the Board in a separate Agenda item.

Board Assurance Framework - Workforce
- The Committee received assurance on the Board Assurance Framework for Workforce.
- Four new corporate workforce risks were considered by the Committee with recommendation to be taken forward for scoring and approval:
  - National job evaluation of nursing roles.
  - Controls for the use of temporary staff.
  - Effective oversight of employee relations.
  - Utilisation of the Apprenticeship Levy.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Operational Human Resources.
  - Social Impact Strategy Update.
  - Staff Survey Update.
  - Time to Care Programme.
  - Workforce Key Performance Indicators.

Information

Mutually Agreed Resignation Scheme
- At the time of the meeting, the Mutually Agreed Resignation Scheme was due to be rolled out in April 2025 for a period of one month (pending NHSE signoff).

Mental Health Annual Conference & Exhibition
- The Chief Executive and several Executives attended the Mental Health Annual Conference & Exhibition on 23 April 2025.
- The event provided an opportunity to exchange information and ideas with senior leaders from other Trusts.

National Memorial Tree Planting Campaign
- The National Memorial Tree Planting Campaign ceremony has been organised for 5 June 2025; when a tree will be planted outside The Lodge in memory of doctors and nurses who have taken their own life.

Draft Workforce Plan 2025/26
- Committee members received the first draft of the Workforce Plan 2025/26.
- This will now be updated following feedback from NHSE.

Action

No Actions for the Board.

Alert

Annual Report & Committee Effectiveness Review
- The Committee endorsed the Committee Annual Report & Effectiveness Review 2024/25.
- This is attached, along with 2025/26 Committee Terms of Reference, for the Board's approval.

Safeguarding Mandatory Training
- The Committee received a new report that highlighted each subject and compliance against designated staff groups. Overall compliance was good but there were some areas where improvement plans were in place. Therefore the Committee referred Safeguarding Mandatory Training compliance to the Quality Committee for oversight and further assurance.

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4. QUALITY COMMITTEE

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

Committee meeting held: 10 April & 15 May 2025

Assurance

Safety Improvement Plans (SIPs):
• An update was received on the SIP for:
  - Transitioning of Children and Young People to Adult Mental Health Services.

Assurance Reports
• The following Assurance Reports were received by the Committee:
  - Board Assurance Framework.
  - Compliments & Complaints Annual Report 2024/25.
  - CQC Assurance Report.
  - Mental Health Act Performance / Activity Report.
  - Patient & Carer Race Equality Framework Report.
  - Patient Experience & Volunteers Annual Report 2024/25.
  - Reducing Restrictive Practice Quarterly Report.
  - PLACE Report.
  - Pharmacy & Medicines Management Optimisation Strategy Progress Update.
  - PSIRF Quarterly Report.
  - Safer Staffing Report for Inpatient Nursing.
  - Sexual Safety Quarterly Report.
  - Suicide Prevention Report.
  - Quality Control Audits.
  - Quality of Care Performance Dashboard.

Annual Reports
• The Committee approved the following Annual Reports. These will be presented to the Board in later Agenda items:
  - Emergency Preparedness Resilience & Response Annual Report.
  - Health & Safety and VAPR Annual Report.

Information

Urgent Treatment Centre
• Capital funding has been identified to develop the Urgent Treatment Centre in Colchester – with an aim to have this implemented before the winter period.

Quality Account 2024/25
• The draft Quality Account 2024/25 was discussed and approved by Committee members, subject to suggested changes.

Proposed Changes to the Use of Oxevision
• The Committee received an update on changes to the use of Oxevision across the Trust, in response to new guidance from NHSE.
• Committee members noted the findings and recommendations, and endorsed the proposals set out in the report.

Strategic Impact Report
• The Committee received an update and assurance on the Trust's Strategic Plan.
• This will be presented to the Board in a separate Agenda item.

Action

No Actions for the Board.

Alert

Annual Report & Committee Effectiveness Review
• The Committee endorsed the Committee Annual Report & Effectiveness Review 2024/25.
• This is attached, along with 2025/26 Committee Terms of Reference, for the Board's approval.

Audit Committee
Annual Report 2024/25

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 1 April 2024 – 31 March 2025.

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

2. Committee Membership

Elena Lokteva, Non-Executive Director chaired the Committee throughout 2024/25. The membership includes two further Non-Executive members, with one being a member of the Quality Committee (Dr Helm until July 2024 and then Dr Jiwani from November 20240 and a further member Ms Raine.

There is a requirement for at least one member of the Committee to have relevant and recent financial experience. For 2024/25, both Elena Lokteva and Jenny Raine fulfilled this criteria.

In attendance at the meeting are the Executive Chief Finance Officer, Director of Finance, Head of Financial Accounts, Senior Director of Corporate Governance, a representative from Internal Audit, a representative from External Audit and the Anti-Crime Specialist. The Committee also provides for the Chief Executive Officer to be in attendance when the Annual Governance Statement is presented, as part of the final approval of the annual report and accounts ahead of presentation to the Board of Directors.

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may also be requested to attend where required.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. 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 2024/25

	Meetings Attended	Total No. Meetings
Membership		
Elena Lokteva	5	5
Dr Rufus Helm (until July ’24)	2	3
Dr Mateen Jiwani (from November ’24)	2	2
Jenny Raine	5	5
In Attendance		
Clare Barley	4	5

	Meetings Attended	Total No. Meetings
Simon Covill	5	5
Denver Greenhalgh	3	5
Paul Scott	1	1
Trevor Smith	4	5

The meeting was also observed by a member of the Council of Governors in their remit of holding Non-Executive Director to account.

3. Meetings

Meetings were held in May, June, July, November 2024 and March 2025, with five meetings taking place during the year.

The five meetings held met the obligations regarding membership, attendance and quoracy, with an amendment made to the Terms of Reference in year to ensure an Associate Non-Executive Director counted towards the quoracy.

4. Terms of Reference

The Committee reviewed its terms of reference in March 2025 and these will be presented to the Board of Directors for approval at its meeting in June 2025, alongside its annual committee report. (Revised attached Appendix 2)

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 (including an update on management actions), 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 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:

- Analysis of Salary Overpayments for the financial year
- Anti-Crime Progress Report and Annual Report
- Annual Report and Accounts (including draft and final versions) and the External Auditors Annual Report
- Annual Review of the Governance Manual (Standing Orders, SoRD, SFI's and DSoD)
- An update regarding Quality Assurance Audits using Tendable
- Claims Annual Scorecard
- Clinical Audit – assurance on progress and delivery and annual report.
- Conflict of Interest Report
- Counter Fraud Annual Report and Functional Standards
- Details of Board of Director Expenses for the financial year
- Digital Procurement Waivers
- External Audit Progress Report
- Internal Audit Progress Report, Follow-Ups and annual work plan.
- Risk Management Framework Assurance Framework Annual Report
- Waiver of Standing Orders
- Write-Offs, Losses and Special Payments from the previous financial year.

6. Duties of the Audit Committee

Committee members carry out a self-assessment of the effectiveness on an annual basis and is facilitated by the Trust Secretaries Office (noting that 2023/24 was undertaken and reported at its meeting in November 2025). The Committee draws on the output of this review to proactively make improvements.

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 2024/25 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from Committees of the Board of Directors. The following significant issues were identified for inclusion in the Annual Governance Statement:

- Lampard Inquiry, both in regards to resourcing and its reputation implications.

- Mental Health inpatient demand and acuity driving temporary staffing levels and out of area placements.

- The Mid and South Essex Integrated Care System financial challenge.

- The CQC rating of acute mental health wards and adult psychiatric intensive care unit (published April 2023 and July 2023)

For the year 2024/25 the Committee delivered its annual schedule of business and therefore considers it has met its terms of reference and discharged the duties delegated to it by the Board of Directors.

8. Priorities for 2025/26

The Committee considered the outcome of the effectiveness review and the progress made to the objectives for 2024/25. It was acknowledged that the last effectiveness review was completed in November 2024, with the Committee meeting on only two occasions and therefore the achievement of the objectives remained ongoing.

Therefore, the Committee agreed to continue with the same objectives for 2025/26, except for a slight change to the clinical audit objective following receipt of an initial report:

- To strengthen the reporting of the Board Assurance Framework and associated controls assurance to the Committee.

- To continue to work (where appropriate) with other Committees of the Board through the sharing of Internal Audit 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 embed the reporting of clinical audit – assurance on process and delivery.

9. Recommendation

The Committee received and approved the annual report and recommend it to the Board of Directors, along with its revised terms of reference for 2025/26.

Appendix 1: Audit Committee Effectiveness Review 2024/25

Background

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

Process

The evaluation took the form of an online survey. Eight people responded to the survey. The results are provided below.

Summary of Findings and Areas for Action

The survey provided an average score of 4.25 (out of 5) which provides a good level of assurance. The table below provides the average score across each of the sections:

	Average Score (Out of 5)
Engagement	4.41
Impact	4.43
Focus	4.33
Team Working	4.21
Leadership	3.82

It should be noted that not all respondents answered all questions and different sections had a different number of questions.

The following statements received the highest scores:

- The Committee has made a conscious decision about the information it would like to receive. (5.00)
- The Committee provides a written summary report of its meetings to the governing body. (5.00)
- The Committee has set itself a series of objectives for the year. (4.86)
- There is a formal appraisal of the committee's effectiveness each year. (4.86)
- We can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of gaps identified. (4.83)
- The Committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives. (4.71)
- The Committee challenges management and other assurance providers to gain a clear understanding of their findings. (4.71)

The following statements received the lowest scores:

- The committee environment enables people to express their views, doubts and opinions. (3.14)
- Debate is allowed to flow, and conclusions reached without being cut short or stifled. (3.29)
- The committee receives assurances from third parties who deliver key functions to the organisation - for example, NHS Shared Business Services etc. (3.43)
- The committee chair has a positive impact on the performance of the committee. (3.50)
- The committee chair is visible within the organisation and is considered approachable. (3.50)
- The committee chair allows debate to flow freely and does not assert his/ her own views too strongly. (3.50)

The following provides a high level summary of the comments and scores:

Areas of Positive Assurance:

- The Committee is well-planned and understands its remit.
- There were positive scores for the Committee setting objectives and setting-out the information it would like to receive.
- There was a comment that the Committee had reviewed its work plan which had led to a more effective and efficient sequencing of agenda items and wider input and interaction with other Board Standing Committees.
- There was a positive score in relation to the Committee understanding its remit and how it works with other committees.
- The Committee has good Non-Executive representation and challenges management and other assurance providers to gain a clear understanding of their findings.

Potential areas for improvement / continued areas of focus:

- There were some comments about the succinctness of papers. The length, detail and focus of papers has been a common theme across the effectiveness reviews of standing committees.
- There was a lower score for the Committee receiving assurance from third parties and a comment regarding ensuring there is a joined-up approach with other Board Committees.
- There were a number of comments regarding ensuring good levels of contribution and debate, with guidance to creating a more open environment and ensuring the Committee is inclusive in hearing voices within the room and allowing discussion to flow freely.

- There was a comment suggesting the benchmarking of peers included in more reports and the impact of the Public Inquiry on the control environment being considered as part of some reports.

AUDIT COMMITTEE
TERMS OF REFERENCE 2025/26

CHAIRED BY:	Elena Lokteva, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Standing 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 all other internal audit codes, 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 resources
- 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 the effectiveness and delivery of the annual Anti Crime Specialist work plan, and approve the Annual Plan
- Approve the Functional Standards submission
- 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 can 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 assessments.

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, and includes Associate Non-Executive Director.	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) Members 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:	**Approved by Board:** April 2025	**Date of Last Review:** March 2024 **Next Review:** February 2026

Finance and Performance Committee
Annual Report 2024/25

1. Background

The purpose of this report is to review the work undertaken by the Finance and Performance Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2024 – 31 March 2025.

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

2. Committee Membership

Loy Lobo, Non-Executive Director chaired the Committee throughout until January 2025, when Diane Leacock, Non-Executive Director took over the role. The membership includes three further Non-Executive members and four Executive Directors.

In attendance at the meeting includes:

- Executive Chief Finance Office
- Executive Chief Operations Officer
- Executive Director of Strategy, Transformation and Digital
- Executive Chief People Officer
- Chair of the Audit Committee (as required)
- Director of Finance
- Senior Director of Governance

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may also be requested to attend where required.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. 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 2024/25

	Meetings Attended	Total No. Meetings
Membership		
Loy Lobo	8	8
Diane Leacock (from May 2024)	6	7
Alexandra Green	7	8
Andrew McMenemy (from May 2024)	4	7
Jenny Raine	4	8
Marcus Riddell (until April 2024)	1	1
Trevor Smith	8	8

	Meetings Attended	Total No. Meetings
Zephan Trent	6	8
In Attendance		
Simon Covill	6	8
Denver Greenhalgh	8	8
Dr Milind Karale	0	5
Elena Lokteva (Audit Committee Chair)	2	2
Ann Sheridan	2	4

The meeting was also observed by a member of the Council of Governors in their remit of holding Non-Executive Director to account.

3. Meetings

Meetings were held in bi-monthly from May 2024, with two extra-ordinary meetings taking place in November 2024 and February 2025 respectively. Therefore, eight meetings took place during the year.

The eight meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Committee reviewed its terms of reference in March 2025 and these will be presented to the Board of Directors for approval at its meeting in June 2025, alongside its annual committee report. (Appendix 2)

5. Arrangements

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

The Committee is responsible for ensuring the appropriate investment of funds, and to oversee the amalgamation and disaggregation of funds arising from potential mergers, acquisitions or organisational reconfigurations.

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

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

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

The Committee received reports on the following within the year:

- Accountability Framework

- Board Assurance Framework
- Financial Results 2024/25
- Cyber Security – Alert & Monitoring Assurance Reports
- Cyber & Information Governance Assurance Report
- EPUT Provider Licence Review
- Estates & Facilities Report
- Performance Report
- Planning Update 2025/26
- The provisional outturn for 2023/24
- Strategic Impact Report
- Time To Care Benefits Realisation Plan

The Committee completed three Board Assurance Framework deep dives during the year:

- Capital
- Cyber
- Demand and Capacity

6. Duties of the Finance and Performance Committee

Committee members carry out a self-assessment of the effectiveness of the Committee. The Trust Secretary's Office facilitates this on an annual basis. The results enable the Committee to draw up a plan for improvement, which, for 2023/24 evaluation was considered at their meeting held in March 2024 and alongside the review of the Committee's Terms of Reference. The Committee identified key objectives / areas of focus for 2024/25:

Objectives 2024/25	**Progress**
To continue to oversee the development of the new Electronic Patient Record system	The Committee received regular updates on the progress of the Electronic Patient Record System, including reports from the UEPR Joint Oversight Committee and associated contractual matters.
To receive all internal audit reports pertaining to finance and performance, where a limited or moderate assurance rating is received	There were no internal audit reports relating to finance and performance which received a limited or moderate assurance rating for 2024/25. There were some comments in the effectiveness review which suggests this area may need further clarification and formalising.
To provide active leadership within the System finance	The Committee received a regular System Partnership and Performance Updates, which included a MSE system summary, forecasts and position updates for the ICB.
To maintain focus on the delivery, and oversee the medium term planning and financial forecasts	The Committee received regular finance update reports, including financial forecasts. The Committee also received updates in relation to the Mid and South Essex Medium Term Plan and reviews of the EPUT Operational Plan prior to formal submission.

The Committee Secretary monitors attendance at the Committee and compliance to reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2024/25 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from Committees of the Board of Directors. The following significant issues were identified for the Annual Governance Statement, within the remit of the Committee:

- Lampard Inquiry, both in regards to resourcing and its reputation implications.
- The Mid and South Essex Integrated Care System financial challenge.

For the year 2024/25 the Committee delivered its annual schedule of business and therefore considers it has met its terms of reference and discharged the duties delegated to it by the Board of Directors.

8. Priorities for 2025/26

The Committee considered the outcome of the effectiveness review and the progress made to the objectives for 2024/25. The Committee agreed the following priorities for 2025/26:

- Maintain an open dialogue around any areas of overlap between Committees, to ensure any areas of overlap are considered by the relevant Committee.
- Ensure connections are made between Internal Audits which receive limited or moderate assurance and the BAF controls within the remit of the Committee.
- Ensure subsequent Internal Audits undertaken, for any areas receiving limited or moderate assurance, are reported back to the Committee for assurance / triangulation.

9. Recommendations

The Committee received and approved the annual report and recommend it to the Board of Directors, along with its revised terms of reference for 2025/26.

Appendix 1: Finance & Performance Committee Effectiveness Review 2024/25

Background

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

Process

The evaluation took the form of an online survey. Six people responded to the survey. The results are provided below.

Summary of Findings and Areas for Action

The survey provided an average score of 4.29 (out of 5) which provides a good level of assurance. The table below provides the average score across each of the sections:

	Average Score (Out of 5)
Team Working	4.60
Effectiveness	4.54
Leadership	4.35
Role & Remit	4.35
Impact	4.27
Internal Control	4.12
Effectiveness	3.70

It should be noted that different sections had a different number of questions.

The following statements received the highest scores:

- The Committee has sufficient authority to perform its role effectively (4.83)
- The committee has the right balance of experience, knowledge and skills to fulfil its role as designed in the terms of reference. (4.83)
- The committee ensures that the relevant executive director/manager attends meetings to enable it to secure required level of understanding of reports. (4.83)
- I understand the messages being given (4.83)
- At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc. (4.83)
- I can provide two examples of where we as a committee have focused on improvements as a result of assurance gaps identified. (4.83)

The following statements received the lowest scores:

- There is no duplication or overlap with other committees. (3.17)
- The committee has a mechanism to keep it aware of topical, legal and regulatory issues. (3.50)
- The committee has set itself a series of objectives it wants to achieve this year. (3.50)

The following provides a high level summary of the comments and scores:

Areas of Positive Assurance:

- The Committee is well-led, with positive scores for the Leadership section and positive comments regarding the chairing of the meeting.

- There were positive comments regarding the level of discussion and having the right membership of the Committee. There was also the understanding that others could be invited to the Committee as appropriate to provide further assurance.

- There was a positive comment regarding the Board Assurance Framework providing reasonable oversight and assurance of control. There were also positive comments regarding the deep dives undertaken by the Committee during the year, against elements of the Board Assurance Framework.

Potential areas for improvement / continued areas of focus:

- There were a number of comments regarding the overlap between other standing committees. The comments varied with some suggesting this was positive, with the Committee focusing on specific areas of a project (e.g. the financials associated with the Time To Care programme). However, some comments appeared more neutral and the specific question around overlap received a lower score (3.17). This Committee may wish to discuss this area to determine if any further action is required.

- There were a number of comments regarding the need to formalise the internal audit reports presented to the Committee. The Committee had an objective in 2024/25 regarding receiving internal audit reports relevant to the Committees remit which received an assurance rating of limited or moderate. However, some comments queried whether certain audits had taken place and perhaps suggested there is uncertainty as to what internal audits are taking place and which should be presented to the Committee.

FINANCE & PERFORMANCE COMMITTEE
TERMS OF REFERENCE 2025/26

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

AUTHORITY:

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

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

Performance

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

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

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

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

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

6 To develop and monitor the implementation of the corporate and Care Unit objectives including Transformation (including Transformation & Efficiency Group reporting) in the Annual and Medium Term Plans. Provide oversight to key major projects and programmes as instructed by the Board of Directors.

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

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

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

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

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

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

	Investment: 13 To establish and monitor compliance with a written Investment Policy (which is periodically reviewed by independent professional advisors) to establish the overall methodology, processes and controls which govern selection of Trust investments. 14 To monitor investments where total revenue resulting from the investment or capital value is within the delegated limits outlined in the Trust's Investment Policy for the Committee. 15 To consider contracts, investments or marketing initiatives/opportunities: • Where a change to the Trust's corporate structure is required (for example establishment of a subsidiary vehicle) • To approve development of ITT that are reportable transactions to NHS England • To review all potential new transactions in the light of potential risks • To review investment properties and vacant properties plans. 16 Ensure that the underlying liquidity of the Trust is maintained where surpluses are used to finance investments. 17 The committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and setting the terms of reference for any external investment consultants. 18 To approve external funding within limits delegated by the Board of Directors.	
ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair, and includes Associate Non-Executive Director. Executive Chief Finance Officer Executive Chief Operations Officer Executive Director of Strategy, Transformation and Digital Executive Chief People Officer	**IN ATTENDANCE:** NED (Chair of Audit Committee) as required Executive Medical Director and/or Executive Nurse Director of Finance Senior Director of Corporate Governance Other Directors / Officers as required
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on performance (contractual, operational and financial) They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Approved by Board:** April 2025	**Date of Last Review:** March 2024 **Next Review:** April 2026

People, Equality & Culture Committee
Annual Report 2024/25

1. Background

The purpose of this report is to review the work undertaken by the People, Equality & Culture Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2024 – 31 March 2025.

The Committee oversees all aspects relating to workforce, culture, leadership, education training and development across the Trust.

2. Committee Membership

Diane Leacock, Non-Executive Director chaired the Committee until October 2024 before handing over the role to Dr Ruth Jackson, Non-Executive Director from December 2024.

Included within the current membership are two other Non-Executive Directors, the Executive Nurse, Executive Chief Finance Officer and the Executive Chief People Officer.

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. 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 2024/25

	Meetings Attended	Total No. Meetings
Diane Leacock	6	6
Alex Green	3	6
Dr Ruth Jackson (from September 2024)	4	4
Dr Mateen Jiwani	4	4
Elena Lokteva	0	3
Andrew McMenemy (from July 2024)	5	5
Marcus Riddell (until April 2024)	1	1
Ann Sheridan	3	5
Trevor Smith	3	6

The meeting was observed by a member of the Council of Governors in their remit of holding Non-Executive Director to account.

3. Meetings

Meetings were due to be held bi-monthly (six times a year), the meetings were held in April, July, September, October, December and February.

The six meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Committee reviewed its terms of reference in February 2025 and these will be presented to the Board of Directors for approval at its meeting in June, alongside this report. (Revised attached Appendix 2)

5. Arrangements

The Committee provides internal assurance regarding the Trust's processes in relation to people, equality and culture. In particular, providing assurance that adequate workforce resourcing governance processes and controls are in place throughout the Trust to identify, prioritise and manage risk, ensure effective and efficient use of resource and protect the health and wellbeing of employees. The Trust also ensures the Trust is working within the legal requirements of a foundation trust and with reference to guiding principles as set-out in the NHS People Plan.

The Committee receives reports from management forums regarding workforce planning, performance, staff experience, equality, diversity and inclusion, training and education. The Committee also received a regular updated from the Executive Chief People Officer of any emergent and topical issues.

The minutes of the Committee are made available to the Board of Directors. The Committee also reports to the Board via a Committee Chairs Report which provides assurance on the items discussed and provides alerts, actions or approvals for the Boards attention.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. The minutes and 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 the scheduled of business.

The Committee received reports on the following within the year:

- Annual Audit of Appraisal & Revalidation
- Annual Workforce Plan and Progress Report
- Appraisal, Talent Management and Succession Planning
- Behaviour Framework
- Board Assurance Framework
- Consultant Recruitment Deep Dive
- Education Strategy Assurance Report
- Employee Relations Case Management Assurance Report
- Equality, Diversity Inclusion Plan
- Freedom to Speak-Up, including self-assessment toolkit
- Independent Review Action Plan, providing updates of action taken following an independent review of historical sexual abuse and harassment and Brockfield House.
- Industrial Action Update, relating to the action taken during the periods of industrial action and the impact on the Trust.

- Leadership Development
- Lived Experience and Volunteers Workforce Update and Recommendations
- Management of Change Assurance Report
- Marketing Update
- Operational Human Resources Assurance Report
- People Promise Exemplar Programme
- Recruitment Strategy Assurance Report
- Social Impact Strategy
- Staff Story
- Staff Survey Results and Improvement Plan; and engagement plan.
- Stakeholder Engagement Assurance Report
- Time to Care
- Virtual Learning Programme, relating to a project to develop a virtual reality learning environment
- Workforce Disability Equality Standards (WDES) and Workforce Race Equality Standards (WRES)
- Workforce Efficiencies Programme
- Workforce Updates, including key issues relevant key performance indicators such as staff turnover, sickness absence etc.

The Committee also received a verbal update from the Executive Chief People Officer for any emergent issues.

6. Duties of the People, Equality and Culture Committee

Committee members undertake 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 develop a plan for improvement, which for 2024/25 was considers at the meeting held in April 2025. The results of the Effectiveness Review is attached at Appendix 1.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2024/25 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from Committees of the Board of Directors. There were no significant issues identified for the annual governance statement in line with the definition of 'significant issue' within the Foundation Trust Annual Report Manual.

For the year 2024/25 the Committee assessed that it had met its terms of reference in the discharge of its duties.

8. Priorities for 2025/26

The Committee considered the outcome of the effectiveness review and considered priorities for 2025/26. The Committee agreed that the People Strategy Implementation Plan would be presented to the next Committee meeting, which would identify the key areas of focus for the Committee for 2025/26, which would address the general comments identified in the effectiveness review.

The Committee identified a further priority area to address the areas for improvement identified in relation to meeting papers:

- Further develop reports presented to the Committee to ensure these are concise and data refined for the Quality Dashboard, to support meaningful discussion at the Committee.

9. Recommendations

The Committee received and approved the annual report and recommend it to the Board of Directors, along with its revised terms of reference for 2025/26.

Appendix 1: People, Equality & Culture Committee Effectiveness Review 2024/25

Background

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

Process

The evaluation took the form of an online survey. Six people responded to the survey. The results are provided below.

Summary of Findings and Areas for Action

The survey provided an average score of 3.95 (out of 5) which provides a reasonable level of assurance. The table below provides the average score across each of the sections:

	Average Score (Out of 5)
Leadership	4.75
Team Working	4.22
Role and Remit	3.98
Internal Control	3.86
Engagement	3.80
Effectiveness	3.70
Impact	3.43

It should be noted that not all respondents completed all questions and each section had a different number of statements.

The following statements received the highest scores:

- The Committee chair has a positive impact on the performance of the committee. (5.00)
- The Committee has structured its agenda to cover its main duties in its terms of reference. (4.80)
- Committee meetings are chaired effectively. (4.75)
- I understand the messages being given. (4.60)
- The Committee chair is visible within the organisation and is considered approachable. (4.50)

The following statements received the lowest scores:

- Reviewed an annual plan, which is clearly linked to risks and assurance needs (3.20)
- Committee papers are distributed in sufficient time for members to give them due consideration. (3.20)
- 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 (3.40)
- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance. (3.40)
- The quality of the committee papers received allows me to perform my role effectively. (3.40)
- At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc. (3.40)

The comments provided alongside the overall scores reflect the work the Committee has undertaken to streamline and focus discussions and papers, with the need to ensure this continues. The following provides a high level summary of the comments and scores:

Areas of Positive Assurance:

- The Committee is well-led, with very positive scores for the chairing of the meeting, including the chair having a positive impact, chairing the meeting effectively and being visible and approachable within the organisation.
- The Committee understands its role and remit. This is evidenced by a good score for the role and remit section and members understanding the messages being given. There was a comment that the role and remit was well-acknowledged, with the Committee working to ensuring the remit is fulfilled.
- There was a positive comment specifically around the Committee monitoring the action plan following the independent review of investigations into allegations of sexual abuse and harassment. It was noted the actions have now become business as usual.

Potential areas for improvement / continued areas of focus.

- There is more work required in terms of papers presented to the Committee. This is reflected in lower scores for quality of papers and the Committee making a conscious decision on the level of information it wishes to receive. There were comments relating to the length of reports, with more analysis required. This was also reflected in comments around improving discussions at the Committee. However, it should be noted that there were positive comments relating to the improved level of data being received by the Committee.
- There were some comments on the receipt of late papers, making it difficult for members to fully digest the information before the meeting. This is reflected in the lower score for the Committee papers being distributed in a timely manner. There was one suggestion that late papers should not be accepted by the Committee.
- There were some general suggestions for potential areas for improvement / focus:
    - The inclusion of Internal Audit Reports / Action Plans to be included in the work plan.
    - The Committee undertaking deep dives for BAF areas, in a similar manner to the Finance and Performance Committee.
    - There was a suggestion for the Committee to receive more external reports, such as from Payroll, Anglia Ruskin University etc.
    - The inclusion of more staff stories to get a better indication of what is happening at ground level.
    - There was a suggestion to consider Committee attendees, with a view to a reduction. The comment did not make clear if it was felt there were too many people at the Committee, as it also referred to the meeting being well-attended.

PEOPLE COMMITTEE
TERMS OF REFERENCE 2025/26

CHAIRED BY:	Ruth Jackson, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Standing Committee Secretary	**FREQUENCY:**	Bi-monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee.

AUTHORITY:

The People Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's people, equality and culture. In particular, that adequate workforce resourcing governance processes and controls are in place throughout the Trust to: a) identify, prioritise and manage risk arising from our status as an employer; b) ensure effective and efficient use of resources through evidence based people and leadership development and c) protect the health and wellbeing of employees. To ensure the organisation is working within the legal requirements of a foundation trust, and with reference to guiding principles as set out in the NHS People Plan.

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

Workforce Strategy

1 To recommend to the Board for approval and oversee delivery of the Trust's strategy and associated implementation plan relating to people and culture.

2 To approve the Trust's strategic workforce plan as part of the overall operational planning process, taking into account local, regional and national policies and /or directions and receive assurance on its implementation.

Workforce Performance

3 To receive assurance and relevant reports detailing compliance with key national and local workforce indicators including progress against local workforce metrics.

Staff Experience

4 To maintain oversight of the Trust's systems and process by which staff are able to raise concerns and ensure that these are fit for purpose and the outcomes are monitored.

5 Receive the annual staff survey results and ensure appropriate actions are taken to address any issues.

Equality, Diversity and Inclusion

6 Receive assurance that the Trust is meetings its statutory and regulatory obligations in relation to equality, diversity and inc lusion and delivers improvements as required.

7 Receive annual reports on the Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality Delivery S tan dards and the NHS EDI Improvement Plan

8 Oversee the Trust's programme of work on EDI for both staff and patients

Learning & Education

9 Receive assurance on the quality and effectiveness of leadership and management development in the Trust

10 Receive assurance on the approach to talent management and succession planning (for roles other than very senior managers)

11 Receive assurance on the implementation of appraisals and mandatory training

12 Receive assurance on the development of career pathways for all roles, linked to learning opportunities and apprenticeships

13 Receive assurance on the provision of high quality professional under and post graduate education

Resourcing

14 To receive reports on sustaibility of staffing within the remit of our recruitment strategy.

Governance and Risk Management

15 Review those entries on the Trust's Board Assurance Framework (BAF) and corporate risk registers which are to be overseen by the Committee and identify any new or emerging risk areas which may need to be added to the BAF.

16 Receive and review the findings of relevant Internal and External Audit reports covering workforce, education and training an d s taff engagement and to assure itself that recommendations are appropriately responded to and implemented in a timely and effective way.

ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair, and includes Associate Non-Executive Director Chief People Officer Executive Chief Finance Officer Executive Chief Operating Officer Executive Chief Nurse	**IN ATTENDANCE:** NED (Chair of Audit Committee) as required Senior Director of Corporate Governance Other Directors / Officers as required Staff Side Representative
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Approved by Board:** April 2025	**Date of Last Review:** April 2024 **Next Review:** April 2026

Quality Committee
Annual Report 2024/25

1. Background

The purpose of this report is to review the work undertaken by the Quality Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2024 – 31 March 2025.

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

2. Committee Membership

Dr Rufus Helm, Non-Executive Director chaired the Committee until July 2024 when his term of office came to an end. Dr Mateen Jiwani, Non-Executive Director / Senior Independent Director then chaired the Committee from September 2024.

Included within the current membership are to other Non-Executive Directors, Executive Nurse, Executive Medical Director, Senior Director of Governance and the Executive Director of Strategy, Transformation and Digital. The Terms of Reference were reviewed in March 2025, whereby from April 2025 the Executive Director of Strategy, Transformation and Digital to step-down from the Committee at which point senior responsible officer for patient experience will transfer to the Executive Nurse, and for the Executive Chief Operations Officer to join the membership.

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. 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 2024/25

	Meetings Attended	Total No. Meetings
Dr Rufus Helm (until July ’24)	3	4
Dr Mateen Jiwani	10	11
Denver Greenhalgh	8	11
Dr Ruth Jackson (from August ’24)	7	7
Dr Milind Karale	8	11
Loy Lobo (as required)	1	1
Elena Lokteva (as required)	4	4
Ann Sheridan	11	11
Zephan Trent	4	11

The meeting was also attended by ICB colleagues (Quality Leads) and observed by a member of the Council of Governors in their remit of holding Non-Executive Director to account.

3. Meetings

Meetings were held monthly, with the exception of August 2024, with eleven meetings taking place during the year.

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

4. Terms of Reference

The Committee reviewed its terms of reference in March 2025 and these will be presented to the Board of Directors for approval at its meeting in June, alongside this report. (Revised attached Appendix 2)

5. Arrangements

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

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

The minutes of the Quality Committee are made available to the Board of Directors. The Committee also reports to the Board via a Committee Chairs Report which provides assurance on the items discussed and provides any alerts, actions or approvals for the Boards attention.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. The minutes and 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 the scheduled of business.

The Committee received reports on the following within the year:

- Board Assurance Framework
- Clinical Audit Annual Priority Programme and Progress & Delivery Assurance Report
- Complaints & Compliments Annual Report
- CQC Compliance Updates, including updates on the implementation of the Improvement plan and details of inspections
- Embedding Quality Improvement at EPUT
- Emergency Preparedness, Resilience and Response Annual Report and self-assessment.
- End of Life Annual Report and Progress Report
- Health & Safety, Security and VAPR Annual Report
- Homicide Report

- Infection Prevention and Control Report and Annual Report
- Learning From Deaths Quarterly Report
- Ligature Risk Reduction Annual Report
- Mental Health Act (MHA) Report and Annual Report
- Patient Experience Annual Report
- Patient Safety Incident Reporting Framework (PSIRF) Quarterly Report and Annual Report
- Patient-led Assessment of the Clinical Environment (PLACE) Annual Report
- Patient Story
- Pharmacy and Medicines Optimisation Annual Report
- Physical Health Annual Work Plan and Progress Report
- Quality Account and Quality Priorities
- Quality and Performance Report, with particular focus on:
    - Absence without Leave (AWOL)
    - Inpatient Ligatures
    - Overdue Safety Action Plans
    - Seclusion and Restraint
    - Violence and Aggression
- Quality Impact Assessment Procedure
- Quality of Care Groups Updates, including
    - Effectiveness of Care
    - Experience of Care
    - Safety of Care
- Quality of Care Strategy Delivery Update
- Quality Senate Proposal
- Reducing Health Inequalities Annual Plan
- Reducing Restrictive Practice Framework and Quarterly Report
- Research & Innovation Strategy Delivery Update
- Safeguarding Quarterly Report, Annual Work Plan and Annual Report
- Safeguarding Thematic Report
- Safer Staffing Report for Inpatient Nursing
- Safety First, Safety Always Year Three Closure Report
- Safety Improvement Plan Progress Reports, including focus on:
    - Embedding Gold Standard Operating Procedure
    - Falls Safety
    - Ligature
    - Multi-Disciplinary Team (MDT) Communication
- Senior Information Risk Owner (SIRO) Annual Report
- Sexual Safety Gap Analysis, Deep Dive and Report
- Strategic Impact Report
- Trust Response to the Greater Manchester Mental Health Report

The Committee also received a verbal update from the Executive Nurse and Executive Medical Director for any emergent issues. Under matters arising, the Committee discussed a number of areas of focus during the year, including:

- Connections between the Ligature Risk Reduction Group and SIP Plans
- Flow & Capacity Reflections on Winter Pressures
- Health Inequalities Deep Dive
- Inpatient Deaths Relating to Physical Health Deep Dive
- Lighthouse Child Development Centre
- Mapping of the Key Safety Improvement Plan Themes
- Self-Harm Incidents Relating to Drugs and Alcohol (Essex STaRS) Deep Dive

- Staff Story: MDT Systems
- Time to Care Operating Model Local Implementation Plan

The Committee set itself the following to improve effectiveness for 2024/25:

To improve our oversight of physical health service provision	√	The Committee has maintained a focus on physical health service provision through: • Physical Health Annual Work Plan and Progress Report • Inpatient Deaths Relating to Physical Health Deep Dive
To improve our oversight of quality issues arising from sub- contracted services	X	The Committee has not received any reports on this in 2024/25.
To receive all internal audit reports pertaining to clinical governance, irrespective of the auditors opinion	NA	Year to date there have not been any reports to bring through to Committee. The Mortality Review Process IA having been received at the Audit Committee will be presented at Committee in May 2025. The following are in draft and will come to Committee following presentation at Audit Committee in May 2025: Patient Safety Incidents Process Falls Management Compliance with Policies – Site Visits
To provide active leadership to the new Quality of Care Strategy and the nine priority areas through reporting from the new executive governance (Safety of Care, Experience of Care and Effectiveness of Care Groups)	√	Reporting from the Quality of Care Strategy governance has been received and under continuous improvement to achieve the right level of information and assurance for the Committee.
To maintain focus on the delivery of the CQC improvement plan	√	The Committee has maintained an overview of progress throughout 2024/25.

6. Duties of the Quality Committee

Committee members undertake 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 develop a plan for improvement, which for 2023/24 was considers at the meeting held in April 2024. The results of the Effectiveness Review for 2024/25 is attached at Appendix 1.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2024/25 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from Committees of the Board of Directors. There were no significant issues identified for the annual governance statement where there were any lapses in control.

For the year 2024/25 the Committee assessed that it had met its terms of reference in the discharge of its duties.

8. Priorities for 2025/26

The Committee considered the outcome of the effectiveness review and the progress made to the objectives for 2024/25. The Committee noted two objectives for 2024/25 had not been achieved and would therefore be carried forward to 2025/26:

- Improve oversight of quality issues arising from subcontracted services.

- Receive all internal audit reports pertaining to clinical governance, irrespective of the auditor's opinion.

The Committee identified additional priorities for 2024/25, based on the outcome of the effectiveness review:

- Develop and streamline papers to ensure these are short and concise, to allow for meaningful discussions to be held by the Committee.

- Ensure members of the Committee or their deputies attend all meetings and relevant subject matter experts join the Committee for specific items if required.

- Oversee the provision of digital support for the development of the new quality dashboard.

9. Recommendations

The Committee received and approved the annual report and recommend it to the Board of Directors, along with its revised terms of reference for 2025/26.

Appendix 1: Quality Committee Effectiveness Review 2024/25

Background

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

Process

The evaluation took the form of an online survey. Five people responded to the survey. The results are provided below.

Summary of Findings and Areas for Action

The survey provided an average score of 4.44 (out of 5) which provides a good level of assurance. The table below provides the average score across each of the sections:

	Average Score (Out of 5)
Leadership	4.91
Engagement	4.67
Team Working	4.62
Impact	4.46
Role and Remit	4.35
Effectiveness	4.31
Internal Control	3.90

It should be noted that not all respondents completed all questions and each section had a different number of statements.

The following statements received the highest scores:

- The Committee has structured its agenda to cover its main duties in its terms of reference. (5.00)
- I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions. (5.00)
- Each agenda item is 'closed off' , so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored (5.00)
- The Committee chair has a positive impact on the performance of the Committee. (5.00)
- Committee meetings are chaired effectively. (5.00)

The following statements received the lowest scores:

- The Committee considers the internal auditor's recommendations for those key controls within its assurance framework (2.67)
- The Committee clearly understands and receives assurances from third parties the Trust uses to manage/operate key functions. (3.25)
- There is no duplication or overlap with other Committees (3.60)

The comments provided alongside the overall scores reflect the work the Committee has undertaken to streamline and focus discussions and papers, with the need to ensure this continues. The following provides a high level summary of the comments and scores:

Areas of Positive Assurance:

- The Committee has become more focused and effective in critiquing the material it receives. This is reflected in the positive scores for the discussions in the Committee and that items are sufficiently 'closed off'.
- The Committee is well-led, which is reflected in the higher scores for the leadership section and higher scores regarding how the meeting is chaired.
- The Committee has a good level of engagement, with positive scores for challenging management to gain a clear understanding of their findings and being able to provide examples of focusing on improvement as a result of assurance gaps identified.

Potential areas for improvement / continued areas of focus.

- The work on streamlining the agenda and papers needs to continue. This is reflected in the score and comments around overlap with other meetings. There were also comments relating to the quality of papers, ensuring these are less lengthy and more focused. There was a comment regarding too many items on the agenda, however, this is contradicted by the positive score for the structured agenda covering the terms of reference for the Committee.
- There was a mixed view on the membership / attendance at Committees. One comment suggested there were too many people at the Committee, however, other comments suggested additional attendees, including key Executive Directors and director-level reports who are responsible for the core elements of delivering quality. It should be noted the statement relating to ensuring relevant executive director / manager attends meetings received a positive score of 4.5.
- There was a recommendation to provide strong digital support for directors to deliver the new quality dashboard.
- There was a comment regarding the Committee only having oversight of the clinical outcomes from clinical audit activity.
- There was a comment regarding the Committee considering how quality issues from subcontracted services are escalated from review and oversight.
- There was one comment which reflected in the need for firmer accountability for time assurances and accountability, rather than focusing on operational compliance.

QUALITY COMMITTEE
TERMS OF REFERENCE 2025/26

CHAIRED BY:	Dr Mateen Jiwani, Non-Executive Director	**TOR AUTHORISED BY:**	Board of Directors
SECRETARIAT:	Board Standing Committee Secretary	**FREQUENCY:**	Monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee.

AUTHORITY:

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

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

Clinical Governance and Strategy

1 To monitor quality of operational performance trends against targets and ensure all statutory and regulatory elements are adhered to.
2 To recommend to the Board of Directors the Trust-wide quality and clinical governance priorities.
3 To recommend the Trust's annual Quality Accounts to the Board of Directors for approval.
4 To review implementation and monitor progress against the Quality of Care Strategy and other improvement initiatives.
5 To receive assurance reports from executive led quality groups (namely Safety of Care; Effectiveness of Care and Experience of Care) and subject matter forums (e.g. Safeguarding and MHA Committee).
6 To consider clinical governance matters referred to the Committee by the Board of Directors, its standing committees or other forums within the Trust.
7 To receive and approve Quality of Care Strategy and annual work plan, and receive assurance reports from all priority steering groups.
8 To receive and review the annual clinical audit programme and progress reporting thereafter.
9 To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
10 To agree the Health and Safety Work plan and monitor progress.
11 To ensure registration criteria of the Care Quality Commission continue to be met and to monitor compliance with the Quality Statements.
12 To ensure processes are in place to oversee, review and analyse mortality trends across the Trust.
13 To assure that the Trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the Trust, so as to identify areas for improvement and ensure that these improvements are effected.
14 To oversee processes to ensure the review of patient safety incidents (including near-misses, complaints, claims and coroners reports) from within the Trust and wider healthcare community to identify areas of focus and learning in response to trends where appropriate.
15 To monitor the development of quality indicators throughout the Trust.
16 To ensure the research programme and governance framework is implemented and monitored.
17 To oversee the Trust's application of policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines, Data Security and Protection Toolkit (DSPT) and the Data Protection Act and to approve the submissions required under the DSPT.
18 To receive assurance that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines including but not limited to NICE guidance and radiation use and protection regulations (IR(ME)R).
19 To receive assurance on the Trusts implementation of and compliance with all current legislation and codes of practice relating to mental health.
20 To receive assurance on the implementation of the Trusts procedures for the management of safeguarding.
21 To ensure that risks to patients are minimised through effective risk horizon scanning: responding to recommendations from external bodies e.g. National Confidential Inquiries into Patient Outcomes and Death; Care Quality Commission surveys and reports; independent reviews and inquiries; National Patient Safety Alerts and other internal learning in connection with PSIRF, safe staffing reports and other quality intelligence.
22 To identify areas of significant risk to be included in the Corporate Risk Register and gain assurance that appropriate priorities and actions to mitigate such risks are in place.

	Governance and Risk Management 23 Review those entries on the Trust's Board Assurance Framework (BAF) and corporate risk registers which are to be overseen by the Committee and identify any new or emerging risk areas which may need to be added to the BAF. 24 Receive and review the findings of relevant Internal and External Audit reports covering covering areas within the remit of the Committee and to assure itself that recommendations are appropriately responded to and implemented in a timely and effective way.	
ATTENDANCE:	**MEMBERSHIP:** Three (3) Non-Executive Directors, one of whom to be the Chair, and includes Associate Non-Executive Director. Executive Chief Nurse Executive Medical Director Executive Chief Operational Officer Senior Director of Corporate Governance	**IN ATTENDANCE / WHEN REPORTS DUE:** NED (Chair of Audit Committee) as required Director of Nursing and Director of Infection Prevention and Control Director of Patient Experience and Participation Director of Patient Safety Director of Risk and Compliance Deputy Director of Nursing for Safeguarding and Mental Health Act Other Directors / Officers as required
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on quality performance and assurance. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	**OUTPUTS:** Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	**Approved by Board:** April 2025	**Date of Last Review:** March 2024 **Next Review:** April 2026

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**PLACE 2024 Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Amy Poole, Associate Director of Patient Experience and Participation, Matthew Sisto Director of Patient Experience and Participation					
Report discussed previously at:	Experience of Care Group (20/03/2025) Quality Committee (10/04/2025) Council of Governors (21/05/2024)					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		✓
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 analysis of the PLACE 2024 report	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Summary of Key Issues

The EPUT supplementary report for PLACE 2024 provides a detailed breakdown for the organisational scores, with some comparative analysis pulled out from the national report, and recommendations detailed within.

General themes

- Patient assessors were pleased that many of their suggested improvements from 2023 had been taken on board. This included improving the garden space for 439 Ipswich Road and encouraging patients to paint on the ward walls during OT activity as a way of introducing colour.
- General signage on approach to sites remain an area of improvement.

General Recommendations

1. Each visit will need 2 patient assessors to be included in the National Publication
2. Each visit will need to allow for a food assessment to be included in the National Publication
3. Local site based teams to continue to support and embrace PLACE visits

Notable improvements:

1. Signage is generally more visible and clear
2. Sites being more accommodating of PLACE visits going ahead.

Recommendations for improvements based on findings from the PLACE 2024 assessments:

1. Improve parking where possible, capacity, markings, access, and disabled provision.
2. Focussed effort to improve dementia and disability domains

Next Steps:

- Finalise PLACE action plan 25/26 and agree with care unit leadership teams in June 2025
- Site specific results have been presented at Standing Committee level

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
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**	

Acronyms/Terms Used in the Report			
PLACE	Patient Led Assessments of Care Environments		

Supporting Reports/ Appendices /or further reading

1. PLACE 2024 Supplementary Report May 25
2. Improvement Works Recently Undertaken
3. Improvement Works Planned to Date
4. Improvement Photos

Lead

Ann Sheridan

Ann Sheridan
Executive Nurse

Essex Partnership University NHS Foundation Trust

2024/25 Capital Projects – Scope of Works

Project	Completion Date	Scope of Works
Environmental Improvements Project – Finchingfield & Galleywood Wards - The Linden Centre	March 2025	• Painting to corridors- walls, ceilings and woodwork • Flooring and whiterock in WCs and bathrooms • Refurbishment of Tea Room and Laundry • General redecoration • Install of anti-barricade doors to Activity Room and Lounge • Install of fire rated shutter to kitchen • Stud work wall to separate fridges from the dining room • Air Con to new fridge store • New dining room furniture
Environmental Improvements Project – Ardleigh & Gosfield Wards - The Lakes and Hennage & Peter Bruff Wards - Kingswood Centre	March 2025	<u>Peter Bruff</u> • Painting to corridors- walls, ceilings and woodwork • Paining to bedrooms- walls and ceilings • Flooring and whiterock in WCs and bathrooms

		• LED lighting to one section of corridor • Refurbishment of kitchen • General redecoration <u>Hennage Ward</u> • Installation of beverage bay • Redecoration to day areas • LED lighting in dining room and lounge • Flooring and redecoration to bedrooms • Wardrobes in bedrooms • Refurbishment of kitchen • Flooring and whiterock in WCs and bathrooms • General redecoration <u>Ardleigh Ward</u> • Replace suspended ceiling in corridor • Blackboard paint in bedrooms • Flooring and whiterock in WCs and Bathrooms • Refurbishment of Kitchen and Tea Room • General redecoration • Strip back woodwork and repaint • Wrapping of doors <u>Gosfield Ward</u> • Replace suspended ceiling in corridor • Blackboard paint in bedrooms • Flooring and whiterock in WCs and Bathrooms • Refurbishment of Kitchen and Tea Room • General redecoration

		• Strip back woodwork and repaint • Wrapping of doors
The Linden Centre - Enhancement of Patient & Family communal areas	March 2025	• New flooring • Reduce ligature toilet • Redecorations • Creating an additional Visitors Room by installation of dividing wall in current room.
Learning Disabilities/Autism Enhancements to Byron Court (UEC Funded)	March 2025	• Development of a sensory room to improve therapeutic space for patients, • Purchase of Learning Disabilities Magic Tables as part of the Happiness Project • Enhancement to the existing de-escalation room to include sensory features such as lighting and music • Improved lighting/dimmers across the facility to support an improved and adaptable environment for patients with autism • Decoration and new artwork • Purchase of new beds and dining room furniture
3 Heath Close - Outpatients Room Improvements & DDA Access (UEC Funded)	March 2025	• New DDA complaint front door • Refurbishment of the Outpatients room circulation areas that have been made wheelchair friendly • Redecorated waiting room • New furniture in the meeting/ treatment room

NHS
Essex Partnership University
NHS Foundation Trust

PLACE 2024 Report

Patient Led Assessments of the Care Environment

Q4 24/25

Introduction

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

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

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

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

Purpose and Background

The purpose of this report is to provide an update to the Board of Directors regarding PLACE following the 2025 assessments and any recommendations for improvements. PLACE visits in 2025 took place between September and November.

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

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

National Publication

NHS England published the PLACE scores into the public domain on the 20th February 2025.

The Patient Experience team ensured that at least 2 patient assessors were present at each site visit and that food assessments took place as necessary.

Scoring

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

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

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

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

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

Table 1- overall rating score

Same question is asked upon leaving

Please Tick

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

Table 2 – overall food rating score

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

Table 3- Individual domain scoring key

Summary Insights

General Themes

- Patient assessors were pleased that many of their suggested improvement recommendations from last year had been taken on board. This included improving the garden space for 439 Ipswich road and encouraging patients to paint on the ward walls during OT activity as a way of enhancing colour.

- General signage on approach to sites remain an area of improvement. Unfortunately, the majority of sites are hard to locate for somebody attending for the first time and car parking availability should still be improved to make it easier for people to find our sites.

Contemporary Trusts

233 organisations took part in PLACE assessments 2024. For comparison3 other trusts have been selected below to demonstrate how EPUT scores compare to Trusts similar in size.

Organisation Name	Commissioning Region	Organisation Type	NHS or Independent	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	EAST OF ENGLAND COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.965	0.8882	0.889	0.8879	0.9671	0.9384	0.8501	0.8772
NORTH EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.9785	0.9239	0.9282	0.9184	0.9686	0.8067	0.9197	0.9427
EAST LONDON NHS FOUNDATION TRUST	LONDON COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.9572	0.8501	0.8971	0.789	0.9457	0.9341	0.8692	0.8513
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	NORTH WEST COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	NHS Trust	0.9918	0.9378	0.9802	0.911	0.9487	0.9813	0.957	0.9676

Organisational overview

Site	Cleanliness	Food	Privacy, Dignity and Wellbeing	CAM	Dementia	Disability
THURROCK COMMUNITY HOSPITAL	383/ 388	168/ 180	114/ 122	178/ 184	185.5/ 196	132.5/ 146
THE BRAMBLES - COLCHESTER	232/ 234	148/ 176	72/ 86	118/ 120	36/56	48/ 78
SAFFRON WALDEN COMMUNITY HOSPITAL	232/ 234	151.5/ 168	82/ 90	120/ 120	86/116	76/ 108
COLCHESTER - THE LAKES	380/ 388	152.5/ 166	102/ 106	163/ 174	44/54	64/ 76
CLIFTON LODGE	229/ 234	158.5/ 168	84/ 84	115/ 120	144/144	114/ 118
CHRISTOPHER UNIT (LINDEN)	212/ 234	135.5/164	76/ 88	100/ 120	48/60	66/ 80
BYRON COURT - 5 HEATH CLOSE	229/ 234	158/ 164	84/ 88	114/ 120	68/70	78/ 84
BROOMFIELD HOSPITAL	325/ 388	150.5/ 166	106/ 124	154/ 184	47/58	68/86
LANDERMERE CENTRE MENTAL HEALTH WARDS, CLACTON-ON-SEA	232/ 234	160.5/ 168	82/88	118/120	142/144	112/ 118
KING'S WOOD CENTRE - COLCHESTER	339/ 388	156.5/ 166	108/128	153/184	40/60	58/ 86
THE ST. AUBYN'S CENTRE, COLCHESTER	384/ 388	163/ 178	114/124	174/184	70.5/72	84.5/ 92

Organisational overview continued

Site	Cleanliness	Food	Privacy, Dignity and Wellbeing	CAM	Dementia	Disability
BROCKFIELD HOUSE	1156/ 1158	150.5/ 166	302/ 304	502/ 504	70/ 72	120/ 126
BASILDON MENTAL HEALTH UNIT, BASILDON	848/ 850	150.5/ 166	234/ 234	376/ 378	80/ 82	112/ 118
THE CRYSTAL CENTRE	366/ 388	174/ 186	120/ 122	171/ 184	135.5/ 140	112.5/ 120
EDWARD HOUSE	370/ 388	156.5/ 166	112/ 122	173/ 184	63/ 72	76/ 90
ST MARGARET'S HOSPITAL	829/ 850	160.5/ 168	224/ 228	366/ 376	332/ 366	214/244
ROCHFORD COMMUNITY HOSPITAL	694/ 696	149/ 168	192/ 196	310/ 312	86.5/ 88	104.5/ 110
ROBIN PINTO UNIT	218/ 234	160.5/ 166	72/ 86	109/ 120	65/ 72	74/ 86
RAWRETH COURT	226/ 230	160.5/ 168	78/ 84	116/ 120	140/ 144	110/ 118
PRINCESS ALEXANDRA HOSPITAL	368/ 388	142.5/ 166	122/ 128	165/ 186	60/ 66	84/ 94
WOOD LEA CLINIC, BEDFORD	230/ 234	150/ 176	84/ 86	117/ 120	69/ 70	74/ 86

Overall Top Performers

Landermere

Clifton Lodge

Thurrock

Overall Lowest Performers

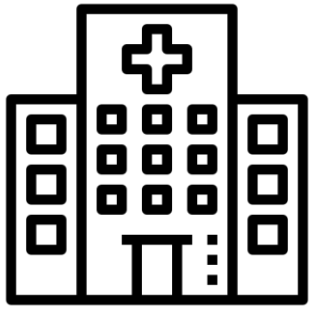
Kingswood Centre

The Linden Centre

439 Ipswich Road

Note: Targeted interventions across all 3 of these sites will have a significant positive impact on the overall averages in 2023 assuming that our other sets maintain the same or improve

Targeted Interventions



Improvement across all domains at the Linden Centre, Christopher unit and Kingswood sites would have the biggest impact on the collective average

Focused improvement effort on domains of ‘Disability’ and ‘Dementia Friendly’ at 439 Ipswich Road, Saffron Walden, the Christopher unit and Edward house should be implemented ahead of 2025 visits

General Recommendations

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

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

Notable improvements:

1. Signage is generally more visible and clear
2. Sites being more accommodating of PLACE visits going ahead with less refusal of assessments upon arrival

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

1. Increasing the available parking where possible, markings, access, and disabled spots too
2. Focussed effort to improve dementia and disability domains

Domain Performance

Domain 1: Cleanliness

Brockfield house

Landermere Ward

Thurrock

Kingswood

The Linden Centre

Christopher Unit

Domain 2: Food & Hydration

1

Kingswood, Landermere, Rawreth court, Robin Pinto, Byron Court, (100%)

2

St Margaret's

3

Thurrock community hospital

1

The Christopher unit

2

Woodlea

3

Derwent Centre

Domain 3: Privacy, Dignity, Wellbeing

Clifton Lodge & Basildon

Brockfield

St Margaret's

Robin Pinto

439 Ipswich Road

Christopher unit

Domain 4: Condition, Appearance & Maintenance

Saffron Walden

Rochford

Basildon

Christopher unit

Linden Centre

Kingswood Centre

Domain 5: Dementia Friendly

Clifton Lodge

Landermere

Woodlea

Kingswood

439 Ipswich Road

The linden Centre

Domain 6: Disabilities & Access

Clifton Lodge

Rochford

Basildon

The Linden Centre

439 Ipswich Road

Kingswood

Visits Data & Insights

Brockfield House

Site Description: Forensic Low Secure Inpatient Service | Care Unit: Specialist Services

2023 Summary

- **Brockfield received full scores for Cleanliness, Privacy Dignity and Wellbeing and Maintenance.**
- Patient Assessors noted how spacious ward environments were at Brockfield and commented on the availability of modern facilities such as video games and basketball courts.
- Patient Assessors noted the availability of fresh fruit and water as positive and encouraging
- Patient Assessors recognised the availability access to outside areas and commented that the gardens and outside courtyards were wheelchair friendly. Those with accessibility requirements could still make full use of the outdoor spaces.

Lagoon, Alpine, Fuji, Forest, Dune, Causeway and Aurora ward were visited on the 24th of October 2024

- **2024 Summary**
- **Brockfield did not receive full scores for any of the PLACE domains**
- Large well maintained building with good security.
- Three of the wards (Forest, Dune and Causeway) benefited from a refurb in 2023 and the refurbishment included replacement doors and door frames, replacement flooring and skirting boards in all rooms, CCTV along corridors and general painting and decorating. Fuji ward was due to go under refurbishment in the following weeks from the PLACE visit
- All wards were very clean and all rooms were well ventilated by large windows along with benefiting from lots of natural light. Oxeheath camera system fitted in every bedroom. Each ward had its own outdoor space. Outside gym equipment available but not used often.
- Really well spaced communal areas such as such lounge/TV area, dining rooms, laundry and kitchens and well documented notices on cupboards, fridges, washing machine and dryers.
- Brockfield house benefits from its own in-house (indoor) gym and sports hall consisting of a badminton court, basketball nets and moveable goal posts.
- Brockfield house has maintained it's overall assessment rating from 2023, 2024 patient assessors were **very confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service improved from 2023, moving from acceptable to good

Improvements from last year

- Replaced doors and door frames, replaced flooring and skirting boards in all rooms, CCTV has been placed along corridors and general painting and decorating has been improved. Point of interest and use of bright colours were visible to patient assessors
- No loose accessible TV wires were observed; ligature risk has been minimised
- Food assessment score improved from acceptable to good

Recommendations for 2025

- To ensure gardens are well maintained and free from weeds and litter
- The outdoor sports area (used for outdoor football) was not so well maintained due to moss and cracks in the ground. The ground is in need of resurfacing as currently this area is a wasted space.

Brockfield House

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	86.67%	100.00%	99.60%	97.62%	98.85%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.83%	88.57%	99.34%	99.60%	97.22%	95.24%

2024

Brockfield house was rated the second highest performer across EPUT for cleanliness, disability, condition appearance and maintenance, privacy dignity and wellbeing and joint second highest for food.

Brockfield house marginally decreased in scores across all domains from the previous PLACE inspection (2023) apart from condition, appearance and maintenance.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Byron Court

Site Description: Learning Disability Inpatient Service | Care Unit: Specialist Services

2023 Summary

- Residents at Byron Court have their main hot meal at lunchtime and light dinner, as this was agreed in a forum and works well for the residents. The use of regular forums at the site to include patients in decisions such as which types of meals are served when was noted by assessors as an effective way of obtaining active feedback from patients.
- Patient assessors noted Byron court as functional but very "tired looking"
- Food was rated highly for this site and patient assessors noted the availability of fresh fruit for patients
- Unfortunately, Byron court received the lowest assessment scores in how well the environment accommodates for those with dementia and disability and access needs
- Byron court has maintained it's overall assessment rating as **2023 patient assessors were confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service was rated as Good

2024 summary

- Byron court has improved it's overall assessment rating from 2023 as patient assessors were **very confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service rating was maintained as Good
- Very impressed with the cleanliness of the place, it felt staff really care and invest a lot of energy in the place.
- Not all taps have been marked blue and red for temperature
- Seclusion room toilet look out thorough window that is half frosted to an external CCTV within eye line, patients have reported that this gives the suspicion of being watched.
- Curved security mirrors are very clean but could have a sign to reassure that its only mirror and not camera, as one would feel uncomfortable using the toilet with the mirror which may be mistaken for camera.
- Seclusion room doesn't have camera fitted. And it was cold compared the rest of the building.

Improvements from last year

- An increase in overall assessment rating; patient assessors were **very confident** that a good level of patient care and experience would be delivered within the environment
- No visible stains on toilet basins were noted
- Hedges have been trimmed back in the garden area

Recommendations for 2025

- Water urn in the patient coffee/tea area seemed a little high, concern of hot water scolding staff and patient
- Fit camera in the seclusion room
- Reposition garden lighting lower so ground can be illuminated
- Replace extractor fan in public toilet
- Increase temperature of seclusion room
- Ensure all taps are marked red or and blue

Byron Court

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
94.02%	100.00%	90.48%	89.17%	54.41%	65.12%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.86%	100.00%	95.45%	95.00%	97.14%	92.86%

Byron court received significantly low scores for Disability and Dementia both within the context of the organisation and compared to EPUT's comparatives in 2023.

In 2024, Byron court was EPUT's most improved site with maintenance in food ratings and significant increases in scores across all other domains

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

The Crystal Centre

Site Description: Acute Adult inpatient Services. Older Adult Inpatient Services. Forensic Low Secure | Care Units: Inpatient and Urgent Care, and, Specialist Services

2023 Summary

- The Crystal centre received full scores for access, social spaces and condition and appearance of external areas
- Patient Assessors reported positive feedback fro the amount of natural light on the wards and the areas of interest on the ward.
- The Garden of Ruby ward was noted as "beautiful" and assessors welcomed the edition of the new flooring throughout Topaz.
- All access scores were passed i.e. are there single sex toilets available with at least one big enough for a wheelchair and is there space for patient family members to visit.
- 2023 patient assessors were **confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service was rated as **Good**

The Crystal Centre was visited on the 9th of October 2024

2024 Summary

- The ward assessment rating has decreased since last year; patient assessors **were not very confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service was rated as Good
- Patient assessors did not feel the ward promoted a welcoming feel due to lack of colour, feeling very clinical, and not having enough art work in the wards.

Improvements from last year

- Signage is more visible on the lead up to the site
- Windows were noted as free from bird mess and cobwebs

Recommendations for 2025

- Ensure all handrails are painted a different colour to the walls
- Promote more colour in the wards with less of a clinical feel
- Some of the walls were noted as dirty and or marked
- Improve cleanliness of ward social spaces
- Improve condition and appearance of building by ensuring any surface damage to walls is repaired ahead of the 2025 PLACE assessment

The Crystal Centre

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
98.71%	98.81%	98.31%	95.11%	95.16%	94.83%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
94.33%	96.67%	98.36%	92.93%	96.79%	93.75%

2024

Slight increases for both Privacy, dignity and wellbeing and dementia were recorded for this years assessment. Areas of improvement for the most impact on overall scores should be cleanliness and condition, appearance and maintenance for next years inspection

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Edward House

2023 Summary

- Edward house was noted as appearing modern, with good signage around the building
- Patients were enjoying time in the garden during the visit and commented to patient assessors how valued the garden space is
- Non slip, non reflective floors meet NHS standard
- 2023 patient assessors **were confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service was rated as **Good**

Edward house was visited on the 9th of October 2024

2024 Summary

- The 2023 scored were maintained; Patient assessors **were confident** that a good level of patient care and experience would be delivered within the environment.
- The overall meal service was also maintained and rated as **Good**
- Brighter colour is needed in all patient facing areas
- Building was reported as feeling dull and too clinical
- Sign on approach looks unsteady

Improvements from last year

- Walls were not noted as dirty

Recommendations for 2025

- Ensure hot and cold taps are distinctly coloured red and blue
- Inspect installation of all signs
- Patients would like an indoor exercise space with exercise bikes or yoga mats

Edward House

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.94%	94.74%	100.00%	94.57%	86.21%	91.11%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
94.33%	96.67%	98.36%	92.93%	96.79%	93.75%

2024

Edward House improved it's ratings in food, dementia and disability from the 2023 assessments. However, decreases in score were noted across food, privacy , dignity and wellbeing and the condition appearance and maintenance domains.

Areas of improvement for the most impact on overall scores should be cleanliness and condition, appearance and maintenance for next years inspection

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Christopher unit

Site Description: Adult Inpatient Services, Psychiatric Intensive Care Unit | Care Unit: Inpatient and Urgent Care

2023 Summary

- The Christopher unit has maintained it's overall assessment rating as 2023 patient assessors **were confident** that a good level of patient care and experience would be delivered within the environment.
- It was welcomed by patient assessors that flooring was Non slippery and matt . This is an improvement from 2022.
- The cleanliness of toilers and bathrooms were an improvement from 2022
- The Christopher unit did not receive full passes on the maintenance and appearance of the building, the tidiness of the building, or surfaces being free from trip hazards.
- Hand sanitisers were empty upon arrival which appeared to create an immediate negative impression for patient assessors
- The overall meal service was rated as **acceptable**

The Christopher unit was visited on the 1st of October 2024

2024 Summary

- The worst site rating; patient assessors were **not at all confident** that a good level of patient care and experience could be delivered within the environment
- The overall meal service maintained its rating as **acceptable**
- Flooring creates squeaking noises
- Environment feels too clinical

Improvements from last year

- Patient assessors were able to sanitise their hands

Recommendations for 2025

- Include more diversity on the food menus
- Explore installation of dimmer switches for rooms
- WiFi is intermittenet and not reliable
- Keep grounds free from trip hazards or where hazards are unavoidable ensure they are clearly marked
- Secure loose ceiling tiles observed in communal areas
- Ensure surfaces are well dusted
- Fit plastic mirrors that were on order at time of visit
- Ensure all stairs have high visibility nosing on treds and risers
- Use colour more effectively to enhance patient orientation i.e. on doors and frames
- Ensure all slopes are clearly marked

Christopher unit

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
92.31%	76.92%	93.02%	88.33%	62.50%	71.79%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
90.60%	72.06%	86.36%	83.33%	80.00%	82.50%

2024

Patient Assessors felt there was a dull, clinical “prison like” feel to the unit. Assessors advised for more points of interest to be added to the walls and to ensure colour can be used more effectively to enhance patient orientation. Assessors did not find the unit easy to find and found the amount of cigarette butts on the pavements gave a negative perception of care.

The subjectivity in assessors is particularly apparent for this assessment as although scores for the dementia and disability domains improved during 2024, the overall assessment rating was still lower than the previous year.

The Christopher unit decreased in cleanliness, food, privacy dignity and wellbeing and condition, appearance and maintenance domains

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

The Linden Centre

Site Description: Adult Inpatient Services, Psychiatric Intensive Care Unit | Care Unit: Inpatient and Urgent Care

2023 Summary

- The Linden Centre has maintained it's 2022 assessment rating as 2023 patient assessors were confident that a good level of patient care and experience would be delivered within the environment**.**
- Patient Assessors were pleased that all flooring was matt, non slippery and non reflective
- Patient Assessors noted the contribution of patient artwork on the walls as decorative and promoting positivity
- Not all rooms have en suites which is wanted by the patients
- The overall meal service was rated as **Good**

The Linden centre was visited on the 1st of October 2024. The assessment scores are reflected from visits on Finchingifeld, Galleywood and Rainbow ward.

2024 Summary

- Patient Assessors rated the different wards within the centre as follows: Rainbow very confident , Finch not very confident , Galley not very confident.
- Decreases in overall ratings are therefore noted for Finch and Galley from 2023 (Rainbow not visited last year)
- The use of colour and non clinical feel in rainbow ward was welcomed by assessors
- Finch and Galley look tired, with patients visibly bored or distressed.
- Staff were vocal in Finch about needing new equipment in the laundry room due to smell

Improvements from last year

- There were no trip hazards in front of fire exits

Recommendations for 2025

- Ensure ambulance bay parking lines are repainted so they are clear
- Ensure entrance doors have high contrast markings on the glass
- Ensure all stairs have high visibility nosing on treds and risers
- Improve sensory room space and understanding of what it is to be used for in Galleywood
- Improve laundry room in finch by fixing equipment (replacing if needed) and installing air vent.
- Display date and time in Finch and Galley
- Install dimmer switches for patient bedrooms
- Repaint ward walls
- Improve cleanliness of toilets

The Linden Centre

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
92.31%	76.92%	93.02%	88.33%	62.50%	71.79%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
90.60%	72.06%	86.36%	83.33%	80.00%	82.50%

2024

Patient Assessors felt there was a dull, clinical “prison like” feel to the linden centre. Finchingfield and Galleywood decreased in their overall assessment rating from 2023 and staff were vocal in Finchingfield that the environment does not aid therapeutic recovery.

The external areas to the site immediately create a bad impression with kerbs not being marked, pathways being too narrow to fit a wheelchair through and skips being placed in car parking bays. During the round table discussion to provide assessment ratings, it was the lead up to site and immediate external areas that created a negative perception of care which patient assessors did not find easy to let dictate overall judgement from the beginning.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Clifton Lodge

Site Description: Dementia Care Home| Care Unit: Specialist Services

2023 Summary

- Patient Assessors were impressed with the welcoming appearance of Clifton Lodge. The bench and flower pots at the front of the building was a noted as a nice feature, however loose paving slabs were noted, and the ambulance bay should be repainted as is currently difficult to see
- Clifton lodge maintained the overall 2022 assessment rating as 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Clifton lodge was the top performer in EPUT for PLACE assessments 2022. In 2023, Clifton Lodge have not scored highly enough to be included in the top 3 performing sites across the trust.
- Clifton lodge scored full marks for Privacy dignity and wellbeing
- The floors had not yet been replaced which was highlighted action from the 2022 assessments.
- The overall meal service was rated as **Good**

Clifton Lodge was visited on the 31st of October 2024

2024 Summary

- The overall meal service was maintained as Good
- Wall displays and bedroom with front doors were greatly endorsed by patient assessors
- Corridors having street names was described as a “fantastic touch” by patient assessors as was having patient likes and dis-likes displayed on patient doors
- Bedrooms were reported as very homely
- Thank you cards being available to read at reception was welcomed by patient assessors
- Cleaning scores from CQC were on display which assessors welcomed
- Readily available information or family throughout the site; which gave a feeling of “real connection with community with having friends of the ward”

Improvements from last year

- No trip hazards were noted

Recommendations for 2025

- Improve tile grouting
- Curtain track in the snug rooms need repainting
- Main dining room plugs need cleaning
- Ensure there is no litter or fox mess around the external building
- Repaint ambulance and general parking bays
- Handrails should be painted a brighter colour for those with visual impairments

Clifton lodge

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.84%	78.57%	97.67%	93.33%	90.15%	88.46%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.86%	97.22%	100.00%	95.83%	100.00%	96.61%

2024

Patient assessors are continually impressed, year on year with the personalisation and homely touches included within the environment in Clifton Lodge.

Clifton lodge is the only EPUT site to receive improved ratings across all domains in 2024.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

The Lakes

Site Description: Acute Adult inpatient Service| Care Unit: Inpatient and Urgent Care

2023 Summary

- Patients were vocal when assessors entered the ward and were keen to share their feelings that the environment is worn, dated and insufficient for their needs
- The lakes has received a significant drop in overall assessment score as patient assessors felt **not very confident** that a good level of patient care and experience will be delivered in the environment. It should be noted that the patients in the lakes at the time of the visit were the most keen to participate in the visit out of all other sites.
- The lakes scored full markings for hand hygiene and equipment cleanliness, privacy dignity and wellbeing and the availability of social spaces
- Internal decoration was noted as acceptable but an area which could be improved with more colour
- The overall meal service was rated as **acceptable** .

The Lakes were visited on the 24th of October 2024

2024 Summary

- Patient ratings for both the ward, and food assessment increased from last year.
- Patient assessors welcomed the input of the ward manager ahead of the visit to explain the ward was particularly volatile on the day of visit

Improvements from 2023

- Overall assessment rating increased from not very confident to confident
- Patients have understanding of where to keep their personal belongings and how to request access

Recommendations

- There remains an opportunity for colour to be used more effectively to enhance patients orientation / coordination e.g. doors and bays painted in a different colour.
- A fire exit in the female ward was not wheelchair accessible

The Lakes

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
93.04%	78.95%	96.72%	94.57%	75.00%	82.05%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.94%	94.29%	96.23%	93.68%	81.48%	84.21%

2024

Significant improvements across the majority of domains were notes for the 2024 inspection. Slight decreases in assessment score were noted for privacy, dignity and wellbeing and condition appearance and maintenance.

Patient assessors explained the lack of car parking accounted for lower ratings of condition and appearance.

One of the highest increases in score across all EPUT sites was recorded for the quality of food at the Lakes.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Kingswood Centre

Site Description: Dementia Care Home | Care Unit: Specialist Services

2023 summary

- Patient assessors viewed on-site indoor and outdoor facilities dedicated for purpose of physical activities and commented these were in good condition and looked attractive, encouraging patients to take part in different activities.
- The lakes has received a significant drop in overall assessment score as patient assessors felt not very confident that a good level of patient care and experience will be delivered in the environment.
- Patient assessors felt the interior of the building was dated, ripped flooring was noted as a safety risk and dirtied toilet paper was littered on bathroom floors. Patient assessors were concerned at the lack of ensuites
- Bathroom on Hennage ward was out of order at time of visit
- A good amount of natural in the bathrooms was observed
- The Kingswood Centre scored full markings for hand hygiene and the availability of social spaces
- The overall meal service was rated as acceptable

The Kingswood Centre was visited on the 24th of October 2024. Assessment scores are based on visits to Peterbruff, and Hennage ward

2024 Summary

- Patient assessors were appalled at the state of Kingswood parking as not even ambulances could reach the site
- Unfortunately, Kingswood has maintained its overall assessment score as patient assessors felt **not very confident** that a good level of patient care and experience will be delivered in the environment. It is worth noting that assessors were clear that this was almost entirely down to the car park
- Estate officer made clear that wards are being refurbed in near future so a lot of building work and general maintenance was underway
- General storage problem in that there is a real lack of space for patients to place their things
- Patient assessors felt the corridors were very dark

Improvements

- Colour of doors and frames had been painted to ensure they were easier to distinguish
- Improvement works were clearly underway at the time of visit
- Points of interest had increased
-

Recommendations

- Re-design car park to staff only
- Re-paint road markings
- Shade contraption in the one of the gardens that is rusting away and needs removing
- Ensure bins are labelled

The Kingswood Centre

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
92.53%	91.89%	98.39%	83.15%	81.03%	84.44%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
87.37%	100.00%	84.38%	83.15%	66.67%	67.44%

2024

Patient assessors asked it be noted that the "inexcusable" state of the car park largely influenced assessment ratings.

Significant drops in ratings were recorded for both dementia and disability domains although food ratings increased.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

The Derwent Centre

Site Description: Acute Adult inpatient Service | Care Unit: Inpatient and Urgent Care

2023 Summary

Sufficient seating in reception.
The Derwent Centre remained the highest rated site across EPUT as 2023 patient assessors concluded that they felt **very confident** that a good level of patient care and experience will be delivered within the environment
ssessors were pleased to see cleaning scores on display
Car parking remained very limited at the Derwent Centre
The Derwent Centre received full marks available for hand hygiene, equipment cleanliness, privacy and dignity and wellbeing and ward social spaces
The overall meal service was rated as **Good**

The Derwent Centre was visited on the 28th of September 2024. Assessment scores are based on visits to Chelmer and Stort wards

2024 Summary

- The Derwent centre received the largest drop in assessment rating for food across all EPUT sites. The overall meal service was rated as **very poor**. This was based on the taste and texture of food items receiving 0/2 points such as the strawberry trifle, the chicken mayo sandwich and the tuna sandwich.
- A decrease in overall assessment score was received from patient assessors feeling very confident that a **good** level of care and experience would be received in 2023 to confident in 2024.
- A contrast between the two wards was noted by assessors; Stort ward coridoors were reported as uninviting with nothing to draw the eyes to. Whereas Chelmer appeared to have a warm feel and the space was immediately visible as very clean.
- Stort had a phone room for patients, but was used more for storage instead. In Chelmer ward the rooms were more inviting and smelt cleaner, with phone room ready to use.
- Laundry room had individual room's storage labelled and stored neatly.
- Patient assessors felt stort ward entrance seemed uninviting, felt narrow and nothing much to look at the walls.
- Chelmer ward, appeared warm welcoming. Assessors noted a nice smell upon entry which alluded to good cleanliness

Improvements

- Windows were cleaner
- Marks on walls had been repaired

Recommendations

- Ensure toilets are not stained
- Ensure floors are kept clean; linen cupboard floor was noted as particularly dirty during 2024 assessment
- Chelmer ward to replicate cleanliness practice of Stort ward
- Replace car park barrier and buzzer to reception as both are broken
- Improve car parking facilities; currently very difficult for staff and visitors to find a parking space without using nearby street parking or PAH general hospital parking

The Derwent Centre

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	93.12%	88.48%	98.72%	100.00%	99.46%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
94.85%	80.00%	95.31%	88.71%	90.91%	89.36%

2024

Improving the external areas of the Derwent centre would have the most impact on assessment ratings.

The Derwent Centre improved in privacy, dignity and wellbeing ratings, however worsened across all other domains. The decrease in disability score is highly likely due to lack of pavement space for wheelchair users in the car park and surrounding paths. If cleanliness practices from Chelmer ward were to be replicated with Stort ward this would also increase overall score.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Rawreth Court

Site Description: Dementia Care Home| Care Unit: Specialist Services

2023 Summary

- Rawreth Court was among the lowest rated for food and hydration in 2022, and has improved into the highest rated within this area in 2023.
- Patient Assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- The patient assessors were also particularly impressed with the signs above the resident's doors which stated "please show courtesy and knock before entering"
- Grounds were noted as very clean
- Good security measures when allowing unfamiliar staff on to site
- The overall meal service was rated as **Good**
- Patients bedrooms doors look like a stained-glass street door with their photo outside and what the patients interest and likes are – very personal and looks like a home
- Dayroom very bright and light

Rawreth court was visited on the 31st of October 2024

2024 Summary

- Rawreth court improved it's overall assessment rating from 2023; as Patient Assessors concluded that they felt **very confident** that a good level of patient care and experience will be delivered within the environment.
- The improved food rating was maintained for the 2024 assessment as **good.**
- Staff were welcoming upon entering the site and adequate seating for patients was noted.
- All parts of the building were signposted well and the thank you cards at reception were observed by patient assessors as a "nice touch".
- Digital clocks with "night" and "day" time presented was welcomed among patient assessors
- Homely, non clinical feel
- Obvious availability and promotion of OT activities creates confidence in level of care provided

Improvements

- Mirrors are clean
- General cleanliness has improved

Recommendations

- Add option to season food
- Ensure any incontinence accidents are dealt with swiftly to avoid lingering smell of urination
- Replace washing machine

Rawreth court

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.15%	100.00%	92.11%	91.67%	86.67%	86.00%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
98.26%	100.00%	92.86%	96.67%	97.22%	93.22%

2024

Rawreth court is EPUTs second most improved site for PLACE 2024 with improvements received in scores across all domains other than food.

Food remained the highest rating of “good” and “100%”.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Robin Pinto

Site Description: Forensic Low Secure Inpatient Service | Care Unit: Specialist Services

2023 Summary

- Patient assessors commented that there was sufficient signage which helped navigate the building as they clearly identified all important/regularly used parts of the building, e.g. wards, outpatients areas etc.
- Robin Pinto has remained it's assessment scoring this year as 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- All toilet doors were consistent and toilet seats, taps and flush handles were in a colour that contrasted with the bathroom walls and door.
- Robin Pinto received full scores for privacy, dignity and wellbeing, hand hygiene and equipment cleanliness and ward social spaces
- The overall meal service was rated as **Good**

Robin Pinto was visited on the 6th of November 2024

2024 Summary

- The overall meal service was rated as **Good**
- Kitchen staff were very accommodating to needs of individual patient, it was observed that when a patient wanted more of one thing and less of the other it was no trouble for them.
- Robin Pinto has remained it's assessment scoring this year as 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Overcrowded car park gives the feeling of a "disorganised facility" many cars were observed as struggling to get out as they were blocked in. Ambulance parking had normal cars parked within their bays. There were some litter in the carpark, dead leaf present possibly due to the season. Sign to the building was hard to see from a distance.
- Car park was well lit with visible CCTV which promoted a feeling of safety among assessors
- Multi faith room observed as a space fit for purpose with availability of prayer mat made clear

Improvements

- Light in de-escalation room had been fixed

Recommendations

- Introduce more variety within Halal options of food
- Seclusion room needs to be brightened with either lights or paint
- Include more points of interest on the walls
- Consider parking provision for visitors; friends and family
- Employ receptionist
- Include more points of interest

Robin Pinto

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
95.30%	98.81%	97.56%	93.33%	80.00%	82.86%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
93.16%	100.00%	83.72%	90.83%	90.28%	86.05%

2024

Improvements to the external areas would have the most significant impact on improving Robin Pintos scores.
At the time of the inspection a receptionist was not present and assessors were informed this is the sites usual practice. Having an individual to meet people coming on to site was also noted by assessors as something that would help improve ratings.

Improvements in Disability, Dementia and food domains were received.

Privacy dignity and wellbeing had the most significant drop in scores. This could be improved by ensuring private rooms for patients to have conversations with staff and lockers in which to store personal belongings are obviously highlighted and easy to locate.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance out assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Rochford Community Hospital

Site Description: Acute Adult Inpatient Services| Care Unit: Inpatient and Urgent Care | Specialist services

2023 summary

Patient assessors noted facilities for carers and families to access meals and snacks within the building at all times of day and night

Rochford maintained its assessment rating from last year as 2023 patient assessors concluded that **they felt confident** that a good level of patient care and experience will be delivered within the environment for all wards visited except Willow. Assessors were **not very confident that a good level of patient care and experience will be delivered in Willow** due to the amount of concerning circumstances such as slippers being used as doorstops and disabled bathrooms being used as store rooms.

Poplar ward was highly praised for the amount of natural light, welcoming space, modern equipment and bright colours.

Sufficient signage which helped navigate the building as they clearly identified all important/regularly used parts of the building, e.g. wards, outpatients areas etc

The overall meal service was rated as **good**

Rochford was visited on the 24th of September 2024. Assessment scores are based on visits to Willow, Beech, Cedar and Poplar ward

2024 Summary

- The overall meal service was rated as **good**; all food available was hot, with plenty of variety and generous portions.
- This year, Willow ward increased its overall rating so that; patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within each ward environment.
- Hospital grounds well maintained and litter free. Lots of trees, seating benches and reasonably sized free-parking carpark.
- Site was well signed and the main reception entrance was easy to find.
- There was a good size a multi faith room for anyone to use on request.
- All four wards were clean, with good facilities, nicely decorated and displayed colourful artwork along the corridors.
- Cedar, Willow and Poplar all rooms had on-suites and oxhealth. The education Centre was a excellent addition for the adolescent with good facilities, including a small gym.
- Outside spaces benefitted from good usable space and CCTV.

Improvements

- No makeshift door stops in use at time of visit
- No handwritten signs on doors as opposed to correctly laminated in use at time of visit
- Bathrooms appeared correctly used

Recommendations

- Staff to consider what could be implemented to create less of a clinical feel to wards and social spaces

Rochford Community Hospital

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
93.17%	76.19%	92.31%	93.55%	78.23%	80.00%

2024

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.71%	88.89%	97.96%	99.36%	98.30%	95.00%

Improvements across all domains were recorded for Rochford from 2023 to 2024; this is largely due to the obvious effort to reassign storage space in Willow ward.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Saffron Walden

Site Description: Inpatient Older Adult| Care Unit: Inpatient and Urgent Care

2023 summary

- Avocet ward maintained last years overall assessment rating score; 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Although clean and appropriate for use, patient assessors felt colour could be used more effectively throughout the ward and a less “clinical” feel should be promoted
- Garden was considered too exposed and easy for public to access
- The clocks on the ward were not silent, this is something requested by NHS england.
- Avocet ward was rated the second lowest in the organisation for Privacy, dignity and wellbeing. This is largely due to the bay bed spaces and lack of ensuite toilets available for each patient
- The overall meal service was rated as **good**

Avocet Ward was visited on the 12th of November 2024

2024 Summary

- The overall meal service was rated as **good**
- Avocet ward maintained last years overall assessment rating score; 2024 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Information for patients and visitors easy to access
- Multi-faith room could do with more visuals to represent multi-faiths

Improvements

- Build up of moss visible on garden furniture was not observed

Recommendations

- Dust vending machine
- Replace anti trapping device on second set of entrance doors
- Fasten handrails
- Clean walls

Saffron Walden

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	85.71%	88.64%	95.00%	85.09%	81.25%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.15%	87.50%	91.11%	100.00%	74.14%	70.37%

2024

There are variations in assessment ratings from last years PLACE assessment to the most recent.

Cleanliness marginally decreased in assessment rating as did dementia and disability. To improve upon the dementia and disability domains would have the most impact on the overall assessment score. Improvements to these domains could be done by ensuring all signs are a fixed height that makes viewing easy, the correct date and time is displayed in all patient areas and all slopes are clearly marked.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

439 Ipswich Road

Site Description: Adult Inpatient| Care Unit: Inpatient and Urgent Care

2023 Summary

- 439 has maintained it's homely feel which was welcomed once again by patient assessors
- 439 has maintained it's overall assessment rating. 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment
- 439 was one of the only EPUT sites to receive full scores on all cleanliness, condition and appearance domains
- 439 Received full scores for ward spaces, hand hygiene and equipment cleanliness and privacy dignity and wellbeing

439 Ipswich Road was visited on the 24th of October 2024

2024 Summary

- 439 has maintained it's overall assessment rating. 2023 patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment
- Environment praised for it's homely feel
- Garden area had been improved with more security added around the area

Improvements

- General signage had improved
- More points of interest had been added with brightly coloured wallpaper
- The garden area was more secure
- The garden area has been cleaned with notable improvements to encourage use

Recommendations

- Consider if a multi faith prayer space can be created
- Remove mould from the shower
- Clean windows
- Could free street parking locations be shared with visitors and families of patients due to limited on site space

439 Ipswich Road

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.44%	N/A	93.18%	91.67%	67.86%	71.43%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.15%	N/A	83.72%	98.33%	64.29%	61.54%

2024

As all patients are entirely self-catering consideration should be made as to whether 439 should be included in 2025 inspections as a food assessment cannot take place.

The age of the building makes the dementia and disability domains are rated consistently low; improvements to the flooring was noted this year as was areas of interest. Lift installation is not possible in this building and the lack of car parking means scores across these domains have not improved, however it is worth noting patient assessors were incredibly grateful their feedback for signage and the garden area had been acted upon and improved from the year prior.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

St Aubyn's Centre

Site Description: Children and Young People Inpatients| Care Unit: Specialist Services

2023 Summary

Assessors were impressed with the range of equipment appropriate to patient age. The blackboard walls were a point of particular interest among the assessors as they noted these appeared valued by the patients and were an effective way of engagement.

The St Aubyns Centre has increased their overall assessment score rating from last year as 2023 patient assessors concluded that they felt very confident that a good level of patient care and experience will be delivered within the environment.

Patient assessors praised the site for how bright, airy and well maintained the wards were.

Classroom spaces were noted as modern and completely appropriate for use

The overall meal service was rated as Good

The St Aubyns Centre was visited on the 24th of October 2024

2024 Summary

- St Aubyns improvement in cleanliness has meant the site is included within EPUTs top 3 sites for cleanliness this year.
- The overall meal service was rated as **Good**
- Patient assessors felt **confident** that a good level of patient care and experience will be delivered within the environment.

Improvements

- "The street" appears to be utilised more
- Focused work to improve standard of multi faith space was underway

Recommendations

- Improve signage on lead up to site to ensure it is easier to locate
- Implement additional storage for patient belongings
- Include more points of interest near bedrooms

St Aubyn's Centre

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	92.68%	98.44%	98.91%	96.88%	95.24%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
98.97%	95.12%	91.94%	94.57%	97.92%	91.85%

2024

The classroom space was viewed as part of the PLACE assessments in 2023 which visibly impressed patient assessors. This year, due to a clash of timetables the space cold not be visited. Arguably if the classroom space had have been observed as part of the 2024 visit the overall rating may have maintained it's assessment as "very confident".

There was a slight decrease across all domains for the st Aubyn Centre in 2024 aside from dementia which improved. Ensuring obvious space is highlighted and improved for patients to store their belongings would have a positive impact on privacy, dignity and wellbeing which would help increase overall score.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Thurrock Community Hospital

Site Description: Older Adult and Adult Inpatient| Care Unit: Inpatient and Urgent Care

2023 Summary

The outdoor seating in the secure spaces outside were noted as appropriate for use and all surfaces were level, firm and free from trip hazards.
Wheelchairs were available within the reception area and there were systems in place which supported patients with hearing and visual impairments including a hearing loop.
Thurrock maintained receiving the highest assessment score rating in 2023 and patient assessors concluded that they felt **very confident** that a good level of patient care and experience will be delivered within the environment.
Social spaces, Hand Hygiene and equipment cleanliness, Dementia- Friendly environment and Access all received full marks.
Thurrock was rated first within the organisation for food **tasting (Good)**

Thurrock was visited on the 23rd of October 2024. Assessment ratings are based on visits to Gloucester and Meadowview

2024 Summary

- Thurrock maintained their rating with patient assessors feeling **very confident** that a good level of patient care and experience will be delivered within the environment.
- Thurrock also maintained their **good** food rating
- Wash basin had clear temperature controls
- Lots of information, such as timetable for activities, carer's information was on display.
- Tea coffee machine in the reception with very welcoming seating spaces for visitors.
- The wards smell nice and clean, bath, shower, toilets are clean and fresh
- Bedrooms were clean and tidy with plenty of room with natural lights via big windows.
- Halloween decorations were welcomed by patient assessors as a nice touch
- Chairs were comfortable and there was plenty of points of interest on the walls.

Improvements

- Red and blue markings on taps to ensure temperature controls are as clear as possible have been repainted
- Loose bricks on external building have been fixed

Recommendations

- Improve directions for pedestrians around external site
- Deep clean glass doors
- Ensure whiteboards with date displayed are updated first thing in the morning

Thurrock Community Hospital

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.23%	98.81%	96.55%	98.37%	98.42%	95.65%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
98.71%	96.43%	93.44%	96.74%	94.64%	90.75%

2024

Thurrock received slightly lower scores across all domains compared to the previous year. Improving accessibility of the external areas would have the most impact on improving scores for 2025.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Landermere

Site Description: Older Adult and Adult Inpatient| Care Unit: Specialist services

2023 Summary

- Landermere received the lowest scores in the organisation for a number of areas including: Cleanliness, Privacy dignity and wellbeing, Dementia, Disability and condition appearance and maintenance
- Landermere received the overall lowest rating for PLACE assessments 2023
- Patient Assessors were **confident** that a good level of patient care and experience will be delivered within the environment but wanted to make it clear that this was **based on the interactions they observed between patients and staff rather than the environment. Therefore, this assessment rating is not necessarily reliable for PLACE**
- Patient Assessors did not feel the rooms and social and communal areas were decorated appropriately. Very bland and dated
- Patient Meal service was rated as **Acceptable**

Landermere was visited on the 15th of October 2024

2024 Summary

- Patient assessors were immediately impressed with the improvements to the external site
- Patient Meal service rating increased from acceptable to **good**
- Patient Assessors were **very confident** that a good level of patient care and experience will be delivered within the environment which is an increase in overall assessment rating from last year
- Moved from one of the least clean last year, to one of the highest scoring sites for cleanliness this year
- Although PLACE is not based on assessing clinical care, patient assessors again wanted it noted that the passion and dedication of staff in this ward in particular is impossible not to mention. Staff are welcoming, patients are clearly happy and there is a very homely, comforting feel to the ward and the care provided there.

Improvements

- Outside netting which was trapping birds has been removed
- The menu; Increased and adapted food option for patient demographic and need
- Car parking although remains limited, bays have been repainted and new outdoor lights have been installed

Recommendations

- Repaint the colour of the handrails as red is proving triggering for patients
- Utilise Dementia-Friendly environment assessment to form an action list of things to improve in site
- Replace flooring
- Toilet rail in end of life room is loose
- Repaint handrails in a different colour

Landermere

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
87.61%	95.24%	86.05%	70.83%	50.00%	54.55%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.15%	100.00%	93.18%	98.33%	98.61%	94.92%

2024

Clacton is our most improved site this year with increases in score up to 96% across dementia and disability domains.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

Basildon

Site Description: Acute Adult inpatient Service| Care Unit: Inpatient and Urgent Care

2023 Summary

2nd overall top performer in the organisation
Received 3rd highest assessment scores for food and hydration
Received 2nd highest assessment scores for privacy dignity and wellbeing
Received highest assessment scores for disabilities and access in the organisation
Patient Assessors were very confident that a good level of patient care and experience will be delivered within the environment
The overall patient meal service was rated as good
Basildon received full scores for cleanliness, hand hygiene and equipment cleanliness, access, maintenance and ward social spaces
Basildon was visited on the 26th of September 2024. The assessment scoring is based on visits to the urgent care department, Cherrydown, Kelvedon, Hadleigh, MH UCD and Grangewater

2024 Summary

- Overall rating has slightly decreased for Basildon 2024; Patient Assessors were **confident** that a good level of patient care and experience will be delivered within the environment
- The meal service rating has been maintained; The patient meal service was rated as **good**
- Hospital grounds well maintained and litter free.
- The main reception entrance was a large space and the site well signed posted to navigate around.
- There is a good size a multi faith room for anyone to use on request.
- All wards were clean, with good facilities, nicely decorated and displayed colourful artwork along the corridors. All rooms had on-suites and oxhealth. Hadleigh ward (males) benefited from a games room with a PlayStation, table tennis and pool table.
- Each ward had access to good outside spaces which had basketball nets, herb garden, seating and CCTV.

Recommendations

- The only criticism of Basildon was that parking is very limited

Basildon

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	98.89%	100.00%	99.47%	97.50%	98.57%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
99.76%	91.43%	100.00%	99.47%	97.56%	94.92%

2024

There a minimal differences in all domain ratings for this year compared to last, apart from food. In 2024, food was rated significantly lower than last year. If scores for the beef casserole, wholegrain rice, and vegetable jalfrzei had have been higher, this difference would not be as stark.

Basildon is encouraged to focus on improving car parking facilities and consistency of food in order to improve ratings next year.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

WoodLea

Site Description: services for People with Learning Disabilities - Low Secure Services

2023 Summary

- Patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Woodlea passed all social space domains, cleanliness condition and appearance and hand hygiene and equipment cleanliness
- Assessors found Woodlea difficult to find with signs obstructed by trees and parked vehicles
- A food assessment was not completed at Woodlea

Woodlea was visited on the 7th of November 2024

2024 Summary

- Well-kept ground, no leaves on ground, hedges were tidy.
- Look of the building didn't appear clinical which patient assessors welcomed.
- Patient Assessors were **very confident** that a good level of patient care and experience will be delivered within the environment
- The seclusion room has a calm feeling about it, very clean,
- Good garden space.
- Quality of facilities was good

Improvements

- Food was available so an assessment could take place
- The patient meal service was rated as good

Recommendations

- Improve signage. Patient Assessors did not feel signs helped navigate the building grounds
- Ensure wheelchair access is not blocked throughout external site
- Ensure signs are not obstructed
- Replace faulty washing machine
- Pool table is unsteady

Woodlea

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
100.00%	N/A	97.50%	98.33%	92.31%	89.47%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
98.29%	78.05%	97.67%	97.50%	98.57%	86.05%

2024

Patient assessors were particularly impressed by the tidiness of Woodlea clinic. Improving the external site i.e. clearly marking speed bumps and car parking spaces would have the most impact on improving scores for next year.

The most improved domain for the most recent inspection was the dementia domain. Dementia is assessed on things such as flooring being matt and non slippery, a silent clock being in place and door frames being painted a different colour to doors.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

St Margarets

Site Description: Older Adult and Adult Inpatient| Care Unit: Urgent care and Inpatient | West Essex Community

2023 summary
Patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
Assessors particularly welcomed the “don’t be bored board” in the TV room in Kitwood
Bedrooms were praised for no touch taps and bright and airy feel
Laundry and dining rooms were noted as clean and tidy
External buildings were noted as being litter free
Communal garden encouraged use by tidy appearance
The overall food service was rated as **Good**

St Margarets was visited on the 19th of November 2024.
2024 Summary
- The building was noted as easy to find and assessors welcomed the free and available parking
- Maintained 2023 assessment rating; Patient assessors concluded that they felt **confident** that a good level of patient care and experience will be delivered within the environment.
- Maintained 2023 assessment rating; The overall food service was rated as **Good**
- Assessors were greeted by staff, and a Doctor who invited feedback and questions, patient assessors explained this gave them confidence that staff are open and transparent, and added trust.
- Clean professional look to all the wards.
- Pictures and names of staff including chaplain, doctors, cleaners and facilities staff, very impressed with the attention to details.

Improvements
- No blocked fire exits were observed during the visit
- Ceiling tiles had been replaced
- Coat hooks had been relaced
- No trip hazards were observed

Recommendations
- Clear lime scale off showerheads
- High surfaces were dusty
- Improve in bed TV positioning so all patients can watch
- Multi faith room should be redesigned to present more faiths

St Margarets

2023

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.76%	92.86%	100.00%	97.09%	97.69%	98.06%

2024

Cleanliness	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
97.53%	97.22%	98.25%	97.34%	90.71%	87.70%

2024

St Margaret's received the highest external site recording throughout the organisation.

Food rating increased for St Margaret's this year, however all other domains declined in assessment rating. The most notable decline was for the disability domain (11%). Disability is assessed on things such as access to hand rails, visibility of access to hearing loops, spaces large enough to accommodate wheelchairs and access to grab rails in toilets. It is worth noting that not all disability requirements are permitted in mental health settings due to ligature risk.

It should be noted that individual patient assessors are rarely the same individuals taking part on the same site visits year on year, therefore although there is assurance our assessment process is robust and auditable, there is a degree of subjectivity which should be taken into consideration when examining annual scores for yearly comparison.

DOCUMENT END

Essex Partnership University NHS Foundation Trust

Capital Projects for 2025/2026

The below capital strategic projects have been approved as part of the Trust's Capital Plan for 2025/2026:

Project	Budget Allocation Inc. VAT	Scope of Works
The Lakes ECT Refurbishment	£986,000	Full refurbishment of existing unit with design changes to assist patient experience. In addition, this will aid the Trust maintaining the services accreditation.
Landermere Centre - Tower Ward Dementia Friendly Improvements	£700,000	Works will be undertaken to improve the environment for patients with dementia including new flooring, signage, new hand rails, artwork, new lighting, wrapping of doors, new furniture and decoration.
CAMHS Seclusion Room Upgrades and Improvement Works	£100,000	To upgrade the seclusion suite to current patient safety standards including installation of resin to walls and improved observation into the suite.
Basildon Mental Health Unit Kitchen Environmental Improvements	£350,000	To refurbish the patient kitchen including new flooring, new lighting and redecoration.
The Lakes Bedroom Door Replacement to Anti-barricade Door Installation	£200,000	Doors were purchased in March 2025.The funding is for the installation of the doors which are expected to be delivered end of June 2025.
Clinical Trials Accommodation Project - Wheelchair Centre, Thurrock	£100,000	A refurbishment project of the old wheelchair centre at Thurrock Hospital will allow the Clinical Trials & Research Team have a dedicated unit.
Basildon MHU Medical Records Project	£100,000	To refurbish large open plan space within Langdon Unit including installation of new ceiling grid, lighting, flooring, and redecoration.
Taylor Centre Furniture Replacement Programme	£50,000	Funding will be utilised to replace old/not fit for purpose furniture

The Trust also submitted a number of bids to Mid & South ICB & Collaborative in April 2025 and the below projects were approved subject to Programme of Works Bid forms to be completed:

Project	Budget Allocation Inc. VAT	Scope of Works
Mental Health ED Diversion - Emerald Unit – Kingswood Centre – Colchester General Hospital	£3,000,000	Refurbishment of a large area within the Emerald Unit at Kingswood Centre will provide a fit-for-purpose alternative to Emergency Department ('ED') for mental health patients in crisis without medical need
Mental Health ED Diversion - Derwent Centre	£2,000,000	Refurbishment of the existing Mental Health Recovery Unit at Derwent Centre will provide a fit-for-purpose alternative to Emergency Department ('ED') for mental health patients in crisis without medical need.
Weymarks - Step Down Facilities Project	£700,000	Refurbishment of four EPUT owned properties in the community, to be utilised by Essex County Council and MH Step Down beds, to support transition of patients from acute mental health beds back into a community setting.
Edward House Seclusion Room and Sensory Room Upgrade	£300,000	To upgrade the seclusion suite to current patient safety standards including installation of shower, resin to walls and improved observation. In addition, work will be undertaken to provide patients with a new sensory room.
Learning Disabilities Crisis House	£300,000	To provide a Crisis House for the Learning Disabilities Service which offers short term support for patients within a residential setting and who do not require hospital admission, but are unable to be on their own or return to their usual home environment.
Outpatient Rooms – Chelmsford & Essex Centre	£200,000	The funding will support the creation of 2 new outpatient rooms within an open plan office area.

Lounge/Dining room at Byron Court

What changes did we make?

- Replaced the dining tables
- Replaced dining chairs
- Replaced some of the sofas
- Replaced the flooring
- Moved the TV cabinet and create an additional seating space
- We replaced the outer door to the garden (far end)

How was our service users/carers involved?

- Information of incoming changes were discussed with the service users and carers
- Plans were shared ahead of works going ahead
- This was done with the support of the Speech and Language Therapist

Next Steps

- Replacing all the older sofas

Lounge area on Byron Court

What changes did we make?

- We have moved the TV cabinet to define the spaces better
- We have added a wall mural to enhance the astatic to create a calm space for service users

How was our service users/carers involved?

- The service users choose the wall mural
- This was done with the support of the Speech and Language Therapist

Next Steps

Add non reflective film to the TV cabinet

Dining area on Byron Court

What changes did we make?

- We have replaced the dining table
- We have replaced the dining chairs

How was our service users/carers involved?

- The service users choose the colour of the dining table and chairs
- This was done with the support of the Speech and Language Therapist

Next Steps

Add display boards for service users activities

No 3 Heath Close

What changes did we make?

- Widened the front door to improve disabled access
- Widened the corridors for improved disabled access to the waiting room and consultation room
- Repositioned the disabled toilet to improve access
- Replaced the flooring to improve ascetics

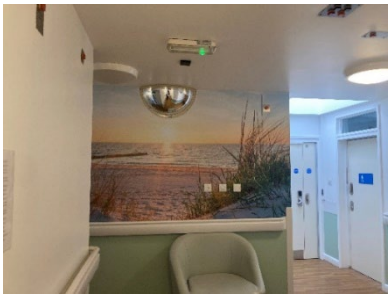
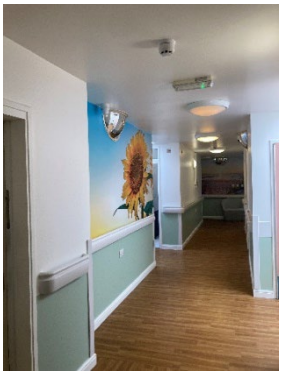
How was our service users/carers involved?

- The service users and carers were informed of the changes and reported positive experiences after the changes was made

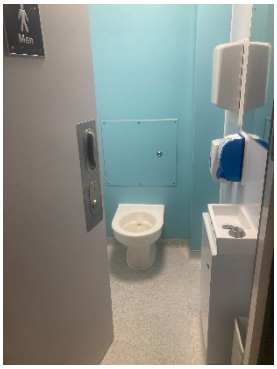
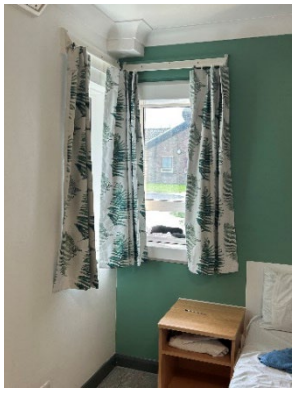
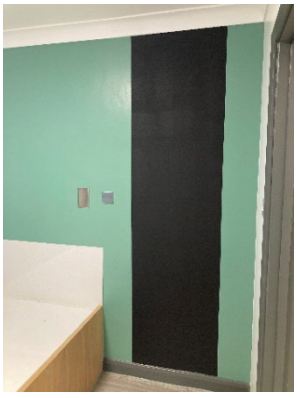
Next Steps

Replace all flooring in the downstairs area to improve uniformity

Photographs of Completed Areas

   	New art work on Henneage Ward- images were selected by Project Manager and Clinical Team with input from Patients
	New patient beverage bay on Henneage Ward allowing patients to make their own hot and cold drinks.

 	New bespoke wardrobes and bedside tables in all bedrooms on Henneage
	Newly painted corridor at the Lakes. Dark grey architraves give a contrast between doors and existing flooring

  	Bathrooms and shower rooms at The Lakes, The Kingswood Centre and The Linden Centre were refurbished.
	Galleywood and Finchingfield had new flooring to the corridors and painting
 	New curtains and a chalk board in all of the bedrooms on Peter Bruff, and at the Lakes.

 	2 Visitors rooms were created from the original visitor's room, which allows both wards to have patient visiting at the same time.
	The dining room at The Linden Centre was decorated with new flooring and furniture and a fire shutter to the kitchen along with air-conditioning.
	Activity Rooms on both Galleywood and Finchingfield were redecorated with artwork and additional new storage.

7.3 CQC ASSURANCE REPORT

Information Item AS 10

REFERENCES

Only PDFs are attached

CQC Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality Committee 15 May 2025					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	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	✓
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
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.	NA	
Describe what measures will you use to monitor mitigation of the risk	NA	

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. 2. An update and escalations as required on progress made against the Trust CQC improvement plan. 3. Internal Assurance against the CQC Quality Statements.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- The Trust has now received the Final Report following the CQC inspection at Brockfield House undertaken in March 2024. The service retained its 'GOOD' rating.
- The Trust received the Final Report following the CQC unannounced Inspection at Clifton Lodge Nursing Home in January 2025. The service was rerated to good across all domains.
- The Trust awaits the CQC report following the unannounced focussed inspection for the Safe and Well Led domains on our Adult Acute and Psychiatric Intensive Care Unit (PICU) Services in November / December 2024.
- 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 96% of actions reported completed by action owners and 77% having been agreed for closure through the Evidence Assurance Process.
- 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**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EAG	Evidence Assurance Group
ICB	Integrated Care Board	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Services		

Supporting Reports/ Appendices /or further reading

- CQC Assurance Report
- Appendix 1 - CQC Compliance Spotlight Report 22 May 2025

Lead

Ann Sheridan
Executive Chief Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Assurance Report

1. Purpose of the report

This report provides the Board of Directors with:

- An update on CQC related activities that are being undertaken within the Trust.
- An update and escalations as required on progress made against the Trust CQC action plan.
- Internal assurance of CQC Quality Statements.

2. CQC Registration Requirements

2.1. Registration

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

2.2. Registration changes

Registered the change of EPUT Chairman.

3. CQC Inspections and Improvement Plans

3.1. Unannounced CQC Inspection

3.1.1. Forensic Inpatient/Secure Wards – Brockfield House

In March 2025, the CQC issued the draft report for factual accuracy and published the final report on the 25 April 2025. The service has maintained its rating of 'GOOD', meaning that it is performing well and meeting the CQC's expectations.

3.1.2. Adult Acute and PICU services

The Trust awaits the CQC draft report following the unannounced focussed inspection for the Safe and Well Led domains on our Adult Acute and PICU Services in November / December 2024.

3.1.3. Clifton Lodge

An unannounced inspection was undertaken at Clifton Lodge Nursing Home on the 9th January 2025 and published the final report in February 2025. The service has an improved rating of 'GOOD' meaning that the unit has made improvements, is performing well and meeting the CQC's expectations.

3.2. CQC Improvement Plan

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

As at 22 May 25:

- 75 (96%) of the Must do / Should do actions have been reported as completed by action owners. Of these, 60 (77%) have been closed following review at the Evidence Assurance process.
- 344 sub-actions complete
- 2 sub-actions past timescale (Nb. Associated with 2 overall actions) weekly monitoring is in place.

During the reporting period, the EAG meetings were held on the 26th March, 9th April, 23rd April and 21st May. These were chaired by EPUT Executive Nurse with ICB representatives, EPUT operational and corporate staff in attendance. In total, 10 actions and their relevant evidence, were discussed and approved for closure.

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

3.3. CQC Enquiries

During the period the CQC raised one (1) enquiry:

Received	Service	Enquiry Related to
18/03/2025	Gloucester Ward, Thurrock	Clinical Practice - Medication

3.4. CQC Notifications

During the reporting period the Trust has made thirty two (32) notification submissions to the CQC including:

- Death of a detained MH patient (2),
- Death of a person using the service (1),
- Allegations of abuse (13),
- Serious injury to a person using the service (16).

4. Annual Programme 2024-25

4.1. Internal Assurance

At the end of April 2025, the Trust is reporting 'Good' compliance across all the five domains. This means that a good level of assurance has been provided by core services during Compliance visits. Identified good practice has been shared with services and care unit leadership via the service reports.

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

4.2. Quality Assurance Visits

The Quality Assurance Visits have continued during the reporting period.

5. Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report

2. Note the assurance on progress against the improvement plan

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Ann Sheridan
Executive Nurse

CQC Compliance Spotlight Report

22 May 2025

Introduction

Essex Partnership University NHS Foundation Trust

The purpose of this report is to provide an update on key CQC compliance requirements including implementation and assurance status against those actions within the CQC improvement plan which are past the original stated timeline and have a recovery plan in place.

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)

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 22nd May 2025) associated with CQC activity.

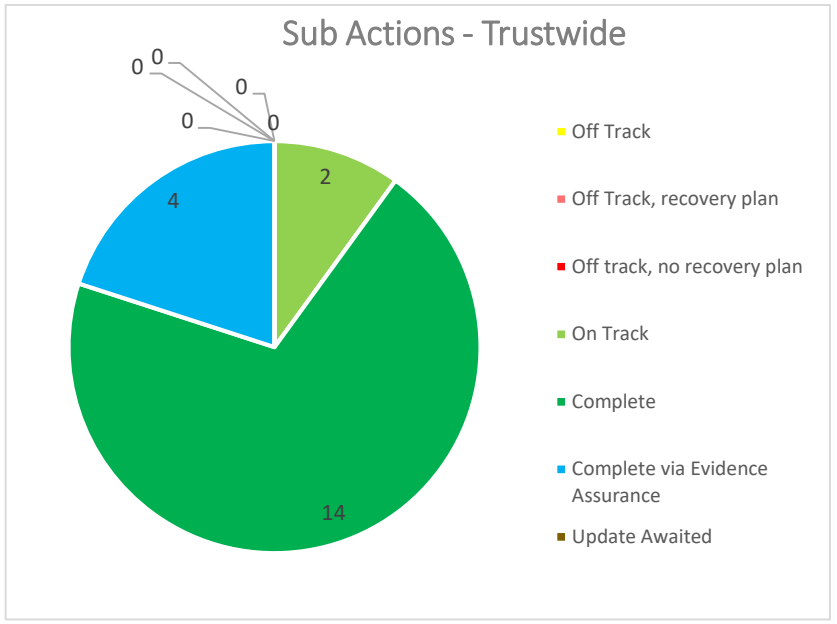
Overview as of the 22nd May 2025:

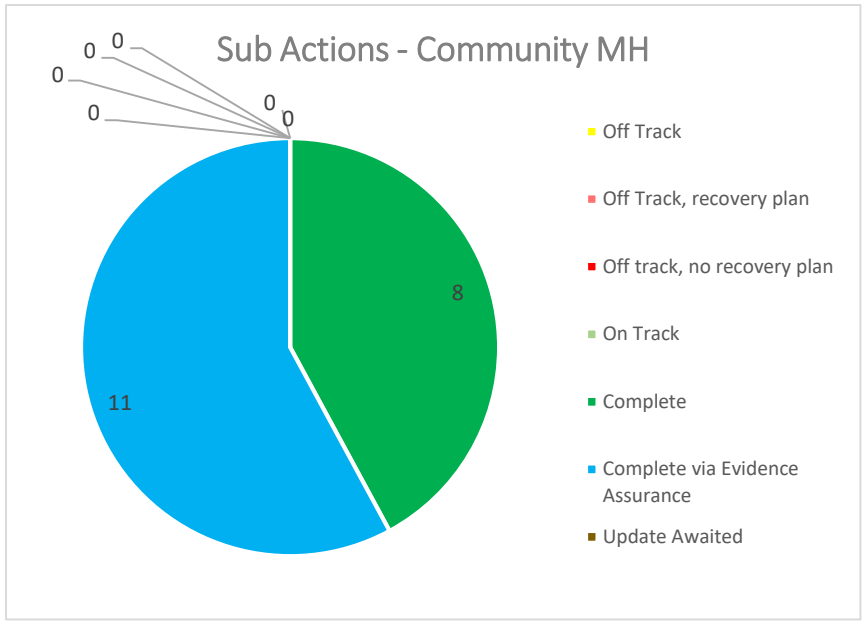
- 75 (96%) of the Must do / Should do actions have been completed.
- 60 (77%) have been closed through the evidence assurance process
- 344 sub-actions complete

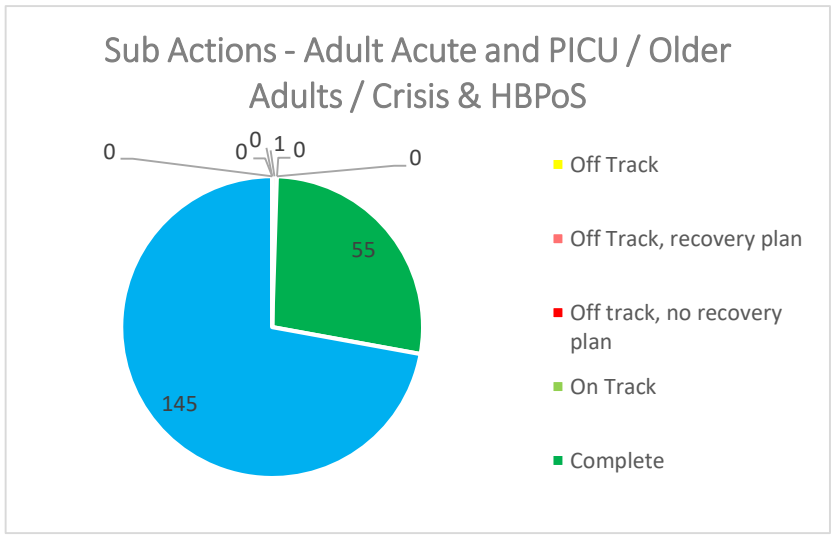
2 sub-actions past timescale as at 22nd May 2025. (Associated with 2 overall actions status) recovery plans are in place.

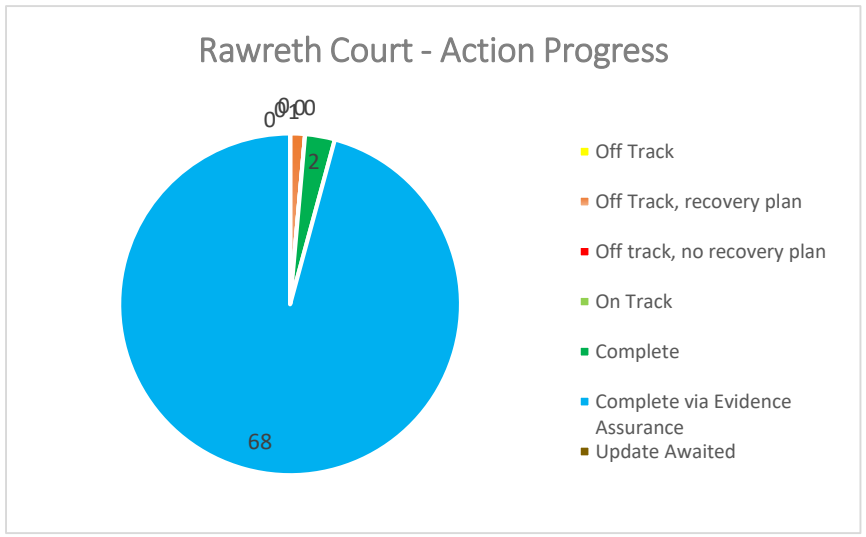
The CQC Action Leads meeting continues to hold action owners to account for delivery. The meeting is chaired by the Senior Director of Corporate Governance and attended by Executive Chief Nurse and Executive Chief Operating Officer.

CQC Action Sit Rep









Sit Rep as at 22nd May 25

- 78 Must do / Should do actions and 348 Sub-Actions identified
- 75 (96%) of the Must do / Should do actions have been completed
- 60 (77%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group
- 15 (19%) have been closed and require evidence to be presented for assurance
  - 8 Must Do
  - 7 Should Do
- 2 sub-actions past timescale (Associated with 2 overall actions status) recovery plans are in place

Please note all actions for LD services have been closed.

CQC Action Recovery Plan

Action Recovery Plan				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
RC10: Queries – Nursing Home admission criteria	RC10.3: To review home admission criteria	Review underway. Requires wider discussion with ICB partners	Meeting held with ICB. Service Specification and CQC Registration to be reviewed. Identify impact prior to any changes being made **Weekly touchpoint to review**	Tendai Ruwona
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.	The CCTV software procurement decision has been escalated to Director of Estates for a decision. The Trust is currently evaluating software that will enable remote access for downloading CCTV footage. It is in the final stages of discussions with Estates, Operations, and Digital to assign ownership of CCTV management to Operations for future downloading. This initiative aims to streamline the process, significantly reducing the time required to respond to requests compared to the existing system. Once the software is approved and implemented, training will be provided to designated staff members through Operations to ensure compliance with Trust policies for downloading footage. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona

CQC Evidence Assurance Sign off Timeline

Actions with Evidence Assurance sign off to date	Actions Awaiting Evidence Assurance	Actions On track	Actions In Recovery
60	15 (8 Must Do Action / 7 Should Do Action)	1 (March 26)	2

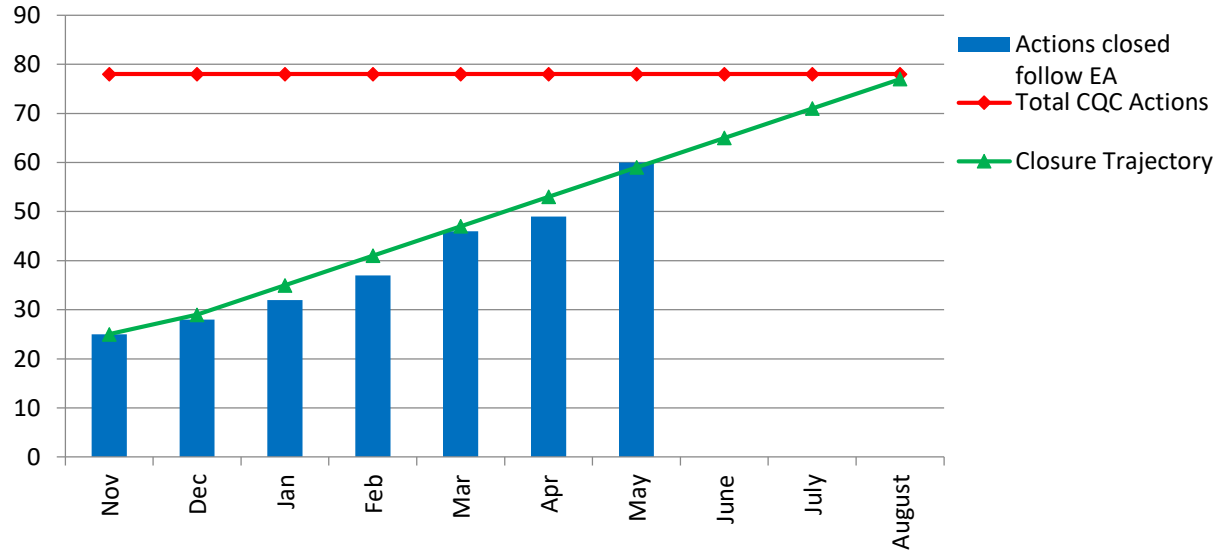
A trajectory has been set to monitor actions being taken forward for EAG sign off.

Previously reported slippage against the trajectory has been recovered and increased focus is remaining with the aim to move ahead of trajectory.

At the target rate all actions will have been through EAG by September 2025.

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 outcomes is currently awaited for 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.



7.4 SAFER STAFFING REPORT FOR INPATIENT NURSING (BI-ANNUAL)

Decision Item | AS | 5

REFERENCES

Only PDFs are attached

Safer Staffing Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Safer Staffing Report for Inpatient Nursing (Bi-Annual)**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Angela Wade, Director of Nursing and DIPC and Charlotte Hoctor Head of Clinical Education and Safer Staffing					
Report discussed previously at:	Quality Committee 15 May 2025					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability	✓	
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance	✓	
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides assurance on staffing levels through an analysis for the period of the review (July 2024 – March 2025).	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the contents of the report
- Confirm acceptance and assurance given in respect of safer staffing regulations and standards

Summary of Key Issues

Safer Staffing reports are statutory arising from the National Quality Board (NQB 2016) expectations on ensuring safe, sustainable, and productive staffing - the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021) assessed as part of CQC 'safe' and 'well-led' domain. Reporting staffing levels assist local Trust Board decision making in ensuring the right staff, with the right skills, are in the right place at the right time.

Having the right nurse staffing levels is fundamental to providing safe and high-quality patient care, as well as creating a positive working environment for our staff.

This report provides assurance on staffing levels through an analysis for the period of the review (July 2024 - March 2025).

Work across the organisation, to ensure there is appropriate oversight of safer staffing levels, has two key components:

- The identification of minimum staffing levels for each inpatient ward on a bi-annual basis based on the Mental Health Optimum Staffing Tool (MHOST) alongside a review of professional judgement and quality measures
- The monitoring of HealthRoster and SafeCare performance reports on Care Hours Per Patient Day (CHPPD) staff/patient ratios and % staff utilisation with appropriate oversight, scrutiny, and actions against staffing utilisation

Recruitment to nursing vacancies continues through appointments of newly registered nurses through local universities and via TRAC vacancy management. The internationally educated recruitment programme concluded in the spring of 2024. Since the previous reporting period, there has been a reduction in the number of Registered General Nurses within our inpatient establishments, due to turnover and recruitment into alternative roles.

For March 2025, total vacancy rates were 19.7% for inpatient and urgent care and 22.1% for specialist care units (Source: IPR 4.3.1 Vacancy Rate as of 01.05.25) against a target ≤ 12%. However, vacancies are covered in the majority of cases by Trust bank staff. As Time to Care posts are recruited to, this vacancy rate will decrease. Total sickness rates are 6.2% for both inpatient & urgent care and for specialist services (Source: IPR 4.5.1 Sickness Absence as at 01.05.25) against a target of ≤5 %.

Our % staff utilisation show periods over 100%. This can be attributed to changes in acuity of patients presenting conditions that have been assessed by ward managers, with matron professional judgement oversight for additional staff to ensure their care needs are met. There are structured processes in place to provide oversight and assurance within the care units SitRep twice daily calls chaired by clinical service managers, who also risk mitigate when actual fill rates fall below 90%.

Care units are continuing to focus on reducing reliance on the temporary workforce following the introduction of the new staffing model and senior leadership oversight and scrutiny (as shown in Appendix 1).

As a Trust, we are now working with NHS England's Safer Staffing Lead to support our leadership, assurance and approach to ensuring the right staff, with the right skills, are in the right place at the right time, and this support will continue in 2025.

From May 2025, the Director of Nursing and Deputy Director of Quality and Safety for Inpatient and Urgent Care will be working with the National Safer Staffing Faculty and Shelford Group to review and update the Mental Health Optimal Staffing Tool (MHOST) on behalf of 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**	

Acronyms/Terms Used in the Report			
CHPPD	Care Hours Per Patient Day	TTC	Time To Care
MHOST	Mental Health Optimum Staffing Tool	WTE	Whole Time Equivalent

Supporting Reports/ Appendices /or further reading
Safer Staffing Report for Inpatient Nursing Appendix 1: Governance Arrangements for Operational Oversight of Deployment of Staff 2025/26

Lead
Ann Sheridan **Ann Sheridan** **Executive Nurse**

Safer Staffing Report for Inpatient Nursing

1. Executive Summary

Safer staffing reports are statutory arising from the National Quality Board (NQB 2016) expectations on ensuring safe, sustainable, and productive staffing - the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021) assessed as part of CQC 'safe' and 'well-led' domain. Reporting staffing levels assist local Trust Board decision making in ensuring the right staff, with the right skills, are in the right place at the right time.

Having the right nurse staffing levels is fundamental to providing safe and high-quality patient care, as well as creating a positive working environment for our staff.

This report provides assurance on staffing levels through an analysis for the period of the review (July-2024 - March 2025).

Work across the organisation, to ensure there is appropriate oversight of safer staffing levels, has two key components:

i) The identification of minimum staffing levels for each inpatient ward on a bi-annual basis based on the Mental Health Optimum Staffing Tool (MHOST) alongside a review of professional judgement and quality measures.

ii) The monitoring of Health Roster and SafeCare Performance reports on Care Hours Per Patient Day (CHPPD) staff/patient ratios and % staff utilisation with appropriate oversight, scrutiny, and actions against staffing utilisation.

Recruitment to nursing vacancies continues through appointments of newly registered nurses through local universities and via TRAC vacancy management. The internationally educated recruitment programme concluded in the spring of 2024. Since the previous reporting period, there has been a reduction in the number of Registered General Nurses (RGN) within our inpatient establishments due to turnover and recruitment into alternative roles.

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From May 2025, the Director of Nursing and Deputy Director of Quality and Safety for Inpatient and Urgent Care will be working with the National Safer Staffing Faculty and Shelford Group to review and update the Mental Health Optimal Staffing Tool (MHOST) on behalf of the Trust.

2. Introduction and Background

This report offers a bi-annual update to the Trust Board on safer staffing in inpatient ward nursing services.

To support and monitor our ward establishment reviews, the Trust continues to use evidence-based tools:

- Mental Health Optimal Staffing Tool (MHOST) to measure patient acuity and dependency, with quality indicators and professional judgement to determine optimal core staffing levels for our inpatient and specialist wards
- The Safer Nursing Care Tool (SNCT) for ward establishments for our community wards; this was rolled out in January 2025 and will include a review to work collaboratively with partner providers in MSE community collaborative (to be presented in the next bi-annual reporting period)

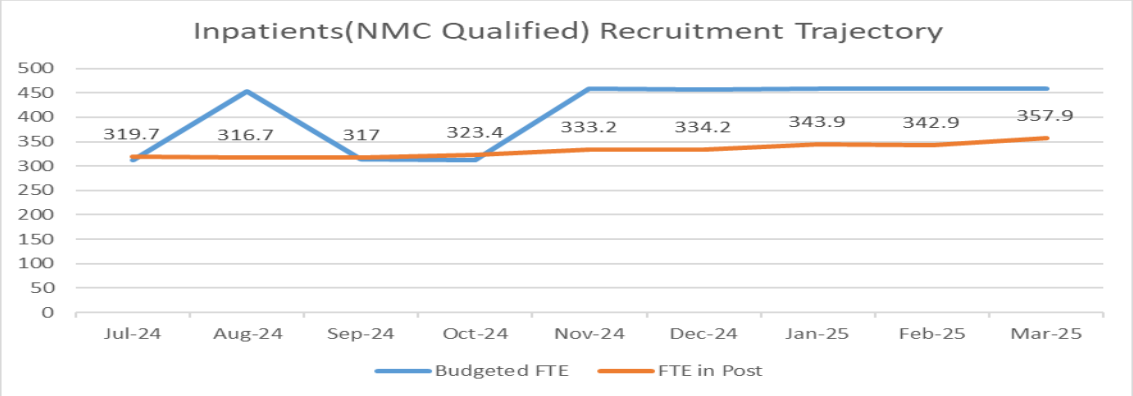
During the reporting period, the Trust continues to progress with the implementation of the Time to Care (TTC) programme. The overall objective is to release significant and quantifiable time to care on inpatient mental health wards through the delivery of the following four core components:

i. Staffing model redesign
ii. Process improvement
iii. Data and technology improvement
iv. Engagement and inclusivity

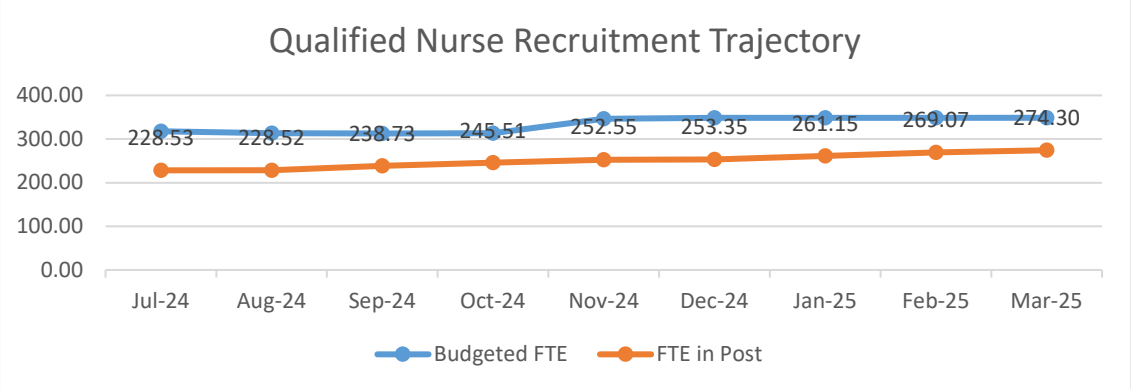
The charts below illustrate recruitment for registered nursing staff for inpatients and urgent care, and specialist services. The budgeted establishments have been adjusted to reflect the establishments agreed within the TTC programme during 2024/25.

The Trust's TTC Executive Steering Committee provides monthly oversight of recruitment trajectories for nursing appointments, with the operational HR Business Partner and Recruitment Team having local delivery responsibilities. The timeline for full recruitment is expected by the end of October 2025 to align with newly registered nurses graduating from university. This is however, a dynamic trajectory as other factors, such as natural turnover and targeted recruitment campaigns, may alter the expected completion timeline.

Mental Health Inpatient Registered Nursing 2024/25



Secure Services Registered Nursing 2024/25



(Source: HR Business Partner for Inpatient and Specialist Services as of end March 2025)

3. Safer Staffing Reports

This section provides insight into the systems and data used to monitor safe staffing for the Trust's inpatient services in the reporting period.

3.1 HealthRoster and SafeCare

EPUT continues to use HealthRoster and SafeCare which are modules within an electronic roster management system to support the effective, safe and equitable utilisation of staff and resources across the Trust. Enabling managers to effectively forward plan and roster staffing requirement by time of day, day of week and by skill level, ensuring that the 'right people, with the right skills, at the right time' are available.

3.2 Safer Staffing trends

For the Trust to be compliant with safe staffing reporting requirements, publication of staffing fill rates is required for all mental health inpatient wards. The Trust also monitor ratios of Registered Mental Health Nurse (RMN) to RGN within ward areas to ensure the professionally registered skill mix meets our patients' needs, and the quality of care is not compromised. Our minimum standards are that we have a RMN rostered for every shift, as well as the supernumerary ward manager, to lead quality care and staff support and development.

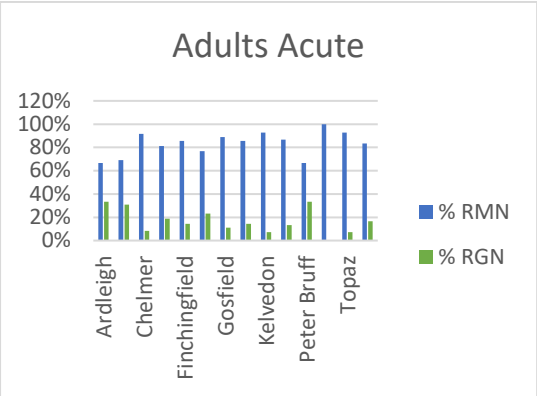
Table - Summary of HealthRoster and SafeCare Performance Care Hours Per Patient Day (CHPPD) staff/patient ratios and % staff utilisation end March 2025

Unit Name	Actual CHPPD	Required CHPPD	Actual Staff:Patient Ratio	Required Staff:Patient Ratio	Actual RN:Patient Ratio	% Utilisation
Mental Health In-Patient						
439 Ipswich road	7.76	7.14	1:3.07	1:3.36	1:8.76	92.08
Ardleigh	9.32	11.92	1:2.57	1:2.01	1:7.24	127.91
Beach	9.25	10.26	1:2.53	1:2.34	1:8.60	110.93
Cedar	9.15	8.12	1:2.61	1:2.96	1:7.06	88.72
Chelmer	8.88	10.61	1:2.70	1:2.26	1:6.84	119.49
Cherrydown	9.27	10.59	1:2.58	1:2.27	1:5.67	114.23
Christopher unit	27.33	32.85	1:0.86	1:0.73	1:2.82	120.19
Clifton Lodge	7.91	11.09	1:3.03	1:2.16	1:14.00	140.19
Finchingfield	10.06	7.85	1:2.37	1:3.06	1:6.32	78.07
Galleywood	8.52	8.95	1:2.82	1:2.68	1:8.00	105.02
Gloucester	8.86	8.87	1:2.71	1:2.71	1:9.09	100.14
Gosfield	17.47	10.78	1:1.26	1:2.23	1:3.29	61.72
Hadleigh	19.93	20.02	1:1.20	1:1.20	1:2.74	100.43
Henneage Ward	11.59	12.15	1:2.07	1:1.98	1:6.27	104.78
Kelvedon	9.39	9.58	1:2.56	1:2.50	1:6.29	102.09
Kitwood Ward	9.55	9.77	1:2.51	1:2.46	1:6.63	102.23
Meadowview	9.19	9.5	1:2.61	1:2.53	1:8.44	103.33
MH Assessment unit	15.91	15.65	1:1.51	1:1.53	1:4.08	98.39
PeterBruff	13.94	14.15	1:1.72	1:1.70	1:4.35	101.54
Rawreth Court	9.13	7.81	1:2.62	1:3.07	1:11.23	85.57
Roding Ward	10.56	7.75	1:2.26	1:3.10	1:5.22	73.42
Ruby	8.46	10.6	1:2.82	1:2.26	1:8.66	125.26
SE Willow Ward	11.63	15.4	1:2.04	1:1.56	1:6.54	132.37
Stort	10.5	10.96	1:2.27	1:2.19	1:5.69	104.33
Topaz	11.78	5.96	1:1.97	1:4.03	1:4.87	50.61
Tower Ward	19.29	16.96	1:1.24	1:1.41	1:4.49	87.95
Specialst In-Patient						
Alpine	12.15	11.2	1:1.98	1:2.14	1:6.47	92.19
Aurora	7.56	6.4	1:3.16	1:3.75	1:5.87	84.67
Byron Court	28.43	14.4	1:0.84	1:1.67	1:2.17	50.66
Cams I/P Poplar	18.94	19.86	1:1.26	1:1.21	1:3.46	104.84
Causeway	13.48	7.94	1:1.77	1:3.02	1:3.81	58.87
Dune	6.28	5.79	1:3.82	1:4.15	1:8.63	92.1
Edward House	9.14	7.4	1:2.63	1:3.24	1:5.56	80.95
Forest	7.53	8.37	1:3.19	1:2.87	1:7.27	111.13
Fuji	21.29	16.3	1:1.13	1:1.47	1:4.55	76.56
Lagoon	15.88	12.02	1:1.51	1:2.00	1:4.91	75.73
Larkwood	40.97	36.67	1:0.59	1:0.65	1:2.38	89.52
Longview	34.95	19.11	1:0.66	1:1.26	1:1.99	54.68
Rainbow Unit	34.52	16.83	1:0.66	1:1.43	1:1.60	48.76
Robin Pinto	6.21	6.13	1:3.85	1:3.91	1:8.74	98.81
Woodlea	14.71	13.32	1:1.64	1:1.80	1:3.65	90.52

(Source: HealthRoster and SafeCare Performance Report March 2025)

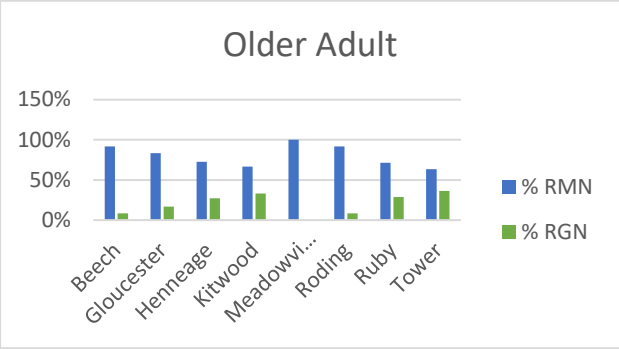
In order to continue to improve monitoring and oversight, the Trust will gain, from May 2025, greater reporting and analysis capabilities through the electronic rostering programme. These will be presented in the next bi-annual reporting period.

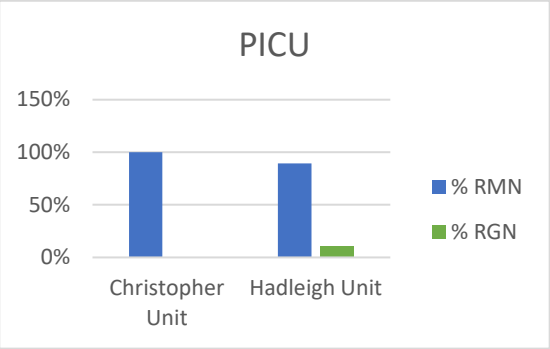
3.3 Skill Mix Ratio RMN/RGN at December 2024

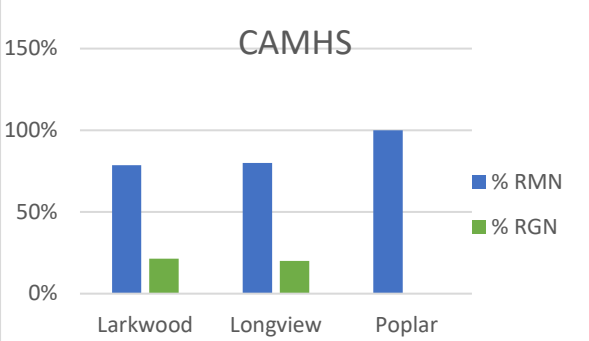


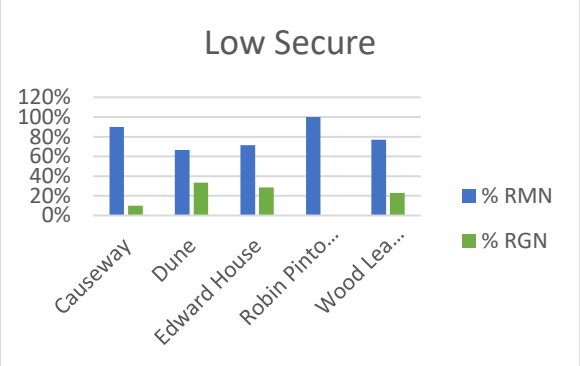
The skills and experiences of RGNs to the mental health wards benefits the holistic care of our patients in a mental health setting and is part of our Fundamentals of Care philosophy. Focussed work within our improving physical health quality priority draws upon the holistic approach of the multi-disciplinary team, and recognises the importance of person centred care. Therefore, upskilling our RMNs with physical health skills remains a priority into 2025/26.

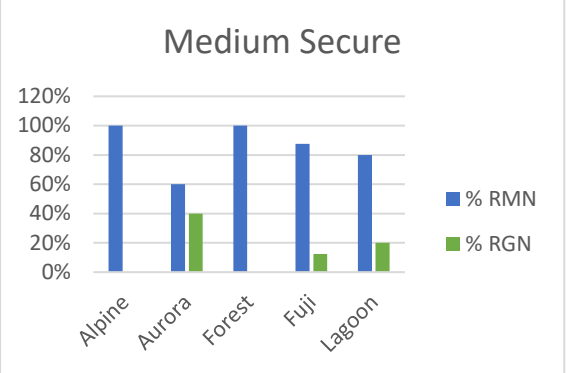
The skill mix ratios shown illustrate the breakdown of RMN and RGN across the mental health inpatient areas. Since the previous report, there has been a reduction from 111 to 70 RGNs in post.











(Source: HealthRoster as at December 2024)

The number of Registered Nurse Associates (RNA) continues to rise across inpatient wards and these roles have the opportunity to register onto 'top up' programmes to complete their nursing degrees. The RNA role impacts positively upon the quality of the care provided, as it holds a registration with the Nursing Midwifery Council (NMC) and can be included in shift rosters as a third registrant, noting their registered professional status has limitations to that of an RMN / RGN so cannot be given full autonomy as a registered nurse, such as taking charge of the shift.

4. MHOST Review of Ward Establishment Needs

4.1 Mental Health Optimal Staffing Tool

During the reporting period, EPUT continued to use MHOST to build accuracy and reliability in capture of acuity and dependency data, using an evidenced based calculation system of identifying patients according to acuity (how ill the patient is) or dependency (how dependent the patient is on care from the ward staff) to calculate CHPPD**.** Repeating the census during a different time of the year to capture seasonal variance.

This approach to establishment reviews applies the resulting CHPPD along with professional judgement and triangulation of quality data.

Professional judgement considers particular local workforce needs within wards to mitigate environmental factors, e.g. if garden areas and food serveries are not directly within the ward footprint. Additionally, if the ward area is geographically isolated, or if the number of beds is higher than national recommendations for the patient group. This requires consideration of additional staff to mitigate environmental factors by the Care Unit Leadership Team for Trust Board approval.

Quality indicators include information from experience sources such as I Want Great Care, complaints and staff concerns/feedback, as well as workforce instability such as vacancies, recruitment / retention or skills mix variance. Along with effectiveness data, such as flow and capacity, concerns including system delayed discharges or extended length of stay need to be taken into consideration. Triangulated with safety intelligence, including patient safety incidents, mortality data and staff harm. It is recommended that if the ward has quality indicator red flags, then the **Recommended MHOST headroom** be applied.

MHOST discussions with ward managers and matrons for each area provide local professional judgement and quality indicator considerations, and these are detailed in the MHOST results.

The results from the use of MHOST bi-annually, along with the review of staff usage across the previous year, are presented to the Trust Board to support recommendations for future workforce planning. It is important that two years of data is available to the Trust to support future workforce planning.

4.2 MHOST Results

The data collection exercises detailed the following:

- 38/38 of the eligible wards participated in MHOST and collected data across 3 weeks in November and December 2024

The tables below compare the current whole time equivalent (WTE) ward staff who work in core 24/7 care teams (registered nurses and unregistered health care assistants).

The tables below also reflect 2024 completed data and include the second MHOST data collection for 2024.

Columns B and C show the MHOST May and December census total WTE and the highest dependency data reported from the two collection periods are shown **in bold**. Column D provides a comparison with the total WTE from TTC establishments.

The data capture has included a 22% headroom.

Column E demonstrates the % ratio between the TTC establishments between registered and unregistered staff to deliver CHPPD needs against the MHOST recommended % ratio for the type of ward.

Columns F, G, and H detail the comparison for registered staff.

Column I shows the recommended headroom total WTE, if there are quality red flags and professional judgement considerations

4.2.1 Inpatient Mental Health Older Adult and Acute Wards
Older Adult Wards

A Ward	B MHOST guided total* WTE May 2024	C MHOST guided total *WTE Dec 2024	D 24/25 Time to Care total* WTE (22%)	E TTC Registered and Unregistered % ratio	F MHOST guided Registered WTE May (22%)	G MHOST guided Registered WTE Dec (22%)	H 24/25 Time to Care Registered WTE (22%)	I MHOST Guided total* with **Recommended headroom** WTE Dec (25.9%)
Beech	33.3	**44.1**	32.68	48% / 52%	15.65	**20.6**	15.71	44.6
Gloucester	**30.3**	17.9	30.14	52% / 48%	**14.21**	8.4	15.71	18.5
Hennage	**35.8**	32.4	27.73	57% / 43%	**16.83**	15.2	15.71	33.6
Kitwood	31.5	**33.7**	25.04	63% / 37%	14.81	**15.8**	15.71	34.8
Meadowview	**43.0**	26.0	35.48	44% / 56%	**20.21**	12.2	15.71	26.9
Roding	**18.8**	15.7	26.54	59% / 41%	**9.31**	7.3	15.71	16.2
Ruby	34.7	**35.4**	25.77	61% / 39%	16.31	**16.6**	15.71	36.6
Tower	**27.3**	14.4	26.44	59% / 41%	**12.83**	6.7	15.71	14.9

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **47% / 53%** for older adult wards and Recommended headroom WTE 25.9%)*

Professional judgement and quality indicators for consideration to WTE requirement – Older Adult:

Beech ward has the **highest bed base** in the Trust at 24 and reported high levels of acuity and dependency during the data collection periods relating to falls, personal care needs, and patients being cared for in the general hospital but requiring Beech staff to remain with them. Compared to the previous data collection, there is a notable increase in staffing requirements. This is also captured within the fill rates for the ward that remains consistently high. The ward received no complaints during the data collection and received written compliments for their quality of care.

Gloucester and Roding wards, during the data collection, **did not operate at full capacity** having empty beds during the census collection period. Additionally, the patients being cared for had **low acuity and dependency**, and this is reflected in the MHOST outcome. Both wards received no complaints but received written compliments.

Meadowview ward reported a lower MHOST outcome compared to the previous data collection demonstrating **lower acuity and dependency** with their patients. Additionally, the ward received a number of letters complimenting the care and no complaints.

Tower ward is an older adult organic ward that provides care to patients with both mental health and physical health needs. It also provides end of life care. It is a **standalone unit** and therefore additional support and cover not readily accessible. Compared to the previous audit, the ward also indicated a lower staffing requirement and this correlates with the **lower acuity and dependency** of the patient group at the time, and had **empty beds** at the time of census data collection.

Ruby, Hennage and Kitwood wards had a **high level of acuity and dependency** reported during the data collection periods, and are routinely caring for people with **physical health problems** as well as delivering end of life care and nasogastric tube feeding, reflected in the data. Additionally, Hennage received letters complimenting the care, and none of the wards received any complaints.

Acute Adults

A Ward	B MHOST guided total *WTE May 2024	C MHOST guided total*WTE Dec 2024	D 24/25 Time to Care total* WTE (22%)	E TTC Registered and Unregistered % ratio	F MHOST guided Registered WTE May (22%)	G MHOST guided Registered WTE Dec (22%)	H 24/25 Time to Care Registered WTE (22%)	I MHOST Guided total* with **Recommended headroom** WTE Dec (27.3%)
Ardleigh	**46.6**	33.5	26.32	60% / 40%	**25.16**	17.9	15.71	35.0
Cedar	**41.4**	27.9	30.14	52% / 48%	**22.34**	14.9	15.71	29.2
Chelmer	31.4	**41.4**	25.04	63% / 37%	16.96	**22.2**	15.71	43.3
Cherrydown	**35.4**	32.0	30.14	52% / 48%	**19.11**	17.1	15.71	33.5
Finchingfield	**31.0**	20.2	26.33	60% / 40%	**16.74**	10.8	15.71	21.1
Galleywood	**37.0**	29.0	25.04	63% / 37%	**19.98**	15.6	15.71	30.4
Gosfield	32.9	**36.5**	27.08	58% / 42%	17.77	**19.6**	15.71	38.2
Ipswich Road	**12.8**	12.2	14.86	37% / 63%	**6.91**	6.5	5.53**	12.7
Kelvedon	**28.8**	24.9	30.14	52% / 48%	**15.55**	13.4	15.71	26.1
MHAU	33.0	**33.4**	37.95	55% / 45%	17.82	**17.9**	20.95	35.0
Peter Bruff	39.6	**42.2**	38.28	55% / 45%	21.38	**22.6**	20.95	44.2
Stort	26.2	**27.1**	26.50	59% / 41%	14.15	**14.5**	15.71	28.3
Topaz	37.9	**47.5**	23.37	67% / 33%	20.47	**25.5**	15.71	49.8
Willow	30.7	**43.3**	31.14	50% / 50%	16.58	**23.2**	15.71	45.4

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **54% / 46%** for acute adult wards and Recommended headroom WTE 27.3%)*

** Not included in TTC uplift

Professional judgement and quality indicators for consideration to WTE requirement - Acute:

The substantive workforce recruitment experiences a continuum of preceptee nurses requiring support and development for the minimum 1-year preceptorship period.

Chelmer, Topaz, Willow and Peter Bruff wards for this data collection, indicates a significantly higher MHOST outcome in comparison to their previous data collection. All wards reported high numbers of **patient safety incidents relating to self-harm**, additionally Willow reported a high number of **patient restraints.** There has been a shift from the previous data collection where Ardleigh and Cedar reported high acuity and this demonstrates the importance of regular data collection using MHOST rather than the reliance on a single outcome score. Peter Bruff received a number of compliment letters and Cedar receiving **1 formal complaint**.

Topaz ward is a mixed adult acute ward with **detox beds** (additional staff rostered as required to accommodate this). During the data collection periods, the ward experienced **staff sickness at a senior level** resulting in skill mix challenges due to the number of preceptees on the ward. Patients also benefit from access to **three gardens** which need to be staffed at all times.

Cherrydown ward received **1 formal complaint** during the data collection. The ward also experienced a change in the manager during the data collection and **patient safety incidents with moderate or above harm.**

Stort ward received **1 formal complaint** during the data collection. Additionally, the ward experienced additional pressures relating to **skill mix** and had **patient safety incidents moderate or above harm.**

439 Ipswich Road is an adult rehab unit. MHOST suggests, like the previous audit, a lower WTE however, this is a **standalone unit** and therefore additional support and cover is not readily accessible.

Galleywood Ward also experienced **staff sickness at a senior level** resulting in **skill mix** challenges. In addition, they reported a high number of **patient safety incidents relating to self-**harm as well as **physical assaults on staff**. **2 formal complaints** were received during the data collection.

Basildon Mental Health unit - all area have g**ardens and serveries away from the ward**.

Finchingfield and Galleywood wards - food **servery away from the ward.**

The majority of the wards regularly experience **bed occupancy above 95%** with Topaz, Cherrydown, Gosfield and Finchingfield **reporting above 100%.**

The wards have experienced **high demand of Section 17** leave with examples of up to 50 requests for one ward within a 24 hour period. This has placed a high demand on the registrants with the requirement to complete the appropriate risk assessment with every application.

4.2.2 PICU MHOST data

PICU

A Ward	B MHOST guided total* WTE May 2024	C MHOST guided total *WTE Dec 2024	D 24/25 Time to Care total* WTE (22%)	E TTC Registered and Unregistered ratio	F MHOST guided Registered WTE May (22%)	G MHOST guided Registered WTE Dec (22%)	H 24/25 Time to Care Registered WTE (22%)	I MHOST Guided total* with **Recommended headroom** WTE Dec (28.5%)
Christopher unit	30.9	**31.5**	35.40	59% / 41%	14.83	**20.6**	20.95	33.3
Hadleigh unit		**21.1**	37.92	55% / 45%		**8.4**	20.95	22.3

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **48% /52%** for PICU and Recommended headroom WTE 28.5%)*

Professional judgement and quality indicators for consideration to WTE requirement – PICU:

Hadleigh unit is running at a **reduced bed capacity due to reduced consultant cover**. The unit did not participate in the original MHOST data collection due to closure for refurbishment and therefore only has December outcome recorded. The recommendation would be to repeat the data collection in 3 months.

Christopher unit reported high number of **patient safety incidents relating to self-harm** and **restraint** as well as **physical assaults on staff**.

4.2.3 Specialist Services MHOST data

Low Secure

A Ward	B MHOST guided total* WTE May 2024	C MHOST guided total *WTE Dec 2024	D 24/25 Time to Care total* WTE (22%)	E TTC Registered and Unregistered ratio	F MHOST guided Registered WTE May (22%)	G MHOST guided Registered WTE Dec (22%)	H 24/25 Time to Care Registered WTE (22%)	I MHOST Guided total* with **Recommended headroom** WTE Dec (23.2%)
Causeway	**16.3**	8.6	23.23	45% / 55%	**8.64**	4.5	10.46	8.7
Dune	14.9	**19.6**	20.68	51% / 49%	7.90	**10.3**	10.46	19.8
Edward House	20.0	**24.5**	40.10	46% / 54%	10.8	**12.9**	18.56	24.8
Robin Pinto	**22.3**	17.1	23.89	66% / 34%	**12.04**	9.0	15.70	17.2
Woodlea clinic	**13.8**	5.7	22.52	46% / 54%	**7.45**	3.0	10.42**	5.8

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **53% /47%** for low secure wards and Recommended headroom WTE 23.2%)*

** Not included in TTC uplift

Professional judgement and quality indicators for consideration to WTE requirement – Low Secure:

Causeway ward had a **50% bed occupancy due to refurbishment** and reported **low acuity and dependency** with low numbers of reporting patient safety incidents; 3 incidents reported during the data collection relating to medication error and patient falls.

Woodlea Clinic and Robin Pinto Unit are a learning disability service. Both are **standalone** units based in Bedford and Luton, therefore, additional support and cover is not readily accessible. Woodlea is currently undergoing building works and **not running at full bed occupancy.**

Edward House has **2 separate wings** which function with separate staff rotas. The ward reported **low acuity** at the census collection period.

Medium Secure

A Ward	B MHOST guided total* WTE May 2024	C MHOST guided total *WTE Dec 2024	D 24/25 Time to Care total* WTE (22%)	E TTC Registered and Unregistered % ratio	F MHOST guided Registered WTE May (22%)	G MHOST guided Registered WTE Dec (22%)	H 24/25 Time to Care Registered WTE (22%)	I MHOST Guided total* with **Recommended headroom** WTE Dec (28%)
Alpine	**20.2**	18.9	33.10	47% / 53%	**10.6**	9.5	15.70	19.9
Aurora	**13.4**	10.6	15.13	49% / 51%	**6.7**	5.4	10.47	11.2
Forest	**26.6**	14.6	23.24	45% / 55%	**13.3**	7.3	10.47	15.3
Fuji	26.2	**30.4**	35.86	44% / 56%	13.1	**15.3**	15.70	32.0
Lagoon	**29.5**	24.0	33.65	47% / 53%	**14.75**	12.1	15.70	25.3

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **50% /50%** for medium secure wards and Recommended headroom WTE 28%)*

Professional judgement and quality indicators for consideration to WTE requirement – Medium Secure:

Alpine ward was running at full bed occupancy with a **low acuity** of patients and no reported incidents, with **ward manager absence.**

Aurora ward during data collection continued to have a high level of patient **stepdown in preparation for discharge**. The ward was **not fully occupied** during this data collection with the patient acuity not a true reflection of a medium secure service.

Fuji ward had a high number of reported **patient and staff safety incidents** during data collection periods relating to **violence and aggression**. The ward had full bed occupancy.

Woodlea clinic are advised to repeat with a peer review to evaluate acuity scoring.

Lagoon ward reported **high acuity** relating to **long term seclusion**, however the ward was **not at full bed occupancy.**

Brockfield House has **multiple outside areas** such as a gym, sports pitch, court yard and gardens that are not directly accessed from the wards.

CAMHS

A	B	C	D	E	F	G	H	I
Ward	MHOST guided total* WTE May 2024	MHOST guided total *WTE Dec 2024	24/25 Time to Care total** WTE (22%)	TTC Registered and Unregistered % ratio	MHOST guided Registered WTE May (22%)	MHOST guided Registered WTE Dec (22%)	24/25 Time to Care ** Registered WTE (22%)	MHOST Guided total* with **Recommended headroom** WTE Dec (29.9%)
Larkwood	**20.6**	18.5	47.93	46% / 54%	**9.98**	9.1	22.08	19.7
Longview	**37.2**	25.4	46.05	49% / 51%	**17.86**	12.5	22.55	27.2
Poplar	**32.0**	25.6	44.79	43% / 57%	**15.36**	12.6	19.20	27.4

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **48% /52%** for CAMHS wards and Recommended headroom WTE 29.9%)*

** Not included in TTC uplift

Professional judgement and quality indicators for consideration to WTE requirement - CAMHS:

All CAMHS ward reported high levels of **patient safety incidents relating to restraints and self-harm** with Longview reporting by far the highest number of incidents during the data collection.

Poplar ward is located on the **first floor** and therefore the **outside garden is accessed via a secure walkway** linking the ward to the garden. The ward reported **high acuity** with one patient in **seclusion.**

Like the previous audit, there continues to be a **50% bed occupancy** for CAMHS on Longview and Larkwood during this data collection with the outcome not providing a true reflection of normal ward activity. Beds managed for this care group are in collaboration with the East of England Provider Collaborative (PC) and have specific criteria for admission. The East of England PC consists of six providers across the region, with EPUT providing a majority of the beds for inpatient mental health care across its two sites; Poplar Adolescent Unit at Rochford Hospital and the St Aubyn Centre, Longview and Larkwood wards. Larkwood is a 10 bedded PICU unit and is the only PICU in the region accepting referrals from all six providers, as well as out of area referrals.

Perinatal Services

A	B	C	D	E	F	G	H	I
Ward	MHOST guided total* WTE May 2024	MHOST guided total *WTE Dec 2024	24/25 Time to Care total* WTE (22%)	TTC Registered and Unregistered ratio	MHOST guided Registered WTE May (22%)	MHOST guided Registered WTE Dec (22%)	24/25 Time to Care Registered WTE (22%)	MHOST Guided total* with **Recommended headroom** WTE Dec (22%)
Rainbow	**15.8**	13.1	21.83	48% / 52%	**8.06**	6.7	10.48	13.8

(Source of EPUT TTC funded WTE - Head of Finance Inpatients, Psychology and Specialist services as at December 2024)

**Total is both registered and unregistered*

*(Note MHOST ratio of registered to unregistered = **51% /49%** for perinatal wards and Recommended headroom WTE 22%)*

Professional judgement and quality indicators for consideration to WTE requirement – Perinatal Services:

The Royal College of Psychiatry advises on perinatal staffing levels: **Service Standards** for Mother and Baby Units (2014) and states that there is a **minimum accepted expectation of staffing levels** in regards to units meeting accreditation standards.

Rainbow unit is the **only perinatal ward** in EPUT staffed by staff with **clinical skills unique to the service**. However, there is cross cover from other site teams at the Linden and Crystal centres. During the data collection, the unit was **not at full bed occupancy** with no reported incidents.

5. Safer Nursing Care Tool (SNCT)

The SNCT, developed to support physical health wards measure patient acuity and / or dependency, will support to inform evidence-based decision making on staffing and workforce. The decision matrix allows staff to measure the acuity (how ill a patient is) and dependency (how dependent a patient is on nursing staff to have their normal needs met, such as moving, going to the toilet, eating and drinking) of patients in a ward. It incorporates the rules to follow to ensure that data is captured accurately, and how to use this information to calculate the optimal level of staff needed in a particular ward using nursing multipliers to ensure the delivery of safe patient care.

The tool was updated by NHSE to incorporate additional indicators that reflect patients who have care needs requiring additional staff. Due to a shortage of trainers from NHSE, there was a delay in receiving the required training in order to use the tool. Training has recently been delivered by the national team and the physical health wards are ready to facilitate their first data collection. A total of two data collections are advised before decisions on staffing are made. This information will be ready for the next staffing report.

Whilst the rollout and embedding of the SNCT comes into fruition, the daily staffing is managed through similar process and systems to the mental health wards with daily SitRep meetings and mitigations put in place according to patient needs and ward requirements.

6. Next Steps

- Ensure Deputy Directors of Quality and Safety provide quality oversight to emphasise the importance of MHOST and ensure adherence to the data collection, sign off of quality indicators and professional judgement with the safer staffing leads and ensure report is included in the care unit's Quality of Care governance meetings
- Safer Staffing Dashboard through PowerBI as part of the Quality Dashboard
- Continue to strengthen e-rostering check and challenge processes
- Development of service specific professional judgement meetings and reporting template

- Work with national and regional safer staffing leads to develop comparison and benchmarking
- Ensure seasonal acuity and dependency variance is considered during the 2025 census collections in order to build confidence
- Build quality assurance through peer review and partner involvement during census data collection and ensure that new ward managers and matrons undertake the required NHSE training

Appendix 1

Governance Arrangements for Operational Oversight of Deployment of Staff 2025/26

Daily Oversight

- Daily operational decision meetings on staff bookings within rotas for the use of temporary clinical staff associated to mental health inpatient and inpatient specialised services. The purpose is to ensure that staff are rostered in line with recognised budgeted establishment.
- Meetings to include the Deputy Director of Quality & Safety (DDQS)/Director of Nursing/HR Business Partner/Finance Business Partner/Rostering Lead.
- In the twice daily Safer Staffing SITREPS, ensure that the SafeCare tool supports the matrons/service managers to be assured that wards are safely staffed to meet CHPPD and establishment – with mitigation recorded with support from wider MDT roles.

This meeting will be supported by:

Report – This will be generated by the rostering team. It will identify adherence with agreed establishment of registered and unregistered nursing staffing for each ward following the framework provided below:

Daily Meeting	Review	Report provided
Mon	Fri, Sat, Sun, Mon & Tuesday	Fri, Sat, Sun Mon & Tues
Tue	Tues & Wednesday	Tues & Wed
Weds	Wed & Thurs	Wed & Thurs
Thurs	Thurs new escalations only), Fri, Sat & Sunday	7 day look forward and look back
Fri	Fri, Sat, Sun (additional escalations only) & Mon	Same report as above

Weekly Oversight

- In addition to daily meetings, there will be weekly oversight meetings that take place on a Thursday to review bookings for the week up to that point, review the weekend bookings and to gain assurance from the daily booking meetings.
- This weekly oversight will be chaired by the Chief People Officer, Chief Nurse and Chief Medical Officer alongside the Associate Director of People – Resourcing. The executive chairs will receive reports from the care unit directors from specialist services and urgent care alongside their DDQS on compliance with bookings.

Report – This will be generated by the rostering team. It will identify adherence with agreed establishment for each ward looking retrospectively at rotas for the preceding 7 days and looking prospectively at rotas for the next 7 days.

Supporting Governance Arrangements for Rostering

The governance associated to staff bookings on our roster system has been strengthened in the latter part of 2024/25 in order to ensure more senior level of oversight and accountability. It is proposed that these escalated governance arrangements continue throughout 2025/26, and are:

- Only Band 8a and above will be able to create additional shifts above demand template following care unit management approval
- Only Band 7 and above will be able to send shifts to the roster for bank and agency
- Establish the standard for '3 month forward rostering' with the ambition of wards moving towards 6 months rostering which will ensure that the right skill mix, annual leave and training is pre-planned where possible reducing need for bank
- That a monthly report of key performance indicators is produced by the rostering team that includes areas, but not restricted to, unused hours, annual leave utilisation, compliance with securing rotas within 3 months, and working towards threshold of 6 months

Leadership Support

It is acknowledged that the governance and performance arrangements provide expectations on performance that are different than set out previously. This has therefore raised expectations alongside a defined change in culture associated to performance management. The purpose of the new accountability is not to inhibit autonomy but to align the executive with care unit management teams, providing support and empowerment.

It is proposed that there should be a realignment of the 3 current leadership forums to provide some focused engagement and support alongside its current remit of providing communication updates.

In particular, in order to support our senior management teams and create alignment with the executive sponsors, for this specific matter, it is proposed that some joint facilitated sessions are established.

These sessions will provide an opportunity to discuss and share experiences between colleagues in a safe space. The purpose is to provide an environment that supports improvement by understanding areas of conflict or concerns. Therefore these sessions can be used to resolve challenges and enhance performance through reinforcement.

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 5

REFERENCES

Only PDFs are attached

Board Assurance Framework 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Board Assurance Framework**					
Executive/ Non-Executive Lead:	Denver Greenhalgh Senior Director of Governance					
Report Author(s):	Roberta Wahnig Head of Risk Management					
Report discussed previously at:	Executive Operational Committee Board of Directors Standing Committees					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
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:	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	✓
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	✓
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.	NA	
Describe what measures will you use to monitor mitigation of the risk	NA	
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 ta 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. Request any further information or action

Summary of Key Issues

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

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

The Board is asked to note

- Board Assurance Framework dashboard providing an oversight, noting:
    - Interim arrangements to commence in June 2025 for Specialist Services Care Unit leadership as we transit Directors (SR4).
    - Assurances received from the CQC inspections of Secure & Forensic wards and Clifton Lodge Nursing Home reflecting good ratings (SR13)
    - Internal Audit opinions of reasonable assurance:

      Cyber Security (SR6)
      Core Financial Assurance (SR8)
      Temporary Staffing (SR8)
      PSIRF (SR13)
      Falls Management (SR13)
      Recording and Monitoring of Therapeutic Observations (SR13)
      Care Plans and Risk Assessments (SR13)
    - 2024 staff survey results reflected within CRR92
- There have been no changes in risk score
- There were no risks de-escalated in this reporting period
- 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 Executive 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 Commission
DP / BCP	Disaster Recovery / Business Continuity Plan	PSIRF	Patient Safety Incident Reporting Framework

Supporting Reports/ Appendices /or further reading

- Board Assurance Framework Dashboard and Risk Movement and Milestones
- Strategic Risk Register
- Corporate Risk Register

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

May-25

EPUT

Strategic Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	11	7

Likelihood	Consequence 1	2	3	4	5
1					
2					
3				SR11 SR10	SR3, SR4 SR9, SR9 SR13
4				SR5 SR12	SR7 SR8
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	7	

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR3	All	Infrastructure	TS	Safety, Experience, Compliance, 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.	As above the ERIC and PAM groups have been fully establish. The group has identified that additional work is needed, with work commenced to pull into one action plan. Annual plan agreed within Capital programme 2025/26.
SR4	All	Demand and Capacity	AG	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The new Operational Model for Inpatient Services is being rolled out following , with the detailed Implementation plan being monitored by the Time to Care Steering Group. The F&P Committee heard example from the Director of Urgent Care and Adult Inpatient Services noting that West Essex had implemented all actions of the TOM and although early days impact was being seen. They also spoke of the new dashboard which had enhanced controls for locally based bed management and there was increase rigour in conversations between inpatient and community mental health teams. The 3 Integrated Care Systems and the Trust have appointed PA Consulting to support the risk share review and conclusion. F&P Committee received an update on progress from PA Consulting at its May meeting - noting that there is a shared commitment with work progressing including agreement of resource transfer, drafting MOU, and the development of a mobilisation plan and trajectories for the next three years. Discussions are ongoing, it's a complex programme of work which is impacting timescale. Further extension to Q2 2025.
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	Rule 9 requests, clarifications and additional information requests continue to be received requiring additional staffing resource to be mobilised. It is anticipated that will reduce June 2025 to be in line with the Project Team's capacity. Constant review of prospective resources being undertaken. An increase in legal support required to finalise statements, and will continue in preparation for the scheduled July 2025 hearings.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR6	All	Cyber Attack	ZT	Safety, Experience, Compliance, 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.	Preliminary baseline assessments complete. Action plan has been development to address gaps and presented to Information Governance steering sub-committee (10.02.25) for onward reporting to the Finance and Performance Committee Seven Actions identified from Audit: six in progress and one completed. Remaining six actions are in progress following meeting with TIA there are no action are outstanding. Penetration test findings mitigation plan on track. Following discussion at F&P Committee it was agreed to review the Target Risk Score - noting that actions being taken will impact only in terms of maintaining the current risk score of 15.
SR7	All	Capital	TS	Safety, Experience, Compliance, 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	Bid submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care, as part of 2025/26 capital plan. F&P Committee received a report noting that Capital spend was above plan month 1.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, 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 andtransformation/restructure activities. Forecast outturn agreed with region and national team.
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, 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	Phase 2 of the digital target operating model commenced in April '25 following which the review and outcome will inform Phase 3. Electronic Patient Record programme continues. F&P Committee have requested an update to list what has been achieved within the Digital and Data Strategy to note progress.
SR10	All	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of Strategy and accompanying implementation plan completed and will report 3 times a year to the People Committee. See new action re: delivery of implementation plan over the lifespan of the People and Education Strategy.
SR11	All	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Review of Strategy and accompanying implementation plan completed and will report 3 times a year to the People Committee. See new action re: delivery of implementation plan over the lifespan of the People and Education Strategy. Note: Links to SR10 and SR12
SR12	All	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16 16 16	The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Following conclusion of the gap analysis (action 4) restructure of the People and Culture Directorate consultation underway. Proposals for culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years. Procurement is planned for delivery in Autumn 25, year one of a three year plan, with the first cohort planned for Q4. The procurement of a Trust-wide culture review and senior leadership development programme agreed by the Executive Team (May 2025) and now progressing through internal / triple log approval governance and will be subject to a tender process. This will provide the Trust with a clear diagnostic on issues of discrimination, accountability and behaviours which will inform the development of the senior leadership programme.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15	15 15 15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	Note a number of IA opinions reflected within the risk entry this month. The Trust is working with the Centre of Excellence and attending national workshops to learn and align EPUT's Quality dashboard development to the NHSE principles. The next developmental version is expected in June 25. SOPHIA platform is now live with a total of 33 published standard operating procedures, with a further 56 in draft. Staff are engaging with the platform with 5,506 confirmed users accessing to date. All policies and clinical guidelines have now been uploaded onto the platform. BCP database is now in place. Condition for full go live (including switching off existing intranet based library) is resolution of the new starter process to ensure there is access to the SOPHIA platform from day one of employment.

Corporate Risk Register at a Glance

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

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	4	4

Likelihood	Consequence 1	2	3	4	5
1					
2					
3				CRR98, CRR11, CRR45, CRR92	
4					
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	Reviewed by Risk Owner
100%	100%	2	

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	MK	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	The Effectiveness Group has been monitoring the progress against year 1 priorities and has agreed the priorities for year 2 (reported to the Quality Committee). Emphasis on a) self harm reduction; b) STORM training; c) Safety Plans; and d) Safe Discharges. As the priorities are developed into a delivery plan this action will be separated into the component parts for future reporting.
CRR45	All	Mandatory Training	PT	Safety	4x3=15	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	TASI Training compliance currently sits at 86% substantive and 73% for Bank which has improved from the previous reporting (April). Compliance checks are complete to remove inactive bank staff who are no longer working for EPUT (over 300 bank staff). Booking for face to face sessions completed and predicting to be fully compliant for substantive staff in June and Bank staff late summer 2025
CRR92	All	Addressing Inequalities	PT	Safety	4x3=15	12 12 12	Staff Experience	Assurances have been updated to reflect the 2024 staff survey results. Sexual safety and unprofessional behaviours pilot underway with Specialist Services. Action timescale extended to reflect pilot and trustwide scale up period.
CRR98	All	Pharmacy Resource	HS	Safety	4x3=15	12 12 12	Continuous state of business continuity plan	Current vacancy factor is 10.2 wte. Of this, eight offers are in place with four commencing in post at the beginning of April and remaining four joining over the next three months; leaving a vacancy factor of 2.2wte. Reassessment of the risk will take place with the potential for de-escalation from the CRR. Reassessment of the risk will take place with the potential for de-escalation from the CRR to business as usual operational management and oversight through the Accountability meetings.

Risk Movement and Milestones

Strategic Risk Movement – two year period (May 23 – May 25)

Risk ID	Initial Score	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
SR1	20	20	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	Closed						
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15
SR4	20	20	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15
SR5	20	15	15	15	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	16	16	16	16
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
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
SR8	15	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
SR9	20									New	20	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15
SR10	16																		New	16	**12**	12	12	12	12	12
SR11	16																		New	16	**12**	12	12	12	12	12
SR12	16																		New	16	**16**	16	16	16	16	16
SR13	20																			New	**15**	15	16	16	16	16

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two year period (May 23– May 25)

Risk ID	Initial Score	May 23	Jun 23	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
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**
CRR45	12	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	12	16	**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	8	**D**					
CRR81	12	16	16	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	**D**					
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**	**12**	**12**	**12**
CRR93	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10	**D**					
CRR94	16	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	10	**D**					
CRR98	20	20	20	20	20	20	20	20	20	20	20	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**	**12**	**12**	**12**

NHS
Essex Partnership University
NHS Foundation Trust

Strategic Risk Register

May-25

EPUT

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1- 4 and have been removed from the report. **Note 2:** Re-assessment of risk following the completion of Estates Strategy is to be completed.
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model (TOM)	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 Team 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 ERIC and PAM Groups Established	Premises Assurance Model in place with assessment	
6-Facet Survey	Review of core premises undertaken through the Estates Strategy	6- Facet Survey completed	6-Facet Survey
Business Continuity Plans	Business continuity plan in place		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
5	Review ERIC data submission against Peer groups and determine efficiencies	Complete	MM	Control	The ERIC and PAM group is now fully established meeting on a monthly basis to collate the data required for these submissions, discussing an action plan and tracking progress. Review undertaken against peer group, scored well for most areas and the following highlighted as efficiencies, variance backlog, waste, utilities and incidents (outlined in R1L Estates and Facilities Summary document). Reporting is undertaken through to the Estates and Facilities Management Assurance Group (EFMAG). Efficiencies identified will be going through to the TEG.
6	Develop action plan for Premises Assurance Model (PAM) outstanding tasks	Second Extension July '25	MM	Control	As above the ERIC and PAM groups have been fully establish. The group has identified that additional work is needed, with work commenced to pull into one action plan, this has impacted on the timescale set, being extended to July 2025.
7	Capital programme to be established for Estates	Complete	MM/JD	Roadmap	Capital Programme – a 10 year plan has been submitted and this is now BAU. Action complete May 2025

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-5, 8 and 9 have been removed from the report. **Note 2**: Action 6, 7 and 8 RAG rated red as timeline is a second extension to the originally stated timeframe. **Note 3**: The control Care Unit Leadership will have an interim Director of Specialist Services commencing from June 2025 to cover the period until the new Director joins the Trust. **Note:** New action 12.

Executive Responsible Office: Executive Chief Operating Officer Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff (including skilled flexible workforce via Trust Bank) Discharge Co-ordinator Teams	Establishment and Fill Rate Director of Operational Performance Agency Framework in place New roles: Activity Coordinators Clinical Flow Lead (Dr Bogdan) Jan '25	Performance Reporting Accountability Framework Meetings	
Care Unit Leadership	Establishment Integrated Director posts ***(Note: interim arrangements that will come into effect from June 2025 for vacancy for Specialist Services Care Unit.***		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Quality of Care Strategy	Dedicated discharge coordinators CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Final Report to Board (2024)	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitReps/ Performance Reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2023/24	Developed including out of area plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System Escalation in place

Bed Stock		157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds			

Actions (to modify risks)		By When	By Who	Gap	Update
6	Demand and Capacity module to be procured and fully implement	Extended June 25	JL	Control	The final capacity and flow model was presented to ET on 02.05.25 and is now expected to go live 19.05.25. Propose to further extend action to June 25, timeline amended to reflect the go live date.
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Extended July 25	AG	Control	The 3 Integrated Care Systems and the Trust have appointed PA Consulting to support the risk share review and conclusion. F&P Committee received an update on progress from PA Consulting at its May meeting - noting that there is a shared commitment with work progressing including agreement of resource transfer, drafting MOU, and the development of a mobilisation plan and trajectories for the next three years. Discussions are ongoing, it's a complex programme of work which is impacting timescale. Further extension to Q2 2025.
8	Implementation of new operating model	Extended June 25	LW	Control	The new Operational Model for Inpatient Services is being rolled out following , with the detailed Implementation plan being monitored by the Time to Care Steering Group. The F&P Committee heard example from the Director of Urgent Care and Adult Inpatient Services noting that West Essex had implemented all actions of the TOM and although early days impact was being seen. They also spoke of the new dashboard which had enhanced controls for locally based bed management and there was increase rigour in conversations between inpatient and community mental health teams.
9	Developing locality demand and capacity plans, taskforce in place to take this forward.	Complete	NB	Control	Implemented the shift trust wide bed allocation to locally based model to ensure local MDT full involvement in discharge planning from the point of admission. Locality oversight of flow in place. This is now business as usual and an accountability protocol to monitor local length of stay targets is under development. Action closed May 2025
10	Appointment of clinical lead for flow and capacity	Complete	AG	Control	Consultant has been appointed to commence Jan 2025
11	Implementation of recommendations following long stay review and system made events across the trust and system	Jun-25	SG	Control	Themes and recommendations for application across the Trust and Essex wide system to support transfer of care of patients clinically ready for discharge presented to SET SIG. SET SIG to oversee progress against recommendations. Governance and oversight of system delays and escalations reviewed and strengthened with new arrangements commenced in January 2025. Following F&P Committee discussion - this action will be expanded to its component parts for greater transparency and accountability of delivery. This will feature in the next reporting round.
12	Implementation of a clinical and operational prioritisation matrix for bed allocation at locality	Apr-25	NB	Control	Implementing the shift trust-wide bed allocation to locality based model to ensure local MDT full involvement in discharge planning from the point of admission. This shift to local accountability will improve the management of flow and improve our patient access to inpatient services where needed.

SR5 - Lampard Inquiry (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1-3, 5 and 7 have been removed from the Board report. **Note 2:** Change of SRO from Nigel Leonard to Denver Greenhalgh. **Note 3:** Maintaining the risk score at 16 following learning from the April hearing and some areas of learning in relation to information submissions to the Inquiry and the potential impact of future requests for both the July hearings and later.

Executive Responsible Office: Executive Director Major Projects Board Committee: Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment and reporting in place.		
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Nigel Leonard) Project Director Browne Jacobson Essex Chambers	Trust Board of Directors	Internal audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry.
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Resources from GW. Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Support for families	Report from HPT to Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee, BOD	Internal audit.
Meetings for Care Units and Wards in place	Schedule of meetings (and delivery of meetings)		

Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Schedule meetings for Care Units and Wards in place	Complete	GW	None	Moved action to a control (see above) with an ongoing schedule in place to attend Care Unit Meetings and completing staff visits. The Committee approved closure of this action.
6	Reviewing resources to ensure (C2) Best value for money; Right skills and resources in place; Operational planning	Extended June '25	GW/GB	Awaiting potential additional Rule 9 Request	Rule 9 requests, clarifications and additional information requests continue to be received requiring additional staffing resource to be mobilised. It is anticipated that will reduce June 2025 to be in line with the Project Team's capacity. Constant review of prospective resources being undertaken. An increase in legal support required to finalise statements, and will continue in preparation for the scheduled July 2025 hearings.
8	Rule 9 progress	End of July 26	GB	Assurance	Currently 6 Rule 9s in draft, 2 finalised requiring additional information and 1 to be submitted in draft. Further Rule 9 requests allocated to Executive Directors and work underway facilitated by project leads. Submitted evidence required within timelines.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*3 x 5 = 15*	*C4 x L3= 12*	**Note 1:** Previous reported completed actions 1 - 8 have been removed from the report. **Note 2**: Following discussion at F&P Committee it was agreed to review the Target Risk Score - noting that actions being taken will impact only in terms of maintaining the current risk score of 15. **Note 3**: Note IA assurance received for Cyber security.

Executive Responsible Office: Executive Director Strategy Transformation and Digital Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC IA Cyber Security (2024/25) **Reasonable Assurance**	NHS Digital Data Security Protection Toolkit (DSPT/CAF) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; IA Cyber Security (2024/25) **Reasonable Assurance**	As above MSE ICS IG & Cyber Levelling Up Project (annual)
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/CAF Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP in place	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**
9	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Revised Timescale July 25	AW	Assurance/Control	Preliminary baseline assessments complete. Action plan has been development to address gaps and presented to Information Governance steering sub-committee (10.02.25) for onward reporting to the Finance and Performance Committee

10	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Jul-25	AW	Assurance/Control	Seven Actions identified from Audit: six in progress and one completed. Remaining six actions are in progress following meeting with TIA there are no action are outstanding. Penetration test findings mitigation plan on track.

SR7- Capital (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	**Note 1:** Previously report completed actions 2 - 4 have been removed from the report. **Note 2:** New Action: Capital Plan for financial year 2025/26 to start development

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

	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 for financial year	JD	Control	Bids submitted for additional capital resources (c£14m) for critical infrastructure, out of area placements, mental health urgent care units and solar energy, as part of 2025/26 capital plan.
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	F&P Committee received a report noting that Capital spend was above plan month 1.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	**Note 1:** Previous reported completed actions 1,3 - 5 and 10 has been removed from the report. **Note 2:** Note extension to management actions as part of action 2 (over delivery of efficiency targets in care units / Directorates to offset the off plan position). **Note 3:** Note new actions 12 and 13 to put in place enhanced controls on committing expenditure. **Note 4**: Note the IA assurance opinions for core financial assurance, temporary staffing and payroll.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee	**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 IA Core Financial Assurance (2024/25) **Substantial Assurance Opinion** IA Payroll including Salary Overpayments (2024/25) - **Reasonable Assurance opinion**	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	NOF 4 Rating
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2025/26			
Forecast Outturn and risk/ opportunities assessments 25/26			
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team - Downward trend in temproary staffing use seen in month 1 (2025/26).	IA Temporary Staffing (2024/25) **Reasonable Assurance Opinion**	

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
2	Deliver Financial Efficiency Target	Mar '26	TS	Control	Non- recurrent and unfound CIPs incorporated into new year plan.

6	Deliver Financial plan for 24/25	Mar '26	TS	Control	Continued enhanced controls, efficiency and productivity improvement andtransformation/restructure activities. Forecast outturn agreed with region and national team.

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.	Complete	AM	Control	Workforce roster management progressed through weekly executive escalation with in-patient mental health services. Additional Accountability Escalation Framework meetings for focus on temporary staffing put in place. This is under review to take forward in house - complete May 2025
8	Investigate & Intervention Programme Activity: Estates commercials review i.e. leases, PFI, PropCo and Valuation options.	Complete	TS	Control	New valuation officer agreed. PropCo all action complete on intervention – financial settlement awaiting response – complete May 25
11	Investigate & Intervention Programme Activity: Property Top-Up Insurance (details provided to PwC).	Complete	DG	Control	Linked to corporate services running cost reductions this was agreed through executive team and has been fully actioned. Complete May 2025
12	Enhanced approval controls for the use of temporary staffing	Complete	AMc	Control	Enhanced approval and controls in place. Reporting includes delivery against workforce planning submission targets and vacancy levels. Temporary staffing targets set for each care group linked to vacancies and demand. Care groups breaching set targets invited to attend weekly Executive oversight meeting to support with actions to deliver improvements. April position reports temporary staffing use 5% under planned delivery and significant improvement in financial spend position. As of April the Trust is operating 2% under workforce planning submission target.
13	Enhanced recruitment controls for Corporate Services	Complete	AMc	Control	Enhanced controls for recruitment to permanent, substantive roles in corporate services and admin and clerical staffing group via Establishment control panels in place. Exceptional case approvals to be granted only on patient safety and business critical grounds

SR9- Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*	**Note 1:** Previously reported complete action 1-10 have been removed from the report. **Note 2:** Note new action 11 and 12 moving to next stages in the Digital Target Operating Model and UEPR. **Note 3**: F&P Committee have requested an update to list what has been achieved within the Digital and Data Strategy to note progress.

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital
Board Committee: Finance and Performance Committee

Controls Assurance

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

Actions (to modify risks)		By When	By Who	Gap	Update
11	Digital Target operating model implementation - phase 2	Sep-25	AW	Control	Phase 2 to commence April following review and outcome will form Phase 3

12	New Action: Implementation of new UEPR	Apr-27	ZT	Control	Electronic Patient Record programme continues and contract awarded and signed.

SR10: Workforce Sustainability

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3= 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 2 - 5 have been removed from the report. **Note 2:** New action 6 regarding implementation of the plan through the lifespan of the People and Education Strategy.

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People and Education Strategy	People Strategy Implementation Plan	Strategy approved by Board of Directors 2024. Bi-annual Strategy Progress Reports to Board	
Recruitment and Retention Strategy	Recruitment & Retention Strategy	Recruitment Assurance Report & People Promise (Retention) Report	System People Board oversight of recruitment, retention and temporary staffing performance
Operational Plans	Accountability Framework meetings monitoring of plan delivery	PECC oversight reporting - month 6 actuals against the plan (noting the revised trajectory presented at the October '24 meeting).	
Workforce Planning and Modelling Team	Care Unit and Corporate workforce plans Operational Planning meeting Workforce Planning meeting	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.	Complete	Chief People Officer	Road Map	Review of Strategy and accompanying implementation plan completed and will report 3 times a year to the People Committee. See new action below re: delivery of implementation plan over the lifespan of the People and Education Strategy. Complete May 25
6	Delivery the People and Education Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee.

SR11: Staff Retention

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note1:** Previously reported completed actions 2 - 5 have been removed from the report. **Note 2**: Implementation of the plan through the lifespan of the People and Education Strategy.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review the People & Education Strategy and associated implementation plan with emphasis in staff retention.	Complete	Chief People Officer	Road Map	Review of Strategy and accompanying implementation plan completed and will report 3 times a year to the People Committee. See new action below re: delivery of implementation plan over the lifespan of the People and Education Strategy. Complete May 25
6	Delivery the People and Education Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee.

SR12: Organisational Development

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L4= 16*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 2-6 have been removed from the report. **Note 2**: New action to deliver the OD and Development Programme.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review People Strategy and associated implementation plan with emphasis on staff retention	Complete	Chief People Officer	Control	Review of Strategy and accompanying implementation plan completed and will report 3 times a year to the People Committee. See new action below re: delivery of implementation plan over the lifespan of the People and Education Strategy. Complete May 25
7	To deliver OD and Development programme	March 28	Director of OD & Culture	Control	Following conclusion of the gap analysis (action 4) restructure consultation underway. Proposals for culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years. Procurement is planned for delivery in Autumn 25, year one of a three year plan, with the first cohort planned for Q4. The procurement of a Trust-wide culture review and senior leadership development programme agreed by the Executive Team (May 2025) and now progressing through internal / triple log approval governance and will be subject to a tender process. This will provide the Trust with a clear diagnostic on issues of discrimination, accountability and behaviours which will inform the development of the senior leadership programme.

SR13 - Quality Governance (At a Glance)

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

Likelihood based on: Incidence of repeat incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions from the Care Quality Commission.

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Note IA assurances on PSIRF, Falls Management, Recording and Monitoring of Therapeutic Observations, Care Plans and Risk Assessment, and Mortality Review Process.
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Nurse Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1**	**Level 2**	**Level 3**
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (2023/24) **Reasonable Assurance Opinion**
Patient Safety Incident Management Team	Team Established		IA PSIRF (2024/25) **Reasonable Assurance Opinion**
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		
Learning Collaborative Partnership	Forum attendance and effectiveness review.		
Learning information communications plan			
Patient Safety Dashboard			
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports (Adult Acute Inpatients and PICU) July 2023 **Inadequate for Safety and Well Led** CQC inspection reports (Brockfield House) April 2025 **Good Rating** CQC inspection reports (Clifton Lodge) February 2025 **Good Rating**
ESLMS			
Patient Incident Response Plan		IA Falls Management (2024/25) **Reasonable Assurance opinion** IA Recording and Monitoring of Therapeutic Observations (2024/25) **Reasonable Assurance opinion** IA Care Plans and Risk Assessments (2024/25) **Reasonable Assurance opinion**	
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA (outcome detail to be added)

Clinical Audit Programme	Annual Plan and Outputs	Quality Committee Oversight	National Audits / Confidential Inquiries Reports and Organisational reports

Quality Assurance Framework: Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits Compliance Reviews (Clinical Audit Plan / Compliance Team Reviews)	Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits		IA Mortality Review Processes 2025 - **Reasonable assurance opinion**.

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Develop and implement Quality Dashboard	Extended June '25	RT / AW	Control	Focus on key metrics for each of the three quality of care areas was presented to Quality Committee (April 2025) with the view of triangulating different metrics and gaining insight to influence practice and provide assurance The Trust is working with the Centre of Excellence and attending national workshops to learn and align EPUT's Quality dashboard development to the NHSE principles. The next developmental version is expected in June 25.
	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
2	Raise the visibility of senior quality leaders within the Trust (through Back to Practice Visits) and embed.	May '25	AS	Assurance	Back to practice visits (Quality visits) are continuing with one of the Directors of Nursing having a focus on physical health services. On track.
3	Refresh awareness of raising patient safety incidents and reporting.	July '25	MA	Control	Datix system amendments have been made and the Datix Manager is providing organised drop in sessions and videos to support staff learning. PS/Datix team are creating programme of bite sized recordings to cover different aspects of Datix reporting to be available for staff to view at any time via the Intranet.
4	Continue to full implementation of the eSOP programme (ensuring that all SOPs are reviewed and uploaded to the new SOPHIA system)	Sep '25	RB/RJ	Control	SOPHIA platform is now live with a total of 33 published standard operating procedures, with a further 56 in draft. Staff are engaging with the platform with 5,506 confirmed users accessing to date. All policies and clinical guidelines have now been uploaded onto the platform. BCP database is now in place. Condition for full go live (including switching off existing intranet based library) is resolution of the new starter process to ensure there is access to the SOPHIA platform from day one of employment. Staff hits more than 5514 (May 2025) with a good level of engagement of the new platform.
5	Deliver Safety Improvement Plans and embedding the learning.	Jun '25	NA	Control	Learning events were held in April 2025 which included a presentation on SIPs and a focus on improvements and learning. Communications plan in development for all staff to support continuous engagement and dissemination of learning. Governance for SIPs in place with an oversight group for regular updates.
6	Review the Quality forums from Care Unit to Board and reporting.	Sept '25	AS/DG	Control	A template has been provided to each Care Unit to support local Quality and Safety meetings that reflects experience, effectiveness and safety of care. An evaluation review and monitoring will be undertaken to confirm impact and sustainability. The minutes of each Quality and Safety meeting are attached to the Care Unit Accountability meeting.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Jul '25	RP	Assurance	Review completed in March '25 - initial findings highlighted some areas of non-adherence to plan. This is being explored to understand the causative factors.

8	To incorporate actions arising from PSII / Homicide Reviews and MHA inspections into the Action Leads Meeting for tracking and evidence assurance.	May '25	NJ/MA/ TM	Control / Assurance	CQC Actions Leads meeting has transformed into a Quality Action Leads meeting., with work underway to link this into the new Quality of Care Group. The membership will be focused on Care Unit / Division representation to keep membership to a minimum. PFD actions added November '24, following a period of embedding other areas will be added.

NHS
Essex Partnership University
NHS Foundation Trust

Corporate Risk Register

May-25

EPUT

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:** Previous reported completed actions 1 - 5 have removed from the report for CRR11.

Executive Responsible Office: Executive Medical Director Director Lead: Dr Nuruz Zaman Deputy Medical Director Leads: Alan Hewitt, Deputy Director of Quality and Safety Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Electronic observations recording tool	In trial phase		
Ward level oversight	Tendable Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos	STORM training		
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	The Effectiveness Group has been monitoring the progress against year 1 priorities and has agreed the priorities for year 2 (reported to the Quality Committee). Emphasis on a) self harm reduction; b) STORM training; c) Safety Plans; and d) Safe Discharges. As the priorities are developed into a delivery plan this action will be separated into the component parts for future reporting.

CRR45: Mandatory Training

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

Initial Risk Score C4 x L5= 20	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note 1:** Previously reported completed actions 1- 4 have been removed from the report. **Note 2:** The further extension of the action to achieve full compliance of 90% of bank staff having received TASI training.

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Extended June'25	PT	Control	TASI Training compliance currently sits at 86% substantive and 73% for Bank which has improved from the previous reporting (April). Compliance checks are complete to remove inactive bank staff who are no longer working for EPUT (over 300 bank staff). The training team have compulsory booked TASI training for bank staff following completion of online training, as per policy. All have been contacted to be booked on to face to face courses and support is being offered along with workshops and lunchtime learning Q&A sessions, predicting to be fully compliant for substantive staff in June 2025. Bank may take until late summer 2025.

CRR92: Addressing Inequalities

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report. **Note 2:** The controls assurance has been updated to reflect the staff survey results from 2024
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	

Executive Responsible Office: Executive Director People and Culture Director Lead: Paul Taylor Board Committee: People Committee	**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 Decrease of 4.93% for "My organisation takes positive action on health and well-being." (Staff Survey Q11a) Increase of 3.21% for "How often, if at all, do you feel burnt out because of your work?" (Staff Survey Q12b) Increase of 1.88% for "In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?" (Staff Survey Q11b) Increase of 0.75% for "During the last 12 months have you felt unwell as a result of work related stress?" (Staff Survey Q11c) Increase of 3.02% 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 14.3% and we have seen a reduction of 4.49% over seven years to 2024

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: Increase of 0.02% for “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers?” (Staff Survey Q14b) Increase of 0.40% 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) Decrease of 1.84% for “On what grounds have you experienced discrimination (ethnicity)?" Staff Survey Q16c
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Extended Sept 25	PT	Control	A three part organisational development plan commenced in April with clinical staff across Specialist Services, focused on unprofessional behaviours and sexual safety (to be completed by the end of May '25). This will be scaled up across the Trust following learning. This 3-part workshop addresses sexual safety, incivility and unprofessional behaviours and aims to bring to life the Behaviours Framework, enhance inclusion and safety for staff. The Sexual Safety Group provides leadership to both patient and workforce foci and reports into the new Executive Quality of Care Group (Co-chaired by the Executive Nurse and Executive Medical Director). A Trust-wide culture review is planned for later in the year and will inform development of the senior leadership development programme.
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	PT	Control	EPUT behavioural toolkit launched, training includes EDI as a core module in High Performing Culture training for management development, and over 120 participants completing this since October '24. RAG rating of the NHS EDI improvement plan actions currently under review to ensure that implementation across the Trust is on track. Note: Risk is to be updated to reflect areas of concern reflected in the WRES and WDES data, as well as wider NHS staff survey (including a decrease in staff reporting reasonable adjustments being in place and BME staff being at a higher risk of bullying, harassment and abuse from service users and members of the public).

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 C4 x L4 = 16	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note 1:** Reassessment of the risk will take place with the potential for de-escalation from the CRR to business as usual operational management and oversight through the Accountability meetings.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	
1	Continue with recruitment campaign	Ongoing	HS	Control	Current vacancy factor is 10.2 wte. Of this, eight offers are in place with four commencing in post at the beginning of April and remaining four joining over the next three months; leaving a vacancy factor of 2.2wte. Reassessment of the risk will take place with the potential for de-escalation from the CRR.

8.2 COMPLAINTS & COMPLIMENTS ANNUAL REPORT

Decision Item | AS | 5

REFERENCES

Only PDFs are attached

Complaints & Compliments Annual Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTROS PART 1	4 June 2025

Report Title:	**Complaints and Compliments Annual Report 2024/2025**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Claire Lawrence, Head of Complaints & PALS, Matthew Sisto Director of Patient Experience and Participation					
Report discussed previously at:	Quality Committee 15 May 2025					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Complaint volumes, themes, response times, service user satisfaction and trust in the integrity of our complaints service.	
Which of the Strategic risk(s) does this report relates to:	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	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	✓
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 number of complaints/ PALS received and closed during the year, response timescales, complaint themes, learning from complaints and compliments, feedback from Complaints Satisfaction Survey, quality assurance feedback from NEDs,	**Approval**	✓
	Discussion	
	Information	

update on the priorities we identified last year, and the priorities set for 2025/26.		

Recommendations/Action Required

The Board of Directors is asked to:

- Note and approve the report for onward sharing.

Summary of Key Issues

The following are some key headlines from the Complaints and Compliments Annual Report

- Total complaints & concerns: 984 (up 5% from 941 in 2023/24)
- Formal complaints received: 249 (down 9% from 275)
- Formal complaints closed: 268, reducing open caseload from 100 to 81
- Formal complaints closed within 60 working days: 44% (up from 29%)
- Formal complaints closed within agreed timescales: 98% (up from 94.8%)
- Average formal response time: 85 working days (down from 100)
- PALS concerns managed informally: 603 (up 12% from 537)
- Top formal complaint category: Clinical practice (147 complaints)
- Re-opened complaints: 13% (vs. 7%)
- Lessons identified: 130 (60%) of 218 formal complaints closed
- Total compliments received: 1,545 (up 15% from 1,344)
- Non-Executive Director review “quality of response letter” rated positively: 100%

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**

Acronyms/Terms Used in the Report			
PALS	Patient Advisory Liaison Service		

Supporting Reports/ Appendices /or further reading
Complaints and Compliments Annual Report 2024/25

Lead

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Complaints & Compliments

Annual Report 2024/2025

May 2025

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PURPOSE

This report provides an overview of the complaints, concerns, and compliments received by the Trust between 1 April 2024 and 31 March 2025 ("2024/25"). It includes data on volumes, response times, and key themes, and highlights learning arising from both complaints and compliments. The report also presents findings from the quality reviews conducted by our Non-Executive Directors and our complaints satisfaction survey— both of which assess the quality of complaint investigations and response letters. Finally, it reviews progress against the priorities set for the previous year and outlines our priorities for 2025/26.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health, and learning disability services to over 3.2 million people across Luton and Bedfordshire, Essex, and Suffolk. With more than 8,000 staff working across 145 sites, our services are delivered not only from Trust premises but also within people's homes and community settings.

The Complaints Team forms part of the Patient Experience portfolio and provides both the Complaints Service and the Patient Advice and Liaison Service (PALS) for people using Trust services. Our role is to support resolution, rebuild trust, and ensure concerns are listened to and acted upon.

While the Complaints Team investigates and responds to formal complaints received by the Trust, many concerns are raised and resolved informally by the services themselves, without a formal investigation. These informal concerns are an important way in which we remain responsive to feedback. They are typically handled through one of the following routes:

- **PALS concerns** – Raised via the Patient Advice and Liaison Service and passed to the relevant service for a direct response.
- **MP concerns** – Raised by individuals through their local Member of Parliament, and responded to directly by the appropriate service.
- **Locally resolved concerns** – Raised directly with a Trust service and resolved informally at a local level without involvement from the Complaints Team.

In some instances, concerns that are initially raised through one of these informal channels are later escalated to be investigated formally—for example, where the issues are particularly complex or where informal resolution is not possible. Regardless of the route taken, all concerns are logged and monitored so that learning can be captured and used to inform service improvements.

Our approach to complaints is complainant-led, focusing on the outcomes that matter most to the person raising the concern. By working in partnership with individuals to agree the most appropriate route to resolution, we have been able to address a greater proportion of concerns informally—enabling faster, more direct responses to less complex issues.

This approach is reflected in the table below, which presents the number of complaints and concerns received, compared with the previous year. Notably, despite a 5% increase in the overall number received, the number of formal complaints has reduced by 9%.

Table 1: Volume received, all types of complaints and concerns

	2023/24	2024/25	+/-
Formal Complaints	275	249	**-9%**
PALS Concerns	537	603	**+12%**
MP Concerns	69	73	**+6%**
Locally resolved concerns	60	59	**-2%**
Grand Total	**941**	**984**	**+5%**

Year Highlights

- Total complaints & concerns: 984 (up 5% from 941 in 2023/24)
- Formal complaints received: 249 (down 9% from 275)
- Formal complaints closed: 268, reducing open caseload from 100 to 81
- Formal complaints closed within 60 working days: 44% (up from 29%)
- Formal complaints closed within agreed timescales: 98% (up from 94.8%)
- Average formal response time: 85 working days (down from 100)
- PALS concerns managed informally: 603 (up 12% from 537)
- Top formal complaint category: Clinical Practice (147 complaints)
- Re-opened complaints: 13% (vs. 7%)
- Lessons identified: 130 (60%) of 218 formal complaints closed
- Total compliments received: 1,545 (up 15% from 1,344)
- Non-Executive Director review “quality of response letter” rated positively: 100%

While we have made significant strides in enhancing our complaints service, we recognise that some patients continue to feel our process lacks impartiality. Feedback from both the 2023/24 and 2024/25 Complaints Surveys indicates a recurring perception that our investigations can appear defensive and biased in the Trust's favour. This perception undermines confidence in our procedures, which aim to be fair, transparent, and focused on learning.

In 2025/26 we aim to address this issue by strengthening the transparency of our process and providing additional training for staff and investigators on unconscious bias and fair decision-making. Our aim is to ensure every complainant can have full confidence in the integrity and fairness of our complaints process.

FORMAL COMPLAINTS

Complaints Process Overview

Complaints received directly by the Trust's Complaints Team are allocated to a Complaints Liaison Officer (CLO), who acts as the primary point of contact for the complainant. The CLO will attempt to make contact with the complainant to discuss the concerns raised, with the aim of agreeing on a clear and appropriate way forward to resolve the issues.

Where appropriate, a formal complaint investigation may be recommended. This is particularly likely when:

- The concerns relate to a past event, rather than an ongoing issue requiring immediate or urgent intervention.
- The nature of the complaint is complex and cannot reasonably be addressed without a detailed investigation.

The Complaints Team conduct independent, evidence-based investigations, focused on providing a fair and impartial view of what occurred. The CLO leads the investigation process, working closely with the complainant and, where necessary, a clinical advisor from the relevant service area.

Once the investigation is complete, a Formal Response Letter is sent to the complainant. This letter outlines how the complaint was considered, the findings of the investigation, and the outcome.

Where failings in care or service have been identified, we acknowledge what went wrong, take accountability, and explain the actions taken to address the issues. The response also includes details of any lessons learned and service improvements implemented as a direct result of the complaint.

Complainants are informed of their right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) should they remain dissatisfied with the outcome.

Complaints Received, Closed and Carried Forward

Carried forward from 2023/24	Received 2024/25	Closed 2024/25	Carried forward to 2025/26
100	249	268	81

Table 2: Complaints received, closed and carried forward

During 2024/2025, the Trust received 249 formal complaints, representing a 9% decrease compared to the previous year's total of 275. This marks the second consecutive year in which the number of formal complaints has declined. The reduction reflects the positive impact of the new complaints process introduced in January 2023, which established a more patient-led approach to resolving concerns.

By working collaboratively with individuals to understand their desired outcomes and agreeing on the most appropriate route to resolution, we have been able to resolve more issues informally—particularly where concerns are related to an ongoing issue, require prompt action, or are of low complexity and do not require a formal investigation.

This is also the second year in a row that we have responded to more formal complaints than we received, leading to a reduction in our overall active caseload. This improvement highlights the efficiency of the revised process and our continued commitment to providing timely and meaningful responses to the people who use our services.

Response Times

Completed within agreed timescale (Target 100%)

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

Every formal complaint is allocated to a Complaints Liaison Officer (CLO) who makes contact with the complainant as soon as possible to discuss the issues raised. The CLO explains how their investigation will be taken forward, and, based on the complexity of the case, provides a likely timescale for completion. If we are unable to meet the original timescale provided, the CLO is responsible for keeping the complainant updated regarding the revised timeframe.

In 2024/25 we completed 98% within the agreed timescale, which was an increase compared to the previous year (95%).

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

While complaint response times naturally vary depending on the complexity of each case, we also monitor performance against a standard internal target of responding within 60 working days (approximately three months). In 2024/25, of the 268 formal complaints closed, 119 (44%) were resolved within this timeframe.

	2023/24	2024/25
Formal Complaints Closed in 2023/24	332	268
Closed within 60 working days (Target 90%)	29% (96)	44% (119)
Closed within Agreed Timescale (Target 95%)	95%	98%
Average Response Time (working days)	100	85

Table 3: Formal complaints response times v. targets, compared with previous year

The results show continued improvement in response times for the second consecutive year. However, we remain some distance from achieving our target of responding within 60 working days in 90% of cases. Resource constraints remain a key challenge, but in 2025/26 we will continue to focus on streamlining our processes to improve efficiency, while ensuring the quality and integrity of our investigations and responses are maintained.

Received per Patient Contacts (by Mental Health and Community Health)

The table below presents the number of patient contacts made in 2024/25 across all Mental Health and Community Services, broken down by locality. Patient contacts refer to any recorded interaction between a patient and a healthcare professional, including face-to-face appointments, phone calls, and virtual consultations. Alongside this, the number of formal complaints received in each area is shown.

The volume of patient contacts provides important context for understanding the complaint figures, as the number of contacts varies significantly between localities due to differences in the scale and nature of services delivered.

Table 4: Formal complaints shown per 1000 patient contacts, by area.

Area (MH Services)	Total Formal Complaints	Total Patient Contacts	Complaints per 1000 patient contacts
Mid & South MH	141	302,960	0.47
North Essex MH	38	100,576	0.38
West Essex MH	22	65,949	0.33
TOTAL Mental Health Services	**201**	**469,485**	**0.43**
Community - South East Essex	9	703,103	0.01
Community - West Essex	13	465,452	0.03
TOTAL Community Services	**22**	**1,168,555**	**0.02**
Grand Total	**223**	**1,638,040**	**0.14**

In 2023/24 the total number of complaints received per 1,000 patient contacts was 0.12.

Received by Care Unit

The services provided by the Trust are organised into distinct Care Units, each responsible for a specific area of healthcare delivery. A Care Unit functions as a management structure, overseeing the performance and quality of services within its area of responsibility. Each Care Unit is led by a dedicated leadership team who work collaboratively to maintain high standards of care, support staff, and ensure the delivery of safe and effective services. Organising services in this way allows for clear accountability, informed decision-making, and a strong focus on both patient experience and service improvement.

The table below shows the number of formal complaints received by each Care Unit in 2024/25, alongside figures from the previous year for comparison.

	2023/24	**2024/25**	**+/-**
Community Delivery Mid and South Essex	88	87	**-1%**
Community Delivery North Essex	30	12	**-60%**
Community Delivery West Essex	34	26	**-24%**
Inpatient and Urgent Care	89	71	**-20%**
Psychological Services	21	37	**+76%**
Specialist Services	10	12	**+20%**
Corporate / Business Units	3	4	**+33%**
Grand Total	**275**	**249**	**-9%**

Table 5: Formal complaints received by Care Unit, compared with previous year

Trend Analysis by Care Unit

The comparative data shows that most areas experienced a reduction in formal complaints received. Significant reductions were seen in Community Delivery North Essex (a 60% decrease) and Community Delivery West Essex (a 24% decrease).

These improvements are largely the result of a stronger emphasis on the informal resolution of less complex concerns. Issues such as staff attitude or communication problems are now more often addressed effectively through direct engagement—such as a meeting between the complainant and the service—rather than through a formal investigation process.

Psychological Services was the only Care Unit to report a significant increase, with complaints rising by 76%—an increase of 16 compared to the previous year. The complaint sub-categories that accounted for the biggest increases for Psychological Services in 2024/25 compared with the previous year were:

- Referrals Appointments (+9)
- Waiting Lists/Times (+3)
- Access to ADHD/ASD Service (+4)

The rise in these categories is linked to a growing number of referrals for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). Greater public awareness of ADHD and other neurodivergent conditions has encouraged more individuals to seek diagnosis and support, placing additional demand on mental health services.

Actions Taken by Psychological Services

The Trust recognises the rise in complaints about waiting times, referrals, and access to ADHD/ASD services, reflecting wider national challenges in neurodevelopmental care. Demand for assessments has grown with public awareness, but current capacity—set by local commissioning—has not kept pace. We are working with commissioners on immediate mitigations and longer-term service redesign, though solutions will take time.

In September 2024, a Quality Senate on Neurodivergence examined systemic pressures and explored needs-based approaches that can guide care without relying solely on full diagnostic

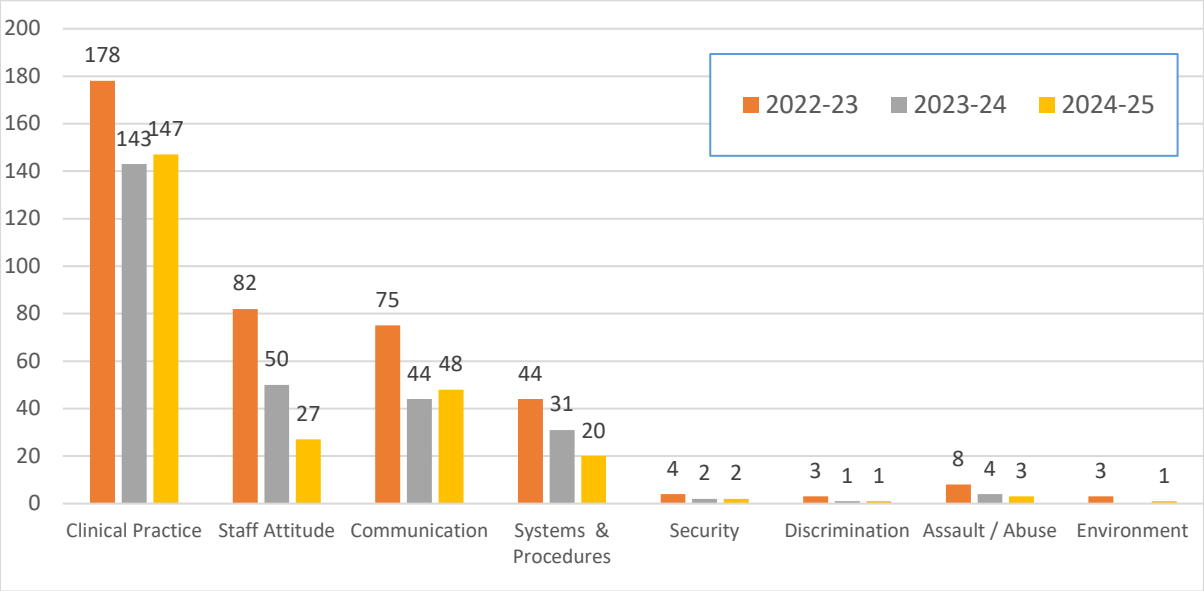
assessments. We are also managing increased prescribing demand after many GP practices withdrew from shared care agreements for ADHD. Resources have been temporarily reallocated for prescribing, and capacity is under review. Ongoing discussions with Integrated Care Boards aim to secure sustainable service delivery.

These steps demonstrate our commitment to tackling root causes of complaints, even as capacity constraints persist locally and nationally.

Complaint Themes

On the Datix Complaints Database, each complaint is assigned to one of eight predefined categories based on its primary issue. The chart below illustrates the three-year trend in formal complaints received across those categories.

Figure 1: Formal Complaints received by main category (three-year trend)



- **Clinical Practice** remained the most frequently reported complaint category in 2024/25. The number of complaints showed only a slight increase from the previous year (147, up from 143), reflecting overall stability in this area.
- **Staff Attitude** complaints decreased for the second consecutive year, representing a 67% reduction compared to 2023/24.
- **Communication** complaints saw a modest rise (48, up from 44), but remain significantly lower than two years ago, when 75 were recorded in 2022/23.

- **Systems & Procedures** complaints also declined for a second year, with only 20 logged in 2024/25—less than half the number reported in 2022/23 (44).
- All other complaint categories remained low and demonstrated an overall downward trend.

Top Ten Sub-categories

Under each main category, there are a number of sub-categories, which drill down further the theme of the complaint. The top ten sub-categories made up 57% of the total formal complaints received in 2024/25 (142 out of 249), as follows:

Table 6: Top ten sub-categories for Formal complaints

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Discharge / Follow Up	20	8%
Communication	Communication breakdown with patient	19	8%
Clinical Practice	Medication	18	7%
Clinical Practice	Assessment & Treatment	16	6%
Clinical Practice	Lack of Community Support	14	6%
Clinical Practice	Referrals / Appointments	12	5%
Communication	Communication breakdown with relatives	12	5%
Systems & Procedures	Waiting Lists/Times	11	4%
Clinical Practice	Unhappy with Treatment	10	4%
Clinical Practice	Diagnosis	10	4%
		142	**57%**

Common themes in the complaints that were categorised under 'Discharge / Follow Up' were:

- **Inappropriate or Unsafe Discharge** – Patients discharged without notice, adequate follow-up, or while still unwell (e.g., suicidal or medically unstable).
- **Poor Communication** – Complaints highlighted unclear discharge decisions, lack of information for patients and carers, and missing or inaccurate documentation.
- **Service Accessibility & Continuity of Care** – Patients reported being discharged due to missed appointments despite valid reasons, or experienced gaps in care due to staff shortages or service limitations.
- **Lack of Compassionate or Person-Centred Care** – Concerns included not feeling listened to, especially during crises, and experiencing dismissive or apathetic interactions with staff.

Complaint Outcomes

When a formal complaint is investigated, a thorough review is undertaken to determine whether there were any shortcomings in the care or service provided. The investigation establishes the facts of what occurred and assesses this against what should have happened, based on relevant regulations, standards, policies, and published guidance.

If the evidence shows a clear discrepancy between the care provided and expected standards, the complaint is recorded as **upheld**. If the investigation concludes that the care or service met the appropriate standards, the complaint is recorded as **not upheld.**

In cases where a complaint raises multiple issues, each point is considered individually. Each is assessed on its own merits and recorded as either upheld or not upheld. Where the findings result in a mixture of upheld and not upheld elements, the overall outcome of the complaint is recorded as **partially upheld.**

268 formal complaints were closed during 2024/25, but a formal investigation was not completed for 50 (18%) cases for the following reasons:

- 6 were withdrawn by the complainant after being logged.
- 2 were initially logged as formal complaints, but were subsequently resolved informally by the service (with the agreement of the person who raised it) to achieve a faster resolution.
- 42 were closed with no investigation for various other reasons, e.g. Patient consent was declined for a complaint made by a 3rd party; a Patient Safety Incident Investigation (PSII) was investigating the same issues so the complaint was closed in agreement with the complainant; complaint was re-directed to a different Trust after discussion with the complainant, a lack of patient engagement can make it impossible to complete an investigation.

The outcomes of the 218 formal complaint investigations completed by the Trust's Complaints Team in 2024/25 are shown in this pie chart:

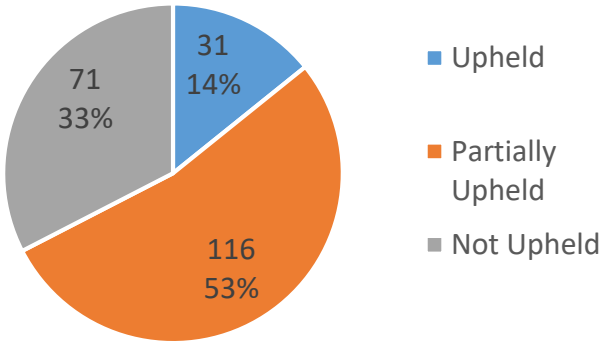


Figure 2: Formal complaints investigations completed, by outcome

Re-opened Complaints

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

Of the 218 formal complaints that were investigated and responded to in the year, 13% (28) were subsequently reopened. The reasons given for requesting the complaint to be re-opened are categorised below in Table 7, alongside the previous year's data for comparison.

Table 7: Reasons for re-opened complaints, compared with previous year

Reason for Re-opened Complaint	2023/24	2024/25	-/+
Inadequate response/ not fully addressed	1	8	+7
Disputes information in response	6	6	-
New questions/ information	8	6	-2
Dissatisfied with investigation	5	6	+1
Unhappy with outcome	3	2	-1
Grand Total	**23/313 (7%)**	**28/218 (13%)**	**+5**

Overall the percentage of complainants that requested a further response has increased to 13%, from 7% the previous year. The number of individuals who felt the response letter was insufficient or failed to fully address their concerns now represents 28% of the reasons cited for re-opening complaints. Comments made include:

- *"Does not feel response letter has addressed the concerns raised"*
- *"Not happy with the level of detail provided"*
- *"Complainant does not feel her concerns have been answered in depth"*

The Complaints Investigation Manager personally reviews all re-opened complaints, and discusses feedback with the Complaint Liaison Officer that investigated and responded to the original complaint. We are committed to learning and improving from the feedback we receive, and the quality of our response letters will be an area of focus for 2025/26.

MP COMPLAINTS

The Trust received 73 concerns from MPs on behalf of their constituents, up by 6% compared with the previous year (69). The top 4 topics for MP complaints were as follows:

- Lack of Community Support (15)
- Unhappy with Treatment (11)
- Access to treatment (9)
- Access to assessment (7)
- Concern for others in the community (6)

LOCALLY RESOLVED COMPLAINTS

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

It is important that we capture the details of concerns that are resolved locally, so that we are aware of emerging issues, and any lessons learned can be recorded and shared as appropriate.

In 2024/25, 59 locally resolved concerns were recorded on Datix, representing a slight decrease of one compared to the previous year's total of 60. The numbers logged are shown below by Care Unit:

Table 8: Locally resolved complaints logged by Care Unit, compared with previous year

Care Unit	2023/24	2024/25	-/+
Community Delivery Mid and South Essex	37	35	-5%
Community Delivery North Essex	12	9	-25%
Community Delivery West Essex	4	7	75%
Inpatient and Urgent Care	6	4	-33%
Specialist Services	0	2	-
Psychological Services	1	2	100%
Total	**60**	**59**	**-2%**

The top nine concern topics accounted for 46 cases, representing 78% of all locally resolved concerns recorded.

Table 9: Top 9 topics of locally resolved concerns for 2024/25

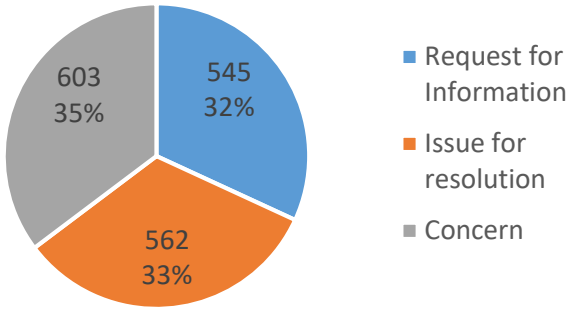
Concern Sub-category	Number received	%
Communication breakdown with patient	23	39%
Referrals / Appointments	4	7%
Inaccurate written records	4	7%
Communication with patients	3	5%
Poor communication between professionals	3	5%
Unhappy with Treatment	3	5%
Medication	2	3%
Consent	2	3%
Staff attitude (rude)	2	3%
Grand Total	**46**	**78%**

PATIENT ADVICE AND LIAISON SERVICE (PALS)

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

The majority of contacts to PALS are either resolved by a PALS Officer at the point of contact, or passed to the relevant service to contact the enquirer and resolve the issue raised. PALS received 1,710 contacts during the year 2024/25, which was a decrease of 5% on the previous year (1,806). A breakdown of the type of enquiries received is shown below.

Figure 3: PALS contacts received, by type of enquiry



In addition, PALS Officers signposted 1,380 enquirers for help to other services/ organisations.

PALS Concerns

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

If the issues raised are complex and require a formal complaints investigation in order to provide a resolution, this would be discussed with the person raising the concerns and, with their agreement, passed to the Complaints Team to manage through the Trust's complaints process. In total, 25 concerns (1.5% of PALS contacts) were passed to the Complaints Team to be investigated as formal complaints in 2024/25.

We remain committed to resolving concerns informally through the PALS service wherever this is likely to achieve the best outcome for the individual raising the issue. In 2024/25, there was a 12.5% increase in the number of concerns managed through PALS, with a total of 603 logged during the year. Of these, the top 11 sub-categories accounted for 73% (439) of all the concerns raised:

Table 10: Top 11 sub-categories for PALS concerns

Main Theme	Sub-category	Number Received	% of Total Received
Communication	Communication breakdown with patient	111	18%
Clinical Practice	Unhappy with Treatment	103	17%
Clinical Practice	Referrals / Appointments	57	9%
Clinical Practice	Medication	37	6%
Communication	Communication breakdown with relatives	31	5%
Clinical Practice	Care	20	3%
Clinical Practice	Lack of Community Support	19	3%
Clinical Practice	Discharge / Follow Up	17	3%
Staff Attitude	Inappropriate behaviour	16	3%
Systems & Procedures	Assessment & Treatment	14	2%
Clinical Practice	Care planning	14	2%
	Total	**439**	**73%**

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

Concern sub-category & Care Unit	Concern Raised	Outcome
Care Psychological Service	Patient finds it difficult to leave his home, does not think he would benefit from therapy. He says calls and appointments with consultant are few and far between. He has contacted crisis on many occasions and is struggling.	PALS referred to service. Service responded putting a plan in place to do a home visit and see what is suitable for the patient.
Patient belongings Specialist Services, The Linden Centre	Patient emailed CQC to raise concern. He is unable to use his phone, as staff will not allow him to use it. Patient broke his TV remote, cannot watch TV as staff took the remote away. Staff have been into his room whilst he was in seclusion.	Integrated clinical lead met with patient. There are legal reasons why patient cannot have mobile phone on the ward, but he can use one with supervision when on escorted leave. Patient damaged the remote control and reason why room was searched was explained to him. Outcome shared with CQC by email.
Referrals/ Appointments Musculoskeletal Physiotherapy (MSK)	The patient is concerned about the time it has taken for an appointment to be made for them with the MSK service.	The MSK service had been trying to contact the patient and left several messages. The referral has been received and a face to face appointment has now been booked.

Response Times

Internal service level: Target =90% within 15 working days

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

In 2024/25:

- 69% of PALS concerns were closed within 15 working days, a slight decrease from 74% the previous year.
- The average response time improved to 14.3 days, down from 15.3 days in the previous year.

While the proportion of concerns closed within the target timeframe has fallen, the improvement in the average response time suggests that the overall handling of concerns has become more efficient. The decrease in cases meeting the 15-day target may reflect increased complexity or volume of concerns, but the shorter average turnaround time indicates that many

concerns are still being addressed more promptly than before. We will continue to monitor both timeliness and quality to ensure a responsive and person-centred service.

PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

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

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

Table 11: Five-year summary of PHSO referrals and investigation outcomes (2020–2025)

	Number of referrals to PHSO	Cases accepted for investigation by the PHSO	PHSO investigation completed	PHSO Outcome
2020/21	39	1	1	Partly Upheld
2021/22	54	0	3	3 x Partly Upheld
2022/23	39	1	0	-
2023/24	64	0	1	Partly Upheld
2024/25	77	0	0	-

In 2024/25, 77 complaints were referred to the PHSO about EPUT services - an increase of 20% compared to the previous year. This increase may be influenced by a range of factors, including greater public awareness and ongoing publicity surrounding the Lampard Inquiry.

It is important to note that this rise does not necessarily reflect growing dissatisfaction with the Trust's complaint responses. In many instances, individuals contact the PHSO without first raising their concerns directly with the Trust. In fact, 20 referrals were not progressed to investigation by the PHSO last year for this reason.

Positively, for the second consecutive year, the PHSO did not accept any complaints for formal investigation.

This suggests that, despite external pressures and heightened scrutiny, the Trust's internal complaints handling process is effective in resolving concerns to a standard that satisfies independent review.

LEARNING FROM COMPLAINTS

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

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

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Examples of Lessons Learned

Lessons were identified in 130 (60%) of the 218 formal complaint investigations closed during the year. Below are several examples of the key learnings from these complaints.

1. Poplar Ward, St Margaret's Hospital (West Essex)

Complaint Summary:
The complainant's mother, diagnosed with dementia, was admitted to Poplar Ward following a fall and surgery. During personal care, the patient, described as non-compliant, sustained a significant leg injury after rolling onto a crash mat and kicking against the bed frame. The family raised concerns regarding the severity of the injury, discrepancies in the explanations provided by staff, and additional bruising. The complainant questioned the overall standard of care and the adequacy of communication surrounding the incident.

Learning Summary:
Staff were reminded of the critical importance of accurately completing and updating body maps in both patient records and at the bedside to ensure effective monitoring of injuries. The importance of adhering to Trust policies, procedures, and communication protocols was emphasized. This learning was disseminated through team meetings and group supervision sessions to reinforce awareness and compliance among staff.

2. Adult Community Psychological Services - South West (Psychological Services)

Complaint Summary:
The complainant raised concerns about a Dialectical Behaviour Therapy (DBT) group therapy session conducted via Microsoft Teams. During the session, another participant was observed with friends present in the background, behaving inappropriately while others shared sensitive personal information. Although the facilitator eventually asked the participant to leave, this occurred halfway through the session, leading to the complainant feeling mistrustful and ultimately withdrawing from the DBT course.

Learning Summary:
Facilitators were reminded to clearly reiterate confidentiality rules and the group contract at the beginning of each DBT session to ensure all participants understand the expectations. An apology was offered for the distress caused, and this issue was addressed in subsequent team discussions to improve group session management.

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3. Basildon Mental Health Unit (MHU) (Inpatient & Urgent Care)

Complaint Summary:
An advocate raised concerns about a lack of understanding and support for a deaf inpatient on Grangewater Ward. The issues highlighted included poor staff awareness of the patient's communication needs, insufficient disability support, and a general lack of knowledge on interacting with individuals with hearing impairments. The advocate sought assurance that actions would be taken to improve both staff practice and the patient's experience.

Learning Summary:
In response, the Trust undertook a review of practices and took steps to improve accessibility and staff awareness. Deaf awareness training is being explored with the Training Department, and staff will receive appropriate training materials. Additionally, 'Accessible Information Standard' posters have been displayed in patient and staff areas to promote inclusive communication. These learning points were shared with staff and reinforced by updated ward signage.

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4. Tendring Specialist Community Mental Health Team Reunion House (North Essex)

Complaint Summary:
The complainant expressed dissatisfaction with communication failures during their care. They were not informed about a change in their care plan—originally, they were to be allocated a care coordinator, but this was changed to a referral for psychotherapy services without prior discussion. Additionally, they were not sent a copy of a letter shared with their GP, leading to confusion and unmet expectations.

Learning Summary:
Staff have been reminded that changes to a patient's care plan should always be discussed with the patient beforehand, whenever possible. If prior discussion is not feasible, patients must be promptly informed of any alterations. Consultants and administrative staff have been reminded to share any correspondence with the patient unless explicitly marked as

confidential. These reminders were reinforced through staff meetings and one-to-one supervision.

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5. Recovery and Wellbeing Southend, (Mid & South Essex)

Complaint Summary:
The complainant raised concerns about their care at the Taylor Centre, highlighting several issues. They were never allocated a care coordinator and were unsure of who their case worker was throughout their involvement with the service. The complainant also noted a lack of continuity, with different staff attending each contact, none of whom seemed familiar with their case. Furthermore, they cited long waiting times for appointments, averaging four to five months, which hindered effective support. The complainant requested an apology and assurances that future communication would be more person-centred.

Learning Summary:
Staff were reminded to review patient notes before appointments, especially when unfamiliar with the patient's history, and to respond appropriately to patient requests and preferences. The Trust reinforced its expectation of professionalism and compassion in interactions with patients and families. This feedback has been incorporated into both individual supervision sessions and team discussions to enhance patient care and communication.

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6. Veterans Team, The Lakes (Specialist Services)

Complaint Summary:
The complainant and their husband raised concerns about delays in receiving therapeutic support, poor communication, and a loss of trust in the psychologist. They expressed that these issues adversely affected the patient’s mental health, and, as veterans, they were concerned that other veterans might experience similar challenges. They sought assurances that lessons would be learned to improve future services for veterans.

Learning Summary:
The following improvements have been made based on the complaint:

- Ensure all emails to patients and families are acknowledged, even if no update is available.
- Review the process for arranging medication reviews to prevent delays.
- Recognise and address delays in therapy or intervention early.
- Consider a phone call with patients before sending letters about removal from a psychologist’s caseload to reduce distress.

An action plan has been implemented to address these concerns, ensuring a more responsive and supportive service for veterans.

7. Specialist Mental Health Team, the Gables (Mid & South Essex)

Complaint Summary:
The complainant, writing on behalf of their brother, raised concerns about the lack of care planning and unprofessional conduct by a staff member at The Gables. The staff member had provided personal contact details, failed to attend appointments, and bought personal items for the complainant's brother. The complainant felt that a letter of apology was insufficient, and that accountability was necessary for the impact on their brother's mental health.

Learning Summary:
The investigation revealed that the staff member had blurred professional boundaries, which led to significant concerns. In response, all staff members will undergo internal training focused on reinforcing the importance of maintaining professional boundaries when interacting with service users. Additionally, the lack of comprehensive care planning was addressed, with an emphasis on ensuring that care coordinators create and share meaningful care plans with service users. This learning has been incorporated into ongoing clinical supervision to ensure continuous improvement in practice.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints Linked to Patient Safety Incidents

All complaints are recorded on the Datix reporting system and cross-referenced with any related incidents to ensure that links between complaints and incidents are identified.

Where a complaint relates to a Patient Safety Incident (PSI), the Complaint Liaison Officer works closely with the Patient Safety Team to ensure a coordinated investigation. This approach helps to avoid duplication and ensures that all aspects of the concern are fully explored. The complainant is kept updated throughout the process.

In 2024/25, 28 complaints were investigated that had links to separate incidents recorded on Datix. Of these, 15 were associated with a Patient Safety Incident. One of these is summarised below.

Example of a Formal Complaint Related to a PSI

Complaint Summary: **Beech Ward, Rochford Hospital**

The complainant raised concerns about poor communication from staff and failures in following proper post-fall procedures after her husband sustained two falls while detained under Section 3 on Beech Ward. She was not kept informed about key developments, including ambulance arrangements, and felt agreed plans for contact were not followed.

Outcome and Learning Summary:

The complaint was partially upheld. Failures were identified in the post-falls procedure and communication with the complainant. Apologies were issued and corrective actions implemented:

- Staff reminded to complete post-falls risk assessments promptly.
- Named Nurse (or deputy) to complete follow-up assessments.
- Staff reminded to keep families updated, especially during key care events.
- Plans to improve staff communication across shifts were initiated.

Legal Claims related to Complaints

Seven new claims were opened that related to complaints during the year—six alleging clinical negligence and one concerning personal injury. Separately, 12 claims linked to formal complaints were closed during the year; these were all submitted prior to 2024/25 and do not include any of the seven newly opened cases.

Of the 12 closed claims, damages were awarded in seven cases, amounting to a combined total of £426,740.

PATIENT DEMOGRAPHICS

Patient demographic information, including ethnicity, age, and gender, is recorded on our complaints database where available. The charts below present a comparison between the demographic profile of patients who made a formal complaint in 2024/25 and the overall demographic profile of our total patient population.

Ethnicity

Figure 4: Formal Complaints by ethnicity of patient

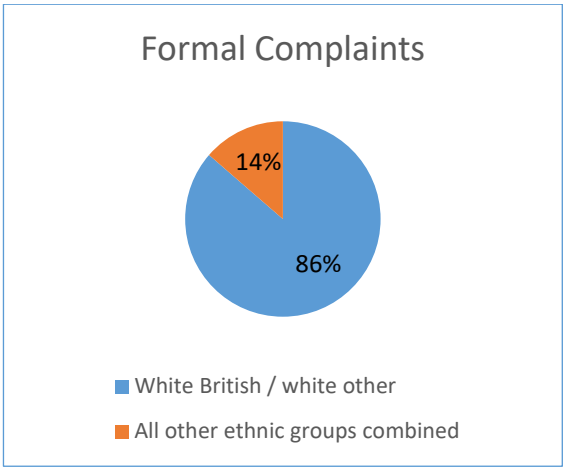
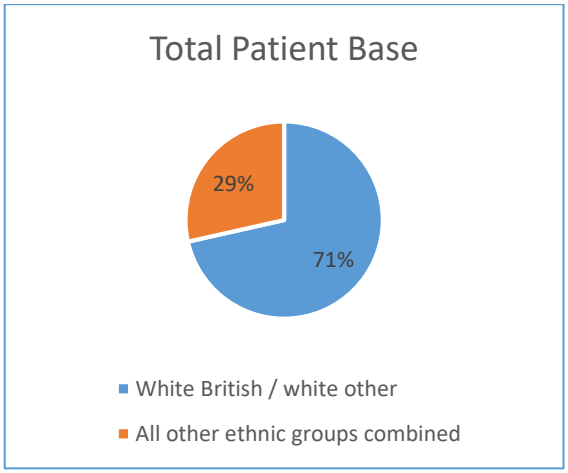


Figure 5: Total patient base by ethnicity



The ethnicity breakdown shows that:

- 71% of the total patient base identify as White British or White Other, while 86% of patients who made a formal complaint were from this group.
- Patients from all other ethnic groups combined make up 29% of the patient base but accounted for only 14% of formal complaints.

What This Tells Us

- White British/White Other patients are proportionately more likely to raise formal complaints compared to their representation in the overall patient population.
- Patients from minority ethnic groups are under-represented among those raising complaints.

This suggests that people from ethnic minority backgrounds may face barriers to using the complaints process — potentially including language barriers, cultural perceptions about complaining, lack of awareness, or trust issues with health institutions.

Age

Figure 6: Formal Complaints by patient age group

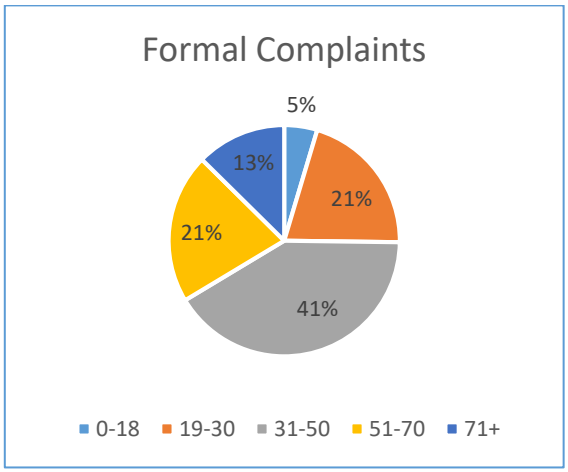
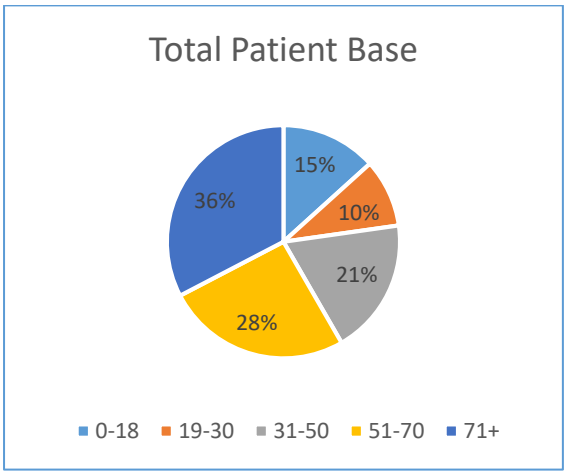


Figure 7:Total patient base by age group



The age breakdown shows that:

- 0–18 years make up 15% of the patient base but account for only 5% of formal complaints.
- 19–30 years represent 10% of the patient base but make up a disproportionately higher 21% of complaints.
- 31–50 years also show a significant over-representation, comprising 21% of the patient base but 41% of formal complaints.

In contrast, older age groups are under-represented:

- 51–70 years make up 28% of patients but only 21% of complaints.
- 71 years and over represent the largest portion of the patient base (36%) but only 13% of complaints.

What This Tells Us

- Younger and middle-aged adults (19–50 years) are significantly more likely to raise formal complaints compared to their proportion in the patient population.
- Children, young people (0–18) and older adults (71+) are much less likely to formally complain, despite being substantial user groups for our services.

This pattern suggests that younger and middle-aged adults may be more confident or willing to use formal complaints processes, while older people and families of children may face more barriers — such as unfamiliarity with the process, feeling uncomfortable complaining, or being unsure how to escalate concerns.

Gender

Figure 8:Formal Complaints by patient gender

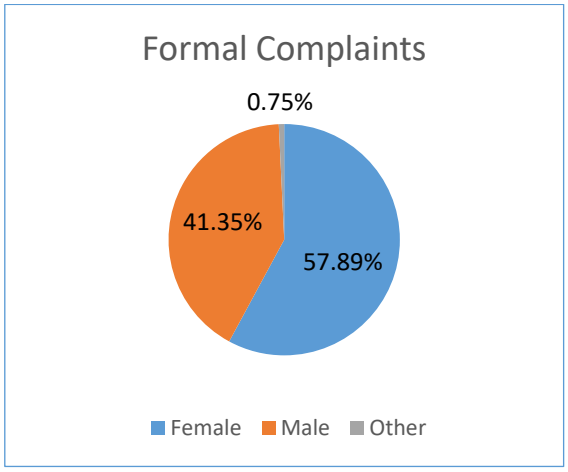
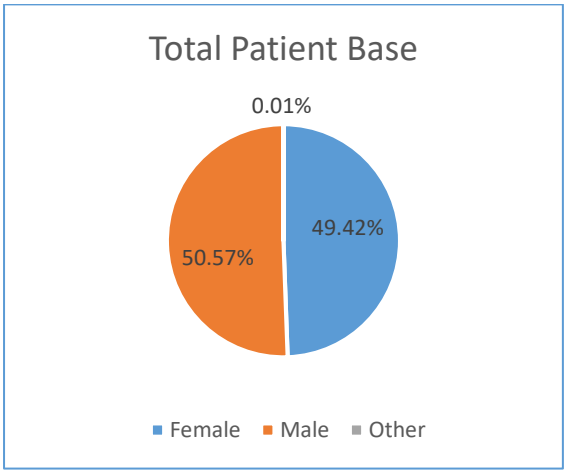


Figure 9: Total patient base by gender



The gender breakdown shows that:

- Females account for 49% of the patient base but make up 58% of formal complaints.
- Males represent 51% of the patient base but only 41% of formal complaints.
- Patients recorded as Other gender make up a very small proportion of both the patient base (0.01%) and formal complaints (0.75%).

What This Tells Us

- Women are more likely to raise a formal complaint than men, relative to their share of the patient population than men.
- Although the proportion of patients identifying as "Other" is very small, it is positive that complaints have been received from this group, highlighting that the process is accessible across genders.

This suggests that women may feel more empowered or comfortable raising concerns, whereas men may face barriers such as perceptions about complaining or reluctance to report issues.

Summary

These findings indicate that while our complaints process is accessible to some groups, there are others who may be less likely or less able to formally raise concerns. We must continue efforts to:

- Make the complaints process visible, welcoming and culturally sensitive.
- Use alternative routes (such as advocacy, family feedback, informal resolution mechanisms) to capture concerns from under-represented groups.
- Regularly review and adapt our approaches to ensure they meet the needs of all our patients and carers.

COMPLAINANT STORIES

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

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

Patient story 1: "This Should Never Have Happened"

Anna's husband, Mark, was admitted to an inpatient mental health ward in 2024. He was struggling with severe anxiety and depression, and it was no longer safe for him to remain at home. Anna hoped that his admission would provide the care and support he needed to begin recovering.

Mark remained on the ward for six weeks, but Anna felt he wasn't making much progress. He was granted some periods of leave, yet still didn't seem well. On one occasion when he was returning to the ward, Anna recalled how he sat in the car pulling at his clothes — clearly in distress. Not long afterwards, she received a call — not from staff, but from Mark himself — letting her know he had been discharged.

Anna was completely unprepared. No one had contacted her ahead of time to let her know this was happening. In fact, she and their two children weren't even at home when Mark returned — they were attending her father's funeral. When she called the ward to find out what had happened, she was told that Mark was considered well enough to go home, and that staff had been too busy to notify her. Although Anna remained calm and polite on the call, she was deeply upset. She hadn't been involved in any discharge planning at all — even though Mark had given consent for staff to share information with her.

The next morning, at around 5am, Anna woke up to find Mark sitting at the end of their bed. He had harmed himself. When she called the ward for help, she was told he couldn't return. Left with no other option, Anna took him to A&E, where he was assessed by the Mental Health Liaison Team. He wasn't supervised while waiting and left the department. Thankfully, the Police later found him safe and brought him home — but Mark admitted to Anna that he had tried to end his life.

The events of that night have left lasting effects. Mark has not yet returned to work. Anna remains shaken by how close her family came to tragedy. Their two young children were in the house when Mark came home that evening and she dreads to think what could have

happened, or what they might have seen. Reflecting on this, Anna said simply: “This should never have happened.”

What We Learned

In response to Anna’s complaint, a full review was carried out. It was clear from the records that Mark had consented for Anna to be involved in his care. Yet she was not included in any discharge planning, and no explanation was documented. Unfortunately, several of the staff involved were no longer working in the service by the time of the investigation, meaning we could not directly ask why this had happened. However, we fully acknowledged that this was a failure to follow best practice.

On behalf of the Trust, a sincere and unreserved apology was given to Anna. Her concerns were shared with senior management and an internal review was requested to understand what went wrong and how we can make sure it doesn’t happen again. The Complaints Team is monitoring this action to ensure it is followed through.

Anna’s story is a powerful reminder of the importance of including families in discharge planning — not just because it is good practice, but because it can make a critical difference to safety and recovery. We are grateful to Anna for coming forward and helping us learn.

Patient story 2: Learning from a Missed Opportunity in Community Care

Jean, aged 90, lives at home with her daughter Sarah, who cares for her full-time. Jean’s complex cardiac condition had been stable for months under the care of the community cardiac team, with regular blood monitoring overseen by a trusted specialist nurse.

In late September, Sarah noticed worrying changes: Jean became confused and her physical health deteriorated. Sarah raised concerns, left messages, and chased updates to check if blood tests had been done, but despite her efforts, they were not carried out.

Eventually, Jean was admitted to A&E as an emergency. Critically ill, she was found to have dangerously low sodium levels, low blood pressure and oxygen, and was experiencing delirium and seizures. Diagnosed with acute and chronic hyponatraemia, Jean spent over two weeks in hospital, suffering confusion and distress throughout.

When discharged, Jean’s condition had changed dramatically. She had lost mobility, needed continence support, and required input from physiotherapy and occupational health teams. Sarah, already struggling with her own health, faced a much greater caring burden.

The day after returning home, Jean's condition worsened again with painful blisters. Despite calls for help, no district nurse arrived until the following day, and even then, blood tests were only taken through the persistence of staff on the ground.

While Sarah praised the compassion shown by individual community nurses, she was left with serious concerns: why hadn't the critical blood tests been done, and why were urgent notes missing from Jean's record? In Sarah's words: *"I'm a huge advocate for the NHS... But someone made a wrong decision with serious consequences. Everything that followed could have been avoided. I just want to make sure this never happens again."*

Sarah raised a formal complaint not to blame individuals, but to understand how the system failed — and to help ensure others are better protected. Her experience is a powerful reminder that clinical safety depends not just on protocols, but on listening, acting promptly, and supporting staff to do the right thing at the right time.

What We Learned

Sarah's complaint prompted a full internal investigation. It was found that Jean's blood tests had been repeatedly deferred without clear clinical justification, and that urgent flags raised by the cardiac team were not properly actioned or documented within the system. The investigation identified communication failures between community services and administrative teams as a significant contributing factor.

Key learning points included:

- **Clearer escalation protocols**: All urgent clinical concerns must be formally documented and flagged for senior clinical review.
- **Training on clinical prioritisation**: Staff were reminded of the importance of prioritising patient safety over routine scheduling concerns.
- **Improved handover processes**: Changes were made to ensure urgent notes are clearly visible and actioned in patient records across all services.
- **Strengthened follow-up systems**: A tracking mechanism was introduced to alert staff when scheduled clinical tasks, such as blood tests, have not been completed within agreed timescales.

An apology was given to Sarah and Jean, acknowledging that had the blood tests been carried out in a timely manner, Jean's emergency admission could likely have been avoided. Sarah's experience directly contributed to changes in practice, with the aim of preventing similar failings for other vulnerable patients in the community.

FEEDBACK ON OUR COMPLAINTS SERVICE

Non-Executive Director Complaint Quality Reviews

The Trust's Non-Executive Directors (NEDs) provide an important and valuable quality review of 10% of complaints that are closed each quarter. The reviewer rates the quality of the investigation and the response, and considers whether the Trust has done all it can to resolve the complaint and if appropriate lessons were identified and taken forward.

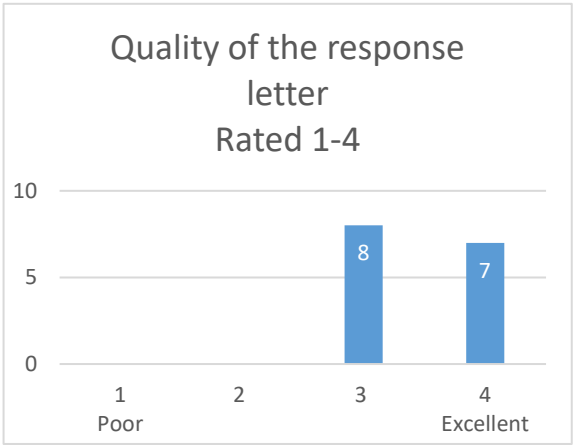
A total of 15 reviews have so far been completed for Q1-Q3 2024/25, which represents 7% of the total formal complaint responses that were sent in the whole year (218). A further 7 reviews will be completed, to ensure that a total of 10% are reviewed.

Of the 15 reviews that have been completed:

- 93% were rated positively for 'how the investigation was handled'
- 100% were rated positively for the 'quality of the response letter'

Figure 10: NED reviews - how the investigation was handled

Figure 11: NED reviews - quality of the response letter



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

Really great communication with the patient throughout the process - well handled

There are words consistent of NHS jargon intermittently. We should always aim to be replying sooner, but it was a reasonable turnaround. Clear and concise investigation

Really good to see the comprehensive set of actions arising from this complaint

Complaints Survey Results

Our complaint response letters include a QR code at the end of every response letter that provides a digital link to our Complaints Response survey, which asks for feedback on people's satisfaction with their experience of the complaints process.

In 2024 we saw a poor response rate to the Complaints Feedback Survey, with only 12 responses received (representing only 5.5% of the total responses sent).

Summary of results 2024/25:

- 37.5% were satisfied that all aspects of their complaint were addressed (v. 28% in 2023/24)
- 27% % believed the complaints process was fair (v. 21% in 2023/24)
- 27% were satisfied with the timescale of the response (v.28% in 2023/24)
- 26% were satisfied with the overall handling of their complaint (v.22% in 2023/24)

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

> Absolutely waste of time they are only there to protect their useless colleagues hopefully the ombudsman will take action. A very disappointed person.

> All conversations between staff, patient and relatives should be recorded. Daily emails to ward and reply within a week.

> There should be more effort to verbally discuss the complaint with the complainant. There should be involvement from everyone involved, including handlers of previous complaints on the same matter and any witnesses. The investigation should not be based solely on the recollection/reports of the person the complaint was about (this is not a balanced, fair approach).

Although satisfaction scores improved compared to the previous year, feedback indicates that we must continue to strengthen trust with those who use our services. Despite the Complaints and PALS teams operating with a degree of independence from clinical services, some individuals expressed concerns that complaint investigations were biased or unfair.

In response, we took several steps in 2024/25 to enhance the fairness and transparency of our processes:

- All members of the Complaints Team completed training provided by the Parliamentary and Health Service Ombudsman (PHSO), aimed at developing skills and confidence in conducting impartial, evidence-based investigations.
- We introduced a new process of sharing the investigation plan with the complainant at the outset, to promote greater transparency and clarity around how we intend to explore their concerns.

Looking ahead to 2025/26, we are committed to building on this progress. Our priorities will include:

- Ensuring all investigations and responses are consistently fair, balanced, and clearly evidence-based.
- Enhancing transparency throughout the process to build greater trust with service users.
- Improving response rates to the Complaints Survey to better capture feedback and guide further improvements.

Direct feedback to Complaints Team

We received lots of positive feedback directly to the team from people that had used the complaints service in 2024/25. Some examples are given below:

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

"Thank you for your response to my complaint. It was endearing to hear that lessons could be learnt from the issues that I raised, at least something good will come of it. The apologies were welcomed for both the lack of support/communication issues and the ongoing situation which never seemed to get resolved and for the personal issues relating to myself which were raised. Thank you once again for all your help in responding to my concerns and for the detailed/outlining of the comments raised.

"Can you please pass my thanks to Jon [Complaints Liaison Officer] for the time and attention this response has taken. It's a really thorough response for a complex complaint and I hope this helps the family understand the process and improvement we've made."

(Comment received from Clinical Advisor from the Service)

"Just wanted to say thank you for the thorough investigation and honesty shown. The empathy in the complaints response. It is very reassuring."

COMPLIMENTS

1,545 compliments were received directly to the services in 2023/24, compared with 1,344 for the previous year. (+ 15%) A selection of compliments are published throughout the year in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

Received by Care Unit

Care Unit	Compliments
Community Delivery Mid and South Essex	718
Community Delivery North Essex	68
Community Delivery West Essex	189
Inpatient and Urgent Care	233
Specialist Services	263
Psychological Services	40
Corporate	34
Total	**1545**

Table 12: Compliments logged by Care Unit

Learning from Compliments

Along with complaints, all compliments received by the Trust are analysed for potential learning that can be shared, as they can provide an excellent opportunity to highlight good practice. Below are some examples of lessons learned from compliments that were shared in internal reports and Trust-wide in the monthly Lessons Identified Newsletter in 2024/25.

> You have a strength, kindness and empathy beyond the uniform. Mum and I couldn't have managed at home without you, Sally. We want you to know how much we both value your support, advice kindness and "road runner speedy actions". Without me even realising, you saved me breaking in half with your gentle persuasion and encouragement to access services I didn't think we needed. On the day mum said goodbye, you gave mum (and me) unfaltering dignity and respect I will never forget. You gave me the strength and support to prepare mum to leave which I could never have done alone. Thank you isn't enough.
>
> **Palliative Care, Thundersley Clinic**

This heartfelt compliment highlights several key elements of good practice in delivering end-of-life care:

- **Compassionate, Person-Centred Care** – Emotional support and empathy were central to both patient and carer experience.
- **Timely, Proactive Support** – Swift actions helped ensure access to essential services when most needed.
- **Empowerment Through Gentle Guidance** – Sensitive encouragement helped the carer manage and access support they hadn't realised they needed.

- **Dignity at the End of Life** – The patient's final moments were handled with unwavering dignity and respect.

I wanted specifically to highlight the first voice of the first team. The shout out goes to Tom on Derwent reception and also Jan. These two people make me feel valued and heard. They give me time to speak to them without pushing me away despite the very busy day they have. They are incredibly kind and caring and deserve FIRST place award for their consideration towards people who need that little bit of kindness in amongst the murky sea of many things. I won't ever forget their kindness towards me.

Home First Team,
The Derwent Centre

This thank you letter identifies some key learning for delivering compassionate clinical care:

- **Warm and Welcoming First Contact –** Reception and admin staff played a crucial role in making the service feel accessible and supportive from the outset.
- **Active Listening and Time Given –** The individuals took time to listen without rushing, helping the patient feel heard and valued.
- **Kindness in Everyday Interactions –** Simple acts of compassion had a lasting positive impact on the person's experience.
- **Recognition of Non-Clinical Staff Contribution –** The compliment highlights the vital role of non-clinical team members in delivering compassionate care.

I would like to thank you for your sensitivity, kindness, professionalism, and support. During what could have been a difficult visit, you made my mum—who is generally suspicious and anxious about all new callers—feel safe and valued. I was also very impressed at the speed and clarity with which you arranged onward interventions and provided continued updates, giving us a clear path forward. Thanks to you, my father is now more open to receiving the support we have been discussing for many months. We hear a lot about the failings of the NHS, but little of the professional services working hard out there. Thank you for your assistance.

Dementia Intensive Support Team,
The Crystal Centre

This thank you note reflects several important principles of high-quality dementia care:

- **Sensitive, Person-Centred Approach** – The team built trust with a vulnerable patient who is typically anxious about new people.
- **Clear and Efficient Coordination** – Onward referrals and support were arranged promptly and communicated clearly.
- **Effective Communication** – Regular updates provided reassurance and a clear plan for the family.
- **Positive Influence on Wider Family Engagement –** The support helped encourage a previously reluctant family member to accept help.

To the Doctors and all the ward staff,

When I arrived, I was at my mental and physical lowest ebb and I honestly believed there was no way back from it.

I give you my heartfelt thanks for nursing me back to where I am today. I realise I have a long way to go, but I'll get there! I have amazing support.

Have a wonderful Christmas and a happy new year.

Henneage Ward,
The King's Wood Centre

Here are the key lessons in good practice drawn from this thank you message:

- **Holistic, Recovery-Focused Care –** The patient experienced improvement in both mental and physical health, suggesting integrated, person-centred support.
- **Restoration of Hope –** The team helped the individual move from a place of despair to a renewed sense of optimism and motivation.
- **Supportive Therapeutic Environment** – The message reflects the impact of a compassionate ward culture that fosters recovery.
- **Continuity of Support Beyond Discharge –** The patient's reference to "amazing support" indicates that care extended beyond inpatient treatment, reinforcing the importance of ongoing encouragement and follow-up.

UPDATE ON PRIORITIES SET FOR 2024/2025

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

Priority	Status	Action Taken
Focus on maximising the integrity of our internal complaints service through the delivery of NHS Complaints Standards training.	Complete	PHSO training completed by the whole Complaints Team (NHS Complaints Standards accredited course), to increase skills and confidence in conducting evidence-based investigations that are balanced and fair.
Build trust with complainants and improve their faith in our service by sharing our investigation plan with them at the beginning of the process.	Complete	This was implemented into our process early last year, with the following benefits: ➢ (a) the complainant is clear on our intended approach and can provide input and feedback at an earlier stage, and ➢ (b) it provides better context for our estimated timescale for completion, which is based on the complexity of the investigation.
Improve response times by providing more effective early dispute resolution, including resolving a greater proportion of concerns via the PALS service.	Complete	We achieved an uplift of 12% in concerns resolved via PALS, which helped reduce Formal Complaint investigations by 12%. This resulted in an improved average response time for Formal Complaints of 85 working days (down from 100 days the previous year).
Implement a robust process for capturing and sharing lessons learned from PALS concerns, to ensure that we are not missing learning opportunities when we resolve complaints informally.	Complete	We have introduced a 'PALS Follow-up Form' which is emailed to the service with every concern logged by PALS, which ask for details of the outcome to the concern and any lessons learned. These are now captured on Datix with the PALS record.
Improve the capture and reporting of the demographic breakdown of our complainants, so we may better identify if there are certain groups who are not speaking up. .	Complete	We now log the Ethnicity, Age and Gender of the patient with the complaint record, where these details are known. An analysis of this data is included in this year's Annual Report.

Engagement with Deputy Directors of Quality and Safety to implement effective feedback and follow up on lessons/ actions	Complete	An effective feedback process is now in place, and DDQS have been engaged to provide monthly feedback on lessons identified.
Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective.	Carry Forward	Work began this year on consolidating complaint categories on Datix, but due to operational pressures this has not been completed.

PRIORITIES FOR 2025/2026

- Reduce the average response time for formal complaint responses by a further 10% (currently 85 working days) through streamlining and improving process efficiency.
- Reduce re-opened complaints to below 8% (from 13%), focusing on quality improvements to address issues classed as 'Inadequate response/not fully addressed'.
- Improve patient confidence in the complaints process by increasing transparency, enhancing staff training on impartial decision-making, and publicly sharing anonymised examples of learning and action.
- Raise findings on under-representation of minority ethnic complainants with the Health Inequalities Steering Group to support action on equitable access to complaints.
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective (Carried forward from 2024/25)

The Complaints Team has made excellent progress over the past year, delivering on the priorities we set for 2024/25 and embedding meaningful improvements across our processes. We have listened carefully to the feedback from people using our service and will use it to further strengthen the way we work — as reflected in the priorities set out for the year ahead. With this strong foundation in place, I am confident we are well equipped to meet the challenges of the coming year.

Report produced by:

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

On behalf of:
Ann Sheridan, Executive Nurse

May 2025

8.3 PATIENT EXPERIENCE AND VOLUNTEERS ANNUAL REPORT

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Patient Experience Annual Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Patient Experience and Volunteers Annual Report 2024/2025**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Amy Poole, Associate Director of Patient Experience and Participation, Matthew Sisto Director of Patient Experience and Participation					
Report discussed previously at:	Quality Committee 15 May 2025					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	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	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?		
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*		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

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

Purpose of the Report		
This report provides the Board of Directors with a review of work undertaken in 2024/25, developments in the Peer workforce, growth and utilisation of the Trust's Lived Experience & Volunteers teams, and focus areas for 2025/26.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note and approve the report for onward sharing.

Summary of Key Issues

Highlights for 2024/25:

- Quarterly IWGC response rates up by comparison to this time last year with a 58% increase in year. The Trust has seen an improvement in the average start rating from 4.7 to 4.78, and a reduction in negative experiences from 5.3% to 2.8%
- Volunteer numbers have been sustained in 2024/25 at 483
- Lived Experience team numbers have grown by 42% to 308 in 2024/25
- Hours of involvement increased by 464% in 2024/25 from 955 to 5388

Recommendations for 2025/26:

- Each service should have at least 1 Lived Experience role/activity to support the delivery and development of the service
- Develop the people participation function and adopt a business-partnering model with People Participation Leads (PPLs) assigned to each care unit. The PPLs will also routinely visit services and sites, to support staff with partnership working and coproduction.
- Implement a SMS solution for iWGC
- Share responsibility of iWGC data collection with operational services
- Share responsibility of CQC Community Mental Health survey if the Trust decides to proceed with this in 2025/26
- Mandate local engagement for senior management and operational staff with the PCREF

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**	

Acronyms/Terms Used in the Report			
iWGC	I Want Great Care		
PCREF	Patient and Carer Race Equality Framework		
SMS	Short Message Service		
CQC	Care Quality Commission		

Supporting Reports/ Appendices /or further reading

Patient Experience and Volunteers Annual Report

Lead

Ann Sheridan, Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Patient Experience and Volunteers

Annual Report 2024/2025

Contents

Purpose

The purpose of this report is to provide an update on the Trust's progress in the patient experience, lived experience, peer workforce, and volunteering domain. This report reflects on progress over the past year with direct reference to the 'Working With People and Communities' enabling strategy; referenced in the Trust's Corporate Strategy 2023 - 2028.

The Aspiration

'Our people (patients, carers, and families included) are involved with key decisions and engaged in driving forward meaningful change; with learning from lived experience at the heart of everything we do.'

To do this, we must consistently involve the people we serve in shared decision-making, co-design, and co-delivery across all of our services and decision making groups.

Our Updated Position

The patient experience portfolio continues to evolve year on year in line with the Trust's context and needs. The portfolio includes:

- Complaints & Patient Advice and Liaison Service (PALS)
- Patient Experience
- Volunteers (inclusive of the Trust's Lived Experience Ambassadors or LEAs)
- iWantGreatCare (iWGC)
- Chaplaincy
- Inpatient Peer Workers

Each of the teams that sit with the portfolio share the common goal of developing our relationship with the people and communities we serve, empowering them to get involved, and to collectively improve services. Until 31st March 2025 the portfolio sat within the Strategy and Transformation directorate, however, from the 1st April 2025, the portfolio has been aligned to the Quality & Nursing directorate under the leadership of the Trust Executive Nurse, Ann Sheridan. The move to the Quality & Nursing directorate will enable the patient experience portfolio to be more closely aligned to improving quality of care, placing lived experience at the centre of quality.

The Trust's strategic direction of placing lived experience within multi-disciplinary and multi professional leadership work streams and core projects has continued to increase in 2024 into 2025, demonstrated by the Quality Priority Steering Group co-chairs, among many other new lived experience leadership roles. As such, we are confident that it has remained clear the partnership we value most, is the one with our patients, their families and carers. The developing reach of the Lived Experience Team, now 300 strong, has meant that it has increased influence over key decisions around quality and improvement within the Trust.

Whilst we recognise that there is a way to go in ensuring all staff work with the people we care for entirely equally, as valued peers and colleagues, we continue to shift the balance of power through subtle and incremental developments.

Transformation

- The team continue to support colleagues from across the NHS, system partners and ICB colleagues to understand and adopt best practice coproduction, utilising our Reward and Recognition Policy
- Ways to get involved and engage remain clear, underpinned by policy, processes and systems
- We have enhanced our staff induction offer and we have trained more LEAs to be able to deliver a staff induction, which has meant a more diverse group being involved
- EPUT have led and established the People Participation Group of the new Unified Electric Patient Record, in partnership with MSEFT
- The three different payment rates of involvement (under the Trust's Reward and Recognition Policy) continue to work well with an increase in lived experience leadership roles. This provides assurance to people with lived experience of the increasing influence in key decision-making at Board level. This includes lived experience leadership roles across all of our major transformation programmes
- Patient Led Assessments of the Care Environment (PLACE) were led by the Patient Experience Team for the third year in row, and the results were included in the national publication. The LEAs that participated as patient representatives, highlighted their sense of empowerment in seeing their feedback from previous years leading to change
- The remit and use of the SUM (Simple, Understandable, and Meaningful) (previously named) PIPE (Patient Information in Plain English) Group has continued to grow and is routinely included in the development and review of patient facing documents
- A large number of the 50 fully trained Peer Workers from our Lived Experience Team, who were part of an inpatient pilot last year, are now in substantive Peer Worker posts in the Trust
- The Lived Experience Ambassador (LEA) function remains established with LEA support weeks scheduled twice a year, inclusive of individual development goals, training needs, concerns and wellbeing
- Our iWGC feedback response rates have increased significantly. Whilst we still strive to include data collection in business-as-usual processes, this provides assurance that our patients, their families and carers, have increasing influence in key decision-making across the Trust. Such feedback identifies best practice, acts as an early warning system for complaints, and is utilised by the Lessons Team
- The former People Participation Committee has been redesigned into the Lived Experience Leadership Group. Every member of this newly formed group is a lead of a specific lived experience work stream and therefore feeds back progress on their own work stream. Such feedback contributes to progressing actions within the Experience Executive Oversight Group
- We updated the Recruitment Policy so that it is mandatory to have an LEA on an interview panel for band 8a roles or above. This has resulted in an increase of LEAs sitting on interview panels

- We identified a gap in the representation of different ethnic communities in our LEA Team and focussed our efforts on changing that in 2024. As a result, we now have an extremely diverse group of LEAs registered (See charts 1 and 2)

Figure 1: Chart 1 2024

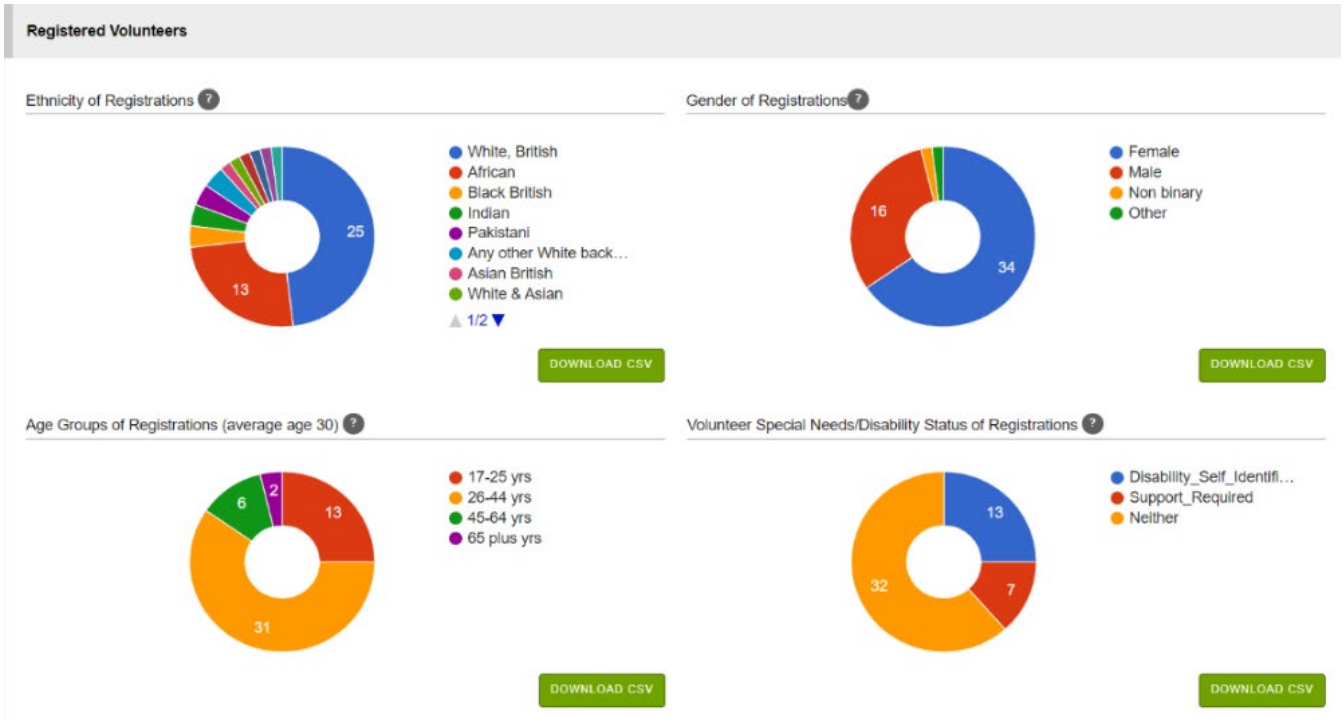
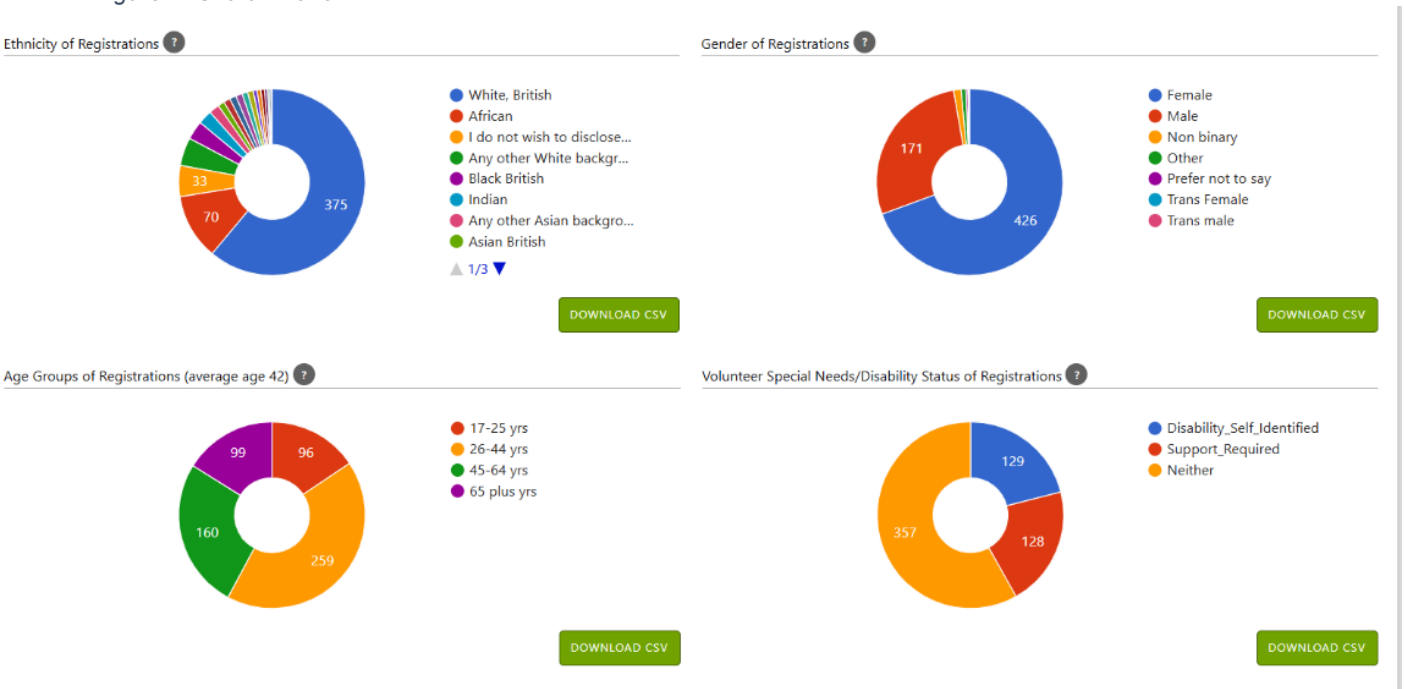


Figure 2: Chart 2 2025



In Essex, the 2021 census data identifies 19 different ethnic groups based on the standard list used for the census. As of March 2023, we reported we had people from 2 different ethnicities sign-up as a Lived Experience Ambassador. In March 2024, we had people from 12 different ethnicities sign-up as Lived

Experience Ambassadors. As of March 2025, we have volunteers (inclusive of Lived Experience Ambassadors) from 20 different ethnicities. This demonstrates the increased reliability and assurance that our volunteering workforce is continuing to increase in representability of the communities we serve.

Engagement Methods

The Lived Experience Leadership Group

This is a key decision-making group around deciding the strategic focus of Lived Experience Practice across the Trust and is made up of our Lived Experience Leads for our critical programmes of work including Time to Care, PCREF and the SUM Group. During the year, it became clear that there were a group of approximately 8 individuals who were particularly invested in the (previously named) People Participation Committee (PPC) and had begun leading their own work streams. As general attendance at the PPC was intermittent, members of the group felt it made sense the group evolve. The committee has maintained the original design to amplify the patient and carer voice to the Executive Team and produce tangible, tracked actions that demonstrate the reciprocal value of the committee.

Coproduction Conference 2024

The 2024 Coproduction Conference was a great success. The conference celebrated the valuable contribution that people with personal experience of using health services are making to shape the care we deliver. More than 120 people attended the event. Guests included staff, volunteers and senior leaders from EPUT, partner organisations, and NHS service providers and commissioners in Essex. We were pleased to welcome guest speakers Lady Julie Jaye Charles CBE and Jan Hutchinson, who spoke about how organisations can work more effectively and meaningfully with patients, families and carers to improve services.

Figure 3: Coproduction Conference 2024

IWantGreatCare

Figure 4 demonstrates the importance of having an IWantGreatCare (iWGC) Reporting and Training Manager in place. In both Q4 2023/24 and Q2 2024/25, our iWGC Reporting and Training Manager role

was put on pause due to budgetary constraints. The drop in feedback for both of these quarters is testament to how effective the role is in maintaining consistent levels of feedback.

Figure 4: IWGC quarterly review count 2023 - 2025

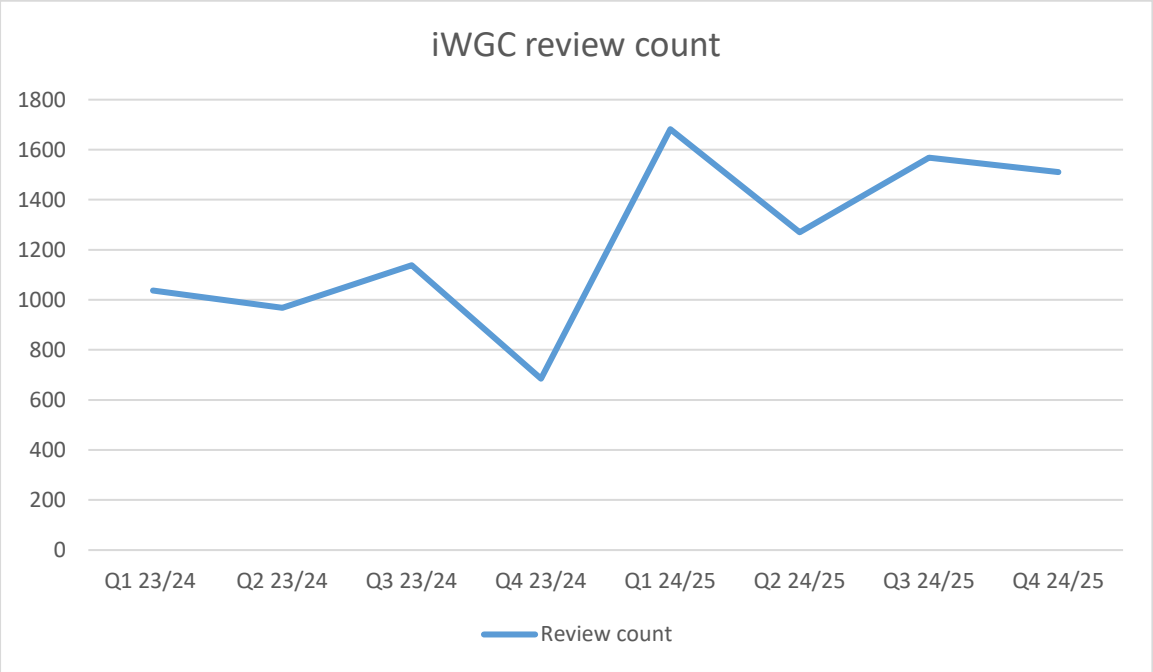
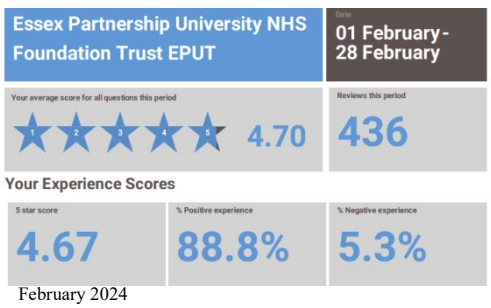
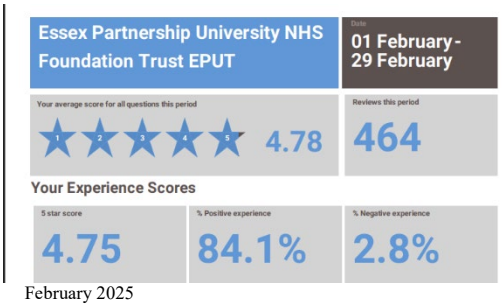


Figure 5 demonstrates a 6% increase in growth within the same calendar month over two consecutive years. Along with the upward trend in response rates, the Trust has seen an improvement in the average start rating from 4.7 to 4.78, and a reduction in negative experiences from 5.3% to 2.8%.

Figure 5: Month on month comparison of IWGC statistics



February 2024



February 2025

After the successful pilot program last year, IWGC volunteers are now working across inpatient units to support and encourage patients, families and carers to leave reviews of their care. The entirety of our iWGC volunteering cohort are health and social care students. By recruiting to this post with our local universities, we are helping to deliver transferable skills to our local community and potentially provide our future workforce with invaluable experience. We plan to reapply this method for further roles next year.

Patients can complete feedback through both digital and paper methods. This personalised outreach method has led to patients reporting an increase in confidence to provide feedback, with volunteers being seen as “more relatable” and able to rephrase questions when needed.

This method also increases accessibility as volunteers can help patients fill out surveys or feedback forms, especially for those who may face barriers to completing them independently, such as language, literacy, or physical limitations. The support provided by volunteers has led to a 76% increase in feedback rates for services with an iWGC volunteer, compared to those without. This suggests utilising our volunteering function to support and facilitate feedback collection, we are better placed to create an environment where patients feel supported and more inclined to share their thoughts, leading to improved feedback rates. Additionally, the physical presence of volunteers on the wards has helped to increase visibility and awareness of the feedback process.

Volunteers Feedback

"As a volunteer, I find immense fulfilment in being able to make a positive impact on people's lives. Volunteering has given me the opportunity to connect with others, learn new skills, improve my communication skills and gain valuable experience. It's incredibly rewarding to see the difference I can make, no matter how small it is.

I believe volunteers are invaluable in gathering feedback from patients. As an impartial and empathetic listener, volunteers can provide a safe space for patients to share their concerns and suggestions. Patients often feel better and at ease sharing their honest opinions with someone who isn't directly involved in their care. This helps to ensure that their voices are heard, resulting in significant advances in patient care and services or the healthcare services." (iWGC Volunteer)

Time to Care

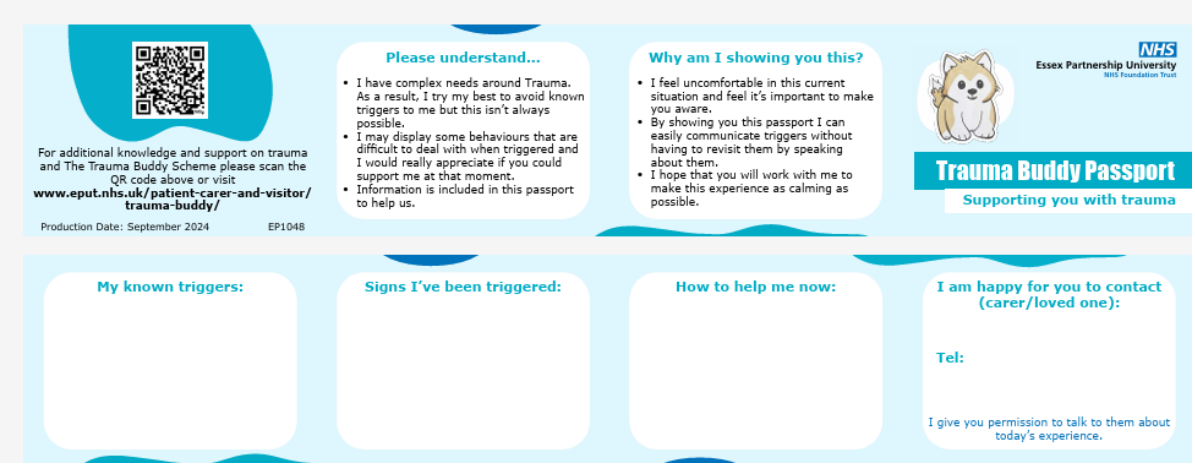
We are proud to have a Lived Experience Coproduction Lead for our Time to Care (TTC) programme. The programme was designed to free up more clinical time so time can be spent on direct patient care by strengthening our multi-disciplinary teams to ensure we have the right mix of skilled and experienced staff to deliver safe, high quality care. This has included implementing a new staffing model inclusive of our Peer Support Workers and Family and Carer Ambassadors. Following a series of inpatient visits, our Coproduction Lived Experience Lead, Jenny Matten has worked with an involvement group of other Lived Experience Ambassadors to coproduce the "Trauma Buddy". Trauma Buddy is a pocket tool shaped as a small booklet that can help staff and patients build a therapeutic relationship faster by gaining insight to an individual's trauma "at a glance", and reduce the risk of further trauma while patients are receiving care in our wards.

Patients can complete the pocket-sized Trauma Buddy with their loved ones and staff in order to help other care professionals understand their individual triggers, and what can be done to support them.

There is also a pocket-sized guide for staff, which gives tips on factors to consider so they can support their patient.

https://youtu.be/PUcS0vJ_plY

Figure 6: Trauma Buddy



Patient Carer Race Equality Framework (PCREF)

As one of the core priority steering groups of the Experience of Care Strategy, significant progress has been made in our efforts to reduce health inequalities throughout 2024/25. Our commitment to addressing health inequalities is being driven through the implementation of the Patient and Carer Race Equality Framework (PCREF).

We have two Lived Experience Leads for PCREF, Tola Gisanrin and Julie Jaye Charles CBE, who are co-chairs of our "Reducing Health Inequalities" Priority Steering Group, and who both apply the PCREF lens to encourage transformational change, focusing on reducing health inequality for racialised groups.

Tola Gisanrin, our Lived Experience Coproduction Lead, has played a pivotal role in our organisation's PCREF implementation journey, and has worked closely with patients to understand their experiences of care, particularly in relation to their spiritual and cultural needs by going into services to undertake qualitative interviews with patients and staff, and working on the themes of these conversations with colleagues in chaplaincy to co-develop a faith and spirituality care assessment.

We are partnering with 'Startchange,' a community interest company founded by our Lived Experience Coproduction Lead, Julie Jaye Charles CBE. Startchange promotes intersectionality and social justice. Together, we are applying their "Men Moving Forward" model to our services, aiming to improve access, experience, and outcomes of mental health services for black men. By recognising the complexities of race, this partnership helps us build more inclusive services for our patients.

In collaboration with our ICB colleagues from Suffolk and North East Essex and the University of East Anglia, we have co-designed cultural awareness training to ensure staff better understand the needs of racialised and ethnically diverse communities. This training will be available on the Blackboard platform starting in April 2025. Tola Gisanrin has been instrumental in developing this training and has established a working relationship with the University of East Anglia to support the creation of additional training modules.

We have strengthened relationships by sharing learning across the three ICBs that EPUT covers, enabling a deeper understanding of how to build meaningful partnerships with minority groups across Essex. For example, a collective Equality Diversity System (EDS) scoring event allowed us to share positive experiences, such as our efforts to educate the homeless about diabetes at local soup kitchens.

Our Lived Experience Team continues to be essential in implementing and developing national frameworks aimed at addressing health inequalities, including EDS 2024, PCREF and PLACE.

A group of five Lived Experience Ambassadors supported our EDS 2024 submission, with the final report uploaded to our website in February 2025 *eds-2024-2025.pdf*.

In response to a request from our national and regional PCREF programme leads, we presented at the Pan Essex meeting in November 2024. This led to the formation of an "across the system PCREF working group." The Mental Health Pan Essex Assurance Group, attended by colleagues from Hertfordshire and West Essex ICB, Suffolk and North East Essex ICB, and Mid and South Essex ICB, is collaborating to share awareness and responsibility for PCREF delivery. The initial presentation resulted in bi-weekly "PCREF across the system" meetings, where we discuss the demographic differences of the three areas EPUT covers and how these affect PCREF implementation. These meetings also provide an opportunity for ongoing learning and collaboration.

Newsletter

At the end of each calendar year, the Patient Experience Team create a newsletter for LEAs and volunteers to summarise achievements of the year, to thank LEAs, volunteers, patients, families and carers for continuing to work with us, and ask for input into proposed plans for the next year.

The newsletter contains case studies of success, word searches and recipes, and has been very well received digitally by the people we serve as a small gesture of gratitude for working with us to continually improve services.

Patient Safety Partners

The Patient Safety Partner (PSP) role is one of our Lived Experience roles and set to become the second involvement role we move from our Reward and Recognition Policy to a substantive post in 2025. The PSPs strive to enhance the safety of our services through effective collaboration, co-production, and continuous learning.

To date, the team has created a tailored PSP handbook for EPUT, which includes guidelines, regulations, the rights and responsibilities of PSPs, and the Code of Practice. Our PSPs are using a re-designed set of patient safety questions for patient walkabouts, which enables patients to choose which category of questions they'd like to answer under the headings of safe, effective, caring, responsive, and well-led.

Southend, Essex, and Thurrock all age mental health strategy, People Participation Group

To ensure the successful implementation of the South, Essex and Thurrock Mental Health (SET MH) Strategy 2023-2028, we have supported the System Implementation Group (SIG) by utilising our

Reward and Recognition Policy and Procedures. The strategy aims to ensure that individuals with lived experience of mental health and professionals in the field collaborate productively to enhance services across Southend, Essex, and Thurrock. As a leader in involving people in this way, EPUT has played a key role in ensuring that individuals with lived experience are central to the strategy, thereby increasing the likelihood of improved outcomes in mental health services across the system. EPUT will continue to coordinate, support, and, when appropriate, lead the implementation of the SET All Age Mental Health Strategy 2023-2028.

Patient Led Assessments of the Care Environment

EPUT was one of 233 trusts that participated in Patient Led Assessments of the Care Environment (PLACE) 2024. PLACE is designed to focus on aspects that matter most to patients, families, and carers. It encourages the participation of patients, the public, and both national and local organisations with an interest in healthcare to assess providers. On the day(s) of assessment, the team visits various areas of the hospital and units (e.g. wards, communal spaces) and completes the relevant scorecards (either paper or digital) based on observed conditions. The results are then sent to NHS England for analysis and benchmarking.

This year, patient assessors were pleased to see that many of their suggested improvements from the previous year were implemented. These included enhancing the garden space at one of our services in Colchester, and encouraging patients to paint on the ward walls during occupational therapy sessions to add more colour to the environment.

General signage remains an area for improvement. Many sites continue to be difficult to locate for first-time visitors, and parking availability needs to be improved to help people find our sites more easily. Feedback from PLACE visits is disseminated to the Quality Committee, local leadership teams, and used to inform change for Estates and Facilities team.

Inpatient Peer Workers

EPUT's Inpatient Peer Workers Team launched in March 2023 and work alongside clinical staff to support patients through their care and recovery.

All of the team have had lived experience of mental health challenges, and provide one-to-one support, group support, help run activities, and work closely with staff to ensure patients' individual needs are being met. The Peer Support Workers are part of the multidisciplinary ward team. Their role involves being empathetic, compassionate and understanding towards patients, showing them they are not alone and providing hope at a time where this may be difficult. They help them along the way through their recovery journey on the ward. For example, one Peer Support Worker supported a service user experiencing psychosis, who was initially too afraid to leave her room due to distressing auditory hallucinations. Being able to leave the ward was necessary for them to be discharged home. For several days, the Peer Support Worker escorted the service user off the ward and on the hospital grounds, helping them to gain confidence. Eventually they felt able to do this alone. During these walking engagements with the service user, the Peer Support Worker was able to learn lots about them, about their mental health history, and the impact this has had on their life.

Peer Support Workers receive specialist peer support training, to give them the tools they need to do intentional peer work. Once completed, they receive certification. They also undertake the mandatory training required to work on inpatient wards, provided by the Trust. In addition to this, Peer Support Workers are encouraged and supported to participate in other training provided by the Trust and other organisations, whether directly related to their role or as part of continuing professional development.

Peer Support Workers are supervised by the Ward Manager as their direct line manager. They are also provided with additional supportive supervision, including reflective and restorative, provided by the Peer Lead. Peer Support Workers work with ward staff, including the Family and Carer Ambassador (FCA), which is a newly created role this year, to involve families, if this is what the patient wants. The FCA role is supporting families and carers, which ultimately supports the patients.

Whilst it is difficult to directly attribute a reduction in incidents to the impact of peer support work, the evidence suggests a strong correlation between the introduction of peer workers into services and a decrease in reported incidents (see image below). Note, peer workers began actively working on the wards in July of 2023.

Figure 7: Reduction of incidents correlating to introduction of peer workers

Peer workers have de-escalated issues between patients and staff and other patients and we have seen a noticeable reduction in incidents on wards with peer workers.

In the Lived Experience Matters podcast created by EPUT, one Peer Support Worker describes how, by regularly talking to a patient, they learnt they were a member of a church and that their faith was important to them. The patient was then able to access online services from their church via a tablet on the ward which put them back in contact with an important community. They said: “It made a major impact on his demeanour, himself, his quality of life. When you are a Peer Support Worker you have time to talk with the patient… and can home in on how to make the patient’s quality of life better.”

Peer support is all about positive practice, in that they support service users with similar lived experiences, providing them with hope and possibilities for change along the way in their recovery journey. Service users report feeling seen, heard, and understood on a more equal footing when engaging with Peer Support Workers. One of the unintended consequences of introducing the Peer Support Worker role has been getting former patients back into paid employment in a really supportive way, bringing hope and meaning to them and those supporting the team on a much deeper level.

Inpatient Peer Worker Feedback

'Being a peer worker has changed my life, I love it' (Peer Support Worker, Secure Service).

'When peer workers are on the ward it feels safer' (Healthcare Assistant, Adult Inpatient Service).

'I haven't experienced anything as well as peer support before, and I have been in hospital a lot over the years. I feel like Peer Support Workers listen to me and understand my perspective more than the other staff.' (Service User, Adult Inpatient Service).

Success Measures

In the Working in Partnership with People and Communities Strategy, six success measures are provided in order to assess the success of the strategic development plan.

- Demonstrable evidence of improvements against all 10 principles of the 'Working With People and Communities' NHS statutory guidance, including centring decision-making and governance around the voices of people and communities, providing clear and accessible public information and having a range of ways for people and communities to take part in health and care services.
- Significant growth in our Lived Experience Team, and evidence of them being utilised at all levels: Where feasible, every governing body has at least one Lived Experience Practitioner, and there is significant evidence of this being central to decision-making, particularly within services
- I Want Great Care: every service is using iWGC, with demonstrable evidence of experience data driving improvement activity, which is feedback to the public
- Coproduction: As an organisation we have a coproduction first approach, and there is significant evidence to support this at all levels. We celebrate and reward good practice seeking national award when we can
- Peer Review: Our peers, (staff, patients and their supporters, and system partners) publicly recognise our improvements in working with people and communities, utilisation of experience data, and our competency for coproduction

The table below provides an overview of progress against each objective and their performance indicators, outlined in the Public Involvement Strategy, and Working in Partnership with People and Communities Strategy.

Success Measure	March 2024	March 2025
Increased involvement	89 opportunities requesting LEA involvement (increase of 93% from March 2023)	198 opportunities requesting LEA involvement (increase of 122% from March 2024)
Increased attendance of forums and networks	Although over 50% of people who attended the EPUT forums in 2023 were members of the public, these were not well attended. With less than a total of 10 attendees at each	Forums have been redesigned. There is now one Lived Experience Leadership Committee. The group remains a key decision-making body and is made up of our Lived

	meeting. Work of the Patient Experience Team this year will be to consider how these forums can be redesigned to increase attendance and serve purpose of providing a listening platform to the people and communities we serve.	Experience Leads for our critical programmes of work including TTC and PCREF.
Volunteering increased across the Trust	484 volunteers; inclusive of LEAs (increase of 79% from 2023)	630 volunteers; inclusive of LEAs (increase of 30%)
Evidence to support a cultural shift	89 opportunities requesting LEA involvement (increase of 93% from March 2023) Coproduction Leads have established place on key working programmes such as TTC and Mental Health Urgent Care Department; running their own involvement groups of LEAs to feed back into wider organisational steering groups.	198 opportunities requesting LEA involvement (increase of 122% from March 2024) Increased Lived Experience Coproduction Leads on key work streams from 2 to 8, this is an increase of 300%.
Better evidence of learning	Learning Collaborative Partnership (LCP) is attended by iWGC Reporting and Training Manager so that lessons identified are coming directly from patient reviews; providing assurance that learning is led by patient, family and carer direct feedback.	iWGC Reporting and Training Manager remains a member of the LCP. Triangulated data from iWGC, complaints and PALS is included in the quarterly report to Experience of Care Group and shared with attendees. iWGC volunteers regularly attend inpatient sites to ensure any learning is being maintained.
Survey responses improved	3828 responses in 2023/24	6031 responses in 2024/25 (58% increase)
Better partner network that delivers real value	Reward and Recognition Policy is inclusive of Voluntary, Community and Social Enterprise (VCSE) partners. 3 partner organisations from the charity and voluntary sector engaging in neurodiversity “doing” group meetings are remunerated under the Reward & Recognition Policy.	Reward and Recognition Policy remains inclusive of VCSE partners. Associate Director of Patient Experience attending improving access, Early intervention and non-clinical support meetings working with colleagues from MIND and Healthwatch to provide support for

		those on the waiting list for treatments. SET MH strategy inclusive of colleagues from Healthwatch and Essex County Council.
Lived Experience Practice (LXP): at all levels, LXP is adopted with a significant increase in Lived Experience roles and activity Trust-wide. Where feasible, every governing body has at least 1 Lived Experience Practitioner, and there is significant evidence of this being central to decision-making, particularly within services.		Since March 2024 Lived Experience Team has grown to 396; an increase of 82%. All quality priority steering groups have Lived Experience co-chairs. Those who attend our Lived Experience Leadership Committee continue to lead on key work streams. Coproduction Leads on work streams such as TTC, PCREF, SET MH Strategy and the SUM Group have increased from 2 individuals to 8, this is an increase of 300%. Requests for lived experience involvement have increased by 122%. Requests for LEAs to be a part of interview panels have increased by 64% Inpatient Peer Support Workers have moved from the pilot to substantive employment, collecting the “Friend of EPUT” Award in 2024.
Significant growth in our Lived Experience Team, and evidence of them being utilised at all levels.	Since March 2023 Lived Experience Ambassador Team has grown by 117% (100 to 217). Coproduction Leads have established places on key working programmes such as TTC and Mental Health Urgent Care Department; running their own involvement groups of LEAs to feed back into wider organisational steering groups.	Since March 2024 Lived Experience Team has grown to 396; an increase of 82%. Those who attend our Lived Experience Leadership Committee continue to lead on key work streams. Coproduction Leads on work streams such as TTC, PCREF, SET MH Strategy and the SUM Group have

		increased from 2 individuals to 8, this is an increase of 300%. Requests for lived experience involvement have increased by 122%.
Coproduction: As an organisation we have a coproduction first approach, and there is significant evidence to support this at all levels. We celebrate and reward good practice seeking national award when we can.	More than 100 people attended the first Coproduction Conference in October 2024. The conference was organised by the Coproduction Champions Network to showcase and celebrate how people with lived experience are contributing to our work and co-designing and shaping our services. Actively recruiting and have successfully filled 4 of the 9 LEA Lived Experience Leads for each of the subgroups of the new Quality Committee. Since March 2023 Lived Experience Ambassador Team has grown by 117% (100 to 217).	2024 conference attended by 120 people with a waiting list for tickets of 15 others. Works for 2025 conference is in progress. All quality priority steering groups have a Lived Experience co-chair. Since March 2024, Lived Experience Team has grown to 396; an increase of 82%.
Peer Review: Our peers, (staff, patients and their supporters, and system partners) publicly recognise our improvements in working with people and communities, utilisation of experience data, and our competency for coproduction.	We asked staff, patients and their supporters to complete a survey as part of the LXP Framework and year-end strategic impact report. The following statements were provided as part of that survey: “I feel that the increase has positively impacted service users in multiple ways. With more Lived Experience Ambassadors there has been an increase in facilities available for us to benefit from” “EPUT provides a broad range of services, and the increase in the number of LEAs has resulted in a more representative cross section of	This year’s testimonials recorded on page 15.

	EPUT users participating in the LEA Team's activities. It's a case of the more the merrier really as you need input across the board - from people who make intensive use of inpatient facilities to those who are outpatient only, from youth to old age. I find that this input of additional voices has resulted in EPUT taking people's views on board" "I feel that this increase has generated more value towards those with lived experience; that we are listened to and heard. That we have a voice and that our inpatient experiences are acknowledged."	

Evidence of Impact

	April 2023	Annual comparison % difference	April 2024	Annual comparison % difference	April 2025
Volunteers	267	+81%	484	-0.2%	483
Lived Experience Ambassadors	132	+ 64%	217	+42%	308
Involvement Activities	46	+43%	26	+112%	55
Hours of Involvement	717	+33%	955.5	+464%	5388

Lived Experience Ambassador Feedback

'I have not felt this good since I had to give up working, 18 years ago' (LEA).

'I had genuine say in who the panel chose as the successful candidate, I actually felt valued' (LEA).

'The Patient Experience Team has empowered me just as much, if not more, than those I see when I go for therapy. The opportunity to be involved in this way, is therapy' (LEA).

'It is refreshing to see a NHS team continue to challenge the norm and remain positive and hopeful for change' (LEA).

'Doing this helps my recovery' (LEA).

Key Milestones

- The success of the Coproduction Conference 2024
- The communications approach to get people involved, and recruitment, is more effective due to having dedicated resource within the Patient Experience Team actively working with our Branding and Marketing Team to ensure organisational alignment
- Developing a People Participation Group for the new Unified Electric Patient Record and receiving full marks in the NHS assurance review under the heading of patient and public involvement in change initiatives
- Associate Director of Patient Experience and Participation leading sessions on the RISE programme, PCREF awareness and Ward Management Development programmes
- Recruiting Family Care Ambassadors as part of the TTC programme
- Piloting “Trauma Buddy” in four of our wards; designed by our TTC Coproduction Lead
- Drafted a health inequalities dashboard using the standard reporting template of PCREF early adopter and pilot sites
- Peer Support Workers are now substantive members of staff
- Working with the University of East Anglia to co-design cultural awareness training for future healthcare staff in line with PCREF
- “Real vs Imagined” workshops with North East Essex community teams
- Our inpatient Peer Support Team won an award for the “Outstanding Friend of EPUT” in the Quality and Excellence Awards
- A MSE System Panel inclusive of patient stakeholders took place in December which collectively scored EPUT as “achieving” across all criteria for the 2024 Equality Diversity System
- Inpatient sites have increased their support for us, developing and improving our ability to work with people and communities by on-boarding Peer Support Workers and Family Care Ambassadors as part of the TTC programme
- Worked with colleagues in employee safety on behaviour pledges that have a focus of anti-discrimination for our inpatient wards which has led to a reduction in recorded incidents
- Lived Experience Ambassadors supported the design and delivery of the North East Essex Mental Health Collaborative Workshop. This interactive day was designed as an opportunity to meet with colleagues from across the system and to focus on partnership and integrated working of mental health services across place base areas. The four themes that are all part of the community mental health pathway: Findings and learnings from Lived Experience, Prevention, Treatment and Living Well

We continue to experience challenges, particularly at a time of immense pressure in the NHS with constrained resources across the board. While none of these challenges are insurmountable, they do present increasing risks. Some of the key challenges we are still to overcome:

- We have lost our iWGC Reporting and Training Manager post

- We have lost our additional People Participation Lead
- The adoption of iWGC has been slower than we would like, and its use is variable
- The utilisation of volunteers and the Lived Experience Team is variable across care units and services

In short, although we have maintained a strong capability for involvement, with the systems and processes in place to support it, we do not have the resource to meet the increasing demands.

Recommendations

We know that we still have a long way to go to achieve the strategic ambition of being the best healthcare provider in this space, although our intent and ambitions remain. Some recommended tactics to support the future delivery of the 'Working with People and Communities' Strategy are as follows:

- Each service should have at least 1 Lived Experience role/activity to support the delivery and development of the service
- Develop the people participation function, and adopt a business-partnering model with PPLs assigned to each care unit. The PPLs will also routinely visit services and sites, to support staff with partnership working and coproduction
- Implement a Short Message Service (SMS) solution for iWGC
- Share responsibility of iWGC data collection with operational services
- Share responsibility of the Care Quality Commission (CQC) Community Mental Health Survey
- Mandate local engagement for senior management and operational staff with the PCREF

The progress we have made is a testament to the dedication of our lived experience teams, volunteers, and partners. However, sustaining this momentum will require strategic investment, increased collaboration, and a shared commitment to embedding lived experience in everything we do. We remain resolute in our ambition to be a national leader in this space.

Our Commitment

Our commitment as a portfolio to the Trust's services and people who use them, remains the same and is based on following five key principles:

1. We will continue to strive to be the best in everything we do, through the amplification of the service user voice, by increasing and elevating involvement and engagement across all our services.
2. We will continue to innovate and lead across our system by increasing and elevating involvement and engagement across all areas of health and social care that EPUT is a deliver partner in.
3. We will enable our services to involve and collaborate in a meaningful way with service users which nurtures a culture that values patient experience through involvement.
4. We will strive to add value across all of ours services through our core capabilities, through the synthesis of patient insight, and by increasing and elevating public involvement and engagement across EPUT.

5. We will continuously improve our offer through evolution and organic growth to meet the needs of the organisation and our systems by increasing and elevating public involvement and engagement across EPUT.

Report produced by:
Amy Poole, Associate Director of Patient Experience and Participation and
Matthew Sisto, Director of Patient Experience and Participation

On behalf of:
Ann Sheridan, Executive Nurse

April 2025

8.4 END OF YEAR GOVERNANCE REVIEWS

Decision Item | DG | 5

REFERENCES

Only PDFs are attached

End of Year Governance 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 June 2025

Report Title:	**End of Year Governance Reviews**					
Report Lead:	Denver Greenhalgh, Senior Director of Corporate Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors Governance Committee (Code of Governance) Council of Governors Finance and Performance Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A – Self-Certification		
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
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 end of year self-assessment reviews undertaken against the Provider License and Code of Governance for NHS Providers.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve the detailed review of Trust compliance against the Provider Licence (including the Code of Governance.

Summary of Key Issues

Provider Licence Review

NHS Foundation Trusts are required to make annual self-certification under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual report submission. There is no requirement to submit these to NHS England, but these must be kept on file and submitted on request.

The Provider Licence was amended in 2023, however, the certificates have not been updated and do not match the new requirements. Therefore, as before, the attached licence review will be filed and relevant forms completed if these become available. Self-certification is required against Section 3 (previously G6 and CoS7 by 31 May 2025, Self-certification is required against NHS2 (previously FT4) and Governor Training by 30 June 2025. The Governor training self-certification was taken forward and agreed by the Council of Governors.

A detailed self-assessment review was undertaken against the requirements of Section 3. General Conditions (G6), CoS7 and NHS2 (FT4) by the Trust Secretary's Office and Finance department. The review indicates the Trust is fully compliant with the provisions of the licence and is attached to this report as Appendix 1.

The Board of Directors is asked to approve the declaration of compliance against the Provider Licence review.

Code of Governance Review

The purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and also confirm that the Trust complies with the provisions, or if not, provide an explanation as to why it has departed from the Code.

The review process has been undertaken as follows:

- Self-assessment against the Code of Governance (Completed)
- Internal independent assessment by the Council of Governors Governance Committee. (Completed)
- Report to Council of Governors (Completed)
- Assurance report to Finance & Performance Committee (Completed)
- Final annual report, including relevant statement to the Board of Directors (4 June)

The self-assessment review of the Trust's position against the Code was undertaken by the Assistant Trust Secretary. The review indicates the Trust is fully compliant with all provisions, except B.2.7 where the Trust has deviated. This Board of Directors composition is Seven Non-Executive Directors (excluding the Chair) and Seven Executive Directors in a voting capacity. In year, the Trust operated with a reduced Non-Executive Director establishment as a consequence of a Non-Executive Director stepping down due to ill health

(March 2024) and another stepping down due to a change in circumstance (October 2024). The Chair took an active decision to hold these positions for recruitment pending the new Chair appointment. This was mitigated in Board Standing Committees with the use of Associate Non-Executive Directors and provisions made for occasions where a board vote may be required. In year, there were no such circumstances where a vote was required.

The Board of Directors is asked to approve the review and the relevant declaration to be made in the annual report.

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

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

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

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Appendix 1: Provider Licence Review Appendix 2: Code of Governance Review

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

EPUT REVIEW OF COMPLIANCE AGAINST THE PROVIDER LICENCE 2024/25 AS AT APRIL 2025

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 1: INTEGRATED CARE			
IC1: PROVISION OF INTEGRATED CARE			
IC1.1	The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph 2.	Compliant	• EPUT utilises integrated care models to provide a range of healthcare services. • EPUT actively works with its partners through both formal and informal mechanisms to foster and enable integrated care • The Trust is actively involved with system working including Board members as members of Integrated Care Boards and the Mid & South Essex Community Collaborative, which is working together with providers of linked services to provide joined-up services. • EPUT has representation on local partnership boards feeding into system wide working and planning • Stakeholders are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership
IC1.2	The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	Compliant	• The Trust Strategic Objectives are in-line with the objectives in the provider licence, such as the delivery of safe, high quality integrated care services, working together with partners to make services better and helping our communities to thrive, which includes reducing health inequalities. • The Trust has developed a number of enabling strategies to support the delivery of strategic objectives; including the Quality of Care Strategy, Working with People & Communities, which specifically supports this condition.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• The Trust has developed and published a Social Impact Strategy and Charter, which aims to be the key driver behind the reducing health inequalities.
IC1.3	The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.	Compliant	• The Chairs Report to the Board of Directors includes a Governance Review which identifies new guidance issued by a range of organisations, including NHS England. This is highlighted to the responsible Executive Director for consideration and reflection in any future developments. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance.
IC1.4	Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests	N/A	
IC2: PERSONALISED CARE & PATIENT CHOICE			
IC2.1	The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	Compliant	• The Trust has internal processes to ensure patient care is as personalised as possible, including the development of personalised care plans. • The CQC Inspection completed in January 2023 (published July 2023) found the Trust provided personalised care across services. Where the CQC identified any areas of improvement for personalised care, this was developed into a CQC Improvement Plan, overseen by the Mid & South Essex Integrated Care Board. • Subsequent inspections of Forensic Inpatient Services and Clifton Lodge (Nursing Home) identified feedback regarding involving people in their care.
IC2.2	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and	Compliant	• The Trust has internal processes which ensure people who use the services are offered information, choice and control to manage their own health and

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.		wellbeing. • The Trust operates a principle of "no wrong door" to ensure individuals are provided with the right level of information and receive the right choice of care wherever they access services. • The Trust operates a principle of purposeful admission for inpatient services to ensure there is a clear pathway for patients entering inpatient services from admission to discharge. • The Trust works with other providers and system partners to ensure the patient pathway is clear, including the Mid & South Essex Collaborative, where partners providing similar services can work together to ensure personalised, holistic care can be provided between organisations. • The Strategic Objective "The Trust will help our communities to thrive" includes ensuring the wellbeing of the local communities and to ensure people are able to manage their own care and wellbeing. The Social Impact Strategy and Charter is now taking this forward. • The previous review for 2023/24 highlighted CQC inspections identifying some areas of improvement in some clinical services for personalised care which was being addressed through the CQC Improvement Plan overseen by Mid & South Essex ICB. As at March 2025, 95% of Must Do / Should Do actions from CQC inspections have been completed are progressing through the evidence review process with the ICB.
IC2.3	Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by	Compliant	• All services have eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts and service specifications. The criteria is reviewed with

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	Commissioners, the person is notified of that choice and told where information about that choice can be found.		commissioners as required. • The EPUT website provides details of service provision by geography and service type. The information includes eligibility criteria and contact details for the service or to find further information. • There are some limitations to choice for some Tier 4 and / or specialised services, where patients may require urgent intervention provided by a particular service provider.
IC2.4	Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	Compliant	• The information on the EPUT website is provided by the individual services and is accurate based upon the service specifications / commissioning contracts. • Commissioners monitor EPUT's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirement.
IC2.5	Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	Compliant	• The EPUT service directory on the website sets-out the services available. • The service information and eligibility criteria is clear on the function of the service and the eligible patients, which allows individuals to make an informed choice in accessing services.
IC2.6	In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	Compliant	• The Standing Orders for the Board of Directors provides a clear procedure for tendering and contracting services, which does not include the providing of gifts and / or benefits in kind for the tendering / contracting of services.
SECTION 2: TRUSTS WORKING IN SYSTEMS			
WS1: COOPERATION			
WS1.1	This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	N/A - Statement
WS1.2	The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Compliant	• The Trust works with other NHS bodies as part of contractual arrangements and collaborative working.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• EPUT has representation on local partnership boards feeding into system wide working and planning • Section 75 arrangements in place with local authorities and the Trust attends Health Oversight Scrutiny Committees (HOSC) with local authorities.
WS1.3	Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i. as necessary and appropriate for the purposes of developing and delivering system plan(s). ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans	Compliant	• As above. • The Financial / Operational Plan is developed alongside the Integrated Care Boards and other NHS bodies to ensure it supports system plans and financial plans.
	b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services. ii. as necessary and appropriate for the purposes of	Compliant	• As above regarding collaborative working and working with local authorities.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	improving NHS services.		
WS1.4	The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a. the Secretary of State for Health and Social Care; or b. NHS England.		• The Trust Secretary's Office receives any new guidance from the Secretary of State for Health and Social Care and / or NHS England and implements as required. • The Chairs Report to the Board of Directors includes a review of any new information / guidance to be shared with the Board of Directors. • The Trust Policy review process includes a requirement for policy authors to horizon scan for any new guidance issued which may impact any policies and procedures, including any relating to co-operation with partners.
WS2: THE TRIPLE AIM			
WS2.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS2.2	When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	Compliant	• The Trust Operational Plan has been developed to consider the quality of care provided, the optimising of resources and the tackling of inequalities. • The Trust Strategic Objectives helping communities to thrive, which includes promoting wellbeing and reducing health inequalities. • The Financial Plan has been developed to take into consideration the financial position of the NHS and local system. • The Trust has robust processes and systems in place to ensure it has the resources necessary to deliver services and support the wider system.
WS2.3	The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	Compliant	
WS2.4	In this condition, "the triple aim" refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	c. more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.		
WS3: DIGITAL TRANSFORMATION			
WS3.1	This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	N/A	• N/A - Statement
WS3.2	The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Compliant	• The Trust Digital & Data Strategy 2023 consider the Health & Care Act 2022 and other guidance published by NHS England. (Page 10) • The Trust has an Information Governance Policy & Procedure in place, which is currently being reviewed, and takes into consideration any legislation as required. • The Trust has an Information Governance Team, responsible for overseeing governance processes within the organisation to ensure it is in line with relevant legislation, including where information is shared as part of cooperation and the triple aim. **Action:** **1. The Information Governance Policy & Procedure was reviewed in 2024 and references the Health & Social Care Act. However, the policy could be reviewed to ensure the references are clearer and specifically references Section 250 of the act.**
WS3.3	The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).		• The Trust Digital & Data Strategy 2023 - 2029 sets-out a plan for data maturity over an 18-24 month period to ensure required levels of digital maturity are reached.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 3: GENERAL CONDITIONS			
G1: PROVISION OF INFORMATION			
G1.1	The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.	Compliant	• The Trust has systems and processes in place to identify and respond to any routine and non-routine information requests. • The Trust submits all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time • Any submissions required are made by the Finance Directorate and retained • Copies of all documents to NHSE are retained
G1.2	Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.	Compliant	
G1.3	The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested.	Compliant	• The Trust has check and balance processes in place, to ensure any information supplied to NHS England is accurate, complete, not misleading and is a true copy of any documentation requested.
G1.4	This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A - Statement
G2: PUBLICATION OF INFORMATION			
G2.1	The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.	Compliant	• The Trust publishes information / documentation on its public website as required and would publish any additional information instructed by NHS England. • The Trust complies with all reporting guidance for annual documents, including the ARM, Quality Account and Constitution.
G2.2	For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals.	N/A	• N/A - Statement

Ref	Condition Summary	EPUT Position	Evidence/Assurance
G3: FIT AND PROPER PERSONS AS GOVERNORS AND DIRECTORS (ALSO APPLICABLE TO THOSE PERFORMING THE FUNCTION OF; OR FUNCTIONS EQUIVALENT OR SIMILAR TO THE FUNCTIONS OF, A DIRECTOR			
G3.1	The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.	Compliant	• The Trust Constitution sets-out disqualifications for acting or continuing as a Director or Governor at EPUT, which includes the criteria provided by this condition. • The Trust has robust systems in place for completing Fit and Proper Persons Test (FPPT), in line with guidance published in 2023. This includes the completion of self-attestations by members of the Board of Directors and a check on public registers to ensure no members of the Board of Directors meets any of the disqualification criteria. • The Trust Fit and Proper Persons Test Policy & Procedure sets-out the requirements for the Board of Directors. • The Code of Conduct for Members of the Board of Directors references the Trust Constitution for any disqualification criteria. • The Council of Governors Code of Conduct includes disqualification criteria, in line with the Trust Constitution, and Governors are required to sign documentation to confirm they do not meet any of the disqualification criteria.
G3.2	The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.	Compliant	• The Fit and Proper Persons Test process described above, is completed as part of the pre-appointment checks prior to any appointment. Annual checks are completed to ensure this is maintained.
G3.3	For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or	Compliant	• As above, the FPPT checks include a review of relevant public registers, including Companies House.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986; iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up; vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.		
G3.4	In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.	Compliant	• The Trust takes into consideration any guidance published by the CQC in relation to FPPT requirements, for example, DBS Checks.
G4: NHS ENGLAND GUIDANCE			
G4.1	Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	Compliant	• The Trust has systems and processes in place to ensure it responds to / meets guidance issued by NHS England. • A monthly Legal Update report is presented to the Executive Team, which would identify any new guidance.
G4.2	In any case where the Licensee decides not to follow the guidance	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.		• Full reviews of NHSE guidance is undertaken by relevant teams including Compliance Team, Trust Secretary's Office, Legal Team, Finance Team as part of reviewing internal processes.
G5: SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS AND RELATED OBLIGATIONS			
G5.1	The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	Compliant	• The Trust has a Board Assurance Framework in place and processes, supportive of the identification and management of risk across the organisation. • Risks are identified and managed at all levels of the organisation, including Board, Standing Committees and local clinical business units. • The Trust undertakes an annual review of compliance with the terms of the provider licence, with actions to address any areas for improvement. • Compliance declarations made by the Board of Directors within required timeframe (note NHSE no longer require these to be submitted)
G5.2	Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness.	Compliant	
G6: REGISTRATION WITH THE CARE QUALITY COMMISSION			
G6.1	The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.	Compliant	• The Trust is registered with the CQC.
G6.2	The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	Compliant	• The Trust CQC Registration has not been cancelled by the CQC to date. • The Compliance Team manages the CQC Registration and any cancellation by the CQC would be notified to NHS England within the relevant timescales.
G6.3	A notification given by the Licensee for the purposes of paragraph 2 shall:		

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	a. be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).		
G7. PATIENT ELIGIBILITY AND SELECTION CRITERIA			
G7.1	The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	Compliant	• Patients' eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts within individual service specifications: available on request • Commissioning contracts are subject to regular reviews. • EPUT website includes its service provision by geography and service type, and contact details. There is limited eligibility criteria included
G7.2	"Eligibility and selection criteria" means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b. if the person is selected, the manner in which the services are provided to the person.	N/A	• N/A - Statement
G8: APPLICATION OF SECTION 6 (CONTINUITY OF SERVICE) - N/A - Section required for Commissioner Requested Services – EPUT does not currently provide any Commissioner Requested Services.			
SECTION 4: TRUST CONDITIONS			
NHS1: INFORMATION TO UPDATE THE REGISTER			

Ref	Condition Summary	EPUT Position	Evidence/Assurance
NHS1.1	The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement
NHS1.2	The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution; b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.	Compliant	• Trust Constitution submitted to NHS England on an annual basis and following any in-year review. • Annual Report & Accounts sent to NHS England upon approval by the Board of Directors.
NHS1.3	Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.	Compliant	• Copies documents listed above submitted to NHS England following approval at Board of Directors.
NHS1.4	The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person.	N/A	• N/A - Statement
NHS1.5	The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	Compliant	• Documents submitted to NHS England via email and would be submitted in any format instructed by NHS England.
NHS1.6	When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is	Compliant	• The documentation is submitted via email with key information in the body of the email advising of the content of the documentation and reason for submitting.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.		
NHS 2: GOVERNANCE ARRANGEMENTS			
NHS2.1	This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	N/A	• N/A – Statement
NHS2.2	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	Compliant	• EPUT has sound corporate governance systems and processes in place, based upon NHS England guidance and other legislation. • The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically
NHS2.3	Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.	Compliant	• The EPUT Green Plan 2021-26 sets-out the Trust ambition for sustainability and the reduction of the Carbon Footprint. • The Digital Strategic Plan 2023 – 2029 provides corporate governance systems and processes, developed in line with NHS England guidance, other digital guidance and legislation. The Strategy will be reviewed on a regular basis and incorporate any new NHS England guidance.
NHS2.4	The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting	Compliant	• The Trust has an effective Board and committee structure with appropriate terms of reference • The Terms of Reference provide clear areas of

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation.		responsibility, reporting lines and accountabilities for each Standing Committee. • Effectiveness reviews of Board and its committees is are completed annually. • Scheme of Reservation and Delegation sets out the powers reserved to the Board and those that the Board has delegated, i.e. the schedule of matters reserved to the Board. This is reviewed annually and reflects delegation derived from the constitution, accounting officer memorandum, standing orders, SFIs, NHSE *Code of Governance* and Board *Code of Conduct* • Reviews of the corporate governance systems included in internal audit annual work programme. • The Trust operates an Accountability Framework, which provides clear accountability for Clinical Business Units.
NHS2.5	The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Compliant	• The minutes of Board of Director meetings and Standing Committees provide details of the effectiveness and scrutiny of all operations. • Regular reports to the Board of Directors cover quality, performance, finance, corporate and clinical governance. • The Board Assurance Framework provides details of any key risks to achieving objectives and is reported to Board on a regular basis. This is supported by a series of local corporate risk registers. • An annual review of the *Code of Governance for NHS Providers* is completed to ensure compliance with all governance requirements. The review completed in 2024/25 indicated the Trust was compliant with all provisions, except B.2.7 where the Trust has deviated. This was caused by the ill health stepping-down of a Non-Executive Director in March 2024 The Board of Directors composition is Seven Non-

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.		Executive Directors (excluding the Chair) and Seven Executive Directors in a voting capacity. In year, the Trust operated with a reduced Non-Executive Director establishment as a consequence of a Non-Executive Director stepping down due to ill health (March 2024) and another stepping down to a change of circumstances (October 2024). The Chair took an active decision to hold these positions for recruitment pending the new Chair appointment. This was mitigated in Board Committees with the use of Associate Non-Executive Directors and made provisions for occasions where a board vote may be required. In year, there was no such circumstances where a vote was required. • An annual review of the provider licence is completed and scrutinised by the Finance & Performance Committee, Executive Team and Board of Directors. • Regular monitoring of progress with objectives set out in the operational plan and enabling strategies, via a regular Strategic Impact Report. • Resources allocated to provision of internal legal services team and to secure appropriate legal advice when necessary.
NHS2.6	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care;	Compliant	• The Board complete an annual appraisal process, including review of skills and meeting of objectives. This is monitored by the Board of Director Remunerating and Nomination Committee and Council of Governors respectively. • The Quality Committee as a standing committee of the Board oversees quality of care considerations for any planning and decision-making processes and reports to the Board of Directors. • The Quality of Care Strategy sets-out the Trust approach to quality and safety over the next few years.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• Accurate, timely and up to date information on the quality of care provided by the Quality and Performance Scorecards and other reports to the Board of Directors. • Governors and members of the public attend Board meetings and can query any information provided to the Board of Directors, including any relating to the quality of care.
NHS2.7	The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.		• Safe staffing reports to Finance and Performance Committee, Quality Committee and Board included in performance, quality and finance reports. • Staffing remains a risk highlighted on the Board Assurance Framework, with the risk recently reviewed and split into three focused areas (Staff Retention, Workforce Sustainability and Organisational Development). • Robust HR recruitment processes and selection criteria and information provided to the Board via the Quality and Performance scorecard. • Time to Care programme currently being implemented, which will ensure the right personnel are completing the right tasks, to ensure better overall staffing. • Fit and Proper Persons Requirements incorporated in employment contracts, contracts and appointing letters to ensure individuals are employed meet the fit and proper requirements. • Regular appraisals in place to ensure individuals are appropriately qualified.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			• Board skills and experience review undertaken when any changes to the Board are being made. The Trust is in the process of implementing the Board-level competency framework recently published by NHS England.
SECTION 5: NHS CONTROLLED PROVIDERS CONDITIONS – N/A – Does not apply to Foundation Trusts			
CP1: GOVERNANCE ARRANGEMENTS FOR NHS-CONTROLLED PROVIDERS			
SECTION 6: CONTINUITY OF SERVICES			
CoS1: CONTINUING PROVISION OF COMMISSIONER REQUESTED SERVICES – N/A – EPUT does not currently provide any Commissioner Requested Services.			
CoS2: RESTRICTION OF THE DISPOSAL OF ASSETS			
CoS2.1	The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	Compliant	• The Finance Directorate maintain an asset register of all capitalised and right of use assets in line with accounting and NHSE guidance. This is subject to external audit and would include both relevant and non-relevant assets that are owned (or have had tenant improvements where leasehold) • Estates retains an asset register for leasehold assets in line with the Asset Register and Disposal of Assets Guidance for Providers of Commissioner Requested Services guidance
CoS2.2	The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	N/A	• EPUT does not currently provide any Commissioner Requested Services
CoS2.3	The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	Compliant	• The register is maintained and updated by the Finance Directorate and is subject to external audit.
CoS2.4	The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.	Compliant	• EPUT is only required to seek NHSE's consent for disposal of assets if NHSE had a concern about its ability to continue as a going concern (currently does not apply). EPUT has a procedure on asset disposals which includes NHSE's requirement for relevant and non-relevant assets
CoS2.5	The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	Condition.		
CoS2.6	The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	Compliant	
CoS2.7	Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	Compliant	
CoS2.10	The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	Compliant	• The Finance Directorate would take into consideration any guidance issued by NHS England in the maintaining of the asset register. • N/A for Commissioner Requested Services
CoS3: STANDARDS OF CORPORATE GOVERNANCE, FINANCIAL MANAGEMENT AND QUALITY GOVERNANCE			
CoS3.1	The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	Compliant	• EPUT has comprehensive corporate and financial governance arrangements, systems and processes in place; these are updated according to changes in guidance/requirements • Compliance with the *Code of Governance* reviewed annually • Annual review of EPUT's constitution, SFIs, SoRD and DSoD against regulation and NHSE guidance • Annual review of Board standing committees' terms of reference against regulation, NHSE guidance and good practice. • Monthly monitoring of performance, quality and finance by Finance and Performance Committee with quarterly review of governance arrangements (Board Governance Framework) and considered at each Board meeting • Risk management programme in place monitored through Finance and Performance Committee and

Ref	Condition Summary	EPUT Position	Evidence/Assurance
			considered at each Board meeting. • Flow and Capacity meetings take place at clinical unit level to ensure services are delivered during periods of high demand or acuity. • N/A – re. Commissioner Requested Service
CoS3.2	In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology	Compliant	• As above regarding consideration of any guidance published by NHS England.
CoS4: UNDERTAKING FROM THE ULTIMATE CONTROLLER			
CoS4.1	The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or	N/A	• Not applicable

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.		
CoS4.2	The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	N/A	• Not applicable
CoS4.3	The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.	N/A	• Not applicable
CoS4.4	For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.	N/A	• Not applicable
CoS4.5	A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is	N/A	• Not applicable

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity.		
CoS5: RISK POOL LEVY			
CoS5.1	The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	Compliant	• No payment requests received from NHSE; any payment required would be made in accordance with licence conditions
CoS5.2	In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	Compliant	
CoS6: COOPERATION IN THE EVENT OF FINANCIAL OR QUALITY STRESS			
CoS6.1	The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	N/A	• N/A – NHS England has not given notice that it is concerned carry on as a going concern.
CoS6.2	When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the	N/A	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.		
CoS7: AVAILABILITY OF RESOURCES			
CoS7.1	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	Compliant	• Operational Plan and Financial Plan developed, setting out details of resource requirements and efficiencies. • EPUT has robust processes and systems in place to ensure it has the resources necessary to deliver its services.
CoS7.2	The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	Compliant	• The Financial Plan developed setting out any plans for entering into agreements and undertaking any activity, with consideration for any material risk to the availability of resources. • The governance documents (SoRD, SFI's, DSoD) provide delegated spend limits for Executive Directors, after which approval would be required by the Board of Directors. Any request for approval by the Board of Directors to undertake a transaction would include consideration of any material risk to the availability of resources. • The Trust Constitution provides for the Council of Governors approval of any transaction defined as "significant" and a procedure is in place for the identification / approval should this occur.
CoS7.3	The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following	Compliant	• EPUT submits certificates/statements as required by NHSE

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".		
CoS7.4	The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	Compliant	
CoS7.5	The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	Compliant	
CoS7.6	The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3	Compliant	• This has not occurred, but the Trust would inform NHS England immediately if any circumstances were to occur.
CoS7.7	The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	Compliant	• The certificates are included in the Annual Report & Accounts, published on the Trust public website.

Ref	Condition Summary	EPUT Position	Evidence/Assurance
SECTION 7: COSTING CONDITIONS			
C1: SUBMISSION OF COSTING INFORMATION			
C1.1	Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	Compliant	• EPUT maintains a costing system that utilises information from the general ledger to calculate planned and fully absorbed costs of providing services. These costs are published on an annual basis • Information can be provided to NHSE as required
C1.2	Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.	Compliant	
C1.3	If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner.	N/A	• The Trust does not sub-contract any services that has been required by NHS England.
C1.4	Records required to be maintained by this Condition shall be kept for	Compliant	• The Storage, Retention & Destruction of Records

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	not less than six years.		Procedure (Appendix 1) provides for any information relating to the ledger (as described above) to be retained for a period of six-years.
C2: PROVISION OF COSTING AND COSTING RELATED INFORMATION			
C2.1	Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	Compliant	• EPUT submits to NHSE all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time in respect of pricing • Copies of all documents are submitted to NHSE and retained by the Finance Directorate.
C2.2	In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested;	Compliant	• Information provided is approved through the relevant and appropriate authorisation processes to ensure information is accurate, complete and not misleading; and is a true copy of the document requested.
C2.3	This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	N/A	• N/A – Statement
C3: ASSURING THE ACCURACY OF PRICING AND COSTING INFORMATION			
C3.1	Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	Compliant	• The Trust operates an internal process for maintaining accurate and complete records in relation to costing. • Internal audit could review the costing and pricing processes within EPUT as part of the internal audit programme, and this assurance could be provided to NHSE as required • Data Quality checks are undertaken by the Information team.
C3.2	This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated	Compliant	

Ref	Condition Summary	EPUT Position	Evidence/Assurance
	representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.		
SECTION 8: PRICING CONDITIONS			
P1: COMPLIANCE WITH THE NHS PAYMENT SCHEME			
P1.1	Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.	Compliant	• All NHS Foundation Trusts continued to operate under the financial regime during 2024/25. The Trust has been paid on the basis of block contract payments for 1st April 2024 to 31st March 2025.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF GOVERNANCE FOR NHS PROVIDERS END OF YEAR REVIEW

2024/25

Code	Provision	Comply	Narrative 2024-25
Section A: BOARD LEADERSHIP & PURPOSE			
A.2. Provisions			
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaborates. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	✓	• The Board of Directors undertakes a review of its effectiveness to ensure efficiency and economy. A review is undertaken annually as part of the Board sign-off of operational plans. These plans include both revenue and prioritised capital budgets with Operational Plans subject to NHS approval. • On an annual basis, the Trust External Auditors perform and Annual Audit Review which includes Value for Money (VFM) assessment. The assessment reviews the proper arrangements are in place to secure economy, efficiency and effective Use of Resources. The 2023/24 annual assessment concluded there were no matters to report by exception on VFM. • NHS England completed a well-led review based on the CQC standards. The results were presented to the Board of Directors in October 2024. The recommendations from the review have been developed into a plan, which will be taken forward via Board Seminar Sessions. • The Trust has performance, quality and finance management systems in place to measure and monitor the Trust effectiveness, efficiency, economy and quality of services on a day-to-day basis. The internal processes are monitored via an integrated performance dashboard and a series of audit processes, including External Audit, Internal Audit and Clinical Audit programmes.

Code	Provision	Comply	Narrative 2024-25
			• The Target Operating Model provides for individual care units to make decisions on the delivery of services by clinical managers which ensures the quality and safety of services for patients. The Accountability Framework provides clarity on the level of responsibility and accountability for the decisions made within the clinical care units. • The Board receives a Quality & Performance Scorecard which provides detailed data to measure the effectiveness, efficiency, economy and quality of services on a regular basis. The scorecard is scrutinised by the Board standing committees and the new Power BI report allows for a more detailed review of all data, including any hotspots and mitigating actions. • The Board Assurance Framework (BAF) is presented at each Board meeting and relevant standing committees, reviewing any key strategic risks and providing updates on any mitigating actions or hotspots for escalation. • The Trust is inspected by the Care Quality Commission (CQC) and the outcomes of any inspection are reported to the Board of Directors to provide assurance on services provided or identifying any issues highlighted by the CQC. • The Trust has a CQC Improvement Plan, which incorporates all areas for improvement identified. The plan is monitored via a CQC Action Leads meeting, which is attended by Care Unit leaders for the identification and implementation of improvement actions. There is also an Evidence Assurance Group, which reviews evidence of action completion to provide additional assurance and ensure impact has led to sustainable change. The Evidence Assurance Group is comprised of our partners from all three ICBs and is chaired by a member of the MSEICB to provide challenge for any actions deemed to have been closed and provide any support for actions requiring input by the wider system. The group increased the number of meetings from January 2025 to increase the pace of assurance.

Code	Provision	Comply	Narrative 2024-25
			• The Compliance Team complete an internal review programme which provides additional assurance in relation to the quality of services and respond to any information requests / inquiries from the CQC. • The Trust works closely with system partners and is involved in collaborative working across the system. Examples include: The Mid & South Essex Community Collaborative partners (EPUT, NELFT & Provide); Mental Health Specialist Commissioning Collaborative detailed in the annual report; and joint working with MSEFT for the joint procurement of new Electronic Patient Record. • The Annual Report for 2023/24 provides a section Key Issues, Opportunities and Risk (Page 14) which includes information on opportunities and risks to future sustainability, lined to the strategic objectives for the organisation.
A.2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaborates. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	✓	• The vision and values of the organisation are underpinned by partnership working. The Vision and Values for the organisation were developed in September 2021 as part of the development of Strategic Objectives, which included consideration of the development of ICB's and the focus on place-based delivery of services. These were developed in consultation with a range of key system partners. • The Vision and Values are underpinned by an overall purpose, which articulates working together with patients, families and system partners as part of the ICB working to ensure there are joined-up services. • The Trust undertakes collaborative working with system partners, including the Mid & South Essex Community Collaborative involving NELFT and Provide Community. • The Vision and Values led to the development of Strategic Objectives, which includes a focus on transformation to develop the culture within the organisation to deliver the vision and values.

Code	Provision	Comply	Narrative 2024-25
			• The Strategic Impact report to the Board of Directors provides an update on key transformation work to develop and drive the culture and behaviours within the organisation to achieve the vision and values of the organisation.
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	✓	• The Quality & Performance Scorecard includes a Workforce & Culture section which provides a range of KPI's for monitoring culture, including staff turnover and sickness absence. • The Staff Survey results are discussed by the Board of Directors on an annual basis, which provides a key indicator in terms of the culture of the organisation. Where the results raise cultural issues, these are developed into action plans to identify and address the concerns. • The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) are additionally used as a measure of internal culture. The results from previous years as well as national comparisons are used to identify potential issues and actions identified to address the concerns. • The Board Assurance Framework was reviewed and the Workforce risk was closed and three new more focused risks identified (Staff Retention, Workforce Planning and Organisational Development) • The Annual Report 2023/24 (Page 101), includes information on staff wellbeing, involvement and recognition, including staff networks, engagement champions and staff recognition scheme. • An externally facilitated external review has been commissioned for 2025/26.
A.2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to	✓	• The Quality & Performance Scorecard provides a range of operational and financial KPI's to regularly monitor the effectiveness, efficiency, economy and the quality of health services provided by the Trust. This is supported by narrative provided in the CEO Report, providing information on key success and hotspots in relation to operational and financial performance.

Code	Provision	Comply	Narrative 2024-25
	the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaborative.		• The KPI's are developed to take into consideration regulatory / contractual requirements and operational / strategic plans which take into consideration partnership and collaborative working. • The Finance & Performance Committee scrutinises the Scorecard and provides any challenge prior to presenting to the Board of Directors. The Quality Committee oversees elements of the quality of services, including the development of the new Quality of Care Strategy. • The Financial Plan for 2025/26 was presented to the Board of Directors in March 2025 and provides information in relation to the development of the Revenue and Capital Plan, which includes meetings at national, regional and local level to agree the financial allocations and plans. • The Trust undertakes collaborative working with system partners, including the Mid & South Essex Community Collaborative involving NELFT and Provide Community.
A.2.5	In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to	✓	• Quality & Performance Scorecard at each Board of Directors meeting and at relevant Committee level (Finance & Performance, People Equality & Culture and Quality). The Power BI scorecard allows data to be reviewed in detail and broken down by relevant demographics. Internal Audit function in place, with programme of work. Audit Committee oversees the programme and provides assurance to the Board of Directors via the Committee Chairs Report.

Code	Provision	Comply	Narrative 2024-25
	provide an adequate and reliable level of assurance.		
A.2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	✓	• The EPUT Strategic Plan 2023-2028 contains plans for each of the clinical care units, which provides information on the local approach to clinical governance. • The Quality of Care Strategy (January 2024) sets-out the Trust approach to clinical governance, including the replacement of the Clinical Governance & Quality Sub-Committee with a multi-professional quality senate. • The Trust has in place a clinical governance structure, which includes subject matter experts, forums and procedural documents. For 2024/25 the clinical governance structure has been redesigned to align with the Quality of Care Strategy with the development of Executive led groups for Safety of Care; Effectiveness of Care and Experience of Care. This is set out in the Quality of Care Strategy. • The Quality Committee focuses on the Trust approach to quality and outcomes. It oversees the establishment of appropriate systems for ensuring effective clinical governance and quality management arrangements are in place throughout the Trust. • The Trust employees key subject matters experts who lead of specific areas of clinical governance e.g. Director of Patient Experience and Participation; Director of Patient Safety; Director of Infection Prevention and Control; etc.
A.2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on	✓	• The Trust has a continuing positive relationship with stakeholders and staff through the delivery of strategic plans and delivering performance against contracts. Any risks to public stakeholders are managed through formal review processes with NHS England and the ICBs through joint actions on specific issues. • Risks are also reviewed via scrutiny meetings with Local Authorities Health and Overview Scrutiny Committees (HOSC).

Code	Provision	Comply	Narrative 2024-25
	significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.		• Members of the Board of Directors engage regularly with the ICB's, including membership of the individual Boards (ICB and ICP). • The Working In Partnership with People and Communities Strategy sets-out the movement towards co-production and co-design, which includes having service user representatives on various groups, quality improvement initiatives and service led programmes. • The Trust has in place a Membership Strategy, which aims to enhance the engagement with its members. • The papers for the Board of Directors are published and members of the public can review performance data using the Power BI system. Members of the public are invited to attend the meeting and submit any questions on any information contained within the Board reports. • The Council of Governors Engagement with the Board of Directors Policy and Procedures sets-out the processes in which the Board of Directors will engage with the Council of Governors, including information to be provided to allow Governors to represent the views of the members at all levels of the organisation. • The Board of Directors (Executive and Non-Executive) regularly attend the Council of Governors meetings. • Executive and Non-Executive Directors attend the Your Voice Meetings, where members of the public are invited to share their views on a particular subject and there is an open session for members of the public to share their views on any subject. • The Trust Annual Members Meeting was last held on the 24 October 2024. • Executive Directors, Non-Executive Directors and Governors undertake some service visits to engage with staff, patients, service users and family members to understand the level and quality of services being provided and represent any views during relevant Board-level discussions.

Code	Provision	Comply	Narrative 2024-25
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	✓	• Annual Report 2023/24 (Page 131) includes an Involvement of Stakeholders section. • The Annual Report 2023/24 (Page 153) includes details of the Mental Health Provider Collaborates in which the Trust is involved. The Annual Report 2023/24 (Page 11-12) includes details of our Care Unit structure and that they are place-based, and describes our key partnerships across four integrated care systems, to maximise local delivery for the local community.
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	✓	• The Trust has a Freedom to Speak-Up Principal Guardian (Bernadette Rochford) to complement existing systems for raising any concerns including line management, Employee Relations, Safeguarding and Student Facilitators. • The Trust has a Freedom to Speak-Up / Whistleblowing Policy, which supports existing arrangements. • The Principal Guardian presents update reports to the Board of Directors and has attended meetings to provide the update. • The Principal Guardian delivered a presentation to the Council of Governors, providing details of the current process and plans for future improvements. • The Trust launched new mandatory training modules for all staff to complete, focusing on the three key elements of Freedom to Speak-Up (Speak-Up, Listen-Up, Follow-Up) • The Freedom to Speak-Up Principal Guarding has an open invitation to address the Board of Directors if there are any significant concerns identified.

Code	Provision	Comply	Narrative 2024-25
A.2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	✓	• The Board of Directors has in place a Conflict of Interest Policy and Procedure which clearly sets-out the process to be followed should a conflict of interest arise. • The Board of Directors has an item at each meeting for Board members to declare any conflict of interest for items on the agenda and action is taken by the Chair should a conflict arise. • The Conflict of Interest register is available on the Public Website.
A.2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	✓	• Board of Director meetings are comprehensively and accurately record in the minutes and include any concerns raised by Directors. • Evidence contained in the minutes that Directors seek assurance relating to concerns they may have and request assurance or action where it is not immediately available. • There have been no instances where a Non-Executive Director has resigned due to having concerns. However, concerns would be circulated to the Board of Directors if this situation were to arise.

Code	Provision	Comply	Narrative 2024-25
Section B: Division of Responsibilities			
B.2. Provisions			
B.2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	✓	• The Board of Directors schedule of business provides items for all future meetings and is used to develop each agenda. The agenda is discussed with the Chair to ensure they are satisfied with the focus of the business and there is adequate time for discussion on all items. • The Chair is provided with an annotated agenda prior to any meeting, which provides information on each item to help ensure the right amount of time is dedicated to each item. • The Council of Governors schedule of business provides the items for all future meetings and is used to develop each agenda. The Lead / Deputy Lead Governor meets with the Chair prior to the Council of Governors to review and agree the agenda. • The Standing Orders for the Board of Directors and Standing Orders for the Council of Governors includes provisions for setting the agenda, including any additional items being added with written permission from the Chair.
B.2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	✓	• Papers and information for Board meetings are shared with Directors via a Board Portal, which allows papers to be uploaded as they are made available. • The papers are circulated to the Council of Governors prior to the Board meetings and for public board meetings posted on our externally facing website. • The Standing Orders for the Board of Directors provides the minimum time for papers to be circulated to Directors prior to any Board of Director meeting. • Governors receive a weekly Governor Update, which includes any additional information to enable them to perform their duties effectively.

Code	Provision	Comply	Narrative 2024-25
			• The Learning and Development Plan for Governors provides topics to ensure Governors have the necessary skills and knowledge to undertake their role. The plan is developed and monitored by the Council of Governors Training & Development Committee. • The Governors receive a Governor Induction booklet upon election and annually, which provides detailed information on the Trust and the role of a Governor.
B.2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	✓	• The Trust operates an open and honest culture, which is underpinned by the Code of Conduct for the Board of Directors, which is based on the Nolan Principles. • The Chair promotes a culture of honesty, openness, trust and debate at each Board of Directors meeting, ensuring that Executive Directors / Non-Executive Directors are provided with the opportunity to constructively challenge each other in an open environment. • The Standing Committees of the Board are chaired by Non-Executive Directors, allowing a detailed scrutiny of items prior to the Board of Director meetings. • The Chief Executive Officer regularly meets with the Non-Executive Directors to share details of the operating of the Trust and any topical / emergent issues. There is a programme of Board Seminar / Development sessions where Executive and Non-Executive Directors meet to discuss certain topics or upcoming strategies / services.
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	✓	• The Council of Governors Relationship with the Board of Directors Policy & Procedure sets-out how the Board and Council will work together effectively, including in the event of any dispute.

Code	Provision	Comply	Narrative 2024-25
			• The Board and Council hold joint seminar sessions twice per-year to discuss key topics of shared interest. • Executive and Non-Executive Directors regularly attend (by invitation) Council of Governor meetings. • Non-Executive Directors meet with Governors quarterly at a constituency level. • The Council of Governors has a quarterly meeting with the Chief Executive Officer who provides information relating to operational matters.
B.2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	✓	• The independence of the Chair is set-out in the recruitment criteria for any appointment. • The Trust operates an electronic declaration of interest system where individuals, including the Chair, are required to make annual declarations. • The role of Chair (Professor Sheila Salmon) and CEO (Paul Scott) are held by separate individual s. The current Chair has not been a CEO of the Trust. • The Trust appointed a new Chair (Hattie Lewelyn-Davies) due to start in post on 1 April 2025. • The Trust has a Vice Chair (Loy Lobo). The role and appointment of the Vice Chair is set-out in the Managing the Absence of the Chair Procedure. • The Trust has a Senior Independent Director (Dr Mateen Jiwani) • The Chair is not a member of the Audit Committee. The Chair of the Audit Committee is Elena Lokteva.
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive	✓	• The Annual Report 2023/24 (Pg109) provides a statement confirming the independence of the Non-Executive Directors following review of the Code of Governance.

Code	Provision	Comply	Narrative 2024-25
	director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval).		• The electronic declaration of interest system requires Non-Executive Directors to make an annual declaration. The Board of Directors agenda includes an item for Board members to declare any interest that may impact their independence for any items on the agenda. • As at 31 March 2025 there are no circumstances identified which are likely to impair the independence of the Non-Executive Directors as outlined in this provision. • The Chair of the Trust has served longer than six-years, however, this was due to an extension to their term of office which was agreed through appropriate governance with NHS England and the Council of Governors. The term of office for the Chair ended on 31 March 2025.

Code	Provision	Comply	Narrative 2024-25
	• is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.		
B.2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	x	• The Board of Directors composition is Seven Non-Executive Directors (excluding the Chair) and Seven Executive Directors in a voting capacity. In year, we operated with a reduced Non-Executive Director establishment as a consequence of a Non-Executive Director stepping down due to ill health (March 2024) and another stepping down due to a change of circumstance (October 2024). The Chair took an active decision to hold these positions for recruitment pending the new Chair appointment. We mitigated this in our Board committees with the use of Associate Non-Executive Directors and made provisions for occasions where a board vote may be required. In year, there were no such circumstances where a vote was required.
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	✓	• There are no Directors who are also Governors of the Trust or any other Foundation Trust.
B.2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the	✓	• The Trust reviews the roles of Non-Executive Directors, including membership / chairing of Standing Committees. This is reviewed and refreshed on appointment of new Non-Executive Directors. • The Council of Governors Nominations Committee reviews a skills matrix to ensure any gaps in skill sets, backgrounds and lived experience are

Code	Provision	Comply	Narrative 2024-25
	council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.		considered as part of any appointment process. This includes ensuring at least one Non-Executive Director has a clinical background.
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	✓	• The Audit and Remuneration & Nominations Committee have clear Terms of Reference in place, setting-out the Chair and Membership. • Other individuals attend the Committees to present papers and discuss items within their portfolio or area of expertise. For the Remuneration & Nominations Committee this is usually only the CEO and Chief People Officer.
B.2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen	✓	• Dr Mateen Jiwani is the current Senior Independent Director. The appointment was undertaken as an expression of interest, approved by the Board of Directors and endorsed by the Council of Governors at respective meetings. • The Senior Independent Director appraises the Chair on an annual basis. The process includes receiving and considering views from the Board of Directors, Council of Governors and a range of external stakeholders / partners.

Code	Provision	Comply	Narrative 2024-25
	by NHS England as set out in the Chair appraisal framework.		
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	✓	• The Board of Directors Remuneration & Nominations Committee leads on any Executive Director recruitment, including final approval of candidates. The Trust appointed a new Executive Chief People Officer in 2024/25. • The Interview Panels and Stakeholder Groups included Non-Executive Directors. • The Board of Directors Remuneration & Nominations Committee receives the outcome of annual appraisals of Executive Directors, including achievement of objectives and the setting of future objectives. The Committee receives an update via a mid-year review of objectives from the CEO. The Chair meets with Non-Executive Directors on a weekly basis, without the presence of Executive Directors.
B.2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	✓	• The Standing Orders for the Board of Directors sets-out the role of the Chair and Chief Executive. The appointment of the Senior Independent Director is included and the role outlined as part of descriptions of specific processes led by the SID. • The Scheme of Reservation & Delegation (SoRD) provides the responsibilities reserved for the Board of Directors and the delegated authority provided to the Standing Committees. • The Standing Committees of the Board of Directors each have a Terms of Reference setting-out the responsibilities of each Committee. • The Annual Report 2023/24 provides records of Board and Standing Committee attendance for individual Directors.
B.2.14	When appointing a director, the board of directors should take into account other	✓	• The job descriptions (Executive Directors) and Terms & Conditions (Non-Executive Directors) sets-out the time commitment for the specific roles.

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	demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chair ship of such an organisation.		• Directors are required to disclose any significant commitments prior to their appointment. • The Declaration of Interest system requires Directors to make annual declarations and identify any new commitments. Any significant commitments would require approval by the Board of Directors Remuneration & Nomination Committee. • No current Executive Directors holds a non-executive directorship of another trust or organisation of comparable size and complexity to EPUT.
B.2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	✓	• The Senior Director of Corporate Governance (Denver Greenhalgh) acts as the company secretary (Trust Secretary) and is accessible for all directors. • The Senior Director of Corporate Governors is a member of the Board (non-voting) and provides any relevant governance advice as required.
B.2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions. • The Board of Directors receives a Quality & Performance Scorecard using Power BI, which allows directors to undertake deep dive reviews of financial and clinical quality data which allows for the scrutiny of performance and assessment of the integrity of internal controls.

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	management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.		• The Board Assurance Framework provides relevant information on the risks and internal control mechanisms. • All Board Standing Committees have Non-Executive Director representation and are chaired by a Non-Executive Director. Any such challenges are recorded in the minutes
B.2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions	✓	• The Board of Directors meets a minimum of six-times per year and holds Extra-Ordinary meetings to consider relevant items outside of this schedule of business. The Board of Directors met eight times in 2024/25. • The Scheme of Reservation & Delegation (SoRD) clearly provides the matters reserved specifically for its decisions. The Board of Directors Schedule of Business provides a list of items for consideration and / or decision for the financial year. • The Standing Orders for the Council of Governors provides the roles and responsibilities of the Council of Governors. The Standing Orders also includes a section setting-out the process for resolving any disagreement between the Board and Council. • The Council of Governors Relationship with the Board of Directors Policy & Procedure provides for the action to be taken should there be a disagreement. The Council of Governors also has a number of procedures in place detailing processes to be undertaken for any statutory function, including a section on the action to be taken should there be a disagreement. • The Annual Report 2023/24 provides details of the governance arrangements for the Trust, including the Board of Directors, Standing Committees and the

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	that are delegated to the executive management of the board of directors.		Council of Governors. The report provides information on any key decisions made, including appointment / re-appointment of Directors.
SECTION C: COMPOSITION, SUCCESSION AND EVALUATION			
C.2: Provisions for Foundation Trusts Board Appointments			
C.2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	✓	• The Trust has two committees responsible for Executive Director appointments and Non-Executive Directors appointments / reappointments as set out in their terms of reference: - Board of Directors Remuneration and Nominations Committee reviews the structure, size and composition of the Board of Directors, considers succession planning and makes recommendations for changes as appropriate; it is responsible for the Executive Director appointment process. - Council of Governors Nominations Committee implements the procedure for the identification and nomination of suitable candidates for Chair and Non-Executive Director appointments / reappointments (for recommendation to the full Council) that fit the succession planning criteria recommended by the Board of Director Remuneration and Nominations Committee. • The Trust commenced a recruitment process in 2023/24, concluding in early 2024/25, for the recruitment of an Executive Chief People Officer, overseen by the Board of Directors Remuneration Committee. • The Trust completed a recruitment process in 2024/25 for the appointment of a Chair and Non-Executive Directors overseen by the Council of Governors Nominations Committee and involving NHS England / ICB.
C.2.2	There may be one or two nominations committees. If there are two, one will be	✓	• See C.2.1

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	responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.		• Composition of the Board of Directors considered as part of appointment process for Board members. • A regular review of skills and experience is undertaken to ensure that the Board has the right skill mix to discharge its duties, including when appointing new Non-Executive Directors. • The Trust implemented the new competency framework published by NHS England, which will support the regular review of skills mix and capability of the Board of Directors.
C.2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	✓	The Chair (Professor Sheila Salmon) chairs both the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee. The Lead Governor or the Vice Chair acts as Chair of the Council of Governors Nominations Committee where items are related to the Chair.
C.2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make	✓	• The Council of Governors Nominations Committee leads on the appointment of the Chair and Non-Executive Directors. • The Council of Governors Appointment of the Chair and Non-Executive Directors Procedure provides the process. The appointment of a new Chair in 2024/25 followed this process.

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	recommendations to the council of governors.		
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	✓	• The Trust engages Executive Search organisations for the recruitment of Directors. • For the appointment of the Executive Chief People Officer, the Trust engaged Alumni to provide independent assurance. • In 2024/25 the Trust engaged Hunter Healthcare for Non-Executive Directors to provide independent support. This will be included in the Annual Report for 2024/25 and was previously declared in the Annual Report for 2023/24 for recruitment undertaken in the previous financial year (Page 111)
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	✓	• The Council of Governors Nominations Committee membership has Governors in the majority, which is outlined in the Terms of Reference for the Committee. • The Interview Panel for the appointment of the Chair and Non-Executive Directors includes Governors as the majority in a voting capacity, as outlined in the Appointment of the Chair / Non-Executive Directors Procedure. • An independent external chair joins the interview panel to provide an objective view of suitability for post for Non-Executive Directors.
C.2.7	When considering the appointment of non-executive directors, the council of	✓	• Arrangements in place between the Board of Directors Remuneration and Nominations Committee and Council of Governors Nominations Committee to

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	governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.		ensure there is a dialogue between the two Committees (as detailed in terms of reference, for continuity Chair of the Trust is Chair of both committees • The appointment process for 2024/25 for the Chair included the views of the Board via the Chief Executive Officer at different points of the process, including chairing the Internal Stakeholder Panel and the Interview Panel to provide additional feedback to support deliberations. • Members of the Board of Directors participate in Stakeholder Panels for the appointment of Non-Executive Directors. The views of the Stakeholder Panel are provided to the Interview Panel for consideration.
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	✓	• The Annual Report 2023/24 (Page 111) provides details of appointment / re-appointment process undertaken during the financial year. • The Terms of Reference for the Council of Governors Nominations Committee is available on request.
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	✓	• The Trust Constitution process for Governors to hold terms of office of up-to three years before re-election. • The election process completed in 2023/24 were undertaken using CIVICA Election Services, which provided the names and biographical information for candidates. The Trust would include any performance related information as necessary.

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C.2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference.
C.2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	✓	• The Board of Directors Remuneration & Nominations Committee leads on the appointment of Executive Directors, as outlined in the Terms of Reference. • The Trust Constitution provides for the Chief Executive Officer to be appointed and removed by Non-Executive Directors, with the appointment being approved by the majority of members of Council of Governors present and voting at a general meeting. • The Appointment of the Chief Executive Officer Procedure in place sets-out the process for Governor involvement in the process and process for the Council to approve the appointment. The procedure sets-out the minimum requirement and the actual process may change in agreement with the Council.

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C.2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	✓	• Procedure for the recruitment of Chair / Non-Executive Directors in place. • Council of Governors Nominations Committee has a clear terms of reference • Recommendations made to Council of Governors by Council of Governors Nominations Committee for appointment of Non-Executive Directors and are recorded in the minutes. • The appointment of the Chair / Non-Executive Directors undertaken in 2024/25 were managed by the Council of Governors Nomination Committee and approved by the Council of Governors.
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	✓	• The Council of Governors appoint Non-Executive Directors for a specific term of office that does not exceed three-years. This is outlined in any reports to the Council and subsequent minutes. • The Trust Constitution provides clear criteria, in line with the 2006 Act, for the removal of a Director and this would be undertaken if required.
C.2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors	✓	• The Terms and Conditions for Non-Executive Directors are available to the Council of Governors on request. • The letters of appointment for Non-Executive Directors sets-out the expected time commitment. This is established as part of the recruitment process with Non-Executive Directors agreeing to the time commitment. • Any additional significant commitments are provided to the Council of Governors Nominations Committee as part of the recruitment process. • The publically available declaration of interest system provides for any new commitments and a process is undertaken to approve any NED who is appointed as a NED of another NHS Body.

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	should be informed of subsequent changes.		• The time commitment of Non-Executive Directors is informally monitored as part of regular NED team meetings. Any issues with time commitment would be reported to the Council of Governors as required. Governors can also raise concerns regarding the time commitment of NEDs if required.
C.3: Provisions for NHS Trust Board Appointments (N/A)			
C.4: Board Appointments: Provisions Applicable to both NHS Foundation Trusts and NHS Trusts			
C.4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	✓	• The Fit and Proper Persons Policy & Procedure sets-out the process for assessing if a person is fit and proper. • The Trust implemented the new Fit & Proper Persons Test requirements issued by NHS England. The Trust Secretary's Office complete all relevant checks of Directors and identifies any concerns to the Chair / CEO for consideration in annual appraisals. • Following annual appraisals, the Chair is required to sign the Fit and Proper Persons Test form to confirm an individual Director is Fit and Proper. Action would be taken if there are any concerns raised as part of this process. • The Trust Constitution sets-out the criteria for disqualification as a Director and Governor, in line with the FPPT requirements. • Directors complete an annual Self-Attestation confirming they do not meet any of the disqualification criteria, as part of the overall FPPT test. • Governors complete a Self-Attestation on appointment, confirming they do not meet any of the disqualification criteria and sign-up to the Council of Governors Code of Conduct.

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C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	✓	• The Annual Report 2023/24 (Page 57 – 65) provides biographies of the Board of Directors, including skills, expertise and experience. • The Annual Report 2023/24 (Page 109) provides a statement of the balance, completeness and appropriateness of the membership of the Board of Directors. • The Annual Report is available on the Public Website.
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	✓	• No current Non-Executive Director has exceeded nine-years in post. • The Chair has been in post for seven years following an extension of their term of office. This was agreed with the Council of Governors and NHS England, including clear rationale and their term of office ended on 31 March 2025.
C.4.4	Elected foundation trust governors must be subject to re-election by the members	✓	• See section C.2.9

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	of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.		• The Trust Constitution provides for Governors to serve a maximum of three terms of office of up to three-years, before having a break of a year before seeking any further term of office.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	✓	• The Annual Report 2023/24 (Page 110) provides details of the regular review of the performance of the Board / Organisation, including internal and external audit. • NHS England completed an independent Well-Led review in 2024-25 and identified no areas of concern. The results of the review were discussed in detail by the Board of Directors, including the identification of any development opportunities. • The Council of Governors complete an annual effectiveness review, including its own performance and that of its sub-committees. • The Board and standing committees undertake an annual effectiveness review. • The Chair and Chief Executive Officer complete annual appraisals of Non-Executive Directors and Executive Directors respectively, which includes a review of performance against objectives. • The appraisal of the Chair is undertaken by the Senior Independent Director.

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			• The Council of Governors Remuneration Committee reviews Non-Executive Director appraisals and meets with each individual to discuss the content. The Committee considers the quality and accuracy of the appraisals and reports back to the Council of Governors.
C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	✓	• Any action plans from annual reviews are presented to the Board of Directors and monitored by the relevant Standing Committee. • The Chair / Senior Independent Director acts on the outcome of appraisals of Non-Executive Directors, recognising strengths and addressing any weaknesses. • The Chief Executive Officer shares the outcome of the Executive Director appraisals with the Board of Directors Remuneration & Nominations Committee to identify strengths and discusses addressing areas of weakness.
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	✓	• NHS England completed an externally facilitated development review of leadership in 2024/25. Details will be included in the annual report for 2024/25.
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their	✓	• The Council of Governors completes an annual effectiveness review of its own performance and its sub-committees. The results are presented to the Council of Governors for discussion and the identification of any actions to be taken forward.

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	responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.		
C.4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents	✓	• The Trust Constitution sets-out the criteria for the disqualification of a Governor, including failing to attend Council meetings and conflicts of interest. The Constitution also provides for the process to be followed for the removal of a Governor if the need arises, which is supported by the Council of Governors Code of Conduct.

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	the proper exercise of their duties. This should be shared with governors.		• The Monitoring of Council of Governors Attendance Procedure provides further context to the terms "consistently and unjustifiably fails to attend" and the process to be followed. The procedure was developed and approved by the Council of Governors. • The Council of Governors followed the process in 2024/25 for the removal of a Governor due to non-attendance at Council of Governors meetings.
C.4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of	✓	• The Trust Constitution includes criteria for the disqualification of a Governor and removal from office where their values and behaviours are not compatible with the Trust. • As above regarding process for removal of a Governor. • The Council of Governors Code of Conduct is based on the Nolan Principles and is based on the Trust values. Governors are required to agree to the Code of Conduct on appointment and includes the process to be followed should a Governor breach the Code.

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	the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.		
C.4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	✓	• See Section C.2.1
C.4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	✓	• To date no Executive Directors have left the Trust outside of the terms of their employment contract.
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to	✓	• The Annual Report 2023/24 (Page 110 – 112) provides details of the Board of Directors Remuneration & Nominations Committee and the Council of Governors Nominations Committee.

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	succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served		• The Annual Report 2023/24 (Page 42) provides details of the Equality Monitoring policies in place. Page 33 provides information relating to the race equality of the workforce, linked with the WRES. • The Annual Report 2023/24 (Page 91 - 92) provides a workforce profile, which provides gender and ethnic balance for senior management and their direct reports.

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	• the gender balance of senior management and their direct reports.		
C.5: Development, Information and Support			
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	✓	**Director induction** • NED induction is included in NED's objectives and is monitored and reviewed by Chair • NED and ED induction programme and information pack reviewed and updated in line with good practice; induction programme is tailored to the Director's requirements based on skills and experience • All Directors new to the NED role completed the NED induction programme • NEDs are encouraged to attend relevant briefings and conferences organised by NHS Providers and other national NHS-related organisations, and provide feedback at the NEDs Discussion Group meeting • Executive Directors undertake corporate induction training programme; additional induction and ongoing training requirements will be identified relevant to role. The Executive Director induction is managed through the Trust's Supervision and Appraisal Policy and Procedure. • Executive Directors are given a 6-month probationary period following commencement with the Trust. Objectives are set for achievement within this probationary period and these are formally reviewed at the end of the probationary period. The outcome of the review is provided to the BoD RemNom Committee. • Non-Executive Directors are given a one-year probationary period following appointment, which is reviewed by the Council of Governors at the end of the 12-month period. S

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			Governor induction • Governor induction programme reviewed and included as part of the Governor Learning & Development Schedule and regularly updated taking account of good practice and relevance to the Trust • Governor Induction Handbook based on documents developed by NHS Providers provided to any new Governors. Individual induction sessions held with new Governors joining the Trust throughout the year due to Governor resignations and Appointed Governors.
C.5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	✓	• Directors individual appraisal and performance evaluations undertaken annually with six monthly reviews • Directors have individual personal objectives and professional/personal development plans. The Trust is currently implementing the NHS England Competency Framework. • Directors have access to training courses/materials as identified in their individual personal development plan • Non-Executive Directors personal development objectives received by Council of Governors Remuneration Committee as part of review/assurance of Non-Executive Directors performance. • The Council of Governors have a Learning & Development Plan, monitored by the Council of Governors Training & Development Committee which identifies a wide range of topics for learning and development. The Plan is regularly reviewed and updated with any new learning requirements. • The Council of Governors Nominations Committee receives training in recruitment prior to any NED appointment process. In 2023/24, this was provided by the Interim Chief People Officer and included areas such as equality, diversity, inclusion and unconscious bias.

Code	Provision	Comply	Narrative 2024-25
C.5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	✓	• The induction programme includes details about the Trust, including operations and key issues, for both Board and Council members. • The Quality & Performance Scorecard presented to the Board of Directors incudes Key Performance Indicators developed to monitor the operational practices of the Trust. The Chairs Report and CEO Report to the Board of Directors / Council Governors provides regular updates on operational matters. • Directors and Governors complete some service visits to understand the operations of the Trust. The Trust is currently implementing a Quality Visits Framework which will formalise the process and ensure a wider range of services are visited. • The Staff Governors meet with Non-Executive Directors as part of Staff Constituency meetings to share the views of staff members. • The summary reports for the Board of Directors and Council of Governors contain boxes providing the Trust Values and indicating if the report impacts any of the values of the Trust. The Board of Directors and Council of Governors were involved in the development of the values when first implemented. • Directors have access to the intranet which includes policies and procedures developed by the Trust. Governors can access policies and procedures through the publication scheme and procedures relevant to the Council are monitored via the Council of Governors Governance Committee and approved by the Council of Governors.
C.5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this,	✓	• See Section C.5.1 • Directors and Governors are invited to attend a wider range of stakeholder meetings and events to engage with stakeholders, this includes constituency

Code	Provision	Comply	Narrative 2024-25
	directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.		meetings, patient forums, Your Voice meetings, ICB meetings, some service visits etc. • Directors are able to claim expenses through the internal EASY expense system, with NEDs accessing this via the Chairs Office. Governors are able to submit expenses to the Trust Secretary's Office for any expense incurred whilst undertaking their role of a Governor.
C.5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	✓	• The appraisal process reviews and agrees training and development needs for each Director. This is undertaken by the Chair (NEDs) and CEO (Executive Directors).
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	✓	• See Section C.5.2 regarding the Learning & Development Plan.
C.5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of	✓	• Comprehensive reports and executive summaries (including detailed appendices) circulated prior to each Board of Directors and Council of Governors meetings, as well as Committee meetings. Standardised approach for all meetings. Information available on website/intranet. • Annual meeting business schedule in place for Board of Directors and Council of Governors. • All Board of Director standing committees and Council of Governors sub-committees have developed a work plan and progress against the plan is regularly monitored

Code	Provision	Comply	Narrative 2024-25
	governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.		• Circulation of papers / uploading of papers to the Board Portal requirements detailed in Board of Director and Council of Governors standing orders • Directors and Governors able to request information as necessary. • Informal confidential briefings prior to each Council of Governors meeting by the Chief Executive Officer • Governor Updates distributed regularly to all Governors • Information on ICS plans, decisions and delivery that directly affect the organisation and its patients are included within reports as relevant to the subject matter.
C.5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	✓	• See section C.5.7
C.5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	✓	• This is covered by Sections above relating to the sharing of information, the induction programmes, the relationship between Executive Directors and Non-Executive Directors and communication between the Board of Directors and Council of Governors.

Code	Provision	Comply	Narrative 2024-25
C.5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	✓	• See Section C.5.7 • The Board of Directors Schedule of Business is developed in conjunction with Executive Directors. Standing Committees of the Board of Directors have clear Terms of Reference and clear work plans are currently being developed. • The Council of Governors Schedule of Business is discussed with the Chair and the Lead / Deputy Lead Governor when planning the agenda for each Council of Governors meeting. The Lead / Deputy Lead Governor can request any additional items to be added to the agenda following consultation with fellow Governors. • Board papers are developed and approved by relevant Board directors to ensure these are concise, accurate and timely. These are reviewed by the Trust Secretary's Office prior to uploading to the Board Portal.
C.5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge as well as at Board Development Sessions • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Advice will be sought from relevant adviser if required as detailed in terms of reference • Any such challenges are recorded in the minutes

Code	Provision	Comply	Narrative 2024-25
	risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.		
C.5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	✓	• Independent professional advice is made available at the Trust's expense to directors in respect of critical or significant activities, e.g. audit, Mental Health Act Managers, legal advisors, other specialist advisors • Appointment of advisers in relation to significant transactions is approved by the Board and the process scrutinised by the Audit Committee. • Board of Director Committees are provided with support as identified in their terms of reference • Board of Director Remuneration and Nominations Committee may, at the Trust's expense, appoint independent consultants or commission independent professional advice if considered necessary (included in terms of reference)
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	✓	• Board of Director Committees are provided with support as identified in their terms of reference. • All Council meetings and committee meetings are supported directly by the Trust Secretary's Office • Trust Secretary's Office also provides day to day support to Governors including regular communications and updates, advice, managing queries, etc.

Code	Provision	Comply	Narrative 2024-25
C.5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	✓	• Non-Executive Directors have the opportunity at Board meetings and standing committee meetings to challenge and/or to request 1:1 meetings with EDs to seek further clarification/assurance • Regular briefing with the CEO with NEDs. • All Board standing committees have Non-Executive Director representation and are chaired by a Non-Executive Director. • Any such challenges are recorded in the minutes • Non-Executive Director skills balance considered in succession planning
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	✓	• Public and members meetings (Your Voice) held virtually and face-to-face. The last Your Voice meeting (October 2024) was held at the Co-Production Conference. • Governors invited to participate in discussions for the new EPUT Strategy. • The Trust has developed a Membership Strategy which sets-out the priorities to ensure Governors are able to canvass the opinion of Trust members and represent these to the Board of Directors. • Annual Report 2023/24 (Page 122) outlines how Governors have 'canvassed' members/public
C.5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views	✓	• Governors have been involved in the forward plans of the organisation, included being included in the development of key enabling strategies in the Trust. This has been undertaken as part of stakeholder engagement and Joint Board / Council Seminar Sessions.

Code	Provision	Comply	Narrative 2024-25
	have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.		
	The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	✓	
C.1.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	✓	• The Trust Constitution (Section 50) includes information on liabilities for the Board of Directors and Council of Governors in-line with this provision.
SECTION D: AUDIT, RISK & INTERNAL CONTROL			
D.2. PROVISIONS			
D.2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of	✓	• The Trust has an established Audit Committee with the membership including three Non-Executive Directors. • The Chair of the Board of Directors is not a member of the Committee. • The Chair of the Audit Committee (Elena Lokteva) is not the Vice Chair or the Senior Independent Director.

Code	Provision	Comply	Narrative 2024-25
	directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.		• The Terms of Reference provides for at least one member of the Committee to have recent and relevant financial experience. This is currently with the Chair of the Committee (Elena Lokteva). • The Terms of Reference provides for a regular attendance of key individuals to support the Committee to ensure competence relevant to the sector in which it operates, including the Executive Chief Finance Officer.
D.2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless	✓	• The Audit Committee Terms of Reference outlines the role and responsibilities of the Committee and covers each of the points included in this provision. Evidence of discussion is included in the minutes of the meeting. • The Audit Committee reports to the Board of Directors at each meeting via the Committee Chairs Report, summarising the work of the Committee in the preceding months.

Code	Provision	Comply	Narrative 2024-25
	expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.		
D.2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected	✓	• The Trust completed a market testing exercise of the External Auditors in 2021/22 and appointed Ernst & Young (EY). The contract is for five-years, with a review every year to confirm re-appointment by the Council of Governors.

Code	Provision	Comply	Narrative 2024-25
	by an NHS trust becoming a foundation trust.		
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	✓	• The Annual Report 2023/24 (Page 112) includes a section on the work of the Audit Committee, which includes significant issues relating to financial statements. • The Annual Report 2022/23 (Page 82) confirms the External Auditors did not complete any non-audit work. The section identifies Ernst & Young as the External Auditors. The section also includes confirmation of re-appointment by the Council of Governors and details of the length and value of the contract. • The Audit Committee completes an annual review of Audit Services and last completed the review in July 2024. The review supports the Council of Governors in reviewing and re-appointing the External Auditors on an annual basis. However, this needs to be included in the annual report.
D.2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to	✓	• The Standing Financial Instructions (SFI's) include a section on the responsibilities of the External Auditors, which does not provide for any non-audit services to be undertaken. The External Auditors do not currently undertake any non-audit work for the Trust and this is not permitted. • The Standing Orders for the Council of Governors provide for the Council of Governors to appoint and remove the External Auditors. The Council of

Code	Provision	Comply	Narrative 2024-25
	supply non-audit services. The council of governors is responsible for appointing external governors.		Governors Appointment of the External Auditors procedure sets-out the process to be followed. •
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	✓	• The Annual Report 2023/24 (Page 65) provides a section outlining the director's responsibility for preparing the annual report and accounts. • The section includes a statement that the Directors consider the annual report taken as a whole as fair, balance and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	✓	• The Board Assurance Framework has been developed to identify and assess emerging and principle risks to the Trust achieving its strategic objectives. The framework is regularly discussed by the Executive Team and presented to the Board of Directors, including any mitigation to emerging risks. • The Annual Report 2023/24 (Page 129 – 131) provides details of the assessments completed to identify and manage risk within the organisation. This includes the identification of significant risks to the achievement of its strategic objectives as at 31 March 2023.
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial,	✓	• As above regarding the Board Assurance Framework and annual report information, which also includes reviewing internal controls relating to quality governance. • The Annual Report (Page 126 – 138) provides the Annual Governance Statement and includes all material controls, including financial, operational and compliance controls.

Code	Provision	Comply	Narrative 2024-25
	operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.		
D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	✓	• The Annual Report 2023/24 (Page 139) provides a statement concluding the adoption of the going concern basis of accounting when preparing the annual accounts. The statement identifies any material uncertainties considered when making the statement.
SECTION E: REMUNERATION			
E.2. PROVISIONS			
E.2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of	✓	• The Chief Executive Officer has a contractual due payment in place (2.5k per quarter) which is based upon achievement of objectives related to the strategic objectives of the organisation. The strategic objectives were developed to align with the interests of service users, patients and use of public money.

Code	Provision	Comply	Narrative 2024-25
	performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. • For NHS foundation trusts, non-executive terms and conditions are		• The Board of Directors Remuneration & Nominations Committee receives a quarterly report outlining the key achievements of the CEO for that period, aligned to the strategic objectives. The Committee considers the report and approves (or not) the contractual due payment for the quarterly period. • The Terms and Conditions for the Non-Executive Directors are set by the Council of Governors Remuneration Committee and Council of Governors. The Terms and Conditions are standard and any changes are approved by the Remuneration Committee, in line with any adjustment to remuneration. •

Code	Provision	Comply	Narrative 2024-25
	set by the trust's council of governors. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.		
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	-	• The Council of Governors agreed to adopt the principles of the Chair and Non-Executive Director Remuneration Structure Framework when setting remuneration levels, whilst not being bound to any previous decision of the Council in the setting of future remuneration. • The Council of Governors Remuneration Committee considers the framework when agreeing any adjustment to Chair / NED Remuneration. However, it should be noted the framework has not been updated since 2019 and does not consider any recommended annual uplift from NHS England. • The remuneration of the Chair is set using the table included in the Framework considering the annual turnover of the Trust. The Council of Governors utilised this table and other relevant information to determine the remuneration of the Chair for the recent recruitment process. • The remuneration of the Non-Executive Directors was originally set in line with the framework, with an adjustment to the uplift recommended to ensure it reflected the additional time commitment of the Vice Chair and Chair of the Audit Committee.
E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration	✓	• Executive Directors are required to make annual declarations of interest which would identify any positions held such as a non-executive director role.

Code	Provision	Comply	Narrative 2024-25
	disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.		• If an Executive Director is released to serve as a Non-Executive Director of another organisation, a statement would be included in the Annual Report as required.
E.2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	✓	• The responsibility for the approval of termination of employment arrangements and / or making of any extra contractual payments to Executive Directors is within the remit of the Board of Directors Remuneration & Nominations Committee and referenced in the Terms of Reference. • During the year, no extra contractual payments have been made to Executive Directors following termination of employment.
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	✓	• This would be undertaken as required. There has been no requirement to do this in 2024/25

Code	Provision	Comply	Narrative 2024-25
E.2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	✓	• The Trust has an established Remuneration & Nominations Committee that includes all Non-Executive Directors as members. The Terms of Reference for the Committee sets-out the roles and responsibilities for the Committee. • The Executive Chief People Officer attends the meeting from time-to-time as required to provide HR advice and is outlined in the Terms of Reference. • The Trust has not used remuneration consultants.
E.2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	✓	• The Remuneration & Nomination Committee Terms of Reference provides the remit of the Committee, including setting remuneration for Executive Directors, including pension rights and any compensation payments. • The Terms of Reference includes for the remit of the Committee the level and structure of remuneration for very senior managers (VSM's).
E.2.8	The council of governors is responsible for setting the remuneration of a foundation	✓	• The Council of Governors Remuneration Committee is responsible for agreeing the remuneration for the Chair and Non-Executive Directors. Recommendations are made to the Council of Governors for approval.

Code	Provision	Comply	Narrative 2024-25
	trust’s non-executive directors and the chair.		

8.5 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR)

Decision Item NL 5

REFERENCES

Only PDFs are attached

EPRR Annual Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Emergency Preparedness, Resilience and Response Annual Report 2024-25**					
Executive/ Non-Executive Lead:	Nigel Leonard Executive Director of Special Projects and EPRR AEO					
Report Author(s):	Comfort Sithole Head of Compliance and Emergency Planning					
Report discussed previously at:	HSSC, Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*			
Summary of risks highlighted in this report	EPRR training availability by NHSE		
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
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.	NA		
Describe what measures will you use to monitor mitigation of the risk	NA		
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 assurance that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue. The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2024-25 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2022.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Discuss and consider the contents of this report.

Summary of Key Issues

Introduction

EPUT is compliant with all of its statutory duties under the Civil Contingencies Act 2004 and associated Cabinet Office Guidance. The Department of Health and Social Care (DHSC) requires all NHS Trusts to be prepared to a category 1 responder and EPUT has systems and processes in place to be prepared to this level and fulfils its civil protection duties.

Governance

The Trust has a nominated Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard). The Chief Executive Officer, Paul Scott holds overall responsibility. There is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning supported by Amanda Webb, Emergency Planning and Compliance Manager for day to day actions

Following the "self-assessment" and the "confirm and challenge" for the NHS England EPRR Core Standards 2024-25 that was led and monitored by the Mid and South Essex Integrated Care Board (MSE ICB), the position reported is that of substantial compliance having reached 94.8% against the 2024-25 Core Standards for EPRR.

All Business Continuity Plans for inpatient services and non-critical sites are currently being reviewed and are stored both locally and centrally by the EPRR team.

EPUT has undertaken EPRR exercises in line with National Guidance.

Continuous Learning

Where learning has been identified, specifically for EPUT, following an incident or exercise, these have been taken forward.

Training

Training has continued in 2024-25 utilising both internal and external courses available.

One of the Compliance Administrators commenced the Level 4 Award in Health Emergency Preparedness, Resilience and Response in April 2024 and has successfully completed the course. The Trust submitted an expression of interest for a place on the Level 4 Diploma in Health Emergency Preparedness, Resilience and Response to develop and support the EPRR Team within EPUT. This was accepted and the second Compliance Administrator will commence the course in Q1 2025/26.

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

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

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

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
ICS	Integrated Care Systems	NHSE/I	NHS England and NHS Improvement
LRF	Local Resilience Forum	ICB	Integrated Care Boards
ICC	Incident Control Centre	LHRP	Local Health Resilience Partnership
BAU	Business as usual		

Supporting Reports/ Appendices /or further reading
Emergency Preparedness, Resilience And Response Annual Report 2025-25

Lead

Nigel Leonard
Executive Director of Special Projects and EPRR AEO

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2024-25

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

23 April 2025


NHS

CONTENTS

INTRODUCTION

PURPOSE

The purpose of this annual report is to provide assurance that EPUT has robust and effective organizational resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity event.

This report also presents evidence of the Trust's achievements and continued commitment to organisational resilience during 2024-2025.

ACCOUNTABILITY

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board. However, the Chief Executive Officer, Paul Scott holds overall responsibility.

In addition, there is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning, supported by Amanda Webb, Emergency Planning and Compliance Manager for day to day actions and duties.

RELEVANT GUIDANCE

This report confirms that the Trust is compliant with all its statutory duties under The Civil Contingencies Act 2004 and associated Cabinet Office Guidance and other relevant legislation and guidance such as:

1. The NHS Act 2006
2. The NHS Constitution
3. The requirements for EPRR as set out in the NHS Standard Contract(s)
4. NHS England EPRR guidance and supporting materials including:
5. NHS England Core Standards for Emergency Preparedness, Resilience and Response
6. NHS England Business Continuity Management Framework (service resilience)
7. Other guidance available at http://www.england.nhs.uk/ourwork/eprr/h
8. National Occupational Standards for Civil Contingencies
9. BS ISO 22301 Societal security – Business continuity management systems

NHS ENGLAND EPRR CORE STANDARDS 2024-2025

As part of the NHS Emergency Preparedness Resilience and Response (EPRR) Framework, NHS England seeks annual assurance that NHS funded services are prepared to effectively respond to emergencies and are resilient in relation to continuing to provide safe patient care. The NHS EPRR process concludes with a submission to the NHS England Board and assurance is provided thereafter to the Department of Health and Secretary of State for Health.

NHS England Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR and are split into ten domains:

1. Governance
2. Duty to risk assess

3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

A self-assessment of compliance with the national EPRR core standards is required to be submitted on an annual basis providing assurance that the Trust is meeting all standards and supply relevant evidence on request.

Following the self- assessment and the "confirm and challenge" that was lead and monitored by the Mid and South Essex Integrated Care Board (MSE ICB), the position reported is that of substantial compliance having reached 94.8% against the 2024/25 Core Standards for EPRR. 55 out of the 58 EPRR Core Standards have been assessed as compliant, with 3 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months).

Core Standards	Total applicable	Fully compliant	Partially compliant	Non-compliant	Agreed actions
Domain 1: Governance	6	6			
Domain 2: Duty to risk assess	2	2			
Domain 3: Duty to maintain plans	11	11			
Domain 4: Command and Control	2	1	1		1
Domain 5: Training and exercising	4	4			
Domain 6: Response	5	5			
Domain 7: Warning and informing	4	4			
Domain 8: Cooperation	4	3	1		1
Domain 9: Business Continuity	10	9			1
Domain 10: CBRN	10	10			
TOTAL	58	55	3		3
Overall compliance (%)	94.8%				

The 2024/25 EPRR annual deep dive focused on Cyber Security. EPUT was assessed as fully compliant.

Deep Dive	Total applicable	Fully compliant	Partially compliant	Non compliant	Agreed actions
Cyber Security	11	11			

The table below illustrates the 3 standards assessed, as "partially compliant" and the action required which has been taken forward:

Domain	Core Standard	Action	Timescale	Update
Domain 4: Command and Control	Trained on-call staff	Continue to escalate and seek improvements regarding on-call (particularly at a GOLD level) training compliance, with the AEO raising the importance of said training at a senior level.	March 2025	80% Executive Team 84% Director on Call Further staff scheduled to attend during 25/26 due to limited courses being made available
Domain 8: Cooperation	LHRP Engagement	Representation at LHRP Meetings	December 2024	EPUT's AEO has been invited wo all meetings, with the Director of Risk & Compliance deputizing in the AEO's absence.
Domain 9: Business Continuity	BC Policy Statement	BCMS/Policy to be reviewed moving away from an annual review for all plans.	March 2025	A review of the Business Continuity Management Plan is underway

During the assurance process, the following areas of good practice were identified:

- Use of the EPRR core standards self-assessment document throughout the year to track EPRR compliance and ongoing improvements made against the standards.
- EPUT Major Incident Plan comprehensive including clear action cards.
- Process for assessing and tracking newly identified risks, including maintaining a watching brief.
- Overall Governance process for EPRR and Risk Management.

CIVIL CONTINGENCIES ACT 2004

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level.

Under Section 1 of the CCA 2004, an "emergency" means:

(a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom;
(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;
(c) War, or terrorism, which threatens serious damage to the security of the United Kingdom.

For the NHS, incidents are classed as either:

- **Business Continuity Incident** - an event or occurrence that disrupts, or might disrupt, an organisations normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

- **Critical Incident** - any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions

- **Major Incident** - is an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. For the NHS this will include

any event defined as an 'emergency' as detailed above.

An additional Incident specific to EPUT;

- **High Profile Incident** is a Trust definition for any incident that requires executive level oversight but does not fall into BCP critical or major incident.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies).

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

1. Assess the risk of emergencies occurring and use this to inform contingency planning
2. Put in place emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance co-ordination
6. Cooperate with other local responders to enhance co-ordination and efficiency

This report provides assurance of how the Trust is meeting these duties as a Category 1 responder.


NHS
Essex Partnership University
NHS Foundation Trust
Working to improve lives
Jared
Davis

RISK ASSESSMENTS

The Civil Contingencies Act 2004 places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. EPUT is a member of the Essex Resilience Forum (ERF) that undertakes this activity.

The purpose of the Community Risk Register is to reassure the communities of Essex that the risks of potential hazards have been assessed, and that preparation arrangements are undertaken and response plans exist.

The top five risks currently identified on both Risk Registers relate to

- Influenza-type disease (pandemic) / major outbreak
- Emerging infectious disease
- Malicious Attacks
- Chemical, Biological, Radiological, Nuclear, and Explosive materials (CBRNE) Incident
- Low Temperatures and Snow

The Trust's approach to emergency planning ensures that we are in a position to respond appropriately in the event of an incident relating to those significant risks identified in the community risk registers. The Trust also uses its standard risk management framework and processes to identify any specific local risks relating to business continuity / resilience and these are managed in line with standard Trust risk management processes.

The Trust maintains a number of detailed plans to address the significant risks identified in the Local Resilience Forums' community risk registers. These align, where appropriate with Local Resilience Forum plans for the same incident types.

MAJOR INCIDENT PLAN

EPUT has a Major Incident Plan that details the role of EPUT in a major incident and how this role fits with those of other NHS organisations and the emergency services.

The Major Incident Plan is formally reviewed at least every three years, but is under continual review to ensure any required amendments are made to reflect learning, changes within the health sector, the Trust or Emergency Planning legislation. No changes were made during 2024-25.

CYBER SECURITY

The Trust's position on Cyber associated risks is report to the Finance & Performance Committee on a monthly basis by the Information Governance and Cyber Risk Teams. The report provides assurance that the Trust has the appropriate protection and controls in place to prevent theft, loss or damage to secure data, devices, services and networks via manual or electronic means.

The overall trust Cyber BAF risk rating of **15** has not changed.

"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 the prevalence of cyber alerts that are relevant to EPUT systems. Consequence based on assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

BUSINESS CONTINUITY PLANS

The Business Continuity Plan is the tactical document that supports the Major Incident Plan and ensures that in the event of a business interruption, the organisation will be able to maintain critical activities and restore normal business activities as soon as possible given the circumstances prevailing at the time.

As a provider service, the Business Continuity plan is the key plan within our Organisational Resilience planning. This plan underpins all other plans as it prioritises our critical activities and allows us to effectively manage our business whatever the incident may be, including Pandemic Flu, Severe Weather and Industrial Action etc.

To underpin the organisational Business Continuity Management Procedure, all services across EPUT have developed Business Continuity plans that:

- prioritise their service activities into 5 levels of priority from critical activities which need to be restored within 1 hour, through to activities which can be progressively restored after 7 working days;
- Detail the strategies for continued delivery of these activities.

Work progressed in 2024/25 to review and ensure local and central storage of all Trust Business Continuity Plans for inpatient services and non-critical sites. BCP compliance at the end of 2024/25 is outlined in the table below:

	% in date	Comparison to last year	Overdue	Total
Corporate	50%	↑	9	18
Urgent Care & Inpatient Services	78%	↑	9	40
Specialist Services	57%*	↓	10	23
Community Delivery Mid & South Essex	77%	↑	10	43
Community Delivery West Essex	97%	↑	1	31
Community Delivery North Essex	100%	–	0	17
Psychological Services	44%	↑	20	36

*Please note that further work undertaken in April 2025 confirmed that specialist services have moved to 100% of BCPs in date.

The EPPR team continues to work with the care groups to ensure that compliance with updating BCPs is maintained and a follow up has been undertaken to all those requiring the annual review in order to improve the compliance rate. Due to these scheduled follow ups with the Care Units, compliance has improved.

A revision of the Business Continuity Management Plan to appraise the BCP review period is underway. This follows discussion with the ICB's during the Core Standards Check & Challenge Session whereby it was recommended to move away from an annual review for all plans.

Domain 9: Business Continuity	BC Policy Statement	BCMS/Policy to be reviewed moving away from an annual review for all plans.	March 2025

COMMUNICATIONS PLAN

A well-informed public is better able to respond to an incident. To minimize the impact of any incident on the community, it is vital to ensure consistent messages that are appropriate to the needs of the audience are communicated effectively.

The Trust has a Communications Plan in place that ensures a timely relay of messages in the event of an incident. There are various means available for utilization i.e. Pando, WhatsApp, intranet, cascade text messages, resilience direct etc.

PARTNERSHIP WORKING

Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. It is thus important that, as well as coordination within individual NHS organisations, the planning for incidents is coordinated between health organisations and at a multi-agency level with partner organisations.

During 2024/25, EPUT continued to attend and work collaboratively with NHSE, ICBs and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

LOCAL RESPONDERS

Local Resilience Forums

Local Resilience Forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others (i.e. Category 1 Responders, as defined by the Civil Contingencies Act).

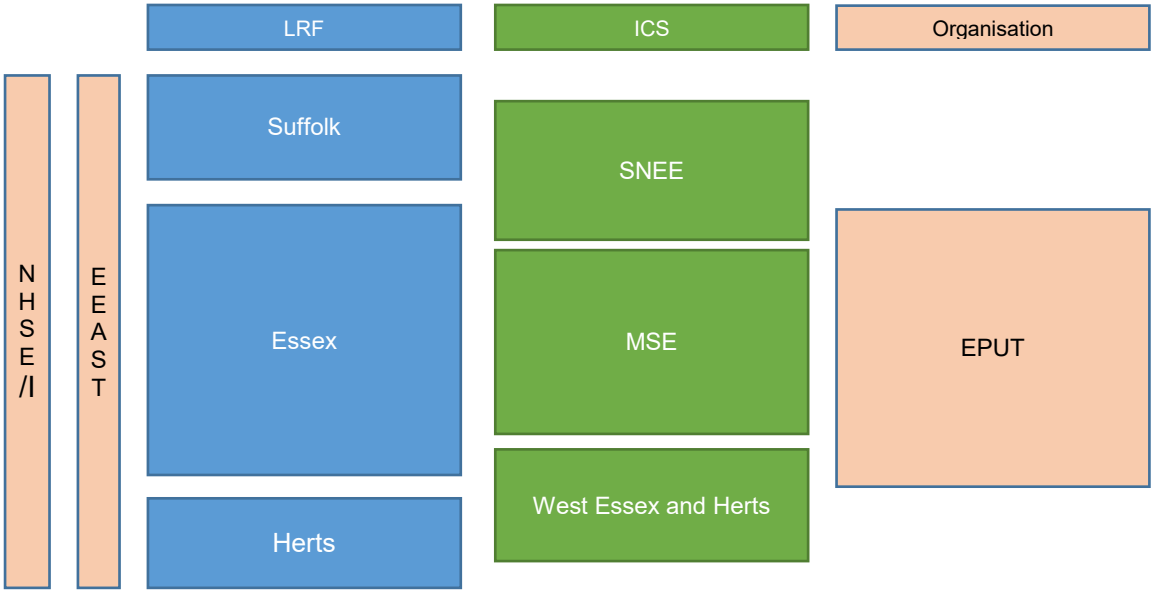
The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

An NHS England representative represents the Trust at the Bedfordshire Local Resilience Forum and Essex Resilience Forum, along with all other NHS providers. Two-way feedback into and from the LRFs is facilitated via Local Health Resilience Partnerships.

Local Health Resilience Partnerships (LHRP)

Local Health Resilience Partnerships (LHRPs) were established in August 2012 across the country as part of 'The Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013' published by the Department of Health in March 2012.

Their purpose is to deliver the national Emergency Preparedness, Resilience & Response (EPRR) strategy in the context of local risks. They bring together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level and provide a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. The LHRPs' footprints map to the LRFs. They therefore offer a coordinated point of contact with the LRF and reflect a national consistent approach to support effective planning of health emergency response.



During 2024/25 the Trust has kept abreast of the work of the LHRPs and attended regular meetings for the three LHRPs

- Essex LHRP – this is the main forum for EPUT attendance
- West Essex and Hertfordshire LHRP
- SNEE EPRR Forum is in place of the LHRP Working Group in Suffolk and covering health and social care EPRR within the SNEE ICS

EPRR EXERCISES

National Guidance states that as a minimum requirement, NHS organisations are required to undertake the following exercised:

- Communications - every six months
- Table top - every year
- Live Play - every three years
- Command Post - every three years
- ICC Equipment test - every three months

COMMUNICATIONS EXERCISE

Exercise Toucan – May 2024

The Exercise Toucan exercise was designed as no notice notification cascades, disseminated via the EPRR single point of contact email address. Exercise Toucan was successful and largely met the set aim and objectives and no issues identified with EPUT responding to the notifications.

Throughout 24/25; communication was tested internally and by the ICB's however these are not formally documented. In the event the ICB encounters any issues, an email is sent to the EPRR team to review. No issues were encountered within the reporting period.

TABLETOP EXERCISES

Exercise Enterprise part B - June 2024

Exercise Enterprise Part B, held on 17th June 2024, was designed to test the regional response to an incident involving mass casualties starting at 2hrs after the incident occurs up until about 7.5 hours after.

The Exercise objectives were:

- To test the activation and planning assumptions of the regional mass casualty plan including roles and responsibilities
- To simulate the flow and format of information between East of England Ambulance (EEAST) (at the scene and Tactical Operations Centre (TOC) for business as usual and incident coordination centre (ICC) for the Incident) and the Casualty Distribution Coordination Cell (CDCC) and Integrated Care Systems including Communications, IT Infrastructure and SitReps.
- To test the management of self-presenters at the receiving hospitals
- To simulate the set up and function of the CDCC including mass casualty capacity capability and distribution utilising a defined sample of simulated patients.

- To compare triage approach and distribution utilising Major Incident Triage Tool (MITT) instead of sieve / sort.
- To simulate distribution from scene of patients in the first hours to receiving hospitals and the formulation of a distribution plan for all P1, P2, P3 at scene
- To allow organisations to test their plans in supporting a mass casualty incident.

Initial feedback on the day was positive with lots of learning from the various representatives involved but nothing specific for Mental Health & Community Trusts.

On the 3rd March 2025, the final report was published and findings relevant to EPUT were:

- The use of JESIP was not evidenced throughout the exercise – All services to take forward.
    - To mitigate this, the JESIP Awareness Training has been added onto EPUT OLM for all Gold representatives and Director on Calls to undertake.
- Mental Health support needs further consideration needed for mass casualty incidents – ICB to take forward
- The Mass casualty plan didn't recognise the position that we regularly find ourselves in now of regarding the number of people in the acutes who are awaiting a MH bed. Our plan focussed on any new presentations rather than quickly "clearing" patients in acutes to create capacity. – ICB to take forward

SNEE ICS Cyber Security Incident Response Exercise - October 2024

Cyber Security Incident Report Exercise (CIRE), held on the 2nd October was written to test the resilience of an ICS experiencing an incident and to encourage joint working and consideration of shared systems and procedures.

The scenario was run with the candidates being in 3 groups dependent on role (Decision Makers, Cyber / Technical Representatives and Subject Matter Experts) to make the response as realistic as possible in an organisation and wider system as each group had different priorities.

The exercise was attended by the Emergency Planning and Compliance Manager and the Associate Director of IT Technical Strategy and Projects/Information Security Manager.

Initial feedback on the day was positive with lots of learning from the various representatives involved and the main learning for EPUT was in regards to management / training / awareness / expectations of the Command Structures

The final report was published on 14th March. Key lessons; which will be taken forward by the ICB, included;

- **Importance of Communication**: Clear communication and defined escalation paths are crucial during a cyber-incident.

- **Collaboration**: Working together with different teams and organisations is essential for an effective response.
- **Preparedness**: Regular updates to the incident response plan and continuous training are necessary to stay prepared.
- **Role Clarity**: Understanding the roles and responsibilities of different team members helps in managing incidents more effectively.

Overall, the feedback indicates that the exercise was well-received, with participants valuing the opportunity to learn, network, and improve their preparedness for cyber incidents.

COMMAND POST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident.

The Trust have maintained a virtual Incident Control Centre. In 2024/25, Command continued to be held via Microsoft Teams with an electronic log maintained by a team of trained Loggists with the support of the EPRR team as required.

There were 5 EPRR events/incidents during 2024/25 whereby the virtual command post was stood up and successfully managed the event/incident.

ICC EQUIPMENT TEST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident. The equipment and rooms are checked quarterly to ensure they are ready to be used when required. The checks include room suitability, telephone lines, major incident paperwork, stationary box and loggist folders. The checks are documented for auditing purposes.

EPRR EVENTS (incl Lessons Learned)

BCP

Industrial Action

During the period of 24/25 Q1, there was one Junior Doctors Industrial Action that took place 0700 27th June to 0659 2nd July 2024.

On the 20th June 2024 the Trust was advised that the East of England region had declared an NHS Incident Level 3. This was enacted in response to the potential for disruption, risk to critical services and impact on patients and staff.

EPRR reflected on the notification of NHS Incident Level 3 and it was agreed that no further action was required as we had already established Command meetings as and when required. This ensured effective management over the period of time to including risk identification, escalation and mitigation.

Administration of Gojo Industries Europe (Gojo)

The Trust was informed by NHS England on the 3rd May 2024 that Gojo Industries Europe went into administration on the 20th April 2024. Gojo were a significant manufacture of sanitising hand gels and hand washing soaps and foams within the NHS.

Various actions were requested (and completed) from the Trust which included:

- Confirmation of current supply held of all products from Gojo
- Risk assessment of the Trust position in line with demand and supply
- Confirmation of new supplier to NHS England (via supply chain)

Confirmation was received that EPUT would be managed in 'Tranche 1' of the transition to the provider which was being managed by Procurement, Estates and IPC.

The incident was managed under BCP with the support of the EPRR team to monitor and advise if the risk increased due to supply and fitting of the dispensers required within the affected Mental Health Inpatient Services.

Learning:
The EPRR team identified that they may not necessarily be notified when teams enact their BCPs. Thus the EPRR Team are working on a process to improve the notification and communication of local BCP activations in addition to a full policy review.

Watching Brief

Joseph Rank House Harlow – Property Decant

During week commencing 24th June 2024, regular updates were provided; via the HWE ICB, following Tactical Cell Group (TCG) meetings that were being held by Essex Fire and Rescue Services (EFRS) in relation to a 12 storey residential building with 132 flats that was undertaking a full decant. Initially the updates were provided for information and awareness only.

On the 28th July 2024 at approx. 5pm, the EPRR team received an email identifying the details of 45 residents that are still residing in the property with the ask to confirm if the individuals were known to EPUT. It was identified that 4 individuals were known to EPUT with vulnerabilities unknown at that time. Director on call was notified and provided details in the event there were any complication / issues over the weekend.

No further updates or concerns were identified.

GP Collective Action

The General Practitioner (GP) members of the British Medical Association (BMA) successfully balloted to take 'collective action' from the 1st August 2024. The 'Collective Action' has enabled each Practice to take a combination of the following measures:

1. Practices should defer signing declarations of completion for "better digital telephony" and "simpler online requests" until further GPC England guidance in by 2025
2. Switch off GP Connect functionality which permits the entry of coding into the GP clinical record by third-party providers.
3. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care).
4. Limit daily patient contacts per clinician to the BMA recommended safe maximum of 25. Divert patients to local urgent care settings once daily maximum capacity has been reached.
5. Stop engaging with the e-Referral Advice & Guidance pathway.
6. Serve notice on any voluntary services currently undertaken which plug local commissioning gaps.
7. See patients face to face as a default, unless there is a compelling reason not to do so.

8. Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and/or rationing, rather than the clinical benefit of your patients.
9. Stop rationing referrals. Refer your patient for specialist care when it is clinically appropriate to do so, via eRS.
1. Outside of 2WW, write a professional referral letter where this is preferable to using a local referral form.
2. Stop rationing investigations. Refer your patient for specialist diagnostic investigations when it is clinically appropriate to do so.
3. 12. Stop unsafe risk-holding to protect the system over the patient. Admit your patient to the local Emergency Department when it is clinically appropriate to do so via a written referral letter to the admitting team.

Sit-reps were completed and provided to each of the ICB's, following Gold Command approval, in addition to attendance at the ICB battle rhythm meetings.

This was managed via a watching brief within EPUT. No further concerns were identified. Silver Command were ready to stand up as required including attending any ICB meetings.

On the 7th March 2025, following agreement between the GPC and NHS England on the GP contractual settlement for 25/26, the BMA made the decision to "pause" GP collective action.

Public Unrest

During early August, there was an escalating situation across the UK shown on the news. This caused some unrest nationally, regionally and locally.

Following regionally and national meetings, attended by the ICB, it was confirmed that *'There was no actionable intelligence of any immediate threat to anywhere in the Greater Essex Area'* therefore an incident was not declared by the ICB.

The Trust held a Gold meeting to discuss and identify support for staff who were affected by the public unrest.

No further updates or concerns were identified.

Flu 2025

3rd January 2025, Silver Command (watching brief) was stood up following concerns raised linked to the increase in Flu across the country. The raised concerns were:

- Flu due to peak in next 8-10 days
- Seeing increase in people over 65
- Seeing increase in staff sickness in community areas
- Regional call held on new year's eve highlighting over ordering of PPE leading to mutual aid request from HCT, shortage of O2 cylinders impacting ambulance service

- No new IPC national guidance
- Broomfield not allowing visiting in high risk areas
- ESNFT implemented wearing of masks
- Weather warning at yellow with potential to move to Amber due to snow and ice

Actions Agreed

- IPC issued guidance for EPUT staff to follow, including mask wearing where there a risk was identified
- Adverse weather action cards were circulated
- IPC informed where groups of staff were off with respiratory illness
- Operations alerted Supplies of any PPE unfulfilled orders
- Silver Command reviewed sickness rates
- Further Silver Command held to review sit rep, mask wearing/IPC guidance, stock levels and sickness

One further Silver Command was held to review completion go actions and identify any further concerns. It was agreed, the Command would be stepped down.

Incident / Event Management

There have been one event that EPRR have proactively managed to ensure an incident did not occur: Ride London (24th – 26th May 2024)

An After Action review was undertaken on the 21st June 2024, following the event.

What went well:

- Community - Due to planning, no issues encountered
- Working from others bases / working from home worked well
- Good organisation including good level of communication utilising various forums.
- Early Planning – Level of detail provided to aid successful planning.
- Urgent Care – Being aware of road closures in advance of road closure – helped planning
- Communications – Meetings, receiving maps, Wednesday weekly.

TRAINING 24/25

An EPRR Training Framework was designed and implemented within the EPRR Team to monitor the compliance with the Minimum Occupational Standards.

During the year a number of Organisational Resilience training courses have been completed by EPUT staff:

Internal Training

General Awareness Training

E-learning resources in relation to organisational resilience & response and Business Continuity Plans are available on the Trust's intranet. Introduction training is provided as part of the Risk Management section on the mandatory staff induction course with compliance monitored via the Workforce Development Team.

External Training

Principles of Health Command Training (Gold)

This program continues to be run by NHS England (East of England) and provides those who may become involved in managing a major incident response with appropriate knowledge and skills to undertake the role. A number of directors and staff are trained and up to date with their training.

- 80% Executive Team – Increase of 40% from 2023-24
- 84% Director on Call – Increase of 22% from 2023-24
- 100% EPRR Leadership

Loggist Training

This program is run by NHS England and the Joint Commissioning Team (based on Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist in a Major Incident Response Team. A fundamental role within any major incident is that of the loggist: the person who is responsible for capturing, through decision logs, the decision-making process that might be used in any legal proceedings following an incident.

A Loggist must be available for all Gold Commands. Therefore, it is vital that a bank of individuals are available to cover the Loggist role in the event of a major incident.

Due to the limited availability of the national courses, an internal course has been developed and tested; in order to meet the Minimum Occupational Standards, aiding the development of EPUT Loggists.

The Trust has 16 trained and in date Loggists; in addition to 6 Loggists requiring refreshers when the next course is held. In addition; we have 24/7 cover through the use of senior staff within the Risk and Compliance and Team to cover the OOH provision

Level 4 Award in Health Emergency Preparedness, Resilience and Response

One of the Compliance Administrators commenced the Level 4 Award in Health Emergency Preparedness, Resilience and Response in April 2024 and has successfully completed the course.

The Trust submitted an expression of interest for a place on the Level 4 Diploma in Health Emergency Preparedness, Resilience and Response to develop and support the EPRR Team within EPUT. This was accepted and the second Compliance Administrator will commence the course in Q1 2025/26.

EPRR WORKPLAN

EPRR Work plan for 2024/25 was developed to incorporate the actions required to fully comply with the Core Standards in addition to development actions identified by the EPPR Lead.

It should also be noted that during 2024/25, the following significant achievements were made by the EPRR team:

- Successful Core Standards Self-Assessment and Check and Challenge process
- Support of incidents including preparation and organisation of Gold and Silver Commands.
- Successful completion of the Diploma in Health Emergency Preparedness, Resilience and Response Programme by one of the Compliance Administrators with the second Administrator starting in Q1 2025/26
- Improved partnership working with the three ICB EPRR Leads
- Involvement in regional exercises
- Effective management of EPRR events to prevent escalation to Critical Incidents

ASSURANCE

The Health, Safety & Security Committee holds responsibility for and oversees delivery of the Trusts annual Emergency Planning, Resilience and Response work plan.

The committee is chaired by the Director/Associate Director of Risk & Compliance and includes representatives from all services areas. The Committee meets bimonthly and considers progress against the work plan as a standing agenda item on a quarterly basis.

A quarterly EPRR report is provided to the Trust Quality Committee, a standing committee of the Trust.

EPRR risks have been highlighted in 2024/25 and have been escalated to appropriate risk registers and included on the Board Assurance Framework

presented to the Trust Board of Directors.

The Executive Director and Non-Executive Director who lead on EPRR have been actively involved in the EPRR work required in 2024/25 and have provided support to the EPRR Team.

Essex Partnership University NHS Foundation Trust

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

Tel: 0300 123 0808

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

9. STRATEGIC INITIATIVES

9.1 TIME TO CARE

Information Item | AG | 7

REFERENCES

Only PDFs are attached

Time to Care 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Time to Care Programme Report**					
Executive/ Non-Executive Lead:	Alex Green Executive Chief Operating Officer					
Report Author(s):	Emily Phillips, Transformation Programme Manager					
Report discussed previously at:	Time to Care Steering Group					
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:	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	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

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

Purpose of the Report		
This report is to update the Board of Directors on the progress of the Time to Care Programme	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
1. The programme remains at red status due to recruitment delays and financial implications against the agreed business case, however this is in the process of being re-baselined and a change request will be presented at the Steering Group in June for approval. 2. The Inpatient and Urgent Care Operational leads continue to make progress against their local implementation plans based on 30-day actions, 60-day actions and 90-day actions, despite experiencing some challenges with OPEL 4 and the Inquiry. Included within the presentation pack is some positive feedback received from patients.

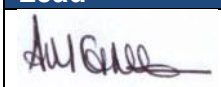
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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**	

Acronyms/Terms Used in the Report			
TTC	Time to Care		

Supporting Reports/ Appendices /or further reading
Time to Care Highlights Report May 2025

Lead
 **Alex Green** **Executive Chief Operating Officer**

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TIME TO CARE HIGHLIGHT REPORT

MAY 2025

STATUS UPDATE REPORT

OVERVIEW		
R	Time	R
	Cost	A
	Quality	A

PREVIOUS RAG STATUS					
REPORTING DATE	22/04	21/03	14/03	28/02	14/021
PREVIOUS RAG	R	R	R	R	A

PROJECT BUDGET	
Project Budget:	£16.9M
Spend forecast:	£16.9M
Actual Spend:	Month 1 Spend £1.4m

TIMELINES	
Forecast End Date	31/03/26
Report Date	15/05/25
Report Author	Emily Phillips
Next Report Date	19/06/25

EXECUTIVE SUMMARY

The programme remains at red status due to recruitment delays and financial implications against the agreed business case. The following corrective measures have been implemented:

- Revisions to the workforce trajectory, originally March 2025 and now ending September 2025
- Revised financial forecast for 2025/2026 to incorporate unmet efficiencies in 2024/2025

To align with the revised recruitment trajectory and cost estimates, a change request is being prepared to adjust the programme's timelines and financial forecast.

Quality remains at an amber status as the programme continues to refine the reporting mechanisms for Key Performance Indicators (KPIs), including the development of ward-level reporting.

Workforce
The programme has recruited 246.05 WTE against a 332.77 WTE target.

Currently, 15.99 WTE are in pre-advert, meaning these posts are approved and progressing toward active recruitment.

An additional 5.3 WTE Peer Support Workers have been approved at establishment control panel and positions will be going out to advert imminently.

Inpatient and Urgent Care Operating Model
The inpatient and urgent care operating model Steering Group convened on 8 May 2025 to review and update local implementation plans based on 30, 60, and 90-day action timelines. Operational leads reported that the OPEL 4 status and ongoing Inquiry have impacted both the implementation process and operational delivery.

Specialist Services
The implementation plan is progressing with a focus on roadshow events to promote and support implementation of the operating model. Communication advising roadshow dates has been circulated to services managers to share with their teams. Development of the standard operating procedure (SOP) is also underway.

Benefits Realisation
The Performance Team are conducting a comprehensive review of all 37 KPI's to determine their current data source and tracking mechanisms. This will determine how each KPI is monitored through the IPR or other data sources. A plan will need to be developed to document the data source for each KPI, assessing whether it is currently being tracked and outline the steps to establish monitoring process for those not yet tracked.

Route to Green (Time, Cost & Quality)
To align with the recruitment trajectory and cost estimates, a change request is being prepared to adjust the programme's timelines. This request will be presented at the Steering Group in June for approval. Once approved, the programme's overall status will transition from red to green, indicating that it is now on track to achieve its revised objectives within the agreed parameters.

ACHIEVEMENTS THIS REPORTING PERIOD AND PROGRESS AGAINST RAG IN THE REPORTING PERIOD

Workforce
A total of 38.75 WTE are in final stages of recruitment:
- 30.13 WTE – Have conditional offers made and are undergoing pre-employment checks
- 8.30 WTE – Have offers accepted and are awaiting confirmed start dates
- 0.32 WTE – Have start dates confirmed

Inpatient and Urgent Care Operating Model
The SOP for the Inpatient and Urgent Care Operating Model has been finalised and approved by the operational teams. Currently awaiting confirmation on whether further approval is required prior to uploading to SOPHIA.

The local implementation plans across 23 wards have been consolidated into a master heat map. This provides an overview of implementation progress made against the 30-day actions (completed), 60-day actions (in progress) and 90-day actions (upcoming). This is included within this pack to provide assurance and visibility on delivery progress.

Specialist Services
SOP workshop dates have been identified and circulated to SOP owners. The SOP is now being reviewed for refinement using the AI tool on SOPHIA. Dates and venues have been confirmed for the roadshow events commencing on 22/05/25 and a roadshow communications has been shared with Service Managers

Benefits Realisation
Scheduled meetings with the benefits owners for the purposeful admission and therapeutic benefits KPI chapters. To define how the KPIs will be measured and monitored over time, ensure clear ownership and accountability when the programme transitions to business as usual and assess the current state ahead of full implementation of the operating model to establish a meaningful baseline for future comparison.

PLANNED FOR NEXT REPORTING PERIOD

Workforce
A total of 26.52 WTE are in the recruitment pipeline:
- 13.55 WTE – In shortlisting
- 8.57 WTE – Interview Stage
- 4.40 WTE – Being advertised. Closing dates for these advertised positions are between 14/05/25 and 21/05/25

Key focus on moving candidates efficiently through each stage of recruitment to fill these roles within the specified timelines and advertise the outstanding 11.98 WTE Registered Professionals positions.

Inpatient and Urgent Care Operating Model
Operational leads continue to update their local implementation plans based on 30-day actions (completed), 60-day actions (in progress) and 90-day actions (upcoming) plans. There is a session at the Inpatient and Urgent Care Operating Model Steering Group on 05/06/25 to discuss and refine the tracking and automation of the 37 agreed KPI's across Financial, Clinical, and Quality, Service and People. Given that some KPI's are monitored within the IPR, it requires collaboration with the performance team and benefit owners to understand tracking methods and explore automation for improved efficiency and accuracy.

Specialist Services
Hold SOP development workshop and complete baseline training needs.

Benefits Realisation
Engage with the benefits owners of the following KPI chapters to confirm accountability and assess the current state prior to full implementation of the operating model:
- Trauma Informed Care
- Safe and Effective Discharge
- Service and People (covering Capacity, Productivity, Staff Wellbeing, and Patient/Family Experience)

Discuss future phases of KPI reporting with the Performance team, focusing on automation and monthly assurance reporting using the Integrated Performance Report (IPR).

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TIME TO CARE
INPATIENT & URGENT CARE OPERATING MODEL

MAY 2025

KEY STAGES OF OUR OPERATING MODEL

PURPOSEFUL ADMISSION

Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient provision for the person's needs and there is a clearly stated purpose for the admission:

- Deciding whether an inpatient admission is required or the person could be supported in the community.
- Agreeing a purpose of admission
- Arranging prompt access to the most suitable available inpatient provision for the person's needs
- C(E)TR to have taken place pre admission and shortly after admission for people with a learning disability and autistic people

THERAPEUTIC INPATIENT CARE

Care is planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission including:

- Purposeful care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital. (Supported by the Red to Green approach)
- Care planning and formulation
- Delivering therapeutic activities and interventions
- Optimising medication regimes
- Reviewing and updating care plans. Meeting the purpose of admission

TRAUMA INFORMED CARE

Acknowledges the need to understand a patients life experience in order to provide and deliver the most effective care for their needs. This approach is expected to support better outcomes for patients and their carer/s.

PROACTIVE DISCHARGE PLANNING & EFFECTIVE DISCHARGE SUPPORT

The person's discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

- Proactive Discharge Planning and Effective Discharge Support
- Development of discharge plan from start of admission
- Regular review of discharge plan throughout admission including early action on any factors that may delay discharge
- Determine person is ready for discharge
- 48 hours' notice of decision to discharge
- 72 hour follow-up arranged
- Details of crisis support services provided
- 72 hour follow-up completed
- HTT support to facilitate discharge
- Ongoing support to maintain the person's wellbeing provided to agreed times

Inpatient & Urgent Care Operating Model Feedback

Quantitative Feedback:

Improved Staff Retention and Reduced Temporary Staffing

- There has been a notable improvement in overall staff retention across the organisation. The staff turnover rate has seen a positive decline from 9.2% in March 2024 to 6.7% by April 2025.

Significant progress has also been made in reducing reliance on temporary staffing within Inpatient & Urgent Care services:

- Agency Staffing: The actual whole time equivalent (WTE) for agency staff decreased from 50.21 WTE in March 2024 to 18.78 WTE in April 2025. This reduction has contributed to delivering financial savings.

- Bank Staffing: Bank staffing levels have similarly reduced, from 736.63 WTE in March 2024 to 562 WTE in April 2025.

Qualitative Feedback:

Professional Nurse Educator – West: Supporting Staff Development and Enhancing Patient Care

"In the role of a Professional Nurse Educator, significant progress has been made in identifying and addressing critical knowledge gap across the wards in West. A combination of 1:1 coaching and group teaching, delivered both in-person and via Microsoft Teams. This has helped to build individuals competencies, enhance nursing knowledge ad confidence, and improve the overall quality of patient care.

I conducted an audit on person-centred care, developed and delivered specialised training on Principles of Care Planning. The controlled drugs (CDs) became a concern, I created a Control Drug refresher teaching session, which I conducted with the assistance of the pharmacy team. Last year, nursing students raised concerns that since we moved from paper medication charts to EPMA, they had not been able to take part in medication administration, to help them complete their competency. I had the opportunity to work with the EPMA team to create EPMA training specifically for nursing students. Now, EPUT students have the opportunity to complete EPMA training and fulfil their medication competency requirements.

I have worked collaboratively with other healthcare professionals to identify and address skills gaps while promoting professional development. I worked in partnership with the End of Life Lead to develop End of Life care bite-sized learning PowerPoint presentations. This forms part of 10-minute bite-sized training sessions on physical health, designed to help mental health staff (both RGN, RMNs and HCAs) understand the management of secondary physical health diagnoses. This is currently an ongoing project.

I am currently completing a Professional Nurse Advocate course. This will enable me to provide emotional support and create a safe environment for staff and students reflection. As a PNA, I will be able to support staff through restorative clinical supervision. I currently offer both individual and group supervision following teaching sessions and when staff require additional support."

Feedback Received From Patients (March & April 2025):

North East Essex: "I want to take a moment to personally thank each of you for your role in supporting my journey thus far I am extremely blessed to be receiving the standard of treatment I am currently receiving; I cannot thank you all enough. This is my defining moment. For the first time, I am in full control of my recovery."

Pitsea: "You all done everything well from day one, you saved my life, I have never felt as bad and scared and so alone, and going to hospital. Each and every one of you that came to me was amazing and so caring and kept me home. The support, advice, kindness and honesty from you all got me to where I am today. You all made time for me to sit, listen and support me as you know my biggest fear is of doctors and medical matters, I feel you enabled me to get a little past that fear. Everything was explained and I was always made to feel heard. I can only say you are one amazing team-each one of you are Earth angels, I feel so blessed and so lucky that you were sent to me, Thank you all so much."

Chelmsford: "It has been a pleasure to spend some time on Christopher Unit last week and this week. Although the nature of the patients is more chaotic then most wards, the ward has felt calm, organised and safe on both occasions. Sometimes there have been patients shouting but the staff team and social areas have remained very calm, still and supportive. There was a sense that things were in control and no one became flustered. You have kept an atmosphere that feels really therapeutic. I know this is not easy to do. It is a credit to you as a team, that you keep focused on the individuals on the ward, as people and not as risks. And as people, not as tasks. Everyone came across and professional and genuinely happy to be there. Thank you for all the hard work, I hope you are able to feel proud of the environment and care you are providing."

9.2 STRATEGIC IMPACT REPORT

Information Item ZT

REFERENCES

Only PDFs are attached

Strategic Impact Report 04.06.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 June 2025

Report Title:	**Strategic Impact Report**					
Executive/ Non-Executive Lead / Committee Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy Alison Ives, Deputy Director of Transformation					
Report discussed previously at:	Executive Committee 15 March People Committee 24 April Quality Committee 15 May Finance & Performance Committee 22 May					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	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		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
	SR13 Quality Governance		✓
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.	NA		
Describe what measures will you use to monitor mitigation of the risk	NA		
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 the end of the second of five years. It also provides updates on the Transformation portfolio. Finally, the report provides reflection on approach to Operational Planning for 2025/26.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and take assurance from the report.

Summary of Key Points

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

Since the last report, there has been informal engagement with the Non-Executive Directors of the Board to revisit their level of confidence in delivery of the Strategic Plan two years since this exercise was last undertaken and to seek feedback on the efficacy of the strategic impact report. Feedback on the report was broadly very positive and improvement modification was suggested and has been incorporated into this version. Notable, in this cycle a single slide dashboard has been added, presenting a small selection of indicators for each Strategic Objective showing the trend since the launch of the Strategic Plan. To note, the indicators selected are all taken from the Integrated Performance Report or other reports routinely presented to the Board or its Committees.

At the end of Year 2 of the Strategic Plan, we have continued to evidence steady progress against each strategic objective within each care unit in the last six months. Any risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

We will deliver safe, high-quality integrated care

- Quality Governance structure fully established with appropriate executive oversight and annual work plans developed for effectiveness, safety and experience of care
- Quality Dialogue in February 2025 reviewed progress against nine quality priorities and informed focus areas for the future
- Co-production conference held in October 2024
- New Quality Assurance Framework launched and incorporated into quality priority work plans
- Approved annual plan for reducing health inequalities in 2025/26 with focus on Race Equity and Smoking Cessation
- Continued work towards implementation of unified Electronic Patient Record – established partnership with Oracle Health, clinical design work commenced
- Significant progress with the sexual safety agenda and unprofessional behaviours including GMC and NMC presentations to senior leadership and executive teams and co-production of interventions for Specialist Services.

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

- Strengthened academic and commercial partnerships in research and innovation and trained more clinicians to lead research
- Board implemented strategic stakeholder relations framework, ensuring consistent messages/approach
- Continued engagement in implementing Southend, Essex and Thurrock all-age mental health strategy, now looking to refresh implementation plan to align more closely with place based transformation and more focus on prevention, early intervention and recovery
- Active partner in development of community provider collaboratives and place based partnerships in all geographies.

We will enable each other to be the best we can be

- Accelerated implementation of Time to Care operating model and recruitment to new posts with benefits monitoring mechanisms put in place
- Developed plan for Community First programme to redesign community operating model
- Progressed delivery of People and Education Strategy with three themes – train, retain, reform
- Conversion of temporary to substantive staff in posts though still operating above workforce plan.

We will help our communities thrive

- Delivery of Multiply Programme across greater Essex - supported over 1,200 adults in Southend, Essex and Thurrock to improve their numeracy skills as a key wider determinant of outcomes, including those in EPUT's inpatient services and HMP Chelmsford
- Commitment to adopt principles of community resilience into collaborations with voluntary sector partners

- Programme of inclusive, local recruitment events across Essex in partnership with colleges and higher education institutions to bring down barriers to high quality work in more deprived areas
- Positioning social impact as key theme of other enabling strategies e.g. people and education (local apprenticeships), estates (community assets), pharmacy and medicines optimisation (medical waste reduction).

Over the past six months we have seen a change in the priorities of the Transformation Team to focus on eight key areas of transformation where we will realise maximum benefits for the safety and care of our patients, and to those schemes which will be instrumental to the successful delivery of our strategies.

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**	N/A

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Strategic Impact Report Month 12 24/25

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

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STRATEGIC IMPACT REPORT

M12 2024/25

EPUT

CONTENTS.

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INTRODUCTION

EPUT

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

OUR VISION

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

OUR VALUES

Strategic objectives

We have four strategic objectives to achieve our vision:

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

Delivered through our target operating model

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Our Year 2 commitments to deliver the strategic plan
Summary of 2024/25 operational 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 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 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 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

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DELIVERY HIGHLIGHTS

M12 2024/25

EPUT

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STRATEGIC IMPACT DASHBOARD

Strategic Objective 1: We will deliver safe, high quality integrated care services

Indicator	M6 23/24	M12 23/24	M6 24/25	M12 24/25	Trend
Incident reporting rate (>44.33)	69.65	66.78	60.57	66.23	↓
No/low harm incident rate (MH) (>93.9%)	92.92	91.90	89.53	87.62	↓
No/low harm incident rate (physical) (>94.6%)	83.97	79.05	77.93	88.57	↑
% patients/families feeling safe in EPUT's care*	94.97	95.87	94.58	93.73	↓

Strategic Objective 2: We will work with our partners to make our services better

Indicator	M6 23/24	M12 23/24	M6 24/25	M12 24/25	Trend
Adult MH ALOS on discharge (<35)	62.13	60.73	73.08	79.87	↑
In appropriate Out of Area Placements (0)	18.33	20.17	28.83	24.17	↑
Virtual Ward occupancy (>90%)	53.0	70.17	63.27	64.07	↑
Weighted accruals to NIHR research studies (5000/yr)	170	132	198	197	↑

Strategic Objective 3: We will enable each other to be the best we can be

Indicator	M6 23/24	M12 23/24	M6 24/25	M12 24/25	Trend
Staff turnover (<12%)	10	9	9.43	8.72	↓
Manager/Leadership Dev Programme uptake	N/A	185	135	28	↓
LEA hours/year		956		5,388	↑
Staff supervision/1-1 support (>90%)	73.13	73.45	72.27	73.60	→

Strategic Objective 4: We will help our communities to thrive

Indicator	M6 23/24	M12 23/24	M6 24/25	M12 24/25	Trend
% workforce from local communities		81	89	89	↑
% BAME staff in roles >B7		21	22	22	→
% procurement spend with local suppliers		31	22	22	→
Social impact grant awarded (£)	61,000 (23/24)		268,000 (24/25)		↑

Note: Indicators for Strategic Objective 3 will be revised to align with those selected by the People & Culture leadership team

*Safety of care and environment are not always relevant for people, particularly those who use our community services which are not specifically mental health related, and as such we have an average of 12% no-response rate for the 2 questions relating to safety, which when excluded from the percentage rating significantly increases the trusts performance rating in the domain of safety within the friends and family test. Further, this gap grows as the quarterly response rate for IWGC increases with over 60% of responses attributable to a community service.

At the end of Year 2 of the Strategic Plan, we have continued to evidence steady progress against each strategic objective within each care unit in the last six months

Strategic objective	Progress on key deliverables
We will deliver safe, high-quality integrated care	**Focus on high quality care** • Quality Governance structure fully established with appropriate executive oversight and annual work plans developed for effectiveness, safety and experience of care • Quality Dialogue in February 2025 reviewed progress against nine quality priorities and informed focus areas for the future • Co-production conference held in October 2024 • New Quality Assurance Framework launched and incorporated into quality priority work plans • Approved annual plan for reducing health inequalities in 2025/26 with focus on Race Equity and Smoking Cessation **Focus on safety** • Continued work towards implementation of unified Electronic Patient Record – established partnership with Oracle Health, clinical design work commenced • Significant progress with the sexual safety agenda and unprofessional behaviours including GMC and NMC presentations to senior leadership and executive teams and co-production of interventions for Specialist Services
We will work together with our partners to make our services better	**Developing strategic relationships** • Strengthened academic and commercial partnerships in research and innovation and trained more clinicians to lead research • We continue to engage proactively with a range of external stakeholders, including the 18 Essex MPs, the three upper tier local authorities - Essex County, Thurrock and Southend City councils - and other key partners and organisations. In the last year, we have hosted 10 visits from MPs to our sites, attended and reported to Health Overview and Scrutiny Committee meetings for all three upper tier local authorities and Initiated a joint project with Cambridge School of Arts (part of Anglia Ruskin University) to co-design and co-produce an artwork with our patients at Brockfield House **Delivering care in partnership** • Continued engagement in implementing Southend, Essex and Thurrock all-age mental health strategy, now looking to refresh implementation plan to align more closely with place based transformation and more focus on prevention, early intervention and recovery. Forthcoming changes to NHS architecture are likely to reduce complexity and unwarranted variation in approach across Greater Essex • Active partner in development of community provider collaboratives and place based partnerships in all geographies

At the end of Year 2 of the Strategic Plan, we have continued to evidence steady progress against each strategic objective within each care unit in the last six months

Strategic objective	Progress on key deliverables
We will enable each other to be the best we can be	**Remodelling our clinical services** • Accelerated implementation of Time to Care operating model and recruitment to new posts with benefits monitoring mechanisms put in place • Developed plan for Community First programme to redesign community operating model **Supporting our staff** • Progressed delivery of People and Education Strategy with three themes – train, retain, reform • Conversion of temporary to substantive staff in posts though still operating above workforce plan

We will help our communities thrive	**Delivery of Multiply Programme across greater Essex**
	• Supported over 300 adults in Southend, Essex and Thurrock to improve their numeracy skills as a key wider determinant of outcomes, including those in EPUT's inpatient services and HMP Chelmsford
	• Delivery across social impact pillars in M6 to M12 includes:
	  • Commitment to adopt principles of community resilience into collaborations with voluntary sector partners
	  • Programme of inclusive, local recruitment events across Essex in partnership with colleges and higher education institutions to bring down barriers to high quality work in more deprived areas
	  • Positioning social impact as key theme of other enabling strategies e.g. people and education (local apprenticeships), estates (community assets), pharmacy and medicines optimisation (medical waste reduction)

Risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

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DELIVERY AGAINST STRATEGIC OBJECTIVES

M12 2024/25

EPUT

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

Trust overall	Care group specific
• Increasing trend in incident reporting rates as evidence of a learning culture since April 2024 • Consistent proportion of low/no harm reports compared with prior year • 12 month review of Care Programme Approach achieved 95% target for first time in two years in October and maintained since – transitioning to new model that focuses on integration of care closer to home • Care Home CQC ratings upgraded to good in all areas • Average monthly increase of 41 patient reported experience measures, a second period of reported increase • 1% decrease in people reporting feeling safe in EPUT's care comparing the first and second halves of the year, but an increase from 91.4% in December to 94.4% in February	**Urgent Care and Inpatients** • Gaining external recognition for development of Trauma Informed Care model • Accepted into NHS Confederation Mental Health and Acute in ED Interface Improvement national programme **Specialist Services** • Concrete feedback from CQC inspection of Learning Disability Services in March from patients, carers and advocates now informing improvements to quality of easy read care plans and investment in facilities • Moved from design to Phase 1 implementation of Mental Health Inpatient model in March as planned **Psychological Services** • EIP/ARMS excellent performance on recent national audit – most rated 'top performing' • Percentage of patients moving through Talking Therapies into recovery increased from 48% in Q1-3 to the target of 52% in Q4 **North East Essex** • Audit of emergency mental admissions in Q3 showed 67% under care of home first team and led to targeted approach to medical students at University of Essex and local GPs • Launched quality improvement project based on incident feedback to improve duty service **West Essex** • Length of stay on virtual ward remains low at eight days. Ongoing work with system partners to address virtual ward occupancy below 80% target – planning system review end Q1 25/26 • 1,456 dialogue+ assessments completed in 2024/25 as a therapeutic intervention delivered as part of integrated mental health service delivery with PCNs **Mid and South Essex** • Steady improvement towards 75% target for delivery of physical health checks for those with severe mental illness and 5% improvement in both February and March • Complimentary feedback received from Admission Prevention & Early Discharge service around the availability of clinical support when needed through the Basildon Transfer of Care Hub.

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

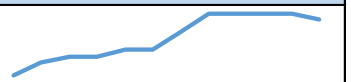
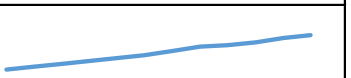
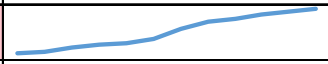
Metric		Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Narrative/ Trend Graph
Patient Safety incident rates (PSIM)	Incident Reporting Rates	>44.33	56.6	57.8	67.5	64.1	65.6	51.4	56.4	65.9	60.9	69.5	67.1	62.4	
	Reduction in PSIs	<3	2	2	0	1	5	0	2	0	0	0	0	0	
Patient Safety Events rated by Harm (not including incidents that have yet to be reviewed)	No/low harm incident rates	>44.33	87%	85%	85%	79%	85%	89%	81%	82%	85%	74%	86%	60%	
	Total incidents reported		2184	2220	2318	2786	2497	2090	2343	2344	2410	2724	2339	2398	
Live Integrated Network Teams	West Essex	6													
	MSE (SEE)	6													
	NEE	10													
PREMS	No. reviews		548	572	569	538	354	326	638	533	397	626	436	450	
	5 star score		4.77	4.82	4.73	4.64	4.81	4.7	4.85	4.67	4.64	4.7	4.67	4.75	
	% Positive experience		77.40%	94.20%	89.50%	86.20%	92.70%	94.20%	96.10%	90.20%	88.70%	81.80%	88.80%	85.60%	
	% Negative experience		3.10%	1.40%	3.20%	5.60%	2.00%	4.30%	1.90%	4.30%	5.30%	4.80%	5.30%	4.00%	

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 work together with our partners to make our services better

Trust overall	Care group specific
• *Quality Together* governance structures in place with ICBs continuing to supporting delivery of Trust quality improvements • In 2024/25, following the success of the peer worker pilot as part of Time To Care in 2022/23, EPUT introduced substantive new peer worker roles focussing on supporting families and carers of people in inpatient services. In total we have advertised 39 posts across inpatient and specialist services with 67% now filled and the remaining in recruitment • 42% year on year increase in number of Lived Experience ambassadors co-producing changes and improvements to services • Sustained focus with university partners on health and care system workforce development and clinical education • First year of research strategy has driven improvements in portfolio balance, weight recruitment to trials and clinical staff training to lead investigations • Research weighted recruitment target revised from 5,000 to 3,200 for 2025/26 agreed with NIHR regional delivery network while research infrastructure and processes are still developing • Secured funding to increased community re-titration of clozapine to reduce inpatient bed days	**Urgent Care and Inpatients** • Improvement in inappropriate out of area placements from an average of 60 M7-11 to 48 in M12 driven by increased peer clinical review; new Clinical Flow lead is leading on a flow improvement programme using quality improvement methodology • Introduced locality-based bed management processes and shared Teams channels, working together with Acute trusts and community services on flow, capacity and quality of inpatient admissions **Specialist Services** • Presentation of CAMHS research at international conference in March • Joint audit with community provider and local authority undertaken leading to development of new Multi-Agency Care Plan for all young people Essex to support reduction of crisis presentations and admission avoidance **Psychological Services** • Development of transgender policy, Recite Me license for NHS Talking Therapies **North East Essex** • Embedded use of Lived Experience Ambassadors on interview panels • Living Well with Dementia pilot rolling out from Brentwood to other communities **West Essex** • Hospital at Home service, delivered in partnership with a range of system partners and Doccla (supplier of wearable technology), was shortlisted for HSJ Digital Awards for Improving Out of Hospital Care through Digital **Mid and South Essex** • Improvement interventions delivered in partnership with Thurrock Council extended e.g. Enhanced Housing First and s177 reviews which are helping residents back to independence and optimising use of resources • Started the roll out of direct booking for the Primary Care MH Service in mid-Essex. Fully implemented in Chelmsford localities and successful to dated and very well received by the PCN. Current phased roll out in the Braintree, Maldon and Dengie area which has also been very well received

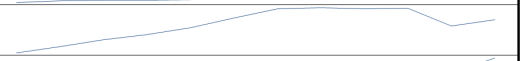
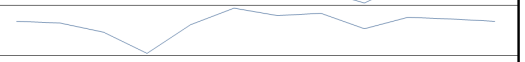
STRATEGIC OBJECTIVE 2: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Metric	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend]
Number of all open studies in a month (cumulative)	22	15	17	18	18	19	19	22	25	25	25	25	24	
non-commercial : commercial	(18:4)	(14:1)	(16:1)	(17:1)	(17:1)	(18:1)	(18:1)	(20:1)	(22:1)	(22:1)	(22:1)	(22:1)	(21:1)	
Cumulative combined all commercial and NIHR non-commercial raw recruitment numbers across all study types	-	393	795	1174	1604	1955	2361	2927	3366	3684	4110	4521	4997	
LSS(x1):Obs (x3.5): IV (x11)	(9%:53%:38%)	2.7%:38%:59.3%	2.1%:39.2%:58.7%	2.8%:22.2%:75%	2.2%:21.1%:76.7%	3.2%:19.6%:77.2%	3.4%:18%:78.6%	Data unavailable						
Cumulative combined study types weighted NIHR non-commercial research studies recruitment numbers	5000	74	187.5	425.5	645.5	769.5	967	1711.5	2162.5	2381	2635.5	2800	2997	
		1.35%	3.41%	7.74%	11.74%	13.99%	17.58%	31.12%	39.32%	43.29%	47.92%	50.91%	54.49%	

Delivery against strategic objective 3 – we will enable each other to be the best we can be

Trust overall	Care group specific
• Reducing trend in staff turnover rates during the year, sustained consistently until 10% against target of 12% • Reduced agency and bank usage while growing number of staff in post • Time to hire reduced by 10 days during Q4 with increasing numbers of candidates, contributing to better staff experience and lower temporary staff costs • Q4 National Quarterly Pulse Survey results showed 29% decrease in turnout from previous quarter and scores against most questions decreased. Focus remains on persistently low scoring areas – perceived standards of care and recommending EPUT as a place to work • National Staff Survey Results 2024 broadly in line with comparator Trusts and EPUT's results from prior year • Reduction of 10 consultant vacancies in the last eight months contributing to better continuity and use of resources • 50 new volunteers recruited • Around 30% increase in time given by Lived Experience Ambassadors	**Urgent Care and Inpatients** • Accelerated recruitment of Time to Care roles as part of inpatient model and reducing use of bank and agency staff during Q4, though still above target to fill key vacancies which are reducing **Specialist Services** • Significant reduction in agency usage during Q4 ending February with 8 WTE against target of 7.19% alongside overall reduction in vacancy rate by 1.5% in three months to 23.5% (including Time to Care vacancies), though still above 12% target • Strong improvement in mandatory training compliance rates across all courses and professional groups **Psychological Services** • MSc CAP training delivery; 75 CAPs trained by April • Working on plan to train enough non-medical prescribers to progress rollout of STOMP clinics (Stopping over medication of people with a learning disability and autistic people) **North East Essex** • Bank and agency usage reducing and low compared to vacancy factor and in comparison to previous year • Staff turnover rate from 12.5% in April 2024 to 6.9% in February 2025 and sustained below 12% target all year **West Essex** • 20% reduction in bank usage over the course of the year and reduction of 13 WTE agency posts • Increasing rates of staff appraisals reaching 86% in February against target of 90% **Mid and South Essex** • Substantive recruitment to 10 posts in Thurrock teams previously covered with agency due to reputational improvements and focus on local recruitment, leading to decrease in continuity of care complaints • Vacancy rate by March was 3.3% , which is a decrease from previous month and has been steadily decreasing in recent months and significantly under the Trust target, which reflects the continuous recruitment ongoing in the Care Unit

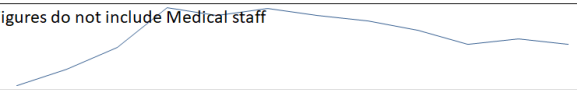
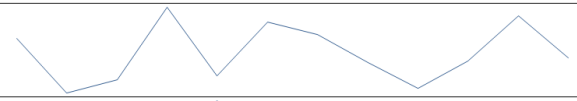
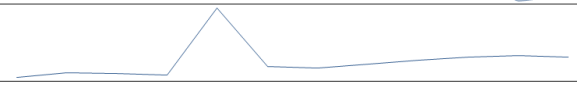
STRATEGIC OBJECTIVE 3:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Metric		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Narrative
Retention rate	Staff Turnover (Target 12%)	9.6%	9.4%	9.3%	9.3%	9.5%	9.5%	9.2%	9.3%	9.0%	8.8%	7.3%	8.7%	
Range and update of learning & development opportunities (inc. volunteers and lives exp. roles)s		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							OCT 2024-MARCH 2025 inclusive (EPUT and SHARED DELIVERY) Leadership Programme: 24 Management Development Programme: 85 Edward Jenner Programme: 15 STORM Training: 23 PSIRF (Systems Approach to Learning from Patient Incidents): 0 Time Management: 43 Minute Taking: 19 VDT MOCA Training: 0 ACT Training: 16 (ACT Team to check and update if incorrect) RISE: MSE 23 (EPUT 10) / EPUT 30 OCT 2024-MARCH 2025 inclusive (DELIVERED BY EXTERNAL PROVIDERS) Leadership Programmes: 5 (one of which is the second year of study) Managers Programme: 0 ACT Training: 1 (ACT Team to check and update if incorrect) APPRENTICESHIPS (Leadership/Management Programmes): Leadership Programme: 2 Management Programme: 0					
Number of PSE and Lived Experience role	Total No. LEAs	217	220	221	221	222	225	248	252	297	297	294	308	
	Total No. Volunteers inc LEA	411	424	439	451	466	487	507	510	507	508	469	483	
	Total New Registrations inc LEA	15	13	15	12	15	19	21	19	15	4	24	34	
	Hours LEA (per month)	728.5	885.9	525.1	764.1	478	532	232	350	188.5	259	192	204	
	No of LEA's involved in activities	117	132	87	77	87	69	57	71	48	86	63	83	
	No of activities Per month	42	41	36	25	40	49	45	46	38	44	43	42	
Staff survey - Pulse results	Reported quarterly	606 people completed the NQPS in Q2, this is a 78% increase when compared with the previous quarter. There was a positive increase in all 9 core areas. 'I am enthusiastic about my job' reported 60.6% in Q1, and 60.9% in Q2, while this is still an increase, the other 8 areas increased by at least 3.5%+.			There was no Q3 survey due to annual staff survey running			492 people completed the NQPS in Q4, This is a 29.3% decrease when compared with previous quarter. All but one of the NQPS scores have shown statistically significant deterioration since the previous quarter with 'I am enthusiastic about my job seeing a positive increase. This was reported as significantly dropping in the previous quarter so it is pleasing to see this rise. Focus remains on persistently low-scoring NQPS questions which include perceptions around standards of care, and recommending the organisation as a place to work.			Data will be available in May			

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

Trust overall	Care group specific
• 89% of EPUT staff live and work in same county during 2024/25, up from 81% in M8 of the prior year • 22% of band 7 and above roles held by BAME colleagues, same as in the first half of the year • 22% of purchase order value was placed with suppliers in Essex, Bedfordshire or Suffolk, same as in the first half of the year • Launched GoGreen Management service as furniture, fittings and equipment re-use programme which will help save money and reduce environmental impact • Hosting 221 apprentices, using 29% of apprenticeship levy with plans in development to increase usage further • Suicide prevention training will remain a focus to drive required 5% improvement and achievement of 85% target • Enable East delivery of Multiply numeracy skills programme via grant funding to Southend, Essex County and Thurrock councils for 1,238 adults without a mathematics GCSE over two years before the programme closed	**Urgent Care and Inpatients** • Developed a focused recruitment and retention plan, including actions to increase local recruitment, voluntary work, opportunities for good quality work which has supported recruitment to Time to Care roles **Specialist Services** • Six new healthcare assistants recruited at the Basildon event in October supported by MSE HCA academy will start working at Brockfield House in Wickford in March, having completed their initial training **Psychological Services** • Southend Rough Sleepers Mental Health team shortlisted for Advancing Health Standards Awards UK 2025 • Expansion of Service User Networks into other service areas following example of Personality Disorder & Complex Needs network **North East Essex** • Partnership with University of Essex and Investigating Countryside and Angling Research Projects (ICARP) to enable residents to learn to fish as an option for social prescription • New Speech and Language Therapist and Podiatrist apprenticeships launched supporting local recruitment and development of substantive workforce **West Essex** • On the day offers made to five of 25 local people attending local recruitment event at Harlow College in January and a further 25 roles offered during National Carers Weeks in partnership with local job centres • Percentage of service users on caseload that have taken up supported employment and education programmes increased to a high of 50% in December against target of 30% **Mid and South Essex** • Thurrock Partnership Complex Housing Intervention Programme extended for two years based on evidence of reduced crisis, unplanned admissions, A&E attendances and demand for police services

STRATEGIC OBJECTIVE 4: WE WILL HELP OUR COMMUNITIES TO THRIVE

Metric		Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Narrative
% of workforce employed from local communities			Snapshot: 5484 out of 6750 (81%) employed and live in same county					Snapshot: 88.9%						Snapshot 88.51%	Data provided as a snap shot as not many changes month on month. Data quality work has been carried out on locations and data refreshed in Mar-25.
% BAME staff in roles >B7			22.06%	22.18%	22.34%	22.63%	22.57%	22.62%	22.57%	22.53%	22.46%	22.36%	22.40%	22.36%	Figures do not include Medical staff 
% procurement spend with local suppliers			29.4%	2.8%	9.2%	44.6%	11.1%	37.4%	31.2%	17.4%	5.3%	18.4%	40.4%	19.8%	
	Preventing Suicide by Ligature	85%	81.8%	80.9%	80.6%	79.0%	87.4%	80.3%	80.2%	80.0%	76.2%	79.1%	79.1%	79.9%	
	Clinical Risk for Registered Staff	85%	89.5%	88.9%	87.3%	87.4%	92.1%	89.5%	89.2%	88.0%	88.6%	88.4%	86.3%	86.9%	
	Clinical Risk for Non-Registered Staff.	85%	89.4%	89.8%	89.7%	89.6%	95.3%	90.3%	90.2%	90.5%	90.8%	91.1%	91.2%	91.1%	
Uptake and evaluation of suicide awareness training	Suicide Prevention & Self-harm Mitigation (Storm):		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.						1st October 2024 to 31st March 2025 •18 Advanced three day courses were offered on the Training Calendar for the above dates and 144 delegates could have attended •1 course was subsequently cancelled due lack of facilitators •We delivered 17 courses and should have had 136 delegates but only 102 attended •Therefore out of the potential 136 available places for the 17 courses which were delivered only 102 attended the training (75%) as some delegates did not turn up and others cancelled				

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TRANSFORMATION DELIVERY FRAMEWORK UPDATE

MONTH 12 2024/25

EPUT

TRANSFORMATION TEAM OVERVIEW

INTRODUCTION

The priorities of the Transformation Team have now changed to focus on eight areas of transformation where we will realise maximum benefits for the safety and care of our patients, and to those schemes which will be instrumental to the successful delivery of our strategies.

The following large-scale key change programmes which have a Board or Executive Committee approved business case or Programme Initiation Document will become the primary focus of the team:

- Time to Care
- Community First programme
- NOVA (EPR)
- EPMA
- Lampard Inquiry
- Medium Term Plan
- Corporate Services Review
- Efficiencies and Operational Planning

Locally owned and sponsored change programmes will continue and the Single Front Door for setting up new projects also remains in place. This will focus on ensuring that local change projects, which require support from other teams, such as digital, finance, people, etc. are set up for success and approved using the trust's agreed processes. It will also help us keep a clear view of all the change going on in the trust and the overall progress against our strategy.

OBJECTIVES & PRIORITIES

Transformation Priorities

The team are working alongside wider colleagues to ensure a safe and controlled transition of several projects and programmes back into the business as the team's focus moves to supporting the eight priority areas of transformation and the governance and assurance that will support these.

Trust Efficiency Targets

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

Alongside this the team has a leading role in reviewing the Trust Corporate Services to ensure they provide a high quality, professional and appropriate service which meets the needs of the care units whilst also delivering efficiency savings.

Aspyre Project Management Solution

Our use of Aspyre will be instrumental in successfully managing and providing assurance on the eight large scale key change programmes.
This project management solution also allows us to maintain a change ideas register and provide assurance on the overall Trust portfolio of change.

Embedding Quality Improvement

Through collaboration with MSE Foundation Trust, the team are accessing QSIR Foundation and Practitioner courses and are now able to provide support, improvement advice and coaching to clinical teams and services engaged in local projects and strategic programmes of work.

Service Catalogue & Skills Matrix

The team has published on the Trust Intranet, a service catalogue which provides details of the services the team offers and how colleagues can engage with these. In addition, it provides more information on the Single Front Door (the starting point for requests for change) and Aspyre.

A skills matrix is under development outlining the skills/profiles of team members providing further opportunities for support and coaching.

Translation & Delivery of Operational Plans for 2024/25

The team fully supported leaders across the organisation from both care and corporate units to fully establish and embed their portfolios of change, ensuring delivery of their strategic priorities. The team were influential in the delivery of trust plans on time and to a high standard.

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TRANSFORMATION DASHBOARD – END OF MARCH 2025

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 Programme and 3 project in Execute, of which • 2 Green • 1 Amber • 1 Red 1 Project on-hold	**Projects** 1 project in Execute, of which • 1 Green • 0 Amber • 0 Red 1 Project on-hold	**Projects** 2 projects in Execute, of which • 2 Green • 0 Amber • 0 Red 2 Pipeline projects and 1 Project on-hold	**Projects** 4 Programmes and 12 projects in Execute, of which • 12 Green • 1 Amber • 3 Red 9 Pipeline projects and 6 Projects on-hold	**Projects** 2 projects in Execute, of which • 2 Green • 0 Amber • 0 Red 1 Pipeline project	**Projects** 3 Programmes and 20 projects in Execute, of which • 8 Green • 0 Amber • 8 Red 79 Pipeline projects and 11 on-hold	**Projects** 3 projects in Execute, of which • 3 Green • 0 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 – Clinical Operating Model Specialist Services	**Example of key projects & programmes** • Health Care Support Worker Academy	**Example of key projects & programmes** • Digitisation of Gold Standard SOPs • Lampard Inquiry • Embed Quality Improvement Methodologies • In-House Immediate Life Support Training	**Example of key projects & programmes** • Integrated Mental Health Primary Care Transformation Programme • Outcome Measures Programme • Specialist Community Mental Health 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 • CAFFM • Efficiency Programme
Projects & Programmes moved to BAU or Closed	**Projects & Programmes moved to BAU or Closed** • Combined Steering Group for Patient Pathways	**Projects & Programmes moved to BAU or Closed** • Embedding Gold Standard SOPs • PSIRF	**Projects & Programmes moved to BAU or Closed** • Specialist Perinatal MH Transformation	**Projects & Programmes moved to BAU or Closed** • NEE Supporting My Recovery Journey	**Projects & Programmes moved to BAU or Closed** • Mobius Browser Upgrade • Proxy Server Replacement • Oxevision Implementation	**Projects & Programmes moved to BAU or Closed** • Woodlea Clinic Refurbishment

All projects in the portfolio have a quality impact assessment completed at initiation to ensure that we have the appropriate steps in place so that any organisational change mitigates adverse impact as far as possible on the quality of care we deliver. The QIA is reviewed throughout the lifecycle of the project to ensure continuous assurance. A project reporting 'Red' highlights the need for increased support, the potential need to develop a recovery plan and the need to introduce additional assurance, it does not mean the project outcomes are compromised or that there will be an effect on the quality impact for patients.

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
Community First Programme	To develop and implement a sustainable, consistent, and responsive model of care for adult community mental health services across EPUT, ensuring effective management of increasing demand, improved patient outcomes, and enhanced staff experience	• Standardise CMHT Functions • Assertive Outreach • Optimising Resources and Competencies • Enhancing Patient Flow and Access • Transforming the Outpatient Model	• Remove inconsistent practice & patient safety incidents • Ensure effective risk management • Reduce recruitment and retention challenges • Improve demand and capacity issues	TBC
NOVA (EPR)	Implementation of a new Electronic Patient Record (EPR) system across MSE Foundation Trust and EPUT. This new, unified EPR system will be a first of type in the NHS and will replace/integrate with current systems across EPUT services in all areas and will be used jointly with MSEFT to cover Basildon, Broomfield and Southend hospitals	• Reduce administrative burden and improve the working practices of our staff • Deliver better and safer patient care and enhance their experiences • Improve the health of our patients and communities through our care functions • Improve how we work with our partners and the health and care system	• Clinicians will have access to the information they need to support quicker and personalised care • Patients will experience smoother, more joined-up care as clinicians communicate effectively across teams, services and organisations – without the need to repeat their story	Go live 2026/27 (End date TBC)
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	May 2025

KEY PROJECTS AND PROGRAMMES – CONTINUED

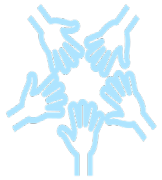
PROJECT/PROGRAMME	AIM	KEY DELIVERABLES	BENEFITS	END DATE
Lampard Inquiry	Support with clinical requests in preparation for the next stage of the inquiry	• Review Rule 9 requests • Draft responses alongside key stakeholders using specialist/historical knowledge • Peer review of responses using specialist/historical knowledge	• High quality Rule 9 inquiry request responses	March 2025
Medium Term Plan	The Mid and South Essex (MSE) medium term plan sets out an ambitious direction for the Integrated Care Board for the next 5 years to improve population outcomes and enable our population to live happier, healthier lives and receive high quality care when they need it. This plan has been developed collaboratively with the ICB and all provider partners in MSE to develop an evidence-based set of strategic opportunities that can deliver improved outcomes and enable us to live within our means	• Address Mental health services in the community • Strengthen Urgent & Emergency care provision & system flow	• Improving population outcomes • Enable our population live happier, healthier lives • Ensure our population receive high quality care when they need it • Reduce unnecessary running costs	March 2030
Corporate Services Review	To review our Corporate Services to ensure they provide a high quality, professional and appropriate service which meets the needs of the care units whilst also delivering required efficiencies	• Deliver cost savings across Corporate Services to bring back into financial balance over the next 2 years	• Enhanced quality services which support our Care Units • Improved efficiency • Reduce unnecessary running costs	March 2026
Trust Efficiency and Operational Planning Programme	Successfully deliver the 2024/25 Trust Efficiency targets across all Corporate and Clinical Care Units, with a primary focus remaining to deliver high quality and safe care to our population	• Ensure all schemes have a Project Initiation Document (PID) and 'Plan on a Page' and a QIA • Tracked delivery of schemes through the centralised Aspyre platform • Report assurance/delivery of schemes through both internal and external governance routes	• Successful delivery of our financial efficiency target	March 2025

SIX MONTH FORWARD PLAN

Resource Utilisation

Through further prioritisation, utilise team resources and capabilities in the right way to fully support the large-scale key change programmes and ensure successful delivery

Review of Trust Change Governance processes



1-3 months

Re-launch of the Transformation and Efficiency Group (TEG), Efficiencies, Planning and Corporate Services Review Delivery Group and related Steering Groups for the eight areas of transformation

Single Front Door (SFD)

Relaunch of the SFD (the starting point for requests for change) with revised entry form questions, triage processes and pathways for delivery

Operating Model

3-6 months

Continuous reviewing of the team purpose and function to ensure it meets the needs of the Trust today and in the future

Continuous Improvement (Reporting)

Continuous development of Aspyre to ensure consistent gold standard reporting which captures key data in order to provide on-going assurance on delivery

NHS
Essex Partnership University
NHS Foundation Trust

OPERATIONAL PLANNING 2025/26

EPUT

EPUT IS CONTINUING TO EVOLVE ITS ANNUAL OPERATIONAL PLANNING PROCESS

Reflections on 2025/26 planning process

- Started with mid-year stock take on in-year delivery, linking to Accountability Framework
- Corporate care units adopted same level of rigour as clinical care units this year with clear priorities for 25/26 from each enabling strategy
- Good level of regular engagement from across the leadership of the organisation providing opportunities for peer check and challenge and collaborative planning
- Early development of high level, internal guidance to inform prioritisation by corporate and clinical care units
- Focus on detailed commitments by care unit for 25/26 complimented by higher level plans for the two following years promoting a longer-term planning outlook
- More robust prioritisation of strategic programmes to inform allocation of resources
- Collaborative prioritisation of capital and revenue requirements with robust peer scrutiny
- Closer triangulation of workforce and financial planning
- Regular opportunities for executive and committee scrutiny
- Stronger link this year between operational planning and Accountability Framework for in year monitoring of delivery and course correction as needed.

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC PLAN REFRESH

EPUT

STRATEGIC PLANS SHOULD BE REGULARLY REVIEWED AND ADAPTED

During 2025/26, EPUT plans to review and update its Strategic Plan

- EPUT's current strategic plan covers five years from 2023/24 to 2027/28
- As we approach the mid-point of the five-year period, EPUT intends to review and update its Strategic Plan for the final two years
- This will be a contained process focused on delivery and will not revisit the fundamental vision, values strategic objectives or core principles of the Trust's enabling strategies
- Reviewing and updating the Strategic plan provides an important opportunity to:
    - Review high level plans in the context of changes to EPUT's external environment since the publication of the Strategic Plan in early 2023
    - Update our stakeholders on the priority work programmes that have emerged or evolved since the publication of the Strategic Plan
    - Identify any deviations from the original plan and allows for proactive adjustments to keep objectives on track
    - Assess emerging risks and opportunities, ensuring that strategic assumptions remain valid in a changing environment
    - Retain focus on high-impact areas, preventing wasted resources on initiatives that are no longer viable.
- The strategic plan review process will commence in Q1 2025, engaging a variety of internal and external stakeholders and present recommendations to the Board.

10. REGULATION AND COMPLIANCE

10.1 DUTY OF CANDOUR ANNUAL REVIEW

Information Item AS

REFERENCES

Only PDFs are attached

Duty of Candour Annual Report 04.06.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	Duty of Candour Annual Report 2024-2025					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Moriam Adekunle – Director of Safety and Patient Safety Specialist					
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	If the Trust does not effectively engage with people who have experienced a degree of harm during the use of our service and offer an apology, then the Trust will be at risk of not fulfilling the statutory requirement under the Duty of Candour.		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance	✓	
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with details of how the Duty of Candour has been implemented across the organisation, and the number of times Duty of Candour has been triggered. The annual report also details how the organisation has fulfilled its' responsibilities in complying with the Duty of Candour requirements for incidents which occurred between 1 April 2024 and 31 March 2025.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Introduction:

The Duty of Candour actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standards. A number of areas of work are in place to support staff in encouraging an open and transparent culture. This includes a training programme, family involvement in investigations and reviews under PSIRF.

The Trust is committed to delivering high quality services with honesty, openness, transparency, accountability, and integrity. All staff are actively encouraged to contribute to an open and honest culture to support Duty of Candour, improvements in patient safety and the patient and service user experience. The Trust considers 'being open' as fundamental to relationships between patients, the public, staff, and other healthcare organisations.

This report provides an annual update as to what extent the Trust has fulfilled its requirement under the Duty of Candour regulation (See table 1 for details). The ability to benchmark against other organisations, is currently dependent on individual organisations sharing their annual report as there is no central repository to access reports nationally. There is a national Duty of Candour review that commenced in November 2024 set to ascertain the effectiveness of Duty of Candour and inform national recommendations. In view of this, the Trust would aim to work with organisations providing similar services to strengthen our position for benchmarking in the next reporting period. This will give us the opportunity to incorporate any changes from the publication of the national Duty of Candour review findings.

Arrangements for Monitoring:

The timeframes for completing the Duty of Candour recording will be set on Datix and will facilitate enhanced monitoring. This will be monitored at a care unit level through the weekly incident review meeting (CIRG) and reported into the monthly care unit Quality of Care Group meetings. Strategic oversight and check and challenge will be provided via the Care Unit Accountability Framework meeting, and up to the Board of Directors. The Patient Safety Incident Management team will introduce a bi-monthly audit and findings will be reported to the Quality of Care Group meeting.

Duty of Candour and Alignment with Complaints Process:

The recording system (Datix) currently does not link Duty of Candour reporting to the complaints module, which means a manual effort is required to track or quantify such issues. A review of complaint data highlights some scenarios where families have referenced not being informed when something has gone wrong, for example, next of kin not being advised when a patient has fallen. It is positive to note that this is not a common or recurring theme across the complaints received in the reporting period.

To strengthen the Trust approach going forward, the following actions will be taken:

- Team discussion and awareness: we will engage the Complaints team in a discussion about the Duty of Candour Policy, specifically how it should be applied by clinical services, and how complaint handlers can check Datix incident records to establish whether the Duty of Candour process was followed where applicable, as part of their complaint investigation
- Improved tracking: we will introduce a process for flagging and tracking any complaints where a failure to follow the Duty of Candour Policy is identified or alleged. This will support future reporting and help ensure any emerging themes are recognised and addressed in a timely way.

This approach will provide better oversight and assurance around compliance with Duty of Candour requirements as part of our wider approach to learning from complaints.

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**	

Acronyms/Terms Used in the Report			
PSIRF	Patient Safety Incident Response Framework	PSIM	Patient Safety Incident Management
FLO	Family Liaison Officer	CQC	Care Quality Commission
PSP	Patient Safety Partners	PSIRP	Patient Safety Incident Response Plan
PSI	Patient Safety Incident		

Supporting Reports and/or Appendices
Duty of Candour Annual Report

Lead:

Ann Sheridan

Ann Sheridan,
Executive Nurse

DUTY OF CANDOUR
ANNUAL REPORT
01 APRIL 2024 TO 31 MARCH 2025

1.0 Introduction

All Health and Social Care Services in England have a legal requirement under the Duty of Candour, which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. An important part of this duty is that we provide an annual report detailing how Duty of Candour was implemented in our services. This report describes how Essex Partnership University NHS Foundation Trust (EPUT) has operated the Duty of Candour during the period between 01 April 2024 and 31 March 2025.

EPUT serves a population of around 3.2 million and services are delivered by more than 5,500 staff. The Trust provides a full range of clinical services covering the county of Essex and parts of Suffolk, Luton and Bedfordshire. The Trust operates over four acute hospital sites; Basildon Hospital, Broomfield Hospital, Colchester Hospital and Southend hospital, as well as over 200 community based healthcare settings including GP practices.

The Trust is committed to delivering high quality services with honesty, openness, transparency, accountability, and integrity. All staff are actively encouraged to contribute to an open and honest culture to support Duty of Candour, improvements in patient safety and the patient and service user experience. The Trust considers 'being open' as fundamental to relationships between patients, the public, staff, and other healthcare organisations.

2.0 Duty of Candour Performance

Duty of Candour applies to all registered providers of both NHS and independent healthcare bodies, as well as providers of social care from 01 April 2015. The duty is overseen by the Care Quality Commission (CQC) as set out in CQC Regulation 20: Duty of Candour. Compliance with the duty is also monitored by ICBs as part of the standard national contract. It specifically relates to incidents where degree of harm is moderate and above.

There are two parts to Duty of Candour; Professional (Part 1) and Statutory (Part 2). The Professional Duty of Candour requires all staff to be open and honest with patients and their families/carers when something goes wrong with their treatment and/or care causes, or has the potential to cause, harm or distress. To enable monitoring, details of when Professional Duty of Candour has been completed is noted in the incident record on Datix.

The Statutory Duty of Candour applies to all notifiable safety incidents. Where notifiable safety incidents meet the following criteria:

- It must have been unintended or unexpected
- It must have occurred during the provision of a CQC regulated activity
- In the reasonable opinion of a healthcare professional, already has, or might result in death, or severe or moderate harm to the person receiving care

Once a review of a notifiable safety incident has been completed as per Patient Safety Incident Response Framework (PSIRF) Policy, a formal letter is sent to the patient or family (as appropriate) to share the findings of the review. The completion of statutory responsibility is recorded on the incident record on Datix.

Table 1: Patient Safety Events 1 April 2024 to 31 March 2025

Indicators	April 2024 - March 2025
Total Number of patient incidents occurring in the year	22,078
Number of patient incidents with degree of harm of moderate and above	2,832
Percentage of patient incidents noted to have Professional Duty of Candour completed (Part 1) moderate harm and above including notifiable incidents	49%
Statutory Duty of Candour (Part 2) completed for reviews under PSIRP:	60%
Statutory Duty of Candour (Part 2) Learning Response Review (Investigation) in progress	40%

The above table provides the number of Patient Safety Events for the reporting period. This includes those incidents that are aligned to the national response and local focus, i.e. Patient Safety Incidents (PSIs), as defined in the Trust Patient Safety Incident Response Plan (PSIRP). The table also provides the percentage of PSIs with Professional and Statutory requirements fulfilled and number of PSIs that are still undergoing a review.

Of the incidents categorised under moderate harm and above, 49% were reported as fulfilling the Professional Duty of Candour. This is a modest improvement from compliance of 46.7% reported in 2023 / 2024. A review into the compliance figures and discussion with operational teams, demonstrated that the requirements were fulfilled in a number of cases and not captured on Datix. As a result, we have embarked on significant improvement intervention working in collaboration with the Deputy Directors of Quality and Safety and Operational Leads, and anticipate increased reporting going forward. The improvements are discussed in Section 6 of this report.

It is also important to note that there are some circumstances where it is difficult to contact family and carers. This is usually as a result of varying reasons such as patient or family not being ready to engage fully, some families having a preference not to engage in the process until after an inquest has taken place (where this is applicable), or lack of a known Next of Kin or significant other. For the latter instance, the Operational team will usually work with Advocacy or Independent Mental Health Advocate Services. In addition to this, there has been lack of assurance on reporting of Duty of Candour where this requirement has been fulfilled.

In last year's report there were a number of areas noted as in progress of being strengthened and key focuses for the organisation. Listed below are those which have been achieved:

1. **Improvements to Datix Incident Reporting Form**
   Degree of harm captured at the time of reporting along with the requirements to complete the information to record that Duty of Candour process has been met or needs to be completed.

2. **Duty of Candour Policy**
   The Duty of Candour Policy have been revised to capture the changes to documentation and to strengthen data capture. The key changes include:
   a. Requirements to record information on Datix incident record and patient records specifically
   b. Record of staff who fulfilled the responsibilities
   c. Date of fulfilling the requirement
   d. Reasons for not fulfilling the requirement where this is applicable

3. **Duty of Candour awareness and implementation**
   Duty of Candour online training currently being revised and approved to align with improved reporting framework

4. **Improving engagement with Patient Safety Incidents**
   Patient Safety Incident Review leaflet developed and now in use. The leaflet outlines the PSIRF review process and how the role of the Family Liaison Officer (FLO) supports patients and families.

3.0 To what extent did EPUT follow Duty of Candour procedures

EPUT has a process for the identification and management of adverse events with the Duty of Candour integrated into the processes.

When applying Duty of Candour, all necessary action is in accordance with the Duty of Candour Procedure. The key stages of the procedure include the following requirements:

- Notify the person affected (or family/relative where appropriate)
- Provide a verbal apology with follow-up in writing
- Carry out a review into the circumstances leading to the patient safety incident
- Offer and arrange a meeting with the person affected and/or their family, where appropriate
- Provide the person affected with detail of the review findings
- Provide information about improvement actions; and
- Make available, or provide information about support to persons affected by the adverse event.

The Patient Safety Incident Management (PSIM) team work closely with the Deputy Directors of Quality and Safety and Care Unit Operational Leadership team to oversee and monitor adherence to the Duty of Candour requirements and engagement with patients and families. The data is starting to demonstrate improvements over the last year in reporting and in closer working with families when an incident occurs.

4.0 Engagement and support – New survey update and development of the Family Liaison Officers (FLOs)

Compassionate engagement and involvement of those affected by PSIs is one of the key aims of the PSIRF. In view of this, the Trust continues to develop and strengthen its processes on engagement, working closely with the Patient Safety Partners (PSPs) who champion and amplify the voice of the patients and service users.

To understand and evaluate the FLO engagement throughout a patient safety incident review, the PSIM team has implemented an engagement feedback survey. There was an initial testing period with the survey to review the process, as well as work through the responses to the questions. The measurable feedback is slow at present, due to the nature of the process being used.

40% of responses were received from the feedback survey sent in Q4 2024/2025. There was positive feedback in information received, frequency of contact agreed, and final approved report shared. In some responses, families felt supported by their allocated FLO and felt they had the opportunity to be involved in the review process. Learning from the family feedback has highlighted some families are not being offered the opportunity to meet with the care unit to review the final report and communication gaps when updating families on progress. The key priorities address these learning areas through improved communication to keep patients / families central to the reviews, along with updates to Datix to support improved monitoring and assurance. The next stage is to continue to monitor feedback. Surveys are sent out as part of sharing the approved report, which is generally the final stage of engagement for a FLO.

The PSIM team is responsible for providing training and support for all FLOs in the Trust. One supportive mechanism in place is the FLO forum, held fortnightly and led by the FLO Lead. The forum provides a space for all active and inactive FLOs to share experiences, coach, and network with others. It is a non-mandatory session but essential to the role, with a high number of attendees recorded over the last year.

A quarterly newsletter has been developed and serves to provide updates to all FLOs in the Trust. This consists of any changes to local process / changes, and also nationally driven information that may be relevant. This has received positive feedback and continues to be rolled out consistently.

Continued ongoing development of FLOs has a notable impact, as the survey is demonstrating, and there has been positive feedback from staff who have acted as a FLO. The Deputy Head of PSIM and FLO Lead have presented at the ICB Lunch and Learn event, with positive feedback on progress to date and experiences shared. There have been requests to attend a further session.

5.0 Information about our process

The process involves a review of each PSI to understand what happened, and learning takes place to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. The commissioning of reviews and investigations comply with the PSIRF. All reviews and investigations have an allocated FLO, who will provide regular contact with the patient / family / carer to provide updates on progress of the review / investigation. All FLOs have received appropriate training and have the skills to respectfully disclose sensitive information and answer questions / concerns the patient / family / carer may have.

There is a register of FLOs in the Trust and they regularly undertake training and attend FLO forums for support. 13 forums have been delivered to date with 62 attendees across those forums. The Trust delivered training to 30 FLOs in the last financial year.

Duty of Candour training is part of Trust Induction and sits in the mandatory training tracker. This is currently under review due to content and to ensure this reflects local and national changes to frameworks.

The Trust recognises PSIs can be distressing for staff also and support is provided for all staff through line management structures, Occupational Health and the Trust's employee support, Here for You.

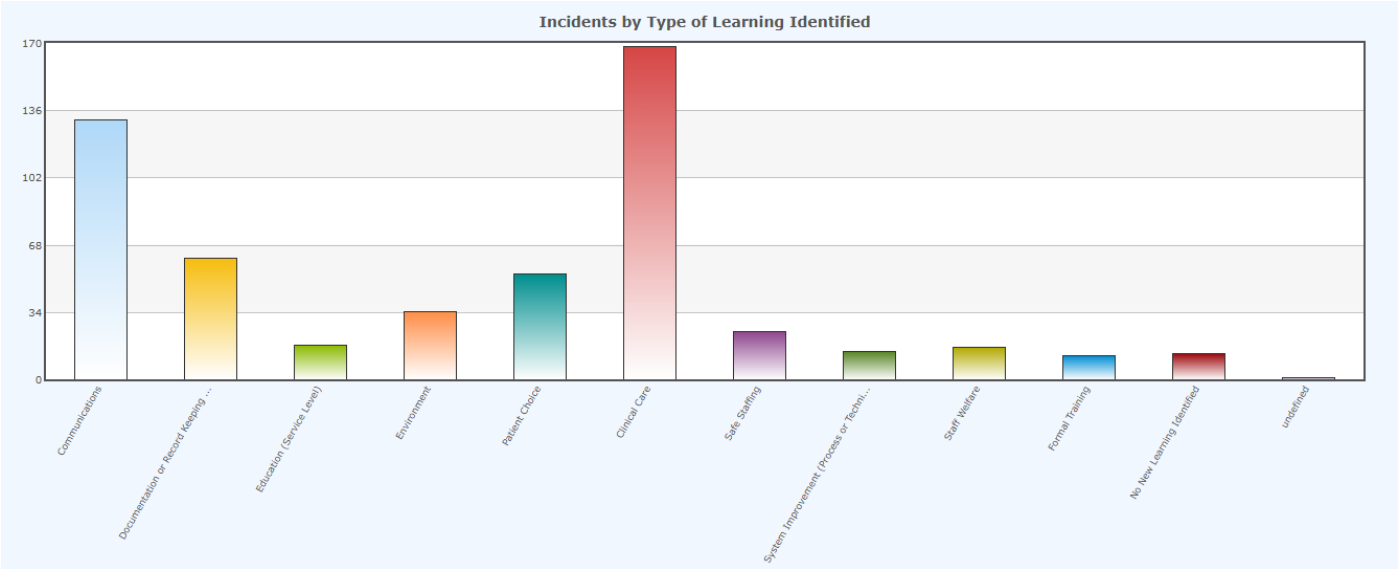
The Duty of Candour process is part of the following policies:

- CP3 Adverse Incident Policy CP3
- CP36 Being Open and Duty of Candour Policy
- Patient Safety Incident Response Framework Policy (in approval stage)
- Patient Safety Incident Response Plan

6.0 What have we learnt

Further to the review of the events that triggered the Duty of Candour, various learning points were identified as follows:

1. Supporting family members and carers to access specialist psychological support for bereavement and trauma.
2. Importance of using NHS numbers when identifying patient information including Next of Kin.
3. Importance to anonymising data and reports when sharing externally to ensure confidentiality is maintained.
4. Setting up of a FLO forum to better support staff, especially on trauma.
5. Development of training for patients with neurological disorders on impact on their mental health.
6. Ensure consistent communication approach with care units that involves speaking with colleagues in addition to using emails.
7. Timely multi-disciplinary approach to reviewing patients in Health Based Place of Safety who require further assessment and treatment.
8. Commissioning of case note reviews and monitoring via the Learning from Deaths Group, and presentation of learning to the Mortality Review Sub-Committee.
9. Contact sheet for communication with family members and significant others now maintained and stored on Datix.
10. Of 403 incidents reported as moderate harm and above (but not specifically PSIs under PSIRP), where Duty of Candour applies, the learning identified is shown in the chart below.



Learning currently being implemented includes:

1. Policy at a glance document developed to support easy access.
2. Development of a survey tool for families and carers to obtain feedback from the engagement process, working collaborative with our PSPs. This has been shared with 10 families to date and ongoing discussions to increase uptake.
3. Established FLO forums, which allow FLOs access to informal support.
4. The FLO Lead in the PSIM team continue to provide one to one support to the FLOs and debrief following conclusion of a case.
5. Each care unit now has a dedicated Patient Safety Lead that acts as a bridge between the PSIM team and the care unit, ensuring that investigations and contact with family is undertaken in a timely manner.

Key Priorities for 2025 / 2026:

The key priorities are as follows:

1. Approval of the revised Duty of Candour Policy.
2. Timeframes for completing the Duty of Candour recording will be set on Datix and will facilitate enhanced monitoring. This will be monitored at a care unit level via the dashboard in Datix and reported into the monthly care unit Quality and Safety meetings, and up to the Board of Directors.
3. Use of data to monitor Trust responses and instigate further quality improvement as required, linking in with the PSPs and Patient Experience team.
4. Improving communication that will keep the patients / families central to the reviews and investigations, working closely with system partners.
5. Deliver Family Engagement Awareness sessions to the wider workface and encourage increased number of people registering as a FLO in the Trust.
6. Duty of Candour Learning Event to be planned for Trust-wide information sharing in addition to policy and mandatory training.

7.0 Conclusion

This is the Trust's fourth year of presenting its Duty of Candour. The organisation continues to learn and refine processes to ensure adherence to the Duty of Candour process. The embedding of the PSIRF process with the right infrastructure and systems at a care unit level with reporting and oversight from ward to Board, will ensure greater compliance with the Duty of Candour, especially the changes to the Datix

System. The PSIM team and other key corporate teams have been working closely with the Care Unit Leadership teams to progress action points in a timely manner.

This report will be shared via the Quality of Care Group and Quality Committee prior to being published on our public website as per the Duty of Candour legislation.

The Board of Directors is asked to:

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

Report prepared by:

Moriam Adekunle
Director of Safety and Patient Safety Specialist

On behalf of

Ann Sheridan
Executive Nurse

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11. OTHER

11.1 USE OF CORPORATE SEAL

Decision Item PS

REFERENCES

Only PDFs are attached

2025 06 04 Use of Corporate Seal.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	04 June 2025

Report Title:	**Use of Corporate Seal**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, EA 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 – *mandatory section*			
Summary of risks highlighted in this report	N/A		
Which of the Strategic risk(s) does this report relates to:	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		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		
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 a summary of when the corporate seal has been used.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
The EPUT Corporate Seal has been used on the following occasions: - 01.04.25 Street Works Licence in respect of the installation of a foul sewer, surface water sewer and chamber adjacent to Thurrock Community Hospital, Long Lane, Grays, Essex, RM16 2PX – Ref: TC-30636 - Deed of Variation relating to S.106 agreement dated 21 March 2006 relating to land known as north east of Colchester former Severalls Hospital and Cuckoo Farm

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**	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

Lead
 Paul Scott Chief Executive Officer

11.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item | HLD | 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

Wednesday 6 August 2025 at 10:00, The Lodge Training room 1