Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

3 December 2025

10:00 GMT Europe/London

Anglia Ruskin University, Lord Ashcroft Building, MAB 101, Chelmsford, Essex, CM1 1SH

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda Dec 2025 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 3 December 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
Anglia Ruskin University, Lord Ashcroft Building,
MAB 101, Chelmsford, Essex CM1 1SH

AGENDA

1	**APOLOGIES FOR ABSENCE**	HLD	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	HLD	Verbal	Noting
PRESENTATION Update on 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:** 1 October 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	Chairs	Attached	Noting
7.3	CQC Assurance Report	DG	Attached	Noting
7.4	Freedom to Speak Up Service	DG	Attached	Noting
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Q1 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data Report	AS	Attached	Approval
Questions taken from the General Public				

9	**STRATEGIC INITIATIVES**			
9.1	Strategic Impact Report M6 25/26	ZT	Attached	Approval
10	**REGULATION AND COMPLIANCE**			
10.1	Annual Review of Governance Documents	DG	Attached	Approval
10.2	Quarterly Report on Safe Working of Resident Doctors	MK	Attached	Noting
10.3	Provider Capability Assessment 2025/26	PS	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. • Letter from the Secretary of State	HLD	Attached	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
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 4 February 2026 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 1 April 2026 at 10:00, The Lodge Training room 1 Wednesday 3 June 2026 at 10.00, The Lodge Training room 1 Wednesday 5 August 2026 at 10:00, The Lodge Training room 1 Wednesday 7 October 2026 at 10:00, The Lodge Training room 1 Wednesday 2 December 2026 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item HLD

2. DECLARATIONS OF INTEREST

Standing item HLD

PRESENTATION: UPDATE ON QUALITY IMPROVEMENT PROJECT ? LIGATURE REDUCTION ? LONGVIEW WARD SCOTT HUCKLE, SERVICE DEVELOPMENT AND ASSURANCE LEAD, SPECIALIST CARE UNIT

Information Item

SH

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 1 OCTOBER 2025

Decision Item HLD

REFERENCES

Only PDFs are attached

Board of Director Part 1 Minutes 01.10.2025 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 01 October 2025
Held in person at Trust HQ, The Lodge

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Simon Covill	SC	Director of Finance (Deputising for Trevor Smith)
Doug Field	DF	Associate Non-Executive Director
Denver Greenhalgh	DG	Executive Director of Corporate Governance
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director
Dr Milind Karale	MK	Executive Medical Director
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
Richard Spencer	RS	Non-Executive Director
Sarah Teather	ST	Non-Executive Director
Zephan Trent	ZT	Executive Director of Digital, Transformation and Strategy

IN ATTENDANCE:

Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Nicole Rich	NR	Director of West Essex Community Delivery and Partnerships
Clare Sumner	CS	Trust Secretary Administrator

There were five member 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 10am.

100/25 APOLOGIES FOR ABSENCE
Diane Leacock, Non-Executive Director
Paul Scott, Chief Executive Officer
Trevor Smith, Executive Chief Finance Officer / Deputy CEO

101/25 DECLARATIONS OF INTEREST
There were no declarations of interest.

102/25 PRESENTATION: WEST ESSEX EPUT COMMUNITY DELIVERY FOR NEIGHBOURHOOD HEALTH
NR delivered a presentation regarding neighbourhood health in West Essex, highlighting the good relationships with partners, including GPs, which provided an innovative exemplar for delivering neighbourhood health. NR highlighted the following:

- The services in West Essex had been on a journey since 2015 in integrating services and delivering wrap-around care for communities.
- The area had been confirmed as wave 1 early integrator for the National Health Implementation programme to accelerate the neighbourhood priorities as part of the governments 10-year plan. This would act as an enabler to develop system relationships and provide the “closer to home” model of care.
- There was the principle of “no wrong door” to help existing integrated neighbourhood teams, linked with six primary care networks and underpinned by good population health data provided by the ICB.
- The key achievements for the existing integrated approach included a 4% reduction for non-elected admissions for over 65s in the current year, compared to the previous year.

Questions and Answers

- ZT commented the presentation was a good example of delivering on all four strategic objectives. It was a good case study of how strategic direction was put into practice.
- ST asked about the responsiveness of partner organisations, including acute trusts and whether integration with the 111 service would be useful. NR advised there were good relationships with partner organisations, including Princess Alexandra Hospital which was the local acute trust. There were good relationships with other trusts and the integrated model had been shared. There was some variation but this was improving. There needed to be more focus with partners in Mid and South Essex, as this can impact on services where individuals cross boundaries. In relation to the 111 service, there was already integration in terms of an individual being flagged and diverted to the care coordination service which deploys a response.
- AG commented on the passion of NR, which had been a key driver in the success of the neighbourhood working. AG asked about the key areas for success for sharing with the wider Trust. NR advised having a model and strategic direction which partners sign up to and delivering against that model of care. There was also a need to have a trusting relationship with partner organisations, to work together to deliver joined-up care and resolve any barriers.
- MJ commented on the relationship between care homes and carers and asked what could be done to help facilitate the change to neighbourhood working. NR advised private providers had different regulations / guidance and a higher turnover of staff which could make relationships challenging. NR advised she would like there to be a summit for care homes to come together to agree the care model and this should be proactively pursued.
- AS commented she had completed a visit to services in West Essex and had received feedback from patients and carers in the confidence they had in the service. AS asked what further support the Board could provide to help continue developing services. NR advised the Board had been very supportive and noted the acceleration of digital would help, such as services having access to real time data to understand hospital discharge and capacity.
- RJ asked what changes can be made for undergraduates to ensure future staff are prepared for the new model of care and have the required skills to deliver the services. NR advised it was important to demonstrate it is possible to care for individuals in their own home and act in a more proactive, less reactive way. NR added that it is important to have a culture change across all services as, for example, there can be challenging conversations where individuals in hospital are identified as being able to be cared for at home.

- LL commented on the challenges of implementing digital innovations, given the breadth and scope of the requirements. LL noted the wave 1 pilot may provide an opportunity to bid for resources to provide digital solutions such as a data system to provide live data.

HLD thanked NR for the presentation and summarised the discussion, highlighting three challenges for the Board to consider:

- The undertaking of a community care summit, to incorporate care homes and private providers.
- The potential to hold a Board Seminar session around community services and how these could be developed.
- The acceleration of digital innovation and the resources required.

NR left the meeting at this point.
RS joined the meeting at this point.

103/25 MINUTES OF THE PREVIOUS MEETING HELD ON 6 AUGUST 2025

The Board of Directors reviewed the minutes of the meeting held on 6 August 2025.

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

104/25 ACTION LOG AND MATTERS ARISING

The action log was reviewed, noting that two actions had been closed, two open actions were not yet due and one open action required an update. The open action related to AG / LL discussing the development of a simulation for flow and capacity. AG advised the discussion had not yet taken place, but would be taken forward in due course.

105/25 CHAIRS 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. HLD highlighted the following:

- Congratulations to Stuart Scrivener in his appointment as Lead Governor and a welcome to DF as a new Associate Non-Executive Director.
- HLD had recently attended a Research and Innovation Conference which was positive and thanked MK for his leadership in this area.
- Work had been undertaken for the Board development process and work was underway to take forward the provider capability assessment.

The Board of Directors:

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

106/25 CEO REPORT

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

- NHS England had published the oversight framework (NOF) for 2025-26, which outlined the new approach to assessing NHS trusts using revised performance metrics. This linked to the provider capability self-assessment and the recently published NHS league tables. EPUT is rated in NOF segment 3, placed in position 36 of 62 non-acute trusts. There were plans in place to improve performance, and the Trust welcomed the increased oversight and transparency.
- Operational planning activity had commenced to ensure the Trust is prepared for the planning guidance to be issued later in the year.

- There was a maternity services review and it was important for the Trust to consider any learning from this process.
- The national neighbourhood programme had selected West Essex and North East Essex for the wave 1 programme. This was a fundamental change to how care for long term conditions is provided.
- The Patient Experience team had worked with community services and Mid & South Essex ICB regarding a new approach for reduced admission of young black and Asian men to hospital.
- There had been an increase in the responses to the quarterly pulse survey which was positive and provided a platform for launching the national staff survey.
- The outcome of the independent review into the procurement process for talking therapies services had been published, advising there were material breaches in the procurement process. The ICB were due to respond to the findings and recommendations.

Questions and Answers

- LL commented on length of stay data and that this had increased year-on-year for the previous five-years. LL understood the reasons for the increase and noted the neighbourhood model of care may help improvement in this area, subject to increased work on discharge. LL asked what additional areas could the Executive Team consider to reduce the key metric. AS advised there had previously been a focus on inpatient services, but unless issues and gaps are addressed within community services this would continue to be a challenge. AS highlighted key programmes such as Community First and the Assertive Outreach project which should address some of these areas.
- AM thanked colleagues for their involvement in the launch of the staff survey and advised the Trust was currently at a 14% response rate, which was higher than previous years at this stage.
- RS commented on the league table position and asked for the Executive Team perspective as to whether the position had been anticipated. AG advised the position was anticipated and it was now important to improve to ensure better patient care, rather than chasing a target. The position demonstrated the positive work that had been undertaken, but provided an opportunity to take the transformation agenda forward. DG advised the some of the rating depended on the system rating and there were some areas outside of the Trust's control. There were also finance elements of the rating and it was important to review and take forward the agenda for the underlying deficit at a rapid pace.

The Board of Directors:

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

107/25 QUALITY AND PERFORMANCE SCORECARD

AG presented the report and invited Executive colleagues to provide updates for their remits.

Operations (AG)

- Mental Health inpatient capacity remained a challenging area which was demonstrated through occupancy rates for Adult and PICU. The occupancy rates for Older Adult and Specialist Services had decreased.
- There had been improvement in Adult length of stay, but there were challenges with sustaining the improvement. There had been a number of individuals with long lengths of stay discharged, which has led to a decrease in open lengths of stay for adults. The Trust had engaged the expertise of a flow consultant to review

data and processes. The work would conclude in the next week and the findings would be brought to the Executive Team and recommendations to the Board of Directors.
- There were new metrics for Talking Therapy services focused on recovery, which were currently showing as positive.

Questions & Discussions
- EL noted the number of areas of improvement identified in the report and asked how the Trust would ensure it celebrated achievements, without losing sight of the amount of further improvement required, especially around community services. ST queried whether there was understanding of when the ceiling for improvement using the current programmes would be reached and when something different may be needed. AG agreed and noted the link between the Time To Care programme and the Community First programme, with the importance of ensuring there are no gaps between. The Time To Care programme focussed on beginning discharge planning earlier which had seen improvement, but there was a need to ensure readmission rates did not increase as a result. There were lots of areas where different innovations were being taken forward to avoid reaching a ceiling, such as changes to Eating Disorder services to be more consultant-led, which had shown positive results.

Nursing (AS)
- The Cardio Metabolic Rate, which was an important indicator for those with long term conditions, had shown good compliance for Early Intervention in Psychosis services.
- Low harm / no harm incidents reported for August remained below the compliance target, but was an increased position from July. There continued to be a weekly oversight meeting to review incidents for any immediate learning.

Questions and Discussions
- RJ noted the low harm / no harm incidents, highlighting that underlying data suggested that some areas were underreporting. RJ asked whether there was now better consistency or if there were outliers in terms of reporting rates. AS advised the weekly oversight meeting provided an opportunity to focus on areas that are underreporting. This had enabled reasons for underreporting to be identified and work undertaken to resolve, such as working with staff to consider what constitutes a patient safety incident and giving staff the confidence to speak up.

People and Culture (AM)
- There had been an increase in newly qualified staff appointed, with the aspiration to reduce the vacancy rate for Band 5 nurses.
- The use of temporary staffing continued to decrease and staff turnover had continued its downward trend.
- There was now a focus on mandatory training and staff appraisals, with compliance rates being reviewed by the end of November for all staff groups.

Questions and Discussions
- MJ asked if there were sufficient staff in place with the right skills compared to previous years and if there was a positive trend going forward. AM advised the position was positive in relation to consultant vacancies. The focus was now on nursing and there was a drill down under way to understand the current establishment and skill sets in preparation for the winter period.

Finance (SC)

- The Trust was slightly behind plan for the overall financial position, which related to costs associated with the Lampard Inquiry.
- The capital position had been discussed at the Finance & Performance Committee with action in place to accelerate and increase the capital spend.
- Cash forecasts were being closely monitored going forward, noting that the position would be impacted by the system financial performance and deficit support funding.

Questions and Discussions

- EL noted the position regarding capital spend and the action being taken, asking if it could be confirmed that there was no negative impact on patient experience whilst the actions were being taken forward. SC advised there was no impact in terms of patient safety with the actions to accelerate expenditures.

The Board of Directors:

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

107/25 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

HLD advised there had been a number of pre-submitted questions submitted by a member of the public who was not present at the meeting. The questions were technical queries relating to the Quality and Performance Scorecard. AG advised she would respond to the queries in writing and these would be recorded at the end of the minutes.

108/25 COMMITTEE CHAIRS' REPORT

HLD introduced a report providing a summary of key assurance and issues identified by Board Standing Committees.

Finance and Performance Committee (RS – on behalf of DL)

- The Committee had drilled down on a number of areas, with a focus on inpatient care. The resulting reflections had noted the importance of developing community services measures and how these are connected with patient flow in inpatient areas.
- There was good discussion around estates and facilities and proactive work undertaken to de-risk catering services and provide more operational support for building maintenance.
- There was an alert to the Board of Directors regarding the cash balance and deficit support funding associated with the system deficit, which had been picked-up as part of the Quality and Performance Scorecard.
- The Deputy Director of Finance from NHS England East of England region had attended the last Committee meeting and provided positive feedback.

People Committee (RJ)

- The Committee had continued to receive improved data, which helped to understand the overall position and understand drivers for any positive or negative performance.
- There had been helpful clinical engagement at the Committee, in terms of driving forward improvements and ensuring these are sustainable.

Quality Committee (MJ)

- There had been a focus on how to measure data in terms of quality and how to benchmark to assess the standards of care. There had been work around the development of a data dashboard, audits, compliance and assurance to ensure the Committee is fulfilling its work plan and terms of reference.

- There had been a focus on mandatory training to ensure it is fit for purpose to deliver safe care for patients. There were concerns raised regarding the accuracy of data related to mandatory training and this would be relayed to the People Committee for discussion.
- There had been a focus on the use of Oxevision to ensure the technology is being used in the correct way and any learning from the Lampard Inquiry is considered.

The Board of Directors:

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

109/25 CQC Assurance Report

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

- The Trust remained fully registered with the CQC and there had been no further inspections since the unannounced visit to Byron Court in July 2025.
- There had been 14 enquiries received from the CQC since the last report, with the majority relating to inpatient services. The key themes identified were around access to leave, communication and restrictive practice.
- The improvement plan had been consolidated to remove actions from previous plans and incorporate actions from recent inspections. The Evidence Assurance Group had also been incorporated into an existing learning group.
- Additional assurance activities had continued, including annual assurance visits and Quality Assurance Visits with partners and Governors.

Questions and Discussion:

- RS noted the reference to changing the governance around the CQC Improvement Plan, asking for further details of the change and how this was beneficial. AS advised there were a number of meetings reviewing similar areas and it was beneficial to bring these into a single plan to avoid duplication. The new plan now incorporated other areas such as Prevention of Future Deaths findings. The Evidence Assurance Group had originally been established due to the large number of actions. As these had reduced and the plan became more focused, the group had been incorporated into an existing forum to avoid duplication. AS advised there would still be evidence of assurance work undertaken in which partners would be involved.

The Board of Directors:

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

110/25 WORKFORCE RACE EQUALITY STANDARD (WRES)

AM presented the report which provided an update on the findings of the EPUT WRES 2025 data, measuring performance. It provided a detailed breakdown and comparison of EPUT's indicators to the previous year, with a breakdown of key data. AM highlighted the following:

- The data had been presented to EPUT stakeholders and an action plan developed that would help deliver the goal of improving the experience of black, Asian and minority ethnic staff working at EPUT.
- The data covered the period 1 April 2024 to 31 March 2025. There were nine performance indicators, of which seven were within reasonable boundaries.
- The areas for improvement related to staff entering a formal disciplinary process and behaviour in terms of bullying or harassment from patients, carers or staff.

Questions & Discussions

- RS noted the data relating to the number of BME staff entering a formal disciplinary being above the national average and asked if the actions were sufficient to address this area. RS queried the number of actions and the potential to lose focus. RS suggested considering focusing on some key strategic issues which may have a greater impact overall. Following discussion, it was agreed that the plan would be reviewed and taken through the People Committee for further discussion.
- LL commented on the metrics included in the appendix, noting these were useful. LL suggested including a trajectory against the metrics in the key summary for future reports.

HLD summarised the discussions, including the agreement from the Board of Directors that the experience of BME staff highlighted by the results was not an acceptable position and further work was required in this area.

The Board of Directors:

1. **Noted the data in Section 4 and Appendix A.**
2. **Noted the proposed actions in Appendix B for delivery in 2025/2026.**
3. **Approved the publication of the WRES.**

Actions:

1. **Develop a trajectory against the metrics included in the WRES/WDES reports for future iterations of the report (AM)**
2. **Review the actions identified for the WRES/WDES to develop key strategic actions to address the concerns identified, to be monitored through the People Committee. (AM / RJ)**

111/25 WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

AM presented the report which provided an update on the findings of the EPUT WDES 2025 data measuring performance. It provided a detailed breakdown of comparison of EPUT's metrics to the following year with a breakdown of key data. AM highlighted the following:

- The data had been presented to EPUT stakeholders and an action plan developed that would help deliver the goal of improving the experience of staff with disabilities (as well as long term conditions and neurodiversity) working at EPUT.
- The WDES measured 10 indicators, of which three had demonstrated improvement.
- There had been an increase in the number of staff declaring a disability, which was a higher proportion than other similar organisations.
- The areas for improvement related to opportunities for career progression and staff feeling pressured to come to work.

<u>Questions & Discussions</u>

- The discussions held as part of 110/25 incorporated the results of the WDES. The summary provided by HLD and the actions identified related equally to the WRES and WDES reports.

The Board of Directors:

1. **Noted the data in Section 4 as well as Appendix A.**
2. **Noted the proposed actions in Appendix B for delivery in 2025-2026.**
3. **Approved the publication of the WDES.**

112/25 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:

- CRR45 Mandatory Training had been refocused as the original risk had been developed following Covid-19. The refocus had been around consistent delivery and the achievement of sustained compliance. There was work under way with the national framework to realign statutory mandatory training.
- The NOF rated impacted SR4 Demand / Capacity and SR8 Use of Resources.
- An assurance framework style was being developed for all quality statements which, once consistently in place, will impact the escalation and de-escalation of risks.

Questions and Discussion

- EL highlighted that current mandatory training requirements go above the requirements, but noted the importance of considering specialist training. For example, the National Maternity Review publishing additional training needs which may impact the mother and baby service provided.

The Board of Directors:

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

Action:

1. **Review CRR45 Mandatory Training to incorporate specialist training requirements. (AM / DG)**

113/25 MENTAL HEALTH ACT ANNUAL REPORT

AS presented the report which provided the Board of Directors with assurance that the Trust has delivered a robust, proactive and effective Safeguarding and Mental Health Act service, as well as providing an overview of activity throughout 2024/25 and developments and challenges anticipated in 2025/26. AS highlighted the following:

- The MHA and Safeguarding Committee played a crucial role in overseeing the use of MHA legislation and the membership included people with lived experience, senior leadership and directors.
- The had been 17 CQC MHA visits during the period, which had provided positive feedback and identified some areas for improvement around care plans and the role of advocates.

Questions & Discussions

- ST commented that it would be useful to have comparators against the data to provide greater context and whether there was more granular data available for some of the broader data groups, such as for ethnicity. AS provided a brief overview of the data, advising that locally, detention rates for individuals aged over 34 are slightly higher than the national average. Nationally, the highest known detention rates are among the 18 to 34 age group (135.9 per 100,000 population), which is approximately 62% higher than the rate for those aged 65 and over (83.8 per 100,000). AS confirmed this would be taken back to the sub-committee for more work around the data.
- ST asked whether it was possible to track the use of MHA around different parts of the Trust. AS confirmed this was possible, although it had not been included in the report. There was evidence that if the community offer in an area is right, or if the individual can access primary care earlier, the use of the MHA is reduced.
- HLD proposed having a presentation at a future Board Seminar session to provide a wider experience and perspective for the use of the MHA in the Trust.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Approved the report for publication.**

Action:

1. **Future Board Seminar session to include a presentation on the enactment and use of the Mental Health Act across the Trust. (AS)**

114/25 INFECTION AND CONTROL ANNUAL REPORT

AS presented a report which provided the Board of Directors with assurance that the Trust had delivered a robust, proactive and effective Infection Prevention and Control (IPC) service, and could demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance. AS highlighted the following:

- The report provided assurance on the proactive and effective implementation of infection control across the Trust. The report was aligned with the national Infection Prevention and Control (IPC) standards, with compliance at 83% and actions in place to address improvement areas.
- There had been an 18% improvement than in previous years, which was linked with changes to governance through the nursing directorate and aligned at care unit level.

The Board of Directors:

1. **Noted the content of the report.**
2. **Approved the report for publication.**

115/25 PARTICIPATIVE CULTURE INQUIRY AND SENIOR LEADERSHIP DEVELOPMENT PROGRAMME

AM presented a report which set out the context, approach and delivery of the participative cultural inquiry and senior leadership development programme. The report also highlighted some areas that address some of the recommendations made by the independent well led development review in 2024.

AM advised the Trust had commissioned BRAP (organisation) and the King's Fund to work in partnership with the Trust for the review.

<u>Questions & Discussions</u>

- RS supported the programme and queried whether the 20 per cent target for BME staff in the pilot of leadership development was achievable. AM advised there were plans to have a junior management programme and the target was proportionate with staff from a BME background in a leadership position.
- RJ noted the three pilot sites for the programme which were to be confirmed and if there was any selection criteria to ensure a diverse and geographical spread. AM advised there were a number of senior groups involved, with the focus currently on gathering information across the whole organisation to inform the process and pilot sites.
- MK asked whether there was a commitment to have a development programme for all leaders and teams across the organisation. AM confirmed this was being developed in stages, with consultant and medical leaders also involved. The use of recognised organisations such as BRAP and the King's Fund should be an incentive for others to be involved and help develop education in the Trust.
- ST asked how the development programme would be integrated with key priorities. There was ambition in the expectation for senior leaders, but it was important that this was reflected in how they are managed. AM advised the Executive Team have an ongoing development programme in place with a

separate organisation who would ensure the programme is aligned with BRAP and the King's Fund. There had been significant work undertaken over the last year to understand what is happening in the organisation and ensuring the programme is linked, with outcome measures to demonstrate success.

The Board of Directors:

1. **Noted the cultural participative inquiry and leadership development programme, including methodology, expected benefits and key performance indicators.**
2. **Discussed the required sponsorship and active participation from the Board to achieve maximum organisational impact.**

116/25 A FRAMEWORK OF QUALITY ASSURANCE RESPONSIBLE OFFICERS AND REVALIDATION - ANNUAL REPORT AND STATEMENT OF COMPLIANCE

MK presented a report which provided information on the implementation of revalidation within the Trust for the 2024/25 appraisal year to provide an annual statement of compliance provided to the higher level Responsible Officer at NHS England. MK highlighted the following:

- The report provided assurance that the Trust was compliant with regulations and the Board of Directors supported the revalidation office.
- The Trust had the same revalidation officer for more than ten years, which had allowed a consistency and a development of process.
- There was a good relationship between medical staffing and the revalidation office, with good processes in place. There had been no non-engagers with the revalidation process for a number of years.
- There was a challenge in the number of appraisers. There is requirement not to have more than six appraisees per appraiser, which is a challenge to meet with current staffing. There were actions in place to address this issue.
- There had been adequate assurance provided from external and internal audits.

Questions and Discussions:

- RJ commented it was good to see compliance rates. RJ asked if there was any work undertaken to collate themes identified from appraisals to improve in any areas of concern raised. MK advised that this does not currently take place, but that he would review and consider completing a review of gaps or training needs from appraisals, with consideration for maintaining anonymity for any information reviewed.
- MJ asked whether there was assurance around the quality of the appraisers, especially where external support is required. MK advised there was a training programme in place and a forum for appraisers to discuss. There was no additional remuneration offered for appraisers which potentially limited the number of individuals coming forward.

The Board of Directors:

1. **Noted the contents of the report and approved the compliance statement.**
2. **Supported the submission of compliance statement to the Higher Responsible Officer at NHS England.**

Action:

1. **Undertake thematic review of appraisal outcomes to identify any gaps or training needs. (MK)**

117/25 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

Cllr. Maxine Sadza, Appointed Governor, Southend-on-Sea City Council asked how much co-production was in place regarding the WRES/WDES. AM advised there was engagement with staff networks, with more work to be undertaken to ensure a good

level of representation. There were other areas of data collection from the staff surveys and feedback provided to staff, networks and union groups.

118/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

119/25 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.

120/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

HLD reflected on discussions including:

- The results of the WRES/WDES, including the position of the Board and the agreed action to be taken.
- The cultural review being undertaken by BRAP and the King's Fund.
- The MHA Annual Report, specifically relating to data and the need to understand further detail.

121/25 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.

122/25 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

There were no items for escalation.

123/25 ANY OTHER BUSINESS

There was no other business.

124/25 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.

125/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 03 December 2025.

The meeting closed at .

Signed: Date: 2025

Hattie Llewelyn-Davies, Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 125/25)

Governor / Member of the Public	Query	Response
Member of the Public (107/25)	**Quality and Performance Scorecard** *Please could you explain what you mean by the following terms used within your report?* 1. ***Rates*** of Patients Clinically Ready for Discharge…….is this the right terminology? 2. Patients with Delayed Transfer of care on PICU, Older Adult and ***Specialist*** Wards ***What constitutes a Specialist ward?*** 3. […..] are within respective ***target limits. What are the target limits for these wards?*** 4. ***Re. PICU figures -does this include [delayed transfers of care to] "step down" on Section to other EPUT wards?*** 5. ***Could you give examples of*** *acceptable* ***system delays?*** *Or are they limited to there being no suitably safe accommodation available in the community.*	1. This represents the percentage of bed days, where patients have been deemed clinically ready for discharge (but have not been discharged), of the overall bed days for that ward. 2. Our Specialist Services ward types are: a) Secure Services b) Child and Adolescent Mental Health Service c) Learning Disability d) Mother & Baby 3. The target limits for these ward types are: a) Adult – **5%** b) PICU – **0%** c) Older Adult – **8.2%** d) Specialist Services – **8%** 4. The calculation for our delayed transfer of care on PICU wards does not include step downs. 5. The highest proportion of our system delays for acute adult and older adult services relate to supported accommodation/placement. Delays may also be attributed to housing and domiciliary care or capacity in specialist or rehabilitation settings. Weekly system escalation meetings are in place to oversee system actions to reduce delays and enable patients to be supported in the right place.

Governor / Member of the Public	Query	Response
Member of the Public	The member of the public was pleased to hear statements regarding anti-discrimination. However, they had attended a previous Board meeting where they had raised concerns about abuse experienced by patients. What was the Board doing to stop the disconnect between the statements made by the Board and the experience of patients?	HLD advised the Board anti-discrimination commitment had led to the statements made at the meeting. There was a strong cultural initiative which would continue to create the culture, commitment, training and support for staff to behave in an appropriate and non-discriminatory way. The member of the public raised some personal concerns and HLD agreed to consider these outside of the meeting.

4. ACTION LOG AND MATTERS ARISING

Standing item HLD

REFERENCES

Only PDFs are attached

Action Log Part 1 03.12.2025 FINAL.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 1 October 2025

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG	Andrew McMenemy	AM	Denver Greenhalgh	DG
Scott Huckle	SH	Ann Sheridan	AS	Milind Karale	MK

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
110/25 October	Develop a trajectory against the metrics included in the report WRES / WDES reports for future iterations of the report	AM	December 2025	A trajectory was developed in support of a separate NED / People & Culture Group on the WRES and WDES. The main metrics raised in the last Board report had showed improvement and the trajectory will continue to be utilised to monitor improvements.	Closed	
	Review the actions identified for the WRES / WDES to develop key strategic actions to address the concerns identified, to be monitored through the People Committee	AM/RJ	December 2025	As above regarding the People & Culture Group. There is also a commitment to provide quarterly updates at People Committee for the key metrics to allow earlier intervention.	Closed	
112/25 October	Review CRR45 Mandatory Training to incorporate specialist training requirements.	AM / DG	December 2025	The Trust has established a new Education Group that will report to People Committee and Executive Committee via an overarching People & Culture Group. The Education Group will consider future requests for specialist training that may be considered mandated at the Trust and make recommendations to the Executive Committee. The risk has been reviewed in line with this	Closed	
113/25 October	Future Board Seminar session to include a presentation on the enactment and use of the Mental Health Act across the Trust.	AS	March 2026	This has been added to the Board planner to take place at the next Board Seminar session in March 2026.	Future Action	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
116/25 October	Undertake thematic review of doctor revalidation appraisals outcomes to identify any gaps or training needs	MK	December 2025	The appraisals undertaken have been reviewed as part of the usual review process and no specific themes have been identified. The appraisals are highly individualised and training needs identified are often dependent on their career trajectory and would not be applicable to a large number of doctors at any one time. The appraisals will continue to be reviewed as part of the usual review process and any themes identified will be identified and acted on accordingly.	Closed	
082/25 August	Discuss the development of a simulation for flow and capacity.	AG / LL	~~September 2025~~ December 2025	Meeting scheduled to take place on the 28 November 2025.	Open	
089/25 August	Develop session for the Board as part of a seminar / development session for Community First and Assertive Outreach, including how the Trust can resolve the issues outlined in the paper	MK / AS	November 2025	Board Seminar Session held on 5 November 2025 to discuss Community First, including Assertive Outreach.	Closed	
048/25 June	Provide a further presentation / report to the Board of Directors in six months, providing further information on the impact of the ligature risk reduction project at Longview Ward and any feedback from young people on their experiences.	AS/SH	December 2025	This has been included on the agenda as a presentation for the meeting on the 5 December 2025.	Closed	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item HLD

REFERENCES

Only PDFs are attached

Chairs Report 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Chair's Report (including Governance Update)**					
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 (including Governance Update)

Lead
Hattie Llewelyn-Davies. **Hattie Llewelyn-Davies** **Chair**

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Transgender Awareness Week

Transgender Awareness week began on Thursday 14 November, leading up to the Transgender Day of Remembrance on 20 November. This is a time to honour the memory of those whose lives have been lost to anti-transgender violence, and to raise awareness of the challenges faced by transgender and non-binary people in our communities and workplaces. We know that this can be a particularly emotional and difficult time for many of our transgender colleagues. I and the Board of Directors, are clear that there is absolutely no place for discrimination or abuse of any kind across our Trust. We are committed to creating a culture where everyone feels safe, respected and valued for who they are. The diversity of our workforce is one of our greatest strengths and that is something that I and the Board are very proud of.

2.2 National Recognition

EPUT have been recognised for work in supporting newly qualified allied health professionals (AHPs) who have recently joined our services, scoring highly in the NHS England AHP Preceptorship Organisational Self Assessment Tool. We scored highly for organisational culture, quality and oversight of preceptorship, empowering preceptees and delivering preceptorship programmes.

Our South East Essex Ageing Well Carers Intensive Support Team reached the finals of this year's Health Service Journal Patient Safety Awards in the Improving Care for Older People category. The Team supports vulnerable and ageing carers in the Southend, Castle Point and Rochford areas who are caring for a person with suspected or diagnosed dementia frailty, or an older person with mental health concerns. Staff complete comprehensive health and wellbeing checks, focussing on physical, mental, social and emotional health to help carers achieve a better balance in their lives between managing their own needs alongside those of the person they care for.

EPUT mental health nurse Sophie Gorden was highly commended in the National Learning Disabilities and Autism Awards in July. Sophie who works in our Lakes inpatient unit in Colchester, uses their lived experience of autism to support people with autism, their families and supporters.

Congratulations to all for their well-deserved national recognition.

2.3 Board Development Programme

This summer is a significant turning point for the NHS with the 10 Year Health Plan with a fresh ambition and a clear vision for long term transformation across the NHS. At the heart of that change is the leadership challenge which requires us all to role model behaviours that create the conditions and culture needed to improve productivity, attract and retain our people, and support them to work in new ways and deliver high quality care for our patients, all while delivering value for money. Board leadership will be a crucial factor in determining success. NHS England in September invited Boards to join the new Board Development Programme, we have submitted an expression of interest to be one of the 25 Boards within the first cohort. If selected, the programme will be tailored to EPUT's context and priorities, and co-developed with the Board, reflecting our specific challenges, ambitions, and starting point. This programme builds on the Insightful Board approach published in November 2024 and supported improvement through the new Learning and Improvement Networks.

2.4 Remembrance Service

Members of our Executive Team led the annual online Remembrance Service for our staff on Tuesday 11 November. This event reflected on the service and sacrifices our Armed Forces make

on our behalf. Staff were also reminded that support is available for all staff impacted by current conflicts across the world through our Employee Assistance team, Chaplaincy and Spiritual care team and the Here for You Service.

2.5 Co-Production Conference

I was delighted to open our recent Co-Production Conference that was held in partnership with Essex County Council, and focussed on how working in partnership with patients, their loved ones and the wider community is vital to delivering better health and care services. Colleagues, lived experience ambassadors and partners heard about the national Culture of Care programme, which aims to change the culture of inpatient care, reasonable adjustments in the workplace, and the experiences of mental health care by older people in racialised communities. Thank you to everyone who helped make the event such a success.

3.0 Legal and Policy Update

3.1 HSSIB Investigations: Emergency Care And Those In Mental Health Crisis

Please see the link below for a copy of the report published on 24 September 2025. The Health Services Safety Investigations Body ("HSSIB") has launched two investigations to examine patient safety issues relating to care pathways for individuals in a mental health crisis who engage with urgent and emergency care services.

The first investigation will focus on the care of patients experiencing mental health crises in emergency departments. It will examine the knowledge, skills and resources available to staff, the impact of the physical environment on care, and staff decision-making around admission and discharge. Set to launch in October 2025, publication of the final report is expected in summer 2026.

For Information:
bevanbrittan.com/insights/articles/2025/hssib-investigations-emergency-care-and-those-in-mental-health-crisis/

3.2 Independent Patient Choice And Procurement Panel Review Of A Proposed Contract Award: Talking Therapies And Psychological Therapies For Severe Mental Health Problems For Mid And South Essex

Please see the link below for a copy of the review regarding the proposed contract award for Talking Therapies and Psychological Therapies for Severe Mental Health Problems in Mid and South Essex, published on 25 September 2025.

For Information:
cr0021-25-cr0022-25-talking-therapies-and-psychological-therapies-for-severe-mental-health-problems-for-mid-and-south-essex.docx

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item PS

REFERENCES

Only PDFs are attached

CEO Report 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 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 an update on news and developments.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Points

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

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
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			
BMA	British Medical Association	ICS	Integrated Care System
ICO	Integrated Care Organisation	EPR	Electronic Patient Record
CQC	Care Quality Commission	ARU	Anglia Ruskin University
WTE	Whole Time Equivalent	JEG	Job Evaluation Group
MARS	Mutually Agreed Resignation Scheme	GMC	General Medical Council
NMC	Nursing Midwifery Council		

Supporting Reports and/or Appendices

CEO report.

Executive/ Non-Executive Lead / Committee Lead:

Paul Scott
Chief Executive Officer

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Industrial Action

The British Medical Association announced that resident doctors would take industrial action from Friday 14 November to Wednesday 19 November. The Trust respects the rights of resident doctors to take action and took steps to ensure that there was as little disruption to our services as possible during this time, with patients affected assessed to ensure appropriate care was in place ahead of the planned industrial action. The 111 mental health crisis phone line also remained open as usual throughout the strike action.

1.2 Farewell to Dr Milind Karale, Executive Medical Director

It is with sadness that Dr Milind Karale, our Executive Chief Medical Officer has taken the decision to step down from his role on the Board in December after an incredible career serving the NHS and EPUT. Milind was appointed Chief Medical Officer in 2012 and devoted himself tirelessly to the quality and patient safety at EPUT and the wider NHS. We are extremely grateful for the many years of dedication, commitment and energy that Milind has brought to his roles. he has overseen many service developments which have had a demonstrable positive impact on the quality of patient care and experience. I would like to say a huge thanks to Milind and to wish him all the best for the future.

1.3 Interim Chief Medical Officer Appointment

Following the announcement of Dr Milind Karale's decision to step down from his role as Medical Director in December 2025, the Trust has initiated a formal recruitment process to appoint a substantive successor. In the interim, Dr Kallur Suresh has been appointed as Interim Chief Medical Officer, effective from 01 December 2025, following a robust internal selection process. We welcome Dr Suresh to his new role. Updates regarding a substantive appointment will follow in due course.

1.4 Lampard Inquiry

The October 2025 public hearings of the Lampard Inquiry concluded on 28 October, having heard further testimony from bereaved families regarding the care, treatment, and deaths of their loved ones. Key themes emerging from the hearings included the integration of physical and mental health care, the management of substance misuse, the care of older patients, and the use of patient monitoring systems. The Inquiry has announced its hearings schedule for 2026, with a focus on illustrative cases aligned with these themes.

Support continues to be available for staff through the Here For You Team and the EPUT Inquiry Project Team. All colleagues are encouraged to engage with the Inquiry, particularly if they believe they hold relevant information, and to respond directly if contacted.

The Inquiry has also announced that it will hold a virtual public hearing on Monday 8 December. The hearing will provide an opportunity for the legal representatives of Core Participants to address the Chair on any procedural issues, as well as the Inquiry's draft Investigative Strategy. They will also summarise any matters raised by Core Participants who do not have legal representation at the hearing on their behalf. Further information is available on the Lampard Inquiry website.

While there is still work to be done, it is important to also reflect on and acknowledge improvements that have been made, including investing in our wards to make them safer and more pleasant, using digital technology to improve patient safety, and most importantly bringing patients, families and carers into the heart of the Trust. We now have over 300 people with lived experience of services working with us across all aspects of care and service development at EPUT. And importantly, it is the voice of our patients that has helped to transform our inpatient services via the Time to Care programme with its focus on activities and engagement, and this is flowing through into changes in our community mental health services via our Community First Programme.

I also recently had the pleasure of attending the third EPUT Co-Production Conference which was held in conjunction with Essex County Council and shone a light on the voice of lived and living

experience workers across our services. The conference was held on World Mental Health Day (10 October),and celebrated the 'Power of Partnership'.

1.5 Flu

The UK Health Security Agency (UKHSA) is reporting flu cases are continuing to rise, with the flu season beginning several weeks early this year. More than 300 EPUT staff have so far had their flu vaccination at the flu clinics run nun by our employee assistance programme. Information about clinics, the vaccine, and the flu is available for our staff on the dedicated flu intranet pages, and we continue to reiterate the importance of NHS staff getting vaccinated to protect themselves, their loved ones and our patients during this winter.

1.6 New Harlow and Colchester Mental Health Urgent Care Units

I am pleased to announce the development of two new Mental Health Care Units (MHUCU) – one at the Derwent Centre, based at Princess Alexandra Hospital in Harlow and one at the Emerald Centre at the Kingswood Centre at Colchester Hospital.

These new services represent a major step forward in improving crisis care, reducing pressure on local hospital emergency departments, and supporting better outcomes for our patients, staff and partners across the system. Both sites will be created by redeveloping unused space and construction will begin in the first week of December, with the aim of both services opening in early summer 2026.

The centres will help adults in mental health crisis get the right care at the right time in a calm and therapeutic space away from the busy environments of hospital accident and emergency departments. Specialist staff will work with patients to understand what has triggered their mental health crisis and ensure they receive the right care in the best place to meet their individual needs, whether that's in hospital or at home, supported by community mental health teams and support organisations.

These two new units will have a positive impact on our local health and care system, easing pressures on the ambulance service and accident and emergency departments, and helping to reduce avoidable hospital admissions and out of area placements so that more inpatient beds are available for those that need them most.

1.7 Planning 2026/27 – 2030/31

The Trust is co-ordinating its activity, performance, workforce and financial plans in line with recently released national guidance. First submissions are to be made 17 December with 2 years' plans (4 years for capital) and integrated medium term planning template giving commentary on areas of non-compliance and Board assurance statements. The guidance was considered by the Finance & Performance Committee and will be discussed in Part Two of the Board meeting.

2. UPDATES

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

Community Care units have been fully engaged in winter system support with adapted usage of west inpatient beds to support acute flow.

The expert flow review is now completed and the implementation of recommendations is under way. The delivery of improvements will monitored through a 90-day plan. We are also participating in the regional Mental Health Learning Improvement Network and had good representation at the launch event in October, focused on length of stay.

To support the shift to locality focused inpatient mental health flow, our crisis services in North East Essex are now being led by the locality care unit under a test and learn project which will inform any future changes in our operating model.

The Time to Care Programme will be moving to business as usual following the recruitment of over 300 new inpatient roles and the rollout of the new operating model. Our future focus will be on the delivery of associated quality and performance benefits.

2.2 Nursing and Quality – Ann Sheridan, Executive Nurse

Allied Health Professional Leadership

The integration of Allied Health Professional (AHP) leadership within Care Units has now been successfully achieved, marking a significant milestone in the ongoing transformation of our leadership structure. This embedding ensures that AHP leadership is closely aligned with operational delivery and patient care, strengthening clinical governance and professional oversight across all services. The initial phase of recruitment has been completed, with interviews for AHP Professional Leads and Service Managers successfully concluded. These appointments will provide strategic leadership and operational support, ensuring consistency in professional standards and service delivery. The next phase of the process will focus on the appointment of AHP Heads and Clinical Managers. These roles are critical in driving forward our vision for integrated care, supporting workforce development, and enhancing patient outcomes through collaborative leadership.

Culture of Care Programme

The Culture of Care Programme, launched by NHS England in 2024 as part of the Quality Transformation Programme, is a two-year national initiative designed to improve the culture within mental health, learning disability, and autism inpatient settings. EPUT is actively engaged in this programme as part of a regional collaborative with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Norfolk and Suffolk NHS Foundation Trust (NSFT), Central and North West London NHS Foundation Trust (CNWL), Oxford Mental Health Partnership (OMHP), and Berkshire Healthcare NHS Foundation Trust (BHFT). Four EPUT wards - Ardleigh, Cedar, Larkwood and Woodlea - have been selected to participate.

Local quality improvement projects are underway, including Cedar Ward's "Punching for Purpose" initiative, which aims to enhance wellbeing and confidence through structured physical activity, and Woodlea Clinic's Patient and MDT lunches, which focus on strengthening relationships and improving collaboration between patients and multidisciplinary teams.

National support for the programme includes a series of webinars delivered by NHS England on key themes such as person-centred risk management, co-production in care planning, and trauma- and autism-informed approaches. These sessions are complemented by face-to-face learning events with regional partners, enabling shared best practice and collaborative improvement across participating organisations.

Patient Experience

EPUT has strengthened its population health approach to directly support care quality and patient experience across key transformation programmes, including Community First, the Essex Peer Academy, and COMPASS. By aligning Joint Strategic Needs Assessment (JSNA) intelligence, Office for National Statistics (ONS) forecasts, and internal quality and activity data, we have established a clearer, shared understanding of the demographic and clinical trends shaping demand on our services. These include rising complexity of needs, increasing prevalence of neurodiversity, and widening health inequalities across Essex.

This intelligence is informing the design and targeting of early-help pathways, peer-led development opportunities, and neighbourhood-based support aimed at reducing avoidable escalation into specialist care. Through close collaboration with operational teams, Integrated Care Boards (ICBs), Essex County Council (ECC), and voluntary, community and social enterprise (VCSE) partners, we are translating population-level insight into practical quality improvements and more proactive models of care. This work is enabling a consistent, system-wide approach that positions EPUT to deliver safer, more responsive, and more equitable services for the communities we serve.

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

Resident Doctor Industrial Action

The Resident doctors staged a five-day strike from 14–19 November 2025, marking their 13th walkout since March 2023. The dispute centres on pay restoration and job security and another major grievance is shortage of training posts. EPUT managed and maintained service provision

ensuring high risk areas were covered and resilience in place. A number of patients (approximately 160) had appointments rescheduled following consultant led risk assessment. It is understood that negotiations remain deadlocked and more industrial action could follow unless a compromise is reached.

Resident Doctor 10 Point Plan

The purpose of NHS England's Resident Doctor 10 Point Plan, published in August 2025, is to fix unacceptable working practices and ensure basic standards are consistently met for the 75,000 resident doctors across the NHS. There is significant political interest, and drive in the 10 point plan continues to increase, as progress is seen as a major bargaining lever to head off future resident doctors industrial action.

In summary the plan aims to;

- Address systemic failures: The plan targets long-standing issues such as payroll errors, poor rota management, lack of rest facilities, and repeated mandatory training.
- Improve working conditions: It sets out clear, actionable steps to enhance wellbeing, fairness, and operational support for resident doctors.
- Restore trust and morale: NHS England acknowledges that continued neglect of these issues has eroded trust and morale, which affects both staff retention and patient care.
- Ensure accountability: Trusts must act within 12 weeks, report progress to their boards, and include outcomes in annual reports. Non-compliance requires formal explanation and corrective action.
- Support wider NHS reforms: The plan aligns with the 10-Year Health Plan for England and is incorporated into the NHS Oversight Framework to ensure long-term impact.

Staff Survey

The Trust has seen its best engagement aligned to the staff survey with over 50% of staff completing the 2025 staff survey. We would like to see this engagement develop over the next couple of years in order that we consistently see engagement levels at 65%.

On its own merit, this year has demonstrated further evidence of improved levels of staff involvement and engagement. The inclusive approach to the staff survey undertaken at local team level has been very encouraging. We have seen more engagement also with corporate and Board leaders at the Trust.

The next step is ensuring we are clear on the feedback and take seriously how we listen to this feedback and how we respond.

Education & Learning

The Trust has agreed a new framework of partnership with ARU commencing in 2026 with a new strategic group alongside a new operational group. Both groups will have representation from both organisations with agreed and aligned objectives that will support better outcomes for students, staff and patient services.

The Trust has also agreed new partnership arrangements with Chelmsford College with plans to offer T-Level placements at EPUT for students at Chelmsford college from September 2026. This is an exciting development that will also be supported with a new framework for work experience at the Trust.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS

REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 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:	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 high level summary of operational performance, quality indicators, safer staffing levels, finance and key NHSE 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:

- Adult Occupancy reduced to 98.6%, remaining out of target (a decrease from 97.3% in September) - Target <93%
- • PICU Occupancy has increased to 97.3%, out of target (an increase from 93.3% in September) – Target <88%
- • Specialist Occupancy has increased to 74.6%, out of target (an increase from 74.6% in September) - Target >95%
- • Older Adult Occupancy has decreased to 96.6%, remaining out of target (a decrease from 96.9% in September) – Target <86%

Data accuracy is contributing to some of the issues; with recording discharges where documents cannot be backdated if they require sign off post discharge, the MH Information Team is working with Wards, Operational Productivity and Systems team to correct these issues.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (excluding Assessment unit) reduced to 59.6 days (down from 85.3 in September) - Target <60 (Oversight Framework)
- 94 discharges in October - 13 long stays (60+ days).
- Adult ALoS (Including the Assessment Unit) reduced to 43.99 days (down from 61.78 in September) - Target <60 (Oversight Framework)

October represented a third successful month of reporting within the new NHS oversight target of 60 days.

Older Adult Average Length of Stay on Discharge

- Decreased in October to 93.2 days (down from 130.4 days in September) - Target <90 (Oversight Framework)
- 25 discharges in October - 13 long stay (60+ days).
- Older Adult current inpatients ALoS has reduced to 115.1 days - target of <90 (Oversight Framework). The new Oversight Framework also changes the Older Adult target length of stay to 90 days (we are still at variance against this new target).

PICU average length of stay

- Increased in October to 80.3 days (from 69.3 in September) – Target <50
- Six discharges from PICU in August,
  - o Hadleigh – 5 discharges
  - o Christopher – 1 discharge
- We are confirming with the national team in regards to definitions around including/excluding Assessment Unit patients.

Rates of Patients Clinically Ready for Discharge:

Patients with a delayed transfer of care on PICU, Older Adults and Specialist wards all continue to report well within their respective target limits. Adults saw a significant reduction in delays from what was reported in August.

Inappropriate Out of Area Placements:

- There was an increase in the number of placements in October.
    - Adult increased by 2

- 28 repatriations in October
    - Adult – 24
    - PICU - 4
- 53 remain OOA in October
    - Adult – 46
    - PICU - 7

The number of OOA remaining at month end is down from September, (57 to 53). Adult decreased by 3 and PICU decreased by 1.

Cardio Metabolic:
Overall compliance saw an improvement at 67.3% in October; but remains below target of >90%:

- Eleven inpatient wards fully compliant in October (Ipswich Road, Ardleigh, Henneage, Tower, Ruby, Meadowview, Edward House, Poplar (CAMHS), Causeway, Byron Court, and Wood Lea).

Nursing staff are completing the BMI, BP, Drink and Smoking sections to near 100% and working to improve the recording of lipids and glucose with medical colleagues.

Community SMI patients under 1-year have seen an improvement in performance in October with a reported 59.6%. Annual health checks for SMI patients on the risk register for the Mid and South Essex Care Unit due to demand v capacity impacting further progress. SystmOne access is being given to teams so they can identify the Health Check gaps to be undertaken. A tracking report used by teams was reinstated in August and expected to support improvements

NHS Talking Therapies:
All three areas are reporting reduced access rates which is typical of summer months, both the 6wk and 18wk wait to treatment are reporting 100%.

The moving to recovery indicator continues to report above the 50% target at 58% in August.

No Harm / Low Harm Incident Rates:
October - No Harm/Low Harm rates continue to make up most patient safety incidents. The weekly Emerging Incident Review Group (EIRG) continues to track staff sign off all incidents.

Workforce:
Sickness has been increasing month on month since May and is now reported in at 5.8% This is in line with past seasonal trends where the sickness recorded is higher in the summer months. Anxiety/stress/depression/other psychiatric illnesses were the most reported reason for sickness.

Temporary Staffing:
Agency usage remains at 1.1% at October. Temporary Staffing spend in month was £4.3m, an increase of £0.2m compared to September due to the school holidays.

Ward Fill Rates:
October reported 27 wards having less than 90% fill rates against the target of <13, this is a reduction from September. The last two years have shown a peak around August/September which may indicate this is seasonal. This pressure is reflected in the Day and Night qualified staff fill rates, with performance reporting almost back within target with day at 90.8% and night at 90.3%

Income & Expenditure
The YTD deficit is £5.1m, £3.5m adverse to plan. The position includes £1.9m of excess inquiry costs and the loss of £1.7m of deficit support funding in M7. Excluding these items the residual £1.5m deficit would be £0.2m better than planned.

Efficiency

Delivery in month of £2.6m. YTD £16.2m (49% of annual plan). This includes over-performance against temporary staffing plans with under performance in Out Of Area Placements.

Capital
Capital spend YTD £6.2m, £5.1m variance to plan with recovery actions and request made to seek deferral of allocations.

Cash
Cash balance £33m, better than planned but with increasing concerns due to Inquiry costs and loss of deficit support funding.

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

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

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

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

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

Executive Lead

Paul Scott
Chief Executive Officer

7.2 COMMITTEE CHAIRS REPORT

Information Item Chairs

REFERENCES

Only PDFs are attached

Committee Chairs Report Part 1 03.12.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 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 note the report and assurance provided.

Summary of Key Points

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

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

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

- Assurance – any key assurances to be provided to the Board.

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

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

1. Audit Committee (Elena Lokteva)
2. Finance & Performance Committee (Diane Leacock)
3. People Committee (Ruth Jackson)
4. Quality Committee (Dr Mateen Jiwani)

Appendix 1 provides Committee meeting dates for January-March 2026, and the 2026/27 financial year.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report Appendix 1: Board Standing Committee Dates January-March 2026, and 2026/27 financial year.

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

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors

3 December 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

NHS
Essex Partnership University
NHS Foundation Trust

1. AUDIT COMMITTEE

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

Committee meeting held: 7 November 2025

Assurance

Internal Audit Progress

- Five audits have been finalised:
  - Cyber Assessment Framework – High Risk (against new standards) – Referred to Finance & Performance Committee which has Cyber Risk oversight responsibility
  - Ann McIntyre Action Plan 2024/25 – Reasonable
  - Apprenticeship Levy – Reasonable
  - Management and Implementation of CQC Recommendations – Substantial
  - Consent – Limited
- Five audits are in progress:
  - Clinical Governance Arrangements
  - Safety Plans
  - Processes for Preventing Future Deaths
  - Follow Up of Limited Assurance E-Rostering Report
  - Follow Up of Limited Assurance Consultant Job Planning Report
- Four recommendations overdue, with Executive attendance to reporting:
  - Rostering
  - Datix
  - Consultant Job Plans
  - Falls
- The Committee received assurance that appropriate governance, assurance and oversight has been put in place for Oxevision.
- Updates on Job Planning will be provided to Audit and People Committees.

External Audit Progress

- The Committee received the final Audit Results Report and Auditors Annual Report for the 2024/25 financial year.

Information

Trust Risks with a Consequence Score of 5

- Following a recommendation by the Quality Committee, the Audit Committee received a report outlining the details of risks held within operational risk registers with an assessed consequence of 5 (excluding those that are reported to the Board regularly through the Board Assurance Framework).
- There are currently three risks meeting this criteria: CRR94 Observation and Engagement; Fire Safety; and Garden Lighting. All have controls in place to reduce the likelihood. The last two are within this year's capital investment plans.
- Arrangements for monitoring risks within this category will be reviewed.

Claims Annual Scorecard Report 2025

- The Committee received a report providing the Trust's Annual Scorecard data relating to the period 1 April 2015-31 March 2025.

Risk Management Assurance Framework Key Controls Report

- The Committee received a report providing an overview of performance against key risk management controls across the Board Assurance Framework, Corporate Risk Register and Care Units for October 2025.

1. AUDIT COMMITTEE *(Cont.)*

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

Committee meeting held: 7 November 2025

Assurance

Clinical Audit – Assurance on Process & Delivery

- A NICE Committee has been established, to be chaired by the Medical Director with core members including Deputy Medical Directors and Directors of Nursing.
- A gap analysis identified 29 NICE Audits as not having the correct documentation in place. Care Units have been given four weeks to complete and submit to the NICE Committee.
- Arrangements for the ongoing oversight of NICE will be considered during the upcoming annual review of Committees.

Anti-Crime Progress

- The Committee received assurance on Counter-Fraud activity at the Trust, including:
  - Failure to Prevent Fraud Offence.
  - National Fraud Initiative Exercise.
  - International Fraud Awareness Week (16-22 November 2025).
  - Counter Fraud Investigations.

Waiver of Standing Orders

- The Committee received a report on Waiver activity during July-September 2025.
- The impact of national timescales and scale of the capital programme was noted, as recorded at the Finance & Performance Committee.
- A Deep Dive into categorisations has been carried out, analysing the Waivers submitted under the 'Other' category.
- The next report will further demonstrate how value for money has been achieved on Capital Waivers.

Action

No Actions for the Board.

Alert

Annual Review of Governance Manual

- The Committee approved the draft Review of Standing Orders; Review of Scheme of Reservation & Delegation; and Review of Standing Financial Instructions & Detailed Scheme of Delegation for presentation to the Board of Directors for final signoff.
- These will be presented in a separate Agenda item.

NHS
Essex Partnership University
NHS Foundation Trust

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 20 November 2025

Assurance

Performance Report

- Assurance on the Trust's performance during October 2025 included the following key areas:
  - Crisis call response times
  - Mental health inpatient capacity and flow, with the findings from the Independent review.
  - Mental health readmissions within 28 days for adults
  - Adult and older adult average length of stay on discharge
  - PICU average length of stay
  - Inappropriate out of area placements
  - OPEL status
  - Cardio metabolic
  - Virtual ward occupancy
  - Urgent community response team two-hour performance
- The Committee also received a copy of EPUT Mid-Year Review Meeting NHSE Follow Up letter for information.

Financial Report

- The Committee received an update on the Trust's Month 7 financial results.
- A separate meeting will be held to discuss reframing SR7 to cover both Cash and Capital in view of the risk to future cash balances from resourcing the Inquiry and the loss of deficit support funding.

Board Assurance Framework Risk Deep Dive: Length of Stay

- A Deep Dive on Length of Stay was presented to the Committee.
- This will be presented to the Board of Directors at a Board Seminar.

Board Assurance Framework Report

- The Committee received the BAF risks aligned with the Committee.

Information

Action

Continued escalation to the Board of future cash risks.

Alert

Strategic Impact Report

- The Strategic Impact Report Month 5 2025/26 was approved by the Committee for presentation to the Board of Directors. This will be presented in a separate Agenda item

NHS
Essex Partnership University
NHS Foundation Trust

3. PEOPLE COMMITTEE

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

Committee meeting held: 30 October 2025

Assurance

Assurance Reports

• The following assurance reports were received by the Committee:
- Board Assurance Framework - Workforce
- Continued Professional Development Planning
- EPUT Apprenticeships
- Freedom to Speak Up Half-Year Update
- Guardian of Safe Working Quarterly Report
- National Staff Survey 2025 and Pulse Survey Quarter 2 2025/26 Update
- Operational Human Resources Assurance Report
- Social Impact Strategy Update
- Strategic Impact Report Month 5 2025/26
- Workforce Key Performance Indicators

Information

Mandatory Training Data Quality for Medical Staff

- The Committee received an update on mandatory training for medical staff, further to the recent discussion at Board.
- Assurance was received that data cleansing has been carried out to provide an accurate position, a new electronic system for recording mandatory training data for medical staff is being implemented, and in the meantime a manual system is in place for recording mandatory training for medical staff.

Workforce Planning

- Workforce planning for the 2026/27 financial year has commenced.
- The People Committee and Board of Directors will receive continual updates throughout the process.

People & Education Strategy

- The first draft of the new People & Education Strategy was shared with the Committee.
- Engagement will be held with a range of stakeholders, and feedback is welcomed.
- It is anticipated that the Strategy will be published in April 2026, with a five-year implementation plan.

Action

No Actions for the Board.

Alert

Strategic Impact Report

• The Strategic Impact Report Month 5 2025/26 was approved by the Committee for presentation to the Board of Directors, subject to the addition of Month 6 data. This will be presented in a separate Agenda item

NHS
Essex Partnership University
NHS Foundation Trust

4. QUALITY COMMITTEE

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

Committee meetings held: 9 October & 14 November 2025

Assurance

Assurance Reports:

- The Committee received the following Assurance Reports:
  - Board Assurance Framework Report
  - Clinical Audit & NICE Quarterly Report
  - CQC & PFD Assurance Report
  - Digital Clinical Safety Framework Update
  - EPRR Core Standards Self-Assessment 2024/25
  - Executive Emergent Issues
  - Learning from Deaths Quarterly Report
  - Learning Lessons Quarterly Update
  - Mental Health Act Annual Report 2024/25
  - Oxevision Deep Dive Report
  - Patient Experience & PSIRF Report
  - Patient & Service User Experience Report
  - PFD Action Plan Spotlight
  - Pharmacy & Medicines Optimisation Annual Report 2024/25
  - PSIRF Quarterly Report
  - Quality of Care Performance Dashboard
  - Reducing Restrictive Practice Report
  - Safety Improvement Plans Progress Report
  - Safer Staffing Report
  - Senior Information Risk Owner Annual Report 2024/25
  - Strategic Impact Report
  - Suicide Prevention Report
  - Time to Care Programme Highlights
  - Working with Neurodivergence

Information

Winter Pressures

- The Committee received an update and assurance on arrangements for the winter period.

Industrial Action

- The Committee received assurance that arrangements had been put in place to maintain quality and safety during junior doctor industrial action in November 2025.

St Andrew's Hospital

- The Trust is working closely with hospital management and ICB colleagues to ensure quality of care for EPUT patients at St Andrew's Hospital.

Community Health Shift Patterns

- Eight-hour shift patterns are being trialled on community health wards.
- It is hoped this change will reduce the risk of staff burnout and attract a greater number of candidates during recruitment campaigns.
- Suitable arrangements for shift changeovers, including digital solutions, are in place.
- The Committee agreed that a quality improvement project will be implemented, with regular updates to the Quality Committee.

Oxevision

- A Deep Dive on Oxevision was received by the Committee.
- Committee members agreed to add a quarterly update report to the Committee Work Plan.
- It was agreed that the phrase '*Remote Monitoring Technology'* should be used instead of brand names.

Controlled Drugs

- A deep dive into the management of controlled drugs will be presented to the Committee in December 2025.

QUALITY COMMITTEE *(Cont.)*

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

Committee meetings held: 9 October & 14 November 2025

Action

No Actions for the Board.

Alert

Learning from Deaths Quarter 1 2025/26 Report
- The Learning from Deaths Quarter 1 2025/26 Report was approved by the Committee for presentation to the Board of Directors. This will be presented in a separate Agenda item.

EPR Core Standards Self-Assessment 2024/25
- The EPR Core Standards Self-Assessment 2024/25 was approved by the Committee for submission to NHSE.

Senior Information Risk Owner Annual Report 2024/25 & Commitment for 2025/26
- The Committee received the Senior Information Risk Owner Annual Report 2024/25.
- The Committee approved the continued commitment to support arrangements to attain compliance against DSPT assertions during 2025/26.

Pharmacy & Medicines Optimisation Annual Report 2024/25
- The Pharmacy & Medicines Optimisation Annual Report 2024/25 was approved by the Committee.

Strategic Impact Report
- The Strategic Impact Report Month 5 2025/26 was approved by the Committee for presentation to the Board of Directors, subject to the addition of Month 6 data. This will be presented in a separate Agenda item.

Remote Monitoring Technology Quarterly Report
- The Committee agreed to add a quarterly report to the Committee Work Plan, to receive updates and assurance on the use of remote monitoring technology at the Trust.

Appendix 1
Board of Directors
3 December 2025

EPUT

BOARD STANDING COMMITTEE DATES JANUARY-MARCH 2026 & 2026/27 FINANCIAL YEAR

1 Purpose of Report

This report provides the dates of the Board Standing Committee meetings for January-March 2026, and the 2026/27 financial year.

2 Board Standing Committee Meeting Dates 2026/27

Audit Committee

2-3pm, Monday 12 January 2026
9.30-11.30am, Friday 6 March 2026
9.30-11.30am, Friday 1 May (Audit Committee Seminar – Draft Accounts)
9.30-11.30am, Friday 8 May 2026
9.30-10.30am, Wednesday 24 June (Extraordinary Audit Committee – Final Accounts)
9.30-11.30am, Friday 31 July 2026
9.30-11.30am, Friday 6 November 2026
9.30-11.30am, Friday 5 March 2027

Finance & Performance Committee

2pm-5pm, Thursday 22 January 2026
9am-10am, Thursday 26 February 2026
9am-midday, Thursday 19 March 2026
9am-10am, Thursday 30 April 2026
9am-midday, Thursday 21 May 2026
9am-10am, Thursday 25 June 2026
9am-midday, Thursday 23 July 2026
9am-10am, Thursday 27 August 2026
2pm-5pm, Thursday 24 September 2026
9am-10am, Thursday 29 October 2026
9am-midday, Thursday 19 November 2026
9am-10am, Thursday 17 December 2026
9am-midday, Thursday 21 January 2027
9am-10am, Thursday 25 February 2027
9am-midday, Thursday 18 March 2027

People Committee

2-4pm, Thursday 26 February 2026
2-4pm, Thursday 30 April 2026
2-4pm, Thursday 2 July 2026
2-4pm, Thursday 27 August 2026
2-4pm, Thursday 29 October 2026
2-4pm, Thursday 17 December 2026
2-4pm, Thursday 25 February 2027

Quality Committee

9.30-11.30am, Thursday 15 January 2026
9.30-11.30am, Thursday 12 February 2026
9.30-11.30am, Thursday 12 March 2026
9.30-11.30am, Thursday 9 April 2026
9.30-11.30am, Thursday 14 May 2026
9.30-11.30am, Thursday 11 June 2026
9.30-11.30am, Thursday 9 July 2026
9.30-11.30am, Thursday 10 September 2026
9.30-11.30am, Thursday 8 October 2026
9.30-11.30am, Thursday 12 November 2026
9.30-11.30am, Thursday 10 December 2026
9.30-11.30am, Thursday 14 January 2027
9.30-11.30am, Thursday 11 February 2027
9.30-11.30am, Thursday 11 March 2027

3 Recommendations

The Board of Directors is asked to note the Board Standing Committee dates for January-March 2026, and the 2026/27 financial year.

Chairs of the Board Standing Committees
3 December 2025

7.3 CQC ASSURANCE REPORT

Information Item AS

REFERENCES

Only PDFs are attached

CQC Report 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 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:	Executive Team 11 November 2025, Quality Committee 13 November 2025, Quality of Care 27 November 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 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.
2. Note the assurance on progress against the improvement plan.

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- The CQC following their unannounced inspection of LD Inpatients (Byron Court) published their report on 19 November 2025, reporting an overall rating of requires improvement. Improvement actions arising from this inspection will be added to the Trust overarching CQC improvement plan.
- Implementation of version 02 of the CQC improvement plan 2025 which includes actions from both the Forensic inspection and MH Adult Acute and PICU inpatient inspection.
- CQC Action plan (v02) overview as of the 31 October 2025:
  - Thirteen regulatory and improvement actions made up of 56 sub-actions in progress to address the improvements required.
  - Of the 56 sub-actions
    - 2 (4%) are in recovery (CCTV, Activity Cancellation KPI reporting)
    - 31 (55%) are on track
    - 22 (39%) reported as complete and pending evidence assurance
    - 1 (2%) awaiting update to confirm complete (Risk assessment reviewed following an incident)
  - 0 (0%) have been closed through the evidence assurance process
- There were twelve CQC enquiries 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 Action Plan Update December 2025

Lead

Ann Sheridan

Ann Sheridan
Executive Chief Nurse

CQC Assurance Report – December 2025

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.

3. CQC Inspections and Improvement Plans

3.1. CQC Unannounced inspection LD Inpatients (Byron Court) 16.07.25

The CQC following their unannounced inspection of LD Inpatients (Byron Court) published their report on 19 November 2025, with the overall rating remaining as requires improvement.

The CQC assessed our wards for people with a learning disability and autistic people between 16 July 2025 and 23 July 2025, visiting Byron Court. Byron Court is a mixed-gender assessment and treatment unit and is commissioned for seven beds as part of the Essex Learning Disability Partnership. At the time of the inspection there was one person at Byron Court. The inspection was comprehensive, covering all the quality statements and all key questions.

The service was 'requires improvement' because of a breach of the legal regulations in relation to Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. In that, the governance system and audits at the unit were not effective in identifying or addressing the areas for improvement that the CQC identified at this inspection, in relation to care and treatment records.

The CQC noted that since their last inspection (2018), the service had made improvements to most of the previous concerns they had identified, where five out of six concerns were now met. The CQC found improvements in staffing; nothing that the service now had enough permanent regular nursing and support staff to keep people safe. The service had ensured that blood glucose machines were fully calibrated. The service had ensured that staff accurately recorded administration of medicines, and that consent to treatment forms were accessible. The service had ensured staff recorded people's vital signs in the physical health observation charts. The service had ensured that staff had access to specialist learning disability and autism training.

Improvement actions arising from this inspection will be added to the Trust overarching CQC improvement plan. The full report is attached at Appendix 2.

3.2. CQC Improvement Plan

CQC Action plan (v02) comprising of improvement actions from CQC inspections in 2025 (Forensic Services and Adult Acute & PICU Services) and open PFD actions. (An update focusing on CQC actions is provided at Appendix 1).

As of 31 October 2025:

- Thirteen regulatory and improvement actions made up of 56 sub-actions have been developed.

- Of the 56 sub-actions

    - 2 (4%) are in recovery (CCTV, Activity Cancellation KPI reporting)
    - 31 (55%) are on track
    - 22 (39%) reported as complete and pending evidence
    - 1 (2%) awaiting update to confirm complete (Risk assessment reviewed following an incident)

- 0 (0%) have been closed through the evidence assurance process

Implementation of the plan continues via the operational CQC Care Unit meetings supported with monitoring and oversight by the monthly Joint Care Unit meeting (reporting to the Quality of Care Group).

3.3. CQC Enquiries

During the reporting period (September/October), the CQC raised twelve (12) enquiries as outlined below.

Received	Service	Enquiry related to
16/09/2025	Kelvedon Ward	Systems & Procedures
22/09/2025	Wood Lea Clinic	Clinical Practice - Poor Care on Ward
22/09/2025	Willow Ward	Systems & Procedures - Visiting Hours
24/09/2025	Peter Bruff Ward	Clinical Practice - Lack of Support
29/09/2025	Peter Bruff Ward	Clinical Practice - Medication
02/10/2025	Outpatients Latton Bush Centre	Clinical Practice - Medication
02/10/2025	Robin Pinto Unit	Clinical Practice - Medication
08/10/2025	Dune Brockfield House	Assault / Abuse
13/10/2025	Larkwood Ward	Systems & Procedures - Visiting House
23/10/2025	Galleywood Ward	Clinical Practice - Ground Leave

Received	Service	Enquiry related to
23/10/2025	Wood Lea Clinic	Assault / Abuse
27/10/2025	Stort Ward	Systems & Procedures - Transfer

3.4. CQC Notifications

During the reporting period (September/October) the Trust has made sixteen (16) notification submissions to the CQC including:

- Absent without leave (5)
- Death of a person using the service (6)
- Serious injury to a person using the service (5)

4. Independent Assurance against CQC Quality Statements

4.1. Internal Assurance (Annual Assurance Visit Programme)

The Trust annual assurance visit programme to promote and monitor adherence to the fundamental standards of care (CQC registration requirements) for 2025-26 continues.

At the end of October 2025, the Trust is reporting 'Good' compliance across all the five domains. This means that a satisfactory level of assurance has been provided by core services during Compliance visits (noting the limitations of these reviews). Identified good practice has been shared with services and care unit leadership via Risk & Compliance reports to Care Unit leadership and Quality and Safety Meeting and Accountability reports.

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

4.2. Internal Assurance (Quality Statements Assurance Framework)

The Quality Statement Assurance Framework continues to be developed to provide trust-wide assurance of compliance with the CQC quality statements/regulatory requirements. This includes review of the thirty-four quality statements against mapped policies/guidelines, committees, feedback methodology, performance indicators, audit data and outcomes. Quality statements that have been reviewed are presented to the Joint Care Unit CQC and Quality of Care Group meetings for insight.

To date, all the safe domain quality statements have been reviewed, and work is underway looking at the effective domain. Where gaps are identified, actions are developed for local and trust-wide improvements.

4.3. Quality Assurance Visits

The Quality Assurance Visits have continued during the reporting period. Four visits were completed and multi-stakeholder reports providing areas of good practice and areas for improvement are highlighted back to the relevant service and Care Unit leadership and followed through the risk and compliance reports provided to the accountability framework governance.

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 Chief Nurse

Appendix 1

CQC Action Plan Update Report

31 October 2025

Introduction

Level of Assurance: Level 1

NHS 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/PFD action plan 02.

The CQC/PFD action plan has been developed in line with Trust process which focuses on engagement, sustainability and ownership of actions. The plan aims to bring together key action plans in the Trust to ensure consistency of delivery, avoidance of duplication and consistent assurance routes. For the outgoing improvement plan, this included:

Version 02 of the action plan includes:

- CQC report Core Services and Well Led (published July 23) – 3 actions remained open at closure of version 01 and have transferred into the new action plan
- CQC report Forensic Services (published April 2025)
- CQC report Acute Wards for Adults and PICU (published July 2025)
- PFD action plans open as at August 2025

Key Messages

CQC Activity

The CQC have issued their inspection report for LD Inpatient services (Byron Court).

CQC Action Plan v02 (2025)

13 CQC improvements being taken forward, this includes 3 must do actions previously issued by the CQC, 4 Regulation Breach actions (RA) and 6 Improvement Actions (IA). Please see slide 4 for progress.

For note,

- 2 actions are in recovery (CCTV access for learning and Activity Cancellation KPI reporting)
- 1 action awaiting update to confirm complete (Risk assessment reviewed following an incident)

Action monitoring is undertaken at the monthly Quality of Care Group which holds action owners to account for delivery. The meeting is chaired by the Executive Chief Nurse. Monitoring is also undertaken at Operational CQC/PFD meetings which take place weekly.

Evidence assurance is presented to the Learning Oversight Group before CQC concerns are closed.

Next Steps

Focus on delivery of actions due in November/December 2025
Call in evidence for actions reported as completed by action owners.

CQC Action Progress Update

NHS Essex Partnership University NHS Foundation Trust

Summary of implementation status

As of the 31 October 2025:

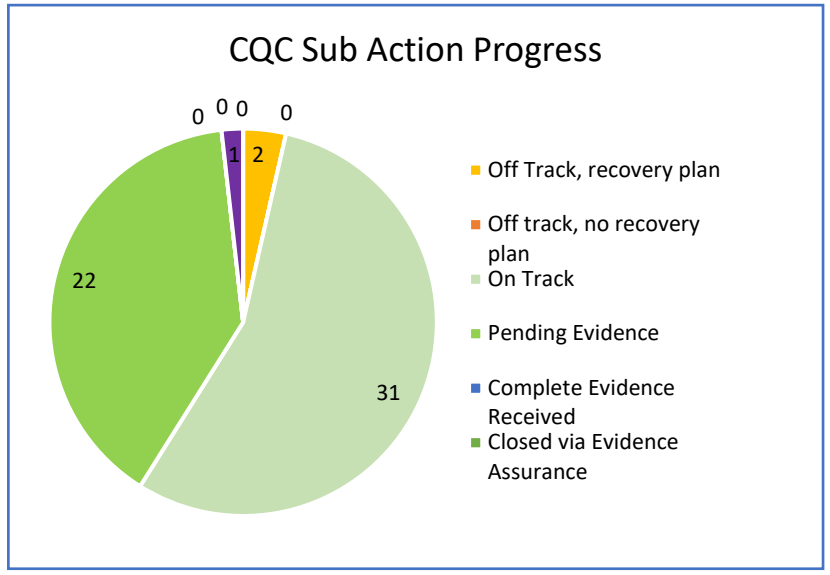
- 13 regulatory and improvement actions made up of 56 sub-actions to address the improvements required.

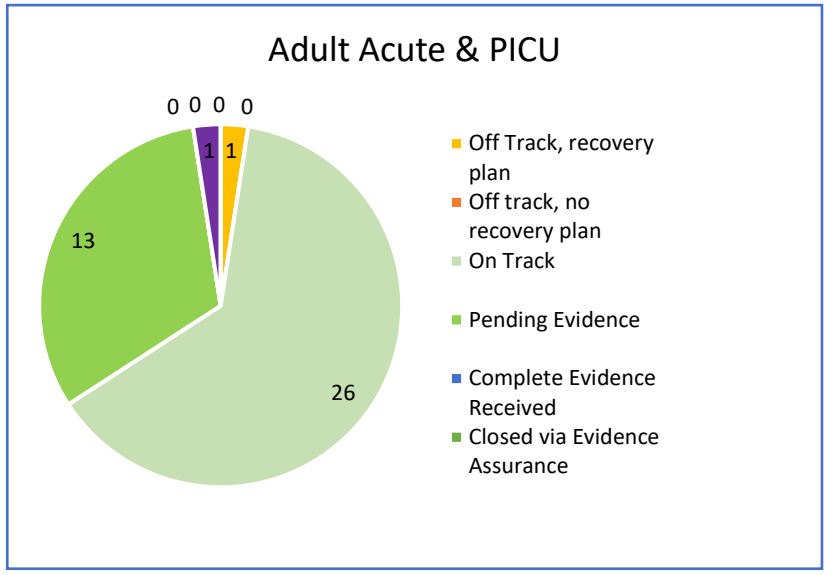
- Of the 56 sub-actions
  - 2 (4%) are in recovery (CCTV, Activity Cancellation KPI reporting)
  - 31 (55%) are on track
  - 22 (39%) reported as complete and pending evidence
  - 1 (2%) awaiting update to confirm complete (Risk assessment reviewed following an incident)
- 0 (0%) have been closed through the evidence assurance process

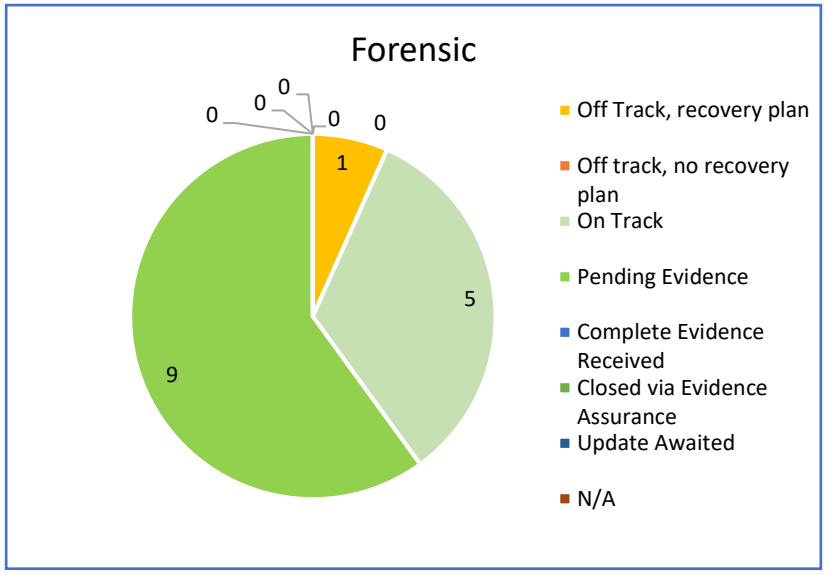
Summary of key activities completed in the reporting period

Actions completed (pending evidence) in the period:

- Patient peer support discussed with patients in Forensic services and focus is on creating a patient focus group.







CQC Action Recovery Plan

Action Recovery Plan				
CQC Concern	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M6: (July 2023 – MH Inpatient Adults) 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. 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 the downloading footage. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona
IA2.4 (April 2025 - Secure Inpatients) Nine patients said that activities were cancelled all the time due to staffing.	IA2.4 Develop and present a quarterly activity KPI report through Care Unit governance, including narrative and mitigations for any cancelled activities.	Work in progress to develop report, all vacancies recruited to, activity programmes available on wards and Therapy Corridor is soon to be open. (Original timescale Sept. 25).	Monthly update to Joint Care Unit and operational Meeting **Recovery Date Jan 2026**	Vijay Chuttoo / Gemma Robertson

SERVICE PROVIDER

Essex Partnership University NHS Foundation Trust

This is an organisation that runs the health and social care services we inspect

Overall **Requires improvement**

Services have been transferred to this provider from another provider

Services have been transferred to this provider from another provider

Report from 19 November 2025 assessment

Ratings - Wards for people with learning disabilities or autism

Overall	Requires improvement
Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good

Well-led

Requires improvement

Our view of the service

We carried out an assessment of Essex Partnership University NHS Foundation Trust, wards for people with a learning disability and autistic people between 16 July 2025 and 23 July 2025. The team visited Byron Court.

Byron Court is a mixed-gender assessment and treatment unit based in Billericay. It is commissioned for 7 beds; however, the trust is commissioned for 11 beds across Essex as part of the Essex Learning Disability Partnership. At the time of our inspection there was 1 person currently at Byron Court.

The team carried out a comprehensive inspection, covering all the quality statements in all key questions.

Byron Court was previously inspected and rated as requires improvement. Following this inspection, the rating remains requires improvement. We rated the service as requires improvement because we found a breach of the legal regulations in relation to Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

Governance systems and audits were not effective in identifying or addressing the areas for improvement that we identified at this inspection.

During our inspection we found there were still concerns as identified at the previous inspection relating to care and treatment records.

Since the last inspection, the service had made improvements to most of the previous concerns we had identified, where 5 out of 6 concerns were now met. We found improvements in staffing; the service now had enough permanent regular nursing and support staff to keep people safe. The service had ensured that blood glucose machines were fully calibrated. The service had ensured that staff accurately recorded administration of medicines, and that consent to treatment forms were accessible. The service had ensured staff recorded people's vital signs in the physical health observation charts. The service had ensured that staff had access to specialist learning disability and autism training.

People's experience of this service

During this inspection we spoke with 1 person and 1 carer. Feedback was positive, and the person we spoke with said staff were kind and respectful, they met regularly with their named nurse, staff were available when they needed support, they felt safe on the ward and were supported to understand risks and how to keep safe. The person we spoke with said they were given a de-brief after incidents. They said staff asked for their feedback about the ward, and they knew how to make a complaint if they needed to, there was a good choice of activities and food on the ward, they were given information about their care and treatment and felt involved in making decisions.

The carer we spoke with said staff were helpful, supportive, welcoming and open to ideas on how to best support their relative, they said the ward was clean and tidy, the food was good, and the staff shopped for their relative's needs. The carer we spoke with said they felt the whole package of care was individualised to their relative's needs, they had a copy of the care plan and were very involved in the reviews of this. They also told us they had been involved in improving and developing the service.

Throughout the inspection we saw positive interactions between staff and people. We saw staff communicate in a way that was suitable for the persons communication needs.

Safe

Good

13 November 2025

We looked for evidence that people were protected from abuse and avoidable harm. At our last assessment, we rated this key question as requires improvement. At that assessment the service was in breach of regulation 12 safe care and treatment and regulation 18 staffing. At this assessment, the rating changed to good.

This service scored 72 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Learning culture

Score: 3

The service had a proactive culture of safety based on openness and honesty, in which concerns about safety were listened to, safety events were investigated, reported thoroughly, and lessons learned to continually identify and embed good practice.

Staff knew what incidents to report and how to report them. Staff reported incidents clearly in line with trust policy. Staff recorded incidents on an electronic incident reporting system. All incidents were reviewed by the ward manager. In the last 12 months, staff had reported 33 incidents. Incidents included self-harm, assault and contact with an object. There were 24 incidents classified as no harm and 9 incidents of low/minor harm. We reviewed these incidents, and they included how staff managed the incident, lessons learned from incidents and actions taken to embed learning.

Staff were de-briefed and received support after an incident. People were de-briefed after incidents in ways that supported their communication needs. The person we spoke with told us they had received a de-brief after incidents, and they found them helpful.

Leaders investigated incidents. Leaders and staff were able to give examples of learning from recent incidents, which had identified training needs for staff, this additional training had been organised by leaders, learning from this was also discussed in team meetings and supervisions, we observed this in minutes from meetings and supervision records.

Staff received feedback from the investigation of incidents, staff met to discuss feedback, lessons learned and to continually identify and embed good practice.

Staff understood duty of candour. They were open and transparent and gave people and families a full explanation when things went wrong.

Safe systems, pathways and transitions

Score: 3

The service worked with people and partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. The service ensured continuity of care, including when people moved between services.

People told us they felt safe on the ward, people said when they were admitted they were given a welcome pack with information in their preferred communication method. Carers told us the ward was welcoming, they said they had been involved in discussions about discharge planning but at present their relative wasn't ready for discharge.

Throughout people's stay on the ward they were visited regularly by the community team to prepare for discharge.

From April 2025 to June 2025 the service had 1 delayed discharge each month. The service attended a fortnightly 'Building the Right Support' meeting with all system partners where discharge pathways for people were discussed. There was also an additional meeting held fortnightly with aim to give oversight and escalation of people who were classed as delayed discharge. The meeting was chaired by the transforming care lead.

The ward team had effective working relationships with teams outside of the service. For example, external teams told us that multidisciplinary team working between both teams on planning and sustaining discharge was really positive, they felt the investment of the team at Byron Court supported them to achieve their function, and there was a strong person-centred approach.

Safeguarding

Score: 3

The service worked with people to understand what being safe meant to them as well as partners on the best way to achieve this. The service concentrated on improving people's lives while protecting their right to live safely, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect.

Staff received training in safeguarding at levels 1, 2 and 3 and staff kept up to date with their safeguarding training. Staff compliance with safeguarding training level 1 was 100%, level 2 was 85.7% and level 3 was 90.9%.

Staff knew who to inform if they had a safeguarding concern. In the last 3 months, 3 safeguarding referrals had reached the threshold for investigation by the local authority. These investigations related to self-harm, lessoned learned had resulted in actions taken by the ward manager, including, extra support and training for staff, competency checks and regular discussion in supervisions and team meetings, a self-harm safety plan had also been developed with the person, this detailed the reasons the person self-harmed and different ways staff should support them. When safeguarding incidents involved staff members, leaders took action to ensure the incident was investigated thoroughly, and the person was then made safe and supported. Staff at the service worked alongside the local authority in conducting all safeguarding investigations. We saw evidence of staff supporting a person by raising a safeguarding alert when the person had disclosed allegations regarding a previous placement.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff could give examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff followed clear procedures to keep children visiting the ward safe. Children were not permitted to visit people on the wards. Visits from children took place in other areas.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. People were only restrained only where evidence demonstrated it was necessary and for the minimum period of time. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

In the previous 3 months there had been 17 episodes of restraint, this had reduced each month, in May there was 9 episodes, in June there was 6 episodes and in July there was 2 episodes. Rapid tranquilisation had been used on 5 occasions between May 2025 and July 2025. At the time of our inspection 81.8% of eligible staff had received trauma and self-injury (TASI) training, 3 staff had not completed the training due to known circumstances and were unable to complete it at this time. Leaders attended regular restrictive practice group meetings.

Involving people to manage risks

Score: 2

The service did not always work with people to understand and manage risks by thinking holistically so that care met their needs in a way that was safe and supportive and enabled them to do things that matter to them.

Staff completed risk assessments for people on admission and reviewed these regularly, including after any incident. Staff told us they involved people and carers in care planning and risk assessment. People and carers told us that staff met with them regularly to review care plans and positive behaviour support plans, they felt they were included in care and treatment and able to contribute.People had signed their care plan and had a copy, carers also told us they had a copy of the care plan.

Staff had co-produced a personal safety plan for self-harm with a person. It detailed the reasons the person may self-harm, and different ways staff should support the person, depending on the reason and emotion they were feeling, there was a display of emotions the person could point to,as they found it difficult to communicate when they were feeling distressed. The person said they felt well supported and safe.

Where there were restrictions on people's freedom, these were discussed and recorded. The service had a list of prohibited items. The service had an easy read version of the blanket restrictions and prohibited items in place. People did not have unrestricted access to outside space, however, staff facilitated access to the garden. People said they felt the restrictions on the ward made sense. Carers told us their relative was safe on the ward and staff managed safety well.

Staff we spoke with showed a good understanding of the management of risk and reducing restrictive interventions. Staff spoke about using restraint and seclusion as a last resort and examples of interventions they would use to manage and de-escalate situations, staff were aware of people's positive behaviour support plans and referred to this, staff said they found them helpful. However, the positive behaviour support plan for a person on the ward was not located on the first day of the inspection as the ward manager told us it had not been completed yet and they were using a plan from a previous service.

The trust had a reducing restrictive interventions policy which included guidance and procedures for managing and reducing restrictive practice. The trust held monthly restrictive practice group meetings, we reviewed the minutes from these meetings, where all areas of restrictive practice were presented. People we spoke with said they felt safe on the ward and that restrictions on the ward made sense.

Safe environments

Score: 3

Staff completed and regularly updated thorough risk assessments of ward areas and removed or reduced any risks identified.

Staff regularly reviewed the environment, identified and managed ligature risks, and mitigated risks quickly to keep people safe. The service had recently purchased anti ligature furniture for the dining room. Leaders ensured staff on the ward had easy access to ligature packs with information on environmental risks, this included a map of hotspot areas. Staff we spoke with knew about any potential ligature anchor points and knew where ligature cutters were located, staff could describe mitigations taken to reduce risk to people's safety. We saw from staff meeting minutes that ligature audits, and their findings were shared and discussed.

Staff could not observe people in all parts of the ward. This risk was identified and recorded within the ligature risk assessment and mitigated using convex mirrors, CCTV and staff observations. At the time of our inspection 100% of eligible staff had completed suicide by ligature prevention training.

The ward used CCTV in communal areas and could use this to review safety incidents. There was a sign to let people and visitors know about the use of CCTV. At all times, 2 members of staff wore body worn cameras, this always included 1 person allocated to observations.

The service was a mixed sex ward; there was a male bedroom corridor and a female bedroom corridor. The corridors were kept unlocked and people had keys to their own bedrooms and people could access their bedrooms without asking staff. There was a process in place for staff to continuously observe the corridor doors when people were present in the communal areas to ensure safety and wellbeing. Estates work had recently been completed and the corridor doors had been moved back towards the bedroom areas to offer more communal space and access to the laundry and sensory room.

Staff had easy access to alarms and people had easy access to nurse call systems, staff also had access to a mobile phone. The service had also purchased radios and were waiting for their radio licence before introducing these.

The service had policies to follow fire and safety practices on site. There was a fire escape plan and fire action notices on the ward which showed the assembly point.

The ward had a dedicated seclusion room. Staff needed to look through 3 different windows to ensure constant observation. There was digital clock with the time and date opposite the room that could be seen if the blind was kept open. The seclusion room had no division between the toilet and sink area and the main seclusion room, there was no shower, people would need to be escorted across to the shower in the Long-Term Segregation area. Leaders told us that there was a plan in place to refurbish the seclusion room, and the funding had been agreed, the plan included changing the layout of the room and included a shower.

Each person had their own bedroom and en-suite bathroom, which they could personalise. People had a secure place to store personal possessions in their bedroom.

The ward had a range of rooms and equipment to support treatment and care. The ward had a quiet room and quiet areas people could use. The ward had a room where visitors could come and meet people, there were alternative rooms off the ward to use if a child was visiting. The ward had a communal living room.

Safe and effective staffing

Score: 3

The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development and worked together effectively to provide safe care that met people's individual needs.

The service had enough nursing and support staff to keep people safe. At the time of our inspection Byron Court had capacity for 7 people. Leaders had calculated the number and grade of nurses and healthcare assistants required based on people's needs.

The service had low vacancy rates. The service did not use agency staff, the service used regular bank staff where needed. Over the last 3 months there had been an increase in the use of bank staff; which leaders told us was due to sickness, annual leave, training, and people's needs. When bank staff were used, they had received the trust induction and training and were familiar with the ward, staff and people.

The service had a high turnover rate. For the last 12 months, staff turnover for the service in June 2025 was 19.6%, this exceeded the trust target of 12%. The service had a high staff sickness rate of 11.5% in May 2025, this exceeded the trust target of 5%.

The ward manager could adjust staffing levels according to the needs of the people. Staffing needs were discussed daily in meetings.

Staff levels allowed people to have a regular one-to-one time with their named nurse. Throughout the inspection we observed enough staff on the ward to facilitate activities. People and carers told us there was always enough staff.

There were enough staff to carry out physical interventions and observations safely and staff had been trained to do so.

There was adequate medical cover day and night, and a doctor could attend the ward quickly in an emergency.The service operated an out-of-hours rota for doctors.

Staff had received appropriate mandatory training. Staff compliance with mandatory training was between 81.8% and 100%; this was due to sickness and a new staff member.

Staff compliance with The Oliver McGowan mandatory training on learning disability and autism was 100%. Additional to this, staff at Byron Court completed specialist learning disability and autism training, This had improved since our last inspection.

The mandatory training programme was comprehensive and met the needs of people and staff. Leaders monitored mandatory training and alerted staff when they needed to update their training.

The service had access to a range of specialists to meet the needs of people on the ward. The service employed a matron, ward manager, deputy ward manager, doctors, nurses, healthcare assistants, psychologists, speech and language therapists and occupational therapists.

Leaders ensured staff had the right skills, qualifications and experience to meet the needs of the people using the service, Leaders had identified that although they had a stable staff team a lot were newer staff, so they had organised extra training sessions to support progress and upskill them.

All staff attended the trust induction programme and shadowed experienced staff before they were fully incorporated into the staff numbers.

Leaders supported permanent staff to develop through yearly, constructive, comprehensive appraisals of their work. At the time of our inspection, 85.9% of staff had received an appraisal.

Leaders supported staff through regular constructive and comprehensive supervision of their work. At the time of our inspection 100% of staff had received supervision.

Leaders recognised poor performance, could identify the reasons, and managed these. The ward manager had identified concerns around observations and as part of the learning from this had organised additional training for staff, carried out competency checks, and followed up by regularly discussing observations in supervisions and in regular monthly team meetings.

Infection prevention and control

Score: 3

The service assessed and managed the risk of infection, detected and controlled the risk of it spreading and shared any concerns with appropriate agencies promptly.

The ward area was visibly clean, tidy and had good furnishing. The ward kept up-to-date cleaning records that demonstrated that the ward area was cleaned regularly. Staff maintained equipment well and kept it clean. The service followed their infection control policy, including hand washing. The service carried out monthly infection prevention and control audits, which included checks on personal, protective equipment (PPE), handwashing, equipment, cleanliness and mattresses. In April and May 2025, the service scored 100% on these audits.

People and carers told us the ward was always clean and tidy.

Staff completed Infection, Prevention and Control training. Compliance in June 2025 for level 1 was 100% and level 2 was 92%.

The trust had a detailed Infection Prevention Control policy, which was reviewed regularly. A policy 'at a glance' with staff responsibilities was also available.

Medicines optimisation

Score: 3

The service ensured that medicines and treatments were safe and met people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happened.

Staff accurately recorded administration of medicines. This had improved since our last inspection. Staff followed good practice in medicines management (which included, transport, storage, dispensing, prescribing, administration, medicines reconciliation, recording and disposal) and in line with national guidance. There were specific systems in place for the management of controlled drugs and medicines that were liable to be misused.

Medicines were stored appropriately. Medicines cupboards were locked when not in use. Medicines prescribed for individual people were labelled and stored correctly. Staff kept up-to-date information about stock. Details of pharmacy contacts were displayed for staff to see easily. Staff knew how to dispose of medicines and associated equipment safely. Staff kept accurate records of medicines. Sharps bins were available on the ward and were marked with the date of opening, as needed. Staff kept records of national medicines alerts and recorded what action they needed to take to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service reviewed people's medicines regularly and provided advice to people and carers about their medicines. People's medicines were reviewed as part of their overall review of their progress at ward rounds. Staff provided information about possible side effects. People were involved in discussions about medicines and care planning. Pharmacists carried out medicines audits. The clinic room was clean, orderly and fully equipped. Cleaning records were available and completed. Staff recorded daily room and fridge temperatures to ensure the safe storage of medicines.

Blood glucose machines were fully calibrated. This had improved since our last inspection. Equipment to support physical health care was available, regularly cleaned, audited and calibrated in line with manufacturer guidance.

The service had emergency medicines and emergency equipment available. Its location was clearly marked in clinic rooms. There was an oxygen cylinder available in the clinic room which was in date. Records showed staff carried out regular checks of the defibrillator and resuscitation equipment.

Page top

Effective

Requires improvement

13 November 2025

We looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At our last inspection, we rated this key question as requires improvement. At this inspection, the rating remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was consistent.

This service scored 58 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Assessing needs

Score: 2

The service maximised the effectiveness of peoples care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. However, not all information about people carried through all of their care and support plans.

Staff completed a comprehensive assessment of people in a timely manner at, or soon after admission. Staff regularly reviewed and updated this assessment at regular time points during their stay at the service.

We reviewed minutes from multidisciplinary meetings, these evidenced people's care and treatment being reviewed by the multidisciplinary team, people and their carers with a person-centred approach being taken to meet people's needs.

Records showed that staff assessed people's communication skills and needs and provided information in a way that was tailored to those needs. For example, the speech and language therapist had completed an assessment of a person, identifying the need for easy read documents. An easy read version of the care plan had been developed and a copy given to the person.

The service had an easy read assessment tool for people with a learning disability receiving psychological therapy. We saw evidence that this has been used successfully with people to assess for anxiety, depression and self-esteem.

We reviewed a person's 'about me' book, this provided comprehensive, valuable, person-centred information. This included, how to support the persons communication needs, understand their likes, dislikes and triggers, how they present when they are well, how to support them to stay well and what helps them if they become unwell. It also included information on the persons physical health needs and how they should be supported.

There was a sensory assessment, screening tool undertaken for people by speech and language therapists. Staff said they were aware of this, had access to it and found it helpful. The document had detailed information about the persons sensory needs and how to support them. When looking at a person's records, we observed that in their positive behaviour support plan it stated they had ear defenders, however this information was not within the person's care plans.

Staff assessed people's physical health needs in a timely manner after admission, and this was reviewed regularly during their time at the service.

Delivering evidence-based care and treatment

Score: 3

The service planned and delivered peoples care and treatment with them, including what is important and matters to them and in lines with legislation and current evidence based good practice and standards.

Staff provided a range of care and treatment interventions suitable for the patient group.

The National Institute of Health and Care Excellence (NICE) recommends that services supporting autistic people should have access to psychosocial interventions for support with managing the core features of autism and building upon life skills. For example, people should have a group or individualised based social learning programme and/or a group of individual activity programme. Where the person may also communicate distress through behaviour, positive behaviour support plans should be used. People had a positive behaviour support plan; there was a grab sheet and a more detailed plan. Staff met with people and carers regularly to review these plans. Staff we spoke to said they were aware of these plans, had access to them, and found them helpful.

The service provided therapeutic activities and support with life skills, facilitated by occupational therapists, psychologists and speech and language therapists. People told us there was a good choice of activities including painting, drawing and cooking. People had requested to do some cooking on the day of our visit and staff had facilitated this.

Staff assessed and met people's needs for food and drink.

How staff, teams and services work together

Score: 2

The service worked effectively across teams and services to support people, making sure they only needed to tell their story once by sharing their assessment needs when they moved between services.

Staff had regular and effective multidisciplinary meetings. There were professionals involved in the assessment and review of people's health, care and treatment, wellbeing and communication needs. Professionals were engaged in reviews and assessments; However, it was unclear how this translated into care plans which were not comprehensive.

Staff shared information about people at effective handover meetings within the team. Nurses and healthcare assistants shared information at the end of each shift. The multidisciplinary team met regularly to review risks and incidents.

The ward team had effective working relationships with other teams within and external to the organisation. They worked closely with the community team, who visited the ward regularly.

Supporting people to live healthier lives

Score: 1

The service did not always support people to manage their health and wellbeing so they could maximise their independence, choice and control, live healthier lives and where possible, reduce their future needs for care and support.

Staff made sure people had access to physical health care, including specialists when required. People could access healthcare appointments that were unplanned, such as accident and emergency, because staff and leaders had devised support plans that worked for people. Plans were created with people, their carers, health professionals and social care professionals. However, these plans were not clearly documented in the persons hospital passport, there was a lack of detail to enable a person looking at it to correctly support the individual. We found a person at high risk of harm when attending hospitals had no information about the specific risks or their support needs for attending a hospital in their hospital passport. We highlighted this to leaders on the first day of our inspection, when we returned a week later for the out of hours visit, this document had been updated with more detailed information.

People had a health action plan, when we looked at this it had also not been fully completed or updated. It contained a handwritten list of medicines, but no information on what the medicines were prescribed for, any health conditions or records of health appointments. This left people at risk of unsafe care and treatment due to a lack of knowledge about their health conditions and how these impacted them. When we returned for our out of hours visit a week later, this document had been completed with the relevant information.

Staff recorded people's vital signs on National Early Warning Scores (NEWS) charts. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients. Charts were completed, where a person had refused physical health checks, this was documented, and we observed staff discussing this at handover.

We looked at an 'all about me' folder, this contained detailed information about the person's physical health needs and how staff should support them.

Monitoring and improving outcomes

Score: 3

Staff continuously monitored people's health, their mental state and wellbeing.

At daily handover meetings, staff noted details of people's sleep, food and fluid intake, personal hygiene, compliance with medication and engagement in activities. Any changes in a person's presentation were discussed at the multidisciplinary meetings.

The Occupational Therapy team used the Model of Creativity (Vona du Toit) to assess people's level of functional ability and needs. The outcome measure used is the Activity Performance Outcome Measure (APOM) which was used to compare initial level of functional ability with pre- and post-discharge functional ability. This was used to monitor the effectiveness of treatment and as evidence for the support and environment needed for people.

Nursing staff used the Health Equalities Framework (HEF) this was used to measure the effectiveness of the service delivery in terms of reducing exposure of people with a learning disability to known detriments of health inequalities.

In addition to formalised outcome measures, the service sought feedback and suggestions from people, relatives, carers and staff to support the identification of service development. For example, recently people had selected the murals to be displayed in the sensory room and day room to uplift the environment.

Consent to care and treatment

Score: 3

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Staff assessed people's capacity to consent to admission and treatment. Staff assessed people's capacity for specific decisions throughout their care and treatment. Records included information about people's capacity and how through their preferred communication, they were able to refuse or give consent for specific decisions. Staff we spoke with told us if people lacked capacity to make a specific decision, staff made decisions in their best interests, recognising the importance of the person's wishes and involving their carers.

Staff took all practical steps to enable people to make their own decisions. People made their own choices and decisions on a day-to-day basis about what they did, what they ate and how they filled their time.

We observed staff mainly communicating with people about their choices, using simple sentences. People had easy read documents to support with communication but mainly preferred to communicate verbally.

Carers told us staff explained consent, confidentiality and how they share information.

Caring

Good

13 November 2025

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At our last inspection, we rated this key question good. At this inspection, the rated has remained good. We observed positive and caring interactions between staff and people. This meant people were supported and treated with dignity and respect and involved as partners in their care.

This service scored 70 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Kindness, compassion and dignity

Score: 3

The service treated people with kindness, empathy and compassion and respected their privacy and dignity.

The service ensured that people using the service were supported by staff in an appropriate and supportive manner, treated them with kindness and understood their individual needs.

Staff attitudes and behaviours when interacting with people showed that they were friendly, respectful and responsive, providing people with help, emotional support and advice at the time they needed it. We observed positive and kind interactions between staff on both our day and out of hours visit.

Staff supported people to understand and manage their care, treatment or condition. Staff provided one-to-one sessions with people and carers to go through their risk assessments, care plan and options for therapeutic activities. Staff supported people to engage in meaningful activities. We observed a community meeting where a person had requested to do some cooking that day, the staff discussed with the person what they would like to cook and the ingredients they would need to use, and staff facilitated this activity.

People said staff treated them well, were kind and supportive and were available when they needed support, carers also said staff were really helpful, supportive, welcoming and open to ideas on how to best support their relative.

Staff understood the individual needs of people, including their personal, cultural, social and religious needs. Staff supported people to maintain and develop their social skills and meet their sensory needs through various activities and tools.

Staff followed policy to keep people's information confidential. Information held on electronic systems was protected. Paper records were held in the nursing station which was kept locked.

Treating people as individuals

Score: 3

The service treated people as individuals and made sure their care, support and treatment met their needs and preferences, considering their strengths, abilities, aspirations, culture, backgrounds and protected characteristics.

Staff within the service had a good understanding of people's mental health, their risk history and their social circumstances outside of the hospital. Occupational therapists supported people to pursue their interests and hobbies. For example, staff supported a person who enjoyed drawing and painting to do this, and they were able to personalise their room with their artwork.

People said they always felt involved in their care and treatment and felt able to make suggestions. One carer said they felt the whole package of care was individualised to their relative's needs and staff were flexible around things such as the food provided on the ward.

Independence, choice and control

Score: 2

The service did not always promote people's independence, so they knew their rights and had choice and control over their own care, treatment and wellbeing.

People and carers told us that staff met with them regularly to review care plans and positive behaviour support plans, they felt they were included in care and treatment and able to contribute. However, we reviewed 1 person's care records, and the person's voice was not always clearly documented.

Staff had co-produced tools with people to support their care, a person had worked with staff to produce something that would help them monitor how they were feeling each day, the person and staff had found this useful, and we observed this being discussed between staff at handover. People were provided with a variety of therapeutic and recreational activities to join, to support their skills and wellbeing.

Staff ensured people could access information on their rights and how to complain. Information about the Mental Health Act and making complaints was displayed on the ward. People were supported to understand their rights by using different ways to communicate, the ward had easy read documents for people that used them.

People and carers were positive about the food and said that people's individual needs and preferences were catered to. People had supervised access to the kitchen, this had been risk assessed and regularly reviewed. Staff supported people in the kitchen when they wanted to access drinks and snacks, however, on our first visit the fridge and cupboards did not contain milk or any food. There was also a hot water urn in the small kitchen which was unsafe for people to use to make a drink. People had a snack box that contained chocolate and sweets. This concern had been raised at an external review of the service but had not been acted on. On our out of hours visit a week later we observed a variety of drinks and snacks on the dining room table for people to access, people said that they could always get drinks and snacks when they wished and staff opened the kitchen when requested.

Responding to people's immediate needs

Score: 3

The service listened to and understood people's views and wishes. They responded to these and acted to minimise any discomfort, concern or distress.

People told us that staff were mindful of their privacy and confidentiality. We observed interactions between staff and people who used the service and saw that these relationships were caring and compassionate, enabling staff to anticipate and meet people's needs quickly and in ways that reduced and mitigated people's discomfort and distress. Staff had co-produced a safety plan with a person that enabled staff to best support the person when they were feeling distressed.

People told us they felt listened to and their feelings were respected. People felt able to approach staff with concerns. We observed people seeking staff support when they had things they wished to discuss. People also felt able to voice their feelings and give feedback in community meetings.

The ward had a new sensory room, which had been co-designed with people using the service, the sensory room was a nice space, with a variety of sensory equipment that had been chosen by people. Staff said the sensory room was used frequently, a person on the ward, would sometimes request to sleep over in the sensory room, which staff had facilitated.

Workforce wellbeing and enablement

Score: 3

The service cared about and promoted the wellbeing of staff and supported and enabled them to deliver person centred care.

Staff had access to chaplaincy and spiritual care, which provided for the spiritual and religious wellbeing needs of staff.

Adjustments were made for staff to support them in their roles. This included reasonable adjustments to working patterns, implementing a flexible working pattern, alongside adjusting staff duties if there were any changes to their physical health.

The service had an employee wellbeing offer for staff. This included an employee assistance programme, psychological support, fast track physiotherapy, post-incident support and occupational health.

The service displayed thank you cards received from discharged people and their relatives/carers, as well as from student nurses who had completed their placements on the ward. Success and recognitions were recorded in the service's supervision records which had a praise section. The celebration and successes for individuals and the whole team were also shared trust wide via internal communication articles. The ward's chef had been recognised for their passion for their work, and the matron had received a high commendation in the trust wide hero and lifetime achievement awards. The service had been recognised for the new sensory room which had been co-designed with people using the service.

Staff told us morale at the service had significantly improved recently. The service had a new ward manager who staff said was approachable, supportive and engaged with staff. Staff said they found senior leaders at the service very supportive. Staff and leaders had identified areas where staff required more support. Extra training had been organised for staff and regular discussions had been had with staff in team meetings and supervisions.

Responsive

Good

13 November 2025

We looked at evidence that the service met people's needs. At our last inspection we rated this key question as good. At this inspection, the rating had remained as good, this meant people's needs were met through good organisation and delivery.

This service scored 75 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Person-centred Care

Score: 3

The service made sure people were at the centre of their care and treatment choices and decided in partnership with them, how to respond to any relevant changes in their needs.

People were involved in co-producing their own care and support plans with staff and these were reviewed and updated regularly. Staff, people and carers said staff regularly met with people and carers to understand their views on care and treatment. These discussions took place in one-to-one meetings with their named nurse and in multidisciplinary team meetings. However, the persons voice was not always clearly recorded. People said they had a copy of their care plan, and this was in an easy read format where required.

Staff monitored people's conditions and discussed any changes at handover meetings, we observed good discussion at handover meetings around people and things that were working well, with staff sharing ideas and advice. People said they regularly met with their named nurse and were involved in their care and treatment, people said they felt able make suggestions at multidisciplinary meetings and felt supported to understand risks and how to keep safe.

The service had an activity coordinator that worked during the week as well as weekends and was responsible for offering and organising leisure-based activities, the activity coordinator was also responsible for ensuring people had the resources and equipment for activities. People had an activity box which had activities designed for them based on their concentration and cognitive needs. Activities were also supported by the ward staff. Therapists attended ward rounds on a Monday and therapy sessions were planned and scheduled during the ward round. Carers told us their relative's care was individualised to meet their needs, and they had regular contact with staff to discuss care and treatment.

Care provision, Integration and continuity

Score: 3

The service understood the diverse health and care needs of people and local communities, so care was joined up, flexible and supported choice and continuity.

Where appropriate, staff made sure people had access to opportunities for education and work. The trust had employment specialists who provided focussed support to people who wanted to explore employment, paid or voluntary opportunities as well as any education programmes that may have been of relevance. For example, a person who had been at Byron Court, was in the process of completing training to become an Expert by Experience for the trust wide Oliver McGowan training programme. Staff had supported the person to attend a trust event that was recruiting for that role. People that had expressed an interest in following a pursuit like this were encouraged to do so and introduced to the Lived Experience Involvement Group. Staff told us that there had been a person on the ward who prior to being admitted had regularly attended college, but on being admitted were not well enough to attend, so staff had arranged for the college to come to them on the ward so that the person could continue with things that were important to them.

Where appropriate, people were supported to access the community to attend various therapeutic activities including, cycling sessions and Sports for Confidence. People were also supported to assess and develop community access, road safety and money skills.

Staff helped people to stay in contact with their families and carers. People said they were supported to have regular visits and phone calls from their family. Carers said the ward was supportive and welcoming and there was always enough staff around, in a non-intrusive way. We observed staff supporting people with phone calls and visits from family.

Providing Information

Score: 3

The service provided appropriate, accurate information in formats that were tailored to individual needs.

Staff ensured people could access information on treatment and local services, in formats tailored to individual needs. There were folders on the ward with easy read information about things like activities, safeguarding, the Mental Health Act, mental health advocacy and how to make a complaint.

Across the ward we saw easy read signs for things such as, what each room was and what different drawers in the kitchen were used for. There was also a folder in nurses' station with a variety of symbols.

Staff had access to equipment and information technology needed to do their work. The nurse's station had enough room and access to computers for staff to be able to sit and do their work.

Leaders had access to information to support them with their management role. This included information on the performance of the service, staffing and people's care. This information was presented and discussed in clinical governance meetings.

Staff made notifications to external bodies as needed. The service submitted notifications to the Care Quality Commission in accordance with requirements. The service submitted safeguarding referrals to the local authority.

Listening to and involving people

Score: 3

The service made it easy for people to share feedback and ideas or raise complaints about their care, treatment and support.

People, relatives and carers knew how to complain or raise concerns. People said if they had any complaints, they would speak to staff or the ward manager in the first instance. There was information on the wards in easy read format about how to make a complaint and advocacy.

Staff understood the policy on complaints and knew how to acknowledge and handle them. Staff and leaders told us people received feedback after investigations into complaints. Staff received feedback on the outcome of investigations into complaints and acted on the findings. In the last 12 months, the ward had not received any formal complaints.

Equity in access

Score: 3

The service made sure that everyone could access the care, support and treatment they needed, when they needed it.

The service met the needs of people. The ward had an accessible bedroom, equipped for people who may have a physical disability and may require a hoist, profiling bed or use of a commode. The service was accessible with step free access in and out, including the garden areas. Byron Court had made adaptions and had a ramp installed and introduced disabled parking bays at the front of the building.

Staff understood the needs of autistic people and people with a learning disability and worked to ensure that barriers faced by people were removed or mitigated against. For example, staff were meeting people's specific communication needs, we saw welcome packs and information sheets available in easy read. People said information was provided to them in a format that met their needs, people had copies of their care plan in an easy read format where required. Easy read symbols were also displayed across the ward.

People had access to chaplains, who worked alongside other health professionals to provide religious and spiritual care for people regardless of faith, belief or philosophy. Chaplains assisted with the practice of religious observance or through listening and dialogue. The service had a multi-faith resource box containing different easy to read literature about different religions/faiths, religious colouring resources for mindfulness and easy read key texts.

People had access to interpreting and translation services, through the trust's contracted provider. Where needed this provided people with interpreters face-to-face, via telephone or video calls based on their needs and preferences.

Equity in experiences and outcomes

Score: 3

The service actively sought out and listened to information about people who were most likely to experience inequality in experience or outcomes. The service tailored the care and support and treatment in response to this.

Staff within the service promoted a culture in which people using the service felt empowered to give their views.

Staff shared adjustments that had been made to accommodate people with diverse needs. Information was also made available in various formats and languages upon request to ensure accessibility.

The service had an equity, diversity and inclusion policy in place to guide staff in ensuring that people were treated fairly. All staff completed training in equality, diversity and inclusion. Staff had access to the trust's identifying and supporting protected characteristics toolkit. This supported staff to recognise and understand protected characteristics and to provide person-centred care for people from those groups. The toolkit included checklists to prompt staff and contact details for the freedom to speak up guardian, staff engagement team, patient advice and liaison service and the chaplaincy service.

Planning for the future

Score: 3

People were supported to understand and make decisions about their future care and support, including those relating to potential medical and psychological needs.

The multidisciplinary team worked collaboratively with people and their carers when planning for each person's discharge. Staff ensured that appropriate arrangements were in place to sustain the person's mental health. This included liaising with health and social care professionals to ensure people had appropriate accommodation to be discharged to and that a package of care was provided by mental health services. The ward liaised with services who had previously supported people, along with inviting them to discharge planning meetings to collaboratively support the person. People and carers said that there was discharge planning in place and supported housing options with care were being sought for 1 person, but at the time this person wasn't ready for discharge. Staff told us the community mental health team regularly visited people to support with preparing for discharge.

Well-led

Requires improvement

13 November 2025

We looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture. At our last inspection we rated this key question as requires improvement. At that inspection, the service was in breach of regulation 17 (good governance). At this inspection the rating remained requires improvement. We found a continued breach of regulation; this meant the management of the service was inconsistent.

This service scored 62 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Shared direction and culture

Score: 3

The service had a shared vision, strategy and culture that was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding and meeting the needs of people and communities.

Staff felt respected, supported and valued. They said the service promoted equity and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff knew and understood the service's visions and values and how they were applied in the work of their team. Staff had the opportunity to contribute to discussion about the strategy for their service, especially where there were changes being made to the service. People and carers were involved in decision making about changes to the service. The senior leadership team had communicated the vision and values to staff and people who use the service.

Leaders were aware of any risks to delivering their strategy and had local action plans to address these that they monitored and reviewed for progress.

Capable, compassionate and inclusive leaders

Score: 3

The service had inclusive leaders with skills, knowledge and experience to lead effectively and do so with integrity, openness and honesty.

Staff and people told us that leaders were visible on the ward, approachable and engaged well with them. Managers said they received good support from senior leaders.

Senior leaders were skilled, experienced and knowledgeable. Experienced leaders had a strong understanding of the service they managed.The ward manager had only been at the service for 9 weeks and was still learning about the service. They could explain clearly the improvements that have been made and how the team was working to provide good quality care.

The ward manager was new to post and had been at the service 9 weeks; they told us they were being well supported by senior leaders. Staff told us they found the ward manager approachable and supportive and that morale had greatly improved.

Leaders completed the Management Development Programme, which had been developed for all line managers, ranging from bands 4 to Associate Director, the programme was mandatory for all new leaders joining the trust.

Freedom to speak up

Score: 3

The provider created a positive culture where people felt that they can speak up and that their voice would be heard

Staff were aware of the term 'freedom to speak up' and what this meant, however, not all staff knew who the trusts freedom to speak up guardians were, but they were able to explain how they would access freedom to speak up information if they needed it. Staff said they felt confident in speaking up and raising concerns, staff told us they felt listened to and where there was learning this was shared amongst staff.

The trust had policies in place that were in line with best practice guidance for freedom to speak up, whistleblowing and complaints. Between 1 July 2024 and 29 July 2025 there had been 3 freedom to speak up concerns raised. The themes were bullying and harassment and inappropriate attitudes and behaviours, which had all been escalated to the care unit leadership and being managed. Staff were given the opportunity to speak up and drive improvement through staff surveys, supervisions and meetings.

Workforce equality, diversity and inclusion

Score: 3

The service worked towards an inclusive and fair culture by improving equality and equity for people who worked there.

The trust had 5 staff equality networks where members worked with the trust to understand the needs of the communities and shape improvements. These networks were Ethnic Minority and Race Equality, Gender Equality, LGBTQ+, Disability and Mental Health, Faith and Spirituality. The trust held the Equality and Inclusion Committee which was embedded into their governance process. Feedback from staff, patient surveys, equality networks and data from the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) were used to inform trends and make improvements.

Leaders had taken action to review and improve the culture of the organisation in the context of equality, diversity and inclusion. Leaders had ensured reporting of racial abuse against staff was prioritised. The trust had added the category of racial abuse to the incident reporting system so that staff were able to report racial abuse and this was monitored. When reviewing incident records, we saw evidence that incidents of racial abuse were being reported.

Staff had access to the Resilience, Intelligence, Strength and Excellence (RISE) programme, a talent development programme aimed to improve Workforce Race Equality Standard (WRES) indicators. The programme was targeted towards Black and Ethnic Minority staff to enhance their career progression.

Staff undertook diversity and inclusion training annually. Staff we aware of information available on the intranet relating to equality and diversity.

Governance, management and sustainability

Score: 1

The service did not always have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support.

Leaders attended regular governance meetings for safety, audit, quality and governance. The trust discussed and addressed key areas of performance, risk, audit, culture and workforce. Minutes showed areas of concern were identified and actions taken to learn and improve.

Leaders completed regular audits on the ward, these included, matron audits, ward manager audits and person-centred care audits. However, these audits had failed to identify the concerns we found. These were where records were not being completed and kept up to date. For example, people's health action plan had a list of medication but no information about their physical health conditions, the plan had not been updated to include any attended or planned health appointments, the hospital passport had also not been fully completed, risks associated with attending hospital had not been outlined, which meant the document did not communicate the person's needs for any hospital visit/admission. Lack of important information in health action plans had been identified during a mental health act review monitoring visit in March 2025, but improvements had not been made as a result of this feedback.

A range of documents were available to staff with useful information, but information was not always recorded and updated consistently across records. For example, a person's positive behaviour support plan said that they had ear defenders, but this information was not reflected in the care plan. We raised these concerns with leaders on our first visit, when we returned for our out of hours visit, work had been carried out to update records.

The systems and processes in place in the service had not been effective in identifying and mitigating these risks. Leaders told us that they had since introduced an extra layer of local auditing to ensure these things are identified. Leaders said they were also liaising with trust auditing leads to look at and review the questions that are being asked in audits. Further work was required to ensure governance systems were effective and fully embedded.

Staff said they had regular team meetings, situation report meetings to discuss any issues or risks, multidisciplinary team meetings, attended safety huddles, received regular lesson learned information and understood their roles. Staff felt the wards were well organised and managed. Staff were able to give examples of the checks they had participated in to ensure the safety of the wards such as security checks, observations, audits and checks of equipment. Staff gave feedback that they received regular supervision and appraisals.

Leaders explained how they communicated and interacted with staff to ensure they managed risk and sought staff views to make improvements. Leaders spoke about their responsibilities in relation to maintaining oversight of the services, by being present and ensuring they had managers and matrons on site. Leaders spoke about having oversight of capacity, budgets, audits, performance, key performance indicators and incident data. They shared clinical dashboards with teams for oversight and review.

The trust held a risk register for specialist services which we reviewed. All risks were identified with risk scores, controls, mitigations with assurance and action review dates. Leaders said staff could make suggestions to add to the risk register which would be escalated to the quality assurance meeting.

Staff knew how to deal with complaints and reported incidents and safeguarding concerns. Leaders shared lessons learned from investigating complaints, incidents and safeguarding issues.

Partnerships and communities

Score: 3

The service understood its duty to collaborate and work in partnership, so the service worked seamlessly for people. Staff shared information and learning with partners and collaborated for improvement.

The service worked well with other agencies, there were established relationships between Byron Court and the Learning Disability Assessment and Treatment unit in North Essex, the matrons and the ward managers liaised regularly to share information and good practice. The service also worked with specialised learning disability colleagues in relevant local authorities, integrated care boards and the local acute hospital trusts.

Staff invited family members and external professionals to meetings so they could discuss any issues and receive any updates about people's / their family member's care and treatment. People that we spoke with told us they were able to give feedback on how to improve the service they received.

Staffhad access to regular team meetings on the wards. Staff were able to propose, exchange and discuss ideas in terms of good practice. Staff could attend reflective practice sessions facilitated by the psychology department.

The servicehad appropriate processes in place to support effective links with the community and with partners. The trust sought feedback from staff, people and carers through surveys and used this feedback to make improvements.

Learning, improvement and innovation

Score: 3

The service focussed on continuous learning, innovation and improvement.

The ward manager subscribed to the Radiant Network which was a clinical and research network hosted by Hertfordshire Partnership University NHS Foundation Trust. It focussed on mental health and behavioural issues associated with intellectual disability, autism and other neurodevelopmental conditions. The ward manager was also of the UK Health and Learning Disabilities Network which connected people with an interest in the health of people with learning disabilities in the UK, they were also a member of the Royal College of Nursing's Learning Disability Nursing Forum, information from these services and resources were shared with the team for learning and improvement.

The ward manager was registered with the Royal College of Psychiatrists Quality Network for Inpatient Learning Disability Services (QNLD) they participated in peer reviews with similar services, which supported the ongoing development and promotion of good practice through continuous learning.

The senior leadership team had a weekly support and reflective huddle which was open to all leaders in the service to attend. The forum was attended by all service leads and psychiatrists and was used to share information and reflect on current challenges. For example, leaders reflected on what more they could do to support the ward through high acuity, anticipated changes to the Mental Health Act and impact on learning disability services. The huddle was intended to offer a safe space for discussion and reflections.

The trust had 5 key messages that were shared with staff monthly, these were on the intranet. The service also kept a copy in the culture of learning folder, and we saw evidence of these messages being discussed in team meetings. The trust also sent out learning alerts, these included what happened, identified learning and actions required with a time frame for completion.

The trust had a lessons identified newsletter, this included learning from deaths, complaints, compliments and patient safety incident management.

Staff that we spoke with said leaders listened and considered any ideas staff shared with them for improving the service or about concerns around people's care.

7.4 FREEDOM TO SPEAK UP

Discussion Item DG

REFERENCES

Only PDFs are attached

Freedom to Speak Up Report 03.12.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 December 2025

Report Title:	**Freedom to Speak Up Service**					
Executive/ Non-Executive Lead:	Denver Greenhalgh – Executive Director for Governance					
Report Author(s):	Bernie Rochford – Principal Freedom to Speak Up Guardian					
Report discussed previously at:	People Committee, 30 October 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)?	No but FTSU provides insight into		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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		
• Review of Freedom to Speak up activity from 01 April to 30 September 2025 • Highlight changes / cultural shift around Speaking Up behaviour	**Approval**	
	Discussion	✓
	Information	✓

• Note work / workflow required to create greater alignment, triangulation of data and clarity around all Speak Up routes across the trust		

Recommendations/Action Required

Once a trust wide Speak Up model has been agreed by PEC / Board an action plan with agreed time frames can be developed for FTSU and used as a live tool for ensuring alignment and improvements are made.

The Board of Directors is asked to:

1. Note the contents of the report
2. Note, in principle, the next steps set out in the priority section as reviewed by the People Committee
3. Provide greater clarity around all Speak Up routes across the trust, how they align and build requirements for the triangulation of data

Summary of Key Issues

In Q1 and Q2 2025-26

3.1 Increased number of people spoke up through FTSU service (~67% of last year's full total)

3.2 The majority spoke up anonymously (48%) rather than openly / confidentially as in previous years

3.4 More people are now using the online form which may be driving anonymity behaviour

3.6 There were two hundred and ninety-one open FTSU cases by the end of Q2

4 (page 6) Speaking Up arrangements across the trust need to be reviewed and aligned

Appendix 2 – Anonymised listing of themes over Q1, Q2 indicate most issues are around unfair application of systems and processes

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			
FTSU	Freedom to Speak Up	MARS	Mutually Agreed Resignation Scheme
PSU	Person / People Speaking Up	HCAs	Health Care Assistants
AHPs	Allied Health Professionals	NGO	National Guardians Office

Supporting Reports/ Appendices /or further reading

Appendix 1 – Freedom to Speak Up Data between 01 April – 30 September 2025

Appendix 2 - Summary of themes from anonymised cases between 01 April – 30 September 2025

Appendix 3 – First six month reflections from the new Freedom to Speak Up Guardian

Lead

Denver Greenhalgh
Executive Director of Governance

Freedom to Speak Up Service

1. Purpose of Report

- Provide a review of Freedom to Speak up activity from 01 April to 30 September 2025
- Highlight changes / cultural shift around Speaking Up behaviour
- Note work / workflow required to create greater alignment, triangulation of data and clarity around all Speak Up routes across the trust

2. Board Responsibilities

2.1 The table below summarises the Trust position against Board responsibilities

Board Responsibility	Requirement	Trust Position
FTSU E-learning Modules	Implement FTSU e-learning modules on a par with mandatory training	August 2025 – The trust moved annual FTSU training to three yearly As of the 01 September 2025, the following achievement of FTSU training is reported: 000 Speak Up 97% 000 Listen Up 92% 000 Follow Up 90%
NHSE FTSU Board Reflection and Planning Tool	Board assessment to reflect and complete FTSU planning tool	Completed and presented to the Board of Director September 2024 (seminar session).
NHSE FTSU Board Improvement Plan	Board to assess, review and monitor progress	Because of capacity in the service, since presenting at the Board of Directors in September 2024, progression of agreed areas of focus had been halted. With a change of SRO – this is being reviewed and a development plan for the service is being developed. This will report to the People Committee in early 2026, along with a timeline for when we will refresh the planning tool.
FTSU Policy review	Align local and national policy by January 2024	Policy review in approval process, with full approval to be achieved at Board of Directors meeting in December 2025. EPUT is adopting the NHSE national policy.

3. Freedom to Speak Up Data

3.1 *Number of cases raised*

One hundred and seventy eight people spoke up (PSU) through the FTSU service (Q1 = 98, Q2 = 82). This is a 36% increase on the same time period from last year. At this 6 month point we are already at 67% of the total number for last year (2024-25) [Appendix 1. Fig 1 and 2]

3.2 *Approach taken to Speak Up*

For the first time since FTSU was launched in 2016, the majority of people spoke up anonymously (48%) during this time period. This has surpassed the number of anonymous at the height of covid and has been

steadily on the rise for the last three years. The remainder of people speaking up (52%) were split between 47 Open (27%) and 45 Confidential (25%) [Appendix 1. Fig 3 and 4]

3.3 *Speaking Up by professional / worker group*

Due to the high number of people speaking up anonymously we do not know the professional group for 80 cases. Where the professional group was made known, the majority of concerns were raised by nurses (30), Admin & Clerical staff (28) and Allied Health Professionals (17) [Appendix 1. Fig 5]

3.4 *Method of contact*

The majority of issues were raised via the online reporting form (81 cases). The same as via phone calls, individual Guardian and shared email accounts combined. A smaller number were raised direct through Teams or face to face. One concern was raised via an Anonymous letter [Appendix 1. Fig 6]

3.5 *Themes and issues raised through the FTSU service*

Concerns around worker safety / well-being was the main reason cited for speaking up (110 cases). Inappropriate attitudes or behaviours is often cited in tandem, which is reflected in these being the top two reasons cited. Raising concerns about patient safety / quality still remains the least reported issue through the FTSU service [Appendix 1. Fig 7 and 8]

3.6 *Number of Open Cases*

At the end of Q2 2025, two hundred and ninety one FTSU cases were open. Seventy two from Q1 and Q2 of this year and two hundred and nineteen outstanding from previous years [Appendix 1. Fig 9].

4. Analysis of FTSU data

It is too soon to know if the rising numbers are a spike or will continue at the same rate for the remainder of the year. The increase in Q1 may in part be due to a feeling of general uncertainty at work and attributable to the local MARs scheme announcement, budget setting, recruitment freezes, changes to agency and bank spend. Increase in casework can impact turnaround times and quality of responses to concerns raised. A service change can prompt numerous concerns being raised about the same issue. Often, before feedback is provided to the person speaking up (PSU), a similar issue may be raised again. Where these issues are raised anonymously we rely on the service to feedback on action taken via a wider team message.

Although each case number represents one person speaking up, it can contain a number of issues. The number of people raising issues anonymously is a worryingly marked shift away from previous years where the majority spoke up openly. The number of anonymous cases raised within the last six months is already more than that for the whole of last year. In perspective, more concerns are now raised anonymously than during peak covid times. The shift *may* be linked to the general feel of uncertainty around job security, MARs announcement, budget freezes, Lampard inquiry. These shifts in speaking up approach are concerning and need to be monitored and explored. There may be pragmatic explanations i.e. ease of use of online forms or it could reflect a wider culture shift, abdicating responsibility, exasperation, time constraints, uncertainty and anxiety around change, fear / futility, or changes in demographic communication styles and preferences.

Anonymous cases can generally be responded to and turned around much quicker than issues raised openly or confidentially. There is less documentation and no repeat lengthy meetings with the PSU who may be in distress or have difficulties expressing themselves. However it also means there is no one to clarify the issues with, feedback to, nor confirm has action been taken and change as a result. There appears to be a number of echo concerns raised in some areas. In addition to speeding up response times, more work around managing expectations of time between raising a concern and receiving a response is needed. Unrealistic expectations may in part be due to the influence speed of social media / AI.

Nurses, HCA's and Admin colleagues generally raise more issues through the FTSU service than any other worker groups. However it appears for the first time more Allied Health Professionals (AHPs) have openly / confidentially contacted the FTSU service over the last two quarters than HCA's or clinical support workers. The data may be misrepresentative given the increasing number of people Speaking Up anonymously but regardless this is another area to monitor as AHPs tend to discuss issues within their professional groups first. The issues raised have been largely around seeking support re understanding processes, access to / understanding information and inappropriate behaviours from consultants.

The increased ease and use of online forms to Speak Up may be driving some of the culture shift towards anonymity. It may also be a reflection of dissatisfaction with issues not addressed by others given the number raised around unfairness and inconsistency. At this stage there is not enough information to determine any exact reason but it is an area for urgent review. It indicates low level communication is not being fostered to address basic everyday issues. This may be due to a number of factors such as frustration, impatience, capability and competence. In the short term, the online conveyor approach to fixing issues might hold things at bay but my concern is for long term sustainability. To grow and develop a pipeline of future fit for purpose managers they need to be able to communicate, discuss, negotiate and be able to listen and problem solve. All colleagues need to develop communication skills around uncomfortable conversations, accountability and ownership for 'what we do together matters".

Previously EPUT was exceptionally high in regards to the number of people who spoke up elsewhere before using the FTSU service. The wording / meaning on the online form changed slightly midterm which means we cannot at the moment report with accuracy on this for Q1 and Q2. We know at least 55% reported doing so which looks to be under reporting for the above reason. Whilst the FTSU service exists as a safety valve to pick up new issues or existing ones that do not appear to have been fully addressed / to satisfaction, the reasons why issues are not addressed at first point of call needs examining. It generally reflects slide / non-alignment / failure demand elsewhere. The FTSU service reflects what is happening within the trust, not just what issues are raised but how and if they are responded to and any changes made as a result.

Concerns around worker safety / well-being were the main reasons cited for speaking up during this period followed by inappropriate attitudes / behaviours. These themes are usually linked and have been on the rise for the last four years. There are numerous reports of inconsistencies, unfairness and variation within and across teams that staff are largely tired of. There was a marked increase in the four* main categories used for data submission to the National Guardians Office, during Q1 compared to previous quarters. *NGO categories of themes are patient safety, worker safety / well-being, inappropriate attitudes or behaviour, bullying / harassment.

Although the number of patient safety / quality issues increased over this period, these still remain the least reported issues through the FTSU service. The data reveals again FTSU is still primarily used for reporting underlying tensions and stressors across the workforce. Whether patient safety / quality issues are reported as primary reasons for speaking up or are secondary to personal relationship work environment issues will be explored in the future. Two of the people reporting detriment after raising concerns came from the same area and relate to a specific set of circumstances; the third reported detriment after raising a grievance. The only recourse to detriment appears to be through raising a grievance which tends to further inflame a situation. More work is needed in this area and to differentiate between retaliatory and process detriment.

Other themes for contacting the FTSU service such as seeking support / advice, signposting, sense-checking, pastoral care, grievances, impact of consultations, leadership, system issues etc are not externally monitored. We made a start in categorising these but as yet the data collection is not reliable enough to report on. The same applies to reliable data on protected characteristics and primary reason for Speaking Up. Work on developing these via a bespoke Datix module is temporarily suspended in order to focus on clearing backlogs.

An anonymised overview of presenting issues raised in the last two quarters evidences this is not what was envisaged at the outset for FTSU services [Appendix 2]. The overview clearly shows most of the issues raised are around unfair application of systems and processes. All routes where staff can speak up through need to align and strengthen to foster a trust-wide Speak Up culture and to reset / stabilise the FTSU service.

By the end of Q2 2025, two hundred and ninety one FTSU cases remained open. Of which, seventy two cases are open from Q1/Q2 and two hundred and nineteen cases outstanding from previous years. Having only one Guardian for nearly two years limited the scope to feedback / chase up for responses to concerns raised. But in the absence of chasing up, there has been relatively little proactive resolution, updates or feedback to resolve / close cases. Hence the demand for / on the service has not reduced.

Since March 2025, an additional full time Guardian joined the FTSU service and is now managing most of the new cases. The majority of which come through as online form anonymous cases. In the short term, these are easier to manage given there is no additional interaction / meetings to discuss issues, check in or feedback provided. However, for reasons previously stated, this is not ideal long term. Although FTSU have not received updates on the majority of outstanding cases, the individuals / cases should all be currently

under the care of Director / Manager / ER oversight. Care divisions are accountable for monitoring learning / change as a result of PSU as Guardians cannot audit this for them.

Our current plan is the new Guardian manages the majority of incoming cases, whilst I will work through the backlog of outstanding cases, categorising them into clearer ER / Clinical / ER & Clinical / other cases for follow up, prioritising in terms of risk, simple, moderate and more complex issues. Load these onto an Accountability Framework for Directors and channel through that oversight process. We will then be in a stronger position to review the service, business approach and where it fits into the wider culture workstream.

Whilst the number of open cases depend on organisational circumstance and culture, by way of comparison Guardians from other trusts* report they are holding around fifteen open cases each with a combined team approach of around forty. Holding two hundred and ninety one cases open is an indicator more needs to be done in the areas of Listening, Following Up and the Speaking Up model used. *These trusts have had a permanent Guardian since the outset who has built up experience, refined processes and relationships which are more established now. A slightly larger, otherwise comparator organisation with a more mature FTSU service reports they are receiving about a third of the cases our service is handling. In part this could be indicative of the maturity of their service, the flow, alignment and triangulation of Speaking Up concerns.

Overall impression of Speaking Up across the trust is there needs to be greater flow, accountability, alignment and consistency within and between different routes colleagues can speak up through. Clarity is needed around who and what is being done, where, how it all ties together and where the FTSU service fits into the overall model for speaking up. The volume of cases increased from the start of covid, as did the complexity of issues and how staff present but has not reset to pre-covid times. Resourcing needs to reflect the demand or explore other routes. We have also had a change in Chair and Executive Director during this time period. The Board reviewing and agreeing the aligning of different approaches would provide greater clarity and assurance for staff as well as improve the quality and efficiency of responses to issues raised, action taken, lessons learnt and change as a result. A consensus approach, information sharing agreements, a reset and re-education of not just Speak Up but how to, when etc would be beneficial.

5. Highs and Lows

Lows

- Some issues are easier to respond to and address than others. Unfortunately in one area where gradually over time fifteen people spoke up, the process became protracted resulting in a lot of distress for many involved. The concerns were escalated but eventually assistance from NHS England was sought. It took at least six weeks to get a part response by which time the situation had deteriorated and I was then unfortunately on leave. The issues I'm informed are now being addressed but one of the learnings from this and another few cases involving collaborative work and partnership between trusts is the need to look at management and cross organisational contract arrangements. Work has begun on this and I am working with the National Guardians Office to explore this gap further as Partnership working looks to be the way forward for the NHS.
- Because the demand on the service has grown, we have not had the capacity to meet the need, which requires a review of the service, resources, approach alongside other Speak Up routes
- The revised FTSU policy is still awaiting clearance and sign off

Highs

- An additional full time Guardian joined the FTSU service in March and is making a great contribution to the service and colleagues, receiving good feedback [Appendix 3]
- The FTSU intranet site has been reviewed and we aim to make greater use of this space
- Some proactive work has been undertaken with four staff service engagement visits, FTSU sessions delivered at five team training or away day sessions and two preceptorship days
- We have received some heart-warming thanks and recognition from staff speaking up

6.Board FTSU Reflection and Planning (RP) Tool

Sue to capacity of the service, since presenting at the Board of Directors in September 2024, progression of agreed areas of focus had been halted.

With a change of SRO – this is being reviewed and a development plan for the service is being developed. This will report to the People Committee in early 2026, along with a timeline for when we will refresh the planning tool.

6. Identified Next Steps and priorities

Evidence indicates a concerning trend and cultural shift in how the FTSU service is being used.

To develop more open Speaking Up, accountability, learning and change, the flow of Speaking Up through the Trust and FTSU service needs reviewing, revising and re-education at all levels / areas. Growing demand of the FTSU service highlights more proactive work at source is needed to make FTSU a fall-back fail-safe service. The flow of Speaking Up across the Trust as well as through FTSU would benefit from a review, which aligns with the action following the assessment using the planning tool.

The immediate areas for focus / development over the next six months are:

1. The Board reach agreement re Speaking Up flow across the trust / FTSU

2. Action plans – Following the above, develop and agree what action needs to be taken and by whom for a Speaking Up re-education programme. To foster a trust-wide open transparent culture of Speaking Up as well as a FTSU service. What FTSU is / isn't / how to make it work for everyone

3. Budget / Recruitment - Build capacity into the FTSU service to meet demand / service need. Understand what budget is available and how the service can fulfil its purpose

7 Recommendations

Once a trust wide Speak Up model has been agreed by PEC / Board an action plan with agreed time frames should be developed and used as a live tool for ensuring alignment and improvements are made.

The Board is asked to:

1. Note the contents of the report
2. Agree, in principle, next steps set out in the priority section and action will be taken to address the cultural shift changes
3. Provide greater clarity around all Speak Up routes across the trust, how they align and build requirements for the triangulation of data

Report prepared by:

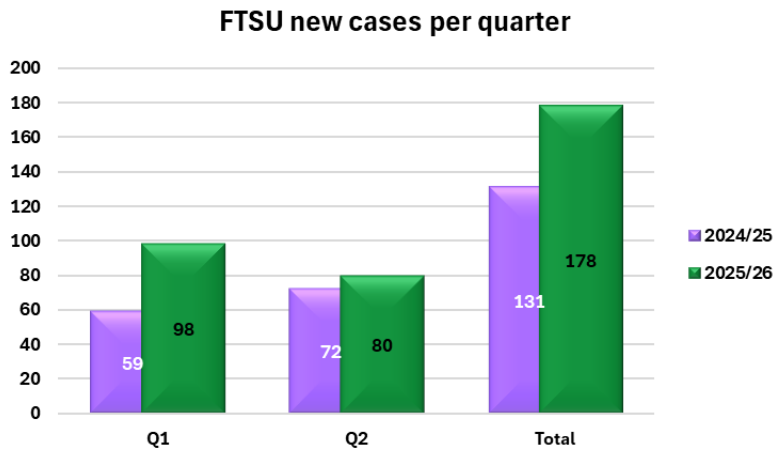
Bernie Rochford MBE
Principal Freedom to Speak Up Guardian

On behalf of:

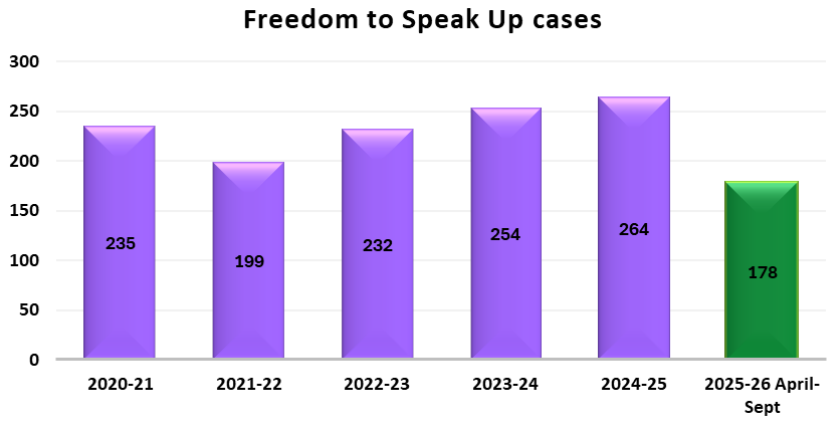
Denver Greenhalgh
Executive Director of Governance

APPENDIX 1 FTSU DATA

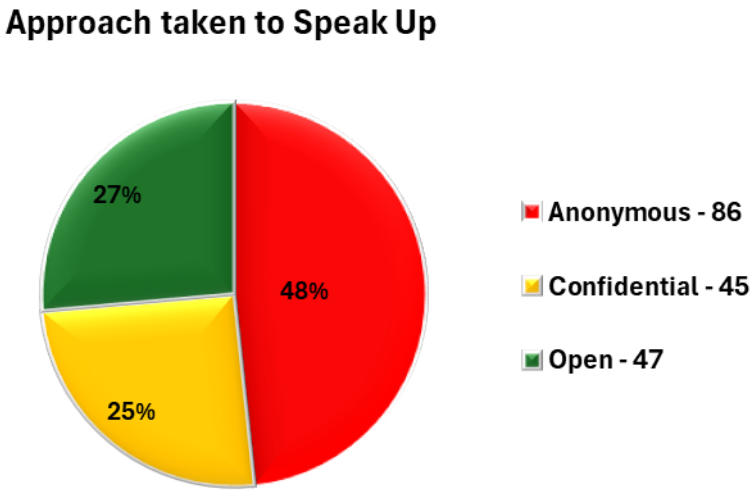
1. *Number of cases raised through the FTSU Service*



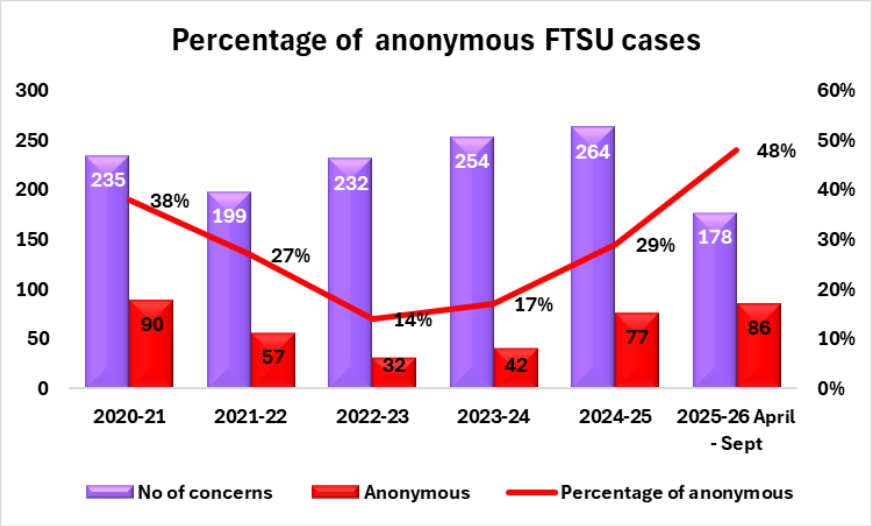
2. *Number of cases raised through the FTSU Service in comparison over time*



3. *Approach taken to Speak Up*



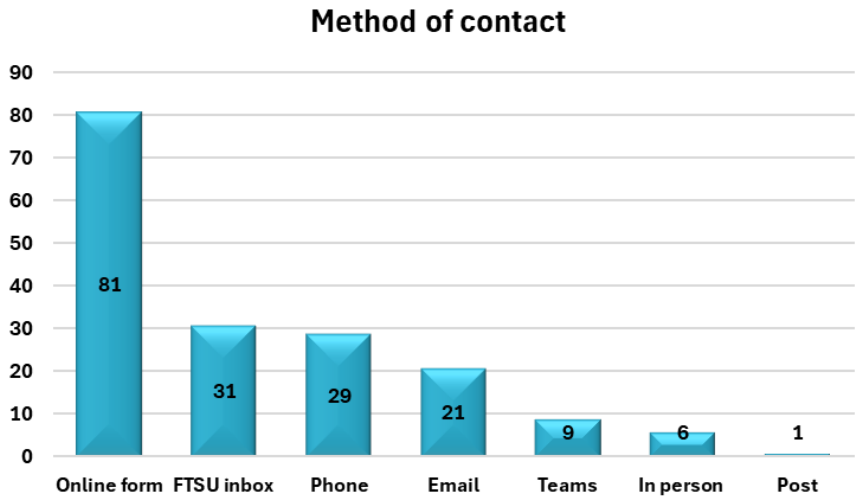
4. *Percentage of Anonymous FTSU cases over time*



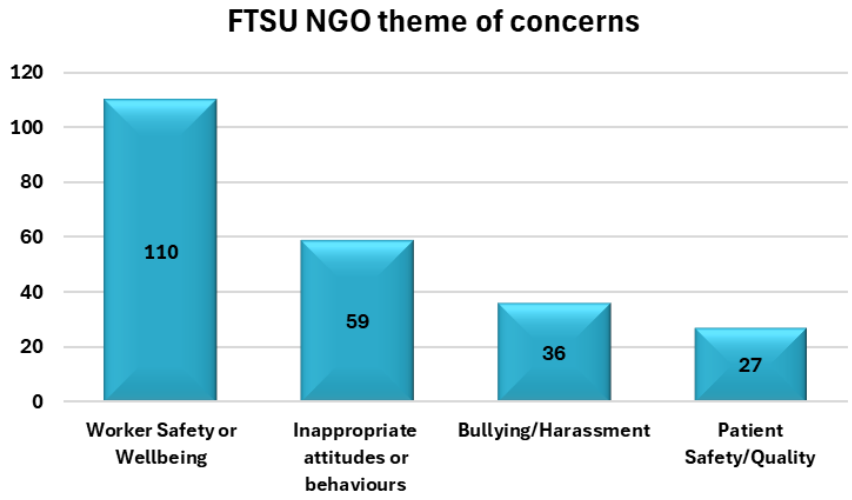
5. *Speaking Up by professional / worker group*

Number of cases raised by professional / worker group	01 April – 30 September 2025
Additional Professional Scientific/ Technical – Social workers, pharmacy, psychology	0
Additional Clinical Service – support clinical roles, HCAs, call operators	14
Admin & Clerical	**28**
Allied Health Professionals	**17**
Estates and Ancillary	5
Medical and Dental	1
Nurses & Midwifery	**30**
Students	2
Other	1
Not Known / Anon	**80**
Total number of colleagues Speaking Up through FTSU	**178**

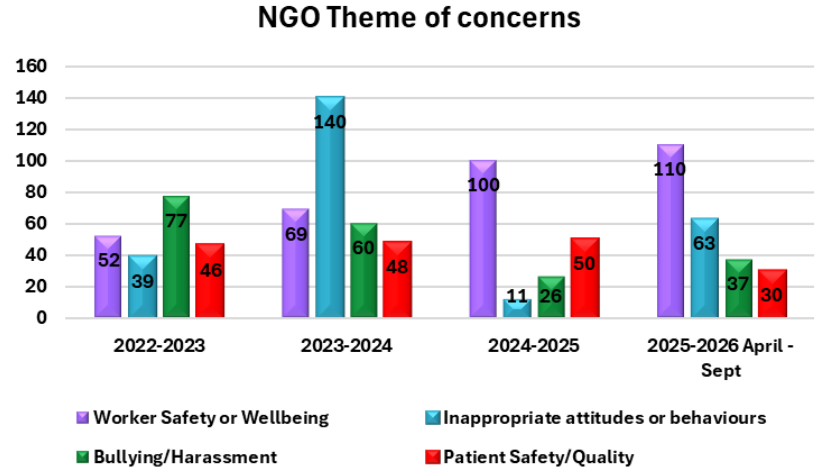
6. *Method of contact*



7. Q1, Q2 Themes and issues raised through the FTSU service (NGO themes)



8. Themes and issues raised through the FTSU service over time



9. Open FTSU cases

Pre 2025-26	2025 – 26 Q1 & Q2	Total Number Open
219	**72**	**291**
Longest open cases that need confirmation of action / closure 27.07.23 08.09.23 21.09.23	*Longest open case that needs confirmation of action / closure* 08.04.25	

Presenting issues raised through the FTSU service Q1 Q2 25/26

#	Case Reference Number	Presenting Issue	Confidentiality	Raised via other route prior to FTSU*	Method of contact
1	25040100	Feels targetted by allegations and multiple investigations	Open	No	FTSU inbox
2	25040200	Financial mixed messages - Someone left the trust claiming / selling back AL. Inconsistency with funding and FTSU not funded (recruitment on hold)	Anonymous	Unknown	Phone
3	25042001	Inappropriate behaviour of colleague, inequity and favouritism	Open	Yes	FTSU inbox
4	25040300	Feedback re FTSU recruitment process and inconsistencies as other positions funded	Confidential	Yes	Teams
5	25040301	Unwarranted patient restraint	Anonymous	Yes	FTSU inbox
6	25040800	Issues re manager behaviour impacting staff	Open	Yes	Teams
7	25040900	Unprofessional / biased / bullying from a nurse in charge. Cultural issues / discrimination and misuse of agency and bank shift allocations.	Anonymous	No	Form
8	25040901	Ward closed for repairs. Staff moved and little communication / update from managers	Anonymous	Yes	Form
9	25040902	Ward closed for repairs / lack of communication / impact on travelling to new site	Anonymous	Yes	Form
10	25041000	Admin manager received bullying from clinical manager after submitting a datix re patient safety	Open	Yes	Email
11	25041000	In support of above and outlined impact on admin team / unsafe / toxic environment	Open	Yes	Teams
12	25041100	Unfair / request policy on why ward can't work > 3 consecutive days, others can work 5 days	Anonymous	No	Form
13	25041500	Cultural and Racial discrimination against white staff (black member of staff reporting)	Anonymous	No	Form
14	25041501	Unfairness and issues re 3 day consecutive work limit	Anonymous	Yes	Form
15	25041600	Ex EPUT staff request mtg. Reporting poor practice / leadership	Open	Yes	Email
16	25041601	Toxic environment in service / team; Believe campaigning against another staff member	Anonymous	Yes	Form
17	25041602	Assistance requested to make contact with two managers	Open	Yes	Email

19	25042200	Staff received a response re the limit on 3 consecutive rule for workers. Not happy with the response and request trust responds to further questions	Anonymous	Yes	Form
20	25042201	Responding to limits on 3 day work for HCA's /others on ward, whilst managers can and other nurses elsewhere	Anonymous	Yes	Form
21	25042202	Increased work pressures on part time staff	Confidential	Yes	FTSU inbox
22	25042203	Concern re manager's comments to team re SU puts them on the radar and overshadows the work being done on the ward.	Anonymous	No	Form
23	25042400	Inability to book bank staff	Anonymous	No	Form
24	25042401	Unfairness / inconsistency within team and one rule for one, one for another	Anonymous	Yes	Phone
25	25042402	Unable to book AL on EOL before retire but HR not responding and passing issue between them.	Open	Yes	Phone
26	25042403	Trust not responding to FOI requests. Feels no option but to go external	Open	Yes	FTSU inbox
27	25042500	Staff expected to attend team meetings without pay	Anonymous	Unknown	Form
28	25042501	Inappropriate behaviour of colleague, inequity and favouritism	Confidential	No	Phone
29	25042502	Unfair bank allocation process	Anonymous	Unknown	Form
30	25042900	How to make an anonymous report	Confidential	No	FTSU inbox
31	25043000	Unfair bank allocation process for weekends - monetary gain	Anonymous	Unknown	Form
32	25043001	Staff capacity and resource to complete mandatory training in order to book bank shifts	Anonymous	Unknown	Form
33	25043002	Staff reprimanded for going to FTSU / completion of mandatory training / booking bank shifts	Anonymous	Unknown	Form
34	25050100	Inappropriate behaviour of colleague, inequity and favouritism	Confidential	Yes	Phone
35	25050200	Unfair bank allocation process	Anonymous	Unknown	Form
36	25050201	Staff expected to attend team meetings without pay	Anonymous	Unknown	Form
37	25050202	Disparity in work allocation, managers working 6 days a week, junior staff told they cannot	Anonymous	Unknown	Form
38	25050500	Manipulation of bank shifts - booking then cancelling so another can benefit	Anonymous	Unknown	Form
39	25050600	Consideration of risks due to change to service - no Paramedic urgent response car	Confidential	Yes	FTSU inbox
40	25050601	Inappropriate, unprofessional, intimidating and demoralising communication and action from ward manager	Anonymous	Unknown	Form
41	25050700	Concerns reported external to team, manager pushed it back to her to deal with	Confidential	Yes	FTSU inbox

42	25050800	Racist comments about AD, feel Directors and FTSU not listening. Reported FTSU to NGO.	Anonymous	Yes	Form
43	25050900	Support and processes following suspension	Confidential	No	Phone
44	25051100	Change in patient needs, workload and staffing levels. Patient abuse to staff, datix's ignored	Anonymous	Unknown	Form
45	25051200	Impact of AD advice on PSU's contract / situation / patient safety	Open	Yes	BR inbox
46	25051201	Vitriolic towards FTSU for lack of action and threat to report to NGO	Anonymous	Yes	Form
47	25051300	Impact of AD advice on PSU's contract / situation / patient safety	Open	Yes	BR inbox
48	25051301	Bank favoured over permanent for bank shifts	Anonymous	No	Form
49	25051302	Impact of AD advice on PSU's contract / situation / patient safety	Confidential	Yes	BR inbox
50	25051303	Pressure put upon clinical staff by management and intimidation from manager	Confidential	No	FTSU inbox
51	25051600	Not agree with EPUT members response to the Lampard inquiry	Anonymous	No	Form
52	25051900	Targetted bullying by Matron, manipulation in recruitment, medication cover ups	Anonymous	Unknown	Form
53	25051901	Unfair recruitment process, favouritism, excluding ward managers from process	Anonymous	Unknown	Form
54	25051902	Unfair recruitment process, favouritism, excluding ward managers from process	Anonymous	Unknown	Form
55	25051903	Unfair recruitment process, favouritism towards Ghanaian staff	Anonymous	Unknown	Form
56	25051904	Matron bullying staff, moved them to another ward	Anonymous	Unknown	Form
57	25051905	Matron bullying colleague following raising a Datix about a favoured colleague	Anonymous	Unknown	Form
58	25051906	Ward manager undermining professional judgement of Nurses regarding Sec 17 and patient garden breaks	Anonymous	Yes	Form
59	25051907	Inappropriate, unprofessional, intimidating and demoralising communication and action from ward manager, discouraging staff from speaking up, personal face-time calls on shift	Anonymous	Unknown	Form
60	25051908	Staff speaking in Yoruba, manager teaching patients the language against their will, breaks down inclusive working environment	Anonymous	Unknown	Form
61	25052000	Unfair recruitment process, favouritism towards current ward manager	Anonymous	Unknown	Form
62	25052001	Staff discouraged to speak up to FTSU by Matron, staff left feeling unable to do so	Anonymous	Unknown	Form
63	25052002	Unfair recruitment process, favouritism towards current ward manager, band 7 sexual relationship with agency staff member providing bank staff	Anonymous	Unknown	Form
64	25052003	Junior staff not permitted to book holiday on weekends, senior staff can, book leave and then work bank paid double time - manipulation of system	Anonymous	Unknown	Form
65	25052200	Follow up support with change of role following assault by patient	Open	Yes	FTSU phone

66	25052201	Service not being funded for accreditation, wanted to talk through how to raise the teams concerns	Open	Yes	FTSU phone
67	25052300	Concern regarding consultant, behaviours, visibility and potential fraud	Anonymous	Unknown	Form
68	25052800	Clarity on annual leave policy - managers booking leave on BH then working bank	Anonymous	Unknown	Form
69	25052801	Clarity on annual leave policy - managers booking leave on BH then working bank	Anonymous	Unknown	Form
70	25052802	New member of staff spoken to inappropriately by manager	Anonymous	Yes	JS inbox
71	25053000	Staff expected to attend team meetings without pay	Anonymous	Yes	Form
72	25060200	Culture of acceptance of bullying and harassment from Consultant Psychiatrist	Confidential	Yes	FTSU phone
73	25060300	Complex - patient and staff member relationship, allegations made by patient about staff	Open	Yes	FTSU inbox
74	25060400	Intimidation and emotional abuse	Confidential	No	FTSU inbox
75	25060401	Lack of leadership in the service / support around neurodevelopment	Anonymous	Yes	Form
76	25060600	Sharing of client information in external meeting	Confidential	Yes	FTSU inbox
77	25061802	Discriminatory comment made by GP, raised internal, nothing done	Confidential	Yes	Training
78	25060900	Flexible working request refused, unequal treatment	Open	Yes	FTSU phone
79	25060901	Colleague not following allocation process	Open	Yes	FTSU phone
80	25061000	Bullying from colleague	Open	Yes	FTSU inbox
81	25061001	Access to OH/EAP information	Confidential	Yes	FTSU phone
82	25061002	1:2:1 decisions, repercussions for speaking up, lack of manager engagement, favouritism and discrimination, leadership	Anonymous	Yes	Form
83	25061003	Inappropriate jokes, disregarding instructions, deliberately miscommunicating or misrepresenting info.	Anonymous	Yes	Form
84	25061100	Preferential treatment regarding recruitment - unofficial shadowing and training	Anonymous	Yes	Form
85	25061101	Changes to staffing changed x2, x1 without notice	Anonymous	Yes	Form
86	25061200	Changes to contract 2 days before start, 6 months given, issues with VISA and first year NQ status	Open	Yes	FTSU phone
87	25061300	Discrepancy in level of banding payment for bank shifts	Anonymous	Yes	Form
88	25061301	Lack of support, information and guidance following client abuse disclosure	Open	Yes	FTSU phone
89	25061800	Bullying and harassment on the ward, cliques and division affecting patient care and staff wellbeing	Open	Yes	FTSU phone
90	25061801	Bullying and harassment on the ward - grievance raised minimal action	Confidential	Yes	FTSU phone
91	25062000	Bullying and harassment, lack of fairness in bank process and working patterns	Open	Yes	FTSU phone

92	25062300	Bullying and harassment, lack of fairness in bank process and working patterns	Confidential	Yes	FTSU phone
93	25062301	Unequitable support for staff member who is pregnant	Confidential	Yes	FTSU inbox
94	25072302	Support with parking and associated costs	Anonymous	No	Form
95	25062303	Support with disciplinary case	Open	Yes	FTSU inbox
96	25062400	Staff member off sick and working elsewhere	Confidential	No	Teams
97	25062700	Dissatisfaction with outcome of grievance	Open	Yes	FTSU phone
98	25063000	Colleague sickness impacting on PSU workload	Open	Yes	In person
99	25070100	Support re disability and capability process and access to paperwork	Open	No	FTSU phone
100	25070101	Outcome of bullying grievance and potential repercussions related to vehicle leasing	Confidential	No	JS inbox
101	25070102	Concerns re AD not in service, pathways not followed etc	Anonymous	No	Form
102	25070103	Concern re outer London weighting expense recall	Open	Yes	In person
103	25070200	Issues with expenses and behaviour of matron	Confidential	No	FTSU phone
104	25070300	Clarity on expenses and advice on reference	Confidential	No	FTSU inbox
105	25070700	Resigned due to harassment by Consultant - Asian to White	Open	Yes	FTSU inbox
106	25070701	Access to support to patients in a timely manner - early intervention	Open	No	Teams
107	25070800	AD continuing to work whilst redeployed, fraud re training and inappropriate comment	Anonymous	No	In person
108	25070801	Concerns re AD not in service, pathways not followed etc	Anonymous	Yes	Form
109	25070802	Support from manager, failed probation, limited feedback	Open	Yes	Form
110	52070901	Lack of follow up from raising a complaint, staff member now back at work	Open	Yes	Teams
111	25071001	Process following serious incident	Open	Yes	FTSU inbox
112	25071100	Support with SAR's request re a patient complaint	Confidential	No	FTSU phone
113	25070500	Changes made to rostering - team view following concerns raised	Anonymous	Unknown	JS inbox
114	25071101	Historic attack by patient, would like compensation	Confidential	No	FTSU inbox
115	25071700	Payroll errors - process managed badly, lack of transparency	Anonymous	Yes	Form
116	25071800	Wants to report concerns externally, not willing to wait 35 days. Did not state the concerns but interview process mentioned and potential fraudulent behaviour	Anonymous	No	FTSU phone
117	25072000	Receiving rota's late, not as per policy 3 months	Anonymous	No	Form
118	25071701	Made to take leave when issues with childcare	Confidential	No	FTSU inbox
119	25072100	Receiving rotas late, not as per policy 3 months. Perceived as punitive for speaking up	Anonymous	Yes	Form
120	25072200	Issue with zoning- staff not able to complete 1:2:1's and patients suffering as a result	Anonymous	Yes	Form

121	25072400	Email received from manager re new starter on difficult ward.	Confidential	No	JS inbox
122	25072401	Advice wanted regarding a protected disclosure	Anonymous	No	FTSU inbox
123	25072402	Outcome of grievance, being made to work with the person who was bullying her	Open	Yes	FTSU inbox
124	25072403	Team restructure, lack of parity in work allocations, creation of new AD post	Confidential	Yes	Teams
125	25072404	Data breach - staff had access to hearing transcript, confidential discussions, all staff not informed as per GDPR	Confidential	No	Teams
126	25072600	Cancellation of bank HCA allegedly led to a ligature incident, no staff available to respond.	Anonymous	No	Form
127	25072601	Rotas being planned 12 weeks in advance - feel it's a punitive response to speaking up	Anonymous	Yes	Form
128	25072602	Teams chat - selective responses, asked to take down messages, only liking positive messages	Anonymous	No	Form
129	25072603	Manager receiving gifts of food from staff, potentially resulting in favouritism around shifts, leave etc	Anonymous	Yes	Form
130	25072604	Bias and favouritism with booking of bank shifts, 90% Yoruba, shifts booked when person on leave leaving them short staffed	Anonymous	No	Form
131	25072800	Clarity on payslip queries	Confidential	Yes	JS inbox
132	25072801	Query re bank pay increase	Confidential	Unknown	In person
133	25072802	Financial hardship, support to see what is available from EPUT as not comfortable to ask manager	Confidential	No	In person
134	25090100	Bullying	Confidential	Yes	FTSU phone
135	25073000	Revisit of concerns following leave, procedural and continued bullying	Confidential	Yes	FTSU inbox
136	25080200	Staff shortages, recruitment to Site office manager posts - roles do not have clear tasks, building up the role, claim waste of resources	Anonymous	No	Form
137	25070400	Request to be line managed by another team leader due to previous grievance for bullying and harassment	Open	Yes	JS inbox
138	25080401	Pressure put upon clinical staff by management and intimidation from manager	Open	No	FTSU inbox
139	25080500	Issues with grievance process, managed by similar people within the team, appealing	Open	Yes	FTSU inbox
140	25080501	Concerns over support from manager and potential bullying	Confidential	Yes	JS inbox
141	25080600	Bullying and process	Confidential	Yes	JS inbox
142	25080700	Ward review meeting, witnessed staff speaking in a derogatory way about a patient	Anonymous	Yes	Form
143	25080800	Difficulties with colleague, raised with manager not assured of actions	Open	Yes	Form
144	25081000	Unfair allocation of work from day managers and night site officers	Anonymous	No	Form

145	25081100	Bullying by manager	Open	No	FTSU phone
146	25081300	Annual leave and allocation impacting on staff wellbeing	Anonymous	No	Form
147	25081400	Access to support for RGN competency sign off	Open	Yes	In person
148	25081500	Temp in clinic 33.3, air con unit broken since June 25	Anonymous	Yes	Form
149	25081501	Temp in clinic 34.5, air con unit broken since June 25	Anonymous	Yes	Form
150	25081501	Temp in clinic 34.5, air con unit broken since June 25	Anonymous	Yes	Form
151	25081800	Multiple concerns within team, leadership, inconsistencies, appointments, manager approach, discrimination, recruitment etc	Anonymous	Unknown	Form
152	25081801	Not agree to temporary redeployment whilst investigation underway	Open	Yes	BR inbox
153	25081802	Inappropriate behaviour by manager / team on RTW	Open	Yes	BR inbox
154	25083100	Clarity on annual leave and carers leave entitlement	Open	No	Form
155	25081900	Allegation of relationship impacting on staff, unfair treatment of staff	Anonymous	Yes	Form
156	25082000	Bullying and micro aggressions from previous manager, now in a space to raise	Open	Yes	FTSU inbox
157	25082100	Manager repeatedly asking staff to take her to the train station during work hours leaving team short staffed	Anonymous	No	Form
158	25082800	Multiple concerns within team, leadership, inconsistencies, appointments, manager approach, discrimination, recruitment etc	Anonymous	Yes	Form
159	25082900	Lack of support with reasonable adjustments, compassionate leave and condition	Open	Yes	FTSU inbox
160	25090101	Fall out from return of team leader and service manager following concerns. Behaviour and communication from team leader	Confidential	Unknown	JS inbox
161	25090300	Issues re leadership and approach within team	Unassigned	Yes	BR inbox
162	25090301	Termination from fixed term contract	Confidential	Unknown	FTSU inbox
163	25090800	Patient's mother banned from ward without following due process. Bullying by Consultant	Confidential	Yes	FTSU inbox
164	25090901	Staff Nurse and support worker in a relationship, working similar shift pattern which is against policy	Anonymous	No	Form
165	25090901	Behaviour of consultant and processes not being followed	Confidential	Yes	FTSU phone
166	25091000	Behaviour of consultant and processes not being followed	Confidential	No	JS inbox
167	25091400	Recruitment / consultation process linked to staff shortages	Anonymous	No	Form
168	25091600	Late cancellation of shifts, not booking bank and staff shortages	Confidential	No	Form
169	25091601	Inappropriate comments from colleague, female appearances, female friendships and personal lives.	Anonymous	Yes	Form

170	25091700	Rotas not being planned 12 weeks in advance	Anonymous	Yes	Form
171	25092200	Bullying by a manager and grievance process	Open	Yes	FTSU inbox
172	25092200	Inappropriate comments and attitude from colleague within the collaborative at a meeting	Open	Yes	FTSU phone
173	25092500	Shouting and swearing incident from administrator	Confidential	Yes	FTSU inbox
174	25092501	Support with reasonable adjustments and stage 1 sickness - unequitable decisions	Confidential	No	FTSU phone
175	25092502	Ability to book annual leave following long term sickness	Confidential	Yes	FTSU phone
176	25092800	Bullying from manager	Open	Unknown	JS inbox
177	25092900	Inappropriate relationship between deputy ward manager and patient, increased assaults, breaches of confidentiality	Anonymous	No	Post / Letter
178	25092901	Not notified was under investigation (historic sexual safety case)	Open	No	JS inbox

*An area to monitor. Whilst the wording of the question changed midyear which alters the data at least 55% of people speaking up state the issue had been raised prior to joining EPUT.

APPENDIX THREE

Janice Scott Freedom to Speak Up Guardian 6-month reflection Q1 and Q2 2025

Starting at the trust in the middle of the Inquiry was a strange time to join as a Guardian. “Business as usual” appears to have morphed into change for the better which many staff struggle to keep abreast of and some managers find it difficult to navigate and embed. Credence is given on the importance of speaking up, however there is work needed to help staff understand their work responsibilities and effectively equip managers with the ability to listen compassionately and effectively and follow up without fear of consequence.

Feedback from two managers following support from FTSU:

“I just wanted to say thank you for your time and support. I recognise that this came into being from an unfortunate situation however, I really found the support and insight very helpful.”

“Following your FTSU session, I really listened to what you said and how you spoke to the staff and it’s changed the way I listen to staff, I’m more empathetic and compassionate with them and I’ve stopped expecting them to be like me”

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item PS

REFERENCES

Only PDFs are attached

Board Assurance Framework 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Denver Greenhalgh, Executive Director for Governance					
Report discussed previously at:	Executive Board Assurance Framework Meeting 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?	For Information and Review		
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 of 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 of the reporting period.
- There have been no changes in risk score
- At the Finance and Performance Committee it was agreed to consider extending SR7 to be inclusive of cash position and capital, considering the increased risk to cash balances from the Inquiry and the loss of deficit support funding.
- There has been no risk agreed for closure
- 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			
SR	Strategic Risk	CR	Corporate Risk
BCP	Business Continuity Plan		

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Executive Director – Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

November 2025

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

Nov-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	10

Likelihood \ Consequence	1	2	3	4	5
1					
2					
3				SR11 SR10	SR3, SR4 SR6, SR9 SR13
4				SR5 SR12	SR7 SR8
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	6	

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.	A dedicated ERIC and PAM group has been established to review the national data submission and informs the strategy and Operating Plan. ERIC and PAM meetings are scheduled back in to pick up actions and forward plan no high or significant risks to note.
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.	Procurement of Contract Appropriate OoAPs Placement - separate work stream for procurement 26 The Trust has further discussed conclusion to the unification process with MSE ICB. In particular as allocations for 26/27 will be based on a Greater Essex footprint and become part of contractual baselines. Length of stay and out of area activity determined and agreed. Financial proposal to be shared with ICB colleagues by end of December 2025. Sign off for the Implementation model to BAU will be at the next Time to Care Steering Group originally planned for 20 November 2025 but has been delayed until December - working to plan. Action further extended to align with sign off. Red RAG rating denotes this is a further extension of action. Findings and recommendations from EPUT Flow Review received. 90 day action plan developed with oversight from the Executive Team and the timeline for full delivery of plan is March 2026. Green RAG rating applied as denotes this action has changed and become a new action in light of the review.
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	Currently nine Rule 9s in draft, 13 finalised and submitted. To date we have received 72 Rule 9 requests, 22 open and in progress. Note the Lampard Inquiry have added 3 additional weeks of hearings in October 2026 and therefore closing statements for the evidence gathering stage of the Inquiry will now be in December 2026. Therefore the timeline for this action has been extended to the end of October 2026 in anticipation that request for information will continue up until this date. The Project Director recruitment process has concluded with candidate proposed start date is 12 January 2026 (with some orientation / induction days being held in December 2025). In the meantime, the Executive Director of Governance continues to hold the role. Netrix is now live - noting the system does have limitations in terms of its use. Scoping undertaken with Executive Team (taking consideration of other priorities across the Trust i.e. Winter Planning, CQC inspection activity, NOVA programme etc.) to increase capacity in the team to respond to the changing nature of Rule requests.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR6	All	Cyber Security	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.	One remaining action outstanding with anticipated completion date of November 2025. All outstanding actions from previous cyber security audit are complete and varified by Internal Audit as action complete.
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	Capital spend YTD £6.2m, £5.1m behind plan, mainly driven due to delays in key strategic estates schemes and EPR (re-forecast subject to agreement of delivery plan and resourcing requirements). Actions to accelerate capital spend are in place. The MH Urgent Care Centres business case has now been approved by NHSE with construction works due to commence in December 2026. The capital forecast has been reduced by £6.7m with an application to DHSC made to defer resource into 26/27, which has not be approved to date. Internal and system brokerage options being explored.
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	At month seven, including excess Inquiry costs of £1.9m the YTD deficit is £3.4m (£2.7m M6). The Trust is £1.8m off plan at M7 (£0.7m M6). Excluding Inquiry the costs the Trust would be £0.2m better than plan. The in-month deficit of £0.7m relates to (i) increased in temporary staffing (half term impact), (ii) excess Inquiry costs, and, (iii) non recurrent non pay expenditure including Out Of Area high cost placements (price rather than volume). The Trust recently received instruction that, from month 7 it should no longer report receipt of Deficit Support Funding (DSF). The annual DSF allocation was £20.5m, planned to be received equally across the year. The impact of removal of DSF is therefore £1.7m per month. This adjustment increases the M7 YTD deficit from £3.4m to £5.1m and the in-month deficit from £0.7m to £2.5m. The position on future DSF eligibility will be subject to continuous review but, for 2025/26 is dependent on System financial target delivery, not specific organisation delivery. The removal of DSF will result in depleted cash balances £10.3m Q3/Q4, associated loss of interest opportunities of c£0.2m and an increased I&E reported deficit. YTD efficiency delivery is £16.2m (49% of annual plan), £0.5m off plan. Results continue to be driven by temporary staff over-performance offset by shortfalls relating to Out Of Area placements due to patient demand with a flow recovery action plan in place and external support engaged.
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	Digital Target operating model implementation - Phase 2 to commence April following review and outcome will form Phase 3. The NOVA programme is progressing, but new risks, linked to system integration and programme complexity - are likely to delay the EPR “go-live” date. Oracle Health has confirmed no additional costs, though extra resourcing will be needed and is being reviewed with Finance.
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.	Reviewing and refining the People and Educations strategy noting presentation of revised draft at Executive Committee and People Committee in October 2025. Revised governance arrangements developing, with approved TOR socialised within consultation groups and aiming to be in place by March 2026. Staff Experience and Inclusion Group to commence in Dec 25. Education Group due to commence Dec 25. Staff Resourcing and planning Workforce Planning due to commence Dec 25. Note RAG rated red as an agreed further extension to this action to Dec 2026.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
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.	The OD & Culture team are looking at options that will be presented to SLT at People & Culture for consideration including internal and external solutions to the recording of exit interviews and developing effective interventions. Annual survey is live and will be looking at exit interview data to create intervention on staff turnover towards the end of the year. As well as new starter experience and contact.
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.	The OD & Culture restructure is live and the next phase underway. Culture review commenced with BRAP and King's Fund for a 12-month pilot. Leadership programme to be established and developed alongside future leadership development with ARU utilising the apprenticeship levy.
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.	All policies and clinical guidelines have now been uploaded onto the platform. Usage and compliance will be monitored through the SOPHIA reporting tool and via the SOPHIA Group. System is now fully live and access to policies on the intranet has been removed. Work will be ongoing to identify eSOPs for development via the SOPHIA Group. A template has been provided to each Care Unit to support local Quality and Safety meetings that reflects experience, effectiveness and safety of care. Now in a period of monitoring for impact and sustainability, with a view to closing the action in September and moving to an active control Next steps to review IA test of sustainability as awaiting final report and consideration of any recommendations. Review of Quality Control Audits (Tendable)completed in March '25 - initial findings highlighted some areas of non-adherence to plan, with a task and finish group having been stood up to deliver changes required on the back of audit recommendations.

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
1	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	0	1

Likelihood	Consequence 1	2	3	4	5
1					
2					
3				CRR11	
4					
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	0	

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 Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25 and outlining priorities for year 2 which are set out in the Trust Quality of Care Plan (QoC). The Quality of Care Group has received the Q2 report which highlighted: increase in suicide deaths in the quarter (note no suicides occurred within EPUT premises and all are current suspected suicides until COD is confirmed). A full project plan is in development for the move from risk stratification to Safety Planning. STORM training compliance has increased to 77% for all urgent care clinicians. Reduction in self harm incidents has continued this quarter. Monitoring has continued looking at correlation between staffing and reduced levels of self-harm and ligature activity.

Strategic Risk Register November 2025

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*	
C5 x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previous reported completed actions 1- 7 have been removed from the report. **Note 2:** Note the allocation of £6m Estates Safety Fund to EPUT to address infrastructure capital items.

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	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs 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**
6	Develop action plan for Estates Returns Information Collection (ERIC) outstanding tasks	Complete	MM	Control	A dedicated ERIC and PAM group has been established to review the national data submission and informs the strategy and Operating Plan.
8	Deliver action plan from Premises Assurance Model (PAM) self-assessment	Sep-26	MM	Control	ERIC and PAM meetings are scheduled back in to pick up actions and forward plan no high or significant risks to note.

SR4- Demand and Capacity (At a Glance)

Risk Description: If we do not effectively address capacity and 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, community and wider system)

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-5, 8-12 have been removed from the report. **Note 2:** Action 6, is reported as complete and will be removed from future reports **Note 3:** New Action 14 regarding Community First transformation Programme

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 integrated flow team, including Discharge Co-ordination Teams, Clinical Patient Flow Leads, Clinical Director for Flow & Capacity, Associate Director for Flow, Bed Management Team	Flow & Capacity Staffing Established under TTC	Performance Reporting Accountability Framework Meetings Demand Flow and Capacity Steering Group	
Care Unit Leadership	Establishment Integrated Director posts		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy Integrated Flow Team Staffing Therapeutic Acute Inpatient Operating Model Introduction of the SMART tool Enhance Sit-rep Process - Locality Based Introduction of the Prioritisation Matrix	Integrated Flow and Care Unit Leadership CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Final Report to Board (2024) Demand Flow & Capacity Steering Group	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23 Development of ED Divergent in NEE and NW due to be operational in '26	Demand Flow and Capacity Steering Group ICB System UEC Task & Finish Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitRep/ Performance Reporting	Updated OPEL framework x3 Locality Based Sit Reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status Flow report within Power BI SMART Tool Foundry Tool in development	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 2025/26	Developed including out of area elimination plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Community First Transformation Programme 4 key work streams			

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAPs beds		

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Demand and Capacity module to be procured and fully implement	Complete Nov 25	JL	Control	Capacity and Flow Model is now in use - SMART TOOL
7	Model Out of Area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer.	Extended Dec 25	SC/JW	Control	Procurement of Contract Appropriate OoAPs Placement - separate work stream for procurement 26 The Trust has further discussed conclusion to the unification process with MSE ICB. In particular as allocations for 26/27 will be based on a Greater Essex footprint and become part of contractual baselines. Length of stay and out of area activity determined and agreed. Financial proposal to be shared with ICB colleagues by end of December 2025. Therefore new agreed timeline of 31 December 2025 to align with this further work. Red RAG rating denotes this is a further extension of action.
8	Implementation of new operating model	Further extended Dec 25	LW	Control	Sign off for the Implementation model to BAU will be at the next Time to Care Steering Group originally planned for 20 November 2025 but has been delayed until December - working to plan. Action further extended to align with sign off. Red RAG rating denotes this is a further extension of action.
13	Demand and Capacity and Length of Stay Programme	Extended Mar '26	AG	Control	Steering groups established, this will feed into the Adult Acute Mental Health Programme and incorporates the Winter Plan (agreed at Board on 3 September) and the Flow Recovery Plan (FRP) hosted by EPUT but with a System wide approach/leadership. MADE events created within EPUT and Essex OOA Providers Findings and recommendations from EPUT Flow Review received. 90 day action plan developed with oversight from the Executive Team and the timeline for full delivery of plan is March 2026. Green RAG rating applied as denotes thisaction has changed and become a new action in light of the review.
14	New Action: Community demand and capacity work stream initiated	Dec-25	KS		Integral to Community First transformation programme and jointly led with ICB Initial reporting from work stream Dec '25.

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*	
C5 x L4 = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1-7 have been removed from the Board report. **Note 2:** The continued significant number of new Rule 9 requests from the Inquiry in the period challenging our capacity.

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 (Denver Greenhalgh) Project Director (Vacancy) 3 Associate Directors 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 £8.6m to end of 2026	Finance reports to Finance and Performance Committee	External audit of provision for the Inquiry completed for 2024/25. (Note additional cost pressure of £6.6m to end of 2026 as consequence of accounting treatment).
Inquiry Response Governance	Inquiry Project Team leadership through 3 ADs Multi-Disciplinary Working Group Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee	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	Lampard Inquiry Oversight Committee	Internal audit.
Support for staff	Project Team Here for You Provision Executive & Leadership team	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.
Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

Actions (to modify risks)		By When	By Who	Gap	Update
8	Rule 9 progress	End of October 26	Associate Directors	Assurance	Currently nine Rule 9s in draft, 13 finalised and submitted. To date we have received 72 Rule 9 requests, 22 open and in progress. Note the Lampard Inquiry have added 3 additional weeks of hearings in October 2026 and therefore closing statements for the evidence gathering stage of the Inquiry will now be in December 2026. Therefore the timeline for this action has been extended to the end of October 2026 in anticipation that request for information will continue up until this date.
9	Recruitment of a new Project Director to ensure we have the right skills and resources in place to service the Lampard Inquiry requests.	Complete	DG	Assurance	The Project Director has stepped back to their substantive position within the Trust (from August 2025) and recruitment process is concluded with candidate offered. The proposed start date is 12 January 2026 (with some orientation / induction days being held in December 2025). In the meantime, the Executive Director of Governance continues to hold the role.
10	Implement Netwrix Search Software	Complete	DG	Control	Netrix is now live - noting the system does have limitations in terms of its impact on reduction in resource of search and therefore we have not reduced the overall risk score as direct relation to the volume of request from the Inquiry.
11	Review and refocus of Project Inquiry resource to align with the skill set required to respond to the latest Rule 9's.	Dec '25	DG	Control	Scoping undertaken with Executive Team (taking consideration of other priorities across the Trust i.e. Winter Planning, CQC inspection activity, NOVA programme etc.) Agreed Compliance Team (leadership and clinical staff) move over to Inquiry Project Team for a period of three months. Resource from clinical leaders and transformation team reallocated to be Inquiry facing (utilising our business continuity planning). We will continue to assess on a weekly basis and mobilise staff as required.

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*	
C5 x L4 = 20	*C 3 x L5 = 15*	*C4 x L3 = 12*	**Note 1:** Previous reported completed actions 1 - 8 have been removed from the report. **Note 2**: Next reporting period will include a full review of controls to assess what additional safeguards the CAF provides and their associated assurances. **Note 3:** Action 9 now passed timescale and expecting completion in November 25.

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)
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) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT/CAF Action plan Implementation following TIAA audit
Business Continuity Plans and National Cyber Team processes	BCP in place	Successfully managed Cyber incident	Annual Testing as part of DSPT/CAF NHS Digital Data Security Centre, Penetration Testing,
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	DSPT/CAF Action plan Implementation following TIAA audit

	Actions (to modify risks)	By When	By Who	Gap	Update
9	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Further Extended End Nov ' 25	AW	Assurance /Control	One remaining action outstanding with anticipated completion date of November 2025. All outstanding actions from previous cyber security audit are complete and varified by Internal Audit as action complete. Note RAG rated red to demote the further extension agreed.
10	**New Action**: Cyber assurance Framework preperation for baseline submission for DSPT will identify any remaining gaps in control for 26/27 full submission.	End Dec '25	AW	Assurance /Control	New action Nov '25.

SR7- Capital (At a Glance)

Risk Description: If EPUT does not have sufficient capital resource, e.g. Estates Backlog, 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*	**Note 1:** Previously report completed actions 2 - 4 have been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

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 funding allocation 2025/26	Capital Project Group forecasting	Capital Planning Group reporting to ET and onto Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources secured	Capital Planning Group reporting to ET and onto 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; Chairing System Investment Group	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2025/26 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	FBC Agreed, contract signed.
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	Estates Safety Funding of £6m has now been fully approved. Final submission of the Programme of Works is planned by October for the UEC funding. The majority of the works are now in the process of being tendered. The Trust continues to work up business cases for future investments in preparation for the announcement of new Estates and Digital national funding for 2026/27. The Trust has approach Frontline Digitisation to support moving the forecast EPR capital underspend funding into 2026/27 to support CDEL Trust capacity, this is driven by slippage in the EPR programme timeline. The Trust is also working through the profile of a number of property disposals as agreed in the Estates Strategy to support the CDEL and capital availability in the year of EPR go-live.

Actions (to modify risks)		By When	By Who	Gap	Update
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	Capital spend YTD £6.2m, £5.1m behind plan, mainly driven due to delays in key strategic estates schemes and EPR (re-forecast subject to agreement of delivery plan and resourcing requirements). Actions to accelerate capital spend are in place. The MH Urgent Care Centres business case has now been approved by NHSE with construction works due to commence in December 2026. The capital forecast has been reduced by £6.7m with an application to DHSC made to defer resource into 26/27, which has not be approved to date. Internal and system brokerage options being explored.

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*	
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1,3 - 5,7-13 has been removed from the report. **Note 2:** Note new external assurance of National Oversight Framework rating of 3 linked to the receipt of deficit funding and system financial performance

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).IA E-rostering - Limited Assurance opinion. IA Consultant Job Plans - Limited Assurance opinion.
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	Oversight Framework and ratings
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 2026/27	Multidisplinary team stood up	Finance and Workforce Committees	NHSE Oversight
Forecast Outturn and risk/ opportunities assessments 25/26	Forecast outturn reports including risks and mitigations	Accountability Framework reporting and F&P	
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team - Downward trend in temporary staffing use seen in month 1 (2025/26).	IA Temporary Staffing (2024/25)Reasonable Assurance OpinionF&P Committee July '25 - Reasonable assurance that temporary staffing controls were working as expected.	

Actions (to modify risks)		By When	By Who	Gap	Update
2	Deliver Financial Efficiency Target	Mar '26	TS	Control	The Finance and Performance Committee have been updated on the Month 4 efficiency performance including key risks and mitigation actions.

Actions (to modify risks)		By When	By Who	Gap	Update
6	Deliver Financial plan for 24/25	Mar '26	TS	Control	At month seven, including excess Inquiry costs of £1.9m the YTD deficit is £3.4m (£2.7m M6). The Trust is £1.8m off plan at M7 (£0.7m M6). Excluding Inquiry the costs the Trust would be £0.2m better than plan. The in-month deficit of £0.7m relates to (i) increased in temporary staffing (half term impact), (ii) excess Inquiry costs, and, (iii) non recurrent non pay expenditure including Out Of Area high cost placements (price rather than volume). The Trust recently received instruction that, from month 7 it should no longer report receipt of Deficit Support Funding (DSF). The annual DSF allocation was £20.5m, planned to be received equally across the year. The impact of removal of DSF is therefore £1.7m per month. This adjustment increases the M7 YTD deficit from £3.4m to £5.1m and the in-month deficit from £0.7m to £2.5m. The position on future DSF eligibility will be subject to continuous review but, for 2025/26 is dependent on System financial target delivery, not specific organisation delivery. The removal of DSF will result in depleted cash balances £10.3m Q3/Q4, associated loss of interest opportunities of c£0.2m and an increased I&E reported deficit. YTD efficiency delivery is £16.2m (49% of annual plan), £0.5m off plan. Results continue to be driven by temporary staff over-performance offset by shortfalls relating to Out Of Area placements due to patient demand with a flow recovery action plan in place and external support engaged.

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 mind-set 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*	
C5 x L3 = 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:** Action 12 progress has highlighted potential slippage with NOVA programme.

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 assessment (Standards Met)
Data quality is of a standard that assures national standards.	Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT “standards met” can be achieved		Internal Audit	DSPT submission and Cyber assurance framework
Investment			
Capital allocation to digital and data initiatives secured	Approved Digital capital plan		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes	Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation			
The space and governance exists to support innovation	CIO discover opportunities from national forums and partners (incl. Academic)	Innovation strategy governance - Strategy Steering Group	
Academic partnerships promote innovation	CIO engagement with academic partners on digital innovation opportunities		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
11	Digital Target operating model implementation - phase 2	Ext Dec 25	AW	Control	Phase 2 to commence April following review and outcome will form Phase 3. Outcomes of MARS and delays in recruitment have influenced phase 2 timescales, potential delay forecasted. Agreed extension to December 2025.
12	New Action: Implementation of new UEPR	Apr-27	ZT	Control	The NOVA programme is progressing, but new risks, linked to system integration and programme complexity - are likely to delay the EPR “go-live” date. Oracle Health has confirmed no additional costs, though extra resourcing will be needed and is being reviewed with Finance.

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 1 - 5 have been removed from the report. **Note 2:** Action 7 over timescale.

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

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
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. Reviewing and refining strategy noting presentation of revised draft at Executive Committee and People Committee in October 2025.
7	Revised governance arrangements in People & Culture directorate with 3 distinct but aligned groups covering Staff Experience, Recruitment & Retention and Education that will all feed into a People & Culture Group. This will then escalate matters of decision to the Executive Committee and matters of assurance to the People Committee.	Extended Dec '25	Executive Director of People and Culture	Assurance	People and Education Strategy and approved TOR have been socialised within consultation groups and aiming to be in place by March 2026. Staff Experience and Inclusion Group to commence in Dec 25. Education Group due to commence Dec 25. Staff Resourcing and planning Workforce Planning due to commence Dec 25. Note RAG rated red as an agreed further extension to this action to Dec 2026.
8	Delivery the Trust Recruitment Plan.	Dec-25	Associate Director of People - Resourcing	Assurance	Consultation meetings with stakeholders both internal and external to develop a clear recruitment plan to support sustainability going forward and be aligned to the People Strategy. This includes aims to have full recruitment for HCA and band 5 nursing as an early area of focus. It also looks at developing a recruitment plan that supports career development and is aligned to our learning and education priorities. Consultations underway via Workshops and sharing of additional draft with a view to launch at the end of the year.

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*	**Note 1:** Previously reported completed actions 1 - 5 have been removed from the report.
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L3 = 12*	

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

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 People Committee	
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 People Committee 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
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. Reviewing and refining strategy with presentation of revised draft at Executive Committee and People Committee in October 2025.
7	To develop a mechanism to review exit information and identify clear trends. This information will be triangulated with pulse and annual staff survey information to better understand interventions to reduce staff turnover.	Dec-25	Director of OD & Culture	Assurance	The OD & Culture team are looking at options that will be presented to SLT at People & Culture for consideration including internal and external solutions to the recording of exit interviews and developing effective interventions. Annual survey is live and will be looking at exit interview data to create intervention on staff turnover towards the end of the year. As well as new starter experience and contact.
8	Delivery of People Promise objectives with an emphasis on new starter experience.	Jan '26	Director of OD & Culture	Assurance	The team are currently revising the new starter experience with proposal associated to improving the induction process as well as enhancing support for new staff within the first 6-12 months of commencing in their new role.

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 1-6 have been removed from the report.

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

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

Actions (to modify risks)		By When	By Who	Gap	Update
7	Revised structure in OD & Culture to meet aims and objectives.	March 26	Director of OD & Culture	Assurance	The OD & Culture restructure is live and the next phase underway.
8	Culture Review and Leadership Development Programme.	March 26	Director of OD & Culture	Assurance	Delivery commenced with BRAP and King's Fund for a 12-month pilot which will include a culture review starting in September 2025. Leadership programme to be established and developed alongside future leadership development with ARU utilising the apprenticeship levy.

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*	
C5 x L4 = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previously reported completed actions 1-3 and 5 and 8 have been removed from the report. **Note 2:** Note further extension of Action 6 in line with Internal Audit sign-off and consideration of any recommendations. **Note 3:** Note further extension of Action 7 to allow sufficient time for the audit recommendation to be fully implemented prior to closing the action. **Note 4**: Action 4 is reported as being complete and will be removed from future reports.

Executive Responsible Office: Executive Chief Nurse
Board Committee: Quality Committee

Key Controls	Controls Assurance 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 (outcome detail to be added)
Patient Safety Incident Management Team	Team Established		IA PSIRF (outcome detail to be added)
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a breach in governance as a consequence of not having adequate oversight of the breaches within the Safe domain.
Learning Collaborative Partnership	Forum attendance and effectiveness review.		CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Learning information communications plan			CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Patient Safety Dashboard			
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports 2024 - 2025 for Clifton Lodge, Brockfield House and Adult MH Inpatients and PICU provided positive assurance.
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

Key Controls	Level 1	Level 2	Level 3
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA Compliance with policies - Site Visits (2024/25) Reasonable Assurance opinion. IA Board Assurance and Risk Management – Substantial Assurance opinion.
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.CQC inspection reports 2024 - 2025 for Clifton Lodge (Good) , Brockfield House (Good) and Adult MH Inpatients and PICU (RI - an improved rating) provided positive assurance.

	Actions (to modify risks)	By When	By Who	Gap	Update
4	Continue to full implementation of the eSOP programme (ensuring that all SOPs are reviewed and uploaded to the new SOPHIA system)	Sep '25 (Complete Nov 25)	RB/RJ	Control	All policies and clinical guidelines have now been uploaded onto the platform. Usage and compliance will be monitored through the SOPHIA reporting tool and via the SOPHIA Group. System is now fully live and access to policies on the intranet has been removed. Work will be ongoing to identify eSOPs for development via the SOPHIA Group.
6	Review the Quality forums from Care Unit to Board and reporting.	Extended Dec '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. Now in a period of monitoring for impact and sustainability, with a view to closing the action in September and moving to an active control.Agreed extensions to end December 2025, pending IA test of sustainability as awaiting final report and consideration of any recommendations. RAG rated red as second extension of action.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Extended Mar 25	RP	Assurance	Review completed in March '25 - initial findings highlighted some areas of non-adherence to plan, with a task and finish group having been stood up to deliver changes rquired on the back of auidt recommendations. Agreed extension to end of March 2026. RAG rated red as second extension of action.

Corporate Risk Register November 2025

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	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1 - 5 have removed from the report for CRR11.
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*	

Executive Responsible Office: Executive Medical Director
Director Lead: Dr Nuruz Zaman Deputy Medical Director
Leads: 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 (achieved year one target of 60% of registered staff)		
Self Harm Clinical Guideline Ligature Environmental Risk assessment and Management Policy		Suicide Prevention Group (Co-chaired with a Lived Experience Ambassador) Ligature Risk Reduction Group	
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 Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25 and outlining priorities for year 2 which are set out in the Trust Quality of Care Plan (QoC). The Quality of Care Group has received the Q2 report which highlighted: increase in suicide deaths in the quarter (note no suicides occurred within EPUT premises and all are current suspected suicides until COD is confirmed). A full project plan is in development for the move from risk stratification to Safety Planning. STORM training compliance has increased to 77% for all urgent care clinicians. Reduction in self harm incidents has continued this quarter. Monitoring has continued looking at correlation between staffing and reduced levels of self-harm and ligature activity.

Risk Movement

November 2025

EPUT

Risk Movement and Milestones

Strategic Risk Movement – two-year period (Nov 23 – Nov 25)

Risk ID	Initial Score	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	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25
SR1	20	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	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15
SR5	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	16	16	16	16	16	16	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	15	15	15	15	15	15
SR10	16												New	16	**12**	12	12	12	12	12	12	12	12	12	12	12
SR11	16												New	16	**12**	12	12	12	12	12	12	12	12	12	12	12
SR12	16												New	16	**16**	16	16	16	16	16	16	16	16	16	16	16
SR13	20													New	**15**	15	15	15	15	15	15	15	15	15	15	15

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two-year period (Nov 23– Nov 25)

Risk ID	Initial Score	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	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 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
CRR45	12	16	16	16	16	12	12	12	12	12	12	12	12	12	12	16	12	12	12	12	12	12	12	12	D	
CRR77	16	16	16	16	16	16	16	16	16	16	16	16	16	8	D											
CRR81	12	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	D			
CRR93	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	10	D											
CRR98	20	20	20	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	D				

8.2 Q1 2025/26 LEARNING FROM DEATHS ? QUARTERLY OVERVIEW OF LEARNING AND DATA REPORT

Decision Item AS

REFERENCES

Only PDFs are attached

Q1 2025-26 Learning from Deaths ? Quarterly Overview of 03.12.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	03 December 2025

Report Title:	**Q1 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, Senior Project Lead (Mortality)					
Report discussed previously at:	Learning from Deaths Oversight Group, Learning Oversight Sub-Committee, Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	On-going risk relating to the resourcing capacity within the learning from deaths workstream being addressed Data processes currently in place continue to be reviewed to further strengthen the Trust's ability to undertake mortality surveillance	
Which of the Strategic risk(s) does this report relates to:	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? *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, at Appendix 1, the final draft ***Q1 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data*** report, which includes the following: • Data relating to deaths recorded on Datix for Q1 2025/26 (1 April – 30 June 2025) • A summary of progress of reviews of deaths occurring in previous periods • Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and approve the information presented;
2. Note the assurance provided by the content of this report that there are robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high quality services; and
3. Request any further information or action.

Summary of Key Issues

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

2. The final draft *Q1 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data* is attached at Appendix 1. This follows the same format as the last report presented to the Board of Directors (Q4).

3. The report presents the data which the Trust is nationally mandated to report to public Board meetings on a quarterly basis– i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. The Q1 2025/26 data was extracted and analysed as at 04/09/25. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q1 data, which is broadly in line with that of previous quarters (as evidenced by the Statistical Process Control analysis undertaken and presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee). The detailed data underpinning this report has been shared with the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee via email for consideration and virtual approval for inclusion; and will be the subject of discussion at their meetings in October.

4. The report also provides an overview of key learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result. This learning is presented in detail on a monthly basis to the Trust's Learning from Deaths Oversight Group and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

5. There continues to be scope to refine and strengthen the mortality reporting, data and review processes. Unfortunately, due to unexpected absence of key staff involved in this work, there has not been as much progress as had been envisaged over the past quarter. As highlighted in previous reports, it is important that this work is progressed as priority for the Trust and appropriate internal staffing resource directed towards it. Options for ensuring this is taken forward as promptly as possible are being explored.

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			
LFD	Learning from deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework		

Supporting Reports/ Appendices /or further reading
Appendix 1 – FINAL DRAFT *Q1 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data Report*

Lead

Ann Sheridan

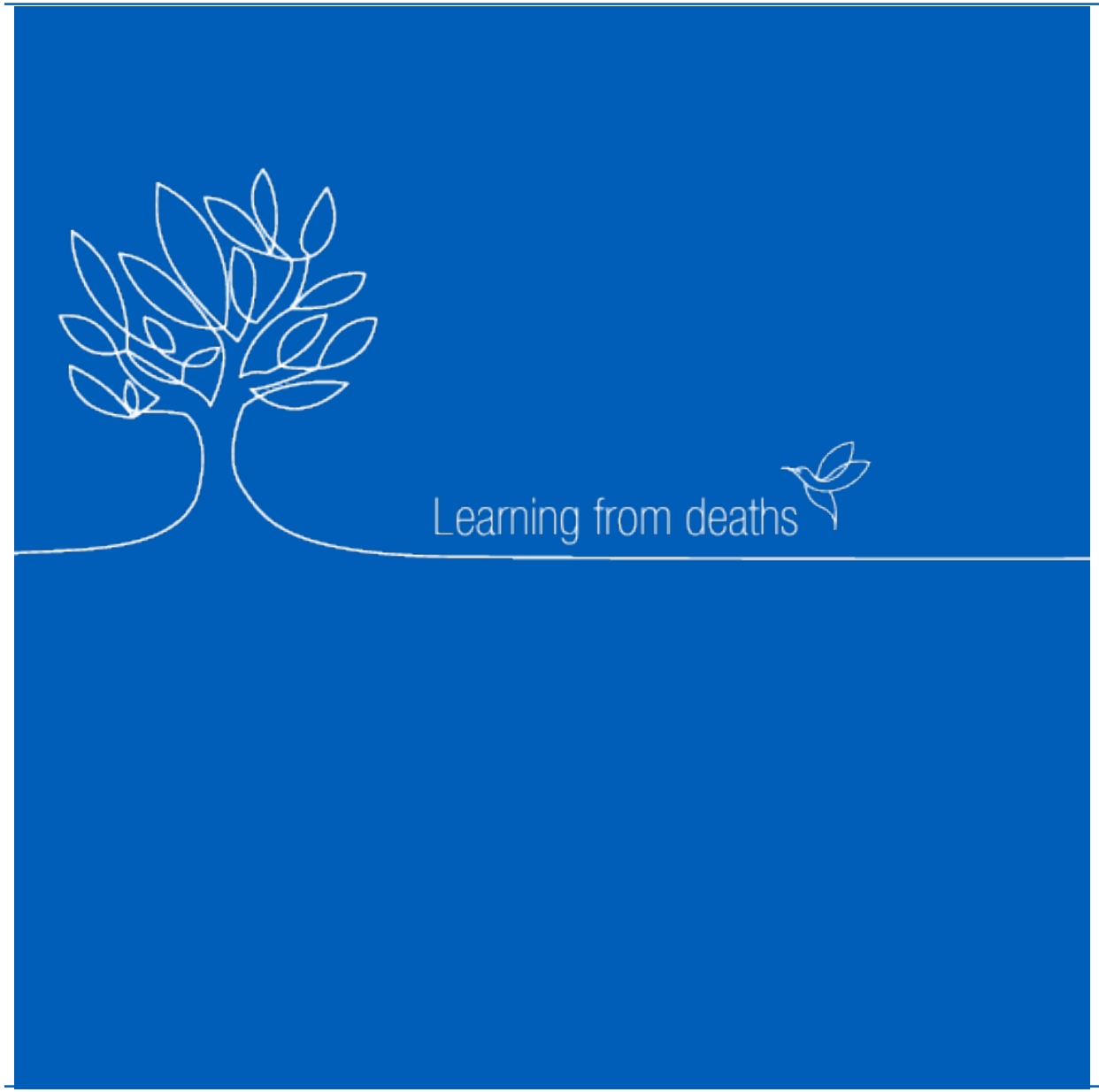
Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 1 - 2025/26

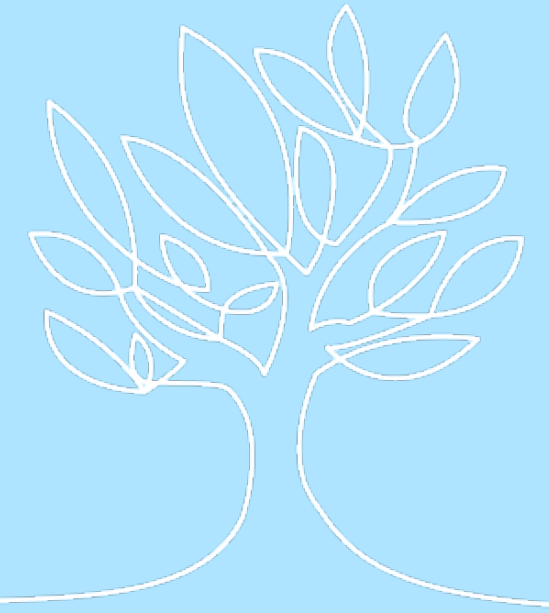


PURPOSE OF REPORT

This report sets out:

- Data relating to deaths recorded on Datix for Q1 2025/26 (1st April – 30th June 2025);
- A summary of progress of reviews of deaths occurring in previous periods;
- Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board of Directors;
- An example of specific learning and action from the review of a death under the Patient Safety Incident Response Framework (PSIRF);
- Conclusions and actions required.

Summary of Quarter 1 2025/26 mortality data (as at 04/09/25) (Page 1)

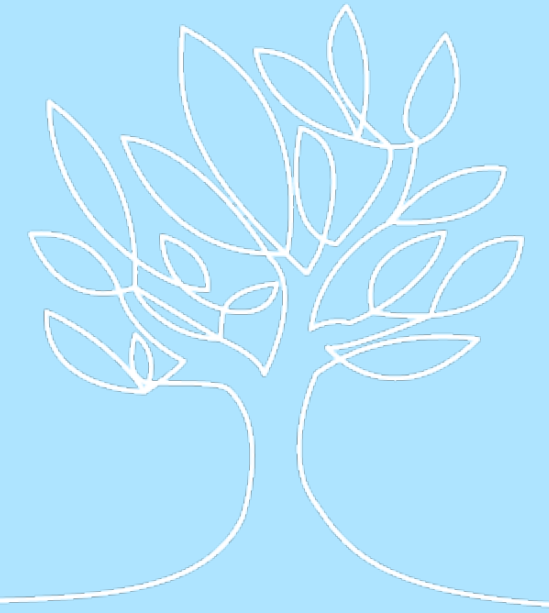


- **Total number of deaths reported:** There were a total of 149 reports of deaths made on Datix, relating to 143 deaths for Q1 2025/26 (including those not falling within the scope for mandatory reporting). To date, a total of 31 of those reported deaths have been deemed in scope for mandated reporting under the policy. Deaths reported on Datix over and above the deaths in mandated scope of the policy provide additional opportunities for the Trust to learn. Statistical Process Control is utilised to monitor the number of deaths reported on Datix and the number of deaths in scope to identify any areas of concern for action. This indicates that the figures for Q1 are within usual parameters.

- **Inpatient / Nursing Homes deaths:** Of the 143 deaths reported in Q1, 2 were EPUT community health services inpatient deaths, 4 were EPUT mental health services inpatient deaths and 2 were EPUT nursing home deaths. The 2 community health services inpatient deaths and the 2 nursing homes deaths have been confirmed as due to natural causes. The cause of death for 3 of the mental health services inpatient deaths is under determination and one death was sadly an unexpected unnatural death. A Patient Safety Incident Investigation is underway for this death under the Trust's Patient Safety Incident Response Framework (PSIRF).

- **LeDeR reporting validation:** All of the 9 reported Learning Disability deaths have been confirmed as reported to the national LeDeR Programme – a programme aimed at learning from the lives and deaths of people with a learning disability and autistic people.

Summary of Quarter 1 2025/26 mortality data (as at 04/09/25) (Page 2)



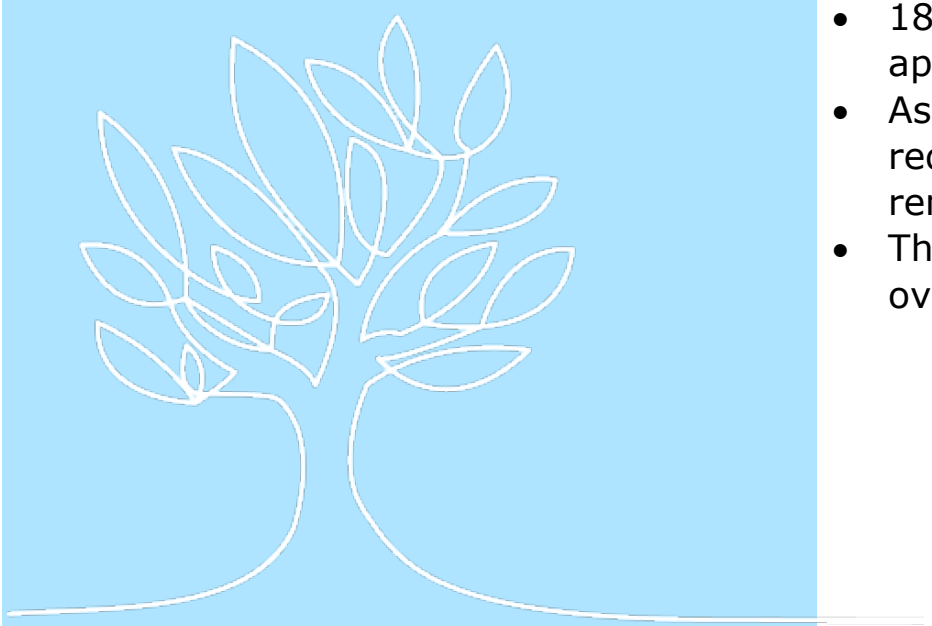
- **Stage 1 (Datix) reviews:** To date, a total of 114 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the Q1 deaths. Stage 1 reviews are still actively awaited for 13 of the deaths.

- **Stage 2 (Clinical Case Note) reviews:** A total of 0 deaths in Q1 have been identified to date for Stage 2 mortality clinical case note review / thematic review.

- **Stage 3 (PSIRF) reviews:** A total of 8 deaths in Q1 have been identified to date for PSIRF review. 2 of those reviews have been completed.

- **Problems in care assessment:** There are 0 deaths for Q1 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The approach to making this determination for deaths reviewed under PSIRF arrangements continues to be under development as there is no national methodology for this. The determination will be made for death reviews already completed under the PSIRF arrangements once the Trust approach is agreed.

High level summary of progress with reviews of deaths occurring in previous periods

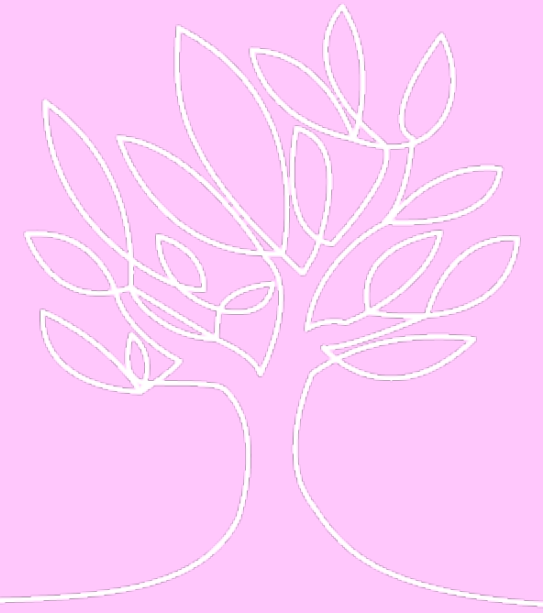


Since the Q4 report to the Board of Directors, the following progress has been made with reviews of deaths occurring in previous periods (as at 04/09/25):

- 94 additional Stage 1 (local Care Unit) reviews have been completed
- 111 additional death reviews have been considered through Care Unit governance processes and agreed for closure at Stage 1 (local Care Unit) review
- 138 less deaths are now coded as being "under query" prior to decision on review level
- A review of all open Stage 2 (Clinical Case Note) reviews has been undertaken and decisions made in terms of progression based on most current information relating to death and circumstances. This has resulted in some Stage 2 review commissioning being stood down where, for example, the death has been reviewed via another Trust review mechanism and learning ascertained
- 18 additional Stage 3 (Patient Safety Incident Response Framework) reviews have been approved
- As at 04/09/25, there were 37 Stage 1 reviews awaiting completion for 2023/25, a reduction from 85 in the Q4 data. Targeted work continues to ensure completion of the remaining reviews, and this position is thus changing on a daily basis
- There has been an improvement on timeliness of completion of Stage 1 reviews with over 50% less outstanding this quarter(16), compared to Q4

Key learning themes emerging from Stage 1 reviews (Page 1)

June 2025 – August 2025



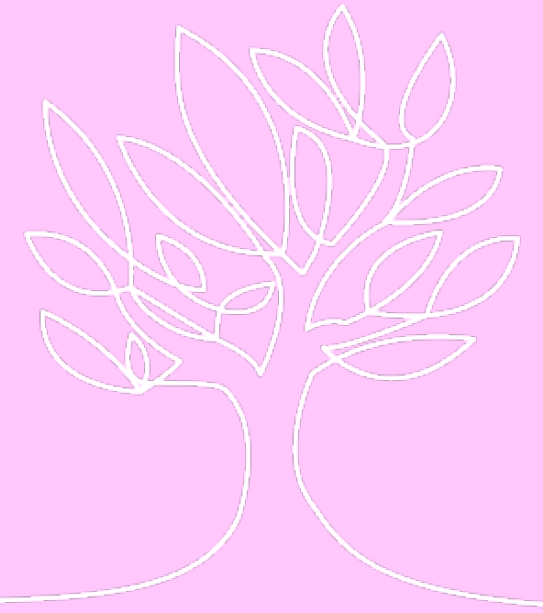
The three most common themes emerging from Stage 1 reviews of deaths in the period were as follows:

- **Theme 1:** Many of the deaths of patients are **expected deaths of patients often receiving end of life care** (cited in 20 reviews)**.** The Trust has a specific workstream in place designed to monitor the quality of end of life care provided by the Trust and to ensure this is strengthened, including quality audits reported via the Trust's governance structures. An example of developmental work being progressed, in response to learning from deaths, is multi-agency collaboration on discussing and developing guidance for the Ambulance Services in terms of patients who have PEACE end of life care plans in place.

- **Theme 2:** The majority of the deaths reviewed are from **physical health causes** (eg long term conditions, terminal illness, physical health crisis, deaths in acute trust hospitals) (cited in 19 reviews). The Trust has a specific workstream in place to strengthen physical health monitoring and care of patients. The workstream has identified specific quality priorities and monitors / oversees achievement of these. An example of developmental work being progressed to strengthen the Trust's contribution to the physical health care of patients receiving mental health services is a quality improvement initiative being facilitated in West Essex to improve uptake of annual physical health checks for patients with Severe Mental Illness (SMI). Actions taken as part of this initiative have included reviewing and strengthening training; strengthening data systems to support the process; and reviewing and strengthening equipment and facilities for these checks.

Key learning themes emerging from Stage 1 reviews (Page 2)

June 2025 – August 2025



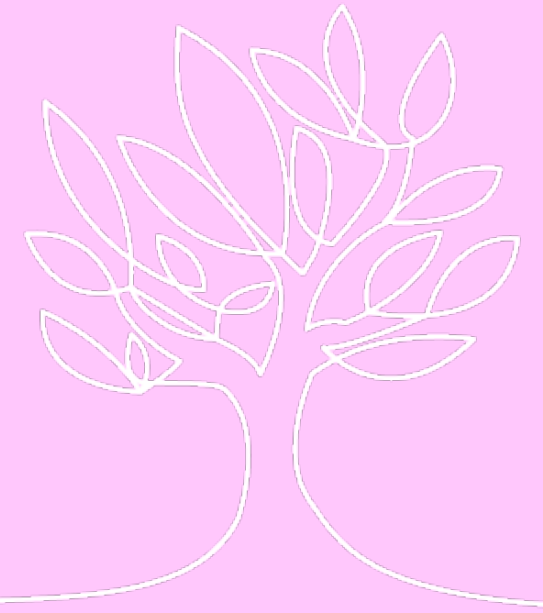
- **Theme 3:** For a number of deaths, **communications** was identified as a learning issue (cited in 12 reviews) including timely communication between EPUT teams, with partner organisations involved in care as well as with patients about their care and with families following a death. The Trust's recent and on-going work under the Safety Improvement Plan programme to strengthen multidisciplinary team approaches and communication; and work to strengthen Duty of Candour requirements across the Trust, takes account of learning in this area.

Other themes emerging from Stage 1 reviews during this period included disengagement, no cause of death information being available and dual diagnosis.

There were also a number of good practice examples cited in reviews and indications that reviewers were utilising the learning identified to inform discussions with local teams about opportunities to strengthen services.

Key learning themes emerging from Stage 3 (PSIRF) reviews

June 2025 – August 2025



Since the last report to the Board of Directors, learning from 8 deaths reviewed and closed under PSIRF have been added into the themed analysis of PSIRF learning emerging.

The three most common themes that learning identified was associated with these 8 death reviews were:

Theme 1: Clinical care (including, for example, undertaking and recording physical health observations, completion of body charts at the point of transfers from EPUT inpatient services to the acute hospital, risk assessments, monitoring patients whilst they are awaiting allocation)

Theme 2: Record keeping (including, for example, need for recording thorough case notes in clinical records including risk factors, recording of MDT meeting discussions and recording the rationale for decisions)

Theme 3: Good practice examples (including evidence of collaborative working between EPUT and acute trust for monitoring patient with joint reviews taking place and personalised care planning)

Other themes identified more than once included communications, physical health, policy and process, staffing and systems.

Action plans are developed for all PSIRF reviews, and their delivery is monitored to completion. Learning is also used to inform the Trust's Safety Improvement Plans (SIPs).

Example of specific learning and actions from a review undertaken under Stage 3 (PSIRF) (Page 1)

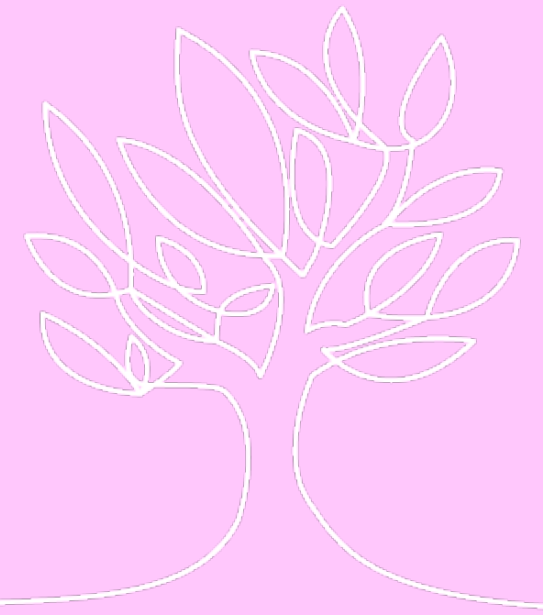
A facilitated "Multi-Disciplinary team" (MDT) review was undertaken of the death of a 58 year old patient who had sadly passed away at home in their sheltered accommodation from physical health issues. Learning identified included the importance of factual documentation, regular physical observation and psycho education, communication with the wider MDT (e.g. GP) and environmental resources.

Recommendations	Example of actions taken to date
1) Record keeping must reflect all work undertaken; and copying and pasting records previous records.	• The review has been discussed in the team's business meeting • A template was used to record depot clinics - records are now personalised • Randomised monthly audits are carried out by team lead with feedback given in supervision • Service has also participated in wider clinical record keeping audits
2) Additional physical health training and training related to psychotropic mediations to be provided.	• Cardio metabolic training is being delivered across the team • "Time to Learn" has been adopted by the service • Operational Team Manager attends "Best Partner" meetings, bringing statutory and voluntary community services together • Clinicians are encouraged to use the Dietician service to support healthy lifestyles

Example of specific learning and actions from a review undertaken under Stage 3 (PSIRF) (Page 2)

Recommendations	Example of actions taken to date
3) Review pathway for information transfer of physical health check information and assurance when patients state that they have accessed this by another provider.	• Physical health leads now have SystmOne access • Working with commissioned community provider of physical health checks for SMI to ensure no duplication and optimal access to health checks can be achieved
4) Review barriers to physical health checks being experienced by the team and feedback into wider work to improve compliance.	• Community mental health training being delivered across MSE • Working with commissioned provider to support compliance in primary care • Working towards providing a physical health check at time of depot administration if location of clinic allows for this

Examples of other sources of learning from deaths that informs Trust learning approaches (Page 1)

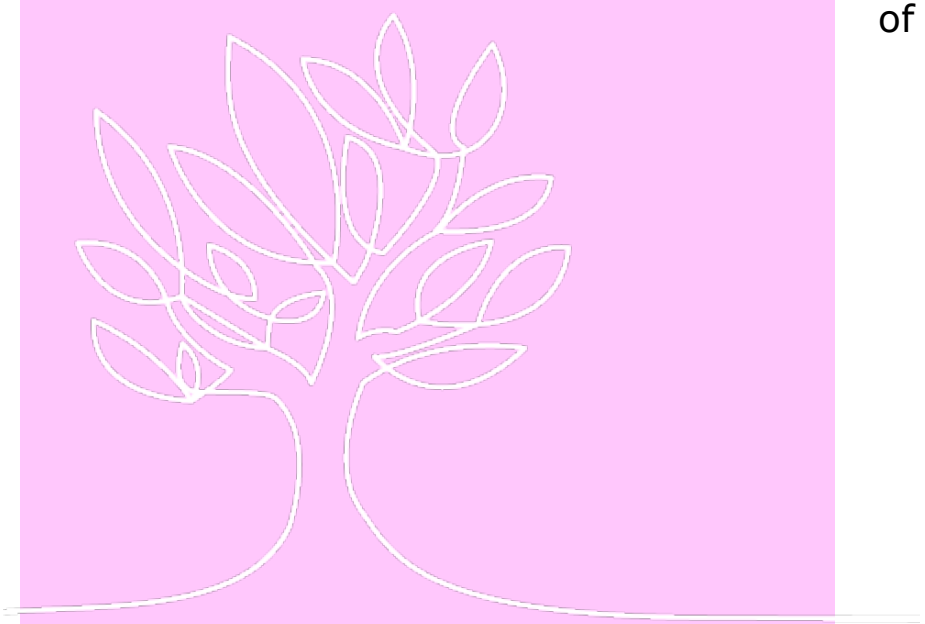


LEDER – National review programme for learning from the lives and deaths of people with a learning disability and autistic people

The Trust has an identified lead for linking into this national programme. All deaths meeting the criteria for the review programme are referred to LEDER; and the Trust is also a member of the Essex Quality Panel considering all completed reviews for the Southend, Essex and Thurrock locality areas. Often care is provided by a number of different service providers and an independent reviewer, therefore reviews care provided by all providers to identify holistic learning. An Essex action plan has been developed to address priorities identified from the learning themes and the Trust actively contributes to delivery of that plan, ensuring that any developments needed to local services are addressed.

Examples of learning from review outcomes reported this quarter include the need for care providers to work more closely together to provide co-ordinated care; and to strengthen the understanding and sharing of end of life care plans for individuals across different care providers. The Trust's End of Life Lead has been consulted on providing support to this work for EPUT.

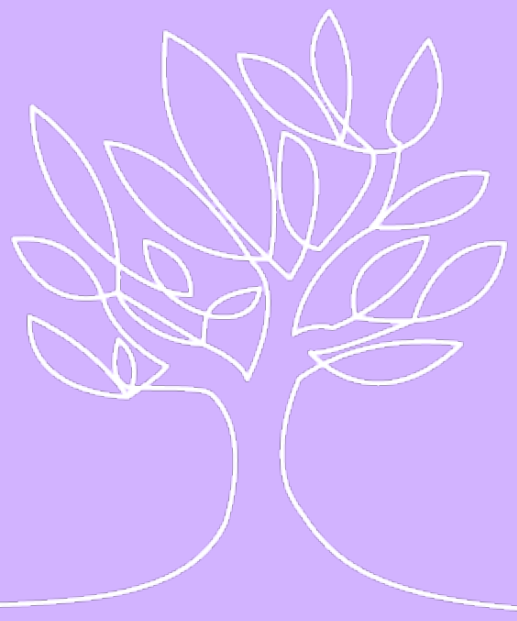
Examples of other sources of learning from deaths that informs Trust learning approaches (Page 2)



Essex Drug and Alcohol Partnership (EDAP) – Multi-agency collaborative approach to the review of deaths

The Trust facilitates a multi-agency approach to the review of deaths of clients receiving services from EDAP. All partners undertake a collaborative review to identify learning and actions required. Learning relating to dual diagnosis clients is presented at a specific learning forum comprising leadership from EDAP organisations and from EPUT mental health services. Key developments that have occurred as a result of this learning is the establishment of operational locality forums to bring together all partners to strengthen collaborative approaches to the assessment and care of clients, delivery of specialised training, and strengthening of record keeping approaches.

CONCLUSIONS AND ACTIONS REQUIRED



- This report provides:
  - Mortality data mandated for reporting to the Board of Directors in support of mortality surveillance. Statistical process control analysis of the data indicates that there are no matters of concern relating to the data for Q1 2025/26.
  - A summary of progress made with reviews of deaths occurring in previous periods.
  - Examples of learning emerging from reviews of deaths being undertaken and actions being taken in response.
- The Board of Directors is asked to:
  - Note and approve the information presented;
  - Note the assurance provided by the content of this report that there are robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high quality services; and
  - Request any further information or action.

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

9. STRATEGIC INITIATIVES

9.1 STRATEGIC IMPACT REPORT M6 25/26

Discussion Item ZT

REFERENCES

Only PDFs are attached

Strategic Impact Report 2025-26 M6 03.12.25 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Strategic Impact Report 2025/26 Month 6**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy					
Report discussed previously at:	Strategy Steering Group 9 October 2025 Executive Committee 14 October 2025 People Committee 30 October 2025 Quality Committee 13 November 2025 Finance & Performance Committee 20 November 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)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board with an update on the implementation of the Trust's Strategic Plan at Month 6 of 2025/26, half way through the five year planning period. This is prefaced by the conclusions from the Strategic Plan Review presented to the private Board meeting in October and incorporates	**Approval**	
	Discussion	✓
	Information	

feedback on how this is presented. It also provides updates on the Transformation portfolio. Finally, the report provides a high level update on the approach to Operational Planning for 2026/27 and beyond.		

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and take assurance from report.

Summary of Key Issues

The Strategic Impact Report presents medium to longer term delivery trends to illustrate progress in delivery of the EPUT Strategic Plan, complimenting the faster cycle of monthly performance reporting. The report is prepared and presented to the Board twice per year. Since the last report, further work has taken place to align reporting metrics and timescales with those that feature in the Integrated Performance Report and other Board or Committee reports as far as possible. The summary dashboard on slide 11 has been adapted to show 12 month rolling averages and movement in key metrics over the last year, to better account for seasonal variation.

At the mid-point of delivery of its five-year Strategic Plan, a review has recently been conducted to evaluate the ongoing relevance and feasibility of the Trust's stated vision, values and strategic objectives in an operating environment that has shifted significantly since the development of its Strategic Plan in 2022. This exercise was based on a range of inputs and has concluded that:

- EPUT's vision, values and strategic objectives remain relevant in the new context
- Deep capacity, performance and finance pressures remain
- Over two thirds of staff understand the Trust's strategic objectives and see their relevance to their role
- Quantitative evidence of delivery against all four strategic objectives is not yet consistently available from across the Trust, though considerable progress is demonstrable across all domains
- Enabling strategies need a consistent delivery roadmap for coherence and impact
- Adoption of AI offers significant potential to rapidly improve quality of care, improved access and address inequalities but requires focus and investment
- Impact on the social determinants of health (anchors work) will likely be better delivered by local neighbourhood partnerships than by sovereign organisations going forward
- Intelligence from patients and families tells us that our organisation needs to become truly trauma-informed to transform culture and quality of care
- A stronger and more influential position for EPUT as a System, Place, and Neighbourhood leader is within reach and desirable.

Operational Planning for 2026/27 - 2027/28 onwards will be informed by the priorities set by the Board that build on the plans already in place to deliver its strategic objectives and deliver the care its local communities deserve.

To achieve its vision of being the leading health and wellbeing service in the provision of health and community care in its current context, EPUT is planning to make three bold moves over the next two years. Adoption of AI

1. Becoming a trauma-informed organisation
2. Taking on Accountable Care delivery

This will require reprioritisation of existing resources. This combined approach will enable EPUT not just to put people at the heart of everything it does, but to **meet people where they are**: through an individualised and culturally sensitive approach to care and organisational management and focusing integrated care delivery in the local communities where people live. Meeting people where they are

recognises the fluid nature of lived experience and is equally applicable to physical and mental health service delivery as well as the variation of personal and professional experiences of our staff.

At the mid-point of the Strategic Plan, the Trust continues to evidence steady progress against each strategic objective over the last six months, although measurable medium term trends remain mixed. Any risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

1. **We will delivery safe, high quality integrated care**
    - The Trust encourages high incident reporting rates as part of its learning and improvement culture. Incident reporting rates have been consistently above target over 2.5 years
    - We expect a large proportion of incidents to have no/low rates of harm. This proportion has been slightly decreasing over 2.5 years but increasing positively in the last six months towards the 93.7% target
    - Over 2.5 years an average of 94.7 % of patients and families report feeling safe in EPUT's care, with many months above the 95% target and relative consistent monthly results.
2. **We will work with our partners to make our services better**
    - System flow in Mental Health services has been and remains challenged as shown through higher than planned length of stay and out of area placements
    - Adult length of stay hit a peak at the end of 2024/25, though improvement initiatives and implementation of the new inpatient operating model have driven a correction in Adult Length of Stay over the last six months, notwithstanding a short-lived increase in M6. Similar improvements in Older Adults are planned in the next period, including the first phase of the programme to transform Community Services
    - Out of Area placements reduced significantly in from 43 in M3 to 22 in M6 despite ongoing wider challenges with system flow.
3. **We will enable each other to be the best we can be**
    - Key People indicators e.g. turnover and supervision rates show sustained improvement over 2.5 years
    - Year on year comparison of Q1 Pulse Survey results shows growing engagement and satisfaction with EPUT's standard of care
    - We have made significant progress since 2021 on the development of our lived experience and volunteers workforce, particularly with growing numbers of peer support roles as part of the new inpatient operating model
4. **We will help our communities thrive**
    - There is evidence of positive progress in local recruitment, environmental sustainability and community social impact delivery
    - The next phase of the estates strategy delivery will create focus on extracting value from community assets owned by EPUT
    - Progress on social value procurement has been limited by capacity constraints.

The Trust is progressing the development of a theory of change and outcome measures as part of ongoing strategic and medium-term planning across the Trust and with partners at system and neighbourhood 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	✓

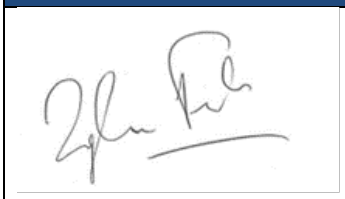
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

Lead



Zephan Trent,
Executive Director of Strategy, Transformation and Digital

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT REPORT

M6 2025/26

EPUT

CONTENTS.

Note: Where possible, data is taken from the October Integrated Performance Report (M5)and the two reports are best read in conjunction for synthesis of shorter and longer term trends in delivery.

The Strategic Impact Report presents medium to longer term delivery trends to illustrate progress in delivery of our Strategic Plan, complimenting the faster cycle of monthly performance reporting

Summary of multi-year trends of delivery against the four strategic objectives

1. We will deliver safe, high quality integrated care
   - The Trust encourages high incident reporting rates as part of its learning and improvement culture. Incident reporting rates have been consistently above target over 2.5 years
   - We expect a large proportion of incidents to have no/low rates of harm. This proportion has very slightly decreased over 2.5 years but increasing positively in the last six months towards the 93.7% target
   - Over 2.5 years an average of 94.7% of patients and families report feeling safe in EPUT's care, with many months above the 95% target and relative consistent monthly results

2. We will work with our partners to make our services better
   - System flow in Mental Health services has been and remains challenged as shown through higher than planned length of stay and out of area placements
   - Adult length of stay hit a peak at the end of 2024/25, though improvement initiatives and implementation of the new inpatient operating model have driven a correction in Adult Length of Stay over the last six months, notwithstanding a short-lived increase in M6. Similar improvements in Older Adults are planned in the next period, including the first phase of the programme to transform Community Services
   - Out of Area placements reduced significantly in from 43 in M3 to 22 in M6 despite ongoing wider challenges with system flow

Note: Where possible, data is taken from the October Integrated Performance Report (M5)and the two reports are best read in conjunction for synthesis of shorter and longer term trends in delivery.

The Strategic Impact Report presents medium to longer term delivery trends to illustrate progress in delivery of our Strategic Plan, complimenting the faster cycle of monthly performance reporting

Summary of multi-year trends of delivery against the four strategic objectives

3. We will enable each other to be the best we can be
    - Key People indicators e.g. turnover and supervision rates show sustained improvement over 2.5 years (see Care Unit breakdown in Appendix 1)
    - Year on year comparison of Q1 Pulse Survey results shows growing engagement and satisfaction with EPUT's standard of care
    - We have made significant progress since 2021 on the development of our lived experience and volunteers workforce, particularly with growing numbers of peer support roles as part of the new inpatient operating model

4. We will help our communities thrive
    - There is evidence of positive progress in local recruitment, environmental sustainability and community social impact delivery
    - The next phase of the estates strategy delivery will create focus on extracting value from community assets owned by EPUT
    - Progress on social value procurement has been limited by leadership capacity constraints in the contracts team.

We are progressing the development of a theory of change and outcome/impact measures as part of ongoing strategic and medium term planning across the Trust and with partners at system and neighbourhood level.

NHS
Essex Partnership University
NHS Foundation Trust

INTRODUCTION

EPUT

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

Risks to delivery against the strategic objectives, controls, mitigations and system dependencies are addressed through the Board Assurance Framework.

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

Strategic Plan Review

We are now at the mid point of our five-year Strategic Plan. We recently reviewed the Plan to check that it is still relevant and feasible and that it reflects our vision, values and strategic objectives and also the significant changes in the wider health and care system that have taken place in the last three years. Our review was based on a range of views and has concluded that:

- Our vision, values and strategic objectives are still relevant
- There are still significant pressures on our services – including capacity, performance and finance
- Over two thirds of our staff understand our strategic objectives and see their relevance to their role
- We do not yet have quantitative evidence that we are delivering against all four strategic objectives in all parts of the Trust, but we can see considerable progress across all domains
- Our enabling strategies – such as those for estates, research and commercial capability - need a consistent delivery plan to ensure they are coherent and have the maximum impact
- Adopting AI offers significant potential to rapidly improve quality of care, improve access and address inequalities but requires focus and investment
- Local neighbourhood partnerships will be better placed than individual organisations to really deliver change on the social determinants of health
- Intelligence from patients and families tells us that our organisation needs to become truly trauma-informed – for both patients and staff - to transform culture and quality of care
- We want to and can achieve a stronger and more influential position at system, place and neighbourhood level.

Operational planning for 2026/27 onwards will be informed by the priorities set by the Board – these priorities build on our existing plans to deliver our strategic objectives and provide the quality of care our local communities deserve.

A new chapter for EPUT: meeting people where they are

We want to be **the leading health and wellbeing service for mental health and community care**. To help us achieve that aim in a rapidly changing world, **we're planning three big changes in the next two years**, using our existing resources.

1

We will explore and develop the potential of AI so we can:

- **Make lasting improvements to quality of care**, so we deliver the service our communities deserve
- **Learn directly from our patients' experience** to drive the changes we make
- **Personalise the care we give,** improve the way we diagnose and treat people, automate referrals and reduce delays
- **Use data and information to prevent ill health,** address inequalities and develop new services faster
- **Automate routine work,** increase time staff can spend with patients and increase job satisfaction

2

Becoming a trauma-informed organisation means recognising how traumatic events affect people's lives and their day-to-day experience of receiving care from, or working at, EPUT. Doing this more quickly will help us to:

- **Deliver better outcomes** for people receiving care
- **Improve quality and safety** in all our services
- **Strengthen wellbeing and resilience** for our workforce

3

Delivering accountable care is about how EPUT takes a lead on delivering integrated healthcare for a defined population, working in a different way with our partners. This supports our strategic objectives of providing safe, high quality integrated care and working with our partners to improve services. For local communities, this will bring:

- **More joined-up care** – reducing duplication and gaps so people have seamless support
- **Better health outcomes** – focusing on prevention, early intervention and coordinated management of long-term conditions to avoid people experiencing a crisis or serious ill health
- **Better use of resources** – ensuring funding follows people, not organisations, across the system, so local people benefit from more efficient services that reinvest savings into frontline care

This combined approach will enable us to continue to put **people at the heart of everything we do and to meet people where they are**: delivering integrated physical and mental health care in local communities which reflects people's individual needs and cultures and recognises the variety of personal and professional experiences of our staff.

NHS
Essex Partnership University
NHS Foundation Trust

Our Year 3 commitments to deliver the strategic plan
Summary of 2025/26 operational plan

Trust overall	• **Progress implementation of digital and data strategic priorities – including the new unified electronic patient record (EPR)** • **Progress the implementation of our estates strategy and our research, innovation and commercial strategy - including developing an AI framework** • **Continue to work towards becoming a trauma-informed and psychologically-informed organisation**
We will deliver safe, high quality, integrated care services	• Progress the Community First programme to transform our community mental health services operating model • Co-produce and agree a plan to improve services for neurodivergent people with our voluntary and community sector partners
We will work together with our partners to make our services better	• Collaborate with partners in the SET All Age Mental Health Strategy Implementation Group to revise shared priorities • Complete alignment of community mental health teams to Primary Care Networks (PCNs) and integrated neighbourhood teams where possible • Roll out new family and carer ambassador roles to ensure patients' views are heard and families and carers are involved in care • Implement our Patient and Carer Race Equality Framework (PCREF) across all services
We will enable each other to be the best we can be	• Complete the implementation of the Time to Care programme to ensure mental health inpatient admissions are purposeful and therapeutic, reduce length of stay and improve system flow and are also less reliant on agency staff • Deliver our corporate services review and start implementing its recommendations • Fully implement the national sexual safety framework • Grow our substantive peer support workforce by 30% and increase our use of lived experience ambassadors by 20%
We will support our communities to thrive	• Bid for National Lottery grant to deliver major social impact intervention with voluntary sector partners via Enable East • Refresh our Green Plan for 2025 onwards to ensure services are environmentally sustainable • Agree our approach to delivering and monitoring social value through procurement • Create partnership arrangements with local colleges and schools across Essex to collaborate on local recruitment initiatives • Ensure our services are provided from the right locations to support patient access and new models of care

NHS
Essex Partnership University
NHS Foundation Trust

DELIVERY HIGHLIGHTS

M6 2025/26

EPUT

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT DASHBOARD – rolling 12 month averages show medium term trends

Strategic Objective 1: We will deliver safe, high quality integrated care services

Indicator	M12 23/24	M12 24/25	M6 25/26	Movement in last year
Incident reporting rate (>44.33)	68.22	62.09	61.64	↓
No/low harm incident rate (>93.7%)	89.92	88.09	86.98	↓
% patients/families feeling safe in EPUT's care*	95.42	94.16	94.09	→

Strategic Objective 2: We will work with our partners to make our services better

Indicator	M12 23/24	M12 24/25	M6 25/26	Movement in last year
Adult Mental Health ALOS on discharge <35	61.43	78.32	76.57	↓
Out of Area Placements (0)	19.25	31.33	31.00	↓
Virtual Ward Occupancy (>80%)	61.58	63.67	65.78	↑
Weighted accruals to NIHR research studies (3200/yr)	N/A	314	212	↓

Strategic Objective 3: We will enable each other to be the best we can be

Indicator	M12 23/24	M12 24/25	M6 25/26	Movement in last year
Staff turnover (<12%)	9.58	9.08	8.89	↓
Manager+Leadership Dev Prog uptake	196	278	150	Changed methodology
LEA & volunteer hours	N/A	445	234	↓
Staff supervision/1-1 support (>90%)	73.29	72.93	74.68	↑

Strategic Objective 4: We will help our communities to thrive

Indicator	M12 23/24	M12 24/25	M6 25/26	Movement in last year
% workforce from local communities	81	89	89	→
% BAME staff in roles >B7	21	22	22	→
% procurement spend with local suppliers	23	22	30	↑
Social Impact Grants (£k)	61	268	24	↓

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 17% no-response rate for the 2 questions relating to safety, which when excluded from the percentage rating significantly increases the Trust's performance rating in the domain of safety within the friends and family test.

At the mid-point of the Strategic Plan, we continue to evidence steady progress against each strategic objective in the last six months, although measurable medium term trends remain mixed

Strategic objective	Progress on key deliverables
We will deliver safe, high-quality integrated care	**Focus on high quality care** • Community First Programme plan agreed and establishment of Steering Group in July and on track to move to execute phase in October. The programme will redesign EPUT's community mental health and outpatient models, realigning capacity with demand and supporting the shift from hospital community • Experiences of neurodivergent people, families and carers identified as a Quality Priority with work plan agreed for 2025/26 focused on embedding a trauma-informed approach, training staff in neurodivergent-led practice and a co-produced improvement plan for children and young people's services • Assertive Outreach community support for those with Serious Mental Illness continuously developing to align with national requirements with plans in place as part of the Community First Programme to develop core standards in partnership with strategic commissioners **Focus on safety** • Positive feedback from CQC on adult acute and PICU ward safety and leadership following December 2024 visits. Ratings upgraded to Requires Improvement to add to Good ratings following earlier inspections of Brockfield House and Clifton Lodge • SOPHIA is improving safety and consistency of care by making it easier for staff to find all Trust-wide clinical and non-clinical policies, guidelines and operating procedures
We will work together with our partners to make our services better	**Working in partnership with people and communities** • By M6, recruited 11 out of planned 14 new family and carer ambassador roles under TTC model to ensure patients' views are heard and families and carers are involved in care • Health Inequalities programme focussing on Patient & Care Race Equality Framework, smoking cessation and improvement access to perinatal services. PCREF early adopter status has driven initial implementation in Q1 of a Power-BI hosted data dashboard marking a significant step towards activity data segmented by protected characteristics which can be used inform improvements • EPUT, in partnership with Start Change, will launch the COMPASS (Community Outreach Mentoring Pathway Advocacy Service Support) pilot programme in September 2025. This six-month initiative is designed to support men aged 18–35 from racialized communities with a history of repeated mental health hospitalisations. **Delivering care in partnership** • Continued engagement in implementing Southend, Essex and Thurrock all-age mental health strategy and refreshed implementation plan to align more closely with place based transformation and more focus on prevention, early intervention and recovery. Live changes to NHS architecture are likely to reduce complexity and unwarranted variation in approach across Essex but have delayed system progress in the last six months • Developing relationships with primary care leaders across Essex to level up primary care mental health provision and build foundations for an emerging neighbourhood health model as part of the implementation of the 10 Year Plan for Health

At the mid-point of the Strategic Plan, we continue to evidence steady progress against each strategic objective in the last six months, although measurable medium term trends remain mixed

Strategic objective	Progress on key deliverables
We will enable each other to be the best we can be	**Improving work lives using technology** • Feedback from the 2024 NHS Staff Survey has driven improvements to staff experience including new guides for managers to support their teams with reasonable adjustments and flexible working, a new project to enhance staff rest areas in community, inpatient and social care teams will launch later this year and plans to launch a staff recognition platform are currently underway • Corporate Services Review is designed to repurpose and revalidate our Trust Target Operating Model to ensure better support our Care Units, patients and families while delivering an ambitious efficiency saving. 52 opportunities have been identified including preparation of a business case for adoption of AI to unlock clinical time and capacity **Supporting our staff** • EPUT has been recognised for achieving areas of excellence for its Allied Health Professions (AHP) Preceptorship achieving 100% in two of the areas evaluated - organisational culture and preceptorship, and the preceptor's role. It scored very highly for quality and oversight of preceptorship, preceptee empowerment and delivering preceptorship programmes • The Trust has partnered with the GMC and NMC to develop a face-to-face training package with colleagues across Specialist Services which will now be rolled out across inpatient services, community settings and corporate teams to ensure all staff understand the expected standards of behaviour expected, increase psychological safety and how to effectively raise concerns • Twenty staff from EPUT, Mid and South Essex NHS Foundation Trust, Mid and South Essex Integrated Care Board and Provide graduated from the RISE programme on 11 July. They are among 187 to have now completed RISE, which supports rising stars in the NHS from Black and minority ethnic backgrounds to ensure staff have equitable opportunities for career development.
We will help our communities thrive	• Enable East launched its Step Forward programme funded by the Kings Trust in August, designed to support people with Learning Disabilities and Autism in Southend and Basildon to build employment skills and support them into local health and care jobs. This will be the last of Enable East's grant funded social impact programmes due to the strategic decision taken in March 2025 to freeze the unit's operations to mitigate exposure to financial risk • Individual Placement Service is launching its Connect To Work service supporting Essex residents to achieve and retain sustainable employment and help address economic inactivity • Over the past year, the Trust has hosted four local recruitment events across Basildon, Colchester, and Epping offering attendees a chance to explore the role of the HCA, connect directly with our services and participate in same-day interviews. Of the 118 individuals who attended, 69 expressed interest in joining the Trust. 58 have been interviewed and 22 have successfully secured positions at EPUT • Building on significant steps towards environmentally sustainable services in the previous years, EPUT's Green Plan for 2025-2028 has been approved

NHS
Essex Partnership University
NHS Foundation Trust

DELIVERY AGAINST STRATEGIC OBJECTIVES

M6 2025/26

EPUT

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

Trust overall	Care group specific
• Quality Data dashboard implementation now enables triangulation of trends to measure impact of improvement initiatives e.g. Safewards Squads and impact on relationship between sickness absence and numbers of restraints in mental health inpatient units • Incident reporting rates sustained well above target for over two years • Decreasing trend in proportion of low/no harm reports, recovered to level of consistency with 2 year average in M5 and sustained in M6 • Rate of restraint showing decreasing trend over 12 months • Work ongoing to strengthen Duty of Candour requirements across the Trust	**Urgent Care and Inpatients** • Plan agreed to pilot re-alignment of Urgent Care to community teams in North East Essex from Q3 to test impact on flow, length of stay and complex case management • Exploring Cambridge in-reach model for patients with Emotionally Unstable Personality Disorder patients to test impact on length of stay and readmission rates **Specialist Services** • Downward trend in self harm safety incidents from prior year average of 192 per month to M6 YTD average of 138 • Downward trend in restraints from prior year average of 99 per month to M6 YTD average of 90 **Psychological Services** • ePrescribing rolled out in Community Adults Eating Disorder Services • Of 52 people 18-25 in North West Essex ending their care in 2024, 96% showed improvement in symptoms **North East Essex** • Perinatal discharges up 10% in M4 creating increased capacity and improved access • Quality Improvement project underway in dementia and frailty services, where psychological support is continued post discharge, to ensure that psychological support identified during admission moves with the service user into the community until completion **West Essex** • Data and analytics improvements have abled segmentation of safety incidents for patients with LD&A to identify trends that need addressing • Quality Improvement co-production project underway to improve uptake of physical health checks, now completing current state process mapping **Mid and South Essex** • Community Collaborative instituted new joint quality oversight and reporting structure. RTT 18 weeks position for adults reduced 32% since M1 across MSE; SE Adult SLT has eliminated 40 week waits ahead of trajectory. Focussed work planned to improve overall adult waits and ASD/ADHD waits for Children & Young People • Community Mental Health teams conducted deep dive into % of pts on s117 aftercare receiving annual care plan review and data cleansing driving performance up to 88% against 95% target

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

Metric	Target	Oct-2	Nov-2	Dec-2	Jan-2	Feb-2	Mar-2	Apr-2	May-2	Jun-2	Jul-2	Aug-2	Sep-2	Trend
Incident Reporting Rates	>44.3	56.29	65.71	60.66	69.42	66.85	62.71	61.33	59.34	63.07	57.85	55.08	61.4	
No/low harm incident rates	>93.7%	87.4	90.6	87.7	88.5	86.7	85.9	86.2	84.0	84.8	84.4	88.5	89.1	
% of patients and families that say they feel safe in EPUT's care		96.2	93.5	91.4	92.8	94.4	94.1	93.5	96.5	93.5	96.1	93.2	93.9	

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

NHS
Essex Partnership University
NHS Foundation Trust

Delivery against strategic objective 2 – we will work together with our partners to make our services better

Trust overall	Care group specific
• There continued to be challenges with patient flow through inpatient services. This has an impact on other areas such as accessibility, financial outcomes and out of area placements. Flow and capacity improvement actions and increased clinical involvement implemented in Q1 delivered sustained improvement since M3 and work remains ongoing • 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 22.61 WTE posts across inpatient and specialist services with 19.86 now filled and 2.75 WTE in recruitment • Last six months of research strategy have driven further improvements in research team stability, portfolio balance, training of clinical staff training to lead investigations, and raising the profile of research across the Trust. Plans to reconfigure the operating model for research are developing to drive requisite improvement in raw and weighted recruitment of patients to clinical trials • Delivered first phase of coastal self-harm and suicide research in partnership with Anglia Ruskin University, focusing on the community of Jaywick. Next phase, pending funding approval, is designed to take a population health approach, linking into the North East Essex neighbourhood programme, and create the platform for co-production, testing and evaluation of a patient navigator model.	**Urgent Care and Inpatients** • Successful capital bid for Mental Health Emergency Departments in West and North East Essex • Adult inpatient length of stay sustained below 25/26 national oversight framework target of 60 days with correction in M6 to 59.6 days (excluding assessment units) following a short-lived peak in the prior month; focussed work in train to achieve 90 day target for older adults. M5 represented the lowest ALoS since September 2024 and represents a below average ALoS over the past 24 months **Specialist Services** • Reviewed Op Courage long term cases with VCSE partner - increasing discharges to high of 96 in M5 • Co-producing improvements to Learning Disabilities services, enhancing family ambassador role and opening designated sensory rooms **Psychological Services** • Implementation of Trauma Informed Care ROOTS tool, clinical and lived experience leads appointed, engagement with senior leadership team now in train • Progress with integrated working between Adult Community Psychology services and drug and alcohol specialists to support those recovering from substance misuse **North East Essex** • Coproduction Lead has established a productive partnership with colleagues from the Suffolk and North East Essex Integrated Care Board and the University of East Anglia to collaboratively design and develop cultural awareness training available to all NHS staff including modules on unconscious bias and self-reflection on personal prejudice **West Essex** • Increased Virtual Ward occupancy from prior year average of 57% to M6 YTD average of 65% • Working with alliance partners to revise community health service specifications to reduce unwarranted variation and embed outcome-based KPIs for completion in October with intention to bring learning to MSE Community Collaborative **Mid and South Essex** • Community Collaborative delivered Integrated Neighbourhood Teams gap analysis to inform next stage of neighbourhood health development

STRATEGIC OBJECTIVE 2: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Metric	Target	Oct-2	Nov-2	Dec-2	Jan-2	Feb-2	Mar-2	Apr-2	May-2	Jun-2	Jul-2	Aug-2	Sep-2	Trend
Adult Mental Health ALOS on discharge	<35	77.53	85.26	74.61	83.15	90.69	90.07	70.63	86.84	66.82	59.84	48.05	85.3	
Out of Area Placements	0	30	17	47	32	27	22	25	41	43	41	25	22	
Virtual Ward Occupancy	>80.0%	67	64	66	59	54	75	67	76	75	61	72	54	
Weighted accruals to NIHR research studies (3200/y	>267	709	458	228	256	171	204	157	117	113	54	34	44	

Note: In September 2025, OOA placement reporting was changed to re-categorise spot purchased placements at Cygnet Colchester as inappropriate, driving an increase in reported OOA placements

Delivery against strategic objective 3 – we will enable each other to be the best we can be

Trust overall

- Progressed implementation of Time to Care (TTC) model adding >300 permanent roles to expand the expertise within our Multi Disciplinary Teams at ward level, enabling more personalised care and giving ward staff more time to concentrate on providing direct patient support. A further 28 WTE will be joining shortly and 10 WTE are in varying stages of recruitment
- As part of an update to the Target Operating Model for EPUT, a Deputy Clinical Director of Psychological Services has been allocated time to participate in the leadership of each of the other clinical care units to strengthen the integration of psychological provision across services
- Growth in lived experience and volunteer has slowed (combined total 780), but utilisation of the team remains high with significant time invested in interview panels and Oliver McGowan training
- Supported 211 EPUT leaders to undertake leadership or management development training in the last six months, an increase of 25 from the prior period and maintaining an upward trend over 18 months
- Continued reduction in temporary staffing utilisation across the Trust
- Reducing trend in staff turnover rates during since M2 peak of 11.1%, maintaining below Trust target
- Rising trend in staff supervision rates since M1, achieving nearly 80% in M4
- Q1 NQPS outturn 16% increase on Q4 24/25 and 46% on Q1 of the prior year. 12.7% more staff reported feeling happy with the standard or care at EPUT

Care group specific

Urgent Care and Inpatients

- Increased staff supervision rate from 71.6% in M1 to a high of 83.1% in M5 against a 90% target and sustained above 80% since that time
- Vacancies reduced and sustained below 12% target since Feb 2025 through growing pipeline of recruits and reducing time to hire

Specialist Services

- Majority of TTC posts filled with rest in recruitment pipeline
- Culture of care pilots in progress on Larkwood and Wood Lea including Trauma Informed approaches to care and staff management
- Neurodiversity passports in place for all neurodivergent individuals

Psychological Services

- Staff appraisal rate redressed following drop from 83.8% in M1 to 70.1% in M4 back to 79.8% in M6 against target of 90%
- MSc CAP Programme has a cohort of 22 confirmed for the Autumn intake, with some additional possible students still awaiting confirmation. Funding has been confirmed by NHSE to cover this and other key level 7 healthcare apprenticeships through the next funding cycle. EPUT remains one of two active CAP training providers in England.

North East Essex

- Vacancies reduced and sustained below 12% target since M2 through maintaining pipeline of recruits and reducing time to hire
- Incremental and sustained increase in mandatory training rates since beginning of year reaching a high of 88% in M6 against 90% target

West Essex

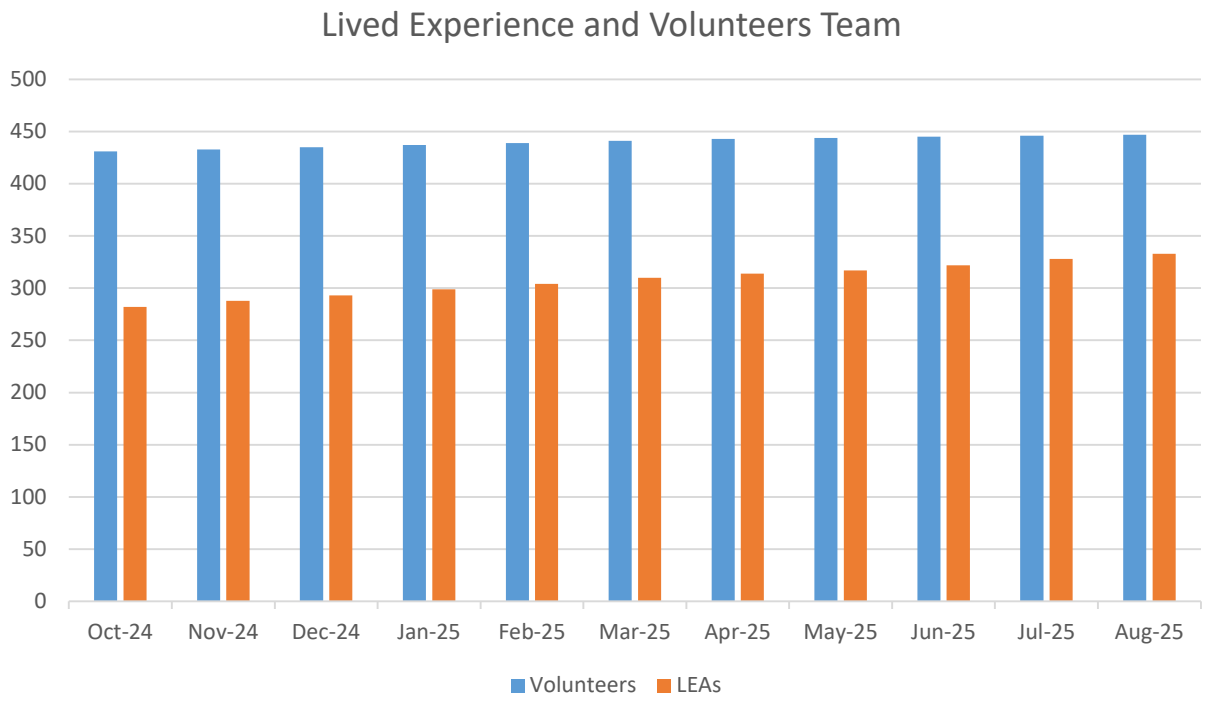
- Incremental and sustained increase in mandatory training rates since beginning of year reaching a high of 88% in M6 against 90% target
- Vacancy rate reducing and below 12% target all year with strong and growing recruitment pipeline

Mid and South Essex

- Collaborative working has resulted in an increased number of places for newly qualified nurses this

STRATEGIC OBJECTIVE 3:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Metric	Target	Oct-2	Nov-2	Dec-2	Jan-2	Feb-2	Mar-2	Apr-2	May-2	Jun-2	Jul-2	Aug-2	Sep-2	Trend
Staff turnover	<12%	9.2	9.3	9.0	8.8	7.3	8.7	8.7	11.1	8.9	8.6	8.4	8.7	
Staff Supervision / 1-to-1 support	>90.0%	72.8	73.9	71.3	74.4	74.8	74.4	70.9	74	77.8	77.9	76.4	77.6	



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, consistent with the prior year average • 22% of band 7 and above roles held by BAME colleagues, consistent with the prior year average • 38% of purchase order value was placed with suppliers in Essex, Bedfordshire or Suffolk, same as in the first half of the year, an increase of 16% on the prior year average • Hosting 133 apprentices, using 26% of apprenticeship levy with plans in development to increase usage further by supporting voluntary and community sector partners • Estates and Facilities team awarded Bronze Award in the Best Reuse Initiative of the Year for the Excellence in Waste Management Awards for the NHS in England recognising their work with GGMS in reusing items such as furniture across the Trust and with other local organisations to reduce landfill waste • Green Plan has avoided 81,314 kg of CO2e emissions attributable to waste produced and prevented approximately 47,000 kg of waste going to landfill and secured <£900k investment in electric vehicle charging and solar panel installation across sites • Exploring continuous improvement in outreach to Armed Forces through rollout of national training programme, aligned with becoming a trauma informed organisation	**Urgent Care and Inpatients** • Open Arts shortlisted at BBC Radio 4 All in the Mind awards for reducing social isolation, improving self esteem and levels of activity for people living with mental health challenged in local communities **Specialist Services** • Liaison & Diversion service now has Peer Support Workers well embedded in new contract. The team has run a number of well attended training sessions for partners to address needs of those in the health and justice system • Working with the locally placed marginalised and vulnerable refugee communities to ensure the needs of children are paramount. All children needs are screened and families are linked with local partners to support their health and Wellbeing **Psychological Services** • Awarded a further round of funding to continue to deliver the paid work experience for aspiring psychologists from disadvantaged backgrounds. This is delivered as a Widening Access programme, where there are three Assistant Psychologists currently progressing through the programme, with a further four places due to be filled **North East Essex** • Actively engaged in successful partnership bid for wave 1 of National Neighbourhood Programme with focus on reducing inequalities • Clacton hub project plan launched – currently reviewing designs and site visit planned for November **West Essex** • Actively engaged in successful partnership bid for wave 1 of National Neighbourhood Programme with plan to scale existing Care Closer to Home and Integrated Neighbourhood Team model to neighbourhood health centres in Harlow and focus on proactive management of long term conditions, working alongside West Essex Citizen and Co-Production network **Mid and South Essex** • Supported South West At Risk Mental State service user is attend Sports for Confidence and secure Table Tennis England funding service user led establishment of a new activity group with specialist equipment.

STRATEGIC OBJECTIVE 4: WE WILL HELP OUR COMMUNITIES TO THRIVE

Metric	Target	Oct-2[illegible]	Nov-2[illegible]	Dec-2[illegible]	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Trend
% workforce from local communities												89%	89%	
% BAME staff in roles >B7		23%	23%	22%	22%	22%	22%	22%	23%	22%	22%	22%	22%	
% procurement spend with local suppliers		31%	17%	5%	18%	40%	20%	46%	34%	32%	34%	39%	43%	

NHS
Essex Partnership University
NHS Foundation Trust

TRANSFORMATION DELIVERY FRAMEWORK UPDATE

MONTH 6 2025/26

EPUT

INTRODUCTION

The Transformation Team are delivering key areas of transformation where we will realise maximum benefits for the safety and care of our patients, and those schemes which will be instrumental to the successful delivery of our strategies.

The following large-scale change programmes which have a Board or Executive Committee approved business case or Programme Initiation Document are the primary focus:

- Community First programme
- NOVA (EPR)
- Medium Term Plan
- Efficiencies Programme inc. Operational Planning
- Corporate Services Review and

The following programmes have closed or are preparing for closure:

- Time to Care (Closing 09/25)
- EPMA (Closed 06/25)

The following programme is a key priority for the Trust but is not currently supported by the Transformation Team:

- Lampard Inquiry

The Single Front Door remains in place and focusses 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 governance. It also enables us to keep a clear view of all the change going on in the trust and the overall progress against our strategy.

Transformation Priorities

The team have been focussing their resource on the following large-scale change programmes:

- Time to Care
- Community First programme
- NOVA (EPR)
- EPMA
- Medium Term Plan
- Efficiencies and Operational Planning Inc. Corporate Services Review

Portfolio Management

The overall portfolio is being tracked and managed by the Transformation Team Portfolio Management Office (PfMO) using the Aspyre project management software.

Locally owned and sponsored change programmes continue throughout the organisation and the Single Front Door is in place in order to set up new projects. The SFD focusses on ensuring that local change projects, which require support from other teams, such as digital, finance, etc. are set up for success and approved using the trust's agreed processes. The PfMO ensure we keep a clear view of all the change going on in the trust and the overall progress against our strategy. The PfMO continue to monitor projects and programmes and provide a source of guidance, tools and templates.

Trust Productivity & 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.

Assurance Reporting

Each month as part of the Executive Operational Committee we provide an assurance report for the Transformation priority projects and programmes.

This report serves several important purposes. It provides confidence in delivery, enables informed decision making, provides independent & objective oversight, highlights risks & identifies when Executive escalation may be required, demonstrates good governance and helps to improve performance and learning.

NHS
Essex Partnership University
NHS Foundation Trust

TRANSFORMATION DASHBOARD – END OF SEPTEMBER 2025

TTC	Community Transformation	Medium Term Plan	NOVA	Efficiencies	Corporate Services Review
Executive Sponsor Alex Green	**Executive Sponsor** Ann Sheridan	**Executive Sponsor**	**Executive Sponsor** Zephan Trent	**Executive Sponsor** Trevor Smith	**Executive Sponsor** Andrew McMenemy & Trevor Smith
Overview Increase professionals in each inpatient team and support the implementation of a new inpatient operating model.	**Overview** To review and remodel secondary care community teams to meet the needs of the Essex population through the provision of a revised consistent, safe and therapeutic service model.	**Overview** The MTP covers a 5-year period and defines a set of opportunities to bring the system back to financial breakeven and deliver improved outcomes for our population.	**Overview** The implementation of a unified Electronic Patient Record (EPR) across EPUT and MSEFT.	**Overview** 2025/26 Efficiency programme has a target to deliver £31.3m in savings through three key schemes (£27.4m), localised efficiency target and MHIS retention (£4.5m).	**Overview** To review 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 of £4m in 2025/26.
Status and RAG* Closing	**Status and RAG*** Planning	**Status and RAG*** Execute	**Status and RAG*** Execute	**Status and RAG*** Execute	**Status and RAG*** Execute

Portfolio Structure
• Overall Programme
  • Clinical Inpatient Operating Model
  • Building Our Workforce
  • Clinical Operating Model Specialist Services
	Portfolio Structure
	• Community First Programme
	  • Outcome Meadures Programme
	  • Move Away from CPA
	  • Assertive Outreach
	  • Community MH Demand and Capacity
	  • Standardising CMHT
	  • Transforming Outpatients
	  • Workforce Optimisation
	• West Essex Community Hospital Beds Review Programme
		Portfolio Structure
		• Overall Programme
		  • Community Accommodation
		  • Improving Patient Flow
		  • Clozapine Clinic Pilot
			Portfolio Structure
			• MSE Community Collaborative Service Integration (NOVA)
				Portfolio Structure
				• Overall Programme
					Portfolio Structure
					• Overall Programme

Transformation team Resource • 1.5 WTE Programme Manager • 0.5 WTE Project Support	**Transformation team Resource** • 0.2 WTE Associate Director of Transformation • 1 WTE Programme Manager • 0.6 WTE Project Manager • 0.8 WTE PMO Analyst	**Transformation team Resource** • 0.2 WTE Associate Director of Transformation • 1 WTE Programme Manager • 0.4 WTE Project Manager	**Transformation team Resource** • 0.6 WTE Project Manager	**Transformation team Resource** • 0.4 WTE Dep Director of Transformation • 0.2 WTE PMO Analyst	**Transformation team Resource** • 0.4 WTE Dep Director of Transformation • 0.2 WTE Programme Manager • 0.4 WTE Project Manager • 0.8 WTE PMO Analyst

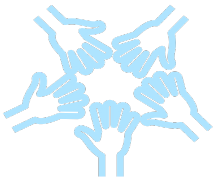
**RAG only for Programmes in execute and closing*

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	September 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)
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
Trust Efficiencies, Operational Planning Inc. Corporate Services Review	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 schedmes through the centralised Aspyre platform • Report assurance/delivery of schemes through both internal and external governance routes • 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 • Successful delivery of our financial efficiency target	March 2026

SIX MONTH FORWARD PLAN

Launch new Governance processes



1-3 months

Launch of the Transformation and Digital Steering Group (TDSG).

This group will review and provide assurance on the Trusts portfolio of locally led projects and programmes. It will endeavour to ensure all change delivers its intended outcomes and benefits.

The group will provide a forum to review and approve new business cases and project initiation documents ahead of submission to ET.

Using the experiences, skills and knowledge of the membership the group will have a key role in ensuring continuous alignment of the portfolio to strategic objectives and make prioritisation decisions to ensure objectives are met

Operating Model

The Transformation Team was originally formed in 2021 and merged with the Service Development Team in early 2023.

The team has evolved and grown and is now made up of project professionals and PfMO specialists who support and manage delivery of the Trusts key priority programmes and projects.

Continuous review of this operating model is required to ensure the right resource is available and allocated to areas that will contribute most effectively to the Trusts overall objectives.

Continuous Improvement - Programme and Project Management

3-6 months

Continuous development of programme and project management methodologies and reporting in order to ensure gold standard delivery and assurance reporting.

NHS
Essex Partnership University
NHS Foundation Trust

OPERATIONAL PLANNING 2026/27

EPUT

2026/27 and medium term planning process

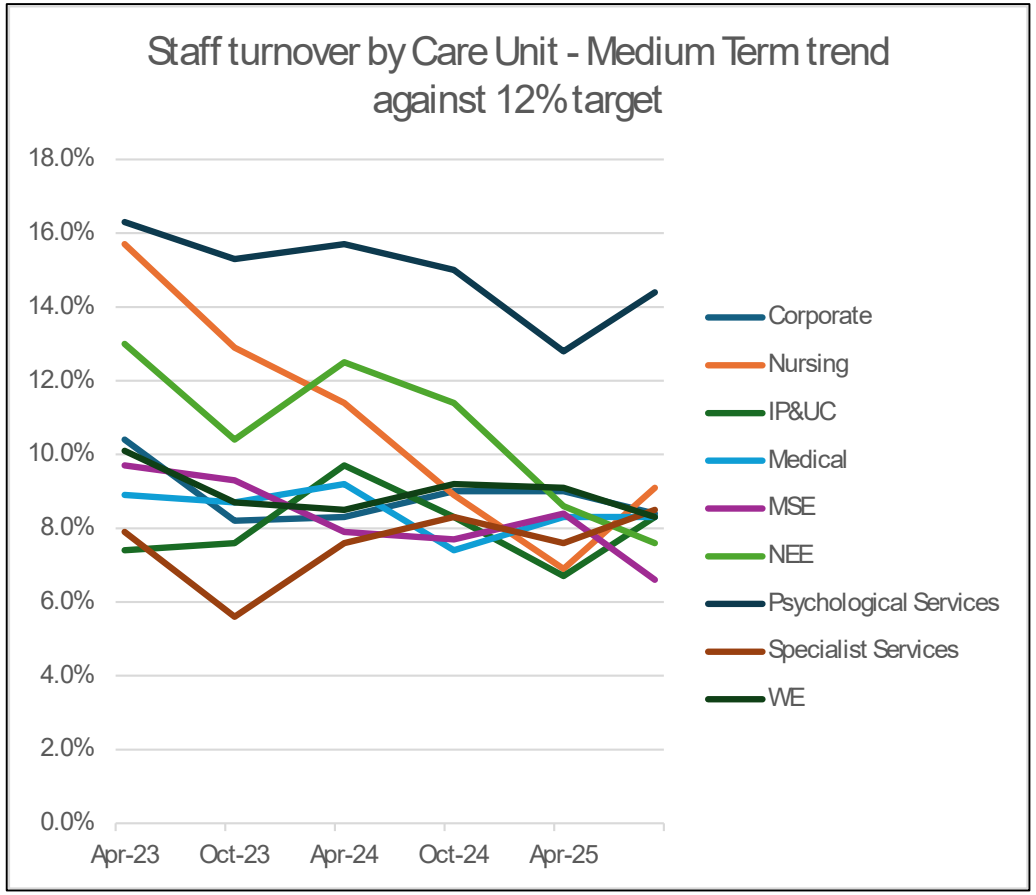
- NHS England published an early version of its Planning Framework for the NHS in England in September 2025, supplemented by further guidance and financial allocations in November
- The move from block contracts to a results based payment model for community providers is already underway and activity and demand assumptions shared with commissioners as part of the first phase of planning
- EPUT will developing a credible, integrated five-year plan joining up strategic and operational plans with robust triangulation between activity, workforce and financial plans to delivery on national and local priorities with strong clinical leadership
- Achieving financial sustainability in 2026/27 through addressing the underlying deficit and removing dependency on deficit support funding will be a key priority to enable the Trust to improve its National Oversight Framework rating
- Anticipating long term capital plan to 2029/30 with individual year allocations for organisations, rather than systems
- The national framework specifies that plans should be:
    - Outcome-focused
    - Accountable and transparent
    - Evidence-based
    - Multi-disciplinary
    - Credible and deliverable
- Under the newly clustered Integrated Care Board, EPUT will align its plans with Essex ICB as its strategic commissioner
- EPUT's plans will be closely informed by the conclusions of the Strategic Plan Review and develop the concept of **meeting people where they are**, enabled by three bold shifts
- The internal process will be designed to identify inter-dependencies between agreed strategic priorities including those in enabling strategies with a clear roadmap for delivery
- It is expected that final plans will need to be approved by the Board in December 2025.

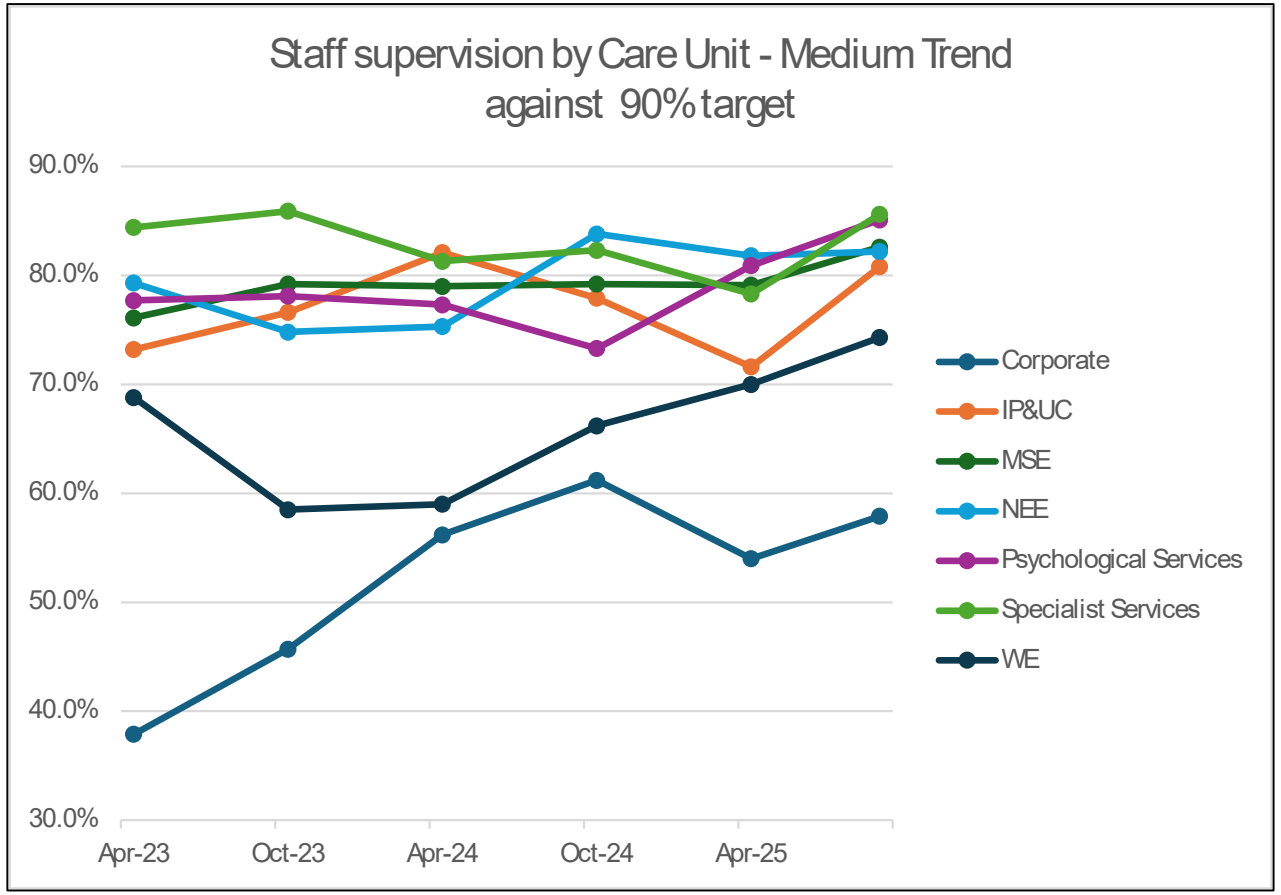
NHS
Essex Partnership University
NHS Foundation Trust

Appendix

EPUT

People & Culture – medium term trends





10. REGULATION AND COMPLIANCE

10.1 ANNUAL REVIEW OF GOVERNANCE DOCUMENTS

Decision Item DG

REFERENCES

Only PDFs are attached

Annual Review of Governance Documents 03.12.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Annual Review of Governance Documents**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Executive Director for Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary Clare Barley, Head of Financial Accounts					
Report discussed previously at:	Executive Operational Committee Audit Committee Council of Governors					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A – these documents provide key governance and financial processes.	
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*		
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	Yes/No	

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

Purpose of the Report		
This report provides the revised Standing Orders for the Board of Directors, Standing Orders for the Council of Governors, the Scheme of Reservation & Delegation, Standing Financial Instructions and Detailed Scheme of Delegation for approval by the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the annual review of the governance documents
2. Receive the recommendation from the Audit Committee for the approval of:
    - Standing Orders for the Practice and Procedure of the Board of Directors
    - Scheme of Reservation and Delegation (SoRD)
    - Standing Financial Instructions (SFI's)
    - Detailed Scheme of Delegation (DSoD)
3. Receive the recommendation from the Council of Governors for the approve the Standing Orders for the Practice and Procedure of the Council of Governors.

Summary of Key Issues

Standing Orders for the Practice and Procedure of the Board of Directors

The annual review of Standing Orders for the Practice and Procedures of the Board of Directors was undertaken with the Audit Committee approving the following amendments

Section	Amendment
Section 9.2 (Pages 27 – 29)	The section has been amended to include all updated regulations and guidance, in relation to the new procurement regulations as detailed above.
Section 9.3 (Pages 29 – 31)	There have been no material changes to process, however the section has been updated to provide more detail related to the requirements of the Procurement Act. Section 9.3.5 has been moved to provide better flow to the document.
Section 9.4 (Pages 31 – 32)	The quotations and internal threshold limits have been amended, to take into account the regulatory financial thresholds. The changes have been made in line with changes to the Detailed Scheme of Delegation (DSoD)
Section 9.5.1 (Page 33)	The definitions have been amended to provide clearer definitions and guidance around when tendering and competitive quotations are not required.
Section 9.6.1 – 9.6.5	This section has been significantly amended to transition into a different approach to the use of waivers. The following changes have been made: • A transition from the terminology of "waivers" with the proposal to refer to these as an SFI Procurement Breach. • The removal of the "other" category from the list of existing rationale for waivers (9.6.3). All categories are clear, and any situation would fit into the categories listed, so the "other" category is not required. • Exception from an SFI Procurement Breach (9.6.4) has been updated, most notably where competitive tendering has been completed, but less than five bids have been received. The proposal is that with all exemptions from SFI Procurement Breaches, that these continue to be documented

	within an award report. This would be a requirement for all regulatory above threshold awards under the Procurement Act 2023. • The addition of Section 9.6.5 which includes the additional terminology of a Regulatory Procurement Breach, which relates specifically to awards that are non-compliant with external procurement legislation.

Scheme of Reservation & Delegation

The annual review of the Scheme of Reservation and Delegation (SoRD) was undertaken with the Audit Committee approving the following amendments:

Section	Amendment
Sections 7.33.1 & 7.33.3) (Page 29)	Change of language "waive" to include SFI Procurement Breach. This change is substantiated within the Standing Orders for the Board of Directors.
Sections 8.34.5 – 8.34.8) (Page 36)	Amendments and additions made in line with changes to the SFI's, regarding staffing and procurement.
Section 8.35.1 (Page 36)	Amended wording to the CEO ensuring there are process in place for identifying and implementing cost improvement and income generation initiatives.
Section 8.58 (Page 39)	Addition of a new section regarding the introduction of Non-Pay Expenditure Control Panel.
Section 15.1.4 (Page 42)	Addition of the Digital Strategy Group to cover any ICT related capital schemes.
Section 17.2.5 (Page 45)	The Director of Finance has been added to this section to ensure there is consistency between the DSoD / SFI's and is not a change in process.

Standing Financial Instructions (SFI's)

The annual review of Standing Financial Instructions (SFI's) was undertaken with the Audit Committee approving the following amendments

Section	Amendment
4 – Definitions / Glossary	Reference to the abolition of NHS England included noting that this requires legislative change and is expected to take two years to complete.
6.3.5	Inclusion of reference that the Chief Internal Auditor is periodically required to attend Executive Management Team meetings.
7.3.1	Inclusion of enhanced monthly financial reports being presented to Accountability Framework meetings. Reference to new NHS Oversight framework.
7.3.2	Further clarity that budget holders are required to review staff lists and the eligibility of staff allowances and additional payments. Further clarity provided on Budget Holders responsibility to raise queries with their finance lead on the figures presented to them in order to ensure figures are robust and all variances explainable. A requirement that SFI Procurement Breaches (formerly waivers) are sent timely and should not be retrospective in nature.

10.3.3	Expanded to ensure Salary Overpayments to follow the Resolution to Overpayment Policy (HR50)
12.3.3d	Confirmation managers have a responsibility to ensure staff are notified of any changes affecting their terms and conditions.
13.2	A new section has been included to detail the role of the Non-Pay Control Panel and to remind staff to ensure all requests are made in advance of need and prior to existing purchase orders / contracts expiring.
13.3.6	All contracts (including DocuSign) to be forwarded to the Procurement dept for inclusion in the contracts register.
17.2.5	Confirmation that approval for all write offs is delegated to either the Director of Finance or Executive Chief Finance Officer only.

Detailed Scheme of Delegation:

The annual review of Detailed Scheme of Delegation was undertaken with the Audit Committee approving the following amendments:

Section	Amendment
1.1e	Confirmation that authorised signatories for charitable funds also need approval by Assistant Director or above.
1.1i	Confirmation that all staff have a responsibility to comply with establishment and non-pay control panels.
2.1a (vii)	Noting that where a contract is in place and signed by both CEO and CFO, the requisition on eProc needs to only be signed by either CEO or CFO.
2.1a (xi)	Contracts to only be signed by Directors and above post procurement / contract approval. This had previously been delegated down to staff in line with their delegated limits.
4	This section has been updated to reflect the latest procurement regulations (Provider Selection Regime Regulations 2023) in line with section 9 of the Standing Orders with proposed new thresholds for the obtaining of quotes / tenders. These new thresholds remain in line, and lower, than those proposed in procurement regulations. • For goods / services up to £11,999 only one quote is required – previously £9,999 • For goods / services up to £74,999 three written quotes are required with support from procurement – previously £24,999 • For goods / services up to £139,688 (£135,018 from January 2026) and construction works of up to £499,999, three written quotations with clear auditable process is required – previously £99,999 • For goods / services / construction works up to £999,999 five written competitive tenders invited with options appraisal form – no change For goods / services / construction works over £1,000,000 five written competitive tenders invited with full business case – no change.

6	Updated to include new processes for use of agency staff and agreement to price cap breaches.
17	Changes to approval route for upgrades or regrades noting that these now need to go to Care Group ECP. Changes to approval route for expenses over three months old which now lies with Director of Service and HR Business Partner (previously ECFP and Director of HR). Confirmation that carry forward of up to one week of contracted hours is in exceptional cases only. Redundancy approval route updated to confirm this is delegated to the ECPO and ECFO, after approval by the EOC and completion of a Redundancy Recommendation form.
19	Arrangements for sponsorship deals is now aligned to CLP51 Hospitality and Sponsorship.
47	Reference to the Legal Panel is now included as part of approval route to engage legal support.

Standing Orders for the Practice and Procedure of the Council of Governors

The annual review of Standing Orders for the Practice and Procedures of the Council of Governors was undertaken with the Council of Governors approving with no recommended changes.

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			
SO	Standing Orders	NAO	National Audit Office
SoRD	Scheme of Reservation and Delegation	SFI's	Standing Financial Instructions
SFI	Standing Financial Instructions	DSoD	Detailed Scheme of Delegation

Supporting Reports/ Appendices /or further reading

Standing Orders for the Practice and Procedures of the Board of Directors
Scheme of Reservation and Delegation
Standing Financial Instructions
Detailed Scheme of Delegation
Standing Orders for the Practice and Procedures of the Council of Governors

Lead

Denver Greenhalgh
Executive Director of Governance

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Document title:	**STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE BOARD OF DIRECTORS**		
Document reference number:	TB01	**Version number:**	8.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Trust Secretary's Office		
Approval group/ committee(s):	Board of Directors Audit Committee Executive Team		
Professionally approved by: (Director)	Executive Director of Corporate Governance		
Executive Director:	Executive Director of Corporate Governance		
Ratification group(s):	Board of Directors		3 December 2025
CQC Quality Statement	Well Led – Governance		
Key word(s) to search for document on Intranet / TAGs:	Standing Orders	**Distribution method:**	☒Intranet

Initial issue date:	01 April 2017	**Last Review date:**	03 December 2025	**Next Review date:**	31 December 2026	**Expiry Date:**	01 January 2027

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Related Trust documents (to be read in conjunction with)
None

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
001	Trust Secretary	Reflects New Constitution	01 April 2017
002	Trust Secretary	Some typographical and factual amendments	01 September 2018
003	Trust Secretary	Recommendations following legal advice	01 September 2019
004	Trust Secretary	Minor Amendments	01 September 2020
4	Trust Secretary	Addition of section to provide delegated authority to Executive Directors as part of a collaborative board (4.6.4) Amendments to formal competitive tendering and where competitive tendering is not required. (9.4, 9.6)	01 September 2021
5	Trust Secretary's Office	Removal of references to "Monitor". Amendment of statements using the "he" pronoun.	01 September 2022
6	Trust Secretary's Office	Alignment with the Code of Governance for NHS Provider Trusts (2023) and amendments through the Health and Care Act 2022 Slight amendments to procurement section to align with latest arrangements.	01 September 2023
6.1	Trust Secretary's Office	Extension applied until January 2025	01 March 2024
7.0	Trust Secretary's Office	New template and minor updates. Inclusion of definition of Associate NED	04 December 2024
8.0	Assistant Trust Secretary Head of Procurement	Annual review. Section 9 amended to bring into line with relevant procurement legislation.	03 December 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

INTRODUCTION

REGULATORY FRAMEWORK

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1 April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act).

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no 120163) and all relevant legislation and guidance.

These Standing Orders add clarity and detail where appropriate. Nothing in these Standing Orders shall override the Trust's constitution, the National Health Service Act 2006 and the Health & Social Care Act 2012.

The Trust's Standing Orders and wider governance arrangements are further supported by various policies and procedures and for financial matters, by the Standing Financial Instructions (SFIs), Detailed Scheme of Delegation (DSoD), and associated finance procedures. These are covered by the Scheme of Reservation & Delegation of Powers of the Board. (SoRD).

As a public benefit corporation, the Trust has the power to act as a corporate Trustee of charitable funds. Under section 11 of the Trustee Act 2000 the Trust can appoint a Charitable Funds Committee and delegate its functions to it. This power includes appointing a committee whose members are not members of the Board of Directors. The Trust has appointed a Charitable Funds Committee that operates in accordance with these Standing Orders and its terms of reference (as approved by the Board of Directors) and the relevant guidance from the Charity Commission.

1 INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair of the Trust shall be the final authority on the interpretation of these Standing Orders (on which they should be advised by the Chief Executive and the Trust Secretary)

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 and regulations made under it shall have the same meaning in these Standing Orders and in addition:

1.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health & Social Care Act 2012 and the Health and Care Act 2022)

1.2.2 **2012 Act** means the Health & Social Care Act 2012

1.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

1.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**

1.2.5 **Budget** means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust

1.2.6 **Chair of the Board** or **Chair of the Trust** or **Chair** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable

1.2.7 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution

1.2.8 **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources

1.2.9 **Committee** means a committee appointed by the Board of Directors

1.2.10 **Committee members** means persons formally appointed by the Board of Directors to sit on or to chair specific committees

1.2.11 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act

1.2.12 **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

1.2.13 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution

1.2.14 **Deputy Chief Executive** means the officer of the Trust appointed under paragraph 30 of the constitution

1.2.15 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.2.16 **Executive Chief Finance** Officer means the Chief Finance Officer of the Trust

1.2.17 **Executive Director** means a member of the Board of Directors appointed under paragraph 31 of the constitution

1.2.18 **Licence** means the Trust's provider licence (no 120163) issued by NHS England on 1 April 2017 (and reissued on 11 October 2017)

1.2.19 **Member** means a person registered as a member of one of the constituencies as set out in paragraph 5 of the constitution

1.2.20 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting

1.2.21 **Nominated Officer** means an officer charged with the responsibility for discharging specific task under the Scheme of Reservation & Delegation

1.2.22 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution

1.2.23 **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust

1.2.24 **SFIs** means the Standing Financial Instructions of the Trust

1.2.25 **Scheme of Reservation & Delegation** is the Trust's scheme of reservation and delegation of powers approved by the Board of Directors

1.2.26 **SOs** means these Standing Orders (for the Board of Directors)

1.2.27 **Trust** means Essex Partnership University NHS Foundation Trust

1.2.28 **Trust headquarters** means The Lodge, Lodge Approach, Wickford SS11 7XX

1.2.29 **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.2.30 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution

1.2.31 **Working days** means a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday

1.3 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

2 THE BOARD OF DIRECTORS

2.1 The general duty of the Board and of each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate Trustee

2.3 The powers of the Trust shall be exercisable by the Board. The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the SoRD and have effect as if incorporated into these SOs

2.5 **Composition of the Board**

In accordance with paragraph 25 of the constitution, the composition of the Board of the Trust shall be:

- A Non-Executive Chair
- Not less than five and not more than eight other Non-Executive Directors
- Not less than four and not more than eight Executive Directors

So that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive in a voting capacity.

2.6 **Appointment and Removal of the Chair and other Non-Executive Directors**

In accordance with paragraph 28 of the constitution and guidance issued by NHS England, the Chair and the other Non-Executive Directors are appointed (and removed) by the Council at a general meeting of the Council

2.7 **Terms of Office of the Chair and other Non-Executive Directors**

2.7.1 The Chair and Non-Executive Directors shall be appointed with terms and conditions of office as decided by the Council at a general meeting taking account of Foundation Trust governance guidance

2.7.2 The Chair and Non-Executive Directors shall be appointed for a term of office of up to three years

2.7.3 The Chair and Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director

2.7.4 The Chair and Non-Executive Directors may in exceptional circumstances serve longer than six years subject to annual re-appointment and subject to external competition if recommended by the Board and approved by the Council. In establishing that the Non-Executive Director continues to be independent, the Chair will take into account guidance and conduct an evidence-based evaluation

2.7.5 Any reappointment after the second term of office for the Chair and Non-Executive Directors shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence. Any extensions need to be clearly explained and agreed with NHS England.

2.7.6 The role of Associate Non-Executive Director is to bring capacity to work of the Board committees where additional skills and expertise would be beneficial in the achievement of organisational objectives. An Associate Non-Executive Director is non-voting and in attendance only at Board meetings.

2.8 Appointment and Powers of Vice-Chair

2.8.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place

2.8.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision

2.8.3 In the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust

2.8.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 2.9

2.8.5 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair and be entitled to exercise all the rights and powers conferred upon the Chair by the constitution including but without limit those set out in these SOs and in the SOs of the Council until a new Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair

2.9 Appointment and Removal of the Chief Executive

2.9.1 In accordance with the constitution paragraph 31.1, the Non-Executive Directors of the Trust will appoint (and remove) the Chief Executive

2.9.2 The appointment of the Chief Executive requires the approval of the majority of the Council at a meeting of the Council in accordance with paragraph 31.2 of the constitution

2.10 Appointment and Removal of Executive Directors

In accordance with the constitution paragraph 31.3, all Executive Directors (excluding the Chief Executive) are to be appointed (and removed) by a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors.

2.11 Appointment of the Deputy Chief Executive

In accordance with paragraph 30.4 of the constitution, the Board of Directors Nominations Committee, which shall comprise all of the Non-Executive Directors, may nominate identified Executive Directors to be the Deputy Chief Executive.

2.12 Joint Executive Directors

2.12.1 Where more than one person is appointed jointly to an Executive Director post, those persons shall count for the purpose of SO 2.6 (composition of the Board) as one person (save that the Executive positions of registered Medical Practitioner or registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions) in accordance with paragraph of 31.4 of the constitution

2.12.2 Where such an arrangement is in force, both individuals shall be able to attend a meeting of the Board provided that at any meeting of the Board they may only count as one individual for the purposes of the quorum and may only exercise one vote between them

2.12.3 Where the two individuals disagree as to how to vote at a Board meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both

2.12.4 The presence of either or both persons shall count as the presence of one person for the purposes of SO 30.17 (Quorum)

2.13 Appointment and Removal of the Senior Independent Director

2.13.1 The Board shall (following consultation with the Council) appoint one of the Non-Executive Directors as the Senior Independent Director in accordance with paragraph 30.3 of the constitution, for such period not exceeding the remainder of the individual's term of office as a Non-Executive Director

2.13.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board (following consultation with the Council) may thereupon appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of this Standing Order.

2.14 **Trust Secretary**

The Chair and Chief Executive shall appoint a Trust Secretary to act independently of the Board, to provide advice on corporate governance issues to the Chair and the Board, and to monitor the Trust's compliance with the regulatory framework, the constitution and the SOs.

2.15 **Role of the Chief Executive**

2.15.1 The Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business

2.15.2 The Chief Executive reports to the Chair and the Board

2.15.3 The Chief Executive is the Accounting Officer and shall be responsible for ensuring the discharge of obligations under all relevant financial directions and guidance issued by NHSE or any other relevant body

2.16 **Role of the Executive Chief Finance and Resources Officer**

2.16.1 The Executive Chief Finance and Resources Officer shall be responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems

2.16.2 The individual shall be responsible, along with the Chief Executive, for ensuring the discharge of obligations under all relevant financial requirements, conditions or notices issued by NHSE or any other relevant body.

2.17 **Role of Executive Directors**

Executive Directors shall exercise their authority within the terms of these SOs, SFIs and the SoRD

2.18 **Role of the Chair**

2.18.1 The Chair shall be responsible for the leadership of the Board (and Council), and chair all Board (and Council) meetings when present

2.18.2 The Chair must ensure effectiveness in all aspects of the Board's role and lead on setting the agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues

2.18.3 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board (and

Council) in a timely manner with all the necessary information and advice being made available to the Board (and Council) to inform the debate and ultimate decisions.

2.18.4 The Chair is responsible for ensuring that the Board and the Council work effectively together

2.19 **Role of Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

3 MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press**

3.1.1 The meetings of the Board shall be open to members of the public and the press in accordance with paragraph 34.1 of the constitution

3.1.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Board will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 18E of Schedule 7 of the 2006 Act, the Board of Directors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed"

3.1.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as detailed in SO 3.1.2 above

3.1.4 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board and such agreement not to be unreasonably withheld

3.1.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Board and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting

3.2 Calling Meetings

3.2.1 Ordinary meetings of the Board shall be held at such times and places as the Board may determine

3.2.2 Meetings of the Board are convened by the Trust Secretary, by order of the Chair. Not less than one-third of the Directors can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary

3.2.3 The Trust shall hold meetings of the Board at least six times in each calendar year

3.3 Notice of Ordinary Meetings

3.3.1 The Trust Secretary shall give to all Directors at least ten (10) working days written notice of the date and place of every ordinary meeting of the Board

3.3.2 Agendas will be sent to Directors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent or extraordinary business under SO 3.4 or SO 3.5.

3.3.3 A notice or other document(s) to be served upon a Director under these SOs shall be manually delivered or sent by post to the Director at their usual place of residence which he shall have last notified to the Trust, or where sent by email, to the address which they shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means

3.3.4 A notice or other document(s) where manually delivered or sent by post shall be presumed to have been served on the next working day following the day of delivery and where sent by email at the time at which the email is sent

3.3.5 Failure to serve notice and supporting papers on any Director shall not affect the validity of an ordinary meeting

3.3.6 Save in the case of urgent meetings, for each meeting of the Board a public notice of the date, time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's head office and on the Trust's internet site for general access at least three working days before the meeting

3.3.7 Before holding a meeting, the Board must send a copy of the agenda of the meeting to the Council

3.4 Notice of Extraordinary Meetings

3.4.1 At the request of the Chair or by at least one-third of the whole number of members of the Board, the Trust Secretary shall send a written notice to all Directors within 10 (ten) working days of receipt of such a request specifying the date and place to discuss the specified business

3.4.2 If the Trust Secretary does not send notice a meeting of the Board within ten (10) working days of receiving a request from the Chair or a requisition from not less than one-third of the Directors pursuant to SO 3.4.1, the Directors who made the requisition may convene the meeting themselves by giving written notice to all Directors; this notice must be signed by all of the Directors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

3.5 Notice of Urgent Meetings

3.5.1 At the request of the Chair or not less than one-third of Directors, the Trust Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Trust Secretary shall give Board members as much notice as is possible in light of the urgency of the request

3.5.2 If the Trust Secretary fails to call such a meeting, then the Chair or at least one-third of the whole number of Board members shall call such a meeting

3.5.3 In the case of a meeting called under SOs 3.4 and 3.5, the notice shall be signed by the Chair or at least one-third of the whole number of Board members

3.5.4 No business shall be transacted at the meeting called under SOs 3.4 and 3.5 other than that specified in the notice. Agendas will be sent to Board members three working days before the meeting and supporting papers shall accompany the agenda, save in the case of urgent meetings

3.5.5 In the case of a meeting called under SOs 3.4 and 3.5 failure to serve such a notice on more than three Directors will invalidate the meeting

3.6 Setting the Agenda

3.6.1 The Board may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted

3.6.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 (ten) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven (7) working days before a meeting may be included on the agenda at the discretion of the Chair

3.6.3 Before holding a meeting, the Trust Secretary must send a copy of the agenda of the Board meeting to the members of the Council and may be sent in any manner permitted under SO 3.3.5 and 3.3.6

3.7 **Petitions**

Where a petition has been received by the Trust not less than ten (10) working days before a meeting of the Board, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting

3.8 **Chair of Meeting**

3.8.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent (and provided the Chair has waived the requirement for the Chair or Vice-Chair to be present under SO 3.17), the Non-Executive Directors present shall nominate a Chair for the meeting from their number and who has no conflict of interest

3.8.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Non-Executive Directors present shall nominate, shall preside

3.9 **Motions**

3.9.1 **Notices of Motion**: A Director desiring to move or amend a motion shall send a written notice thereof at least ten (10) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda

3.9.2 **Withdrawal of motion or amendment**: A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair

3.9.3 **Motion to Rescind a Resolution**: Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Board member who gives it and also the signature of four other Board members, to include at least one non-executive director and one executive director. Such notice shall be sent at least ten (10) working days before the meeting to the Chair, who shall insert in the agenda for the meeting. When any such motion has been disposed of by the Board, it shall not be possible for any Board member other than the Chair to propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate

3.9.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto

3.9.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Director to move:

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceed to the next business*
- the appointment of an ad hoc committee to deal with a specific item of business; or
- that the motion be now put*

Provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate

3.9.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion

3.10 **Chair's Ruling**

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final

3.11 **Voting**

3.11.1 Subject to the following provisions of this clause, questions arising at a meeting of the Board shall be decided by a majority of votes. Each Director shall have one vote:

- In the event of joint Executive Directors, SO 2.13 shall apply. In case of an equality of votes the Chair shall have a second casting vote

- no resolution of the Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present

3.11.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands

3.11.3 A paper ballot may also be used if a majority of the Directors present so request in which case any person attending by telephone, teleconference, video or computer link shall cast their vote verbally (such verbal vote to be recorded in the minutes)

3.11.4 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained

3.11.5 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot)

3.11.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote

3.11.7 Directors may participate (and vote) in Board meetings by telephone, teleconference, video or computer link with the prior agreement of the Chair; participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting

3.11.8 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director and has a responsibility to consult with the Executive Director if available. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director, but has a responsibility to consult with the Executive Director if possible and to ensure their views are included within the debate, prior to the vote taking place. An officer's status when attending a meeting shall be recorded in the minutes

3.12 **Minutes**

3.12.1 The minutes of the proceedings of a meeting shall be drawn up by the Trust Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it

3.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting

3.12.3 Minutes shall be retained in the Trust Secretary's office

3.12.4 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by any applicable guidance

3.12.5 As soon as practicable after holding a Board meeting, the Trust Secretary must send a copy of the approved minutes of the meeting to the members of the Council of Governors

3.12.6 Where Directors have concerns that cannot be resolved about the running of the Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes. On resignation, a Director should provide a

written statement to the Chair for circulation to the Board, if they have any such concerns

3.13 **Informal Meetings and Meetings as a Committee**

3.13.1 The Chair should hold meetings with the Non-Executive Directors without the Executives Directors present

3.13.2 Led by the Senior Independent Director, the Non-Executive Directors should meet without the Chair present, at least annually, to appraise the Chair's performance, and on other such occasions as are deemed appropriate

3.13.3 Notwithstanding anything in these SOs, the Directors may meet informally or as a committee of the Board at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation

3.14 **Amendment of Standing Orders**

3.14.1 These SOs may be amended without the need to amend the constitution. These SOs may be amended only if:

- a notice of motion under SO 3.9.1 (Notices of Motion) has been given
- not fewer than half of the total number of Non-Executive Directors vote in favour of the amendment
- at least two-thirds of Directors are present
- the amendment proposed does not contravene a statutory provision or direction made by NHS England

3.14.2 For the avoidance of doubt, SO 3.16 (Quorum) shall not apply to the variation of the SOs and the higher quorum required in this SO 3.14 (Variation and Amendment of Standing Orders) shall be reached

3.15 **Record of Attendance**

3.15.1 The names of the Chair, Directors and all others present at the meeting (other than members of the public and media) who are present at a meeting of the Board shall be recorded in the minutes

3.15.2 A meeting of the Board refers to officers being physically present and officers being present via the use of technology, as defined in SO 3.17.5 and 3.18

3.16 **Quorum**

3.16.1 Seven (7) Directors including not less than two (2) Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive) and not less than two (2) Non-Executive Directors (one of whom must be the Chair or the Vice-Chair) shall form a quorum provided that a meeting shall be quorate if:

- the Chief Executive has waived the requirement for the Chief Executive or the Deputy Chief Executive to be present; and
- the Chair has waived the requirement for the Chair or the Vice-Chair to be present

3.16.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum

3.16.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business

3.16.4 The above requirement for at least two (2) Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee)

3.16.5 Board Directors may participate (and vote) in its meetings by telephone, teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

3.17 **Meetings: Electronic Communication**

3.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof

3.17.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board or of a standing committee or sub-committee of the Board shall be regarded for all purposes as being present and personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication

3.17.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at

the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair is physically present

3.17.4 Meetings held in accordance with this SO are subject to SO 3.16 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting

3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 The NHS Act 2006 provides for all the powers of the Trust to be exercised by the Board on its behalf. It also states that the Board may delegate any of its powers to a committee of Directors, to an Executive Director or arrangements for functions to be exercised by or jointly with another relevant body.

4.2 Subject to such requirements, conditions, notices or guidance as may be given by NHS England, the Board may make arrangements in these SOs for the exercise, on behalf of the Board, of any of its functions by either a committee, an Executive Director, another relevant body or a joint committee with another relevant body.

4.3 In each case subject to such restrictions and conditions as the Trust thinks fit

4.4 Where a function is delegated (as detailed in the Trust's SoRD, i.e. delegation to committees or officers) the Trust retains full responsibility

4.5 **Emergency Powers**

The powers which the Board has retained to itself within these SOs may in emergency situations be exercised by the Chief Executive or in their absence, the Deputy Chief Executive, provided that prior to taking such action, the Chief Executive has consulted with and gained the agreement of the Chair or in their absence, the Vice-Chair. Where time permits the Chair should contact all Board members in writing to allow the opportunity for objection. The exercise of such powers by the Chief Executive shall be reported to the next formal meeting of the Board held in public for ratification

4.6 **Delegation to Committees and Officers**

4.6.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with statute and such requirements, conditions, notices or guidance as may be given by NHS England. The constitution and terms of reference of these committees and their specific executive powers shall be approved by the Board

4.6.2 The Board may delegate certain functions of the Trust to an Executive Director

4.6.3 The Chief Executive shall prepare a detailed SoRD identifying the functions to be delegated to either an Executive Director or a committee of the Board. The proposals shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the detailed SoRD that shall be considered and approved by the Board as indicated above

4.6.4 The Board may delegate executive powers to an Executive Director to make decisions on behalf of the Board of Directors as part of a Collaborative Board. However, this must be in line with limitations set by the DSoD and SoRD.

4.6.5 Nothing in the SoRD shall restrict or limit the responsibility of the Executive Chief Finance Officer to provide information and advice to the Board in accordance with any statutory requirements, but subject to his discharge of these statutory requirements, the Executive Chief Finance and Resources Officer shall be accountable to the Chief Executive for the performance of his role

4.6.6 The arrangements made by the Board as set out in the SoRD shall have effect as if incorporated in these SOs

5 COMMITTEES

5.1 The National Health Service Act 2006 states that:

5.1.1 The Board shall appoint an Audit Committee of Non-Executive Directors to perform such monitoring, reviewing and other functions as appropriate in accordance with this SO and the constitution paragraph 43

5.1.2 The Board shall appoint a Remuneration Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors in accordance with SO 2.10 and 2.11 and the constitution paragraph 37

5.2 Subject to the NHS Act 2006 and the regulatory framework and any such guidance as may be issued by NHS England, the Board may appoint standing committees of the Board (ref SO 4.6 Delegation to Committees and Officers)

5.3 The SOs of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits

5.4 There is no requirement to hold meetings of committees in public

5.5 Each such standing committee (including their sub-committees and working groups) shall have terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

5.6 Committees are authorised to establish sub-committees which shall operate as working groups and shall have no delegated executive powers from the Board or a committee of the Board

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted

5.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS England and/or the law, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the regulations and directions made by NHS England and/or the law

5.9 The committees established by the Board are attached at Appendix A of the SOs

5.10 The Board may change the committees, without requirement to amend these SOs

5.11 A Board member or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board shall resolve that it is confidential

5.12 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 All Board members have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with interests of the Trust. Any Director who has an interest in a matter they are required to declare in accordance with paragraph 36 of the Trust's constitution shall declare such interest to the Board and:

A. Shall withdraw from the meeting and play no part in the relevant discussion or decision; and

B. Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

6.1.2 Details of any such interest shall be recorded in the Register of Interests of Board members. At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes. Any changes in interests should be declared in accordance with the requirements of paragraph of the Trust's constitution

6.1.3 Any Board member who fails to disclose any interest required to be disclosed under the preceding clause must permanently vacate their office if required to do so by a majority of the remaining Board members and (in the case of a Non-Executive Director) by the requisite majority of the Council

6.1.4 Board members' directorships of companies which may conflict with their management responsibilities should be published in the Trust's annual report. As the Trust maintains a Register of Interests which is open to the public, the disclosure in the annual report may at the discretion of the Board, be limited to a comment on how access to the information in that Register may be obtained

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision

6.1.6 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Trust Secretary

6.2 Register of Interests

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members. In particular the Register will include details of all Directorships and other interests which have been declared by both Executive and Non-Executive Board members in accordance with paragraphs 36 and 40 of the Trust's constitution

6.2.2 The Trust Secretary will keep these details up to date by means of an annual review of the Register in which any changes to the interests declared during the preceding 12 (twelve) months will be incorporated. It is the responsibility of each member of the Board to provide an update to the Trust Secretary of their register entry if their interest changes

6.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it

6.3 Register of Gifts and Hospitality

6.3.1 A Register of Gifts and Hospitality will be maintained by the Trust Secretary for Board members and staff

6.3.2 The Register will be published on the Trust's website in line with regulatory requirements.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

7 CONFLICT OF INTEREST AND PECUNIARY INTEREST

7.1 **Disclosure of Interest**

Subject to the following provisions of this SO, if a Board member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall disclose that interest to the Board and/or meeting as soon as he becomes aware of it Interest

7.2 **Conflict of Interest**

During the course of a Board meeting (or other meeting) if a conflict of interest is disclosed, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision

7.3 The Board may exclude the Director from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration

7.4 Any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director shall not be treated as a pecuniary interest by the Trust for the purpose of this SO

7.5 For the purpose of this SO, a Board member shall be treated, subject to SO 7.7, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.5.1 they, or a nominee of theirs, are a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.5.2 they are a partner of, or are in the employment of a person with whom the contract was made or are proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and, in the case of sibling, parent, child, cohabiting spouse or civil partner or person living together with them as partner, the interest of one shall, if known to the other, be deemed for the purposes of this SO to also be an interest of the other.

7.6 A Board member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.6.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body

7.6.2 of an interest in any company, body or person with which they are connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter

7.7 In the event that the Board member having an indirect pecuniary interest in a contract (including a proposed contract or other matter) by virtue of holding securities of the company concerned, then for the Board member to be able to participate in the consideration or discussion of the contract (or other matter), and vote on any question with respect to it, the following requirements need to be met:

7.7.1 If one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total nominal value of issued share capital of the company concerned; or

7.7.2 If more than one class of share capital is held, the Board member holds the lower of £10,000 or 1/100th of the total issued share capital of that class

However, it remains the responsibility of the individual to disclose their interest

7.8 This SO applies to a committee or sub-committee or a joint committee of the Board as it applies to the Board and applies to any such committee or sub-committee as it applies to a Director.

8 STANDARDS OF BUSINESS CONDUCT POLICY

8.1 All Board members must comply with the Trust's standards of business conduct policy as amended from time to time.

8.2 All Board members should comply with this SO 8, Appendix B national guidance contained in HSG 1993/5 Standards of Business Conduct for NHS Staff. The Trust's Counter Fraud Policy and Procedure and any such guidance issued by NHS England or the Department of Health and Social Care from time to time

8.3 **Interest of Officers in Contracts**

8.3.1 If it comes to the knowledge of an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein

8.3.2 An Officer should also declare to the Chief Executive in accordance with Trust procedure, any other employment, business or other relationship of theirs, or of a spouse/partner/other family member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust

8.3.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff, in accordance with Trust procedure

8.4 Canvassing of, and Recommendations by, Board Members in Relation to Appointments

8.4.1 Canvassing of Board members of the Trust or of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the contractor for such appointment. The contents of this provision of the SO shall be included in application forms or otherwise brought to the attention of contractors

8.4.2 A Board member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this clause of this SO shall not preclude a Board member from giving written testimonial of a contractor's ability, experience or character for submission to the Trust

8.4.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.5 Relatives of Board Members or Officers

8.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Board member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal

8.5.2 Every Board member and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Board member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made

8.5.3 On appointment, Board members (and prior to acceptance of an appointment in the case of officer Board members) should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust

8.5.4 Where the relationship to a Board member of the Trust is disclosed, SO 7 applies.

9 TENDERING AND CONTRACT PROCEDURE

9.1 Duty to comply with Standing Orders and Standing Financial Instructions

9.1.1 The procedures to be followed by the Trust in relation to all contract opportunities and for awarding of all contracts shall comply with the SOs, SFIs, the detailed scheme of delegation and the Trust's Tendering & Quotation Policy and Procedure outlined in 9.3 and 9.4 below.

9.2 Duty to comply with Legislation Governing Public Procurement & Guidance

9.2.1 With regard to trust procurement activity the Trust shall adhere to;

- Procurement Act 2023
- Procurement Regulations 2024
- The Public Contract Regulations 2015 (as amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020).
- Operational Guidance to the NHS Extending Patient Choice of Provider (Department of Health and Social Care).
- NHS England Guidelines.
- Cabinet Office Guidelines.
- Crown Commercial Services Guidance.
- Health Care Services (Provider Selection Regime) Regulations 2023 (PSR)
- The Department of Health's "Capital Investment Manual" and "Estate Code" in respect of capital investment and estate and property transactions save where either has been superseded by later published guidance.
- In the case of management consultancy contracts the Department of Health guidance "The Procurement and Management of Consultants within the NHS" or any successor guidance issued by the Department of Health and Social Care.

All such legislative and regulatory requirements are incorporated into the Standing Financial Instructions (SFIs) & Scheme of Delegation and shall inform the procedures applied when awarding all forms of contract. .

9.2.2 For ease of reference, Health Care Services are governed by Provider Selection Regime Regulations 2023 (PSR) and Non-Healthcare Service are governed by The Public Contract Regulations 2015 (as amended by The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020) and the Procurement Act 2023.

9.2.3 The financial thresholds applicable to NHS trusts (which are classified as "central government authorities" under the Procurement Act 2023 and accompanying guidance) can be accessed via the Cabinet Office.

9.2.4 Figures are inclusive of VAT and should include all extensions and renewals and reflect the cumulative annual contract value if the contract is for a period more than one year. Contracts must not be artificially broken down to avoid the application of the Regulations.

9.2.5 There is no minimum value threshold for contracts that are subject to the NHS Provider Selection Regime (PSR). All services which fall within the scope of PSR must be arranged in line with the Regime.

9.2.6 During procurements the Trust should have regard to the requirements of the Public Services (Social Value) Act 2012 and its supporting regulations and guidance, as amended. The NHS has committed to embedding social value into its procurement processes, aiming to secure social, economic, and environmental benefits. The trust will utilise the NHS Social Value Playbook, published in June 2025, which provides guidance on how to treat social value

in NHS procurement, emphasising the importance of including it as a core requirement in contracts and as a social value theme for suppliers. The Playbook outlines practical steps at each stage of the procurement lifecycle, including specification development, market engagement, evaluation of bids, and contract management. When tendering a minimum of 10% of the evaluation criteria will be based on Social Value.

9.3 **Formal Competitive Tendering**

9.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any Procurement Legislation or as otherwise set out in the Trust's Tendering and Quotation Policy and Procedure and/or the DSoD.

9.3.2 Competitive tenders under the PA2023, PSR or PCR15 should be sought before the end of all existing contracts within a reasonable timeframe determined by the anticipated complexity and resource required. If the value of the tendering exercise is over £1 Million, the results of the tender should be reported to the Board of Directors.

9.3.3 The Trust shall ensure that invitations to tender, whether regulated by the Procurement Act 2023 or otherwise, adopt a fair and transparent process. Where a tender process is conducted the Trust shall, in order to ensure best value is obtained, invite a sufficient number of firms/individuals to provide fair and adequate competition having regard to their capacity to supply the goods or materials or to undertake the service or works regulations. DSoD details requirements for number of bids expected through a competitive process.

9.3.4 A competitive procedure is the default for public contracts. Direct award (i.e. awarding a contract without competition) above threshold contracts are only permitted when one or more of the statutory "direct award justifications" apply (see Section 41 and Schedule 5 to the Procurement Act 23).

9.3.5 Direct award justifications cannot be used as a discretionary or administrative workaround. They will only be approved when the Trust can clearly demonstrate that:

i) A direct award justification under the Procurement Act 2023 is met;

ii) The relevant notice requirements (e.g. Transparency Notice) are complied with; and

iii) The proposed supplier is not subject to mandatory exclusion, unless an overriding public interest can be justified.

9.4 Quotations

9.4.1 The Trust shall ensure that quotes are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any Procurement Legislation or as otherwise set out in the Trust's Tendering and Quotation Policy and Procedure and/or the DSoD.

9.4.2 Quotation thresholds are set out within the DSoD. Quotations apply where good or services provided amount to less than £139,688 (£135,018 from January 2026) inclusive of VAT (exemption for works projects where the threshold is £499,999 inclusive of VAT).

9.4.3 Where quotations are required over £11,999 inclusive of VAT, they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board. The Chief Executive or the nominated officer (via the DSoD) should select the quotations which gives the best quality and value for money. If this is not the lowest cost then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record

9.4.4 Where quotations are required over £74,999 inclusive of VAT, they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board, and they should be evaluated on a set of evaluation criteria. The Chief Executive or the nominated officer (via the DSoD) should select the quotations which gives the best quality and value for money based on the evaluation criteria identified within the request for quotation.

9.4.5 Quotations should be requested and received in writing, (subject to limits specified in SFIs and occasions when verbal quotes can be obtained).

9.4.6 All quotations should be treated as confidential and should be retained for inspection. A written record of verbal quotations should also be retained.

9.4.7 Non-competitive quotations in writing may be obtained for the following purposes. In either case an SFI Breach must be recorded.

i) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or the nominated officer, possible or desirable to obtain competitive quotations

ii) the goods/services are required urgently.

9.5 Where tendering or competitive quotation may not be required

9.5.1 Formal tendering and quotation procedures are not required when:

a) Where the requirement is covered by an existing contract (e.g. Crown Commercial Services or NHS Supply Chain) where EPUT has opted into a national contract.

b) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members, including the Trust. The lead organisation must work in adherence to all legislation and guidance set out within 9.2.

c) For quotations under £139,688 (inc of VAT) (£135,018 from January 2026) where the supply can be obtained under a framework agreement that has itself been procured in compliance with all legislation and guidance set out within 9.2 and the price is certain. Allowable frameworks are aligned to NHS England's Framework Accreditation Programme and limited to frameworks ran by Accredited Framework hosts.

d) Salary recharges – including seconded staff, staff provided by another authority, and Graduate Management Trainees

e) Where requirements under the Health Care Services (Provider Selection Regime) Regulations 2023 permit the use of a procedure that does not require a competitive process.

f) When Section 41 (and one or more of the justifications in Schedule 5), section 42 or section 43, of the Procurement Act applies. A competitive procedure is the default for public contracts and procurement must be consulted in line with 9.3.4.

9.6 Where tendering or competitive quotation is required, but is not conducted

9.6.1 It is essential to distinguish between a breach of Standing Financial Instructions (SFI) and a breach of procurement regulations, as each represents a different type of non-compliance and triggers a different governance and assurance response.

Breach Type	Definition	Examples	Governance Route
SFI Procurement Breach	Internal process or control with the SFI's has not been followed.	Exceeding delegated authority; skipping internal approval steps.	Internal audit, finance / governance review.
Regulatory Procurement Breach	External procurement law or regulation has been breached.	Failing to advertise under PA23, unlawful direct award.	Procurement & legal external support required.

9.6.2 An **SFI procurement breach (historically referred to as waivers)** occur where the requirements or processes set out in these Standing Financial Instructions are not followed. This may include, but is not limited to:

- Failure to obtain quotes or conducted competitive tendering in line with DSoD requirements.
- Failure to obtain the required internal approvals before committing expenditure.
- Non-adherence to delegated financial limits.
- Not following the prescribed internal processes for requisitioning, ordering, receipting, or payment.

9.6.3 When an SFI Procurement Breach is recorded, one for the following reasons must be listed:

i) Where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender.

ii) Specialist expertise, such as ongoing maintenance contracts, is required and is available from one source only.

iii) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging a different contractor for the new task would be inappropriate.

iv) There is clear benefit to be gained from maintaining continuity with an earlier project. (The benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering)

v) Sole source supplier

9.6.4 An SFI Procurement Breach does not need to be reported when:

i) Any of the exceptions to formal tendering of quotation in 9.5.1 apply.

ii) Following a competitive tender process where less than five bids were received. This would however be subject to both procurement and Executive Director Approval to proceed.

iii) Following market testing, the Trust decides to bring a contract in-house.

Please note that if any of the exceptions listed above are met, an award report will be required. All award reports must be facilitated through procurement. Please consult procurement.

SFI breaches are considered internal control failures and will be subject to review, investigation, and, where appropriate, corrective action. SFI breaches must be reported using the SFI Breach Report Form, obtained through

procurement. These will reported to the executive team by procurement on a weekly basis and may require escalation depending on severity.

9.6.5 A **regulatory procurement breach** refers specifically to non-compliance with external procurement legislation or statutory guidance (see 9.2). This may include, but is not limited to:

- Failure to advertise contracts in accordance with the Public Contracts Regulations 2015, Procurement Act 23 & PSR.
- Direct awards made without lawful justification or without following the prescribed legal procedures.
- Inadequate contract award notices or transparency requirements not being met.
- Contracts agreed between the Trust and suppliers where regulatory thresholds have been exceeded.

Procurement regulatory breaches carry legal, financial, and reputational risks, and may expose the Trust to legal challenge or financial penalty. All such breaches must be reported to the Trust's Procurement Lead and escalated as appropriate to Legal, Governance, and Executive Team (ET). Under no circumstances will procurement endorse or support a regulatory breach award.

9.7 **Private Finance/ProCure 23**

The Trust may consider using PFI/ProCure 23 when considering a capital procurement. When the Board proposes that PFI/ProCure 23 be considered:

9.7.1 The Chief Executive shall demonstrate that the scheme represents value for money and genuinely transfers risk to the private sector

9.7.2 The proposal must be specifically agreed by the Board

9.7.3 Trust competitive tendering/quotations procedures should apply where necessary.

9.8 **Contracts**

9.8.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

A. these SOs;

B. the Trust's SFIs;

C. EU Directives and other statutory provisions;

D. any relevant and mandatory directions including NHS England guidance on Risk Evaluation for Investment Decisions, the DoH's Capital Investment Manual, Estate Code and guidance on the Procurement and Management of Consultants;

E. such of the NHS Standard Contract Conditions as are applicable.

Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.8.2 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.9 **Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

9.10 **Legally Binding Contracts (LBC) for the Provision of Healthcare**

Legally binding contracts for the supply of healthcare services shall be drawn up in accordance with legal advice, best practice and use the NHS Standard model contract. These legally binding contracts will be administered by the Trust.

9.11 **Cancellation of Contracts**

Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

9.11.1 if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or

9.11.2 if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

9.11.3 if in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Bribery Act 2010 and any other appropriate legislation

9.12 **Determination of Contracts for Failure to Deliver Goods or Material**

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

9.12.1 such default; or

9.12.2 in the event of the contract being wholly determined the goods or materials remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.13 **Contracts involving Funds Held on Trust** shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act

10 DISPOSALS

10.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

10.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer

10.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust

10.1.3 items to be disposed of with an estimated sale value of less than £5,000

10.1.4 items arising from works of construction, demolition or site working, which should be dealt with in accordance with the relevant contract

10.1.5 land or buildings concerning which DoH or other statutory body guidance has been issued but subject to compliance with such guidance.

11 IN-HOUSE SERVICES

11.1 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

11.1.1 Specification group, comprising the Chief Executive or nominated officer/s and specialist

11.1.2 In-house tender group, comprising a nominee of the Chief Executive and technical support

11.1.3 Evaluation team, comprising normally a specialist officer, a supplies officer and the Executive Chief Finance Officer or their nominated representative. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team

11.2 All groups should work independently of each other. No officer is able to sit on both the in-house tender group and the evaluation group

11.3 The evaluation team shall make recommendations to the Executive Operational Sub-Committee and/or the Board, in accordance with the Trust's DSoD.

12 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents**

12.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by two executive directors.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Executive Chief Finance and Resources Officer (or an officer nominated by them and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Directorate).

12.3 **Register of Sealing**

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. The report shall detail the description of the document, the date of sealing and the names of persons who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

13 SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee with delegated authority.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

14 MISCELLANEOUS

14.1 **Standing Orders to be given to Board Members and Officers**

It is the duty of the Chief Executive to ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

14.2 **Documents having the standing of Standing Orders**

SFIs, DSoD and the SoRD shall have effect as if incorporated into SOs.

14.3 **Review of Standing Orders**

SOs shall be reviewed annually by the Board. The requirement for review extends to all documents having the effect as if incorporated in SOs.

14.4 **Dispute Resolution**

14.4.1 Where there is a dispute between the Board of Directors and the Council of Governors, the procedure set out in the Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance should be referred to and followed

14.4.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible

14.4.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute

14.4.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

15 RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

15.1 The Council has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its Licence. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the Trust. The Council is responsible for representing the interests of Trust members and the public and staff in the governance

of the Trust. Governors must act in the best interests of the Trust and should adhere to its values and code of conduct. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty

15.2 Governors should discuss and agree with the Board how they will undertake these and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice. Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan

15.3 Board members are to present to the Council at a general meeting the annual accounts, any report of the auditor on them, and the annual report

15.4 The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). The Trust will comply with the NHS Foundation Trust Annual Reporting Manual. The Council may request that a matter which relates to the annual accounts or forward planning for the Trust is included on the agenda for a meeting of the Board

15.5 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.

15.6 The annual report should include a statement from the Board on how performance evaluation of the Board, its committees and its Directors is conducted and the reason why the Trust adopted a particular method of performance evaluation

15.7 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing

15.8 If the Council does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position

15.9 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors

15.10 In accordance with the Code of Governance for NHS Provider Trusts (February 2023) the roles and responsibilities of the Council of Governors are set out in Appendix C.

16 Overlap with Other Trust Policy Statements/Procedures, the Standing Financial Instructions, The Provider Licence and The National Health Service Act 2006.

16.1 **Specific Policy Statements**

These SOs must be read in conjunction with the following policy statements and documents which shall have effect as if incorporated in these SOs:

16.1.1 the Standards of Business Conduct and Conflicts of Interest Policy for Trust staff

16.1.2 the Code of Conduct for Board Members

16.1.3 the Staff Disciplinary and Appeals Procedures

16.1.4 the SFIs adopted by the Board in accordance with all financial regulations, directions and guidance issued by NHS England and any other relevant body

16.1.5 the SoRD approved by the Board

16.1.6 The Detailed Scheme of Delegation

16.1.7 Tendering and Quotations Procedure

16.1.8 the Trust's Counter Fraud Policy

16.2 **Specific Guidance and Legislation**

These SOs must be read in conjunction with any directions and guidance issued by NHS England, the Department of Health and Social Care and any other relevant body and in accordance with the following:

- National Health Service Act 2006
- Health and Social Care Act 2012
- DH Caldicott Guardian Manual 2010 (and any subsequent versions)
- Human Rights Act 1998

- Freedom of Information Act 2000 and relevant guidance from the Information Commissioner Office
- Equality Act 2010
- Data Protection and Security Toolkit (April 2018) (and any subsequent versions)
- Bribery Act 2010
- Data Protection Act 2018 and relevant guidance from the Information Commissioner's Office
- Code of Governance for NHS Provider Trusts (February 2023) (and any subsequent versions)
- any other relevant legislation and guidance as applicable from time to time.

16.3 **Potential Inconsistency**

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in SO 16.2 above (the Legislation), the Legislation shall prevail.

In the event of any conflict or inconsistency between these SOs and the Licence and/or the constitution, the Licence and/or the constitution shall prevail.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix A: Committees of the Board of Directors

1. Audit Committee
2. Charitable Funds Committee
3. Finance & Performance Committee
4. People Committee
5. Remuneration and Nominations Committee
6. Quality Committee
7. Lampard Inquiry Oversight Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix B: Standards of Business Conduct for NHS Staff

Prevention of Corruption – Bribery Act 2010

The Trust has a responsibility to ensure that all Directors (and staff) are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

- bribing, or offering to bribe, another person (section 1);
- requesting, agreeing to receive, or accepting a bribe (section 2);
- bribing, or offering to bribe, a foreign public official (section 6);
- failing to prevent bribery (section 7)

All Directors (and staff) are required to be aware of the Bribery Act 2010 and should also refer to the remaining provisions in this Appendix B for further guidance in relation to this duty as well as any other national guidance.

2. NHS staff are expected to abide by the seven principles of public life (Nolan) at all times:

2.1 **SELFLESSNESS**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends

2.2 **INTEGRITY**: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties

2.3 **OBJECTIVITY**: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

2.4 **ACCOUNTABILITY**: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office

2.5 **OPENNESS:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

2.6 **HONESTY**: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

2.7 **LEADERSHIP**: Holders of public office should promote and support these principles by leadership and example.

3.0 IMPLEMENTING THE GUIDING PRINCIPLES ABOVE:

Gifts

3.1 With the exception of items of little value (less than £6) such as diaries, calendars, flowers and small tokens of appreciation (including seasonal gifts), which may be accepted, all offers of gifts should be declined. In cases of doubt, advice should be sought from your line manager. A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value. Any personal gift of cash or cash equivalents (e.g. tokens) must be declined whatever its value. All Directors (and staff) should report immediately all offers of unreasonably generous gifts to the Trust Secretary and return promptly any unacceptable gifts, with a letter politely explaining the terms of this policy and stating that you are not allowed to accept them.

Hospitality

3.2 Hospitality will be in accordance with Trust's policy on hospitality and sponsorship.

Raising concerns

3.3 It is the duty of every member of the Board (and staff) to speak up about genuine concerns in relation to criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and the cover up of any of these in the workplace. The Trust has a whistle-blowing policy that sets out the arrangements for raising and handling staff concerns. The procedure for reporting specific concerns relating to fraud are described below at 3.5.

Freedom to Speak Up

3.4 The Trust's Freedom to Speak Up Guardian is contactable by email and telephone and contact details are available on the Trust's intranet for all staff needing to raise a concern about patient or staff safety. For example, matters may be raised such as unsafe patient care; unsafe working conditions; inadequate induction or training for staff; lack of, or poor, response to a reported patient safety incident or a bullying culture across a team.

Counter fraud / Anti-Crime

3.5 All Directors (and staff) are required not to use their position to gain financial advantage. The Trust is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. The Trust's Directors (and staff) should inform the Executive Chief Finance Officer immediately, unless the Executive Chief Finance Officer is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken

3.6 The Trust's Directors (and staff) can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff, and any caller who wishes to remain anonymous may do so.

3.7 Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The Executive Chief Finance Officer will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised

3.8 The Trust's Directors (and staff) should not ignore their suspicions, investigate themselves or tell colleagues or others about their suspicions.

Preferential treatment in private transactions

3.9 Individual Directors must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. (This does not apply to concessionary agreements negotiated with companies by the Directors, or by recognised staff interests on behalf of all staff for example, NHS staff benefits schemes.)

Contracts

3.10 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to the standards set out in Appendix B and are encouraged to also follow the professional standards set out in the Ethical Code of the Chartered Institute of Purchasing and Supply.

Favouritism in awarding contracts

3.11 Fair and open competition between prospective contractors or suppliers for all contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

3.11.1 No private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long running series of previous contracts.

3.11.2 Each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

3.11.3 The Trust should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

3.12 The Trust will wish to ensure that all invitations to potential contractors to tender for NHS and non-NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

3.13 No Directors should engage in outside employment that may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area; the Trust will be responsible for judging whether the interests of patients could be harmed.

Intellectual property

3.14 The Board of Directors should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by the Trust's employees in the course of their duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Directors should build appropriate specifications and provisions into the contractual arrangements that they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases

3.15 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles

3.16 In the case of collaborative research and evaluative exercises with manufacturers, the Trust should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under their contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Standards of business

3.17 All Directors who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to these standards; and

3.17.1 Maintain the highest standard of integrity in all business relationships

3.17.2 Reject any business practice which might reasonably be deemed improper

3.17.3 Never use their authority or position for their own personal gain

3.17.4 Enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way

3.17.5 Foster the highest standards of professional competence amongst those for whom they are responsible

3.17.6 Optimise the use of resources which they have influence over for the benefit of the organisation

3.17.7 Comply with both the letter and the intent of: - the law of countries where the contracts are executed or as otherwise stated in the contracts - Chartered Institute of Purchasing and Supply guidance on professional practice

3.17.8 Declare any personal interest that might affect, or be seen by others to affect, their impartiality or decision making

3.17.9 Ensure that the information they give in the course of the work is accurate

3.17.10 Respect the confidentiality of information they receive and never use it for personal gain

3.17.11 Strive for genuine, fair and transparent competition

3.17.12 Not accept inducements or gifts, other than items of small value such as business diaries or calendars

3.17.13 Always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision

3.17.14 Remain impartial in all business dealing and not be influenced by those with vested interests.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix C: Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council which are to be carried out in accordance with the constitution and the Trust's licence include:

General Duties

1. To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

2. To represent the interests of the members of the Trust and the interests of the public.

Non-Executive Directors, Chief Executive and Auditor

3. To approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council

4. To approve the appointment and removal of the Chair and the Non-Executive Directors. The Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board

5. To approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the Remuneration Committee of the Council. All Non-Executive Directors and elected Governors should be submitted for re-appointment or re-election at regular intervals. The performance of Executive Directors should be subject to regular appraisal and review. The Council should ensure planned and progressive refreshing of the Non-Executive Directors

6. To set the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors on the recommendations of the Remuneration Committee of the Council. The Council should consult external professional advisers to market-test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive Director

7. To approve the appointment of a candidate as Chief Executive of the Trust recommended by the Non-Executive Directors

8. To approve the criteria for the appointment, removal and re-appointment of the auditor

9. To approve the appointment, removal and re-appointment of the auditor on the recommendation of the Audit Committee

Strategy Planning

10. To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate

11. To collaborate with the Board in the development of the forward plan

12. Where the forward plan contains a proposal that the Trust will carry out activity other than the provision of goods and services for the purpose of the NHS in England, to determine whether the proposal will interfere in the fulfilment by the Trust of its principal purpose and notify its determination to the Board

13. To approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the Trust

14. To approve entering into any significant transactions (as defined by the Board from time to time) in accordance with the 2006 Act and the constitution

15. To approve proposals from the Board for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

16. When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

17. To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council

Representing Members and the Public

18. To prepare and from time to time review the Trust's membership engagement strategy and policy

19. To notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, if these concerns cannot be resolved at local level

20. To report to the members annually on the performance of the Council

21. To promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy

22. To seek the views of stakeholders and feed back to the Board

Essex Partnership University
NHS Foundation Trust

Document title:	**SCHEME OF RESERVATION & DELEGATION (SoRD)**		
Document reference number:	FP12	**Version number:**	9.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Executive Director of Corporate Governance		
Approval group/ committee(s):	Executive Team, Audit Committee & Board of Directors		
Professionally approved by: (Director)	Audit Committee		
Executive Director:	Chief Executive Officer		
Ratification group(s):	Board of Directors		
CQC Quality Statement	Well-Led - Governance		
Key word(s) to search for document on Intranet / TAGs:	Scheme, Reservation, Delegation	**Distribution method:**	☒Intranet

Initial issue date:	01 April 2017	**Last Review date:**	01 December 2025	**Next Review date:**	31 December 2026	**Expiry Date:**	01 January 2027

POLICY SUMMARY

The purpose of the Scheme of Reservation & Delegation (SoRD) is to set out the powers reserved to the Board of Directors and those that the Board has delegated. It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply.

The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the SoRD will be undertaken by the Executive Director of Corporate Governance Senior Director of Corporate Governance.

Services	Applicable	Comments
Trust wide	✓	

The Director responsible for monitoring and reviewing this policy is Chief Executive Officer

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
001	Trust Secretary	Replaces SEPFP12, Replaces NEP Scheme of Delegation, Minor – reflects new constitution and revised SFIs	01 April 2017
002	Trust Secretary	Minor – typographical amendments	01 August 2018
003	Trust Secretary	Not Documented	01 September 2019
004	Trust Secretary	New template used. Tables made consistent resulting in changes to document references. Addition of section delegating authority as part of the Major Incident Plan.	01 September 2020
005	Trust Secretary	Section 2.6: This section has been amended to provide for the new process agreed by the BoD Remuneration & Nomination Committee to allow the CEO to identify an Executive Director to act as Deputy CEO in their absence. The statement has also been amended to provide for formal acting-up status to an Executive Director should it be required for the CEO / CFO to approve income or expenditure and the CFO is acting as the CEO. Section 2.8: Section added to provide a general statement to allow the Board to delegate authority to Executive Directors to make decisions on behalf of the Board for any community collaborative board to ensure it functions effectively. Clarity has been made that this must be in-	01 September 2021

		line with any limitations provided by the DSoD.	
006	Trust Secretary	Updated to include People, Equality and Culture Committee, in place of People, Innovation and Transformation Committee	01 September 2022
6.1	Trust Secretary	References to LCFS amended to CF / ACS (Counter Fraud / Anti-Crime Specialist(s))	01 September 2022
007	Trust Secretary	Updated in line with the Health & Care Act 2022.	27 September 2023
7.1	Trust Secretary	Updated in line with the Health & Care Act 2022. 7.1 – Extended to January 2025	27 September 2023
8.0	Assistant Trust Secretary	Updated to include the Lampard Inquiry Oversight Committee, amended to allow for more than one individual to be designated as Deputy CEO and correction of five reference to be gender inclusive.	04 December 2024
9.0	Assistant Trust Secretary	Annual review. Amendments to job titles and the name of the People Committee and to sections to bring into line with amendments to the Standing Orders and SFI's / DSoD	03 December 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

CONTENTS

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Scheme of Reservation & Delegation (SoRD)

1 INTRODUCTION

1.1 The Code of Governance for NHS Provider Trusts (2023) *requires* that responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations.

1.2 The schedule of matters reserved for decision by the Board of Directors (the Board) and those the Board has delegated are set out in this document.

1.3 The Board remains accountable for all of its functions, including those, which have been delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to perform its monitoring role.

1.4 All powers of the NHS Foundation Trust (Trust), which have not been retained as reserved by the Board or delegated to a committee of the Board (including arrangements for functions to be exercised by or jointly with another relevant body) will be exercised on behalf of the Board by the Chief Executive (CEO).

1.5 The National Health Service Act 2006 (the Act) designates the CEO of the Trust as the Accounting Officer. The Act states that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. The Accounting Officer has the personal duty of signing the Trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

1.6 The CEO is ultimately accountable to the Board and has overall executive responsibility for the Trust's activities.

2 PURPOSE

2.1 The purpose of this document is to set out the powers reserved to the Board and those that the Board has delegated. It forms part of the Trust's corporate governance framework, which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply.

2.2 The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted without proper authority. It does this by ensuring that all staff are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.3 The Board reserves certain matters to itself, which are set out in the SoRD, which is the schedule of matters reserved to the Board.

2.4 The Detailed Scheme of Delegation (DSoD) identifies any functions, which the CEO will perform personally and those delegated to other Executive Directors or officers. All powers delegated by the CEO can be reassumed by them should the need arise.

2.5 The SoRD shows only the 'top level' of delegation within the Trust. The Scheme should be read in conjunction with the system of budgetary control and other established procedures within the Trust.

2.6 If the CEO is absent, powers delegated to them may be exercised by an Executive Director who is formally acting up as CEO. Formal acting-up status shall be confirmed in writing by either the CEO or the Chair.

Where the Executive Chief Finance and Resources Officer (ECFO) is appointed to act up as the CEO, a further executive shall be named to act up with the ECFO for the purposes of approving expenditure and income up to an amount delegated by the DSoD a responsibility normally conferred to the CEO and ECFO. Formal acting-up status shall be confirmed in writing by either the Chair, CEO, or the CFO.

If the ECFO is absent powers delegated to them may be exercised by a Director of Finance.

2.7 The key documents in the corporate governance framework include:

- Standing Financial Instructions (SFIs)
- Detailed Scheme of Delegation (DSoD)
- Constitution
- Standing Orders (SOs) for the Board of Directors

2.8 The Board has delegated to any Executive Director who is a member of a collaborative board, such authority as agreed to be necessary in order for the collaborative board to function effectively in discharging its responsibilities as set out in any agreement. For the avoidance of doubt, this cannot exceed financial limits set-out in the Trust Detailed Scheme of Delegation (DSoD)

3 DECISIONS RESERVED TO THE BOARD OF DIRECTORS

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
Constitution	General Enabling Provision	3.1	3.1.1	The Board is responsible for ensuring on-going compliance by the Trust with its licence, its Constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligation
			3.1.2	The Board may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors
			3.1.3	Any functions of the Trust that have been reserved to the Board shall be exercised by the Board on behalf of the Trust or may be delegated by the Board to a committee of Directors or to an Executive Director
			3.1.4	All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual standing committees, sub-committees, joint arrangements with other relevant bodies, Directors or officers
N/A	Regulation & Control	3.2	3.2.1	Approve Standing Orders For The Practice and Procedures of the Board of Directors (SOs) and a schedule of matters reserved to the Board (Scheme of Reservation & Delegation – SoRD), Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business, including the ability to suspend, vary or amend SOs
			3.2.2	Ratify any urgent decisions taken by the Chair and/or CEO
			3.2.3	Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				the extent to which a member of the Board may remain involved with the matter under consideration
			3.2.4	Approve the corporate structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity, this will comprise of details of the structure of the Board and its committees and sub-committees. Organisational structures below ED are the responsibility of the CEO who may delegate this function as appropriate
			3.2.5	Delegate executive powers to be exercised by committees or sub-committees of the Board or joint arrangements with other relevant bodies and approve the committee structure of the Board including associated terms of reference and the required accountability arrangements
			3.2.6	Receive and consider reports from committees of the Board and, where relevant, approve any recommendations made by the committees
			3.2.7	Approve governance arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust
			3.2.8	Approve the Trust's banking arrangements
			3.2.9	Ratify any urgent or emergency decisions taken by the Chair and/or CEO in accordance with SO (Emergency Powers) of the SOs
			3.2.10	Consider instances of failure to comply with SOs and take action where appropriate
			3.2.11	Approve the disciplinary procedures for officers of the Trust
			3.2.12	Approve the systems and processes for escalating and resolving

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				quality issues, including the escalation of such issues to the Board where appropriate
			3.2.13	Ensure there are adequate systems and processes maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery (including systems and processes to ensure effective financial decision-making, management and control)
			3.2.14	Establish standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
			3.2.15	Call meetings of the Board
			3.2.16	Approve the minutes of the proceedings of Board meetings
			3.2.17	Review the Constitution and SOs annually
N/A	**Committees**	3.3	3.3.1	Appoint and disestablish committees that are directly accountable to the Board
			3.3.2	Establish terms of reference and reporting arrangements for all Board committees
			3.3.3	Ratify the appointment/removal of Board committee members
			3.3.4	Receive reports from committees including those which the Trust is required by its constitution, or by the regulator or by the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action thereon
N/A	**Strategy, Business Plans and Budgets**	3.4	3.4.1	Define the strategic aims of the Trust with due regard to the views of the Council of Governors (Council)
			3.4.2	Approve proposals for ensuring the quality and safety and for applying the principles and standards of clinical governance as set out by relevant bodies (including the

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions) of services provided by the Trust.
			3.4.3	Approve and monitor the Trust's programme of risk management which must identify risks and liabilities, evaluate them and ensure adequate responses/actions are in place and monitored
			3.4.4	Approve outline and final business cases for Capital Investment over the agreed thresholds detailed in the SFIs
			3.4.5	Approve annual budgets.
			3.4.6	Ensure plans take timely and appropriate account of quality of care considerations.
			3.4.7	Approve the annual plan and forward plan (also known as the Trust's Five Year Plan)
			3.4.8	Consider a merger, acquisition, separation or dissolution of the Trust (such an application may only be made with the approval of more than half the members of the Council of Governors (CoG)).
			3.4.9	Consider a significant transaction as defined in the constitution. A significant transaction may only be entered into if approved by more than half of the Governors voting at a meeting of the Council
			3.4.10	Approve proposals for acquisition, disposal or change of use of land and/or buildings over the agreed thresholds detailed in the SFIs
			3.4.11	Approve PFI proposals
			3.4.12	Approve the appointment of bankers and the opening of bank accounts
			3.4.13	Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature as set out in the Detailed

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				Scheme of Delegation
			3.4.14	Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the CEO and ECFO for losses and special payments previously approved by the Board
			3.4.15	Approve individual compensation payments in accordance with Trust Detailed Scheme of Delegation (DSoD)
			3.4.16	Approve proposals for action on litigation against or on behalf of the Trust as per the financial limits set out in the Detailed Scheme of Delegation
			3.4.17	Review the use of NHS Resolution risk pooling schemes.
			3.4.18	Approve proposals for ensuring equality and diversity in both employment and the delivery of services
Constitution	Audit	3.6	3.6.1	Approve the appointment (and where necessary the dismissal) of internal auditor (the recommendation in respect of the external auditors is made by the Audit Committee to the Council)
Audit Committee			3.6.2	Receive an annual report from the Audit Committee
Constitution	Annual Reports and Accounts	3.7	3.7.1	Approve the Annual Report and Accounts for the Trust
			3.7.2	Approve the Charity Accounts as corporate trustee
			3.7.3	With regard to the views of the Council, prepare the information as to the Trust's forward plan in respect of each financial year to be given to NHS England
			3.7.4	Present to the Council at a general meeting, the annual accounts, any reports of the auditors on them and the annual report
N/A	Monitoring	3.8	3.8.1	Receive such reports, as the Board sees appropriate from committees in respect of their exercise of powers delegated as well as from members of the Board and officers of the Trust in

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Doc. Ref.	Authority	SoRD Ref.	Decisions Reserved to the Board of Directors	
				order to continually appraise the affairs of the Trust
			3.8.2	All returns required by NHS England and the Charity Commission will be reported, at least in summary, either in a specific report to the Board or by a committee report
			3.8.3	Receive reports from the ECFO on financial performance and requirements of NHS England, and the Director with the portfolio for other areas of performance
			3.8.4	Approve the making of declarations in accordance with statutory requirements and /or at the request of NHSE
			3.8.5	Monitor the delivery of business plans (including any changes to such plans) and receive internal and where appropriate external assurance on such plans and their delivery

4 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

The Board may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board from time to time taking into account where necessary the requirements of the regulator and/or the Charity Commission (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with the SOs, Board committees may not delegate executive powers to sub-committees.

A list of committees together with their terms of reference shall be maintained by the Senior Director of Corporate Governance.

The Board has delegated decisions/duties to the following committees:

SoRD Ref	Committee	Decisions / Duties Delegated by the Board to Committees
4.1	Audit Committee	Terms of Reference

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

4.2	Charitable Funds Committee	Terms of Reference
4.3	Finance & Performance Committee	Terms of Reference
4.4	People Committee	Terms of Reference
4.5	Remuneration & Nominations Committee	Terms of Reference
4.6	Quality Committee	Terms of Reference
4.7	Lampard Inquiry Oversight Committee	Terms of Reference

5 SCHEME OF DELEGATION DERIVED FROM THE CONSTITUTION

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
4. Powers	Board of Directors	5.1	5.1.1	All the powers of the Trust shall be exercised by the Board on behalf of the Trust
			5.1.2	Any of these powers may be delegated to a committee of Directors or to an Executive Director
13. Annual Members Meeting	Executive Director of Corporate Governance	5.2	5.2.1	The Trust shall hold an annual meeting of its members which shall also be open to members of the public
14. Council of Governors	Executive Director of Corporate Governance	5.3	5.3.1	The Trust is to have a Council of Governors that will comprise of both elected and appointed Governors
18.3. Council of Governors Skills & Knowledge	Chair Executive Director of Corporate Governance	5.4	5.4.1	The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such
23.1. Council of Governors Travelling Expenses	Executive Director of Corporate Governance	5.5	5.5.1	The Trust may pay travelling expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust.
30.1. Appointment of the Vice Chair	Chair Council of Governors	5.6	5.6.1	The Chair shall be entitled to advise the Council of the NED who is recommended by the Board for appointment as the Vice-Chair

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
30.2. Appointment of the Acting Chair				
30.4. Appointment of the Senior Independent Director	Board of Directors	5.7	5.7.1	The Board shall, following consultation with the Council, appoint one of the NEDs as the SID
30.5. Appointment of Deputy CEO	Remuneration & Nomination Committee	5.8	5.8.1	Appoint individual Executive Directors to be the Deputy Chief Executive in line with agreed procedure
31.1. Appointment and Removal of CEO	Chair Non-Executive Directors	5,9	5.9.1	The NEDs shall appoint or remove the CEO. The appointment shall require the approval of a majority of the COG present at a meeting of the Council
31.3. Appointment and Removal of Other Executive Directors	Remuneration & Nomination Committee	5.10	5.10.1	A Committee consisting of the Chair, CEO and the other NEDs shall appoint or remove other EDs
19.2. Council of Governors Meetings (Exclusion)	Chair	5.11	5.11.1	The Chair may exclude any person from a meeting of the Council/Board if that person is interfering with or preventing the proper conduct of the meeting
34.1. Board of Directors Meetings (Exclusion)				
34.2. Board of Directors Meetings	Executive Director of Corporate Governance	5.12	5.12.1 5.12.2	Send a copy of the agenda to the Council prior to holding a Board meeting Send a copy of the minutes of a Board meeting to the Council (as soon as reasonably practicable)

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution
37.2. Remuneration & Terms of Office	Remuneration & Nomination Committee	5.13	5.13.1 Decide the remuneration and allowances and other terms and conditions of office of the CEO and other EDs
38 / 39 / 40. Registers	Executive Director of Corporate Governance	5.14	5.14.1 Compile and maintain including admission/removal from registers including: • Register of members • Register of members of the Council of Governors • Register of interests of Governors • Register of Directors • Register of interests of Directors 5.14.2 Make the above registers available to the public in line with the conditions in the constitution
41. Documents Available for Public Inspection	Executive Director of Corporate Governance	5.15	5.15.1 The Trust shall make the following documents available for inspection by members of the Trust/members of the public free of charge at all reasonable times: • Constitution • Latest annual accounts, including any report of the auditor on them • Latest annual report • Documents relating to a special administration of the Trust
43. Audit Committee	Audit Committee	5.16	5.16.1 Perform such monitoring, reviewing and other functions for an Audit Committee as are appropriate
44. Accounts	CEO (Accounting Officer)	5.17	5.17.1 The Trust shall prepare in respect of each financial year annual accounts in line with regulatory requirements
45.1. Annual Report	Board of Directors	5.18	5.18.1 Prepare an annual report for submission to NHS England and laying before Parliament
45.2 – 45.7. Forward Plan	Board of Directors	5.19	5.19.1 Prepare the forward plan having regard to the views of the Council

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Constitution Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
47. Instruments	Board of Directors	5.20	5.20.1	Authorise the procedure for the use of the seal
48.1. Constitution Amendments	Board of Directors	5.21	5.21.1	Make amendments to the constitution (subject to more than half the Council and Board approving amendments)
Annex 5. Model Election Rules	Board of Directors	5.22	5.22.1	Retention and public inspection of election documents (para 57.1) – these will be destroyed after one year unless otherwise directed by the Board
			5.22.2	Consent (or not) to the application for inspection of certain documents relating to an election (para 58)
Annex 9. Significant Transactions	Strategy & Planning Committee	5.23	5.23.1	Assess the significance of the overall risk of a transaction that exceeds the definition as detailed in section 1 of Annex 9 Significant Transactions of the constitution

6 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM (AUGUST 2015)

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
1.	CEO	6.1	6.1.1	The National Health Service Act 2006 (the 2006 Act) designates the CEO of an NHS FT as the Accounting Officer
			6.1.2	The Board has agreed that to support the Accounting Officer to discharge their duties the following functions will be delegated as identified below
3.	CEO	6.2	6.2.1	The Accounting Officer has the duty to prepare the accounts in accordance with the 2006 Act
			6.2.2	An Accounting Officer has the personal duty of signing the NHS FT's accounts

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
			6.2.3	By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.
5.	CEO	6.3	6.3.1	Regardless of the source of the funding, the Accounting Officer is responsible to Parliament for the resources under their control.
7. General Responsibilities of the Accounting Officer	CEO	6.4	6.4.1	Responsible for the overall organisation and management
	Chief People Officer		6.4.2	Responsible for staffing of the Trust
	ECFO		6.4.3	Responsible for the Trust's procedures in financial and other matters
	ECFO		6.4.4	Ensure there is a high standard of financial management in the Trust as a whole
			6.4.5	Ensure the financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust
			6.4.6	Ensure financial considerations are fully taken into account in decisions on Trust policy proposals
8-11: Specific Responsibilities of the Accounting Officer	ECFO	6.5	Responsible for ensuring:	
			6.5.1	the propriety and regularity of the public finances for which they are answerable
			6.5.2	the keeping of proper accounts
			6.5.3	prudent and economical administration
			6.5.4	the avoidance of waste and extravagance
			6.5.5	the efficient and effective use of all the resources in their charge
	CEO		6.5.6	personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content as prescribed by NHS England in accordance with the Act

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
	ECFO		6.5.7	comply with the financial requirements of the Trust's provider licence
			6.5.8	ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the Trust)
			6.5.9	ensure that the resources for which the Accounting Officer is responsible are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
	ECFO or Director with Portfolio for Estates		6.5.10	ensure that assets for which the Accounting Officer is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
	ECFO		6.5.11	ensure that any protected property (or interest in) is not disposed of without the consent of NHS England
	CEO		6.5.12	ensure that conflicts of interest are avoided, whether in the proceedings of the Board, Council or in the actions or advice of the Trust's staff, including the Accounting Officer
	ECFO		6.5.13	ensure that in the consideration of policy proposals relating to the expenditure for which the Accounting Officer is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board
	CEO		6.5.14	ensure that there are effective management systems appropriate for the achievement of the Trust's objectives, including financial monitoring and control systems, have been put in place

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
			6.5.15	ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the Trust), including a critical scrutiny of output and value for money • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively
	CEO ECFO		6.5.16	Ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the Public Sector Internal Audit Standards.
12 – 15: Advice to the Board	CEO ECFO	6.6	6.6.1	Ensure that appropriate advice is tendered to the Board and the Council on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the PAC, transactions for which they are accountable
	CEO		6.6.2	The Board and the Council of an NHS FT should act in accordance with the requirements of propriety or regularity. If the Board, Council or the Chair is contemplating a course of action

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				involving a transaction which the Accounting Officer considers would infringe these requirements, the Accounting Officer should set out in writing his/her objection to the proposal and the reasons for this objection. If the Board, Council or Chair decides to proceed, the Accounting Officer should seek a written instruction to take the action in question. The Accounting Officer should also inform NHS England of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHS England, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that the Accounting Officer is overruled, the instruction must be complied with, but the Accounting Officer's objection and the instruction itself should be communicated without undue delay to the Trust's external auditors and to NHs England. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction
			6.6.3	If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to the Accounting Officer's wider responsibilities for economy, efficiency and effectiveness, it is the Accounting Officer's duty to draw the relevant factors to the attention of the Board and the Council and to advise them in whatever way he/ she deems appropriate. If the advice is overruled, and the proposal is one which the Accounting Officer would not feel able to defend to the PAC as representing value for money, the Accounting Officer should seek a written instruction before proceeding. NHS England /I should be informed of such an instruction, if possible before the decision is implemented. It will then be for NHS England to consider the

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				matter, and decide whether or not to intervene
			6.6.4	If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 2 and 3 above before the decision is taken, the Accounting Officer must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards
16 -20: Appearance before the Public Accounts Committee	CEO	6.7	6.7.1	Appear before the PAC furnishing the PAC with an explanation of any indications of weaknesses in the matters covered by the paragraphs of the Accounting Officer Memorandum headed *The Specific Responsibilities of an NHS FT accounting Officer* to which the PAC's attention may have been drawn/ about which it may wish to question the Accounting Officer and ensuring the accuracy of evidence furnished. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence. In practice, the Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his/her accountability
21 -23: Absence of an Accounting Officer	CEO	6.8	6.8.1	The Accounting Officer should ensure that they are generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the Trust who can act on their behalf if required
	Board of Directors		6.8.2	If it becomes clear to the Board that the Accounting Officer is so incapacitated that they will be unable to discharge these responsibilities over a period of four weeks or more, the Board should appoint an acting Accounting Officer, usually the Deputy CEO, pending the Accounting Officer's return. The same applies

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Memorandum Ref.	Delegated To	SoRD Ref.	Duties Derived from the Constitution	
				if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted
	Acting Accounting Officer		6.8.3	The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time to submit them to the Minister, the NHS FT may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

7 SCHEME OF DELEGATION FROM THE STANDING ORDERS FOR THE BOARD OF DIRECTORS

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
1.1.	Chair	7.1	7.1.1	Save as otherwise permitted by law, the Chair has the final authority in interpretation of SOs (as advised by the CEO and the Senior Director of Corporate Governance)
2.4. Board of Directors	Board of Directors	7.2	7.2.1	The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Scheme of Reservation & Delegation (SoRD) and have effect as if incorporated into the SOs
2.9 Vice-Chair appointment	Board of Directors	7.3	7.3.1	Recommend the appointment of the Vice-Chair / Acting Chair to the Council of Governors
2.9.5. Acting Chair appointment			7.3.2	In the absence of the Chair, the Vice-Chair / Acting Chair will act as the Chair of the Trust
2.10 CEO appointment	Chair Non-Executive Directors	7.4	7.4.1	Appoint (and remove) the CEO subject to approval by Council of Governors

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
2.11 Executive Directors appointment	Remuneration & Nomination Committee	7.5	7.5.1	All EDs (excluding the CEO) to be appointed (and removed) by a Committee consisting of the Chair, CEO and other NEDs
2.12 Deputy CEO appointment	Remuneration & Nomination Committee	7.6	7.6.1	Appoint individual EDs to be the Deputy Chief Executive in line with agreed procedure
2.14 Senior Independent Director appointment	Board of Directors	7.7	7.7.1	Appoint one of the NEDs as the SID in consultation with the Council of Governors
2.15 Senior Director of Corporate Governance appointment	Chair CEO	7.8	7.8.1	Appoint a Senior Director of Corporate Governance
2.16 Role of the Chief Executive Officer	Chair CEO	7.9	7.9.1	Implement the decisions of the Board in the running of the Trust's business. The CEO is the Accounting Officer (see dedicated section in terms of specific delegated responsibilities)
2.17 Role of the Executive Chief Finance Officer	ECFO	7.10	7.10.1	Responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems
	ECFO CEO		7.10.2	Responsible for the discharge of obligations under all relevant financial directions and guidance issued by NHS England or any other relevant body
2.19. Role of the Chair	Chair	7.11	7.11.1	Responsible for the leadership of the Board (and Council) and chair all Board (and Council) meetings when present
			7.11.2	Ensure effectiveness in all aspects of the Board's role
			7.11.3	Lead on setting agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
			7.11.4	Ensure key and appropriate issues are discussed by the Board in a timely manner with all necessary advice being available to inform debate and decisions
			7.11.5	Responsible for ensuring that the Board and Council work effectively together
2.20. Role of the Non-Executive Directors	Non-Executive Directors	7,12	7,12,1	May exercise collective authority when acting as members of or when chairing a committee of the Board which has delegated powers
3.1 / 3.2 / 3.3 / 3.4.2 / 3.5 Board meetings	Board of Directors	7.13	7.13.1	For special reasons including commercial confidentiality, may exclude members of the public and press
			7.13.2	Determine times and places for ordinary meetings of the Board
			7.13.3	Not less than one-third of Directors (or the Chair) can requisition the Senior Director of Corporate Governance to call a meeting by giving written notice
			7.13.4	If the Senior Director of Corporate Governance does not send a notice of a meeting of the Board within ten working days of receiving an order from the Chair or a requisition from more than one-third of Directors, the Directors who made the requisition may convene the meeting
			7.13.5	The Chair or at least one-third of the Board may call an extraordinary or urgent meeting if the Senior Director of Corporate Governance fails to call such a meeting
	Chair or Board of Directors		7.13.6	Request in writing to the Chair a matter to be included on the agenda at least ten working days before the meeting
3.2.2 / 3.3 / 3.4 / 3.5 Meetings	Executive Director of Corporate Governance	7.14	7.14.1	Meetings of the Board are convened by order of the Chair, or more than one-third of Directors who give written notice to the Senior Director of Corporate Governance
			7.14.2	Issue notice of meetings
			7.14.3	Issue notice of and calling of extraordinary meetings and urgent

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				meetings
			7.14.4	Send agendas to Directors not later than three working days before the meeting; supporting papers, wherever possible, will accompany the agenda save in the case of the need to conduct urgent business
			7.14.5	Display at the Trust's head office and website a public notice of the date, time and place of the meeting including the public part of the agenda at least three working days before the meeting (save in the case of an urgent meeting)
			7.14.6	Send a copy of the agenda to the Council of Governors before the Board meeting
3.6 / 15.1 Setting the agenda	Chair or Board of Directors	7.15	7.15.1	Can determine certain matters to be included on every agenda for an ordinary meeting
			7.15.2	Include petition if received not less than 10 working days before a meeting
3.8 Chair of meeting	Chair Vice Chair / Acting Chair Non-Executive Directors	7.16	7.16.1	Chair all Board meetings and associated responsibilities
			7.16.2	Chair meeting if the Chair of the Trust is absent from a meeting
			7.16.3	If the Chair and Deputy Chair are absent (or disqualified from participating) a NED as nominated by other NEDs, will preside
3.9 Motions	Directors	7.17	7.17.1	Move or amend or withdraw or rescind a motion
3.10 Chair's Ruling	Chair	7.18	7.18.1	Give final ruling on questions of order, relevancy, and regularity and other matters of meetings
3.11 Voting	Directors	7.19	7.19.1	Have one vote (with the exception of joint EDs)
	Chair		7.19.2	Determine voting method (oral/show of hands)
	Directors		7.19.3	A majority of Directors present can request a paper ballot
			7.19.4	Request voting (other than by paper ballot) to be recorded to show how each Director present voted/abstained
	Officer		7.19.5	Entitled to vote if appointed formally by the Board to act up for an

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				ED during a period of incapacity/vacancy
	Chair		7.19.6	Has a second or casting vote in the event of equality of votes
3.12 / 3.15 Minutes	Executive Director of Corporate Governance	7.20	7.20.1	Ensure meetings are minuted and submitted for agreement at the next meeting where they will be signed by the person presiding at it
			7.20.2	Record the names of the Chair, Directors and all others present at the meeting (other than members of the public and media)
			7.20.3	Retain minutes
			7.20.4	Circulate minutes including sending approved minutes to Council of Governors and make public
	Directors		7.20.5	Ensure minutes record any concerns that cannot be resolved about the running of the Trust or a proposed action
3.13 Informal and committee meetings	Chair	7.21	7.21.1	Hold meetings with NEDs without EDs present
	Senior Independent Director		7.21.2	Meet with the NEDs without the Chair present at least annually to appraise the Chair's performance and on other such occasions as deemed appropriate
	Board of Directors		7.21.3	May meet informally or as a Board committee at any time
3.14. Amendments of Standing Orders	Board of Directors	7.22	7.22.1	May amend SOs without the need to amend the constitution
3.16 Quorum	CEO	7.23	7.23.1	Waive requirement for CEO or Deputy CEO to be present at a meeting
	Chair		7.23.2	Waive requirement for Chair or Vice-Chair to be present at a meeting
4. Exercise of functions by delegation	CEO	7.24	7.24.1	Prepare a detailed Scheme of Reservation & Delegation identifying the functions to be delegated to either an ED or a committee of the Board for approval by the Board
	Board / Directors		7.24.2	Formal delegation of executive powers to committees which it has formally constituted; however, the Trust retains full responsibility

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	CEO / Deputy CEO		7.24.3	The powers which the Board has retained to itself within the SOs may in emergency situations be exercised by the CEO or in their absence, the Deputy CEO, provided that prior to taking such action, the CEO has consulted with and gained the agreement of the Chair
4.7 Non-compliance with Standing Orders	All Executive Directors	7.25	7.25.1	Disclosure of full details of any non-compliance with SOs shall be reported to the Chair and CEO as soon as possible and to the next formal meeting of the Board for action and ratification
	All Staff		7.25.2	Duty to disclose any potential or impending non-compliance with the SOs to their ED who in turn has a duty to report to the CEO and the Chair as soon as possible
5 Committees	Board of Directors	7.26	7.26.1	Appoint an Audit Committee of Non-Executive Directors.
			7.26.2	Appoint a Remuneration Committee of Non-Executive Directors
			7.26.3	Appoint standing committees of the Board
			7.26.4	Approve the appointments to each committee formally constituted
			7.26.5	Standing committees to have terms of reference and powers, and be subject to such conditions, such as reporting back to the Board, as the Board decides
	Standing Committees		7.26.6	Standing committees may establish sub-committees that do not have delegated executive powers from the Board or committee of the Board
6 Declarations / Register of Interest	Directors	7.27	7.27.1	Statutory duty to avoid a situation in which they have a direct or indirect interest that conflicts (or may conflict) with the interests of the Trust
			7.27.2	Declare interests to the Board that are required to be declared (under constitution) and ensure an update is provided if their interests change

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	Executive Director of Corporate Governance		7.27.3	Ensure Register(s) of Interests is maintained
	Executive Director of Corporate Governance		7.27.4	Take reasonable steps to bring the existence of the Register to the attention of the local population and publicise arrangements for viewing it
			7.27.5	Keep the Register of Interests up-to-date by means of an annual review in which any changes to interests declared in the preceding 12 months will be incorporated
6.3 Register of gifts and hospitality	Executive Director of Corporate Governance	7.28	7.28.1	Maintain a register of gifts and hospitality for Board members and staff
			7.28.2	Publish on Trust's website in line with regulatory requirements
7 Conflict of interest and pecuniary interest	Directors Standing Committees	7.29	7.29.1	Disclose any pecuniary interest (as defined in SOs) in any contract/proposed contract/other matter and is present at a meeting at which the contract/other matter is being considered
			7.29.2	Withdraw from a meeting if a conflict of interest is disclosed
			7.29.3	SO also applies to a committee/sub-committee/joint committee of the Board
8 Standards of Business Conduct Policy	Staff Directors	7.30	7.30.1	Comply with the Trust's Standards of Business Conduct Policy at all times
			7.30.2	Comply with national guidance contained in NHS England *Standards of Business Conduct policy* (ref Appendix B of SOs), *the Standards for Members of NHS Boards and CCG Governing Bodies in England (Nov 2013)* (ref Appendix C of SOs), Trust's Policy for Fraud and Bribery, and any such guidance issued by NHSE or the DHSC from time to time.
8.3 Interests of officers in contracts	Staff	7.31	7.31.1	Disclose any pecuniary interest in a contract to which they are a party (or has been or is proposed to be)

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
	Staff Directors		7.31.2	Disclose to the CEO any other employment, business or other relationship of theirs or of a spouse/partner/other family member that conflicts or might reasonably be predicted that could conflict with the interests of the Trust
	Staff		7.31.3	Declare interests/employment/relationships on a Register of Interests for staff
8.5 Relatives of Board members or officers	Staff Directors	7.32	7.32.1	Disclose whether they are related to any other Board member or holder of any office in the Trust
			7.32.2	Disclose to the CEO any relationship between themselves and a candidate for staff appointment of whose candidature the Board member or staff member is aware
			7.32.3	On appointment Board members should disclose to the Board whether they are related to any other Board member or holder of any office in the Trust
	CEO		7.32.4	CEO to report any disclosures under 7.32.2 to the Board of Directors
9 Tendering and contract procedure	CEO	7.33	7.33.1	Where it is decided that competitive tendering is not applicable an SFI procurement breach is required, the reasons should be documented and reported by the CEO to the Executive Operational Sub-Committee and to the next available meeting of the Audit Committee
	CEO or Nominated Officer		7.33.2	Responsible for selecting quotations which gives the best quality and value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be stated in a permanent record
	CEO ECFO		7.33.3	Competitive quotations should be obtained. Where this is not possible and none of the reasons apply (under SO 9.5) an SFI procurement breach document is required, to be approved by the CEO and ECFO.The decision needs to be reported to the Audit

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
				Committee
	CEO		7.33.4	Responsible for ensuring best value for money can be demonstrated for all services provided under contract or in-house
	CEO Board of Directors		7.33.5	Demonstrate that a PFI/Procure23 scheme represents value for money and genuinely transfers risk to the private sector
	Board of Directors		7.33.6	Approve PFI/Procure23 proposal
	CEO Nominated Officer		7.33.7	Endeavour to obtain best value for money in relation to contracts
			7.33.8	CEO will nominate an officer to oversee and manage each contract on behalf of the Trust
			7.33.9	CEO will nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts
			7.33.10	Competitive tendering or quotation procedures will not apply to the disposal of any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the CEO or nominated officer
	Evaluation Panel		7.33.11	Make a recommendation to the Executive Operational Sub-Committee and/or Board of Directors in relation to in-house services and in accordance with the DSoD
12. Custody of Seal and Sealing of Documents	Executive Director of Corporate Governance CEO ECFO	7.34	7.34.1	Keep the common seal of the Trust in a secure place and maintain a register of sealing in line with Trust procedure.
	CEO ECFO Executive Directors (not within the originating directorate)		7.34.3	Approve and sign all building, engineering, property or capital documents
	Board of Directors		7.34.4	Receive a report of all sealings at least quarterly

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders	
13. Signature of Documents	CEO or Nominated Executive Director	7.35	7.35.1	Approve and sign all documents which will be necessary in legal proceedings involving the Trust, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to another executive director for the purpose of such proceedings
			7.35.2	Sign where authorised by resolution of the Board on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub- committee or standing committee with delegated authority
14. Standing Orders	CEO	7.36	7.36.1	Ensure that existing Board members, officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs
14.4. Dispute Resolution	SID	7.37	7.37.1	Make all reasonable efforts to mediate a settlement to a dispute that involves the Chair
	Executive Director of Corporate Governance		7.37.2	Deal with any membership queries and other similar questions including any voting or legislation issues in the first instance
15. Council of Governors	Board of Directors	7.38	7.38.1	Present to the Council of Governors at a general meeting the annual accounts, any report of the auditor on them, and the annual report
			7.38.2	Explain in the annual report their responsibility for preparing the annual report and accounts and the approach to quality governance
			7.38.3	Comply with Annual Reporting Manual including stating they consider the annual report and accounts as fair, balanced and understandable and provide the necessary information so that the Trust's performance, business model and strategy can be assessed; as well as approach to quality governance.
	External Auditor		7.38.4	Statement about reporting responsibilities

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SO Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Orders
	Audit Committee		7.38.5 Agree with the Council the criteria for appointing, reappointing and/or removing external auditors

8 SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFI'S)

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
1.1.2	Audit Committee	8.1	8.1.1 Approval of all Trust wide financial procedures and financial control procedures
1.1.3	ECFO	8.2	8.2.1 Advice on interpretation or application of SFIs
1.1.5	Board of Directors Staff	8.3	8.3.1 Disclosure of non-compliance with SFIs as soon as possible to the ECFO; ECFO to report to the Audit Committee
5.3	CEO	8.4	8.4.1 Responsible as the accounting officer to ensure financial targets and obligations are met and have overall responsibility for the system of internal control.
5.4	CEO ECFO	8.5	8.5.1 Accountable for financial control but will, as far as possible, delegate their detailed responsibilities
5.5	CEO	8.6	8.6.1 To ensure systems and processes in place so that all Board members, officers and employees, present and future, are notified of and understand SFIs
5.6	ECFO	8.7	Responsible for: 8.7.1 Implementing the Trust's financial policies and co-ordinating corrective action 8.7.2 Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented 8.7.3 Ensuring that sufficient records are maintained to explain

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				Trust's transactions and financial position
			8.7.4	Providing financial advice to members of Board and staff
			8.7.5	Design, implement and supervise systems of internal financial control
			8.7.6	Maintaining such accounts, working papers, etc., as are required for the auditors to carry out their statutory duties
5.7	All Board Members & Employees	8.8	8.8.1	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions, and Financial Procedures. and Schemes of Delegation
5.8	CEO	8.9	8.9.1	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply
6.1.1	Audit Committee	8.10	8.10.1	Provide independent and objective view on Governance and assurance processes and arrangements
6.1.2	Board of Directors	8.11	8.11.1	Members of the Audit Committee have recent and relevant financial experience or have appropriate training
6.1.3	Audit Committee	8.12	8.12.1	Assess the work and fees of external audit on an annual basis to ensure that the work is of a high standard and that fees are reasonable
6.1.4	Audit Committee	8.13	8.13.1	Recommend to the Council of Governors re: the appointment/re-appointment of external auditors
6.1.5	Chair of Audit Committee	8.14	8.14.1	Where there is evidence of ultra vires transactions, improper acts and other important matters these should be raised at Board Meetings. Exceptionally, refer to NHS England any matters of concern, having raised it with the Chief Executive Accounting Officer and Executive Chief Finance Officer
	ECFO	8.15	8.15.1	Ensure an adequate internal audit service, for which they are

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
6.2.1				accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed)
	ECFO	8.16	8.16.1	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption, in consultation with Local Counter Fraud Specialist
6.3.1 – 6.3.2	Chief Internal Auditor	8.17	8.17.1	Review, appraise and report in accordance with best practice
	Chief Internal Auditor	8.18	8.18.1	Produce an annual audit opinion on the effectiveness of the systems of internal control
			8.18.2	Raise with the ECFO immediately any matter which involves or thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity
6.3.3	Chief Internal Auditor	8.19	8.19.1	Attend audit committee meetings
6.3.4	Chief Internal Auditor	8.20	8.20.1	Report directly to the ECFO and refer audit reports to Auditees as appropriate
6.3.6 6.3.12	ECFO	8.21	8.21.1	Provide Internal Auditors and External Auditors with information
6.3.7	Council of Governors	8.22	8.22.1	Appoint external auditors
6.3.9	Audit Committee	8.23	8.23.1	Ensure external auditors appointed by the Council meet the criteria included by the NAO Code of Audit Practice and the Local Audit and Accountability Act 2014
6.3.13	ECFO	8.24	8.24.1	Forward to NHS England within 30 days any public Interest report issued by auditors
6.4	CEO ECFO	8.25	8.25.1	Ensure compliance with the Counter Fraud Functional Standards including the appointment of the Local Counter Fraud Specialist
6.5	CEO	8.26	8.26.1	Ensure compliance with NHS violence prevention and reduction standard
7.1.1	CEO	8.27	8.27.1	Compile and submit to the Board an Operational Plan which

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans and in the format specified by NHS England. The annual business plan will contain: • a statement of the significant assumptions on which the plan is based • details of major changes in workload, delivery of services or resources required to achieve the plan • and have due regard to the views of the Council, including confirmation by the Council that they are satisfied that any activities undertaken by the Trust for non-primary purposes will not to any significant extent interfere with the fulfilment of their principle purpose or other functions
7.1.2 7.1.3	ECFO	8.28	8.28.1 Submit budgets to the Board for approval 8.28.2 Monitor performance against budget, submit to the Board financial estimates and forecasts
7.1.5	ECFO	8.29	8.29.1 Ensure adequate training is delivered on an on-going basis to budget holders
7.1.6	Board of Directors	8.30	8.30.1 Take appropriate action to manage and overcome any potential operational deficit and decide on the appropriate use of any forecast operational surplus
7.2.1	CEO	8.31	8.31.1 Delegate budget to budget holders
7.2.2	CEO Budget Holders	8.32	8.32.1 Must not exceed the budgetary total or virement limits set by the Board
7.3.1	ECFO	8.33	8.33.1 Devise and maintain systems of budgetary control and reporting
7.3.2	Budget Holders	8.34	Ensure that: 8.34.1 no overspend or reduction of income that cannot be met from

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			virement is incurred without prior consent of Board 8.34.2 approved budget is not used for any other than specified purpose subject to rules of virement no permanent employees are appointed in excess of available resources as approved by Board or Director without the approval of the CEO 8.34.3 ensure that there is compliance with the system of budgetary control established by the ECFO 8.34.4 budgetary virements are only undertaken in line with the Detailed Scheme of Delegation 8.34.5 staff change forms (including staff leavers / terminations / change of base / entitlements / High Cost Allowances) are actioned at the earliest opportunity to remove the risk of incorrect payments being made to staff. 8.34.6 staff lists are reviewed and returned to finance on a monthly basis including responsibility to review eligibility of staff allowances and additional payments. 8.34.7 queries on figures presented to them must be raised with their finance or HR lead (as necessary) to ensure figures are robust and all variances are clearly explainable. 8.34.8 All SFI Procurement Breach requests are sent for timely approval and are not retrospectively completed.
7.3.3	CEO	8.35	8.35.1 Ensure there is a process in place to identify and implement cost improvements and income generation activities in line with the Operational Plan
7.5.1	CEO	8.36	Submit to NHS England as per the Single Oversight Framework: 8.36.1 financial performance measures have been defined and are monitored 8.36.2 reasonable targets have been identified for these measures

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			8.36.3	a robust system is in place for managing performance against targets
			8.36.4	reporting lines are in place to ensure overall performance is managed
			8.36.5	arrangements are in place to manage/respond to adverse performance
			8.36.6	relevant financial information is submitted to the statutory authorities and other relevant organisations (e.g. NHS England and ICBs).
8.1	ECFO	8.37	8.37.1	Preparation of annual accounts.
9.1.1	ECFO	8.38	8.38.1	Managing banking arrangements, including provision of banking services, financing, working capital facilities, reporting on accounts and working capital facilities, operation of accounts, preparation of instructions for operating accounts and list of cheque signatories
9.1.2	Board of Directors	8.39	8.39.1	Approve banking arrangements, financing and working capital facilities
9.4	ECFO	8.40	8.40.1	Commercial banking arrangements reviewed at regular intervals
10.	ECFO	8.41	8.41.1	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash
10.2.3	All Employees	8.42	8.42.1	Duty to inform ECFO of money due from transactions which they initiate/deal with
10.5	ECFO	8.43	8.43.1	Monitoring and reporting to the Board of Directors that the Trust is complying with its obligation under the Health and Social Care Act 2012 that the total income derived from its principal purpose is greater than its total income from the provision of goods and services for 'any other purpose' and seeking Council of Governors

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				approval when it is proposed to increase by 5% or more the proportion of income received from non-primary purposes
11.1 11.2	CEO	8.44	8.44.1	Ensure the Trust enters into suitable Legally Binding Contracts (LBC) with service commissioners for the provision of NHS services, devised to minimise risk
11.4	CEO Directors holding portfolios of Finance, Integrated Clinical Services and Contracting	8.45	8.45.1	Ensure that regular reports are provided to the Board detailing actual performance against signed LBCs
11.5	ECFO	8.46	8.46.1	Maintain a public and up-to-date schedule of Commissioner Requested Services as required by the Trust's Terms of Authorisation
12.1.1	Board of Directors	8.47	8.47.1	Establish a NEDs' Remuneration Committee for EDs
12.1.2	Board Remuneration and Nomination Committee	8.48	8.48.1	Report in writing to the Board of Directors its advice and its bases about remuneration and terms of service of directors
12.2.	CEO delegated to Executive Directors	8.49	8.49.1	Approval of variation to funded establishment of any department
12.2.1	CEO delegated to Executive Directors	8.50	8.50.1	Appointment of staff, including agency staff
12.3.1 12.3.2	CEO delegated to Chief People Officer	8.51	Payroll: 8.51.1 8.51.2 8.51.3 8.51.4 8.51.5	 specifying timetables for submission of properly authorised time records and other notifications final determination of pay and allowances making payments on agreed dates agreeing method of payment issuing instructions (as listed in SFI 8.3.2)
12.3.3	Nominated Managers*	8.52	8.52.1	Submit time records in line with timetable

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
			8.52.2 8.52.3	Complete time records and other notifications in required form Submitting termination forms in prescribed form and on time
12.3.4	Chief People Officer	8.53	8.53.1	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies
12.4	Executive Director with Portfolio of People Management Nominated Managers*	8.54	8.54.1 8.54.2	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation Deal with variations to, or termination of, contracts of employment
12.5	ECFO	8.55	8.55.1	Issue instructions to staff regarding procedures to be followed when payments are to be made to individuals who are not employees of the Trust
13.1 13.1.2c	CEO	8.56	8.56.1	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. (Please see Detailed Scheme of Delegation)
13.1.3	CEO	8.57	8.57.1	Set out procedures on the seeking of professional advice regarding the supply of goods and services
13.2	Non-Pay Expenditure Control Panel	8.58	8.58.1	Approval of all non-pay expenditure poroposals exceeding the value stated in the Standing Financial Instructions and regardless of funding source.
13.3.1	Requisitioners*	8.59	8.59.1	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought
13.3.1	ECFO	8.60	8.60.1	Advise the Board regarding the setting of thresholds above

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed
			8.60.2	Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds
			8.60.3	Be responsible for the prompt payment of all properly authorised accounts and claims
			8.60.4	Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable
			8.60.5	A timetable and system for submission to the ECFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment
			8.60.6	Instructions to employees regarding the handling and payment of accounts within the Finance Department
			8.60.7	Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
13.3.4	Appropriate Executive Director	8.61	8.611	Make a written case to support the need for a prepayment
	ECFO		8.61.2	Approve proposed prepayment arrangements
	Budget Holder		8.61.3	Ensure that all items due under a prepayment contract are received (and immediately inform ECFO if problems are encountered)
13.3.5d	CEO	8.62	8.62.1	Authorise who may use and be issued with official orders.
13.3.6	Managers Officers	8.63	8.63.1	Ensure that they comply fully with the guidance and limits specified by the ECFO

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
13.3.7	CEO ECFO	8.64	8.64.1 Ensure that Standing Orders are compatible with Department of Health requirements re building and engineering contracts. 8.64.2 Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Director.
14.1	ECFO	8.65	8.65.1 Trust's cash flow management
14.2	ECFO	8.66	External borrowing: 8.66.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The ECFO is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest 8.66.2 Any application for new borrowing will only be made by the ECFO or by an officer so delegated by him/her
			8.66.3 The ECFO will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by NHS England 8.66.4 Assets supporting Commissioner Requested Services shall not be used as collateral for borrowing. Non Commissioner Requested assets will be eligible as security for a loan
14.3	ECFO	8.67	Investments 8.67.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by NHS England 8.67.2 The ECFO is responsible for advising the Finance and Performance Committee on investment strategy and

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			shall report periodically on the performance of investments held 8.67.3 The ECFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained as specified in the Trust Operating Cash Management Policy
15.1.1 15.1.2	CEO	8.68	Capital investment programme: 8.68.1 ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans 8.68.2 responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost 8.68.3 ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences 8.68.4 ensure that a business case is produced for each proposal in line with limits approved by the Board of Directors
15.1.2	ECFO	8.69	8.69.1 Certify professionally the costs and revenue consequences detailed in the business case for capital investment
15.1.3	CEO ECFO	8.70	8.70.1 Issue procedures for management of contracts involving stage payments
	ECFO		8.70.2 Assess the requirement for the operation of the construction industry taxation deduction scheme 8.70.3 Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure
15.1.4	Executive Operational Committee CEO ECFO	8.71	8.71.1 Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Approval will be granted in line with limits in detailed scheme of delegation.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
	Finance & Performance Committee Capital Projects Program Group (CPPG) Digital Strategy Group			
15.1.5	ECFO	8.72	8.72.1	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes
15.2 15.3	ECFO	8.73	8.73.1	If required, demonstrate that the use of private finance/Procure 23 represents value for money
	Board of Directors		8.73.2	Proposal to use PFI/Procure 23 must be specifically agreed by the Board
15.4.1	CEO	8.74	8.74.1	Maintenance of asset registers including right of use assets (on advice from ECFO)
15.4.3	ECFO	8.75	8.75.1	Responsibility for ensuring that commissioner requested property is not disposed (unless agreed with main commissioner and informed to (NHS England
15.4.4	ECFO	8.76	8.76.1	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
15.4.7	ECFO	8.77	8.77,1	Calculate capital charges in accordance with NHS England requirements.
15.4.8	Board of Directors	8.78	8.78.1	Approve the use of non-commissioner requested assets for the development of services
15.5.1	CEO	8.79	8.79.1	Overall responsibility for fixed assets
15.5.2	ECFO	8.80	8.80.1	Approval of fixed asset control procedures
15.5.4	All Senior Staff	8.81	8.81.1	Responsibility for security of Trust assets including notifying discrepancies to ECFO, and reporting losses in accordance with Trust procedure
16.2	CEO	8.82	8.82.1	Delegate overall responsibility for control of stores (subject to

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				ECFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Please see attached Detailed Scheme of Delegation)
	ECFO		8.82.2	Responsible for systems of control over stores and receipt of goods
	Designated Pharmaceutical Officer		8.82.3	Responsible for controls of pharmaceutical stocks
	Designated Estates Officer		8.82.4	Responsible for control of stocks of fuel oil and coal
16.3	Nominated Officers*	8.83	8.83.1	Security arrangements and custody of keys
16.4	ECFO	8.84	8.84.1	Set out procedures and systems to regulate the stores
16.5	ECFO	8.85	8.85.1	Agree stocktaking arrangements
16.6	ECFO	8.86	8.86.1	Approve alternative arrangements where a complete system of stores control is not justified
16.7	ECFO	8.87	8.87.1	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items
	Nominated Officers*		8.87.2	Operate system for slow moving and obsolete stock, and report to ECFO evidence of significant overstocking
16.8	CEO	8.88	8.88.1	Identify persons authorised to requisition and accept goods from NHS Supplies
17.1.1	ECFO	8.89	8.89.1	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers
17.2.1	ECFO	8.90	8.90.1	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft
17.2.2	All Staff	8.91	8.91.1	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				The head of department / nominated officer should then inform the CEO and ECFO
	ECFO		8.91.2	Where a criminal offence is suspected ECFO must inform the police if theft or arson is involved, following consultation with LSMS. In cases of fraud and corruption ECFO must inform the relevant Operational Fraud Team in line with SoS directions and consult with the Counter Fraud Specialist where appropriate.
17.2.3	ECFO	8.92	8.92.1	Notify NHS Counter Fraud Authority and External Audit of all frauds
17.2.4	ECFO	8.93	8.93.1	Unless trivial, notify Board of Directors, Local Security Management Specialist & External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness
17.2.5	ECFO Director of Finance	8.94	8.94.1	Approve write-off of losses (within limits delegated by Trust)
17.2.7	ECFO	8.95	8.95.1	Consider whether any insurance claim can be made
17.2.8	ECFO	8.96	8.96.1	Maintain losses and special payments register
18.1	Executive Director with Portfolio of Information & IT	8.97	8.97.1	Responsible for accuracy and security of computerised data
18.2	ECFO in conjunction with Executive Director with Portfolio of Information & IT	8.98	8.98.1	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation
18.3	Relevant Officers	8.99	8.99.1	Send proposals for general computer systems to ED with portfolio of IT
18.4 18.5	Executive Director with Portfolio of Information & IT	8.100	6.100.1	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy,

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)
			completeness and timeliness of data during processing, transmission and storage, and allow for audit review 6.100.2 Seek periodic assurances from the provider that adequate controls are in operation
18.6	Executive Director of Strategy, Transformation and Digital, in conjunction with ECFO	8.101	Where computer systems have an impact on corporate financial systems satisfy themselves that: 6.101.1 systems acquisition, development and maintenance are in line with corporate policies 6.101.2 data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists 6.101.3 ECFO and staff have access to such data 6.101.4 Such computer audit reviews are being carried out as are considered necessary
19.2	CEO	6.102	6.102.1 Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
19.3	ECFO	8.103	8.103.1 Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients
19.6	Departmental Managers	8.104	8.104.1 Inform staff of their responsibilities and duties for the administration of the property of patients
20.5	ECFO	8.105	8.105.1 Primary responsibility to the Board of Directors for Charitable Funds
21.2	CEO	8.106	8.106.1 Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
21.3	Executive Director of Corporate Governance	8.107	8.107.1 Review Register of Interests on an annual basis to link in with disclosures of annual report

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
22.1	CEO	8.108	8.108.1	Maintaining archives for all documents required to be returned
23.1	CEO	8.109	8.109.1	Risk management programme
	Boards of Directors		8.109.2	Approve and monitor risk management programme
23.3	Board of Directors	8.110	8.110.1	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self- insure should be reviewed annually
23.5	Executive Director of Corporate Governance ECFO	8.111	8.111.1	Consult NHS Resolution in case of doubt as to the power to use commercial insurers
23.6	Executive Director of Corporate Governance ECFO	8.112	8.112.1	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution, the Director holding the portfolio of Insurance and Risk Management shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The ECFO shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the ECFO shall ensure that the Board is informed of the nature and extent of the risks that are self- insured as a result of this decision. The ECFO will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed. The ECFO shall ensure that the arrangements entered into for commercial or fleet are appropriate.
23.7	ECFO	8.113	8.113.1	Ensure documented procedures cover management of claims and

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SFI Ref.	Delegated To	SoRD Ref.	Duties Derived from the Standing Financial Instructions (SFI's)	
				payments below the excess amount as defined by NHSR
24.1	CEO	8.114	8.114.1	Ensure there are processes in place to oversee the management of new business development and income generation opportunities, and ensuring compliance with the Terms of Authorisation, Risk Assessment Framework and available best practice guidance
24.2	Board of Directors	8.115	8.115.1	Ensure there is a governance framework in place to scrutinise and consider new initiatives as necessary
24.3	Council of Governors	8.116	8.116.1	Ensure involvement in the approval process of all 'significant transactions' as per NHS England's definition in the Risk Assessment Framework, any transactions in excess of £10m and a significant overall risk rating based on the Trust's risk management framework
24.5	Finance and Performance Committee	8.117	8.117.1	Consideration of investment, initiatives or opportunities where a change to the Trust's corporate structure is required or potential significant risk

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Detailed Scheme of Delegation document.

9 MAJOR INCIDENT PLAN

In the event of a Business Continuity, Critical or Major Incident being declared leading to the activation of the Major Incident Plan (RM14) a Major Incident Response Team (MIRT) will be established consisting of a Gold Command. Delegated powers will be given to the Gold Commander who will be the CEO / Deputy CEO or Director on call should this be out of core business hours.

END

Essex Partnership University NHS Foundation Trust

Document title:	**STANDING FINANCIAL INSTRUCTIONS**		
Document reference number:	FP10	**Version number:**	sV 2.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All Staff
Author:	Clare Barley, Head of Financial Accounts		
Approval group/ committee(s):	Audit Committee Executive Operational Committee Policy Oversight Reference Group Senior Finance Staff		
Professionally approved by: (Director)	Simon Covill, Director of Finance		
Executive Director:	Trevor Smith, Executive Chief Finance Officer / Deputy Chief Executive		
Ratification group(s):	Board of Directors		03 December 2025
CQC Quality Statement	Well-Led – Governance		
Key word(s) to search for document on Intranet / TAGs:	Finance, Financial, SFI	**Distribution method:**	☒Intranet

Initial issue date:	01 April 2017	**Last Review date:**	04 December 2024	**Next Review date:**	01 September 2025	**Expiry Date:**	01 December 2025

Related Trust documents (to be read in conjunction with)
(Refer to the main body of the text) Trust Constitution Schedule of Reservation and Delegation Detailed Scheme of Delegations Supporting Finance Procedures

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1.0	Associate Chief Finance Officer (SEPT)	Replaces NEP Standing Financial Instructions	01 April 2017
1.0	Associate Chief Finance Officer (SEPT)	GDPR	01 August 2018
2.0	Head of Financial Accounts	Replaces SEPTFP10 and NEP Standing Financial Instructions. No Key changes documented	26 September 2018
3.0	Head of Financial Accounts	Not Documented	01 September 2019
4.0	Head of Financial Accounts	Annual Review	01 September 2020
4.0	Head of Financial Accounts	Annual Review	01 September 2021
5.0	Head of Financial Accounts	Not Documented	01 September 2022
5.1	Head of Financial Accounts	LCFS changed to Counter Fraud / Anti-Crime Specialist(s) throughout	01 September 2022
6.0	Head of Financial Accounts	Annual review 2.3.10 – Removal of external audit formal responsibility with respect to Quality Report 2.4.9 – References to Standards of Conduct for both temporary staff and BoD have been included in addition to those references for substantive staff 8.5.2 – New section which reminds staff of the need to ensure any compliance checks around use of individuals who are not employees of the Trust are completed ahead of any work commencing 9.2.6(c) – Amended to provide confirmation that contracts should only be signed with the prior approval of the procurement / contracts department and then be in line with delegated authority limits 11.3 – References to Procure 22 replaced with Procure 23 11.4.1 – Section updated to confirm that registers for right of use assets will also be maintained (following implementation of new accounting standard on leases in 22/23) 19 – Section updated to clarify that responsibility for NHS Resolution and Risk Management lies with the Senior Director of Corporate Governance, and that commercial insurances lies with the ECFO.	01 September 2023
6.1	Head of Financial Accounts	Extension of review until January 2025	01 March 2024

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
7.0	Head of Financial Accounts	Annual review and transferred into new template. Foreword – updated to confirm annual requirement for Budget Holder to read Governance Manual. Section 1.1.2 – updated for PORG Section 7.3.2 – updated for Budget Holders responsibilities around staff lists and change forms Sections 12.2.1 / 13.2.1 – reference to control panels included Section 13.2.6 – reference to electronic signing of contracts included.	04 December 2024
sV 1.0	Policy Team	Uploaded to SOPHIA document library	19 March 2025
sV 2.0	Head of Financial Accounts	Annual review: amendments to reflect new Procurement regulations, and changes to quotation / tendering thresholds.	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Foreword

These Standing Financial Instructions (SFIs) together with the Essex Partnership University NHS Foundation Trust's (the NHSFT) Constitution, and Standing Orders, provide a business and financial framework within which all Executive Directors, Directors, Non-Executive Directors and officers of the NHS Foundation Trust will be expected to work. All Executive Directors, Non-Executive Directors, Directors and other members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These documents fulfil the dual role of protecting the interests of the NHSFT and protecting staff from any possible accusation that they have acted less than properly. On an annual basis, Budget Holders will be asked to confirm that they have read the documents and understand that failure to comply is a disciplinary matter.

In addition to the Standing Orders and SFIs, there is a Detailed Scheme of Delegation and a Schedule of Reservation and Delegation which taken together are referred to as the 'Governance Manual'. These are further supported by Finance Procedures and locally generated rules and instructions. Existing Finance Procedures, Procedure Notes and locally generated rules and instructions shall apply until these are revised (except where specifically overruled by these SFIs).

The SFIs have been formally adopted by the Board of Directors and shall have effect as if incorporated in the standing orders.

Any queries regarding the contents of this document should in the first instance be raised with the Head of Finance or Finance Business Partner responsible for your area.

Executive Chief Finance Officer

December 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1 Introduction

1.1 GENERAL

1.1.1 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the NHSFT. They are designed to ensure that financial transactions are carried out in accordance with the law, Government policy and the requirements of the Department of Health and Social Care (DHSC) and NHS England (NHSE) in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders, Schedule of Reservation and Delegation and the Detailed Scheme of Delegation adopted by the Board of Directors.

1.1.2 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They are not intended to provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **The supporting finance policies and procedures must be approved by the Policy and Oversight Ratification Group on the recommendation of the Finance Policy Group.**

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions, then the advice of the Executive Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar and comply with the provisions of all associated documents.

1.1.4 FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS OR STANDING ORDERS IS A DISCIPLINARY MATTER THAT COULD RESULT IN DISMISSAL.

1.1.5 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Chief Finance Officer at the earliest opportunity.

1.1.6 The NHSFT may be responsible for providing shared financial and other corporate services to other NHS organisations.

The specific services to be provided will be defined in legally binding contracts between the NHSFT and the receiving organisation. Where these contracts do not cover a specific matter, the NHSFT's Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation and Detailed Scheme of Delegation will take precedence.

1.1.7 The Trust has entered into collaborative arrangements in respect of the provision of core services. The specific arrangements will be defined in legally binding contracts between all parties and where these contracts do not cover a specific matter, the Trust's Standing Orders, Standing Financial Instructions, Schedule of Reservation and Delegation, and Detailed Scheme of Delegation will take precedence.

2 Principles

2.1 These Standing Financial Instructions (SFIs) together with the Essex Partnership University NHS Foundation Trust's (the NHSFT) Constitution, and Standing Orders, provide a business and financial framework within which all Executive Directors, Directors, Non-Executive Directors and officers of the NHS Foundation Trust will be expected to work. All Executive Directors, Non-Executive Directors, Directors and other members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

2.2 These documents fulfil the dual role of protecting the interests of the NHSFT and protecting staff from any possible accusation that they have acted less than properly. On an annual basis, Budget Holders will be asked to confirm that they have read the documents and understand that failure to comply is a disciplinary matter.

3 Scope

3.1 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust.

4 Definitions / Glossary

4.1 Any expression to which a meaning is given in Health Service Acts, or in Financial Directions made under the Acts shall have the same meaning in these instructions; and

Term	Definition / Meaning
Accounting Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For the Trust, this is the Chief Executive.
Board of Directors / Board / Board Member / Member of the Board	The Chair, Executive and Non-Executive directors of the Trust collectively as a body in accordance with the constitution. This consists of both voting and non-voting members.
Budget	A resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Term	Definition / Meaning
Budget Holder	The Director or employee with delegated authority to manage finances (including income, pay, non-pay expenditure and capital where relevant) for a specific area of the organisation.
Chair of the Board / Chair of the Trust / Chair	The person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or otherwise unavailable.
Chief Executive	The person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	A committee appointed by the Board of Directors.
Constitution	The Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.
Council of Governors / **Council**	The Council of Governors of the Trust as described in paragraphs 14 and 18 the constitution.
Deputy Chief Executive	The Officer of the Trust nominated by the Chief Executive to act as their Deputy.
Director / **Senior Director**	A Director (as appointed by a Senior Director or an Executive Director respectively) of a service who does not hold Executive Director status and therefore is not a member of the Board of Directors.
Executive Director	A member of the Board of Directors appointed under paragraph 31 of the constitution.
Funds held on trust	Those funds which the Trust holds on date of incorporation, or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
Legal Adviser	The properly qualified person or legal firm appointed by the Trust to provide legal advice.
NHSE	The office or an officer of NHS England. In March 2025, the government announced the abolition of NHSE with its functions transferring to the Department of Health and Social Care (DHSC). This process requires new legislation and is expected to take two years to complete.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks under the Scheme of Reservation and Delegation.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Term	Definition / Meaning
Non-Executive Director	A member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.
NHS Act	The National Health Service Act 2006 as amended by the Health and Social Care Act 2012, and Health and Care Act 2022.
Officer	An employee of the Trust or any other person holding a paid employment or office with the Trust. This also includes employees of third parties contracted and seconded from other organisations when acting on behalf of the Trust.
Principle Purpose	The delivery of goods and services for the purposes of the health service in England, as per Section 164 of the Health and Social Care Act 2012.

4.2 Wherever the title Chief Executive, Executive Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them or act on their behalf.

4.3 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

5 Responsibilities and Delegation

5.1 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Schedule of Reservation and Delegation.

5.2 The Board will delegate responsibility for the performance of its functions in accordance with the Schedule of Reservation and Delegation adopted by the Board of Directors.

5.3 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accounting Officer accountable to Parliament, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Trust Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

5.4 The Chief Executive and the Executive Chief Finance Officer will delegate specific responsibilities, but they remain accountable for financial control.

5.5 It is a duty of the Chief Executive to ensure that systems and processes are in place so that the Board of Directors and other employees are notified and understand their responsibilities within these Instructions.

5.6 The Executive Chief Finance Officer is responsible for:

a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

d) Advising the Board of Directors regarding the financial performance, legality and vitality of the Trust.

And, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Chief Finance Officer include:

e) The provision of financial advice to other members of the Board of Directors and employees;

f) The design, implementation and supervision of systems of internal financial control; and

g) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the NHSFT may require for the purpose of carrying out its statutory duties.

5.7 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the NHSFT;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources; and

d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Finance Procedures and the Schemes of Delegation.

5.8 Any contractor or employee of a contractor who is empowered by the NHSFT to commit the NHSFT to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

5.9 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Executive Chief Finance Officer.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

6 Audit

6.1 AUDIT COMMITTEE

The National Health Service Act 2006 specifies that auditors of NHSFTs shall comply with the directions of NHS England under paragraph 24 (5) of Schedule 1 to the Act with respect to the standards, procedures and techniques to be adopted.

6.1.1 In accordance with Standing Orders (and as set out in the National Health Service Act 2006) the Board of Directors shall formally establish an Audit Committee, comprising of Non-Executive Directors, with clearly defined formal terms of reference. The role of the Audit Committee will be to provide an independent and objective review of governance and assurance processes and arrangements.

6.1.2 The Board of Directors shall satisfy itself that the Chairman and members of the Audit Committee have recent and relevant financial experience or have appropriate training.

6.1.3 The Audit Committee must assess the work and fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable.

6.1.4 The Audit Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the external auditors. If the work has been satisfactory and the charges reasonable, the Council of Governors may re-appoint the auditors for the following year without the need for a formal selection process. However, in line with National Audit Office Audit Code and the Local Audit and Accountability Act 2014 (LAAA), the NHSFT will undertake a market-testing exercise for the appointment of the external auditors at least once every 5 years.

6.1.5 Where the Audit Committee considers there is evidence of ultra vires transactions, improper acts, or other important matters that the committee feel it is justified to escalate, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS England having been raised with the Executive Chief Finance Officer and Accounting Officer.

6.1.6 The Executive Chief Finance Officer, Audit Committee and Trust Governor shall be involved in the selection process when/if an audit service provider is changed.

6.2 EXECUTIVE CHIEF FINANCE OFFICER

6.2.1 The Executive Chief Finance Officer is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) Ensuring that the purpose, authority and responsibility of internal audit is formally defined by the NSHFT in the Terms of Engagement with regard to professional best practice;

c) Deciding at what stage to involve the police in cases of misappropriation, in consultation with the Violence and Abuse Prevention and Reduction Advisor (VAPR), and other irregularities not involving fraud or corruption. Where fraud and corruption is suspected and in consultation with the Counter Fraud / Anti-Crime Specialists, any irregularities should be investigated as appropriate.

d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

i. a clear opinion on the effectiveness of internal financial control, risk management and organisational controls;

ii. major internal control weaknesses discovered,

iii. progress on the implementation of internal audit recommendations,

iv. progress against plan,

v. strategic audit plan covering the coming three years,

vi. a detailed plan for the coming year.

e) Ensuring that the Chief Internal Auditor delivers an annual audit opinion on the effectiveness of the system of internal control.

6.2.2 The Executive Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the NHSFT;

c) the production of any cash, stores or other property of the NHSFT under a member of the Board and employee's control; and

d) explanations concerning any matter under investigation.

6.3 AUDIT

(A) ROLE OF INTERNAL AUDIT

6.3.1 Internal Audit will, in accordance with recognised professional best practice and as included in the agreed plan for the year, review, appraise and report upon:

a) the extent to which the achievement of the NHSFTs objectives are monitored;

b) the extent of compliance with, and the financial effect of risk associated with, relevant established policies, plans and procedures;

c) the adequacy, efficiency and application of financial and other related management controls;

d) the suitability and effective usage of financial and other related management data;

e) the extent to which the NHSFT's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. fraud and other offences,

ii. waste, extravagance, or inefficient administration,

iii. poor value for money or other causes.

f) Internal Audit will produce an annual audit opinion on the effectiveness of the systems of internal control

6.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Chief Finance Officer must be notified immediately. (See also SFI 13 – Disposals and Condemnations, Losses and Special Payments).

6.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the NHSFT.

6.3.4 The Chief Internal Auditor shall report directly to the Executive Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take the necessary remedial action within a reasonable period shall be reported to the Executive Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit the Chief Internal Auditor shall have access to report directly to the Audit Committee.

6.3.5 The Chief Internal Auditor shall co-ordinate internal audit plans and activities with line managers of the function being audited, external audit and other review

agencies to ensure the most effective audit coverage is achieved and publication of effort is minimised. The Chief Internal Auditor will periodically be invited to Executive Management Team.

6.3.6 The NHSFT will provide the Chief Internal Auditor with every facility and information which is reasonably required for the purposes of the functions under the terms of engagement.

(B) EXTERNAL AUDIT:

6.3.7 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors (also refer to 6.1.4 above).

6.3.8 The initial appointment must be made as soon as possible and no later than the end of the first period for which the NHSFT will be preparing accounts.

6.3.9 The NHSFT must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the NAO Code of Audit Practice and the Local Audit and Accountability Act 2014 (LAAA).

6.3.10 The external audit responsibilities (in compliance with the requirements of DHSC and NHS England) are as follows:

1. to assess if they are satisfied that the accounts comply with the directions provided including compliance with the NHS Foundation Trust Annual Reporting Manual and the DH Group Accounting Manual (where relevant)

2. to assess if they are satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts

3. to assess if they are satisfied that proper practices have been observed in compiling the accounts

4. to assess if they are satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources and to provide commentary in line with the reporting criteria stated in the Code of Audit Practice 2020.

5. to comply with any directions given by NHSE as to the standards, procedures and techniques to be adopted, i.e. to comply with the NAO Code of Audit Practice and LAAA 2014.

6. to consider the issue of a public interest report

7. to certify the completion of the audit

8. to express an opinion on the accounts

9. to refer the matter to NHSE if the NHSFT, or an officer or Board Director of the NHSFT, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

10. to read the monthly / quarterly reports required under NHS Oversight Framework, annual report and comparing the information to ensure there are no material inconsistences;

11. to review reports arising from Care Quality Commission planned and responsive reviews of the NHSFT and any consequent action plans developed by the NHSFT.

6.3.11 External auditors will ensure that there is a minimum of duplication of effort between themselves and relevant regulators. The auditors will discharge this responsibility by:

1. reviewing the statement made by the Chief Executive as part of the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the NHSFT

2. reviewing the results of the work of relevant assurors, for example the Care Quality Commission, to determine if the results of the work have an impact on their responsibilities

3. undertake any other work that they feel necessary to discharge their responsibilities

6.3.12 The NHSFT will provide the external auditor with every facility and all information which they may reasonably require for the purposes of their functions under Part 1 of the 2006 Act

6.3.13 The NHSFT shall forward a report to NHSE within 30 days (or such shorter period as may be specified) of the external auditor issuing a public interest report in terms of Schedule 5 paragraph 3 of the Act. The report shall include details of the NHSFT's response to the issues raised within the public interest report.

6.4 FRAUD, BRIBERY AND CORRUPTION

6.4.1 In line with their responsibilities, the Trust's Chief Executive and Executive Chief Finance Officer shall monitor and ensure compliance with best practice on prevention of fraud, bribery and corruption.

6.4.2 The Executive Chief Finance Officer shall nominate a suitable person to carry out the duties of the Counter Fraud / Anti-Crime Specialists

6.4.3 The Counter Fraud / Anti-Crime Specialists shall report to the Trust's Executive Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority.

6.4.4 The Executive Chief Finance Officer is responsible for providing detailed procedures to enable the NHSFT to minimise and where possible, eliminate fraud and corruption. These procedures are included in the NHSFT's Fraud and Bribery Policy (CP11) which sets out action to be taken by persons detecting a suspected fraud and responsibilities for investigating it.

6.4.5 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the NHSFT is accountable to, through:

1. Encouraging prevention;
2. Promoting detection; and,
3. Ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

6.4.6 Proven instances of fraud, theft and corruption shall normally be dealt with as gross misconduct under the NHSFT's disciplinary policies and procedures.

6.4.7 It is expected that all officers shall act with utmost integrity, ensuring adherence to all relevant regulations and procedures. This responsibility has been delegated to the Executive Chief Finance Officer who will produce and issue these to the appropriate Directors and Budget Managers who should in turn ensure that all staff have access to these.

6.4.8 The Executive Chief People Officer is responsible for ensuring that steps are taken at recruitment stage to establish, as far as possible, the previous record of potential officers in terms of their propriety and integrity.

6.4.9 Staff are expected to act in accordance with the NHSFT's Standing Orders, Standing Financial Instructions and the Standards of Conduct (outlined in HRPG27a Appendix 2 for substantive staff, HRPG59 Appendix 1 for temporary workers and the Code of Conduct CP15 for the Board of Directors).

6.4.10 The Bribery Act 2010 replaced the "Prevention of Corruption Acts 1906 and 1916" with new corporate and individual offences of bribery. The Executive Chief Finance Officer is responsible for ensuring that all staff and contractors are made aware of the Act and implementing procedures designed to ensure compliance with the Act by the Trust and staff. Any breach of the Act may result in criminal proceedings being commenced.

6.4.11 Non-Executive Directors are subject to the same standards of accountability and are required to declare and register any interest which might potentially conflict with those of the NHSFT.

6.4.12 The Counter Fraud / Anti-Crime Specialists shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls, and evaluate the implication of fraud on the system of risk management, control and governance, reported to the Audit Committee.

6.4.13 Staff employed by the NHSFT are encouraged to raise any concerns they may have regarding suspected fraud and/or corruption (Please refer to the Fraud and Bribery Policy CP11 and the NHSFT's Freedom to Speak Up Whistle Blowing Policy CP53. They can do this through:

1. Their line manager;
2. Internal Audit;
3. The Executive Chief Finance Officer;
4. The NHSFT's Counter Fraud / Anti-Crime Specialists; or,
5. The NHS National Fraud and Corruption Reporting Line.

6.4.14 Any abuse of the procedures, such as unfounded or malicious allegations, will also be subject to full investigation and appropriate disciplinary action where appropriate.

6.5 SECURITY MANAGEMENT

6.5.1 In line with their responsibilities, the Trust's Chief Executive will monitor and ensure compliance with best practice on NHS security management.

6.5.2 The Trust shall nominate a suitable person to carry out the duties of the Violence and Abuse Prevention and Reduction Advisor (VAPR) as specified by the Secretary of State for Health guidance on NHS security management.

6.5.3 The Trust shall consider the need for a nomination of a Non-Executive Director to be responsible to the Board for NHS security management.

6.5.4 The Trust shall prepare a Security Policy that sets out measures to protect staff, visitors, premises and assets.

6.5.5 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Executive Director with the lead for Security Management and the appointed Violence and Abuse Prevention and Reduction Advisor (VAPR).

6.6 Further guidance is available in FP09-05 Monitoring of Internal and External Audit Protocol, FP13 Financial Redress and CP11 Fraud and Bribery Policy.

7 Annual Planning, Budgets, Budgetary Control, And Monitoring

7.1 PREPARATION AND APPROVAL OF ANNUAL PLANS AND BUDGETS

7.1.1 The Chief Executive will compile and submit to the Board of Directors an Operational Plan in a format prescribed by NHSE which takes into account financial targets and forecast limits of available resources based on the Trust's Strategic Plans. The Operational Plan will contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan;

c) and, have due regard to the views of the Council of Governors, including confirmation by the Council of Governors that they are satisfied that any activities undertaken by the NHSFT for non-primary purposes will not to any significant extent, interfere with the fulfilment of their principle purpose or other functions.

7.1.2 Prior to the start of the financial year the Executive Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets to the Finance and Performance Committee, ahead of formal Board of Directors approval. These budgets may subsequently be amended as a result of the preparation of the Operational Plan, and any such changes should be reported to the Board at the earliest opportunity. Such budgets will:

a) Include income, revenue operational expenditure and capital expenditure which will:

i. be in accordance with the aims and objectives set out in the Operational Plan;

ii. accord with workload and manpower plans;

iii. align with the wider system financial plan.

b) Be produced following discussion with appropriate budget holders;

c) Be prepared within the limits of available funds; and

d) Identify potential risks, and mitigating strategies.

7.1.3 The Executive Chief Finance Officer shall monitor financial performance against budget and the operational plan, including activity, workforce and other targets. These shall be periodically reviewed, and reported to the Finance and Performance Committee, ahead of assurance being provided to the Board of Directors at every ordinary meeting of the Board.

7.1.4 All budget holders must provide information as required by the Executive Chief Finance Officer to enable budgets, plans, estimates and forecasts to be compiled.

7.1.5 The Executive Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage resources successfully.

7.1.6 The Board of Directors must take appropriate action to manage and overcome, where possible, any potential operational deficit and decide on the appropriate use of any forecast operational surplus.

7.2 BUDGETARY DELEGATION

7.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and will normally form part of individual job descriptions. Through the annual budget setting and approval process, budget holders will be set:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement;

e) achievement of planned levels of service; and

f) the provision of regular reports.

7.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

7.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

7.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

7.3 BUDGETARY CONTROL AND REPORTING

7.3.1 The Executive Chief Finance Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

a) Detailed monthly financial reports to the Accountability Framework meetings, Executive Operational Committee and Finance and Performance Committee, and monthly financial assurance reports to the Board of Directors. Finance reports to the Executive Operational Committee and Finance and Performance Committee will be in a format agreed with the Executive Chief Finance Officer and may include the following:

i. income and expenditure to date showing trends and forecast year-end position;

ii. summary cash flow and forecast year-end position;

iii. capital project spend, projected outturn against plan and fixed asset disposals;

iv. explanations of any material variances that detail any movement from the plan at the end of the current month position;

v. performance against DHSC / NHSE monitoring and Oversight metrics and ratings currently in force;

vi. any changes to key financial assumptions underpinning the operational and strategic plans;

vii. the use of working capital facilities and the management of working capital (if applicable);

viii. key balance sheet performance including cash, debtors and creditors:

ix. details of any corrective action where necessary and the Chief Executive's and/or Executive Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, workload and manpower budgets;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

7.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board;

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

c) no permanent employees are appointed in excess of available resources as approved by the Board of Directors, without the approval of the Chief Executive and,

d) ensuring compliance with the systems of budgetary control established by the Executive Chief Finance Officer.

e) budgetary virements are only undertaken in line with the Detailed Scheme of Delegation

f) staff change forms (including staff leavers / terminations / change of base / entitlements / High Cost Allowances) are actioned at the earliest opportunity to remove the risk of incorrect payments being made to staff.

g) staff lists are reviewed and returned to finance on a monthly basis including responsibility to review eligibility of staff allowances and additional payments.

h) queries on figures presented to them must be raised with their finance or HR lead (as necessary) to ensure figures are robust and all variances are clearly explainable.

i) All SFI Procurement Breach requests are sent for timely approval and are not retrospectively completed.

7.3.3 The Chief Executive is responsible for ensuring there is a process to identify and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operational Plan and the Strategic Plan as authorised by the Board of Directors.

7.4 CAPITAL EXPENDITURE

7.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 11.)

7.5 FINANCIAL PERFORMANCE AND MONITORING:

7.5.1 The Chief Executive is responsible for ensuring that:

1. financial performance measures have been defined and are monitored;
2. reasonable targets have been identified for these measures;
3. a robust system is in place for managing performance against targets;
4. reporting lines are in place to ensure overall performance is managed;
5. arrangements are in place to manage/respond to adverse performance; and,
6. relevant financial information is submitted to the statutory authorities and other relevant organisations (e.g. NHSE and ICB's).

8 Annual Accounts and Reports

8.1 The Executive Chief Finance Officer, on behalf of the NHSFT, will:

a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSE may, with the approval of the Treasury direct;

b) ensure that, in preparing annual accounts, the NHSFT complies with any directions given by NHSE with the approval of the Treasury as to:

1. The methods and principles according to which the accounts are to be prepared; and
2. The information to be given in the accounts.

c) Ensure that a copy of the annual accounts and annual report and any report of the external auditor on them, are laid before Parliament and that copies of these documents are sent to NHSE as required in the Annual Reporting Manual for Foundation Trusts.

8.2 The NHSFT will prepare a combined annual report and accounts as required by paragraph 26 of Schedule 1 of the Act. This will be presented to the Board of Directors for approval and received by the Council of Governors at a public meeting. A copy will be forwarded to NHSE. The report will give:

a) Information on any steps taken by the NHSFT to ensure (taken as a whole) the actual membership of its public constituency is representative of those eligible for such membership;

b) Information explaining the impact of any non-primary purpose income on the delivery of goods and services for their principle purpose (i.e. the delivery of goods and services for purposes of health services in England); and

c) Any other information required by NHSE.

9 Bank Accounts – Also Refer to SFI 10: External Borrowing and Investments

9.1 GENERAL

9.1.1 The Executive Chief Finance Officer is responsible for managing the NHSFT's banking arrangements and for advising the NHSFT on the provision of banking services, operation of accounts, financing and working capital facilities.

9.1.2 The Board of Directors shall approve the banking arrangements, financing and working capital facilities.

9.2 BANK ACCOUNTS AND WORKING CAPITAL FACILITIES

9.2.1 The Executive Chief Finance Officer is responsible for:

a) Bank accounts, financing and working capital facilities;

b) Establishing separate bank accounts for the NHSFT's non-exchequer funds;

c) Reporting to the Board of Directors when working capital facilities are committed, liquidity headroom calculations, details of potential drawdown's and when accounts are overdrawn;

9.3 BANKING PROCEDURES

9.3.1 The Executive Chief Finance Officer will prepare detailed instructions on the operation of bank accounts that must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the NHSFT's accounts and limitations on single signatory payments; and

c) The committed working capital facility (where relevant) approved by the Board of Directors to be operated under the terms and conditions agreed with the bank and approved by the Board of Directors;

9.3.2 The Executive Chief Finance Officer must advise the NHSFT's bankers in writing of the conditions under which each account will be operated.

9.3.3 All funds shall be held in accounts in the name of the NHSFT. No officer other than the Executive Chief Finance Officer shall open any bank account in the name of the NHSFT.

9.4 TENDERING AND REVIEW

9.4.1 The commercial banking arrangements of the Trust should be reviewed at regular intervals by the Executive Chief Finance Officer to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business, where appropriate.

10 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

10.1 INCOME SYSTEMS

10.1.1 The Executive Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

10.1.2 The Executive Chief Finance Officer is also responsible for the prompt banking of all monies received.

10.2 FEES AND CHARGES

10.2.1 The Executive Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in-kind such as subsidised goods or loans of equipment) is considered, the NHSFT's policies on these matters shall be followed.

10.2.2 In receiving cash payments, the Trust should adhere to the maximum value for a single transaction as specified in the Money Laundering Regulations.

10.2.3 All employees must inform the Executive Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, and other transactions.

10.3 DEBT RECOVERY

10.3.1 The Executive Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

10.3.2 Income not received should be dealt with in accordance with losses procedures.

10.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated. Salary overpayments will be recovered in accordance with HR50 – Resolution of Salary Overpayments.

10.3.4 Further guidance is available in FP04-01 Raising Invoices and Credit Notes, and FP09-11 Credit Control Policy.

10.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

10.4.1 The Executive Chief Finance Officer is responsible for:

a) approving the form of all receipt books, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the NHSFT.

10.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor "IOUs."

10.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Chief Finance Officer.

10.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the NHSFT is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the NHSFT from responsibility for any loss. A senior officer within each area responsible for holding cash, in discussion with the finance department, should ensure there are suitably secure arrangements in place to minimise the risk of loss.

10.4.5 Further guidance is available in FP02-03 Staff Guidance Notes – Cash Income and FP02-02 Safe Custody of Controlled Stationery.

10.5 INCOME FROM NON-PRINCIPAL PURPOSES

10.5.1 The Executive Chief Finance Officer is responsible for monitoring and reporting to the Board of Directors that the NHSFT is complying with its obligation under that the Health and Social Care Act 2012 that the total income derived from its principal purpose (i.e. the delivery of goods and services for the purposes of the health service in England) is greater than its total income from the provision of goods and services for "any other purposes" including the provision of private healthcare.

10.5.2 The Executive Chief Finance Officer is responsible for ensuring that the approval of the Council of Governors is obtained when it is proposed to increase by 5% or more the proportion of income derived from the provision of goods and services for non-primary purposes.

11 Contracts with Commissioners

11.1 The Chief Executive supported by the Executive Directors holding the portfolios of Finance, Operational Services and Contracting, are responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the Operational and Strategic Plans.

11.2 Contracts with commissioners shall be devised to minimise risk. The contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract should be considered.

11.3 In carrying out these functions, the following should be taken into account:

1. activity (e.g. bed days, attendances, etc. attached to the legally binding contracts);
2. payment terms and conditions;
3. billing systems and cash flow management;
4. any other matters of a financial nature;
5. the contract negotiation process and timetable;

6. the provision of contract data;

7. monitoring arrangements;

8. amendments to contracts;

9. discretion to use spare capacity; and

10. any other matter relating to contracts such as joint responsibility for the delivery and achievement of CIPs, QIPPs etc.

11. any requirements of the NHS Constitution.

11.4 Regular reports detailing actual performance against signed contracts should be provided to the Board of Directors by the Directors holding the portfolios of Finance and Performance.

11.5 As required by the NHSFT's Terms of Authorisation, the NHSFT will maintain a public and up-to-date schedule of Commissioner Requested Services.

12 Terms of Service, Allowances and Payment of Executive Directors and Employees

12.1 REMUNERATION AND TERMS OF SERVICE

12.1.1 In accordance with Standing Orders, the Board of Directors shall establish a Remuneration Committee for Executive Directors with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

12.1.2 The Committee will:

a) advise the Board of Directors of their decisions in relation to the remuneration and terms of service for the Chief Executive and Executive Directors including:

i. all aspects of salary (including any performance-related elements/bonuses);

ii. provisions for other benefits, including pensions and cars.

iii. arrangements for termination of employment and other contractual terms;

b) monitor and evaluate the performance of the Chief Executive and Executive Directors

12.2 STAFF APPOINTMENTS

12.2.1 No Executive Director or employee may engage, or re-engage employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Executive

b) unless approved by any establishment control panels in operation at the time; and

c) within the limit of their approved budget and funded establishment.

12.2.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees covered under the national Agenda for Change pay rates.

12.3 PROCESSING PAYROLL

12.3.1 The Executive Chief People Officer, together with support from the Executive Chief Finance Officer where appropriate, is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

12.3.2 The Executive Chief People Officer, together with support from the Executive Chief Finance Officer where appropriate, will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee and officers;

h) procedures for payment by cheque (by exception) or bank credit to employees and officers;

i) procedures for the recall of cheques and bank credits

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash; and

m) a system to ensure the recovery from leavers of sums of money and property due by them to the NHSFT.

12.3.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the relevant Executive Directors instructions and in the form prescribed by the Executive Chief People Officer;

c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement;

d) ensuring staff are notified of any changes affecting their terms and conditions; and

e) where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Head of Employee Relations must be informed immediately.

12.3.4 Regardless of the arrangements for providing the payroll service, the Executive Chief People Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

12.4 CONTRACTS OF EMPLOYMENT

12.4.1 The Board of Directors shall delegate responsibility to the Executive Chief People Officer for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and

b) Dealing with variations to, or termination of, contracts of employment.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

12.5 PAYMENTS TO INDIVIDUALS WHO ARE NOT EMPLOYEES OF THE TRUST

12.5.1 The Executive Chief Finance Officer is responsible for issuing instructions to managers concerning:

a) Making payments of agency invoices

b) Making payments to self-employed individuals

c) Making payments to limited companies

d) Additional compliance requirements to be followed in assessing the employment status of individuals who are not employees of the Trust.

12.5.2 Staff must ensure that all compliance checks in respect of the use of individuals who are not employees of the Trust are completed ahead of any work commencing.

12.5.3 Further guidance is available in FP01-04 Payments to individuals who are not employees of the Trust.

13 Procurement and Non Pay Expenditure

13.1 DELEGATION OF AUTHORITY

13.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

13.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

b) the maximum approval value for each manager and the system for authorisation above that level; and

c) delegate approval for establishing new or amending existing authorised signatories (via associated processes / forms) to the relevant Assistant Director, Director or Executive Director.

13.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

13.2 NON-PAY EXPENDITURE CONTROL PANEL

13.2.1 To ensure robust financial governance and the appropriate use of public funds, the Trust has established a Non-Pay Expenditure Control Panel (NPCP) for the review and approval of all non-pay expenditure proposals exceeding £2,499 including VAT and regardless of funding source.

13.2.2 This control mechanism is a mandatory part of the financial authorisation process and must be followed in addition to existing approval routes defined within the Scheme of Delegation and other relevant Trust policies. Expenditure should not be committed without first obtaining the relevant approval from the panel.

13.2.3 All requests to panel should be made in good time ahead of need or end of existing purchase order / contract.

13.2.4 There are a number of agreed exclusions to the non-pay expenditure control process as detailed on the appropriate form available from the procurement team.

13.2.5 The purpose of the panel is to:

- Ensure that proposed expenditure is necessary, clearly justified and aligned with Trust priorities;
- Support effective budgetary control and maintain compliance with agreed financial plans;
- Confirm that appropriate procurement routes and value for money principles have been applied;
- Reduce the risk of unwarranted or duplicated expenditure by challenging spend proposals and exploring alternative options, including potential joint System procurements.
- Ensure compliance with NHS and public sector financial governance standards;
- Enhance transparency and provide a documented audit trail for decisions related to significant non-pay spend.

13.3 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

13.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the NHSFT. In so doing, the advice of the NHSFT's adviser on supply shall be sought, and policies and procedures on procurement are to be followed at all times including compliance with any non-pay control panels (if in operation). Where this advice is not acceptable to the requisitioner, the Executive Chief Finance Officer (and/or the Chief Executive) shall be consulted.

13.3.2 The Executive Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

13.3.3 The Executive Chief Finance Officer will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be

obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

b) prepare procedural instructions (where not already provided in the Detailed Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of directors/employees authorised to certify invoices

ii. Certification that:

— goods have been duly received, examined and are in accordance with specification and the prices are correct;

— work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

— in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

— where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

— the account is arithmetically correct;

— the account is in order for payment;

— VAT is appropriately accounted for.

iii. A timetable and system for submission to the Executive Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv. Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

13.3.4 Where material (and not agreed under the terms of the contract or licensing arrangements), prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages i.e. cashflows must be discounted to NPV using the base rate specified by the Executive Chief Finance Officer.

b) the appropriate Executive Director must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the NHSFT if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c) the Executive Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

13.3.5 Official Orders must:

a) Be consecutively numbered via an electronic procurement system;

b) Be in a form approved by the Executive Chief Finance Officer;

c) State the NHSFT's terms and conditions of trade;

d) Only be issued to, used by or electronic access granted, to those duly authorised by the Chief Executive.

13.3.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Executive Chief Finance Officer and that:

a) all contracts (other than for a simple purchase permitted within the Detailed Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are actioned as per the NHSFT's procedures;

b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement and comply with the latest Public Sector Procurement Directives. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

c) contracts (including electronic forms of signing e.g. docusign) must only be signed with the prior approval of the procurement / contracts department, and be in line with delegated limits. All contracts must be forwarded to the Procurement department for inclusion in contracts register.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars

   ii. hospitality as per the Trust's policy

e) no requisition/order is placed for any item or items which cannot be accommodated within total available resources;

f) all goods, services, or works are ordered on an official order except those detailed on the 'PO Exceptions List' which is maintained by the Purchasing Department. This includes for example: purchases from petty cash and agency payment, .or where alternative control mechanisms are in place. The Executive Chief Finance Officer or their nominated Deputy should review the 'PO Exceptions List' on an annual basis and ensure, where possible, these are minimised;

g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Executive Chief Finance Officer;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Chief Finance Officer ; and

l) petty cash records are maintained in a form as determined by the Executive Chief Finance Officer.

13.3.7 The Chief Executive and Executive Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

13.4 Further guidance is available in Section 9 of the Standing Orders, CP08 Purchasing Policy, FP01-03 Requisitioning of Goods and Services and FP02-01 Petty Cash Guideline.

14 External Borrowing and Investments

14.1 The Executive Chief Finance Officer will be responsible for the management of the NHSFT's cashflow.

14.2 **EXTERNAL BORROWING**

14.2.1 The Executive Chief Finance Officer will advise the Board of Directors concerning the NHSFT's ability to pay interest on, and repay, both the originating capital debt and any existing or proposed new borrowing. The Executive Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest.

14.2.2 Any application for new borrowing will only be made by the Executive Chief Finance Officer or by an officer so delegated by them. The Board of Directors is required to approve the acceptance of all external borrowing agreements.

14.2.3 The Executive Chief Finance Officer will prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by NHS England.

14.2.4 Assets supporting Commissioner Requested Services (CRS) shall not be used as collateral for borrowing. Non-Commissioner Requested assets will be eligible as security for a loan.

14.3 **INVESTMENTS**

14.3.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within terms of guidance as may be issued by NHSE in accordance with the NHSFT's Operating Cash Management Policy.

14.3.2 The Executive Chief Finance Officer is responsible for advising the Finance and Performance Committee on investment strategy and shall report periodically on the performance of investments held.

14.3.3 The Executive Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

14.4 Further guidance is available in CP40 Operating Cash Management Policy and FP09-10 Operating Cash Management Guideline

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

15 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

15.1 CAPITAL INVESTMENT

15.1.1 The Chief Executive, supported by the Executive Chief Finance Officer:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

15.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is prepared in accordance with the detailed scheme of delegation issued by the Chief Executive on the advice of the Executive Chief Finance Officer and approved by the Board of Directors. Where the financial value outlined in the detailed scheme of delegation is met, the Chief Executive supported by the Executive Chief Finance Officer shall ensure that a business case is produced setting out:

i. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

ii. appropriate project management and control arrangements;

b) that the Executive Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case and where required is submitted to the Board of Directors in accordance with the detailed scheme of delegation;

c) business cases requiring legal and tax expertise have been subjected to appraisal by the NHSFTs legal and tax advisor or the most appropriate legal and tax advice obtained.

15.1.3 For capital schemes where the contracts stipulate stage payments, the Executive Chief Finance Officer will ensure there are processes in place for their management.

The Executive Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Executive Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.1.4 The approval of a detailed capital programme by the Finance and Performance Committee and Board of Directors at the start of the financial year shall constitute approval for the initiation of expenditure on any scheme, subject to any further approvals required by the Digital Strategy Group (for ICT schemes) and associated governance being undertaken. Any new bids made in year or requests to vire money between schemes, need to be presented to the Capital Projects Programme Group and approved in line with the detailed scheme of delegation.

15.1.5 The Executive Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

15.2 PRIVATE FINANCE

15.2.1 The Trust may test for PFI when considering capital procurement. When the Trust proposes to use finance that is to be provided other than through its contracts, the following procedures shall apply:

a) The Executive Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) The proposal must be specifically agreed by the Board.

15.3 PROCURE 23

15.3.1 NHS ProCure 23 has been developed by the Department of Health with the objective of promoting better capital procurement in the NHS.

15.3.2 The Trust may consider P23 as a possible procurement route when considering building projects above the amount specified in the detailed scheme of delegation.

15.3.3 When the Board proposed, or is required, to use the P23 procurement route, the following should apply:

a) The Chief Executive and Executive Chief Finance Officer shall demonstrate that the use of P23 represents the best combination of value for money, project delivery time, and build quality, when compared with alternative procurement routes.

b) The proposal must be specifically agreed by the Board

The selection of a Principle Supply Chairman Partner (PSCP) must be carried out in accordance with Department of Health guidelines.

15.4 ASSET REGISTERS

15.4.1 The Chief Executive is responsible for the maintenance of registers of assets (including Right of Use assets), taking account of the advice of the Executive Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

15.4.2 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets falling within the boundaries of IFRS16 and to be capitalised.

15.4.3 The NHSFT must not dispose of any property that supports a Commissioner Requested Service (CRS) without the agreement of the Trust's main commissioner and notification to NHSE, where notice has been given in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. This includes the disposal of part of the property or granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

15.4.4 The Executive Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in the statement of financial position against balances on fixed asset registers.

15.4.5 All land and buildings should undergo an interim revaluation every third year, and a formal revaluation every five years, in accordance with HM Treasury guidance. Investment properties are revalued on an annual basis.

15.4.6 The value of each asset shall be depreciated using agreed methods and asset lives.

15.4.7 The Executive Chief Finance Officer of the Trust shall calculate and expense capital charges in the form of depreciation and PDC dividends, to the Trust's expenditure budget each month. The Executive Chief Finance Officer shall ensure PDC dividends are paid to HM Treasury in accordance with guidance.

15.4.8 The Board of Directors may approve the disposal of non-CRS assets to raise funds for the development of services

15.5 SECURITY OF ASSETS

15.5.1 The overall control of fixed assets is the responsibility of the Chief Executive, as advised by the Executive Chief Finance Officer for the accounting aspects and for the physical management and control.

15.5.2 Asset control procedures must be approved by the Executive Chief Finance Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to / approved by the Director of Finance or Executive Chief Finance Officer and noted to / approved by the Audit Committee as per the Detailed Scheme of Delegation.

15.5.4 Whilst each employee and officer has a responsibility for the security of property of the NHSFT, it is the responsibility of the Board of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to the property of the NHSFT as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

15.5.5 Any damage to the NHSFT's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

15.5.6 Where practical, assets should be marked as NHSFT property.

15.6 Further guidance is available in FP05-03 Capital Expenditure Sanctioning, FP05-02 Disposal of Fixed Assets, FP05-04 Annual Verification of Assets and Notification of In-Year Transfers and FP05-01 Leasing Procedure.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

16 Stores and Receipts of Goods

16.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stock take;

c) valued at the lower of cost and net realisable value.

16.2 Subject to the responsibility of the Executive Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to employees by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees, subject to such delegation being entered in a record available and approved by the Chief Executive and the Executive Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

16.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

16.4 The Executive Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

16.5 Stocktaking arrangements shall be agreed with the Executive Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

16.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Chief Finance Officer.

16.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Executive Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Executive Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.8 For goods supplied via NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the charge.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

17 Disposals, Condemning, Losses and Special Payments

17.1 DISPOSALS AND CONDEMNING

17.1.1 The Executive Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemning and ensure that these are notified to managers. The NHSFT must not dispose of property that supports Commissioner Requested Services (CRS) without the approval of the Trust's commissioners and without informing NHSE, if NHSE has given notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern. These procedures shall comply with all appropriate Standing Orders and SFI's in addition to the requirements specified in the NHSFTs Policies and Procedures manual.

17.1.2 When it is decided to dispose of an NHSFT asset, the head of department or authorised deputy will determine and advise the Executive Chief Finance Officer of the estimated market value of the item, taking account of professional advice valuations where appropriate

17.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Chief Finance Officer;

b) recorded by the Condemning Officer in a form approved by the Executive Chief Finance Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Chief Finance Officer.

17.1.4 Officers shall satisfy themselves as to whether or not to condemn, where evidence of negligence and shall report such evidence to the Executive Chief Finance Officer who will take the appropriate action.

17.1.5 Further information is available in FP05-02 Disposal of Fixed Assets and RM13 Waste Management Policy.

17.2 LOSSES AND SPECIAL PAYMENTS

17.2.1 The Executive Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

17.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Executive Chief

Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Executive Chief Finance Officer must immediately inform the police, following consultation with the Violence and Abuse Prevention and Reduction Advisor (VAPR), if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Executive Chief Finance Officer must inform the Counter Fraud / Anti-Crime Specialists.

17.2.3 The Executive Chief Finance Officer must notify the NHS Counter Fraud Authority (via the appointed Counter Fraud / Anti-Crime Specialist) and the External Auditor of all frauds.

17.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Chief Finance Officer must immediately notify:

a) the Board of Directors

b) the Local Security Management Specialist; and

c) the External Auditor.

17.2.5 The approval of the writing-off of losses is delegated to the Director of Finance or Executive Chief Finance Officer only. Delegated limits are set out in the detailed scheme of delegation.

17.2.6 The Executive Chief Finance Officer shall be authorised to take any necessary steps to safeguard the NHSFT's interests in bankruptcies and company liquidations.

17.2.7 For any loss, the Executive Chief Finance Officer should consider whether any insurance claim could be made.

17.2.8 The Executive Chief Finance Officer shall maintain a Losses and Special Payments Register.

17.2.9 Further detailed guidance is available in FP09-01 Losses and Special Payments.

18 Information Technology

18.1 The Executive Director with the portfolio for ITT, and who is responsible for the accuracy and security of the computerised data of the NHSFT, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the NHSFT's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation 2016;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system (including those obtained by external agency arrangements) and that such computer audit reviews as they may consider necessary are being carried out.

18.2 The Executive Chief Finance Officer, in conjunction with the ITT department, shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible NHS bodies, directors and employees will send to the Executive Director with the portfolio for ITT:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.4 The Executive Director with the portfolio for ITT shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.5 Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director with the portfolio for ITT shall periodically seek assurances that adequate controls are in operation.

18.6 Where computer systems have an impact on corporate financial systems the Executive Chief Finance Officer in conjunction with Executive Director with portfolio for ITT, shall satisfy themselves that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) finance staff have access to such data; and

d) Such computer audit reviews are being carried out as are considered necessary.

19 Patients' Property

19.1 The NHSFT has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

19.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

That the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

19.3 The Executive Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

19.4 The NHSFT will maintain a separate account for patients' money, which will be opened and operated under arrangements agreed by the Executive Chief Finance Officer. Any income relating to patients money which may temporarily be included within exchequer funds, will be reconciled and reported separately on a regular basis.

19.5 In all cases where property of a deceased patient is of a total value in excess of £10,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £10,000 or less, forms of indemnity shall be obtained.

19.6 Staff should be informed, on appointment, by the appropriate senior manager of their responsibilities and duties for the administration of the property of patients.

19.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.8 Further detailed guidance is available in FP09-02 Patient Property and Money Procedure and FP09-02a Welfare Department Procedure.

20 Funds Held on Trust (Charitable Funds)

20.1 Standing Orders state the NHSFT'S responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the NHSFT, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust.

20.2 The Schedule of Reservation and Delegation and the Detailed Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom.

20.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

20.4 The over-riding principle is that the integrity of each fund must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20.5 The Board of Directors hereby nominates the Executive Chief Finance Officer to have primary responsibility to the Board of Directors for ensuring that Funds Held On Trust (Charitable Funds) are administered in line with our Standing Orders, Charity Commission guidance and other statutory provisions. The Executive Chief Finance Officer will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of all Trust Funds for the discharge of the Board of Directors responsibilities as Corporate Trustees.

20.6 Further detailed guidance is available in FP09-03 Charitable Funds.

21 Acceptance of Gifts by Staff and Declaration of Interest

21.1 The acceptance of gifts, hospitality or consideration of any kind from contractors or other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The NHSFT's standards of business conduct guidance (copy available from the Trust Secretary's Office), must be followed, and the Chief Executive notified immediately so that appropriate action can be taken.

21.2 The Chief Executive shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff.

21.3 The Trust Secretary should review the Register of Interests for the Trust on an annual basis to tie in with the disclosures within the annual accounts.

21.4 The Register of Interests should also be referred to, prior to any major contracts in excess of £500,000 being awarded.

22 Retention of Documents

22.1 The Chief Executive, and the relevant Executive Director, shall be responsible for maintaining archives for all documents required to be retained.

22.2 The documents held in archives shall be capable of retrieval by authorised persons.

22.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

23 Insurance and Risk Management

23.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

23.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) decision on which risks shall be insured; and

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing the Annual Governance Statement within the Annual Report and Accounts.

23.3 The Board of Directors shall decide if the NHSFT will insure through the risk pooling schemes administered by NHS Resolution) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decide not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

23.4 The Executive Chief Finance Officer is required to consider and make proposals to the Board of Directors regarding commercial insurance. In addition, the Executive Chief

Finance Officer will consider the use of top-up building insurance to the NHS Resolution risk pooling scheme where appropriate.

23.5 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Executive Director for Governance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Senior Director for Corporate Governance shall ensure that documented procedures cover these arrangements.

23.6 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Executive Director for Governance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Executive Director for Governance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

23.7 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Executive Director for Governance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

24 New Business/ Income Opportunities

24.1 The Chief Executive will ensure that there are processes in place to oversee the management of New Business Development and Income Generation opportunities. Such processes must ensure compliance with the Trust's terms of authorisation and adherence to NHS Oversight Framework and mandatory reporting requirements. The Trust's processes will also adhere to best practice guidance including Risk Evaluation for Investment Decisions (REID) or any subsequent guidance that may be issued by NHSE.

24.2 The Board of Directors will ensure there is a governance framework in place to scrutinise and consider any new initiatives which contain one or more of the following characteristics:

- an equity component;
- significant reputational risk;
- potential to destabilise the Trust's core business;
- the inclusion of material contingent liabilities.

24.3 In the event a 'significant transaction' is being considered, then the Council of Governors also need to be involved in the approval process. The term 'significant transaction' is as per NHS definition detailed in the Oversight Framework, plus any other transaction in excess of a £10 million threshold and which has an overall risk

rating (based on the Trust's risk management framework) which in the reasonable opinion of the Board of Directors, is considered to be significant.

24.4 The Finance and Performance Committee shall be chaired by a Non-Executive Director and comprise both Executive and Non-Executive Directors. The remit of this Committee will include:

- to establish the overall methodology, processes and controls of the Trust's investments and marketing initiatives/opportunities;
- to ensure that robust processes are followed;
- to ensure that Council of Governors approval has been obtained for any investment that would increase the proportion of income from non-principle purposes by 5% or more;
- to evaluate, scrutinise and monitor significant investments and marketing initiatives / opportunities.
- to ensure appropriate safeguards are in place for the investment of exchequer funds and review treasury management activities and performance.

24.5 The committee will also be responsible for consideration of investments or marketing initiatives / opportunities:

- where a change to the Trust's corporate structure is required (for example establishment of subsidiary vehicle);
- there is potential significant risk associated with the project in accordance with REID or established best practice guidelines.

24.6 The initial evaluation of any initial marketing opportunities and to engage in any tender processes may be delegated by the Board of Directors to the Executive Operational Committee, and / or the Finance and Performance Committee in accordance with approved limits.

24.7 Approval of new contracts in relation to new business opportunities will be the responsibility of the Board of Directors unless delegated to the Executive Operational Committee within approved limits.

25 Training requirements

All Budget Holders are required to adhere to this document with queries directed to their relevant Finance Business Partner in the first instance.

26 Monitoring and audit

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Monitoring of compliance with this document is undertaken by senior Trust staff and Trust auditors. Non-compliance can lead to disciplinary action being taken.

27 Approval and implementation

27.1 The Standing Financial Instructions will be approved by the Board of Directors based on recommendation from the Audit Committee.

28 Preliminary equality analysis

28.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

(Refer to Appendix 1)

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 1: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Date (DD/MM/YYYY)	24/10/2025	
Directorate / locality / department	Finance	
Name of new policy / service / function	Annual review	
Is this a new policy / service / function or a change / review to an existing one?	Annual review	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: Clare Barley	Role: Head of Financial Accounts
	Name:	Role:
	Name:	Role:
Name of relevant director of services	Simon Covill	
Contact email address of lead assessor	c.barley@nhs.net	

Actions as a result of this EIA:
Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)		**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:		**Role:**	
Date:			

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	N	
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	N	
Age	N	
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	N	
People who are/were Married or are/were in a Civil Partnership	N	
People who are Pregnant or are on Maternity / Paternity Leave	N	
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	N	
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	N	
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	N	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	N	

Essex Partnership University NHS Foundation Trust

Document title:	**DETAILED SCHEME OF DELEGATION**		
Document reference number:	FP11	**Version number:**	sV 2.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Clare Barley, Head of Financial Accounts		
Approval group/ committee(s):	Audit Committee		07 November 2025
Professionally approved by: (Director)	Simon Covill, Director of Finance		
Executive Director:	Trevor Smith, Executive Chief Finance Officer / Deputy Chief Executive		
Ratification group(s):	Board of Directors		04 December 2024
CQC Quality Statement	Well-Led - Governance		
Key word(s) to search for document on Intranet / TAGs:	Scheme of Delegation, DSoD, limits	**Distribution method:**	☐Intranet

Initial issue date:	01 April 2017	**Last Review date:**	04 December 2024	**Next Review date:**	01 September 2025	**Expiry Date:**	01 December 2025

Controlled Document

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance Officer

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1.0	Associate Chief Finance Officer (SEPT)		01 April 2017
2.0	Head of Financial Accounts	Not documented	26 September 2018
3.0	Head of Financial Accounts	Not Documented	26 September 2018
4.0	Head of Financial Accounts	Not Documented	01 September 2019
4.0	Head of Financial Accounts	Annual Review	01 September 2020
5.0	Head of Financial Accounts	Not Documented	01 September 2021
6.0	Head of Financial Accounts	Not Documented	01 September 2022
6.1	Head of Financial Accounts	LCFS changed to CF / ACS (Counter Fraud / Anti-Crime Specialist(s)) throughout	01 September 2022
7.0	Head of Financial Accounts	Annual review 2(w) – Change relates to SFI 9.2.6c to provide clarity that contracts should not be signed without the prior approval of the procurement / contracts department, and then once approval has been obtained, this needs to be in line with delegated authority limits 17e(ii) – Further clarity provided to confirm that travel expenses in excess of 3 months need to be approved by the ECFO and Director of HR / Associate Director of HR / HR Business Partner 22 – Updated to reflect responsibility for insurance 38 – Use of seal has been updated from requiring Chair / Chief Executive to any two Executive Directors following amendment to Standing Orders	01 September 2023
7.1	Head of Financial Accounts	Extension Approved for review – January 2025	01 March 2024
8.0	Head of Financial Accounts	Annual review – updates include need for timely completion of staff change forms and Budget Holder approval of staff lists, reference to	04 December 2024

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
		establishment and non pay control panels, and introduction of Provider Selection Regime.	
sV1.0	Policy Team	Uploaded to SOPHIA document library	21 March 2025
sV2.0	Head of Financial Accounts	Annual review: new procurement regulations and associated changes to quotation and tendering limits.	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DETAILED SCHEME OF DELEGATION

BM	Budget Managers
HoE	Head of Estates / Property Management
CEO	Chief Executive Officer
ECFO	Executive Chief Finance Officer
ECPO	Executive Chief People Officer
DoF	Director of Finance
HoF	Heads of Finance
HoFA	Head of Financial Accounts
DHoFA	Deputy Head of Financial Accounts
HoP	Head of Procurement
HRBP	HR Business Partner
AD	Assistant / Deputy Directors or direct report to a Director
Dir	Director / Senior Director (but not a formal member of the BoD)
ED	Executive Director
EoC	Executive Operational Committee
BoD	Board of Directors
FPC	Finance and Performance Committee
CPPG	Capital Projects Programme Group
PORG	Policy Oversight and Ratification Group
ECP	Establishment Control Panel

The above titles may change as restructures are undertaken. Equivalent job titles may need to apply in terms of the authority being delegated and where this is uncertain, approval from the finance department should be sought.

In the event that staff to which authority has been delegated are absent, then approval / authority reverts to line manager or equivalent (and related) post.

All limits quoted are assumed to include VAT irrespective of whether this is reclaimable or not.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

		AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.1	**MANAGEMENT OF BUDGETS (PAY, NON PAY AND INCOME) IN LINE WITH GOVERNANCE MANUAL**		
a	At individual budget level	BM	SFI Section 3 / FP03-01 Budgetary Control
b	At service level	AD, Dir or ED	
c	For the totality of services covered by the Assistant Director (or equivalent) or Service Director	Dir, ED or CEO	
d	For all other areas (including, but not limited to, utility bills, phone bills, inter-NHS invoices, lease car invoices, which may be charged to a delegated budget or control account).	DoF, HoF, HoFA or DHoFA	
e	Approval of authorised signatory forms (revenue, capital and charitable)	AD, Director or ED	
f	Approving expenditure (revenue or capital) up to an increase of 10% on the tender price or £20k whichever is the lower.	Director	
g	Approving expenditure as above, but up to a maximum of £100k.	ED	
h	Approving expenditure as above, but over £100k	BoD	
i	Compliance with all Establishment Control and Non-Pay Control Panels	All Staff	
2.1	**NON-PAY REVENUE AND CAPITAL EXPENDITURE – APPROVAL OF REQUISITIONS, ORDERING AND PAYMENTS OF GOODS AND SERVICES (INCLUDING STAND-ALONE SYSTEMS E.G., NHS SUPPLY CHAIN) AND SIGNING OF CONTRACTS**		

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Requisitions / invoices must not be raised in such a way to bypass financial limits or establishment and non-pay control panels.				
a	i)	Up to an individuals authorised signatory limit but not exceeding £4,999	Other Authorised Staff	SFI Section 9 / FP01-03 Requisitioning of Goods and Services
	ii)	Requisitions / invoices up to £9,999	Budget Manager	
	iii)	Requisitions / invoices up to £24,999 or up to individuals authorisation limit (whichever is lowest)	Assistant Director	
	iv)	All requisitions / invoices from £25,000 to £49,999	Director or ED	
	v)	All requisitions / invoices from £50,000 to £99,999	Executive Director / Director of Pharmacy (drugs only)	
	vi)	All requisitions / invoices from £100,000 to £249,999	CFO or CEO	
	vii)	All requisitions / invoices from £250,000 to £999,999 (where requisition is supported by a signed contract, either the CFO or CEO can approve requisition)	CFO and CEO	
	viii)	All requisitions / invoices over £1 million with exception of agreed exemptions:	Reserved for Board and verification against Register of Interest	
		• All payroll related transactions including HMRC, pensions and deductions via payroll provider / direct engagement supplier	DoF, HoFA, HoF or DHoFA	
		• All NHS and independent sector transactions relating to the East of England provider collaborative and the Mid and South Essex community collaborative arrangements	CFO and CEO	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

• NHS Commissioned Contracts and sub contracts that flow from them and for Provider Selection Regime (PSR) awards	CFO and CEO	
ix) Placing official orders on receipt of a signed valid requisition up to £249,999	HoP	
x) Placing official orders on receipt of a signed valid requisition over £250,000	HoP with CEO, ECFO, DoF, HoF or HoFA	
xi) Signing of contracts (including electronic signing e.g Docusign) – All contracts must be shared with Procurement team for addition to the contracts register.	Directors and above subject to limits above in (iv) to (viii) post procurement / contracts approval	
b Non-pay expenditure in excess of allocated resources and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a) to (viii).	Dir, ED or CEO	
2.2 BUDGET VIREMENTS		
a **Virements within a cost centre / care group / directorate**		SFI Section 3 / FP03-01 Budgetary Control
i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	
ii) Within pay / non-pay lines above £100,000 and all transfers between pay and non-pay lines	Dir or ED	
b **Virements between care groups / directorates**		
i) Within pay / non-pay lines (but excluding transfers between pay and non-pay) up to £100,000	BM	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	ii) Within pay / non-pay lines above £100,000 and all transfers between pay and non-pay lines	Dir or ED	
3.1	**CAPITAL EXPENDITURE**		
a	Approval of the release of funds to individual capital schemes and ability to vire between capital allocations,		SFI Section 11
	i) Up to £100,000	CPPG (with noting to FPC)	
	i) Up to £999,999	CEO or ECFO (with noting to FPC)	
	ii) Over £1,000,000	FPC	
b	Approval of any new capital allocations not included in Operational Plan, and any requests which exceed total capital allocated in Operational Plan	FPC	
c	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations.	Director for Estates / HoE	
d	Financial monitoring and reporting on all capital scheme expenditure.	ECFO / DoF	
3.2	**LEASES/LICENSES/PFI**		
a	Extension of existing or new leases for equipment and other assets, where there is a pre-negotiated framework agreement lease and no Right of Use Asset arising (e.g. photocopier)	As per 2.1	FP05-01 Leasing Procedure
b	Termination of lease relating to pre-negotiated framework agreement lease and no right of use asset	BH in conjunction with Purchasing Department	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

c Extension of existing or new leases containing a Right of Use Asset (equipment or property) and with whole lease term revenue or capital impact of,		
i) Up to £100,000	CPPG	
ii) Up to £999,999	CEO or ECFO	
iii) Over £1,000,000	FPC	
d Termination of lease containing a Right of Use Asset	CPPG	
e Letting of premises to outside organisations	CPPG on recommendation of Director of Estates	
f Approval of rent based on professional assessment	CPPG on recommendation of Director of Estates	
g Preparation and signature of all tenancy agreements / licences for all staff subject to Trust Policy on accommodation to staff	HoE / Director of Estates	
h Capital and revenue variations to PFI contract	Limits as per 3a	
4 REQUIREMENTS FOR QUOTATION, TENDERING AND CONTRACT PROCEDURES FOR EXPENDITURE / INCOME PROPOSALS, WHETHER CAPITAL OR REVENUE, PURCHASES OR DISPOSALS		
In line with regulatory thresholds, limits are based on the value for the length of the contract. In the interest of ensuring that a wide range of contractors have the opportunity to submit competitive quotations, each competitive quotation exercise should, where possible, provide for the opportunity for at least one contractor to bid that has not quoted within the preceding		SFI Section 11 / Standing Orders Section 9

12 months. Contract opportunities will be advertised on the 'Contract Finder' website (or relevant system in use) in line with current DH limits.

The use of framework agreements should be considered where appropriate.

All quotes and Bid Request/Option Appraisal/FBC should be appended to order when raised.

Goods / services must not be ordered in such a way as to bypass financial limits stated in the Governance Manual or compliance with non-pay control panels.

a Obtaining a minimum of 3 written quotations (with support from procurement) for all goods/services over £12,000 and up to £74,999.

b Obtaining a minimum of **3 written quotations** including a clear auditable selection process and Bid Request form recommended by CPPG where applicable,

- for goods/services from £75,000 to £139,688 (to £135,018 from January 2026)
- for construction works from £75,000 to £499,999

c i) Invite a minimum of 5 bidders (where available) to submit written competitive tenders with Options Appraisal form recommended by CPPG where applicable,

- for goods/services from £139,689 (from £135,018 from January 2026) to £999,999
- for construction works from £500,000 to £999,999

ii) Invite a minimum of 5 bidders (where available) to submit competitive tenders for goods / services above £1,000,000 (including construction works) with Full Business Case recommended by CPPG where applicable

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	d New business developments and Income Generation opportunities. The ability to approve tender submissions where;		SFI Section 20
	i) Annual Tender price up to £10m.	EOC	
	ii) Annual Tender price above £10m	BoD	
	iii) Annual Tender price on Sole Supplier cumulatively on a number of different projects above £10m.	BoD	
	iv) All transactions deemed to be significant in terms of a deminimus limit of £10m (per annum) and the Trusts risk management framework (and in addition to above delegated approval) require involvement of Council of Governors		
	e Approval of contract in reference to new business ventures	BoD	
5	**SETTING OF FEES AND CHARGES** (subject to 4e for new business / tender opportunities)		
	a Overseas visitors, income generation and other ad-hoc patient related services	ECFO and Operational ED's	SFI Section 6 and 7
	b Price of NHS Contract Charges for all NHS legally binding contracts be they block, cost per case, cost and volume or spare capacity	CEO and ECFO	
6	**ENGAGEMENT OF STAFF NOT ON THE ESTABISHMENT**		
	a Booking of medical locums	Medical ECP	HR40 Deployment of Temporary Workers Policy
	b Booking of nursing agency staff • Less than 4 weeks utilisation	BM	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

• Non establishment post • More than 4 weeks utilisation • Price cap breach / Healthcare Assistant agency use	Daily Oversight Group ECP Director or ECP	
c Booking of other clinical staffing groups • Less than 4 weeks utilisation • More than 4 weeks utilisation / non-establishment post • Price cap breach	 BM ECP Director or ECP	
d Booking of all other agency staff • Admin and clerical • Other	 ECP and NHSE ECP	
e Breaching of agency cap and thresholds • Rate greater than £750 per day • Rate greater than £100 per day • Rate 50% above price cap	 NHSE CEO or On Call ED CEO or On Call ED	
7 ENGAGEMENT OF CONSULTANCY SERVICES (as defined by prevailing NHSE guidance and applicable to revenue expenditure only)		
a Up to £49,999 (including irrecoverable VAT and costs / expenses)	Dir or ED (and noting to Audit Committee)	
b Over £50,000 (including irrecoverable VAT and costs / expenses)	NHSE via EOC using Consultancy Template (and noting to Audit Committee)	
8 EXPENDITURE ON CHARITABLE AND ENDOWMENT FUNDS		
a Up to £5,000 per request or up to individuals charitable fund authorised limit	Fund Manager or nominated deputy	SFI Section 16 /

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

b Up to £5,000 per request	Fund Manager or Service Director	FP09/03 Charitable Funds
c Up to £10,000 per request	Charitable Fund Committee	
d Above £10,000 per request or above authorisation limit	BoD	
e Overall financial management of Charitable Funds	Financial Trustee	
f Overall management of Charitable Funds	BoD	
9 CONDEMNING AND DISPOSAL		
a Items of equipment which are obsolete, obsolescent, redundant, irrepairable or cannot be repaired cost effectively:		SFI Section 13 / FP05/02 / RMPG13c
i) Individual items not on the asset register	BM or Facilities	
ii) Individual items on the asset register up to £10,000	DoF (& noting to Audit Committee)	
iii) Individual items on the asset register up to £100,000	ECFO (& noting to Audit Committee)	
iv) Individual items on the asset register above £100,000	Audit Committee (& noting to BoD)	
b Land and buildings which are surplus to Trust requirements or held for sale	BoD (as detailed in Operational / Annual Plan)	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

10	**DEBTOR WRITE OFFS / OTHER WRITE OFFS / LOSSES AND SPECIAL PAYMENTS**		
	a Up to £10,000 per item	DoF (& noting to Audit Committee)	SFI Section 13 / FP09/01
	b Between £10,000 and £99,999	ECFO (& noting to Audit Committee)	
	c Over £100,000 per item	Audit Committee (& noting to BoD)	
	d Special Severance Payments (irrespective of value)	HM Treasury	
	e Financial remedy to a complaint:		CPG2 (Appendix 2)
	i) A direct quantifiable loss of up to £50	Director	
	ii) A direct quantifiable loss of over £50 / All non-quantifiable losses	ECFO, NED & Lead Director for Complaints	
	iii) All financial remedies approved by the Ombudsman	Director or ED for relevant service	
11	**REPORTING OF INCIDENTS TO THE POLICE**		
	Where a criminal offence is suspected of a non-fraud nature	Diector, AD, Managers, ECFO, DoF or nominated deputy	SFI Sections 2 and 13
	Where a criminal offence is made against a member of staff	All staff	
12	**PETTY CASH DISBURSEMENTS**		
	a Expenditure up to £100	Petty Cash Holder	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

b Expenditure in excess of £100	Approval of CEO, ECFO or DoF	
c Reimbursement of clients' money	Welfare & Cashier Officer	
13.1 RECEIVING GIFTS		
a Gifts from current or potential suppliers / contractors:		
i) Low cost branded promotional items (e.g. pens / post-its) up the value of £6 can be accepted and do not need to be declared	All staff	
ii) Anything else should be declined whatever their value	All staff	
b Gifts from other sources (e.g. patients, families, service users):		
i) All cash and vouchers to individuals to be declined	All staff	
ii) Modest gifts of less than £50 can be accepted and need not be declared	All staff	
iii) Gifts over £50 can be accepted on behalf of the Trust (not by individual) with the approval of the Service Director and must be declared	Director & Declaration Form	
13.2 ACCEPTING HOSPITALITY		
a Meals and Refreshments:		
i) Under £25 can be accepted and need not be declared	All staff	
ii) Between £25 and £75 can be accepted and must be declared	All staff & Declaration Form	
iii) Over £75 are to be routinely declined	All staff	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

iv) In exceptional circumstances, over £75 can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
b Travel and Accommodation:		
i) Modest offers related to attendance at events can be accepted and must be declared	All staff & Declaration Form	
ii) In exceptional circumstances, other offers which go beyond modest or are of the type the Trust would not usually offer can be accepted with the approval of the Service Director and must be declared	Director (in writing) & Declaration Form	
13.3 OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)		
a Outside employment	All staff & Declaration	
b Shareholdings and other ownership issues	All staff & Declaration	
c Patents / intellectual property rights	All staff & Declaration	
d Loyalty interests	All staff & Declaration	
e Accepting sponsorship	Director in conjunction with Trust Secretary	
f Sponsored research	Research & Innovations Department	CPL19
g Sponsored posts	HR Business Partner and HoF	
h Clinical private practice	All staff & Declaration	CP48 / CPG48
13.4 DONATIONS TO EPUT CHARITY		

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	a From current / potential suppliers should be declined	All staff	Charitable Funds Policy & Procedure
	b In exceptional circumstances, such donations can be accepted with the approval of the Service Director and must be declared	Director & Declaration Form	
	c Other donations / legacies can be accepted	All staff	
13.5	**OTHER INTERESTS / DECLARATIONS (ALL TO BE DECLARED)**		
	At every stage of procurement, steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. Records will be kept that show a clear audit trail of how conflicts have been identified and managed. Conflicts of interest must be declared.	All staff & Declaration	CP8 / CPG8
14	**IMPLEMENTATION OF INTERNAL / EXTERNAL AUDIT AND COUNTER FRAUD / ANTI-CRIME RECOMMENDATIONS**	Directors	SFI Section 2
15	**MAINTENANCE AND UPDATE OF TRUST FINANCIAL PROCEDURES**		
	a Approval of finance policies and procedures	PORG	
16	**INVESTMENT OF FUNDS**		
	a Investment of Exchequer Funds (day to day)	DoF	SFI Section 5
	b Investment of Charitable Funds	Charitable Funds Committee	SFI Section 16 / FP09/03a (appendix 1)
17	**PERSONNEL AND PAY**		SFI Section 8

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

a		**Additional Increments** The granting of additional increments to staff within budget and where level is not supported by service / experience or in line with NHS terms and conditions	Remuneration Committee	HR57 / HRPG57
b		**Upgrading and Regrading** All requests for upgrading / regrading shall be dealt with in accordance with Trust Procedure and there shall be no provision beyond this for regrading of posts	Care Group ECP in conjunction with HRBP	Job Matching and Evaluation Policy and Procedure HR15 / HRPG15
c		**Establishments**		
	i)	Additional staff to the agreed establishment with specifically allocated finance	Care Group ECP	
	ii)	Additional staff to the agreed establishment without specifically allocated finance	Care Group ECP	
d		**Pay**		
	i)	Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director or AD of HR, Director, BM or Manager with delegated authority	
	ii)	Authority to complete and authorise positive reporting forms / finalise rotas in Health Roster	Director, AD, BM or Manager with delegated authority	
	iii)	Authority to authorise overtime	Director, AD or ECP	
e		**Travel and Subsistence Expenses**		

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	i)	Authority to approve up to three months following month in which expense was incurred	AD, BM or Manager with delegated authority	
	ii)	Authority to approve if over three months following month in which expense was incurred	Director of Service and HRBP	
f		**Leave**		
	i)	Approval of annual leave	Line or Departmental Manager	
	ii)	Approval of carry forward in exceptional circumstances of annual leave up to a maximum of one week (of contractual hours)	Line or Departmental Manager	
	iii)	Approval of carry forward of more than one week (of contractual hours) of annual leave where there has been no long term absence in the year	ECPO	
	iv)	Approval of carry forward of more than one week (of contractual hours) of annual leave where there has been absence due to maternity / long term sickness	Line Manager in accordance with Equality	Employee Wellbeing & Management of Sickness Absence (HR26 / HRPG26b), Maternity & Adoption, Paternity, Parental Leave & Shared Leave Procedure (HRPG24b)
	vi)	Compassionate leave (see HR Policy for limits)	Line or Departmental Manager	Leave Policy HR24 / Special Leave

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

			Procedure HRPG24c
	vii) Special leave arrangements including paternity and carers leave (see HR Policy for limits)	Line or Departmental Manager	Special Leave Procedure HRPG24c
	viii) Leave without pay	Director	Special Leave Procedure HRPG24c
	ix) Medical staff leave of absence	Medical Director or Deputy Medical Director & CEO	
	x) Time off in lieu	Line or Departmental manager in accordance with local procedures / AFC terms and conditions	
	xi) Maternity leave – paid and unpaid	Automatic approval with guidance	Leave Policy HR24 / HRPG24b
g	**Sick Leave**		
	i) Reinstatement of half pay in accordance with S14.9 of AfC terms and conditions of service	Director	Employee Wellbeing & Management of Sickness Absence Policy / Procedure HR26 / HRPG26b
	ii) Return to work part time on full pay to assist recovery	Line Manager in accordance with Equality Act	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	iii)	Extension of sick leave on full pay or half pay in accordance with Section 14.12 of AfC terms and conditions	Director in conjunction with AD, Head of Operational HR or HRBP	
h		**Extended Study Leave or Study Leave Outside the UK**		
	i)	Study leave outside the UK	Relevant Remuneration Committee & Workforce Development Approval Panel	Whitley Council / NHS T&Cs (AFC) & CE / Study Leave Policy HR18
	ii)	Medical staff study leave (UK)	Workforce Development Approval Panel	Trainee & Trust Grade Doctors Procedure HRPG18c
	iii)	All other study leave (UK)	Workforce Development Approval Panel	Study Leave Policy & Procedure HR18 / HRPG18a/b
	iv)	General study leave	Line Manager	
i		**Relocation Expenses**		
		Authorisation of payment of relocation expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		HR57 / HRPG57
	i)	Up to £8,000	Director	
	ii)	Over £8,000	CEO / ECPO	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	j	**Authorised Mobile Phone Users**		
	i)	Requests for new posts to be authorised as mobile telephone users	Director (plus Director for IT)	
	k	**Renewal of Fixed Term Contract**	Care Group ECP in accordance with Recruitment & Retention Policy (HR57)	HR57 / HRPG57
	l	**Redundancy** All redundancies arising from organisational change or ending of a fixed term contract (where applicable)	ECPO and ECFO (after approval by EOC and completion of Redundancy Recommendation Form)	Organisational Change Policy and Procedure HR1 / HRPG1a
	m	**Ill-Health Retirement** Decisions to pursue retirement on the grounds of ill-health	Line or Departmental Manager in accordance with Trust Procedure and in conjunction with Occupational Health and HR Department	HR26 / HRPG26b / HRPRG27a
	n	**Dismissal** (including ending of Fixed Term Contracts)	In accordance with Trust Procedure	HR1 / HR27a / HR26 / HR56 / HR59
18	**AUTHORISATION OF NEW DRUGS**			
	a			

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

		With additional implications of up to £9,999 per annum (compared with existing therapy)	Medicines Management Group	
	b	With additional implications of over £9,999 per annum (compared with existing therapy)	Quality of Care Group	
19	**AUTHORISATION OF SPONSORSHIP DEALS**			
	a	Authorisation of commercial sponsorship deals up to £500	Line Manager (noting by Trust Secretary)	CLP51 Hospitality and Sponsorship (includes approval forms)
	b	Authorisation of commercial sponsorship deals between £501 and £1,000	Director (noting by Trust Secretary)	
	c	Authorisation of commercial sponsorship deals over £1,000	Director of Pharmacy and Medicines Management Group (noting by Trust Secretary)	
20	**AUTHORISATION OF RESEARCH PROJECTS**		Research & Innovation Oversight Group	
21	**AUTHORISATION OF CLINICAL TRIALS**		Research & Innovation Oversight Group	
22	**INSURANCE POLICIES AND RISK MANAGEMENT**			
	a	Risk Management and NHS Resolution	Executive Director for Governance	SFI 19
	b	Commercial Insurance (e.g. property, fleet)	ECFO	SFI 19

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

23	**PATIENTS AND RELATIVES COMPLAINTS**			
	a	Overall responsibility for ensuring that all complaints are dealt with effectively	Lead Director for Complaints	CP02 Complaints Policy
	b	Responsibility for ensuring complaints relating to a directorate are investigated thoroughly	AD	
	c	Medico-legal complaints – co-ordination of their management	Lead Director for Complaints	
24	**RELATIONSHIPS WITH PRESS**			
	a	Non-emergency general enquiries		CP51 Media Policy
	i)	Within hours	Director of Communications or Communications Team	
	ii)	Outside hours	On Call Press Officer or Senior Communications Rota	
	b	Emergency enquiries		
	i)	Within hours	Director of Communications or Communications Team	
	ii)	Outside hours	On Call Press Officer or Senior Communications Rota	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

25	**INFECTIOUS DISEASES AND NOTIFIABLE OUTBREAKS**	Duty Officer, Director on Call or ED for Operations	
26	**EXTENDED ROLE ACTIVITIES**		
	Approval of nurses to undertaken duties / procedures which can properly be described as beyond the normal scope of Nursing Practice	CEO, Medical Director and Executive Nurse	
27	**PATIENT SERVICES**		
	a Variation of operating and clinic sessions within existing numbers, i) Outpatients ii) Other	EDs in consultation with Medical Director EDs in consultation with Medical Director	
28	**FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE**		
	Professional recognition, honorary contracts and insurance of medical staff Work experience students	Director Director	HR23 Placement & Work Experience Policy
29	**REVIEW OF FIRE PRECAUTIONS**	Fire Safety Officer	
30	**REVIEW OF ALL STATUTORY COMPLIANCE LEGISLATION AND HEALTH AND SAFETY REQUIREMENTS, INCLUDING CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH**	Head of Corporate H&S and VAPR	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

31	**REVIEW MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AUTHORITY (MHRA) AND DRUG ALERTS ISSUED BY THE CENTRAL ALERTING SCHEME**	Director of Pharmacy or Accountable Officer for Controlled Drugs	
32	**REVIEW COMPLIANCE WITH ENVIRONMENTAL REGULATIONS (EG THOSE RELATING TO CLEAN AIR AND WASTE DISPOSAL)**	HoE and AD's	
33	**REVIEW OF TRUST'S COMPLIANCE WITH THE DATA PROTECTION AND FREEDOM OF INFORMATION ACTS**	Lead AD or Lead Director for Data Protection & FOI	
34	**MONITOR PROPOSALS FOR CONTRACTURAL ARRANGEMENTS BETWEEN THE TRUST AND OUTSIDE BODIES**	Lead Director for Contracting	
35	**REVIEW THE TRUST'S COMPLIANCE WITH ACCESS TO RECORDS ACT**	Lead Director for Information	
36	**REVIEW OF THE TRUST'S COMPLIANCE CODE OF PRACTICE FOR HANDLING CONFIDENTIAL INFORMATION IN THE CONTRACTING ENVIRONMENT AND THE COMPLIANCE WITH SAFE HAVEN PER EL(92)60**	Lead Director for Information	
37	**THE KEEPING OF A DECLARATION OF INTERESTS REGISTER**	Trust Secretary / ED	SO Section 6
38	**ATTESTATION OF SEALINGS IN ACCORDANCE WITH STANDING ORDERS AND USE OF SEAL**	Any two Executive Directors	SO Section 12
39	**THE KEEPING OF A REGISTER OF THE USE OF THE TRUST SEAL**	Trust Secretary	SO Section 12
40	**THE KEEPING OF THE HOSPITALITY REGISTER**	CEO and Directors for their respective services	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

41	**RETENTION OF RECORDS**	Lead Director for Information	SFI Section 18
42	**CLINICAL AUDIT**	Quality Committee	
43	**OPENING OF TENDERS**		SO Section 9
	a Responsibility for ensuring conflict of interest forms are completed	Contracts Department	
	b Responsibility for reviewing audit trail of current and closed tenders	Contracts Department	
44	**CARRY OUT DUTIES RELATING TO FRAUD AND CORRUPTION**	Counter Fraud, Anti-Crime Specialist or ECFO	
45	**AUTHORISING, MANAGING AND PROCESSING CLINICAL NEGLIGENCE AND INSURANCE CLAIMS**		
	a Day to day management of clinical negligence and insurance claims	Lead Director for Clinical Negligence / Insurance	
	b Authorisation of payments for clinical negligence and insurance claims,		
	i) Up to £10,000	Lead AD	
	ii) Up to £50,000	Lead Director for Clinical Negligence / Insurance	
	iii) Above £50,000	As per limits in section 2.1	
46	**LEASE / SALARY SACRIFICE CARS**		

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

	a	Authority to designate posts eligible for lease cars involving a Trust contribution (Standard or Senior Manager schemes)	Director	
	b	Requisitions and ordering of leased vehicles on receipt of authorisation from manager	DoF, HoFA or DHoFA	
	c	Payment of invoices and signing of contracts	DoF, HoFA, or DHoFA	
47	**LEGAL SERVICES**			
	Authority to engage any of the Trust's panel law firms		Persons authorised in legal protocol following approval by the Legal Panel	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 1: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

Date (DD/MM/YYYY)	24/10/2025	
Directorate / locality / department	Finance	
Name of new policy / service / function	Review of existing	
Is this a new policy / service / function or a change / review to an existing one?	Review of existing	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: Clare Barley	Role: Head of Financial Accounts
	Name:	Role:
	Name:	Role:
Name of relevant director of services	Simon Covill	
Contact email address of lead assessor	Trevor Smith	

Actions as a result of this EIA:

Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

	E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)	**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:		**Role:**	
Date:			

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	N	
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	N	
Age	N	
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	N	
People who are/were Married or are/were in a Civil Partnership	N	
People who are Pregnant or are on Maternity / Paternity Leave	N	
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	N	
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	N	
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	N	
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	N	

Essex Partnership University NHS Foundation Trust

Document title:	**STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE COUNCIL OF GOVERNORS**		
Document reference number:	TB02	**Version number:**	sV 3.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All Staff
Author:	Chris Jennings, Assistant Trust Secretary		
Approval group/ committee(s):	Board of Directors Council of Governors CoG Governance Committee		
Professionally approved by: (Director)	Denver Greenhalgh, Senior Director of Corporate Governance		
Executive Director:	Denver Greenhalgh, Senior Director of Corporate Governance		
Ratification group(s):	Council of Governors Board of Directors		03 December 2025
CQC Quality Statement	Well – Led Governance		
Key word(s) to search for document on Intranet / TAGs:	Standing Orders	**Distribution method:**	☒Intranet

Initial issue date:	03 April 2017	**Last Review date:**	03 December 2025	**Next Review date:**	31 December 2026	**Expiry Date:**	01 January 2027

What we do together matters

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Related Trust documents (to be read in conjunction with)
Trust Constitution

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
001	Trust Secretary	Minor – Reflects New Constitution	01 April 2017
003	Trust Secretary	Recommendations by Legal Advisor following review of Trust Constitution	01 September 2019
004	Trust Secretary	Updated to include references to digital working and virtual meetings. Updated sections relating to Conflict of Interest to reflect national guidance.	23 September 2020
5.0	Trust Secretary	Section 3.5.3: Amended to provide Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly. Section 3.7.3: Amended to provide action to be taken if a Governor vacancy cannot be filled. Section 14.7.3: Amended to clarify the formal location of a meeting when held completely virtually.	01 September 2021
5.1	Trust Secretary	Section 3.5.3: Amended to provide Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly. Section 3.7.3: Amended to provide action to be taken if a Governor vacancy cannot be filled. Section 14.7.3: Amended to clarify the formal location of a meeting when held completely virtually.	01 September 2021
6.0	Trust Secretary's Office	Minor Amendments	27 September 2023
6.1	Trust Secretary's Office	Extension for review granted until January 2025	01 March 2024
7.0	Trust Secretary's Office	Transferred to New Template Minor Amendments	02 October 2024
sV 1.0	Policy Team	Uploaded to SOPHIA document library	21 March 2025
sV 2.0	Policy Team	Extension PORG approved until end of December	08 October 2025
SV3.0	Trust Secretary's Office	Amendments to references to reflect layout changes caused by the transfer of the document into a new template.	03 December 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1 Introduction

1.1 Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1st April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act), by Monitor (now part of NHS England).

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no: 120163) and all relevant legislation and guidance.

These standing orders add clarity and detail where appropriate. Nothing in these standing orders shall override the Trust's constitution, the National Health Service Act 2006, the Health & Social Care Act 2012 and the Health and Care Act 2022.

The Trust's standing orders and wider governance arrangements are further supported by various policies and procedures.

The principal place of business of the Trust is The Lodge, Lodge Approach, Wickford, Essex SS11 7XX.

2 Interpretation

2.1 Unless otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary).

2.2 Any expression to which a meaning is given in the National Health Service Act 2006 or regulations made under it shall have the same meaning in these standing orders and in addition:

2.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

2.2.2 **2012 Act** means the Health & Social Care Act 2012.

2.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**.

2.2.5 **Chair of the Board** or **Chair of the Trust** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the

Vice-Chair of the Trust if the Chair is absent from a meeting or is otherwise unavailable or such other Non Executive Director as may be appointed as acting Chair in accordance with these SO.

2.2.6 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.

2.2.7 **Committee** means a committee appointed by the Council of Governors.

2.2.8 **Committee members** means persons formally appointed by the Council of Governors to sit on or to chair specific committees.

2.2.9 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.

2.2.10 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution.

2.2.11 **Directors** means the Executive and Non-Executive members of the Board of Directors.

2.2.12 **Executive Director** means a member of the Board of Directors, including the Chief Executive, appointed under paragraph 31 of the constitution.

2.2.13 **Lead Governor** is the person appointed by the Council of Governors in accordance with the *Code of Governance for NHS Provicers (May 2022).*

2.2.14 **Licence** means the Trust's provider licence (no: 120163) issued by NHS England (Monitor) on 1st April 2017.

2.2.15 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

2.2.16 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.

2.2.17 **SOs** mean these Standing Orders (for the Council of Governors).

2.2.18 **Trust** means Essex Partnership University NHS Foundation Trust.

2.2.19 **Trust Secretary** means a person appointed by the Chair and Chief Executive as the Trust Secretary.

2.2.20 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution.

2.2.21 **Working days** a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday.

2.3 Words importing the plural shall import the singular and vice-versa.

2.4 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

3 Council of Governors Roles and Responsibilities

3.1 The purpose of these SOs is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations.

3.2 The roles and responsibilities of the Council which are to be carried out in accordance with the Trust's constitution, license and the Code of Conduct for NHS Provider Trusts (February 2023) (and any subsequent versions) are:

3.3 **General Duties**

3.3.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so.

3.3.2 To represent the interests of the members of the Trust and the interests of the public.

3.4 **Chair and Non-Executive Directors**

3.4.1 To approve the policies and procedures for the appointment and removal of the Chair and/or Non-Executive Directors in accordance with any guidance issued by NHS England and on the recommendation of the Council's Nominations Committee.

3.4.2 To appoint and remove the Chair and other Non-Executive Directors. The Council should only exercise its power to remove the Chair or any other Non-Executive Directors after exhausting all means of engagement with the Board.

3.4.3 To approve the policies and procedures for the appraisal of the Chair and Non-Executive Directors on the recommendation of the Council's Remuneration Committee. The performance of Non-Executive Directors should be subject to regular appraisal and review. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council should ensure planned and progressive refreshing of the Non-Executive Directors.

3.4.4 To decide the remuneration, allowances and other terms of office for the Chair and Non-Executive Directors having regard to the recommendations of the Council's Remuneration Committee. Professional advisers should be consulted to market test the remuneration levels of the Chair and other Non-Executives Directors at least once

every three years and when there is a material change to the remuneration of the Chair or another Non-Executive Director.

3.5 **Chief Executive**

3.5.1 To approve the appointment of the Chief Executive of the Trust.

3.6 **Auditors**

3.6.1 To approve the criteria for the appointment, removal and re-appointment of the auditor.

3.6.2 To appoint, remove and reappoint the auditor having regard to the recommendation of the Trust's Audit Committee.

3.7 **Strategy Planning**

3.7.1 To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate.

3.7.2 To collaborate with the Board in the development of the Trust's forward plan.

3.7.3 Where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purpose of the NHS in England, to determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and notify its determination to the Board.

3.7.4 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the NHS in England, approve such a proposal.

3.7.5 To approve entering into any significant transactions (as defined under paragraph 49 and Annex 9 of the constitution) in accordance with the 2006 Act and the constitution.

3.7.6 When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution.

3.7.7 To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council.

3.8 **Representing Members and the Public**

3.8.1 To prepare and from time to time review the Trust's membership engagement strategy and policy.

3.8.2 To notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level.

3.8.3 To report to the members annually on the performance of the Council.

3.8.4 To promote membership of the Trust and contribute to opportunities to recruit and engage members in accordance with the membership strategy.

3.8.5 To seek the views of stakeholders and feedback to the Board.

3.8.6 All business shall be conducted in the name of the Trust.

4 The Council of Governors

4.1 Composition of the Council

The composition of the Council shall be in accordance with paragraph 14 of the constitution.

4.2 Appointment of the Chair

The Chair is appointed by the Council as set out in paragraph 28 of the constitution.

4.3 Terms of Office of the Chair

The provisions governing the period of tenure of office of the Chair are set out in Board of Directors SO 2.8.

4.4 Role of the Chair

4.4.1 The Chair is not a member of the Council. However, under the regulatory framework, they preside at meetings of the Council and holds a second or casting vote.

4.4.2 Where the Chair has died or has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, and there will be an absence of a Chair for less than 3 months the Vice-Chair of the Board shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

4.4.3 Where an absence of the Chair has or will exceed a period of 3 months the Council at a general meeting shall appoint one of the Non-Executive Directors as the acting Chair. Before a resolution for such an appointment is passed, the Board shall be entitled to advise the Council of the Non-Executive Director (who may be the Vice-Chair) who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision. The Vice Chair shall act as Chair until an appointment of an acting Chair is made by the Council.

4.5 Role of the Lead Governor

4.5.1 The Lead Governor shall be appointed by the Council.

4.5.2 The Lead Governor will facilitate communication between NHS England and the Council where Governors have concerns about the leadership provided to the Trust

by the Board or in circumstances where it would be inappropriate for the Chair to contact NHS England, or vice versa (for example, regarding concerns about the appointment or removal of the Chair).

4.5.3 Having a Lead Governor does not prevent any other Governor from making contact with NHS England directly if they feel this is necessary. However, any Governor should consider contacting the Lead Governor prior to contact with NHS England. For the avoidance of doubt, a person holding the role of Lead Governor shall not assume greater power or responsibility than other Governors. Where the Trust chooses to broaden the Lead Governor's role, the Chair and the Council should agree what powers should be included.

4.6 Termination of Office and Removal of Governors

4.7 Paragraphs 16, 17 and Annex 6 paragraph 5 of the constitution sets out the period of tenure of office of Governors and provisions relating to the termination or suspension of office of Governors.

4.8 Vacancies amongst Governors

4.8.1 Where a vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement.

4.8.2 Where a vacancy arises amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacant office for the unexpired balance of the retiring member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

4.8.3 Where the vacancy cannot be filled, consideration will be given for holding a by-election, based on cost of the election and the proximity of any by-election to other elections to the Council of Governors.

4.9 Appointment and Powers of Vice-Chair

4.9.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place.

4.9.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision.

4.9.3 Subject to SO 3.4.2 and SO 3.4.4 in the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust.

4.9.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 3.8.

5 Meetings of the Council

5.1 Subject to SOs 4.2.1 and 4.2.2 below and any other provisions of these SOs, the Council may only exercise any powers and make decisions when in formal session. The Council may be advised by committees appointed by the Council but may not devolve any decision making powers to these committees, which, for the avoidance of doubt, shall operate as working groups of the Council.

5.2 Admission of the Public and the Press

5.2.1 The meetings of the Council shall be open to members of the public and the press.

5.2.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Council will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 13(2) of Schedule 7 of the 2006 Act, the Council of Governors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed."

5.2.3 The Chair may exclude any person from a meeting of the Council if that person is interfering with or preventing the proper conduct of the meeting.

5.2.4 Nothing in these SOs shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

5.2.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Council and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting.

5.2.6 All decisions taken in good faith at a meeting of the Council or of any committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

5.3 Calling Meetings

5.3.1 Ordinary meetings of the Council shall be held at such times and places or via digital platforms as the Council may determine.

5.3.2 There shall be not less than four meetings in any year except in exceptional circumstances.

5.3.3 Meetings of the Council may be called by the Trust Secretary, or by the Chair. Not less than one-third of the Governors in office can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary stating the business to be considered at the meeting.

5.4 Notice of Ordinary Meetings

5.4.1 The Trust Secretary shall give to all Governors at least 10 (ten) working days written notice of the date and place of every ordinary meeting of the Council.

5.4.2 Agendas will be sent to Governors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent business under a meeting called under paragraph 5.5.

5.4.3 A notice or other document(s) to be served upon a Governor under these SOs shall be delivered by hand or sent by post to the Governor at the place of residence which he shall have last notified to the Trust, or where sent by email, to the address which he shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means.

5.4.4 A notice or other document(s) where delivered by hand or sent by post shall be presumed to have been served on the next working day following the day it was sent and where it was sent by email at the time at which the email is sent.

5.4.5 Failure to serve notice and supporting papers on any Governor shall not affect the validity of an ordinary meeting.

5.4.6 Save in the case of urgent meetings, for each meeting of the Council a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office and on the Trust's internet site for general access at least three working days before the meeting.

5.5 Notice of Urgent/Extraordinary Meetings

5.5.1 At the request of the Chair or not less than one-third of Governors, the Trust Secretary shall send written notice of a meeting to all Governors as soon as possible after receipt of such a request. The Trust Secretary shall give Governors as much notice of the meeting as is practicable in light of the urgency of the request.

5.5.2 If the Trust Secretary does not call a meeting of the Council of Governors within ten (10) working days of receiving a requisition from Governors pursuant to SO 5.5.1, the Governors who made the requisition may convene the meeting themselves by giving written notice to all Governors; this notice must be signed by all of the Governors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

5.5.3 In the case of a meeting called under SO 5.5.2, the notice shall be signed by the Chair or by at least one-third of Governors in office.

5.5.4 No business at a meeting called under SO 5.5.2 shall be transacted at that meeting other than that specified in the notice. Agendas will be sent to Council members three (3) working days before the meeting and supporting papers, shall accompany the agenda, save in the case of urgent meetings.

5.5.5 In the case of a meeting called under SOs 5.5.2 failure to serve such a notice on more than three (3) Governors will invalidate the meeting.

5.6 Setting the Agenda

5.6.1 The Council may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted.

5.6.2 A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least seven (7) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) working days before a meeting may be included on the agenda at the discretion of the Chair.

5.7 Motions

5.7.1 Notices of motion: A Governor desiring to move or amend a motion shall send a written notice thereof at least seven (7) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

5.7.2 Withdrawal of motion or amendment: A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.7.3 Motion to Rescind a Resolution: Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. Such notice shall be sent to the Chair at least 10 (ten) working days before the meeting, who shall insert it in the agenda for the meeting. When any such motion has been disposed of by the Council, no Governor may propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate.

5.7.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.7.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Governor to move one of the following motions:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*
(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

Provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

5.7.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.8 **Petitions**

Where a petition has been received by the Trust not less than 10 (ten) working days before a meeting of the Council, the Chair of the Council shall include the petition as an item for the agenda of the next meeting of the Council.

5.9 **Chair of Meeting**

5.9.1 At any meeting of the Council the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or another Non-Executive Director, if there is one present, shall preside.

5.9.2 If the Chair, Vice-Chair and all Non-Executive Directors are absent, the Lead Governor, if present, shall preside. If the Lead Governor is not present, such Governor to be appointed from amongst the Council present shall preside.

5.10 **Chair's Ruling**

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

5.11 **Record of Attendance**

5.11.1 The names of the Chair and Governors present at a meeting shall be recorded in the minutes. Board Directors who attend a meeting will be recorded in the minutes as 'in attendance'.

5.11.2 Governors who are unable to attend a Council meeting should advise the Trust Secretary in advance of the meeting so that their apologies may be submitted.

5.11.3 A meeting of the Council refers to officers being physically present or officers being present via the use of technology, as defined in SO 5.17.

5.12 **Quorum**

5.12.1 The quorum for every meeting of the Council shall be one-third of the total number of Governors in office on the date of the meeting, a majority of whom must be Public Governors.

5.12.2 If at the time of the meeting no quorum is present:

(a) The Chair shall announce a 30 minute delay
(b) If after the delay a quorum is present, the meeting shall proceed
(c) If a quorum is not present after the delay, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such a time and place as the Chair shall determine and a notice of the adjourned meeting shall be circulated to Council members. When the meeting reconvenes, if a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum

5.12.3 Where during a meeting of Council a quorum is no longer present:

(a) The Chair shall announce a five (5) minute delay
(b) If after the delay there remains no quorum, the Council meeting shall be adjourned

5.12.4 Where the Council is adjourned under SO 5.12.3(b), the Trust Secretary shall list the uncompleted business from the meeting as the first items for consideration at the next following meeting of Council.

5.12.5 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.12.6 Governors may participate (and vote) in its meetings by telephone, teleconference, video or computer link in accordance with SO 5.17 below. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

5.13 **Voting and Decisions**

5.13.1 At the end of a discussion on business not subject to a decision, the Chair may summarise the view of the Council for recording in the minutes.

5.13.2 On any matter requiring a decision, Council shall determine its position by voting.

5.13.3 Subject to statutory or constitutional requirements, a decision of the Council is reached by a majority of Governors present and voting. Votes in abstention shall not be counted in determining a majority. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting

vote. No resolution can be passed if it is opposed by all of the Public Governors present and voting.

5.13.4 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

5.13.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

5.13.6 On the request of the one-third of the Governors present, a recorded vote shall be taken:

(a) The Trust Secretary will call the names of all Governors
(b) Each Governor shall declare their vote as 'In Favour', 'Against' or 'Abstain'
(c) The vote of each Governor shall be recorded in the minutes accordingly

5.13.7 On the request of the majority of Governors present at the meeting, a vote may be taken by secret ballot:

(a) Each Governor shall be issued with a ballot paper allowing a vote of 'In Favour', 'Against' or 'Abstain'
(b) Each Governor shall have the opportunity to vote in secret
(c) The Trust Secretary shall count the ballots, and record the number of votes cast for each option on the minutes
(d) Governors may not record their vote in the minutes if a secret ballot is taken.

5.14 **Voting by Paper Ballot**

5.14.1 If the Chair of the Trust calls an extraordinary meeting of the Council under Sos 5.3 – 5.5 they may, subject to SO 5.14.2 below, determine that any Governor may cast their vote on the matter(s) to be dealt with at the meeting by paper ballot in accordance with the process set out at SOs 5.14.3 - 5.14.5 (inclusive) below.

5.14.2 The Chair may only determine that Governors may cast their vote by paper ballot on any matter where this is compatible with the 2006 Act.

5.14.3 Where the Chair makes a determination pursuant to SO 5.14.1 in respect of any extraordinary meeting of the Council, the Trust Secretary shall circulate a ballot paper to all of the Governors together with the papers for the meeting.

5.14.4 Any Governor may cast their vote at the meeting or by:

(a) marking the ballot paper, in accordance with the instructions on the ballot paper, to show how he wishes to vote
(b) subject to SO 5.14.6, signing the ballot paper
(c) returning the ballot paper to the Trust Secretary so that it arrives before the date and time stipulated on the ballot paper.

5.14.5 Governors must return the ballot paper by hand, by email or by post. Any ballot paper received on or after the date and time stipulated shall be rejected.

5.14.6 If a Governor returns a ballot paper to the Trust Secretary by email, the ballot paper does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

5.14.7 Any votes duly cast by paper ballot shall be added to the votes cast by Governors voting in person at the meeting. Unless otherwise provided by the Trust's constitution or by law, every matter shall be determined by a majority of votes cast and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors voting, whether at the meeting or by paper ballot.

5.14.8 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all ballot papers for at least twelve (12) months from the date of the meeting in respect of which the votes were cast. The votes (whether in person or by ballot) shall recorded in the minutes in accordance with SO 5.13.

5.15 **Prevention of Disorder at a Meeting**

If there is disorder in the public gallery (including members of the public attending in a virtual capacity) at a meeting of the Council:

5.15.1 The Chair may direct those causing the disorder to leave the meeting, and they shall thereupon leave and not return to the meeting.

5.15.2 The Chair may suspend the meeting to a stated time (not longer than 30 minutes from the time of the suspension) to allow order to be restored

5.15.3 If those causing disorder refuse to comply with the Chair's direction, the Chair may move that the public gallery be cleared to allow the Council to proceed in proper order.

5.15.4 A motion under SO 5.15.3 shall be voted on immediately and without debate.

5.15.5 If Council agrees to a motion under SO 5.15.3, the Chair shall suspend proceedings until the public gallery is cleared; the gallery shall remain cleared for the remainder of the meeting, unless the Council shall otherwise decide.

5.16 **Written Resolution Process**

5.16.1 Subject to SO 5.16.2, the Council may use the process for adopting a written resolution set out in this SO 5.16 to enable it to transact business between meetings of the Council. The process for adopting a written resolution shall not be used to replace meetings of the Council.

5.16.2 The Council may only use a written resolution for transacting business where this is compatible with the 2006 Act.

Proposing written resolutions

5.16.3 At the Chair's request, the Trust Secretary shall propose a written resolution to the Governors**.**

5.16.4 A written resolution is proposed by giving notice of the proposed resolution to the Governors. Such notice shall stipulate:

(a) the proposed resolution; and
(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the Trust Secretary
(c) Notice of a proposed written resolution must be given in writing to each Governor. Notice by email or post is permitted.

Adopting written resolutions

5.16.5 Unless otherwise provided by the Trust's constitution or by law and subject to SO 4.16.7 below, a proposed written resolution shall be adopted when it has been signed and returned to the Trust Secretary by hand, by email or by post by a majority of the Governors.

5.16.6 If a Governor returns a written resolution to the Trust Secretary by email, the written resolution does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

5.16.7 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been returned by the requisite number of Governors pursuant to SO 5.16.6 above, by the longstop date.

5.16.8 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Council of Governors' meeting in accordance with these SOs.

5.16.9 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

5.17 **Meetings: Electronic Communication**

5.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

5.17.2 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council or of a committee of the Council shall be regarded for all purposes as being present and personally attending such a meeting provided that, and only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

5.17.3 A meeting at which one or more of the Governors attends by way of electronic communication shall be deemed to be held at such place at which the Chair is physically present. If the meeting takes places by way of electronic communication entirely, the meeting shall deemed to have been held via the electronic communication platform and will be recorded in the minutes as such.

5.17.4 Meetings held in accordance with this SO are subject to SO 5.12. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

5.17.5 The minutes of a meeting held in this way must state that it was held (whether wholly or partly) by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

5.18 **Minutes**

5.18.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the person presiding at it, including electronically.

5.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.18.3 Minutes shall be retained in the Trust Secretary's office.

5.18.4 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5.19 **Additional Powers**

5.19.1 The Council may require one or more of the Directors to attend a Council meeting to obtain information about the Trust's performance of its functions or the directors' performance of their duties, and to help the Council to decide whether to propose a vote on the Trust's or Directors' performance.

5.19.2 The Trust may choose to involve Governors in hospital/service visits or volunteering. However, Governors acknowledge that they do not have a right to inspect Trust property or services and they are not under a duty to meet patients and conduct quality reviews.

5.19.3 Governors may refer a question concerning whether the Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act to the Panel for Advising Governors appointed by NHS England under the 2006 Act.

5.20 **Variation and Amendment of Standing Orders**

5.20.1 Any variation of these SOs shall not constitute a variation of the constitution. These SOs shall be amended only if:

(a) unless proposed by the Chair, a notice of motion under SO 4.7 has been given; and
(b) not fewer than half of the Trust's Governors vote in favour of amendment; and
(c) at least half of the Governors are present at the meeting at which the amendment is considered; and
(d) the variation proposed does not contravene a statutory provision or requirement, condition or notice issued by NHS England; and
(e) the amendment is approved by the Council.

6 Arrangements for the Exercise of Council Functions

6.1 The Council may not delegate its functions to any committee of the Council. Subject to the constitution and any requirements of NHS England, the Council may appoint committees to assist the Council in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly of the Chair and members of the Council.

6.2 A committee appointed under this SO 6 may, subject to such requirements, conditions or notices as may be given by NHS England or such directions as may be issued by the Council, appoint sub-committees consisting wholly of members of the committee.

6.3 The SOs of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the chair of the committee as the context permits, and the terms "member of the Council" or "Governor" is to be read as a reference to a member of the committee also as the context permits.

6.4 There is no requirement to hold meetings of committees established by the Council in public.

6.5 Each such committee shall have such terms of reference and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the regulatory framework and any requirement, condition, notice or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

6.6 The Council shall approve the terms of reference and appointments to each of the committees which it has formally constituted.

6.7 The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

6.8 A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable)

until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.

6.9 A Governor or a non-Governor in attendance at a committee or of a meeting of the Council shall not disclose any matter dealt with by the committee or the Council, notwithstanding that the matter has been reported or concluded, if the Council or committee resolves that it is confidential.

6.10 The Trust Secretary or their deputy or assistant will attend all meetings of the committees in support of them.

6.11 Notwithstanding anything in these SOs, the Chair and Governors may meet informally or as a committee of the Council at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation. For the avoidance of doubt, no business shall be conducted at such meetings.

7 Prevention of Conflicts of Interest

7.1 Declaration of Interests

7.1.1 The Trust recognises that, as volunteers, Governors may have private interests that could conflict with those of the Trust. It is the responsibility of Governors to ensure that any potential conflicts of interest are registered and declared at meetings in accordance with this SO and paragraph 22 of the constitution.

7.1.2 The Trust policy for Conflicts of Interest, Gifts and Hospitality (CP80) defines a conflict of interest as “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

7.1.3 A conflict of interest may be

- **Actual:** There is a material conflict between one or more interests.
- **Potential:** There is the possibility of a material conflict between one or more interests in the future.

7.1.4 Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see if different and perceived conflicts of interests can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

7.1.5 Interests fall into the following categories:

(a) Financial interests: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

(b) Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision

they are involved in making, such as increasing their professional reputation or promoting their professional career.

(c) Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

(d) Indirect interests: Where an individual has a close associationwith another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

7.1.6 Governors must declare interests which are relevant and material to the Council. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment

7.1.7 At the time Governor's interests are declared they should be recorded in the Council register of interests and in the minutes of the relevant meeting at which the declaration is made. Any changes in interests should be declared at the next meeting following the change occurring.

7.1.8 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.9 During the course of a meeting of the Council, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.1.10 There are a number of common situations which can give rise to risk of conflicts of interest, as follows:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership issues
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

7.1.11 The interests of Governors' spouses or partners if living together, in contracts are to be declared. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an

interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2 Register of Interests

7.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors. In particular the register will include details of all directorships and other actual and potential interests which have been declared by Governors, as defined in paragraphs 22 of the constitution and SO 7.1

7.2.2 The Trust Secretary shall keep these details up to date by means of an annual review of the register, for which Governors will be required to complete a further declaration via an Annual Declaration of Interest Form. It is the responsibility of each Governor to provide an update to the Trust Secretary of their register entry if their interests change. The form will also require Governors to provide consent to process and publish this information as per GDPR or equivalent requirements.

7.2.3 The register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

7.2.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by the NHSE/I.

7.3 Interests of Relatives, Spouses and Partners

7.3.1 A Governor is required to declare, as if it was their own interest, interests owned or otherwise held by:

- Their spouse or civil partner
- Any person with whom they have a long-term relationship as a couple on a domestic basis
- Their children, step-children or other minors living in the same household as them
- Any parent, grandparent, uncle or aunt living in the same household as them

7.3.2 Where a declaration is made under SO 6.3, the Governor shall declare and the Trust Secretary shall note on the Register:

- The name of the individual having the interest
- Their relationship to the Governor making the declaration.

7.4 Interest of Governors in Contracts

7.4.1 If it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.4.2 A Governor should also declare to the Trust Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, civil partner or person living together with them as partner, that conflicts or might reasonably be predicted could conflict with the interests of the Trust. Interests, employment or relationships declared, are to be entered in a register of Governor's interests.

7.4.3 Further details are included in the Conflict of Interest, Gifts and Hospitality policy & procedure.

8 Standards of Business Conduct

8.1 Standards of Conduct

8.1.1 The Council shall agree, from time to time, codes of conduct for the proper execution of the office of Governor.

8.1.2 Governors must comply with the Council's Code of Conduct, the requirements of the regulatory framework, the constitution and any guidance, requirement condition or notice issued by NHS England.

8.2 Canvassing of, and Recommendations by, Members of the Council of Governors in Relation to Appointments

8.2.1 Except in relation to the appointment of a person as a member of the Trust, a Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.2.2 This SO does not prevent a Governor from contributing to the appointment of a Non-Executive Director to the Trust or the Chief Executive in accordance with the statutory requirements.

8.2.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

9 Miscellaneous

9.1 Standing Orders to be given to all Governors

9.2 It is the duty of the Trust Secretary to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these SOs.

9.3 Review of Standing Orders

9.4 The SOs shall be reviewed annually by the Council. The requirement for review extends to all documents having the effect as if incorporated in the SO.

9.5 Potential Inconsistency

9.6 In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in these SOs, the legislation shall prevail. In the event of any conflict or inconsistency between these SOs and the licence and/or the constitution, the licence and/or the constitution shall prevail.

10 Dispute Resolution

10.1 Where there is a dispute between the Council of Governors and the Board of Directors, Governors shall follow the procedure set out in the current Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance.

10.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

10.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

10.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

11 Relationship Between the Board of Directors and the Council of Governors

11.1 Governors should discuss and agree with the Board how they will undertake their statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice.

11.2 Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts (including any report of the auditor on them) and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

11.3 The annual report should state how performance evaluation of the Board, its committees, and its Directors, including the Chairman is conducted and the reason why the Trust adopted a particular method of performance evaluation.

11.4 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the appointed Lead Governor. A record should be kept of the number of

meetings of the Council and the attendance of individual Governors and Directors and it should be made available to members on request.

11.5 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Trust's Audit Committee, which provides information to the Governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

11.6 If the Council does not accept the Audit Committee's recommendations, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.

11.7 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors

10.2 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Information Item MK

REFERENCES

Only PDFs are attached

Quarterly Report on Safe Working Hours for Resident Doctors.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3rd December 2025

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

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	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*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Resident Doctors Forum, any unresolved issues is further escalated to the Executive Medical Director. Medical Staffing ensures that the Resident doctors working hours are in line with the Resident Doctors contract 2016.		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
The purpose of this report is to provide assurance to the Board that doctors in training and safety rostered and that they working hours are compliant with the terms and conditions of their contract.	**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 National recruitment of trainees is an ongoing issue, however the intake of trainees in our Trust has improved, leaving less gaps on the rota.

2. Gaps in the rota are managed by existing doctors within the Trust and no agency locums were used.

3. 12 Exception reports were raised in this quarter:
   a) One trainee stepped down on 2 occasions and received payment as per the Trust Acting Down policy.
   b) Three trainees worked extra hours following their on-call shift. Trainees received payment and Trust was fined.
   c) Seven exception reports were raised by trainees for working extra hours on the ward, time off in lieu was given.

4. The Trust was fined a total of £467.54 in this quarter for three exception reports.

5. Resident Doctors took part in the Industrial Action from 25 July until 30 July 2025. A total of £57,670.00 was spent on shadow rota to cover gaps to ensure patient safety.

6. The bi-monthly Resident Doctor's Forum (RDF) is well attended by Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved in a timely way and escalated to Clinical Tutors/DME/Senior Managers where necessary.

7. The Board to note that there is an increase in the number of exception reports in the current and previous quarter. There has been a recurring pattern of trainees raising exception reports in the inpatient unit. This was escalated to the relevant Clinical Tutor of those areas, a review on the ward structure to provide medical cover is being considered. The on-call monitoring exercise would also provide information on areas where increased medical cover is required.

8. The Board to note that the fine amount incurred by the Trust is high in the first two quarters of 2025 in comparison to the previous year. Time off in lieu is given to trainees as a default, but in circumstances where there is a breach of contractual hours or if higher trainees step down to provide cover for core trainees, a payment to trainees is required in line with the Resident Doctors contract.

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			
FY1	Foundation Year 1	RDF	Resident Doctors Forum
FY2	Foundation Year 2		
DME	Director of Medical Education		

Supporting Reports/ Appendices /or further reading
Quarterly Report on the Safe Working of Resident Doctors

Lead

Dr Milind Karale
Executive Medical Director

QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

1 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 EXECUTIVE SUMMARY

This is the thirty third quarterly report submitted to the Board on Safe Working of Resident Doctors for the period 1 July to the 30 September 2025. The Trust has established robust processes to monitor safe working of resident doctors and report any exceptions to their terms and conditions.

Exception Reports:

A total of 12 exception reports were raised in this quarter.

- 12 and 13 July 2025: ST5 had to step down for 2 hours (in total) to attend to clinical work on site. Outcome: Trainee will receive £130.02 and the Trust was fined £216.66.
- 14 August 2025: Core trainee (CT) worked an extra 2 hours following the on-call shift. Outcome: Trainee will be paid £82.76. The Trust was fined £139.88 as it is a breach of contractual working hours.
- 15 August: Foundation Year 1 trainee worked 30 minutes, extra on the ward. Outcome: Time off in lieu.
- 15 August 2025: CT1 worked extra 30 minutes on the ward. Outcome: Time off in lieu.
- 21 August 2025: CT1 worked an extra 30 minutes on the ward. Outcome: Time off in lieu.
- 22 August 2025: A GP (General Practitioner) trainee worked 1 hour extra on the ward. Outcome: Time off in lieu.
- 22 August 2025: CT1 worked extra 45 minutes on the ward. Outcome: Time off in lieu.
- 25 August: FY1 worked extra 45 minutes on the ward. Outcome: Time off in lieu.
- 28 August 2025: Core trainee worked extra 30 minutes on the ward. Outcome: Time off in lieu.
- 29 August: FY1 worked extra15 minutes on the ward. Outcome: Time off in lieu.
- 6 September 2025: CT1 worked extra 1 hour 30 minutes following on call shift due to excessive workload and to ensure safe hand over. Trainee will be paid £67.00 and the Trust is fined £111.00

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 6 Aug 2025.

Doctors in Training Data (Average across reporting period)

Total number of posts EPUT Training Scheme inclusive of foundation and GP	**170**
Total number of psychiatry training posts	**112**
Total number of doctors in psychiatry training on 2016 Terms and Conditions	**97**
Total number of foundation posts	**40**
Total number of GP posts	**18**

Total number of vacancies across all grades	**17**
Total vacancies covered LAS/Agency	**13**
Total gaps	**4**

Figures include psychiatry trainees who work less than full-time and two trainees may be occupying one post

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick	144	144	0	1703	1703
Total	144	144	0	1703	1703
Total Cost	**£104,965**				

Resident Doctor Industrial Action

Resident doctors took part in the industrial action held from 25 July 2025 until 30 July 2025. The Trust ensured that patient safety was not compromised, and a shadow rota was set up to cover both day and night shift across all five areas of the Trust.

In total 502 hours were covered by internal locums plus 5 consultants were stood down on each of the evenings so a total of £57,670 was spent on the shadow rota.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.

Fines:

Trust was fined a total of £467.54 for the exception reports raised on 12 and 13 July, 14 August and 6 September 2025.

Issues Arising:

1. On-call monitoring activity is currently being held to determine the workload across all sites of the Trust and for all grades of Doctors

2. The Board to note that there is a rising trend in trainees raising exception reports. This is due to trainees being more aware of their rights under the Terms and conditions of the Resident Doctors contract as well as their workload. The areas where trainees raise exception reports repeatedly have been escalated to the respective Clinical Tutors. The inpatient medical cover structure is currently investigated to avoid repeated exception reports being raised.
3. The Trust is hoping that the on-call monitoring exercise would help identify areas to align medical cover based on clinical needs, thereby reducing the number of exception reports being raised.
4. The Board also to note that the Fine amount is more in the first two quarters of this year compared to previous quarters in 2024/2025. The Board to note that where possible trainees are given time off in lieu by default, however in circumstances where higher trainees have to step down to provide cover for core trainees or if trainees work extra hours following their on call shift, payment has to be made, and Trust incurs a fine. This is in line with the Resident Doctors contract.

3 Action Required

The Board of Directors/ Committee is asked to:

1 Note the contents of the report.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

10.3 PROVIDER CAPABILITY ASSESSMENT 2025/26

Information Item PS

REFERENCES

Only PDFs are attached

Provider Capability Assessment 2025-26 03.12.25.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Provider Capability Assessment 2025/26**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Denver Greenhalgh, Executive Director of Governance					
Report discussed previously at:	Board of Directors 1 October 2025					
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)?	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 the EPUT Provide Capability Self-Assessment submitted to NHS England.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to

1. Note the report and assurance provided.

Summary of Key Points

As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability, using this alongside providers' National Oversight Framework (NOF) segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards were asked to assess their organisation's capability against a range of expectations across six areas derived from the insightful provider Board. The Board of Directors completed the self-assessment for the following areas:

- Strategy, Leadership and Planning (Confirmed)
- Quality of Care (Partlially Confirmed)
- People and Culture (Partially Confirmed)
- Access and Delivery of Services (Partially Confirmed)
- Productivity and Value for Money (Confirmed)
- Financial Performance and Oversight (Confirmed)

The Trust completed a detailed and transparent self-assessment of each of the areas and ensured that all statements were backed up with relevant evidence.

The Board of Directors agreed delegated authority to approve the 2025/26 submission for the Chair and Chief Executive Officer, due to the timescale for submission being outside Board schedule of meetings, with support from the Vice Chair and Executive Director of Governance. The assessment was submitted to NHS England on the 22 October 2025 and is attached to this report for information. As this will be annual self-assessment we will align the areas with Board Committee forward planners to ensure a constant oversight going forward.

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

Appendix 1: Provider Capability Assessment 2025/26 Submission

Executive/ Non-Executive Lead / Committee Lead:

Paul Scott, Chief Executive Officer

Provider Capability - Self-Assessment Template | **Essex Partnership University NHS Foundation Trust**

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*Rated Compliant on balance whilst one line of enquiry has an action relating to it around formalising board-wide succession planning, the other 11/12 lines of enquiry are noted as compliant.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Partially confirmed**	*Staff training and appraisals regarding patient safety and quality: The current appraisal information is associated to compliance. However the existing appraisal framework does not include opportunities to consider training regarding patient safety and quality alongside continuous improvement.Enhancements are expected.* *External Learning Integration: Dissemination of national insights is limited; a new reporting process is planned.* *Triangulation of Data: The current infrastructure does not fully support integration of qualitative and quantitative data with benchmarks. Full implementation, including NHSE comparative metrics, is planned.* *Understanding the variation for patients with protected characteristics: Work is underway to address disparities in access and experience through research partnerships and community engagement.*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Partially confirmed**	*The Trust does not yet have a comprehensive system for reviewing staff skills across all levels. Plans are in place to enhance this via launching of a new appraisal framework with clear 3 year plans around leadership development. Supported with changes in the Education resource alongside an Education Plan* *Mandatory training compliance is monitored but not consistently acted upon at Board level. New KPIs and risk-based reporting are planned to improve oversight.* *While staff feedback is collected through multiple channels, triangulation across forums and surveys is still developing. The People Committee is tasked with improving this integration to better inform care improvements.*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*While formal mechanisms to track unwarranted variation are not yet embedded, plans are in place to implement Quality Dashboards that will support this. Current data limitations, particularly around protected characteristics, hinder detailed analysis.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*Full compliance against lines of enquiry*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*Full compliance against lines of enquiry*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

Signature: Hattie Llewelyn-Davies

Name: Hattie Llewelyn-Davies, Chair

Date: 22 October 2025

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11. OTHER

11.1 USE OF CORPORATE SEAL

Decision Item PS

REFERENCES

Only PDFs are attached

Use of Corporate Seal 03.12.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	3 December 2025

Report Title:	**Use of Corporate Seal**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, Executive Assistant					
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? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	~~Yes/~~No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with 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: - 04.11.25 Building Contract: Design, construction and installation of solar photovoltaic system installation – Rochford Hospital - 04.11.25 Contract Warranty: Design, construction and installation of solar photovoltaic system installation – Rochford Hospital - 04.11.25 Building Contract: Design, construction and installation of solar photovoltaic system installation – Clough Road - 04.11.25 Contract Warranty, construction and installation of solar photovoltaic system installation – Clough Road.

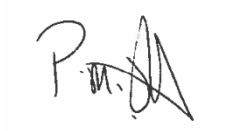
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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		x
Data quality issues		
Involvement of Service Users/Healthwatch		
Communication and consultation with stakeholders required		
Service impact/health improvement gains		
Financial implications:	**Capital £** **Revenue £** **Non Recurrent £**	
Governance implications		
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

Letter from the Secretary of State

REFERENCES

Only PDFs are attached

Letter to NHS staff from the Secretary of State and NHS Chief Executive, 19 November 2025.pdf

Department of Health & Social Care

NHS England

19 November 2025

Dear colleagues,

We wanted to thank you all for your efforts over the past few days to keep our NHS services running for patients during the latest round of industrial action.

Following the superb response earlier in the year, it is sometimes harder to do it all over again the next time. But you have not only equalled your achievements from the summer, in many places you have surpassed them.

We know the time, energy and expertise that goes into this – not just on the strike days themselves, but in the days and weeks beforehand as you plan and prepare.

We also know that for lots of you – including many resident doctors – working during strikes is incredibly challenging and is often accompanied by annual leave being rearranged, long hours being worked, and personal plans being cancelled.

To those who have made sacrifices, and to those who have supported your colleagues through the past few days, you have our heartfelt thanks – and your patients will also be incredibly grateful for your commitment to them.

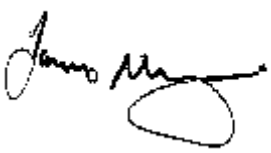
While this period of industrial action has come to an end, we know the weeks and months ahead of us will not be easy. Winter is now upon us, and we know that the flu season is yet to peak. It is so important that we do everything we can to maintain the high standards you have set, and to continue to look after our colleagues and demonstrate the outstanding teamwork of which you should all be so proud.

We also remain dedicated to doing all we can to avoid any further rounds of industrial action. Not just because of the toll it takes on our staff and patients, but because we are genuinely committed to improving working lives and conditions for our resident doctors, as we are for all NHS workers. This has, and will continue to be, the starting point for all our conversations with the BMA.

Thank you once again for the part you have played over the last few days, and for all that you do each and every day on behalf of our patients.

Yours sincerely,

Rt Hon Wes Streeting MP
Secretary of State for Health
and Social Care



Sir James Mackey
Chief Executive
NHS England

11.3 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item ALL

Verbal

11.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL

Verbal

12. ANY OTHER BUSINESS

Information Item ALL

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

13. QUESTION THE DIRECTORS SESSION

14. DATE AND TIME OF NEXT MEETING

Wednesday 4 February 2026 at 10:00, The Lodge Training room 1