Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

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6 August 2025

10:00 GMT+1 Europe/London

Microsoft Teams

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda 06.08.2025.pdf

Meeting of the Board of Directors held in Public
Wednesday 6 August 2025 at 10:00

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

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	HLD	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	HLD	Verbal	Noting
PRESENTATION **Here Comes the SUN: Paving the Path to Empowerment and Service Innovation** Bryony Dale – Service User Network Manager for Personality Disorder and Complex Needs Carolyn Pardey - Expert by Experience - Service User Network for Personality Disorder and Complex Needs Anne-Marie Martin – Clinical Psychologist, Psychosis United Phillip Cross – Peer Support Worker, Psychosis United				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 4 June 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	AS	Attached	Noting
7.4	Freedom to Speak Up Annual Report	JS	Attached	Approval
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Learning from Deaths	AS	Attached	Approval
Questions taken from the General Public				
9	**STRATEGIC INITIATIVES**			

9.1	Intensive and Assertive Community Treatment for People with Severe Mental Health Problems	MK	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
10.1	Quarterly Report on Safe Working Hours for Resident Doctors	MK	Attached	Noting
10.2	Safeguarding Annual Report	AS	Attached	Approval
Questions taken from the General Public				
11	**OTHER**			
11.1	Correspondence circulated to Board members since the last meeting.	HLD	Verbal	Noting
11.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.4	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 1 October 2025 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 3 December 2025 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item | HLD | 10:00

2. DECLARATIONS OF INTEREST

Standing item | HLD | 10:02

PRESENTATION: HERE COMES THE SUN: PAVING THE PATH TO EMPOWERMENT AND SERVICE INNOVATION

Information Item BD 10:04

Bryony Dale ? Service User Network Manager for Personality Disorder and Complex Needs
Carolyn Pardey - Expert by Experience - Service User Network for Personality Disorder and Complex Needs
Anne-Marie Martin ? Clinical Psychologist, Psychosis United
Phillip Cross ? Peer Support Worker, Psychosis United

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 4 JUNE 2025

Decision Item HLD 10:19

REFERENCES

Only PDFs are attached

Board Part 1 Minutes 04.06.2025 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 04 June 2025
Held Virtually via MS Teams

MEMBERS PRESENT:

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

IN ATTENDANCE:

Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Scott Huckle	SH	Registered Mental Health Nurse (Presentation)

There were four Public Governors / staff members present.

LL welcomed everyone to the meeting, and welcomed RS and ST to their first EPUT Board meeting as Non-Executive Directors.

The meeting commenced at 10am.

046/25 APOLOGIES FOR ABSENCE
Hattie Llewelyn-Davies, Chair

047/25 DECLARATIONS OF INTEREST
There were no declarations of interest.

048/25 PRESENTATION: QUALITY IMPROVEMENT PROJECT – LIGATURE REDUCTION, LONGVIEW WARD
SH delivered a presentation regarding a quality improvement project undertaken to reduce ligatures on child and adolescent mental health wards. SH highlighted the following:

- The project commenced in November 2023 to utilise quality improvement methodology to address an increase in ligature incidents on a CAMHS Unit. The aim of the project was to reduce incidents on the ward by 40% by 2024.

- The project was supported by the multi-disciplinary team (MDT) and a driver diagram was developed to help staff identify ideas for potential change. The driver diagram identified four areas as primary drivers that could lead to positive change: staff, MDT, processes and young people. The primary drivers identified a series of secondary drivers, such as speaking with young people to gain feedback and discuss alternative ways to ask for staff support.
- Following the interventions being enacted, a review of ligature incidents noted the management of the incidents had significantly improved and the severity of incidents had declined. The number of incidents fluctuated, but had generally reduced and there was an increase in young people removing their own ligatures and using DBT skills whilst the ligature was in situ. Staff reported feeling more comfortable and confident, with an improvement in morale.
- The incidents of ligature were given a rating to illustrate the intensity and outcome of the incident, with L1 as the young person removing the ligature themselves and L4 where restraint and / or ligature cutters were required. This would allow themes to be identified and narrative provided around the incident. The rating system is currently being piloted, but requires an update to Datix (incident reporting platform) to help with data gathering.
- Following the completion of the project, there was the potential to expand this to all other inpatient wards.

Questions & Discussions

- PS thanked SH for the presentation and noted the project showed the value of the quality improvement process and the importance of gaining views from patients and staff. PS asked whether families and carers were involved in the project. SH advised families and carers were involved regarding the approach and observations, but were not involved in the mutual expectation meetings as these were between staff and young people.
- PS suggested the outcome of the project was a good opportunity to review and update protocols around ligature management.
- DL commented the project was a good example of learning in action and the positive outcomes which could be reached. DL asked whether there is confidence that staff will be able to recognise the levels of the ligature incident in order to react appropriately. SH advised this was part of the training to identify escalations and to be able to identify when the severity may change requiring stronger intervention. The safety of the young people was always paramount.
- AG commented it was an emotive subject and commended staff for having the courage to review and change practice. The project outcome was a good example of trauma informed care. AG asked how the patient mix in the service impacts the ability to implement the interventions. SH advised the mutual expectation meetings are held quarterly, to ensure the message of how ligature incidents are managed is shared with new patients and ensures they are incorporated into the management of their interventions.
- RJ asked what impact the change in practice has had on observation levels. SH advised there was currently anecdotal data suggesting the level of enhanced observations had decreased, but this would need to be monitored further, including the identification of measurable data.
- MK highlighted the importance of having a good local induction on the wards to focus on the new approach, DBT and understanding the complexities the young people on the ward may have.
- The Board discussed the positive approach in recognising the different ways in which patients present and how staff react to the behaviours. The behaviours may be different in different cohorts, but the methodology remains the same and the approach can be implemented in other areas. The Board also discussed the

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importance of changing the culture of ligature management, rather than only changing the environment. This should be combined with other transformation areas, such as purposeful admission.

- In response to a query regarding the impact on other areas of restrictive practice, SH advised there was anecdotal feedback that there was less restrictive practice in response to ligature incidents, but that a further review would be needed to identify additional outcome measures and the impact on other areas such as length of stay.

The Board agreed for a further presentation or report to be provided in the next six months to demonstrate the impact of the project over a longer time period and potentially allow a young person to share their experience.

LL thanked SH for the presentation and the positive discussions it had generated.

Action:

1. **Provide a further presentation / report to the Board of Directors in six months, providing further information on the impact of the project and any feedback from young people on their experiences. (AS / SH)**

SH left the meeting.

049/25 MINUTES OF THE PREVIOUS MEETING HELD ON 02 APRIL 2025

The Board of Directors reviewed and approved the minutes of the meeting held on 2 April 2025 as an accurate record, noting the record of questions from Governors and the responses.

050/25 ACTION LOG AND MATTERS ARISING

The action log was reviewed, noting there were two open actions:

- A help function for Power BI - this was in progress and not yet due for completion
- Length of stay on psychiatric intensive care units (PICU) – this would be covered in the Quality and Safety Scorecard agenda item.

051/25 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

LL presented a report providing the Board of Directors with a summary of key headlines and shared information on governance developments within the Trust since the last Board meeting. LL highlighted the following:

- The positive outcome of the CQC inspection of Brockfield House, which had achieved a rating of “Good” across all domains.
- The changes to the Board of Directors, noting the arrival of Richard Spencer and Sarah Teather in April and May respectively.

The Board of Directors:

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

052/25 CEO REPORT

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

- The Lampard Inquiry public hearings took place in April and May, which reinforced how important it was to serve the Inquiry and encourage staff to share their views. The Inquiry provided a good opportunity to listen to different perspectives on the experience of mental health, and ensure the reflections are taken to ensure the Trust plans and procedures are right.
- The NOVA Unified Electronic Patient Record project had continued to progress.

- The work of the Trust to continuously improve services is being recognised through success in national award schemes for the Rough Sleepers Mental Health Team and the Essex Perinatal Mental Health Service.

The Board of Directors:

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

053/25 QUALITY AND PERFORMANCE SCORECARD

PS presented the report, providing a high level summary of performance against quality priorities, safer staffing levels and key operational performance metrics. The report was taken in conjunction with the CEO Report, with Executive Directors providing relevant updates.

Operations (AG)

- The bed occupancy for adult mental health remained over target at 98%, with older adults at 94% which is an increase from previous months. PICU bed occupancy had increased in April to 78%, which remains under the target of 88%, but has been increasing over the last 12 months.
- AG had reviewed the lengths of stay on PICU following discussing at the last Board meeting and was assured that the long lengths of stay were related to acuity and complexity.
- A locality model for flow and capacity had been implemented in response to the BAF risk, which was providing better ownership at local level. This was in conjunction with the Power BI dashboard available to clinical staff, which included a profile of patients admitted in real time.
- There had been a small increase in the number of individuals placed out of area in month, with 22 repatriated and an overall reduction by the end of the month. The challenge was to sustain this trajectory, with a number of actions and controls in place which are beginning to show improvement.
- There had been an increase in virtual ward occupancy for community health services in both west and mid and south Essex.
- AG advised areas reporting significant upward or downward trends were reviewed at accountability framework meetings and the Finance and Performance Committee.

<u>Questions & Discussions</u>

- EL commented she had reviewed bed occupancy data from neighbouring Trusts and noted their occupancy rates were below 90%. EL asked how the Trust was working with peer organisations to potentially learn from their approach. AG advised there was learning improvement network in place that would be chaired by the CEO of Princess Alexandra Hospital Foundation Trust which will take forward the work of learning from peers.
- In answer to a further query on timescale, AG advised there was not yet a timescale of when the network will report back on learning, but that she would keep the Board informed of the outcome. PS added there was recognition that system learning in the East of England Mental Health Network could be improved and learning needed to take place in systemic way.
- LL commented on being able to accurately record discharge data due to delays in the receiving of documentation. LL advised he would raise this through the Finance and Performance Committee.

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People and Culture (AM)

- The position in relation to temporary staffing continued to improve, with the bank use target being met for the last financial year. There had been some small increases in recent weeks, but this was still within target.
- The national target for reducing agency usage was a 30% reduction, with EPUT currently seeing a 40% reduction. The focus continued to be on ensuring staffing levels were sufficient to keep patients safe and deliver high quality services.

Questions & Discussions

- RS asked whether there was a financial risk associated with the new job evaluation guidance recently published and whether the utilisation of apprenticeships had been considered. AM advised work was under way with Finance to identify risks and an analysis will be provided to the People Committee. AM advised the Trust has the infrastructure in place and was prepared. In relation to apprenticeships, this was a priority area and opportunities to utilise this were available.

Finance (TS)

- The Month 1 (M1) deficit of £0.7m was slightly better than planned, with 65% of expenditure being staff related. The progress made in relation to temporary staffing had underpinned the ability to report an improved position for Month 1.
- It was important to continue to see sustained improvement for temporary staffing and out of area placements in Month 2. If the progress continues, this could allow a reassessment of the BAF core for SR8 Use of Resources.
- The Trust continued to actively progress with the applications for capital monies. This is in addition to £17m of local programme funding and £6m for the Nova unified electronic patient record. The Trust currently has applications for £13m worth of funding in progress and would continue to monitor through the Finance and Performance Committee.

The Board of Directors:

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

054/25 COMMITTEE CHAIRS' REPORT

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

Audit Committee (EL)

- The Committee had discharged its duties for 2024/25 in alignment with the Terms of Reference.
- The Internal Audit opinion at the end of the financial year was reasonable, with Risk Management arrangements achieving substantial assurance.

Finance and Performance Committee (DL)

- The Committee had received a comprehensive report regarding flow and capacity, examining the length of stay over 12 months. The Committee was pleased to note the flow and accountability framework had been developed, for the Committee to receive assurance in this area.

People Committee (RJ)

- There had been more focus on the Board Assurance Framework, including reviewing the oversight in relation to employee relations.

- The draft workforce plan had been submitted to NHS England and a revised version will be presented to the Committee.

Quality Committee (RJ on behalf of MJ)

- The Quality Account had been approved, which had been underpinned by information provided in the performance dashboard.
- The Committee had discussed a paper regarding Oxevision and the published NHS guidance.
- The Committee had discussed positive news in relation to capital funding being identified for the creation of an Urgent Care Department in Colchester.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**
2. **Approved the annual reports and Terms of Reference for the Standing Committees.**

055/25 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 registration had been updated to include the new Chair of the Trust.
- Two reports from previous inspections had been received (Brockfield House and Clifton Lodge) which received overall ratings of Good. A further report is awaited for the inspection of Adult Acute and PICU wards.
- The Improvement Plan from previous inspections continued to be implemented, with 96% completed by the action owners and now awaiting external scrutiny. There were two items which remained open regarding CCTV and the registration of the two Nursing Homes.

The Board of Directors:

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

056/25 SAFER STAFFING REPORT FOR INPATIENT NURSING

AS presented the report which provided assurance on staffing levels through an analysis for the period of the review. AS highlighted the following:

- The report focused on inpatient mental health wards in accordance with national requirements. The report provided assurance regarding safer staffing levels through the use of the Mental Health Optimal Staffing Tool (MHOST), Health Roster and Safe Care programme reports.
- The data identified times when the safer staffing rate was above 100%, which was where additional staff were required to manage patient acuity. There were assurance processes in place to manage staffing levels, including twice-daily calls with senior manager oversight, which reviewed staffing levels in greater detail.
- AS advised the next iteration of the report would also include physical health wards.

<u>Questions & Discussions</u>

- AM highlighted Strategic Risk 10 (SR10) Workforce Sustainability, noting the importance of focusing on quality nursing vacancies. The progress made regarding lowering the vacancy rate for Health Care Assistants had provided an overall positive position.

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- DL noted that Ardleigh Ward and Clifton Lodge were under their required Care Hours' Per Patient Day (CHPPD), but over 100% on their staff utilisation, asking if this was due to the high acuity of the patients. AS advised work was under way for the nursing homes as the service provided was focused on social care, with the safer staffing methodology focused on mental health services. Ardleigh Ward high utilisation was due to the acuity of patients, particularly for a cohort of patients with a long length of stay. Work was under way to gain the right staffing mix for the ward and to find the right placements for the patients currently on the ward with longer lengths of stay.
- ZT highlighted the variation in MHOST results between May and December, which reflected the change in the acuity of patients. ZT took assurance from the use of the tool, alongside other internal processes, including the review of demand and capacity on a daily basis.
- RJ commented on the importance of understanding what drove vacancy rates and how to optimise the uptake of roles by graduates, which is being taken forward by the People Committee.

The Board of Directors:

1. **Noted and the content of the report.**
2. **Confirmed acceptance and assurance given in respect of safer staffing regulations and standards.**

057/25 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:

- There were a significant number of assurance areas provided by independent auditors, including substantial assurance for Risk Management.
- The discussions at the Board had provided assurance for SR4, SR8, SR10 and SR13.
- The results of the staff survey had been incorporated into SR12 Organisational Development.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Did not request any further information or action.**

MJ joined the meeting at this point.

058/25 COMPLAINTS AND COMPLIMENTS ANNUAL REPORT

AS presented a report which provided an update on the number of complaints / PALS enquiries received and closed during the year, response timescales, complaint themes, learning from complaints and compliments, feedback from the Complaints Satisfaction Survey, quality assurance feedback from NEDs, updates on the priorities identified for 2024/25 and the priorities set for 2025/26. AS highlighted the following:

- The annual report had been scrutinised by the Quality Committee, focusing on the volume of complaints, response times and learning identified.
- The number of compliments received had increased and the response times for complaints had improved.
- Complaints in relation to psychological services had increased, which was in line with national complaint levels and issues around waiting times, primary care and accessing information. The Trust was working with system partners to address the concerns identified.

<u>Questions & Discussions</u>

- RS asked if there was any information available or a way of understanding individuals who wanted to complain but did not. AS advised the data showed fewer complaints from young people, which indicated advocacy work was required for those individuals.
- ST asked how information was triangulated, including the staff survey and friends and family test, to gain a holistic picture of the care being provided. AS advised this was being taken forward through the Quality Dashboard, to identify quality indicators to allow a focus on the experiences of patients and their family members.

The Board of Directors:

1. **Noted the contents of the report and approved for onward sharing.**

059/25 PATIENT EXPERIENCE AND VOLUNTEERS ANNUAL REPORT

AS presented a report which provided a review of work undertaken in 2024/25, developments in the Peer workforce, growth and utilisation of the Trust's Lived Experience and Volunteers teams, and focus areas for 2025/26. AS highlighted the following:

- The annual report showed improvements in patients' lived experience as well as progress made with peer support workers and volunteers.
- There had been an increase in the number of hours for people volunteering and an increase in the number of peer support workers through the Time To Care programme.
- The feedback from I Want Great Care had improved in terms of number of respondents and positive feedback received.

Questions & Discussions

- The Board discussed digital developments, including the development of real time feedback to help staff make changes in advance, rather than following incidents.
- In response to a query regarding engagement with the voluntary sector in relation to community services, AS advised this was part of the wider engagement with primary care and the third sector which would be taken forward.
- ZT congratulated the team on improvements across a number of areas of lived experience, which linked with the strategic plan.

The Board of Directors:

1. **Noted the contents of the report and approved for onward sharing.**

061/25 END OF YEAR GOVERNANCE REVIEWS

DG presented a report which provided details of the end of year self-assessment reviews undertaken against the Provider Licence and Code of Governance for NHS Providers. DG highlighted the following:

- A full review had been completed of the Foundation Trust Licence. The review had identified compliance with the provisions of the licence, highlighting CoS7 regarding continuity of service and NHS2 regarding the code of governance.
- A full review had also been completed against the *Code of Governance for NHS Providers* which has a "comply or explain" principle. The review confirmed the Trust was compliant with all provisions except B.2.7, where the requirement was for more than half of the Board of Directors to be independent NEDs (excluding the Chair). The provision during the year was for the Trust to have seven NEDs, but the Trust had made a purposeful decision to hold two vacancies which occurred during the year, pending the appointment of a new substantive Chair.

This had been noted in the report and would be included as a statement in the annual report.
- The Council of Governors had received and approved the declaration relating to providing Governors with sufficient training.

The Board of Directors:

1. **Approved the detailed review of Trust compliance against the Provider Licence (including Code of Governance).**

062/25 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR)

NL presented a report which provided assurance that EPUT has effective organisational resilience measures in place to respond to a major incident, critical incident or business continuity issue. NL highlighted the following:

- The Trust was compliant with statutory duties under the Civil Contingencies Act and associated guidance from the Cabinet Office.
- The Trust had undertaken a self-assessment, followed by a "confirm and challenge" process conducted by Mid and South Essex ICB. The assessment achieved an overall score of 95%.
- The report identified a number of areas of good practice, as well as three areas where the Trust is partially compliant and the actions being undertaken.

Questions & Discussions

- RS commented that the top five risks highlighted in the report did not include power outages and asked if this was something that had been considered. NL advised that this issue had been identified and was monitored through local health resilience forums.
- DG highlighted the data showing business continuity plans as low in some areas, providing assurance that this related to plans requiring review, rather than the absence of a plan. NL agreed and advised that services were finding it difficult to review the plans on an annual basis. A process was under way to focus on priority plans for an annual review, with lower priority areas moving to two-yearly reviews.

The Board of Directors:

1. **Discussed and considered the contents of the report.**

063/25 TIME TO CARE

AG presented a report which provided an update on the progress of the Time To Care (TTC) programme. AG highlighted the following:

- The programme was currently RAG rated as "red", but recent approved changes linked to recruitment trajectories and costings should ensure the project moves to a "Green" rating.
- There had been good levels of recruitment and the impact of peer support workers has been positive, with funding secured for further workers to be recruited.
- The report provided details of the progress by area, with West Essex currently at 98% implementation. There were some benefits being realised for local ownership of patient flow, resulting from the locality model.
- The report provided feedback relating to improved staff retention, reduction in temporary staffing and significant progress on increasing substantive staffing on inpatient wards.

The Board of Directors:

1. **Noted the content of the report.**

064/25 STRATEGIC IMPACT REPORT

ZT presented a report which provided an update on the implementation of the Trust's Strategic Plan as at the end of the second of five years, as well as updates on the Transformation portfolio and reflection on approach to Operational Planning for 2025/26. ZT highlighted the following:

- The Trust strategy was in its third year of implementation, with considerable progress made for each strategic objective and enabling strategies.
- The report contained details requested by NEDs of a strategic impact dashboard which provided key measures through committees to measure the impact of strategy implementation. The dashboard highlighted that tangible progress had been made, but that this had not seen much movement in strategic impact.
- Work was under way on a mid-point review of the strategy, which will ensure the Trust always maintains a five-year forward view.

Questions & Discussions

- The Board discussed the strategic impact dashboard, with the suggestion of including more graphical information to help interpret the information presented.

The Board of Directors:

1. **Noted and took assurance from the report.**

065/25 DUTY OF CANDOUR ANNUAL REVIEW

AS presented a report which provided details of how the organisation has fulfilled its responsibilities in complying with the Duty of Candour requirements for incidents which occurred between 1 April 2024 and 31 March 2025. AS highlighted the following:

- The intention of the duty of candour legislation is to ensure that EPUT is open and transparent with people who use its services. It applies as soon as reasonably practicable after the screening of the Datix incident by the local manager who becomes aware that a notifiable safety incident has occurred
- There are two parts to Duty of Candour. The first is professional which requires staff to be open and honest with patients and their families or carers when something goes wrong. This is noted and monitored through recording via the Datix incident reporting system.
- There is a statutory duty of candour for all notifiable incidents where an incident has occurred which could result or appear to have resulted in the death of the patient, where it relates directly to the incident or severe, moderate or prolonged psychological harm to the patient.
- The Trust ensures that both parts of the Duty of Candour are applied to ensure the Trust remains open and honest with patients, families and carers.

Questions and Discussions

- In answer to a query as to whether compliance with duty of candour could be measured over time and compared to other similar trusts, AS advised that the Trust has a weekly Emerging Incident Review Group and monthly Accountability Forum. Both allow the Trust to gather data to understand both compliance and themes and feedback from patients and families.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Did not request any further information or action.**

066/25 USE OF THE CORPORATE SEAL

PS presented a report which provided details of use of the Corporate Seal since the last Board of Directors meeting.

The Board of Directors:

1. **Noted the use of the Corporate Seal.**

067/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

068/25 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.

069/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

The Board reflected on the presentation and the theme around identifying data to provide trend analysis, which impacted a number of items discussed.

070/25 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.

071/25 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 risks identified for escalation.

072/25 ANY OTHER BUSINESS

HLD thanked John Jones and Paula Grayson for their commitment and support to EPUT and predecessor organisations during their time as Governors. HLD also thanked Jenny Raine for her contribution as a Non-Executive and Associate Non-Executive Director.

073/25 QUESTION THE DIRECTORS SESSION

Questions were taken from the general public at different points of the meeting and these have been summarised in Appendix 1 along with any questions submitted prior to the meeting.

074/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 06 August 2025.

The meeting closed at 12.43.

Signed: Date: 2025

Hattie Llewelyn-Davies, Chair

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Appendix 1: Governors / Public / Members Query Tracker (Item 072/25)

Governor / Member of the Public	Query	Response
Paula Grayson, Public Governor	The Cardio Metabolic measurements were not consistent across all services, what was the Trust doing to decline in this measurement?	This was a key area of focus for the Trust as it was vital to care for the physical health of patients. There had been some positive areas, such as for Early Intervention in Psychosis Teams. Where compliance has slowed or stalled in some areas, this will be improved through the Time To Care programme and scrutiny at ward level. There will also be some focused work on community services where the measurement has declined.
	Can improving staffing trends be linked to delivering more holistic care for patients? How can the Trust demonstrate that the improvements made are leading to delivering intended outcomes?	The improvements in staffing have demonstrated improvements to patient care by ensuring more permanent staff with the expertise and knowledge are working in services. Improvements include a reduction in restrictive practice and an increased focus on individual needs. Feedback from visits to services has demonstrated a difference being made where Time To Care has been implemented, including wards feeling calmer and more therapeutic activities taking place.
John Jones, Lead Governor	JJ reflected on 15 years of observing EPUT and predecessor organisation boards, noting the increased level of trust between NEDs and Executives. There had also been a sustained improvement to meeting papers, and he suggested the Trust may be able to reduce the level of detail or provide links to detail held elsewhere rather than including it in the reports.	

DRAFT

4. ACTION LOG AND MATTERS ARISING

Standing item | HLD | 10:21

REFERENCES

Only PDFs are attached

Action Log Part 1 06.08.2025.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 4 June 2025

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG	Ann Sheridan	AS		
Scott Huckle	SH	Zephan Trent	ZT		

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
048/25 June	Provide a further presentation / report to the Board of Directors in six months, providing further information on the impact of the project and any feedback from young people on their experiences.	AS/SH	December 2025	This has been added to the Board Schedule.	Future Action	
033/25 April	Provide an update on the development of a support guide function for the Power BI dashboard and / or the development of a training video.	ZT	August 2025	This was discussed a the Board Seminar Session in July, providing details of the existing support function and training video available through the Power	Completed	
	Provide an update in relation to long lengths of stay for PICU services and patients being stepped down from the service.	AG	June 2025	Update provided at the Board meeting in June, advising a review of length of stay had been completed for PICU wards and assurance provided that the long lengths of stay related to the acuity and complexity of the patients.	Completed	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item HLD 10:23

REFERENCES

Only PDFs are attached

Chair's Report 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 2025

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

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

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

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

Lead
Hattie Llewelyn-Davies. Hattie Llewelyn-Davies Chair

CHAIR'S REPORT

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Lampard Inquiry

Lampard Inquiry public hearings took place during July, and heard from bereaved family members who gave evidence concerning the deaths of loved ones who were under the care of North Essex Partnership Trust, South Essex Partnership Trust and EPUT. Family members shared moving descriptions of the care and treatment received, and gave recommendations for improvements. I attended a number of the hearings and was moved to hear of the experiences of these families. We must do all we can to support Baroness Lampard and her team. The Trust Board and I continue to encourage staff to engage with the Inquiry Team openly so that the Inquiry can deliver recommendations to improve mental health care for all. There are further public hearings scheduled to take place in October.

2.2 Changes to Board of Directors and Council of Governors

As Paul will also highlight in the CEO Board Report, I would like to formally note changes to the Board of Directors, with Nigel Leonard leaving the Trust after three decades of NHS service. We are extremely grateful for the many years of dedication, commitment and energy that Nigel has brought to his roles, during which he has overseen many service developments which have had a demonstrable positive impact on the quality of patient care and experience. Nigel is well known and highly regarded across the Trust and health care system, and will be very much missed. Thank you Nigel, and we wish you the very best for the future. In recent years Nigel has led the Trust's response to the Essex Mental Health Inquiry, and latterly the Lampard Inquiry – Denver Greenhalgh, Director of Corporate Governance, will be taking on Nigel's responsibilities relating to the Lampard Inquiry.

I'd also like to note that Doug Field will be joining us shortly as an Associate Non-Executive Director. Doug brings financial and commercial expertise covering retail, property and professional services, and has held leadership roles in the public and charity sectors. Doug will formally join us in the middle of August, subject to the completion of the full on boarding process.

These last months has also seen significant changes to our Council of Governors, with two long-serving members of the Council, John Jones and Paula Grayson completing their maximum terms of office. John was our Lead Governor and provided a calm, professional critical friend to EPUT during his time in office. Paula brought her passion for learning and HR expertise to support fellow Governors and expert input into our Board appointment processes. We also saw the departure of Dianne Collins and David Norman, Public Governors for Essex Mid and South, who left due to personal circumstances and I hope to welcome them back in the future.

I would also like to congratulate all new Governors who have joined us following the recent elections. I look forward to welcoming them to EPUT at our upcoming induction sessions and at the next Council of Governors meeting.

2.3 Review of Patient Safety Across the Health and Care Landscape

A Review of Patient Safety Across the Health and Care Landscape, commissioned by the Department of Health and Social Care was recently published. The review by Dr Penny Dash, Chair of NHS England, looks at the work of a number of bodies created to support improvements to include patient safety, including the Care Quality Commission, National Guardian's Office and Healthwatch England. The review considered any overlaps or gaps in functions and makes a number of recommendations to streamline patient safety and improve accountability across the health and care sector.

2.4 Eradicating Modern Slavery in NHS Supply Chains

Karin Smyth (Minister of State for Secondary Care) has issued a written update on eradicating modern slavery in NHS supply chains:

- The review of modern slavery risk in NHS supply chains published on 14 December 2023 found that 21% of suppliers are at high risk of slavery and human trafficking.
- The Government aims to introduce a single, enforceable approach to modern slavery covering all supply chains across the NHS. These regulations will require all public bodies to assess modern slavery risks in the supply chains, and take reasonable steps to address them.
- The Government has responded to the consultation and regulations are due to come into force in 2026.

2.5 Poplar Therapeutic Education Department Praised by Ofsted

I was delighted that Ofsted has praised the Poplar Therapeutic Education Department following a recent inspection. The department supports young people with their education during their admission to Poplar Child and Adolescent Mental Health Ward at Rochford Hospital. Ofsted recently published their findings, grading behaviour and attitudes as Outstanding, with quality of education, personal development, leadership and management of sixth form provision all rated Good. The inspectors highlighted how teaching staff identify special education needs and disabilities accurately and staff adapt their teaching to build on pupils' interests and support them to gain qualifications. The Ofsted report also highlighted how staff were deeply committed to providing a safe haven for the pupils.

2.6 CQC Rating

Following visits in November and December last year to EPUT adult wards and psychiatric intensive care units, the CQC have recently published inspection findings which highlight the upgraded ratings from *Inadequate* to *Requires Improvement*. The visits focussed on the domains of whether services were safe, and whether services were well led.

This follows *Good* ratings earlier in the year as a result of inspections to both Brockfield House and Clifton Lodge.

2.7 Resilience, Intelligence, Strength and Excellence (RISE) Programme – Recent Graduates

Congratulations to the latest graduates of the RISE programme. The award winning talent development programme was expanded this year to staff working for NHS service providers across the wider Mid and South Essex Integrated Care System. Twenty staff from EPUT, Mid and South Essex NHS Foundation Trust, Mid and South Essex Integrated Care Board and Provide graduated 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. The NHS Workforce Race Equality Standard (WRES) shows that staff from Black and ethnic minority backgrounds are less likely to progress into senior leadership positions compared to staff from white backgrounds. RISE aims to tackle this and at EPUT, our WRES findings for 2024 showed more Black and minority ethnic staff were likely to access non-mandatory training and career progression and development compared to the previous year.

3.0 Legal and Policy Update

3.1 Data (Use and Access) Bill 2025 Passed by Parliament

Please see the links below for copy of the Act that has been approved. I will update you as soon as the commencement date has been released in relation to schedule 15 and Section 121 and inform you should there be any commentary or announcements regarding the potential introduction of regulations connected to these provisions. **For Information: Data (Use and Access) Act 2025; Data (Use and Access) Act 2025 publications - Parliamentary Bills - UK Parliament**

3.2 Immigration Reforms 2025: What sponsoring employers should expect this Summer

Please see the link below for a copy of the Immigration White Paper published on 12 May 2025. Subject to parliamentary approval, it is expected these changes will take effect from 22 July 2025 with transitional arrangements. **For Information: Restoring control over the immigration system: white paper - GOV.UK**

3.3 AI is Improving Communications Practice, but adoption remains even
Please see the link below for a copy of this report published on 23 June 2025. AI is beginning to reshape how NHS communications teams work and improve practice, but access to tools and skills is uneven and clearer governance is needed to ensure safe and effective adoption. **For Information**: **Artificial-intelligence-use-in-NHS-communications.pdf**

3.4 Has the Time Finally Come for Community Health Services?
Please see the link below for a copy of this report published on 24 June 2025. The Community Network unpacks what is needed to realise the ambition of delivering care closer to home and the challenges ahead. **For Information: Has the time finally come for community health services? | NHS Confederation**

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 10:28

REFERENCES

Only PDFs are attached

CEO Report 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	06 August 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**	

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

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

1. Receive and note the content of the report.

Summary of Key Points

The report attached provides information on behalf of the CEO and Executive Team in respect of key matters and strategic developments.

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

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

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

Acronyms/Terms Used in the Report			
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 Changes to Board of Directors

Nigel Leonard, Director of Major Projects and Programmes will be leaving the Trust at the end of August. Nigel has been a valued colleague on the Trust Board since EPUT was formed, as well as our predecessor organisations, and will be missed.

During his time at EPUT Nigel has overseen the closure of Runwell Hospital, overseen the Trust application to become a Foundation Trust, led the mass vaccination programme during the Covid-19 pandemic, as well as more recently leading our response to the Essex Mental Health and Lampard Inquiries. I would like to take the opportunity to say a huge thanks to Nigel and wish him all the best for the future. The wider Board and I will miss his experience and insight.

1.2 Industrial Action 25 – 30 July

The British Medical Association (BMA) undertook planned industrial action between Friday 25 July and Wednesday 30 July. This follows the renewed mandate for industrial action announced on 8 July 2025 by the BMA. The ballot saw a turnout of 55 per cent of those eligible to vote, with 90 per cent of those voting in favour of taking action. The result granted the BMA a six-month mandate for industrial action. The Trust respects the rights of doctors to take action, and contingency plans were in place to ensure we maintained urgent care and preserved patient safety throughout the strike days. The 111 mental health crisis line remained open throughout the strike action.

1.3 10 Year Plan and ICB Changes

The NHS 10-Year Plan sets a clear direction towards more integrated, joined-up care, with ICSs as the foundation for system-level collaboration. Within this, there is growing interest in Integrated Care Organisations (ICOs) as a way to align NHS providers and partners under a single framework to deliver seamless, efficient services. We will work with our ICS and partners to explore how we can support and provide effective and innovative leadership to such models locally, ensuring any approach reflects our commitment to our key priorities and core values.

We are also mindful of the evolving role of ICBs, as they begin to delegate some commissioning and planning responsibilities directly to providers. This shift places greater emphasis on providers, collaboratives and partnerships working together to take shared accountability for delivery and outcomes. We will continue to be a constructive partner in these discussions, offering our expertise and support to help shape sustainable and effective arrangements that meet the needs of our population.

1.4 NHS Operating Framework

The new NHS Operating Framework sets clearer expectations for how systems and providers are supported and held to account, with a strong emphasis on improving access, quality and productivity across all sectors — including community and mental health services.

For us, the key drivers to improvement will include strengthening our operational and financial performance, reducing waiting times in community and mental health pathways, improving flow and capacity management, delivering against our agreed recovery trajectories, and continuing to improve quality standards. This is in line with

the priorities in our operating plan and longer term strategies. We will continue to engage constructively with our system partners and NHS England to address these priorities and work towards earning greater autonomy as our performance improves.

1.5 EPR

Our Electronic Patient Record (EPR) implementation programme continues to progress, with an external assurance partner recently completing an assessment of our readiness for Gateway 2. This has provided valuable independent feedback, and the Programme Board now has a clear set of actions to address ahead of the next stage.

A key focus remains ensuring we maintain appropriate levels of clinical input and leadership throughout the programme, alongside developing a robust, agreed plan for our future-state clinical pathways.

The benefits of a unified EPR are well understood, particularly in improving the quality and timeliness of clinical information sharing, both within our organisation and across system partners, which will ultimately support safer, more integrated care. As we move forward, we remain mindful of the need to safeguard and enhance the vital interfaces between primary care and community services, ensuring that the EPR supports joined-up care across the whole patient journey.

1.6 CQC

The Care Quality Commission has recently published its inspection findings for adult acute wards and psychiatric intensive care units and upgraded their rating from *Inadequate* to *Requires Improvement*. The visit in November and December last year inspected the two key questions of, are services safe and are services well led. The report noted that improvement had been made to the previous breaches, and identified that 23 out of 25 were now met.

The upgrade in rating follows our Forensic service at Brockfield House, and Clifton Lodge, which were both rated as *Good* in inspection reports published by the CQC earlier this year.

We have now received official confirmation from the CQC that the Section 29A warning notice has been lifted following an assessment in December 2024.

1.7 Lampard Inquiry

At the July Hearing, the Inquiry focused on hearing oral evidence from twelve bereaved families concerning the deaths of individuals under the care of the South Essex Partnership Trust (SEPT) and North Essex Partnership Trust (NEP). Although not initially planned for in scope for the July Hearing, the Inquiry also heard oral evidence from two families about the death of a family member whilst under the care of Essex Partnership University NHS Trust (EPUT). These illustrative cases spanned from 2002 to 2022 and cover a range of services. The families through the sessions brought clear focus to their loved ones and their individual circumstances.

The Inquiry will sit again for three weeks from 13 October 2025, where further evidence related to the circumstances of those who died will be heard. The Board and I remain committed to serving the Inquiry, and encouraging our staff to engage with the Inquiry, sharing any experiences or information, both positive and negative. By being open and transparent, we can support Baroness Lampard and her team to provide the answers that patients, families and carers are seeking.

1.8 Improving Flow

Like all parts of the NHS, our acute hospitals and mental health services are under significant pressure. Every day, we see people coming to emergency departments in crisis, needing urgent support for their mental health. Our shared goal is to ensure every patient gets safe, timely care in the right place. However, the system is stretched, and we know that some people are waiting too long in A&E while the best plan for their care is agreed.

Mental health services are working hard to improve flow through our wards and community teams, embedding our Time to Care operating model. We know we have a significant part to play in reducing the waits in emergency departments. At the same time, many of the delays we see are due to wider challenges such as housing, social care and the rising complexity of needs, which no single part of the NHS or social care can solve alone. Acute hospitals also have a duty to care for people with mental illness while the next step is arranged, and we are working in partnership to ensure their staff have the right training, advice and liaison services to help them feel confident in doing so.

2. FURTHER UPDATES

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

Use of the newly developed Power BI inpatient dashboard continues to be rolled out through the Inpatient and Urgent Care Group, to improve oversight of current mental health inpatient stays.

Recruitment to Time to Care posts has progressed in line with the rebased plan. Work continues to fully roll out and embed the new operating model on our inpatient mental health wards.

Operations have stood up the Winter Planning Process across our mental health and community services, with our system partners, with the plan to be signed off through Executive and Board governance.

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

The final signed audit opinion for the final accounts and annual report 2024/25 was received on 29 July 2025.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Learning Event 10th July

The EPUT Learning Event held on 10 July 2025 focused on improving patient care through reflections on key areas. A patient case study was used to demonstrate how Fundamentals of Care and Quality Improvement (QI) projects would have improved the care of the patient case study presented. The event also addressed enhancing mental health patients' involvement in physical health monitoring and reducing disparities in physical health care for individuals with severe mental illness. Key initiatives included staff training, patient education, and implementing structured care plans to prevent diagnostic overshadowing and improve holistic care in mental health inpatient settings. The event was interactive and gave opportunity for discussion, and attendees were encouraged to make pledges that were captured as part the discussions/actions. Post-event resources are currently being produced and will be available soon.

EPUT / PAH Partnership
As a result of ongoing partnership work between EPUT and PAH Speech and Language Therapists, there has been some improvement in community SLT referral waiting lists for video fluoroscopy. Both organisations have also agreed to work in partnership regarding Falls Prevention and Management. This was agreed at a meeting last week led by both organisations' Executive Chief Nursing Officers.

Visiting Professor Appointment
Dr Rebecca Pulford, Director of nursing and CNIO has been appointed as Visiting Professor of the Faculty of Health, Medicine and Social Care at Anglia Ruskin University (ARU) for the period of July 2025 to July 2028. Since joining EPUT, Rebecca has become a key partner with the Faculty of Health, Medicine and Social Care and has developed close working relationships with the senior leadership team. This has resulted in several key outcomes, including the implementation of actions for the Nursing & Midwifery action plan to meet NMC standards with EPUT, the introduction of Fundamentals of Care Framework to both the School of Nursing and School of Midwifery and Community of Practice, and the development and implementation of an EPUT/ARU joint post for a Lead Nurse for Clinical Learning Environment Quality – a first of its kind.

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

Job Evaluation
The NHS Staff Council and its Job Evaluation Group (JEG) have recently completed a review of the national job matching profiles for nursing and midwifery and these were published on 3 June 2025. EPUT has a steering group comprised of staff side representatives for collective job descriptions. This implementation group are working collaboratively ensuring the local action plan is in place with realistic milestones for reporting and oversight.

Mutually Agreed Resignation Scheme (MARS)
A MARS scheme was initiated in May and June 2025 to support the flexibility of the organisation to address periods of rapid change and service re-design. Panels were established for consideration, review and confirming applications during June and July. The Trust received 80 applications with 29 of those accepted for MARS. All individuals have received the outcome of their application and for those successful, settlement agreements are being administered and the necessary exit arrangements put in place. The first of these resignations will take place from 24 July 2025.

Flu Planning – Winter 2025/2026
The second highest reason for absence in EPUT during last year was flu, with the equivalent of 14,453 FTE days lost. Increased staff take up of flu vaccination will therefore support the reduction of absenteeism due to flu and provide enhanced protection to prevent the spread of infection to colleagues and patients. For this winter planning the Trust's Occupational Health provider (OH) PAM will provide a nurse to hold flu clinics for staff over October, November and December 2025. Scoping work is underway to identify suitable space. It is proposed that the clinics will be arranged across the geography of the county in order to make attending the clinics as convenient as possible, particularly for our front line staff.

RISE Programme
The RISE (Resilience, Intelligence, Strength, and Excellence) programme, led by the EPUT, is a customised talent development initiative designed for staff from Black, Asian, and minority ethnic backgrounds. Launched in 2021, the programme aims to

foster leadership potential, address inequalities and support career progression for employees from bands 2 to 8b. In July, we celebrated the graduation of our fourth cohort, with participants showcasing a range of Quality Improvement (QI) projects that have delivered measurable improvements to both workforce and patient outcomes.

Sexual Safety and Unprofessional Behaviour

Our National Staff Survey results (October 2024) highlighted that 3.5% of the workforce had experienced unwanted behaviour of a sexual nature from other colleagues, a deterioration of 0.5% from the previous year. As part of our commitment and the statutory duty under the *Worker Protection (Amendment of Equality Act 2010) Act 2023* to prevent sexual harassment in the workplace, the Trust has partnered with the GMC and NMC to develop a face-to-face training package with colleagues across Specialist Services. Across 2025-26, this will 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.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS 10:33

REFERENCES

Only PDFs are attached

Quality and Performance Scorecard 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	06 August 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	

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 increased and remains outside target in June. PICU Occupancy remains within target threshold after a small reduction on May. Specialist Occupancy remains below the >95% target in June.

Older Adult Occupancy further increased in June and continues to exceed the target threshold <86%.

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

Adult ALoS reduced in June; however remains outside the target of <35. There were 87 discharges, 35 of whom were long stays (60+ days). When including the Assessment Unit this decreases to 55 days.

A new Oversight Framework was published at the end of June with changes to be implemented on our measurement. The Adult inpatient target will be 60 days, whereby the inclusion of the assessment unit will be reported as meeting target.

Older Adult average length of stay increased in June due to 4 patients discharged with stays over 250 days and remains outside the target of <74. There were 31 discharges, 22 of whom were long stay (60+ days). The average length of stay for inpatients currently on Older Adult wards remained the same in June, also remaining outside the target of <80. 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 reduced in June and remains outside the target of <50 days at 95. There were six discharges from PICU in June, four x Hadleigh and two x Christopher Unit, one of whom was a long stay (Hadleigh 363 days).

Rates of Patients Clinically Ready for Discharge:
Patients with a delayed transfer of care on Adult, PICU, Older Adults and Specialist wards all continue to report well within their respective target limits.

Inappropriate Out of Area Placements:
During June one patient was stepped down from PICU to Adult out of area placements.

There was a reduction in the number of placements in June (Adult reduced by three, Older Adult reduced by one and PICU increased by one).

Following the repatriation of 24 (20 Adult and four PICU), there were 66 remaining (56 Adult, two Older Adult and eight PICU) Out of Area Placements (OOA) at the end of the month.

The number of patients in an OOA bed at the end of June (66) increased from that reported at the end of May (58, Adult increased by six and PICU increased by two).

ICB system partners have requested a Remedial Action Plan for the reduction of OOA placements.

OPEL Status:
There were 21 days at OPEL 4 status in June.

Cardio Metabolic:
The indicator for health checks for SMI patients in Early Intervention Psychosis services continues to report good compliance remains above target of >90% at 96% in June.

Inpatient areas had Seven wards fully compliant in June (439 Ipswich Road, Henneage, Tower, Kitwood, Topaz, Meadowview and Wood Lea). Overall compliance has reported gradual reductions over the last several months.

Specialist (excluding Learning Disabilities & Mother & Baby) remains the lowest performing area. This is due to staff shortages on Alpine, Lagoon and Forest wards. Rehabilitation wards remain above the 90% target.

For SMI patients in the Community Teams under 1 year the overall compliance position continues to improve and is nearing the 65% target reporting 62% in June following sustained month on month increases.

The blood lipids / glucose test (cholesterol, blood glucose or HbA1c measurement) remains the least completed element of the physical health check form. This is in part due to limited availability of trained staff, sickness, vacancies and delays in test results being returned.

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

All three areas are reporting reduced access rates, both the 6wk and 18wk wait to treatment are reporting 100%.

The Talking therapy percentage moving to recovery reports at 59% in June which is the highest ever reported.

Virtual Wards
Occupancy levels reported at 75% across MSE and West Essex.

Workforce:
After 3 months within target, the sickness absence rate has returned outside the threshold from 4.8% in May to 5.6% in June. This rise in absence aligns with higher levels of acuity as well as the heat waves during this time that had an impact on the reasons for absence. The absence rate also influenced an increase in temporary staffing use, particularly bank staff use toward the latter part of June 25.

Staff turnover has reduced from a peak last month and has returned to levels that the Trust has experienced and within the target of 12%. There is a current review of turnover when benchmarking against similar organisations and it is likely the target of 12% will be reduced. Apart from a one month spike the staff turnover has been positive and take consideration of an enhanced strategy on the nationally sponsored people promise programme.

Temporary Staffing:
The number of booked Agency shifts continues to reduce, with each month reporting the fewest ever to which June is no exception at 841 (the first time we have reported under 1000). All units saw a reductions compared to the previous month, with the exception of Specialist Services, where booked shifts increased from 10 in May to 26 in June. Temporary Staffing spend in month was £3.8m, reflecting a downward trend with a £0.2m reduction compared to the previous month.

The daily oversight governance with care unit clinical leads in Inpatient and specialist services continues to focus on reducing temporary staffing. This has demonstrated a continued and sustained reduction in the use of agency staff with bank on a downward trajectory apart from a rise in the latter part of June.

Ward Fill Rates:
The Number of wards with less than 90% fill rates is showing an increasing trend. June reports 27 against the target of <13.

The overall performance for staff fill rates continues to achieve target (for day/night un/qualified) but the margin of target attainment is reducing, with the Day/Night Qualified staff both reporting 91% and 92% respectively for June (against 90% target).

Income & Expenditure
The in-month deficit £0.6m, YTD deficit £1.9m, £0.4m better than plan.

Efficiency
Delivery in month £1.9m, YTD delivery is £5.6m, in line with plan and supported by temporary staffing improvements.

Capital
Capital spend YTD £1.4m, £2.9m below planned spend. The Trust is working to accelerate programmed activities over the remainder of the year

Cash
Cash balance £33.3m, including receipt of deficit support funding and reduced capital spend. Cash balances are planned to reduce in future months.

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

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

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

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

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

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

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Information Item | Chairs | 10:47

REFERENCES

Only PDFs are attached

Committee Chairs Report (Part 1) 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 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	Assurance provided for internal controls as part of Committee discussions.	
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	

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 (Dr Ruth Jackson)
4. Quality Committee (Dr Mateen Jiwani)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report

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

6 August 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: 4 July 2025

Assurance

Internal Audit Progress
- One audit has been finalised:
  - Locality Sites Compliance with Policies and Procedures – Reasonable Assurance.
- Four audits are in progress:
  - Data Security and Protection Toolkit 2024/25.
  - Ann McIntyre Review 2024/25.
  - Consent.
  - Management and Implementation of CQC Actions.
- Two recommendations relating to Consultant Job Plans are overdue.

External Audit Progress
- At the time of the meeting, the Finance Team were continuing to work closely with EY to resolve issues raised relating to the Trust's 2024/25 financial accounts.

Waiver of Standing Orders
- The Committee received a report on Waiver activity during April-May 2025.
- Around half of the Waivers received during this period were retrospective. The Committee will continue to monitor backdated Waivers throughout the financial year.

Clinical Audit – Assurance on Process & Delivery
- An assurance report relating to Clinical Audit was discussed by the Committee.
- Suggestions were made for improvements to the report format and content. The report will be revised and re-presented at the next Committee meeting.

Information

Anti-Crime Progress
- The Trust received a Green overall rating.
- The Economic Crime and Corporate Transparency Act will start in September 2025.
- The National Fraud Initiative Exercise is underway.
- Section 12 Mental Health Act Assessment and Project Athena is progressing well.
- An audit relating to polygamous working is currently underway.
- One working whilst sick case has been concluded, with the subject required to repay an overpayment. This will also be investigated by the Police and the NMC.

Alert

No Alerts for the Board.

Action

No Actions for the Board.

NHS
Essex Partnership University
NHS Foundation Trust

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 24 July 2025

Assurance

Emergent Issues

- The Committee discussed a number of emergent issues which helped inform the meeting. These included both national changes in the oversight framework and local changes in ICB configurations, roles and responsibilities. The Committee noted the importance of continuing to work collaboratively with system partners.

Performance Report

- Assurance on the Trust's performance during June 2025 included the following areas:
  - Flow and Capacity
  - Response times for 111 crisis services: Positive assurance provided for an improvement in response times, with action being undertaken to reduce delays where staff experience aggression from callers.
  - Occupancy rates for inpatient services, including details of changes to rates, with two areas within target, and two outside of target range, noting continued movement. The report also noted challenges regarding staff recording of date of discharge which was being taken forward.
  - Average Length of Stay, including positive assurance regarding continued reduction in some areas, but noting a likely increase as longer stay patients are discharged.
  - Out of Area Placements, noting a decrease in June, however, this remains an area of challenge until a unified solution is reached.
  - The number of individuals detained under the Mental Health Act. The Committee agreed to monitor this and highlight to the Quality Committee as required.

The Committee provided positive feedback for changes made to the Integrated Performance Report.

Financial Report

- The Committee received an update on Month 3 financial results (a YTD deficit of £1.9m, which was £0.4m better than plan) and capital. The Committee noted positive assurance for YTD deficit and cash balance as ahead of plan, noting capital spend is behind plan, with work underway to recover the position.
- Risk and mitigations included the Inquiry costs and out of area placements.
- The Committee noted the position and the increased challenge as the year progresses.

Operational Plan Progress Report

- The Committee received an update on the operational and strategy planning process, noting a more comprehensive report would be presented in October..

Board Assurance Framework Report

- The Committee Received the BAF risks aligned with the Committee. The Committee noted the discussions held at the Committee impacted the following strategic risks:
  - **SR4 Demand and Capacity:** Assurance provided regarding controls in place, noting challenges in relation to commissioning and response delays for the crisis line. Positive assurance provided in relation to the Time To Care programme.
  - **SR5 Statutory Public Inquiry:** Noted risk highlighted in the Financial Report regarding resourcing the Lampard Inquiry, to be pulled through in the overall BAF.
  - **SR7 Capital:** Noted capital spend is behind plan, but work was underway to recover the position.
  - **SR8 Use of Resources:** Positive assurance provided regarding deficit and cash balance, but noted future financial challenges as highlighted in the Emergent Issues section.
  - **SR10 Workforce Sustainability:** Positive assurance provided in relation to the use of temporary staffing and the overall staffing position for the Trust.

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 24 July 2025

Assurance (cont.)

Time to Care Progress Update

- The Committee received an update on progress with the Time To Care programme, including the re-baselining of timescales.
- There were positive updates in relation to recruitment and the embedding of new operating models. There was some variation in implementation, with some areas such as West Essex seeing excellent progress.

Visit to St. Margaret's Community Hospital

- The Committee discussed positive feedback provided by a member following a recent visit to St Margaret's Hospital for the opening of a new communal area. The Committee discussed the importance of therapeutic environments, including minor changes which could have big impact on the experience of services.

Electronic Patient Record (EPR)

- The Committee received a verbal update in relation to the EPR programme which was now at localisation phase of the programme. The first mental health modules had been shared and clinical staff were thanked for their time in helping review these modules.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

NHS
Essex Partnership University
NHS Foundation Trust

3. PEOPLE COMMITTEE

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

Committee meeting held: 26 June 2025

Assurance

People Strategy
- The Committee is in support of proposals to commence a refresh of the Trust's People Strategy.
- Further updates will be provided to the Board as work progresses.

Temporary Staffing
- The Committee received assurance that, at the time of the meeting, temporary staffing levels were on track to achieve the targets within the Operational Plan for Quarter 1.

Assurance Reports
- The following Assurance Reports were received by the Committee:
  - Board Assurance Framework – Workforce
  - Equality & Inclusion Annual Report 2024/25
  - Guardian of Safe Working Annual Report 2024/25
  - National Quarterly Pulse Survey – Quarter 1 2025/26
  - Workforce Key Performance Indicators.

Alert

Freedom to Speak Up Annual Report 2024/25
- The Committee approved the Freedom to Speak Up Annual Report 2024/25 for presentation to the Board of Directors for ratification. This will be presented in a separate Agenda item.

Mutual Agreement Resignation Scheme (MARS)
- The scheme has now concluded. An update will be provided to the Board in a separate Agenda item.

Information

Staff/Student Story
- A Speciality Doctor, who joined EPUT in August 2021 as an international medical graduate, attended the meeting to provide an account of their experience at the Trust .
- Overall, this had been very positive, and they felt supported by their mentor and team.
- They suggested the experience of international recruits could be enhanced further with more opportunities to pursue professional interests and career aspirations, and the introduction of formal arrangements for networking with peers.

People & Culture Directorate Away Day
- A People & Culture Directorate Away Day was held in June, with a variety of presentations and discussions about the Directorate's future aims for the next 12 months alongside measuring effectiveness

Job Evaluation
- The Committee received a report providing an update on the national review of nursing and midwifery job profiles agreed as part of the 2024/24 pay deal.
- An internal steering group has been formed to provide continual engagement with staff side.
- People and Finance Teams are working together on financial and HR arrangements.
- An action was agreed to take forward a paper to Board associated to Job Evaluation.

Anglia Ruskin University (ARU)
- A meeting has been held with ARU to align strategic aims and directions.
- There was good discussion, with all parties in agreement about vision and strategic aims.
- Further updates will be provided as work progresses.

Action

No Actions for the Board.

4. QUALITY COMMITTEE

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

Committee meetings held: 12 June & 10 July 2025

Assurance

Assurance Reports
• The following Assurance Reports were received by the Committee:

- Board Assurance Framework.
- CQC Assurance Report
- Infection Prevention & Control Quarterly Report.
- Learning Disability Improvement Standard Report.
- Mental Health Act Report.
- Neurodiversity Report.
- Patient & Carer Race Equality Framework Report (including an updated 2025/26 Plan).
- Physical Health Annual Report 2024/25.
- Reducing Restrictive Practice Quarterly Report.
- Safeguarding Quarterly Report.
- Sexual Safety Quarterly Report.
- Time to Care Update.
- Quality of Care Performance Dashboard.

Information

Neurodiversity Discussion
• An Autism Specialist Consultant Psychiatrist attended the Committee to provide their perspective of neurodiversity work at the Trust.

Sexual Safety Discussion
• A colleague attended the Committee to share her experience of sexual safety during her roles as Student Nurse and Band 5 Nurse at the Trust.

Medication Clinical Practice
• The Committee received a report reflecting on clinical practice relating to medication.

Oxevision Update
• The Committee received a verbal update on the review of Oxevision procedures.

Patient / Family Story
• Committee members watched a short video, sharing the story of an autistic person using the Trust's mental health services.

Alert

Learning From Deaths Quarter 4 2024/25 Report
• Committee members approved the Learning From Deaths Quarter 4 Report.
• This will be presented to the Board in a separate Agenda item.

Ligature Annual Report 2024/25
• Committee members approved the Ligature Annual Report 2024/25.
• This will be presented to the Board in a separate Agenda item.

Action

No Actions for the Board.

7.3 CQC ASSURANCE REPORT

Information Item AS 10:57

REFERENCES

Only PDFs are attached

CQC Assurance Report 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	06 August 2025

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Executive Director – Governance					
Report Author(s):	Comfort Sithole, Head of Compliance and Emergency Planning. Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality Committee 10 July 2025, Quality of Care 24 July 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

3. Asked to approve the archiving of the CQC improvement plan and a refresh to create version 2 to include residual open actions and new actions arising from recent inspection activity.

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- An unannounced CQC visit is underway at Bryon Court (LD Inpatients). To date this has included two site visits (one day and one evening) and a follow up information request. The CQC have indicated that they will be speaking to stakeholders and to members of the unit leadership team as part of the inspection.
- The Trust received the final Report following the CQC unannounced focussed inspection for the Safe and Well Led domains on our MH Adult Acute and PICU Inpatient Services in November / December 2024. The service has achieved an improved rating of 'Requires Improvement' from the previous rating of 'Inadequate'. Following the issue of the report the Trust has received formal notification of the S29A warning notice (issued after the Dispatches programme) has been lifted, as the CQC have received suitable assurance in relation to the areas of concern identified in 2022.
- The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made, with 94% having been agreed for closure through the Evidence Assurance Process.
- As EPUT moves forward with new improvement actions to address the findings of the latest inspection reports, it is proposed that we archive the current version of the improvement plan, by formally acknowledging the achievements to date and approving the carry forward of the remaining open actions (along with their history) to the next version (v2: 2025).
- There were nine 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	✓

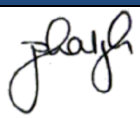
Impact on equality and diversity	
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**

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 Inspection Report Adult Acute and PICU

Lead



Denver Greenhalgh
Executive Director – Governance

CQC Assurance Report

1. Purpose of the report

This report provides the Board of Directors with:

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

2. CQC Registration Requirements

2.1. Registration

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

2.2. Registration changes

Registration of two new Non-Executive Directors, Sarah Teather and Richard Spencer.

3. CQC Inspections and Improvement Plans

3.1. Unannounced CQC Inspection

1.1.1 Learning Disability Inpatients - Byron Court

An unannounced CQC visit is underway at Bryon Court in July-August 2025. To date this has included two site visits (one day and one evening) and an information request. The CQC have indicated that they will be speaking to stakeholders and to members of the unit leadership team as part of the inspection.

3.1.2 Forensic Inpatient/Secure Wards – Brockfield House

Following review of the CQC inspection report issued in April 2025, the Forensic Inpatient Service have developed an improvement plan to address areas for improvement identified within the report.

Due to the outcome being a ‘good’ rating, it is noted that the CQC have not asked EPUT to submit an action plan. However, the Care Unit are taking forward improvement actions associated with:

- Patient involvement in the development of their individual care plans
- Provision of user friendly copies of care plans (including a review of the length of care plans)
- Continued focus on supporting patients to raise concerns and to have responses to raised concerns.

All actions have been Compliance checked and challenged and the action plan has been approved by the CQC Leads Group subject to final amendments. Action progress will be monitored to completion through agreed CQC improvement plan governance, including the evidence assurance process with our ICB colleagues.

3.1.3 Adult Acute and PICU services

An unannounced inspection was undertaken on our Mental Health Adult Acute and Psychiatric Intensive Care Unit Inpatient Services in November/December 2024, with the report published on 11 July 2025. The service received an improved rating of 'requires improvement' and positively reports that 23 of the previous 25 concerns raised having been addressed (full report attached at Appendix 1).

Following the issue of the report the Trust has received formal notification of the S29A warning notice (issued after the Dispatches programme) has been lifted, as the CQC have received suitable assurance in relation to the areas of concern identified in 2022 (copy attached at Appendix 2).

The CQC have highlighted two areas where regulation was not being met and asked for a Decision Review Action Plan to be submitted. The two are:

- Continued evidence of systems and processes not always being used safely, to prescribe, administer and record medicines.

- Continued concerns relating to staff supervision and appraisal rates and relating to safe prescribing, administration and recording of medicines which resulted in a breach in safe care and treatment. This further triggered a breach in governance due to the insufficient oversight of these issues.

Development work underway to review the report findings using SEIPS methodology to identify causal factors. As with the above Forensic Services report the review also picks up identified non-regulatory areas for improvement, these will use the terminology of 'should do' as a common language within our process.

Our MH Adult Acute and PICU Inpatients Services are developing an improvement plan to address the regulatory breaches identified within the report. These will be monitored following the previous process for Must do actions. In addition an improvement plan is being developed to address the additional areas for improvement which will be monitored as CQC Improvement Actions and follow the same process as previously used for "Should do" actions.

A new CQC improvement/action plan 2025 is in development which will include actions from both the Forensic inspection and MH Adult Acute and PICU inpatient inspection.

3.2. CQC Improvement Plan 2022-2025

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

The plan consists of 78 'must do' / 'should do' actions (Note: combination of some actions into one), with 348 sub-actions associated with CQC inspection activity.
Overview as of the 24 July 2025:

- 75 (96%) of the Must do / Should do actions have been completed

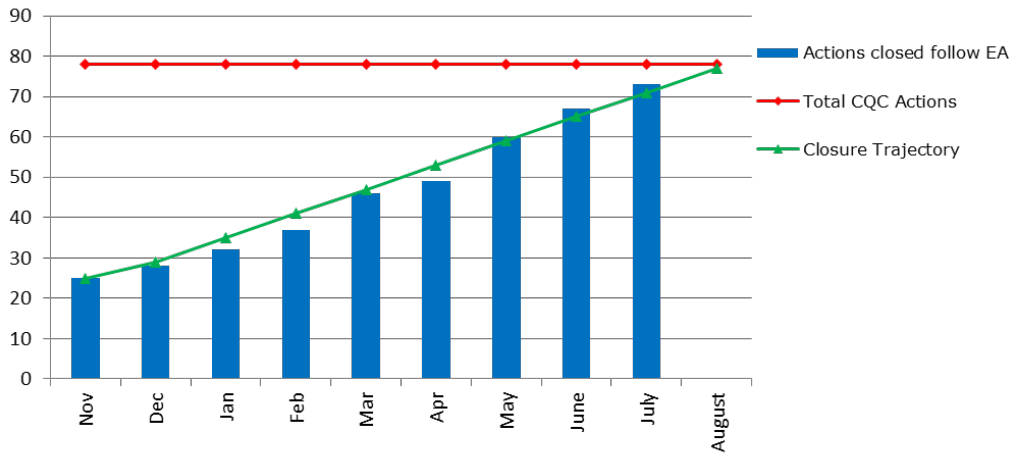
- 73 (94%) have been closed through the evidence assurance process and 2 are planned for evidence assurance presentation in July/early August 3035

- 3 (5%) of the Must do actions are proposed for transferred to a refreshed CQC Improvement plan for 2025

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

A trajectory to monitor actions being taken forward for EAG sign off was established in 2024.

Previously reported slippage against the trajectory has been recovered and increased focus has remained which has moved closure of actions ahead of trajectory.



During the reporting period, the EAG met on the 4 June, 2 July (chaired by EPUT Executive Chief Nurse) and 23 July (chaired by EPUT Executive Director for Governance). ICB representatives and EPUT operational and corporate staff in attendance.

At the current rate, all actions will have been through EAG by August 2025. The two remaining items in the pipeline for the Evidence Assurance Group; one 'must do' (M38 Use of covert medication); and one 'should do' (S1 Internal Inquiry). Following these approvals there are just three actions remaining on the current version of the improvement plan, covering:

- M21 (Medicine Management) – incomplete action ongoing is the full transition of refresher training to be annual. Training may also need to be reviewed to address concerns raised in the recent CQC inspection report.

- M15 (Patient Informal rights) – incomplete action assurance to facilitate closure of the action

- M6 (incident reporting) - incomplete action ongoing associated with the CCTV sub-action to procure and implement new software to enable easier access to footage.

Where independent assurance is received from inspection it has been utilised for the EAG assurance process, alongside our internal evidence.

3.3 CQC Improvement Plan Refresh

In 2022-2023, EPUT teams underwent a number of high profile and challenging reviews, culminating in the requirement to submit multiple action plans to the Care Quality Commission.

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

New Process - Given the scale of the challenge, EPUT took the opportunity to review its process of responding to inspection reports with a view to wider engagement at service / ward level and to gain deeper understanding of the causes of the findings and co-design solutions that would be impactful and sustainable. In addition, to define lines of accountability and a set of behaviours for those identified as 'action owners'.

Engagement - The feedback from the teams involved was excellent and throughout the process we have seen:

- ✓ High levels of engagement with the process and ownership for the actions
- ✓ Teams and individuals sharing good practices to scale up
- ✓ Pockets of excellence in continuous improvement capability
- ✓ Honesty and openness
- ✓ Open-mindedness to embrace a new process and the supporting the standard of work

Approach - Actions were grouped into five themes for improvement: Governance and culture of learning; Clinical care; Environment and equipment; Technology and data; and Staffing.

The output was the development of a single CQC Improvement Plan encompassing all actions across the range of reviews. This brought a benefit of ease of oversight, consistency of delivery, removal of duplication as new reports were added; ease of sharing themes and solutions across services. The single oversight and evidence assurance route consisted of:

- Weekly CQC Leads Meeting (Chaired by the Executive Director for Governance) – created a weekly check in and confirmation of actions being 'on

track' and enable early identification of barriers to change. And, preliminary review of evidence to support closure of the actions from the plan.

- Monthly Evidence Assurance Group – held in partnership with our ICB quality leads from the three Essex facing ICBs (HWE, MSE and SNEE). Originally chaired that the MSE ICB Chief Nurse, this is now chaired by EPUTs Executive Chief Nurse.

- Executive Team – receive a monthly SitRep report and detail of any actions reported as 'off track' and the plans to recover these actions.

- Quality Committee / Board of Directors – receive a bi-monthly report of progress as an integral component of the CQC activity report.

Learning is further shared through the Learning Collaborative Partnership.

Next Steps - As EPUT moves forward with new improvement actions to address the findings of the latest inspection reports, it is proposed that we archive the current version of the improvement plan, by formally acknowledging the achievements to date and approving the carry forward of the remaining open actions (along with their history) to the next version (v2: 2025) and we seek the Board's approval for this approach.

3.3. CQC Enquiries

During the reporting period, the CQC raised nine (9) enquiries as outlined below.

Received	Service	Enquiry related to
07/05/2025	439 Ipswich Road	Communication breakdown with relatives
07/05/2025	439 Ipswich Road	Unhappy with Treatment
08/05/2025	Cedar Ward	Assessment & Treatment
15/05/2025	Wood Lea Clinic	Staff to patient physical assault
15/05/2025	Wood Lea Clinic	Staff to patient physical assault
29/05/2025	Kelvedon Ward	Failure to follow procedures
13/06/2025	Mental Health Assessment Unit Basildon MHU	Not documented
13/06/2025	Inpatient Services	Consent to Treat
16/06/2025	Lighthouse Child Development Centre	Referral and Treatment

3.4. CQC Notifications

During the reporting period the Trust has made twenty three (23) notification submissions to the CQC including:

- Death of a detained MH patient (3),

- Absent without leave (1)
- Death of a person using the service (5)
- Allegations of abuse (7),
- Serious injury to a person using the service (7)

4. Annual Programme 2024-25

4.1. Internal Assurance

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

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

4.2. Quality Assurance Visits

The Quality Assurance Visits have continued during the reporting period.

5. Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report

2. Note the assurance on progress against the improvement plan

3. Asked to approve the archiving of the CQC improvement plan and a refresh to create version 2 to include residual open actions and new actions arising from recent inspection activity.

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Denver Greenhalgh
Executive Director - Governance

Care Quality draft assessment for Essex Partnership University NHS Foundation Trust-Acute wards for adults of working age and psychiatric intensive care units

Overview

Overall Rating: Requires Improvement

The service is not performing as well as it should and we have told the service how it must improve.

Summary

Safe	Not assessed
Well-led	Not assessed

Overall Service Commentary

We carried out an inspection of Essex Partnership University NHS Foundation Trust acute wards for adults of working age between 18 November 2024 and 12 December 2024. The team visited 9 acute wards including:

-Peter Bruff and Ardleigh wards at Colchester Mental Health Hospital

-Chelmer ward at the Derwent Centre

-Finchingfield and Galleywood ward at the Linden centre

-Cherrydown Ward at Basildon Mental Health Unit

-Cedar ward at Rochford Hospital

-Hadleigh ward at Basildon Mental Health Unit and the Christopher Unit at the Linden Centre which were PICU wards.

The team looked at all the quality statements for safe and 7 for well led. The trust's acute wards were previously inspected in 2023 and rated as inadequate. Following this inspection, the rating had improved to requires improvement. During our inspection, we found there were still concerns as identified at the previous inspection, relating to staff supervision and appraisal rates. We found there continued to be issues relating to safe prescribing, administration and recording of medicines which resulted in a breach in safe care and treatment. We also identified a breach in governance due to the oversight of these issues.

Although the trust had made improvements to dignity and respect, which were identified at the previous inspection, we observed 2 poor interactions from staff towards patients on Ardleigh ward during this inspection. However, we conducted a night visit and gained further assurance on staff engagement with patients. Overall, the trust had made improvements to patient care plans which were now holistic and reviewed regularly, but they did not always evidence patient involvement. Despite feedback from patients that the ward environments were generally clean, there were some delays to maintenance repairs being completed at Rochford and the trust were in the process of refurbishing wards.

Since the last inspection, the trust had made improvements to the previous breaches we had identified where 23 out of 25 breaches were now met. We found improvements in reporting and recording of incidents and the trust ensured staff followed their updated observation policy. There were now enough regular staff working on wards, including psychology staff. Maintenance work had been completed so staff could observe patients from all areas. The trust ensured patients understood the use of the contact-free patient monitoring system and sought consent. Patients had access to nurse call alarms and all sites had an updated prohibited items list. Improvements were also made to ensure processes were in place to support staff working at night. The trust assessed and mitigated risks concerning the sexual safety of patients and incidents of racial abuse to staff were reported and appropriate actions taken. Informal patients were informed of their rights and were able to leave the ward safely. Wards now had separate search rooms or areas to conduct patient searches in private. The trust had conducted work to embed a restrictive practice reduction plan and reviewed and reduced blanket restrictions. The trust worked with staff to ensure they maintained professional boundaries and that staff were now up to date with mandatory training.

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Overall People's Experience

Patients on most wards felt able to raise concerns and knew who to raise these with. Patients had mixed views about their experiences of admissions, transitions and discharges on the wards. Most patients told us they felt safe on the wards. Patients told us that although they were usually given a copy of their care plans and risk assessments, they were not always involved in these. Patients told us that there were enough staff available, they could see a doctor when they needed to, they could access activities and therapy and access community leave. Patients were generally satisfied with the environment and equipment on the wards and said the wards were clean, tidy and well maintained. Patients were not always given medicines which met their individual needs or in line with manufacturer recommendations. Patients sometimes experienced delays in accessing medicines to take away when being discharged or utilising leave. Patients that we spoke with told us they were able to give feedback on how to improve the service they received.

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Safe

Rating: Not assessed

Percentage Score: 62.00 %

► **Amending judgements**

Summary

This service is not always safe

Commentary

At our last inspection we rated this key question as inadequate. Following this inspection, the rating has improved to requires improvement. Since the last inspection, the trust had made improvements to the previous breaches we had identified where 23 out of 25 breaches were now met. During this inspection, we found 1 breach of the legal regulation safe care and treatment for prescribing, administering and recording of medicines, which was also identified at the last inspection. Although there were processes in place to ensure patients were receiving their medicines safely and as prescribed, these were not always being followed. Medicine allergies were not always recorded on prescription charts. There were sometimes gaps in administration records where it was not clear if a prescribed medicine had been given or not. Care plans we reviewed for specific health conditions sometimes lacked detail or had inconsistencies in the information included between different documents. Staff did not always follow NICE guidance when using rapid tranquilisation. Instances we reviewed of the use of rapid tranquilisation (RT - use of medicines intramuscularly to reduce extreme agitation/distress) showed that

required post dose physical health monitoring was not being completed in line with the Trust policy or national guidance. Staff did not review when required medicines to ensure its continued use was appropriate and having the desired effect. Some records indicated that patients were given medicines over the maximum recommended doses within a 24 hour period.

However, the trust had effective processes in place for learning from incidents and complaints which were shared across wards. Multi-Disciplinary Team meeting minutes demonstrated patients' views were sought and the trust engaged with partners to support patients with their admissions and discharge. The trust had a clear process to record and investigate safeguarding concerns. The trust took a proportionate approach to imposing restrictions on patients and restrictive practice was reducing. There were appropriate staffing levels and skill mix to meet patients' needs. Although there were some issues with the environment and repairs, the trust had a refurbishment plan in place and were fixing the faults. The trust had an infection, prevention and control (IPC) policy, which was reviewed regularly, wards were clean and hygienic with suitable facilities to enable effective Infection Prevention Control.

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Safe

Learning culture

Overall Score

1 **2** 3 **4**

▶ **Amending judgements**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

Patients on most wards felt able to raise concerns and knew who to raise these with. We observed a community meeting at Cherrydown ward Basildon mental health unit where patients were encouraged to give open and honest feedback. All patients except those at Basildon Mental Health Unit and Rochford Hospital said they had a de-brief following an incident. We saw examples of meeting minutes where patients had raised issues on all wards. However, community meeting minutes did not always demonstrate follow up of actions and outcomes.

Feedback from staff and leaders

Staff we spoke with knew what incidents to report and how to report them. Staff told us they had received feedback following safety incidents and where actions had been taken. Staff and managers told us they had debriefs following incidents. Managers explained the processes for dealing with accidents, incidents and complaints and gave examples of these. For example, following the first week of our inspection, a dashboard had been promptly created to improve the monitoring of rapid tranquilisation. Learning from this was shared across sites. Staff and managers were aware of a tailgating incident on Peter Bruff ward where action to install an airlock was taken.

Processes

There were systems in place for the recording of incidents and immediate actions taken to address these. The trust had effective processes in place for learning from incidents and complaints which were shared across wards and sites. Staff feedback and clinical governance meetings demonstrated that complaints and incident learning were regularly shared and that processes had been embedded. For example, staff and managers described being involved in learning and participating in safety huddles, de-briefs, reflective practice meetings and team meetings. Staff also spoke about receiving regular incident information in the form of monthly 5 key messages and regular incident briefings. Managers spoke consistently about attending meetings to review learning from incidents. The trust had current improvement plans reflecting their current issues. We reviewed these and saw these were logged, reviewed and acted upon to ensure improvements were made. Managers spoke about learning from deaths and inquests across all wards. The trust were still working on improving their oversight of deaths and embedding their processes to combine learning and outcomes from inquests. However, we did see that the trust reviewed themes of deaths, for learning, in the monthly inpatient quality and safety committee meeting. In November 2024, themes surrounding learning from deaths were associated with neurodivergence and physical health. As a result, the trust were reviewing their environments to ensure sensory needs were supported for neurodivergent patients and were working with learning disability and autism commissioners to support the trusts neurodiversity strategy.

To improve physical health monitoring the trust ensured staff were still able to obtain physical health checks of patients using a non-contact approach where staff measured vital signs such as pulse, breathing rate and movements without having to touch patients who declined physical health checks. The trust were also ensuring staff recorded physical health checks for patients that were taken using the non-contact approach so that all physical health checks were being recorded.

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Safe

Safe systems, pathways and transitions

Overall Score

1 **2** 3 **4**

► **Amending judgements**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

Most patients told us they felt safe on the wards. Patients had mixed views about their experiences of admissions, transitions and discharges on the wards. Most patients said they were given information on admission and shown around the ward. However, many patients said they were frustrated with the delays to being discharged, although 2 patients had a positive experience with this. Some patients felt they needed more employment and housing support when transitioning back into the community.

Feedback from staff and leaders

Staff orientated patients to the ward and said they provided patients with information about their treatment, rights, advocacy and welcome information.

Managers were aware of challenges they faced with the environment at their mental health suite in Colchester where patients were first seen and assessed leading to admission to hospital. These included access to food and showers and the environment, which were not comfortable for patients, as the room was small and did not have a window. Managers were taking action to improve their patients experience of this service.

Managers sometimes experienced challenges in managing patient flow between admissions and discharges. They spoke about the impact of delayed discharges and other system delays that led to patient bed capacity issues. This meant there could sometimes be no beds available to admit patients from urgent care. Senior leaders were aware of this and continued to ensure discharge co-ordinators, liaison staff and urgent care teams were addressing challenges with patient risk, flow and discharges. The trust were working with general hospital colleagues to improve how they worked together to support mental health patients and improve patient flow at general hospitals.

Managers spoke about some pathways not being clearly defined, specifically pathways for patients with emotional and unstable personality disorder and learning disabilities. Managers said this impacted patient flow across the wards.

Staff and managers spoke about the high acuity on wards and that managing risk could be a challenge but that keeping patients safe was their priority.

As a result of recent incidents, managers implemented a new observation policy to improve staff observations of patients. This focused on engagement with patients, staff well-being, tailoring observations to meet patients' needs and observations being regularly reviewed.

Staff and managers spoke about the challenges they sometimes faced when working with the police who referred to the right care, right person model where this could be a challenge in managing the risk for patients on leave or under urgent care.

Managers had links with social services and external organisations which enabled them to support patients with access to the community, transitions and discharges.

Feedback from Partners

We sought feedback from members of integrated care boards, local authorities and other stakeholders across Essex, to obtain their view of the trusts systems, pathways, patient flow, safety and quality. Integrated Care Board members attended several of the trust's quality and safety meetings where they received information and assurance, challenged and discussed actions and mitigation. They said they worked well with the trust and staff were open and approachable.

Integrated care boards worked with the trust to focus on complex patients and those with long stays and who were homeless. They participated in various forums with the trust, where patient flow, discharges, safety and quality were discussed.

The Integrated Care Board participated in the trusts patient safety oversight group which was part of the Patient Safety Incident Response Framework (PSIRF) providing a strategic direction and ensuring the trust aligned with national and local safety priorities.

Processes

Managers ensured safe systems by having oversight of the wards through regular meetings with ward managers and matrons. Senior managers reviewed incident data, action plans, care pathways, and held regular meetings with managers and teams. Following the previous inspection, managers introduced a clinical site officer to ensure the oversight, safety and function of each site during out of hours and at the weekend. The officer ensured tasks and roles were allocated sufficiently, the services were safe, and staff were supported with breaks and well-being. They also held regular safety huddles with staff to ensure this was an embedded practice at night.

The trust had policies on referrals, admissions and discharge outlining the process in place for these. Multi-Disciplinary Team meeting minutes demonstrated patients' views were sought and the trust engaged with partners to support patients with their admissions and discharge. The trust recorded estimated dates of discharge in care review meetings. However, not all wards recorded barriers to discharge, and the actions taken to address these. Evidence of involvement with care co-ordinators and other stakeholders supporting discharge were evident in minutes.

The trust had discharge co-ordinators working with wards and partners to discharge patients. The trust were revising their pathway model where they were reviewing the purpose of an admission and reasons for delays to discharges with system partners and discharge co-ordinators. The aim of this was to focus on any obstacles to discharge to improve the patient flow and

discharge process. Senior managers said they worked with local integrated care boards and local authorities to review the timeliness of patient admissions and discharges with the focus to improve system flow and patient experience. Managers also spoke about implementing the time to care model that had enabled teams to improve the standards of care that were consistent across wards.

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Safe

Safeguarding

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

We spoke with patients of which most told us they felt safe on the wards. Community meeting minutes took place regularly on the wards and safety and well-being were discussed. Patients said they were able to raise concerns, and that staff took action to address these. However, patients did not always receive the outcome from investigations.

Feedback from staff and leaders

Staff knew how to make a safeguarding referral and escalate concerns. Staff could describe how they had protected patients from harassment and discrimination, including those with protected characteristics under the equality

act. For example, staff shared an incident where they had identified and reported financial abuse. Staff knew how to recognise adults and children at risk of or suffering harm and were aware of the processes to follow to report and record this. They worked with internal departments and external agencies to protect patients.

Observation

During the inspection, we generally observed patients being supported by staff who understood how to protect patients from harm. However, we observed 2 poor interactions from staff towards patients on Ardleigh ward where staff were not observed to be engaging or responsive to patients. We shared our observations with the trust. The trust were aware of some challenges on Ardleigh ward and had moved senior staff to work on the ward to focus on embedding their acute therapeutic inpatient model, 'Culture of Care.' This included modelling behaviour, providing support with safeguarding and working with their advocacy provider to improve the experience of care for patients. We also conducted a night visit where we gained further assurance on the engagement and interactions between staff and patients.

We observed staff quickly and appropriately defuse a potential incident at another location. We saw posters displayed on wards giving information about safety, advocacy, patients' rights and how to make a complaint.

Processes

The trust had a clear process to record and investigate safeguarding concerns. We reviewed the safeguarding log, which was up to date, included details about safeguarding incidents and if it was being investigated internally or by the local authority. The log demonstrated reporting, oversight, review and safeguarding outcomes. The trust had a safeguarding policy and clear processes in place for staff to follow. Managers spoke about a sexual safety charter they had embedded on the wards. Staff participated in mandatory sexual safety training and managers developed flow charts for staff to follow on how to manage sexual safety incidents and what actions to take.

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Involving people to manage risks

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

We spoke with patients who told us that although they were usually given a copy of their care plans and risk assessments, they were not always involved in these. We spoke with 6 patients at Colchester Mental Health hospital, 3 patients on Ardleigh ward fed back that incidents of restraint they were involved in were not always managed well. However, patients on other wards reported better experiences of being restrained. Some patients felt staff managed incidents well and supported them in situations of distress. Some patients felt that de-briefs after an incident had enabled them to be more involved in how their care was managed in the future.

Feedback from staff and leaders

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 gave several examples of interventions they would use to manage and de-escalate situations. Staff said they knew patients, and this helped them to support patients and prevent potential incidents from escalating. Staff spoke about understanding patients' formulations of risk and positive behaviour support plans so that they knew how best they could support them. Staff regularly updated care plans and risk assessments following incidents. We saw examples where risk assessments had been updated following incidents of restraint that included patient views. Managers

told us they reviewed incident information to monitor trends at locations and sent incident briefings to staff so that they were aware of the themes and trends for their service.

Processes

The trust had a reducing restrictive interventions policy which included guidance and procedures for managing and reducing restrictive practice. This was aligned to the trusts quality of care strategy led by directors and included input from expert by experience and safety partners. The trust joined the reducing restricting collaborative partnership agreement where other trusts were responsible for assuring the quality of each other's reducing restrictive practice work and undertook peer review visits.

The trust held monthly restrictive practice group meetings. We viewed minutes between September 2024 and November 2024 where all areas of restrictive practice were presented. Senior leaders told us that a thematic review of seclusion and Long Term Segregation was completed which showed a reduction in restraints, use of seclusion and long term segregation and the number of non-fixed ligatures on adult wards from September 2024 compared to last year. The trust felt the focus on Safewards (a program that aims to reduce the restraint and seclusion of patients on psychiatric wards) had helped to reduce these. At the Basildon mental health unit, a number of staff had completed the Post Graduate certificate in reducing restrictive practice.

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Safe

Safe environments

Overall Score

1 2 **3** **4**

▶ **Amending judgements**

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

Patients were generally satisfied with the environment and equipment on the wards, although some patients raised concerns about the facilities on Ardleigh ward. Two patients said the kitchen could be messy, the toilets were sometimes blocked, and soap and tissue roll were not always replenished. Overall, patients said they could access the garden and could access drinks and snacks. Patients had access to lockers to store personal belongings and valuable items. Following risk assessments, patients could use ward or mobile phones on the wards. Most patients said the environments were comfortable but 1 patient at the Linden Centre and 1 patient at Rochford hospital said the wards were noisy and echoey.

Feedback from staff and leaders

Staff we spoke with knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff had access to personal alarms along with radios to communicate across wards and used body worn cameras on the ward with the aim to reduce risks to patient and staff.Staff assessed environmental risks to patients and took action to reduce risks where possible. Staff were aware of the security on the ward and what the role of the person allocated to security involved. Staff described the processes for searches and how they conducted observations on the wards. Staff were aware of blind spots within the service and knew how to mitigate against these. The trust had fitted mirrors and closed-circuit television to monitor communal areas and staff used enhanced observations to support patients with additional risks.

Observation

We observed a potential ligature risk in patient bedroom corridors and in rooms on Chelmer ward at the Derwent Centre. However, on review of the ligature risk assessments these were included, rated and mitigated.

We also observed that the ward storeroom was cluttered, and the emergency evacuation chair was blocked in on Chelmer ward, which would be difficult to access in an emergency which we raised with managers. Parts of the environment on Cedar ward at Rochford hospital had delays to some repairs on the ward. Two accessible bathrooms and two extra care bedrooms required repairing and although reported had lengthy delays to being fixed. These rooms were not in use at the time of the inspection. Patients used en-suite facilities to shower in their bedrooms. Cedar ward had no seclusion room which could be challenging when managing a patient at risk.

Wards at the Linden centre had a laminated ‘hot spot’ document that was not up to date and was complex which made it hard for new staff to retain. We observed that the ligature hot spot document, rated as red and amber, did not indicate if actions were completed.

We reviewed maintenance logs for Cedar ward where the heating was a reoccurring issue that required repairing. Several bedrooms were reported to have heating that was not working and although this was repaired, they were reported as not working repeatedly. However, overall, across the trust repairs were fixed in a timely manner.

Processes

Although the trust completed regular and up to date environmental, health and safety risk assessments, managers had not ensured the repair of some aspects of the ward environments at the Linden Centre, Rochford hospital and the Derwent centre. However, the trust generally made repairs in a timely manner. The trust had a process in place in line with its therapeutic observations and engagement policy to carry out patient observation.

The service was clean, generally comfortable, decorated and furnished well. The wards complied with guidance and there was no mixed sex accommodation. We observed staff having easy access to, and using, alarms and patients had easy access to nurse call systems in their bedrooms. In addition to observations, the trust used the monitoring system called Oxevision, where infrared cameras were used to remotely track and monitor patients’ vital signs 24 hours a day whilst they were in their bedrooms. Staff were able to monitor patients’ well-being, detect potential risks and were alerted if patients presented with a risk to their safety. The trust sought consent from patients prior to using Oxevision and we observed consent forms, posters and information informing patients of its use. Staff explained the purpose of Oxevision to patients and requested consent from patients on admission.

Staff on Hadleigh ward at Basildon Mental Health Unit, had not completed daily trolley checks on 3 occasions during October 2024 and the suction machine was not recorded as being cleaned in the cleaning records. The suction

machine was kept at the back of a cupboard and was not left on charge so that staff could use this in case of a choking emergency.

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Safe

Safe and effective staffing

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

We spoke with patients across 9 wards who all told us that there were enough staff available, they could see a doctor when they needed to, they could access activities and therapy and access community leave. Some patients felt 2 wards were busy and that staff were not always visibly present in the communal areas.

Feedback from staff and leaders

Managers reported that staffing had improved across the wards with the introduction of the time to care approach. Staff we spoke with knew their patients and their needs well. Managers were able to adjust staffing levels to meet the needs of the patients on the ward. Managers told us they tried to ensure regular bank staff were booked when required. Patients had access to a multidisciplinary team including for example, medical staff, nursing staff, health care assistants, activity co-ordinators, occupational therapists and

psychology. Staff also told us they benefited from having access to specialist nursing support. This included physical health nurses, tissue viability nurses and Parkinson's nurses where they were needed.

The trust used the Mental Health Optimal Staffing Tool (MHOST), to review and assess their staffing numbers. Following CQC's on-site visit, CQC received concerns about the changes to staffing levels and the potential impact on staffing levels and safety on some wards. Managers responded to these concerns and explained they had recently reviewed and changed their staffing levels to increase the number of registered nurses on shift. The aim was to reduce the number of temporary staff being used, improve the quality of care and to utilise a more multi-disciplinary team approach that included new peer and family ambassador roles.

Observation

As part of the inspection, we observed 9 out of 9 wards. Our observations showed that on the days we visited the wards there were enough staff to complete therapeutic observations and to actively engage with patients. However, some staff interactions with patients on Ardleigh ward were not supportive or engaging when patients had made requests or were seeking support. For example, we observed a staff member calling a patient rude. We conducted a further night visit and gained assurance on staff engagement and interactions with patients.

Processes

The trust held twice daily calls on staffing with operational directors and senior nurse involvement to look at all rostering with escalations in place where patient and staff safety concerns were identified. They also held weekly meetings to look at safer staffing alongside temporary staffing with patient safety and staff wellbeing at the centre of decision making.

The wards had low vacancy rates. At the time of inspection, the vacancy rate for whole time equivalent qualified nurses ranged between 4.7 for Finchingfield ward and 0.2 on Ardleigh ward with the remaining wards ranging between these figures. Healthcare assistants' vacancy rates were low with the only vacancy being on Finchingfield ward at 0.7.

The service had varied sickness rates in October 2024, ranging between the highest on Finchingfield ward at 14%, 7% on Chelmer ward and 8% on Galleywood ward and Christopher unit. The lowest sickness rate was 1% on Cherrydown ward. The wards had an increasing turnover rate in October 2024,

which varied between wards. The highest turnover rate was 21% on Finchingfield ward, 19% on Chelmer ward, 18% on Galleywood ward and the lowest was 1% on Cherrydown ward which had reduced since the previous month. The remaining wards had a turnover rate varying between 5% and 10%.

Managers used bank staff and agency staff to fill shifts to cover sickness, absence and vacancies. Managers tried to book regular bank and agency staff when required. The trust was proactive in recruitment including the use of overseas recruitment and internal staff development. The trust had a comprehensive mandatory training programme in place with training to meet the needs of staff and patients. Training figures showed staff were compliant with mandatory training including Mental Health Act Training and Intermediate Life Support. On some wards managers did not ensure staff received regular supervision and appraisals.

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Safe

Infection prevention and control

Overall Score

1 **2** 3 **4**

▶ **Amending judgements**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

On 8 out of the 9 wards we visited patients said the wards were clean, tidy and well maintained and the wards had good domestic teams. On Ardleigh ward patients said there were times when there was no soap or toilet roll in the bathrooms and patients had to ask staff. We observed this being discussed in the community meeting.

Feedback from staff and leaders

Staff said the environment was kept clean and there were appropriate arrangements for maintaining good standards of cleanliness and hygiene. Leaders carried out quarterly infection, prevention and control audits to monitor cleanliness and hygiene and ensure infection, prevention and control processes were effective.

Observation

Wards were clean and hygienic, the wards had suitable facilities to enable effective infection prevention control. There was suitable guidance in the buildings to prompt patients on safe infection prevention control, for example, we saw posters displayed on handwashing. On 8 out of 9 wards food was stored hygienically. On 1 ward we observed items in the dairy and patient fridge that were not labelled or dated, and the patient refreshment area was not clean. However, staff addressed these issues once we had let them know. On Finchingfield ward at the Linden Centre, cleaning record checks were not recorded 6 times in October 2024 and 6 times in November 2024.

Processes

The trust had a detailed Infection Prevention Control policy, which was reviewed regularly, a policy at a glance with staff responsibilities was also available. IPC audits and action plans were viewed for 5 wards, out of 9 with compliance over 80% on all action plans were sent out after audits and there was evidence of actions being taken and signed off. Quarterly Infection Prevention Control audits were also carried out with 8 out of 9 wards 80% and above.

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Safe

Medicines optimisation

Overall Score

1 **2** **3** **4**

▶ **Amending judgements**

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

Patients were not always monitored after receiving rapid tranquilisation (RT - use of medicines intramuscularly to reduce extreme agitation/distress). Some records indicated that patients were given medicines over the maximum recommended doses within a 24 hour period or without the recommended interval between doses. Patients' care plans for specific health conditions lacked detail or had inconsistencies in the information included between different documents. Although patients were supported to receive their medicines in a timely and effective way, they were not involved in decisions about how they would like to receive their medicines to ensure this met their individual preferences, where possible. Some medicines which are recommended to be given prior to other medicines or before food and drink to ensure they would be as effective for the person as possible were not being given in line with the manufacturer's recommendation or at the correct times. Patient discharges and leave were sometimes delayed due to limitations and complications with the new electronic prescribing system. This caused a delay in them getting their prescribed medicines ready in time for the leave. However, the trust were aware of these issues and were taking action to address these.

Feedback from staff and leaders

Staff we spoke to about rapid tranquilisation were not clear on what the trusts monitoring and debrief policy was or how they were expected to follow it. Pharmacy staff we spoke with were aware of issues regarding rapid tranquilisation and were providing further training to staff on this. Staff we spoke to were unaware of the administration guidance and clinical pharmacy

checks had failed to identify the need to give medicines earlier than was written on the prescriptions. This meant that some medicines may not be working as effectively as they should be for those patients. Staff told us they received a mix of online and face to face training to support them with medicines management. There had also been seminars provided by the pharmacy department into the appropriate way to manage controlled drugs. Staff attended handover meetings where patients' treatment with medicines would be reviewed. Any errors, omissions or concerns with medicines were escalated at this meeting. Staff told us pharmacists were available on the ward every day and they received deliveries from the pharmacy dispensary 3 times a day. Outside of regular hours staff had access to an on-call service and emergency medicines cupboards to ensure timely access to treatments if needed. One member of staff told us that pharmacy's presence and support on the unit was 'invaluable.'

Observation

On most wards we visited staff recorded cleaning record checks of the clinic rooms however on Hadleigh ward staff failed to record cleaning record checks of the clinic room on 3 occasions during October 2024 and we could not locate any record for September 2024.

We also identified gaps in room temperature recording and gaps for the end of month review by managers on Finchingfield ward and Galleywood ward.

Controlled drugs were stored in line with requirements and routine checks of levels were completed by staff.

Processes

Managers had not ensured staff regularly recorded cleaning checks, room temperatures and equipment checks on Hadleigh ward and Finchingfield ward. There were processes in place to ensure patients should receive their medicines safely and as prescribed, however these were not always being followed. There were sometimes delays in patients obtaining prescribed medicines because staff had not escalated concerns of medicines not being in stock, this included antibiotics where a delay in initiating the treatment could lead to a deterioration in the person's condition. The Trust had recently implemented a new electronic prescribing and medicines administration (ePMA) system. Staff were still in the process of learning the system and understanding the data it holds and how it could be used to help inform safer and more effective care. Medicine allergies were not always recorded on

prescription charts which increased the risk staff may give a medicine which a person was allergic to. There were also sometimes gaps in administration records where it was not clear if a prescribed medicine had been given or not.

We could not find records of follow up investigations which ensured the medicine was given as prescribed. Care plans we reviewed for specific health conditions sometimes lacked detail or had inconsistencies in the information included between different documents. For example, an epilepsy care plan lacked any detail about the type of seizures that occurred, potential triggers and treatment recommended, another for diabetes management had different target ranges for blood glucose and when to give rapid acting insulin. Where patients were prescribed medicines which can impact on their physical health and require routine monitoring this was not being recorded. Care plans and risk assessments often failed to identify these medicines and what the expectation was for staff to keep patients treated with specific medicines safe. Some prescriptions for ‘when required’ (PRN) medicines lacked important details such as the maximum daily dose of the indication that the medicine is prescribed for.

Instances we reviewed of the use of rapid tranquilisation (RT - use of medicines intramuscularly to reduce extreme agitation/distress) showed that required post dose physical health monitoring was not being completed in line with the Trust policy or national guidance. However, following this feedback, the trust had developed a dashboard to improve the monitoring of rapid tranquilisation.

There was a high use of ‘when required’ (PRN) oral medicines for the management of anxiety/agitation and insomnia on both wards. Where these medicines were being used regularly and at the highest available dose, we did not see mention of this use being reviewed in multi-disciplinary team meetings to ensure its continued use was appropriate and having the desired effect. Some records indicated that patients were given medicines over the maximum recommended doses within a 24 hour period or without the recommended interval between doses. This could lead to over sedation and increased risk of side effects from medicines. We were not assured that PRN medicines were always being used safely. There were a number of errors that had been identified by the trust and recorded for both wards visited at Colchester. However, some of these errors are the same as we identified on the inspection, which would suggest that learning and changes to practice were not being effectively implemented when things do go wrong.

Well-led

Rating: Not assessed

Percentage Score: 62.00 %

► Amending judgements

Summary

This service is not always well-led

Commentary

At our last inspection, we rated this key question as inadequate. Following this inspection, the rating had improved to requires improvement. We found one breach of the legal regulations in relation to good governance where there continued to be gaps in the management and support arrangements for staff, as identified in the previous inspection. For 4 wards, Ardleigh, Cherrydown, Christopher Unit and Hadleigh supervision rates ranged between 53% to 74% and for 2 wards Ardleigh and Cherrydown ward, appraisal rates were 65% and below.

We also found there continued to be evidence of systems and processes not always being used safely to prescribe, administer and record medicines which resulted in a breach in safe care and treatment.

However, staff knew the trust's visions and values and were involved in the development and ongoing review of these. Staff and leaders ensured any risks to delivering the strategy, including relevant local factors, were understood and had an action plan to address them. They monitored and reviewed progress against delivery of the strategy and relevant local plans. Leaders were knowledgeable about issues and priorities for the quality of services and could access appropriate support and development in their role. Duty of Candour records showed the trust were open and honest with patients and relatives. The trust had policies in place that were in line with best practice guidance. Staff said they felt able to speak up and were listened to and where there was learning this was shared amongst staff. Despite the oversight of medicines and staff support, governance processes mostly operated effectively, and performance and risk were managed well. The trust promoted workforce equality, diversity and inclusion and worked with partners and communities. There were processes in place to ensure that learning happened when things went wrong, and from examples of good practice. Leaders encouraged reflection and collective problem solving.

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Shared direction and culture

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff were able to explain what the visions and values of the trust were and how they applied to their role, staff said the visions and values were discussed regularly in meetings and supervisions and they were able to give feedback on these. Staff said they felt respected, valued and supported.

Processes

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.

The trust had developed a quality of care strategy which they planned to embed between 2024 and 2026. The emphasis of this strategy was to focus on quality through safety, experience and effectiveness using patients lived experience of care. The trust implemented the time to care model based on learning from the past and guidance for best practice. This included a new staffing model to broaden the skills in teams and a focus on purposeful admissions and discharges. This also focused on training and development in trauma-informed care, racial-equity and autism. Staff had fedback some concerns about this model and approach to care. The trust had put measures in place to support staff with these changes and were working at ways to engage staff in this process.

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Capable, compassionate and inclusive leaders

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff felt supported by managers and told us the overall culture of the service had improved since the last inspection. Managers described how changes to the structure of management had made a positive impact in allowing better oversight and scrutiny. Leaders were visible within the service and had the experience, capacity, capability, and integrity to ensure that the organisational vision could be delivered, and risks were well managed.Staff spoke positively about the introduction of the clinical site managers to support the wards out of hours and at weekends.

Processes

Managers had developed and embedded a protocol to check staff were not sleeping on duty at night. This protocol was introduced along with the clinical site officers. This followed the previous inspection where we raised concerns in relation to staff sleeping at night. We also had feedback from some patients during this inspection that there were instances of staff sleeping when they should be undertaking observations. Managers had embedded this protocol to minimise this. Interventions included reducing patient observations to 30 minutes instead of an hour from midnight until the day shift, 30 minute well-

being checks of staff on day and night shifts and the implementation of the site officer who checked allocation of tasks, ensuring staff were getting the correct breaks, doing walk rounds, offering breaks and drinks.

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Well-led

Freedom to speak up

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff were aware of the term 'freedom to speak' 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 able to speak up and were listened to and where there was learning this was shared amongst staff.

Processes

The trust had policies in place that were in line with best practice guidance for freedom to speak up, whistleblowing and complaints. Between September and December 2024 there had been 9 whistleblower complaints across the 9 wards we visited, the themes were team culture, staffing levels and staff conditions. Staff were given the opportunity to speak up and drive improvement through staff surveys, supervisions and meetings.

The trust used a scoring system to evaluate inpatient staff survey results. Results showed that out of 364 staff respondents, the trust received a score of 6.84 out of 10 for ‘we have a voice that counts’. Out of 355 staff responses, the trust scored 7 for staff engagement. Staff also felt ‘recognised and rewarded’ and scored 5.93 out of 10 compared to the overall organisation result of 6.37 out of 10.

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Well-led

Workforce equality, diversity and inclusion

Overall Score

1 **2** 3 **4**

► **Amending judgements**

Summary

Good – This service maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff told us they had equality champions on wards including Black and Ethnic Minority champions, LGBTQ+, personality disorder and neurodiversity champions. Staff were aware of information available on the intranet relating to equality and diversity and knew where they could access this information. Staff spoke about information from the equality networks being widely publicised and shared with staff across the organisation. Most staff said managers were open and there was a zero tolerance to bullying or harassment.

Staff spoke about 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.

Processes

The trust had a workforce race equality standard action plan (2024- 2025) and a workforce disability action plan (2024-2025) where all indicators were reviewed and updated to ensure progress had been made. The trust had made a commitment to embed the Patient Care Race Equality Framework (PCREF) to involve patients and carers in decisions of care, treatment and policy making. PCREF is designed to ensure racialized communities have fairer access to services, improved outcomes and better experiences of services.

The trust had 5 staff equality networks including Ethnic Minority and Race Equality, Gender Equality, LGBTQ+, Disability and Mental Health, Faith and Spirituality where members worked with the trust to understand the needs of the communities and shape improvements. 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. This was an area highlighted at the previous inspection where not all staff said they would report this. Managers 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. Data showed that reporting of incidents of racial abuse had increased by 244% where 82 incidents were recorded between 1 April 2022 and 31 December 2022. This rose to 279 between 1 April 2023 and 31 December 2023.

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Well-led

Governance, management and sustainability

Overall Score

1 **2** **3** **4**

► **Amending judgements**

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff said they had regular team meetings, situation report meetings to discuss any issues or risks, multi-disciplinary team meetings, attended safety huddles, received regular lesson learned information and understood their roles. Most 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 feedback that they received regular supervision and appraisals, however, supervision and appraisal rates remained low for some wards.

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. Managers spoke about having oversight of capacity, budgets, audits, performance, key performance indicators and incident data. They shared clinical dashboards with teams and managers for oversight and review.

Processes

The trust did not have sufficient oversight of staff supervision and appraisals and did not ensure systems and processes were being used safely to prescribe, administer and record medicines. These issues were breaches at the previous inspection where the trust held an action plan to address both these areas. However, this was not currently active, so they did not remain an area of focus by managers. Further work was required to ensure governance systems were fully embedded.

However, there were 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 were taken to learn and improve.

The trust held a risk register for inpatient and urgent care which we reviewed for December 2024. All risks were identified with risk scores, controls, mitigations with assurance and action review dates. The highest risk related to the use of inappropriate out of area placements which was rated as extreme,

and bed availability was rated as high. Leaders said staff could make suggestions to add to the risk register which would be escalated to the quality assurance meeting.

The trust had made efforts to improve the quality of and the culture of care delivered across the organisation by implementing the Quality of Care Strategy and the Time to Care model. These focused on improving the quality and safety on wards with a focus on co-production and improving the staffing levels.

Staff knew how to deal with complaints and reported incidents and safeguarding concerns. Managers shared lessons learned from investigating complaints, incidents and safeguarding issues. Following the previous inspection, the trust had made improvements in relation to learning from incidents and to improve safety. The trust reviewed deaths and patient safety inquests, but they were still working on embedding this to ensure a formalised process was in place to include inquest outcomes and associated learning was jointly reviewed.

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Well-led

Partnerships and communities

Overall Score

1 **2** 3 **4**

► **Amending judgements**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

Patients we spoke with talked about using leave to access the local community and community facilities. Some patients raised frustrations about delays to discharges and that they needed more support with transitioning back into the

community for areas to do with employment and housing.

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

Feedback from staff and leaders

The trust had 5 staff equality networks including Ethnic Minority and Race Equality, Gender Equality, LGBTQ+, Disability and Mental Health, Faith and Spirituality where the trust worked with members to understand the needs of the communities and shape improvements.

Staff had 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.

Staff told us that they completed mandatory training and were encouraged to engage in training that was in addition to their required training. They shared learning within team meetings, team debriefs and within reflective sessions.

Feedback from Partners

Integrated Care Boards told us they worked with the trust through various forums focusing on quality, safety and performance. Integrated Care Board members felt that the trust's staff and leaders were open and approachable, and they worked well together to address operational needs.

The trust held a monthly trust wide meeting with Essex police where they engaged on issues and worked well together to form solutions. The trust had contacts with the police and were able to contact them quickly if they needed to.

Processes

The trust worked with integrated care board members and worked in partnership with housing providers, social care providers and other healthcare organisations to facilitate discharges of patients from the service.

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

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Well-led

Learning, improvement and innovation

Overall Score

1 2 3 4

► Amending judgements

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

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

Leaders told us about a project on Peter Bruff ward where an anti-ligature and anti-barricade alert called 'Safe Hinge' on doors was being trialled. The system was designed for mental health environments to reduce the risk of ligatures and barricading and included a full door alarm to alert staff of any ligaturing or barricading attempts on doors. The trust were trialling this in one bedroom.

Staff told us about a quality improvement project on Cherrydown ward to support staff, so they did not sleep on shift at night. Staff developed a protocol on this which was shared across the trust. The protocol included reducing staff observations of patients from 1 hour to 30 minutes.

Stort ward conducted a quality improvement project, where the aim was to reduce the use of seclusion by 15% by December 2024, which was achieved. This included the team working through a number of change ideas evaluating how these impacted on reducing restrictive practice on the ward. The ward presented their findings so that their learning could be shared.

Staff received training across the trust on culture of care sessions covering trauma-informed care, racial-equity and autism.

Basildon Mental Health Urgent Care Department were nominated for the NHS parliamentary awards for excellence in urgent care and were one of the finalists.

Staff spoke about receiving regular incident themed learning emails so that they were aware of the themes and learning from incidents in their areas.

Processes

The trust had a process in place where they met regularly to review learning from deaths. The trust were still in the process of fully embedding this. The trust had various meetings in place to ensure that safety, quality, performance, improvements and learning were actioned and reviewed.

The trust had made a commitment to embed the Patient Care Race Equality Framework (PCREF) to involve patients and carers in decisions of care, treatment and policy making. The Linden Centre were involved in piloting this piece of work.

Senior leaders spoke about launching a new quality strategy in January 2024 which runs to 2028. This had been co-produced and had key objectives related to safety, effectiveness and experience and included end of life care, neurodiversity and health inequalities.

The trust worked on reducing complaints for the last two years where they completed a co-produced quality improvement project to improve the complaints process. The trust saw a 30% reduction in formal complaints.

The trust were involved in a discrimination and violence pilot where a racial abuse scrutiny panel took place at Basildon police station. The aim of the panel was to ensure that the outcomes of hate crimes involving NHS staff were appropriate and addressed the barriers to reporting these and to maximise the trust and confidence that NHS staff have in the police. As a result, a number of investigations had been reopened, police committed to being more visible, a joint action plan was developed, and further meetings were planned with the police.

The trust embedded a new records system to ensure all teams could access and were using the same system. The trust also rolled out a new electronic prescribing and medicines administration system for prescribing, ordering, administering and recording medicines.

The trust had key quality of care governance priorities for 2024 and 2025 that included a plan for each quarter. The priorities included 3 main areas including safety, focusing on reducing restrictive practice, infection prevention control and safeguarding. Secondly, effectiveness, specifically focusing on improving physical health, suicide prevention and medicines optimisation and lastly experience, with a focus on reducing health inequalities, promoting neurodiversity and end of life care. This work was still on-going.

The trust reviewed quality improvement projects in their inpatient quality and safety committee meetings. These included patient case studies on inquest learning and long term segregation. The trust noted a reduction in seclusion and long term segregation, self-harm and ligatures for the last two months in September 24.

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Paul Scott
Trust Head Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

30 July 2025

Dear Paul,

I am writing to you to confirm that we have now lifted the previous 29A Warning Notice that was served on 30 October 2022. We have lifted this Warning Notice following our assessment in December 2024. During this assessment we received suitable assurances in relation to the areas of concern identified in the Warning Notice on 30 October 2022.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Hazel Roberts

Deputy Director of Operations- East of England

7.4 FREEDOM TO SPEAK UP ANNUAL REPORT

Decision Item JS 11:02

REFERENCES

Only PDFs are attached

FTSU Board Report 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 2025

Report Title:	**Freedom to Speak Up Service – Annual Report**					
Executive/ Non-Executive Lead	Nigel Leonard – Director of Major Projects and Programmes					
Report Author(s):	Janice Scott - Freedom to Speak Up Guardian					
Report discussed previously at:	People Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relate 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 strategic risks.		
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. Currently on the Directorate Risk Register		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with: • An update on the Freedom to Speak-Up (FTSU) service activity 1st April 2024 to 31st March 2025 • Assurance on the FTSU arrangements with identified strengths and areas for improvement.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the contents of the Annual report.
2. Agree, in principle, next steps set out under "priorities for service development 2025/26."
3. Support greater collaborative work around Speak Up routes across the trust.

Summary of Key Issues

The attached report provides the following key points:

- Increased capacity within the team has resulted in increased awareness raising of the FTSU service and a strengthening of concerns management and case closures.
- A higher number of anonymous concerns were raised which generic and targeted engagement is planned to support understanding and trust building in the FTSU process. A more comprehensive reporting process will provide greater intelligence on the root cause of concerns and support the triangulation of concerns in partnership with other service departments.
- Following a review of FTSU escalation processes based on staff, manager and director feedback, a more localised and informal process of resolving concerns with escalation where relevant has been introduced.
- The 2025/26 delivery plan will focus on targeting staff less likely to engage or speak up and reintroduce the FTSU Champion roles to increase the reach of the service.

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

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

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

Acronyms/Terms Used in the Report			
ER	Employee Relations		

FTSU	Freedom to Speak Up		
NGO	National Guardians Office		

Supporting Reports and/or Appendices

Freedom to Speak-Up Annual Report

Executive Lead:

Nigel Leonard
Director
Major Projects and Programmes

FREEDOM TO SPEAK-UP

1. PURPOSE OF REPORT

This report provides the Board of Directors with:

- An update on the Freedom to Speak-Up (FTSU) service activity 1st April 2024 to 31st March 2025
- Assurance on the FTSU arrangements with identified strengths and areas for improvement.

2. BACKGROUND TO FREEDOM TO SPEAK UP

Following the Francis Inquiry and subsequent reports in 2013 and 2015, Freedom to Speak Up (FTSU) was developed as one of the recommendations. The initiative is to develop a more open, responsive and psychologically safe environment throughout the NHS which enables staff to feel confident to speak up when things go or may go wrong, to ensure a safer and more effective working environment. The FTSU service follows recommendations and guidance set by the National Guardians Office (NGO).

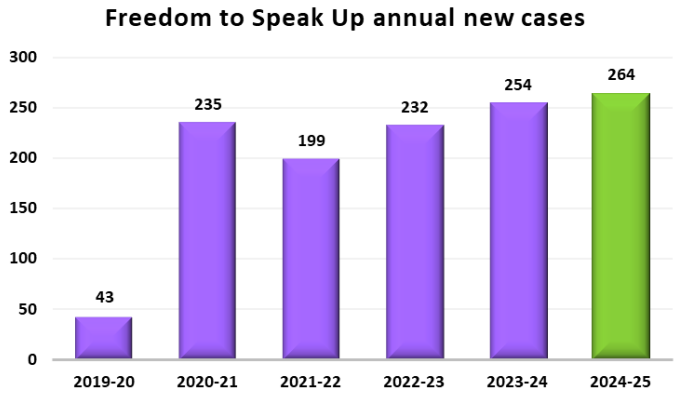
The Trust has committed to the ethos of speaking up through the appointment of substantive guardian roles and encouraging and supporting all staff, managers and leaders to fully engage in the process. The role of the guardian has changed over the years and whilst initiated to support patient safety concerns, the remit has widened to “anything that gets in the way of patient care or affects your working life”. NHS England

Priority was given to ensuring an effective process underlies the escalation of staff concerns. Attaining assurance, identifying and embedding learning and working with managers to ensure they understand how to listen and follow up on staff concerns has proved somewhat difficult due to capacity.

3. REPORT AND ANALYSIS OF FTSU CASEWORK UNDERTAKEN 2024-25

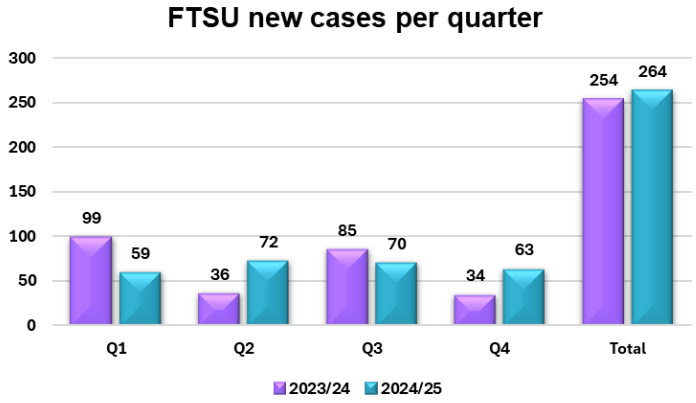
3.1 This year has seen further progress in developing and embedding the principles of speaking up, further encouraging and enabling staff to speak up and raise their genuine concerns regarding patient and staff safety. The ongoing leadership commitment to speaking up, has proved valuable and the commitment to increase capacity has resulted in an additional Guardian to support the service with further recruitment planned.

3.2 There has been a slight increase of 4% in the number of new cases from the previous year, which is encouraging as staff choosing to speak up to the Guardian evidences the importance of having an alternative and confidential route for staff to utilise.

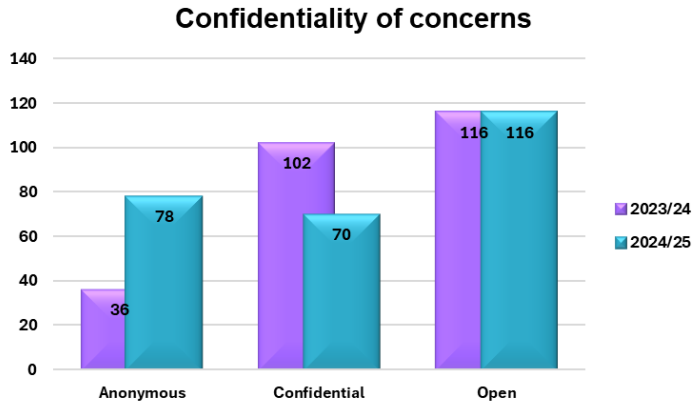


It is important to recognise the majority of speaking up occurs more informally on a daily basis through corridor conversations, team meetings and supervisions and staff have multiple avenues to ask questions, offer suggestions or query practice. There are also several support services which offer the space for staff to share any concerns they may have. Staff will also utilise more formal trust process as a means of escalating their concerns.

3.3 The number of new concerns each quarter has fluctuated over the year in comparison with the previous year. Each case number represents one individual speaking up and it should be noted that when a significant change happens within a service, this might prompt numerous concerns being raised about the same issue. This is particularly pertinent for quarter 4 where the number is almost double. It is normal practice for a rise in cases to occur in quarter 3 following FTSU month, so it is encouraging to see a consistent pattern.



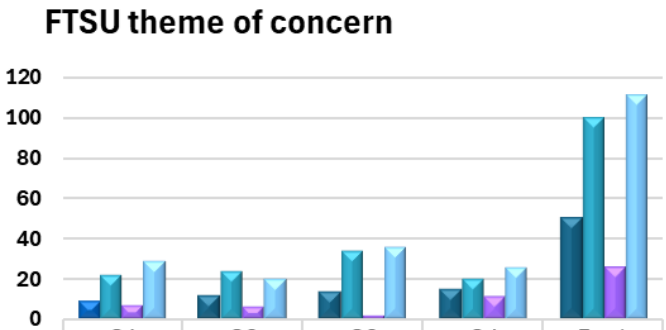
3.4 A total of 264 cases were raised via FTSU in the last year. 44% of concerns were raised openly which is a slight decrease from 46% for the previous year. Open concerns are when the staff members identity has been shared with their consent. Open concerns are often a reflection of how safe staff feel to speak up and their confidence in the speaking up process. It is also noted by staff in many of these cases that they have previously spoken up locally or feel they have exhausted other routes and have approached FTSU as a last resort. The data on this aspect is now being recorded and will be reported on a quarterly basis.



14% of concerns were raised anonymously last year in comparison to 29% this year. This is in part a reflection of the ability for staff to raise their concerns anonymously via the online reporting form, this is also an indication of staff's reluctance to be identified due to fear of repercussions which is often cited in their forms. The form has been updated to reflect the importance of having more comprehensive information for the concern to be looked in to, also the importance of being able to provide feedback to the reporter in the hope this will encourage them to share their identity in confidence.

40% of concerns were raised confidentially last year in comparison to 26% this year, this is when the guardian knows the identity of the reporter but maintains their confidentiality when raising their concerns.

It is preferable that staff raise their genuine concerns anonymously than to not raise them at all. The commentary with these concerns indicates that staff have raised their concerns locally and did not feel they were addressed. The number of staff choosing to remain anonymous or have their concerns shared confidentially makes building confidence in the process and management of concerns a priority for the next year.



	Q1	Q2	Q3	Q4	Total
Patient safety/quality	9	12	14	15	50
Worker safety /wellbeing	22	24	34	20	100
Bullying or harassment	7	6	2	11	26
Inappropriate attitudes or behaviour	29	20	36	26	111

3.5 It is recognised that when staff speak up, their concerns may cross multiple themes due to the complex nature of some of their issues, so the number of themes will often be more than the number of people speaking up.

This year has seen a reduction in the number of cases of bullying or harassment reported to FTSU which is positive and may be an indicator that staff are more aware of how to raise those concerns through more formalised routes or they are not happening as often. However, it is noted that the highest reported theme is inappropriate behaviours or attitudes which indicates there is more emphasis needed on staff observing and practicing the Trust values and behaviours. Incidentally, this coincides with last year's highest national reported theme.

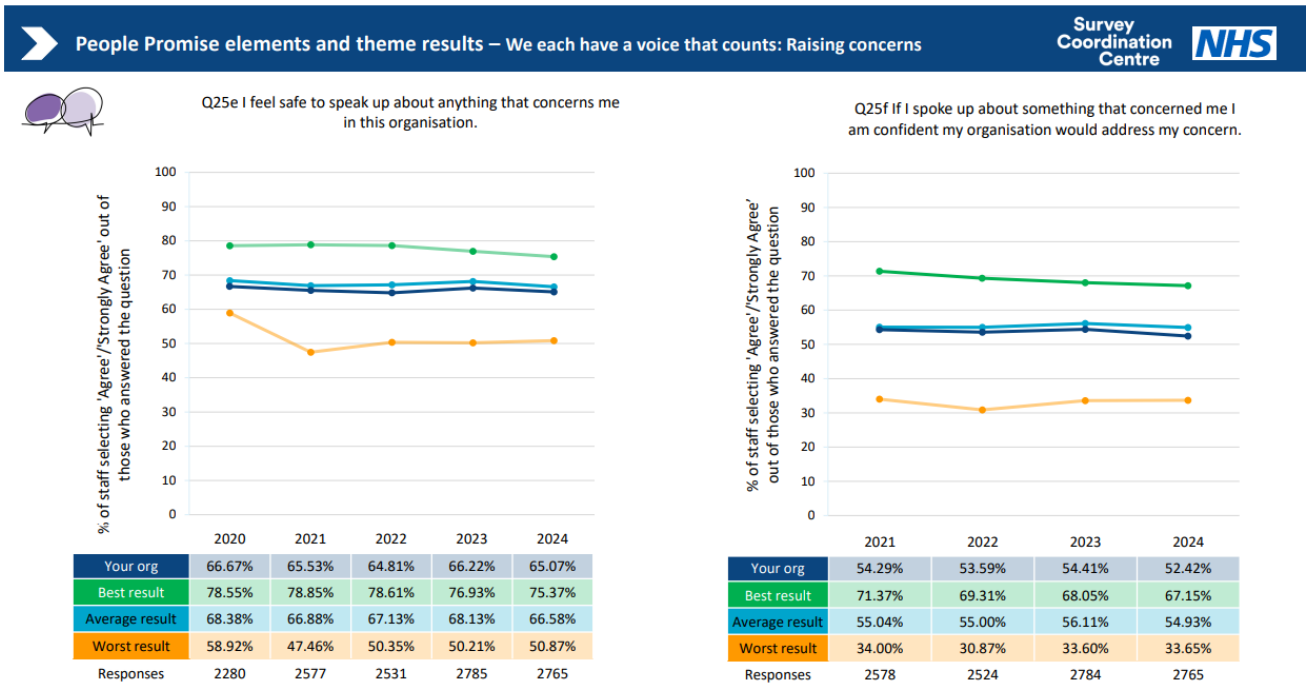
The number of patient safety/quality issues has risen in the last year at 19.9% of overall concerns raised. This also correlates with the NGO national figure of 18.7%*. It is encouraging to see FTSU at EPUT being utilised for what it was originally introduced.
*National Guardians Office Annual Speaking up data report 2023/24

Whilst reporting against the NGO themes is beneficial, it is important to more accurately reflect the nature of the themes of concerns being raised. Future reporting will include more intelligence on themes such as infrastructure and environment, sexual safety, the application of systems and processes and whether issues are linked to the culture of a team or relate to a protected characteristic. This will enable the trust to better identify patterns in particular areas and look at addressing the cause of the issue.

4. NATIONAL STAFF SURVEY RESULTS

This year's National Staff Survey results in relation to the People Promise element 3 "We each have a voice that counts" identifies a small but noticeable decline from previous years.

Whilst not the lowest scoring trust, EPUT have maintained scores below the national average which is a cause for concern and worth noting particularly during the current time and with regards to staff feelings and experiences in line with the Lampard Inquiry. Building staff trust and confidence in speaking up is crucial and particularly imperative in the coming next year.



5. LEARNING FROM CASEWORK

5.1 Whilst the year has provided strong examples of where the management of staff concerns via FTSU has worked well with Director oversight and supervision, the move to embedding directorate specific concerns as part of the Accountability Framework Governance structure is seen as a potential way forward and consideration on the best way to introduce this change is part of the objectives for FTSU during this year. This model has had its successes and managers' report it has been helpful to have director oversight, involvement and support.

There has also been considerable feedback from managers and leaders across varying levels who report feeling disempowered and undermined when concerns are escalated to directors which they have not had the opportunity to try and resolve. The model is being reviewed to provide the appropriate level of escalation in agreement with the staff member involved. This means staff are more in control how their concern is resolved and the relevant managers empowered to follow up on the concerns. This should help enhance trust in the speaking up culture and process, provide an opportunity for a quicker resolution which will support a positive working environment and is a more local, interactive and informal way of resolving concerns.

5.2 The reported inability of staff and managers to have open and honest conversations with each other if there is a concern due to the fear of complaints being raised against them is an issue which is being supported by Organisational Development. FTSU will continue to work collaboratively with other support services to better support the early resolution of concerns, with consent from the person speaking up.

5.3 There have been a few key cases where suffering detriment has been cited following staff raising their initial concerns. It has been identified that a process for supporting staff through detriment is necessary and the National Guardian's Office (NGO) Detriment Guidance published in January 2025 will be used as a basis for developing a process for EPUT in partnership with the ER team.

5.4 As capacity within the team has increased, a clearer process for the recording and management of concerns with due regard for confidentiality has been put in place. The introduction of FTSU service engagement events which provides a unique opportunity to reach all levels of staff, particularly those who are less likely to speak up has been implemented. This enables all staff to share their suggestions for improvement and concerns, providing crucial information for service leaders to consider and take action where relevant. A programme of engagement will be developed for the coming year.

6. PRIORITIES FOR SERVICE DEVELOPMENT 2025-26

6.1 Significant work has been undertaken throughout the year to align speaking up processes with national guidance and directives. The NGO recently published the "Requirements for recruiting and embedding Freedom to Speak Up Guardians' framework, which identifies that trusts should complete the NGO planning and reflection tool at least every two years. This improvement tool is designed to help understand the strengths in the FTSU offer and identify any areas for improvement.

The tool was completed in December and identified areas of best practice and areas for improvement for the Trust and the FTSU team, much of which has been identified throughout this report. A FTSU improvement plan with key objectives will be developed and monitored as part of the plans to develop the service. This will be overseen by People Committee.

The recruitment and training of FTSU Champions is a key priority for the service. The Champion role will support the development of speaking up by providing a more localised, "in the moment" support to staff who want to talk through a concern. They will be trained to listen and signpost staff where needed and will be a significant role which raises awareness on the process of speaking up, listening up and following up.

Robust policy and case management and process	Increase staff confidence in speaking up	Empower and support our leaders to listen and follow up	Embed organisational learning from speaking up casework
• Policy review and update	• FTSU communication and marketing strategy	• Management training on FTSU	• Strategic alignment of FTSU within the trust
• Consistent and compliant case management	• Generic and targeted service engagement plan	• Manager specific engagement and support	• Assurance metrics for FTSU
• Case monitoring and assurance framework	• Collaborative concern resolution	• Supporting managers with concerns and engagement	• Triangulation of concerns data

7. CONCLUSION

The Trust has had its highest number of FTSU concerns this year which is comparable with other trusts. The FTSU service and process is better established and the increase in capacity will benefit the Principal Guardian with both the reactive and proactive aspects of the service.

The multiple concerns raised for similar issues and concerns which span the directorates, evidence that staff are aware they have an alternative route to speak up and raise their concerns. The concerns include patient safety and quality of care concerns, as well as issues related to an individual or group regarding the application of process and policies which may impact on staff. This shows that the premise of FTSU to support staff with the escalation of anything that gets in the way of patient care or affecting a staff members working life is still applicable.

8. ACTION REQUIRED

The Board of Directors are asked to:

1. Note the contents of the Annual report.
2. Agree, in principle, next steps set out under "priorities for service development 2025/26."
3. Support greater collaborative work around Speak Up routes across the trust.

Report prepared by:

Janice Scott
Freedom to Speak Up Guardian

On behalf of: Nigel Leonard
Executive Director of Major Projects & Programmes

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11:12

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 11:15

REFERENCES

Only PDFs are attached

Board Assurance Framework 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	06 August 2025

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Executive Director - Governance					
Report Author(s):	Roberta Wahnig, Head of Risk Management					
Report discussed previously at:	Executive Operational Committee Board of Directors Standing Committees					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	All high-level risks included in the Strategic and Corporate Risk Registers		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Statutory Public Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	NA		
Describe what measures will you use to monitor mitigation of the risk	NA		
Are you requesting approval of financial / other resources within the paper?	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 a high-level summary of the strategic risks and high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the report 2. 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, noting a number of IA reviews providing controls assurance within the reporting period:
    - SR8 – IA opinion of limited assurance for Consultant Job Plans has been added to the controls assurance (negative) for Scheme of Delegation.
    - SR13 – Compliance with Policies – Site Visits – IA opinion of reasonable assurance added to the Quality Governance Policy, Guidelines and SOP's additionally Board Assurance and Risk Management – IA opinion of substantial assurance.

      Actions are being taken to address the identified weaknesses in controls through management actions (which are overseen by the Audit Committee).
- The following level 3 assurances provided for through the CQC inspection report for Adult Mental Health Inpatient Wards and Psychiatric Intensive Care Units:
    - SR13 - providing positive assurance for controls associated with learning from patient safety incidents and adverse events; positive assurance against clinical staff mandatory and essential training; and the three recent inspection reports providing positive assurance for the quality assurance framework.

      Also negative assurance in association with the breach in clinical governance as a consequence of not having oversight of the areas of identified regulation breach within the safe domain.
    - SR11 – providing negative assurance for staff experience, as inspection found low rates of supervision and appraisal.
- There have been no changes in risk score
- There have been two risks de-escalated in this reporting period in line with the Trust stated tolerance:
    - **CRR45 Mandatory Training** – Risk Assessment has been reviewed and following latest mandatory training compliance rates showing TASI compliance at 85% (substantive staff) and 73% (bank staff) the risk is de-escalated to the People and Culture Risk Register. Risk score is maintained at 12.
    - **CRR98 Pharmacy -** Pharmacy vacancies 6.5% dropping to 1.9% with recruitment in the following months. Business continuity plan has been de-escalated as the vacancy rate is below target (10%). The risk is de-escalated to the Nursing and Quality Risk Register. Risk score is maintained at 12 with a view to reduce the score to 8 for closure.
- 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 – Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

July 2025

EPUT

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

July 25

EPUT

Strategic Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	11	7

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

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	8	

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.	ERIC and PAM groups have been established; this has identified that additional work is needed and underway to pull into one consolidated action plan.
SR4	All	Demand and Capacity	AG	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The new Operational Model for Inpatient Services has been rolled with detailed Implementation plan monitored by the Time to Care Steering Group. Progress evident in all ward areas with some achieving 100% chapter implementation. Full implementation is being monitored by the time to care steering group, with a revised timeline of September 2025 for all wards to achieve 100%. Capacity and flow model now live. Now in an adoption programme into time to care / capacity and flow with full utilisation from end October 2025. Implemented the shift trust-wide bed allocation to locality based model to ensure local MDT full involvement in discharge planning from the point of admission. This shift to local accountability will improve the management of flow and improve our patient access to inpatient services where needed. Matrix for bed allocation being used and reviewed Complete. We continue to evaluate and reflect through PDSA cycles to optimise the model.
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	We continue to receive clarifications and Rule 9 requests from the Lampard Inquiry. We have in place a procedure for assessing the asks, and the resources needed to deliver. Two Associate Directors have been appointed within the team structure (as per plan) to lead on ongoing disclosure of information and programme manage - complementing the Associate Director already on post for staff support. We will be reviewing the Inquiry provision over the Summer to ensure we continue to have the right skills and resources in place to serve the Lampard Inquiry. Note extension of action inline with this activity. Currently nine Rule 9s in draft, 13 finalised and submitted. 2 finalised requiring additional information and 3 to be submitted in draft.

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.	DSPT submission for 2025 complete, internal audit assessment complete, audit findings and associated action plan monitored though IGSSC. DSPT audit and submission paper to go July F&P. Action Complete. Of the Seven identified actions - four are now complete, remaining three require project implementation to introduce new technologies, resource capacity and funding to be prioritised though local digital governance resulting in extended timescale for implementation - forecasting 3 months (Oct 25).
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	Bids submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care, as part of 2025/26 capital plan. The Trust has been successful with a number of bids (c£6m). The Capital programme should all bids be approved totals >£36 million – the largest programme the Trust has ever undertaken. F&P Committee receive monthly updates, whilst noted at the July meeting of being behind plan the Committee was assured of the plans to recover this position. The Committee also noted that a stocktake of capital priorities would be undertaken in the summer.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20	20 20 20 15 15 15	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	Non- recurrent and unfound CIPs incorporated into new year plan. The Finance and Performance Committee were assured that the delivery was currently in line with plan, and noted the challenges to full delivery in 2025/26. Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Revenue position Month 3 numbers remain better than plan, however £1.8 million deficit and significantly heightened risks re Inquiry resourcing, associated cost pressures and forecast outturn following audit of accounts. The Finance and Performance Committee was assured of improved temporary staff utilisation, efficiency delivery and associated MARs programme.
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15		The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation	Phase 2 to commence April following review and outcome will form Phase 3. EPR Programme governance established with reporting lines of assurance up to board
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.	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025.
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.	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025. Note: Links to SR10 and SR12

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
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.	Culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years.
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15	15 15 15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	Note IA opinion of site visit reasonable assurance provided (this is where adherence of policies at service level is tested). And, Assurances provided through the recent CQC inspection report for Adult MH Inpatients and PICU. Four actions have been completed to achieve active controls and assurance covering: development of the quality dashboard; raising the visibility of senior quality leaders; refreshed the raising of patient safety incidents and reporting; and put in place governance for SIPs. Review of the Quality Control Audits (Tendable) one year post implementation has been completed - initial findings highlighted some areas of non-adherence to plan. This is being explored to understand the causative factors. CQC Actions Leads meeting has been reposition to be a Quality Action Leads to oversee a wider set of improvement actions, and has become an integral component of the Executive Quality of Care Group. PFD actions added November '24, following a period of embedding other areas will be added. The timeline has been extended to August to embed the transfer of the Quality Leads Group over and establish its rhythm. The reporting to the Evidence Assurance Group remains in place for closure of actions. The Trust has now held two learning events to share patient safety areas of focus, which have been well attended by staff, service user, system colleagues and CQC.

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
4	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	4	4

Likelihood	Consequence 1	2	3	4	5
1					
2					
3				CRR98, CRR11, CRR45, CRR92	
4					
5					

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	2	

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	MK	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	The Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25, including: Work has been undertaken on performance data leading to the development of a more detailed data set reflecting the demographics of EPUT populations relative to incidents of suicide and self harm, this is now included in the Quality Dashboard and will support focus on specific groups of our patients. The steering group prioritised a series of deep dives areas where assurance was sought regarding the progress of actions intended to deliver improvement (including presentation of from NHS Talking Therapies team and National Rail presentation of a thematic analysis). Achieved target of training 60% of registered staff in STORM training across urgent care. Co produced case for change for the Trusts move from risk stratification to a more personalised approach to risk and safety planning. Year 2 priorities are focusing on : a) self harm reduction inc finalisation case for change to move towards personalised risk assessment and safety planning; b) STORM training, increasing compliance to 95%; c) Reduction in fixed and non-fixed ligatures by 10% and d) Safe Discharges.
CRR45	All	Mandatory Training	PT	Safety	4x3=15	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	TASI Training compliance currently sits at 86% substantive and 73% for Bank. Compliance checks are complete with removal of inactive bank staff, which totals over 300. The training team have compulsory booked TASI training for bank staff following completion of online training, as per policy. All have been contacted to be booked on to face to face courses and support is being offered along with workshops and lunchtime learning Q&A sessions, predicting to be fully compliant for substantive staff . Bank by late summer '25. ***The risk is de-escalated to the People and Culture Risk Register. Risk score is maintained at 12 . The risk will be removed from future reporting of the Corporate Risk Register*** .

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR92	All	Addressing Inequalities	PT	Safety	4x3=15	12 12 12	Staff Experience	The procurement of a Trust-wide culture review and senior leadership development programme will provide a clear diagnostic on issues of discrimination, accountability and behaviours which will inform the development of the senior leadership programme. Agreed by the Executive Team on 19th May and this will now go through further internal/triple lock approvals and a mini competition procurement process. Note: risk currently being refreshed by the Executive Chief People Officer.
CRR98	All	Pharmacy Resource	HS	Safety	4x3=15	12 12 12	Continuous state of business continuity plan	Pharmacy vacancies 6.5% dropping to 1.9% with recruitment in the following months. Business continuity plan has been de-escalated as the vacancy rate is below target (10%). ***The risk is de-escalated to the Nursing and Quality Risk Register. Risk score is maintained at 12 with a view to reduce the score to 8 for closure. The risk will be removed from future reporting of the Corporate Risk Register.***

Strategic Risk Register

July 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*	**Note 1:** Previous reported completed actions 1- 5 and 7 have been removed from the report.
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee	**Controls Assurance**

Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model	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 Premises Assurance Model (PAM) outstanding tasks	Second Extension July '25	MM	Control	ERIC and PAM groups have been fully establish. The group has identified that additional work is needed, with work commenced to pull into one action plan.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-5, 8, 9 and 10 have been removed from the report. **Note 2**: Action 6, 7, 8 and 11 RAG rated amber as timeline is extension to the originally stated timeframe, noting system programmes and progress being made. **Note 3**: The control Care Unit Leadership will have an interim Director of Specialist Services commencing from June 2025 to cover the period until the new Director joins the Trust.

Executive Responsible Office: Executive Chief Operating Officer Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff (including skilled flexible workforce via Trust Bank) Discharge Co-ordinator Teams	Establishment and Fill Rate Director of Operational Performance Agency Framework in place New roles: Activity Coordinators Clinical Flow Lead (Dr Bogdan) Jan '25	Performance Reporting Accountability Framework Meetings	
Care Unit Leadership	Establishment Integrated Director posts ***(Note: interim arrangements that will come into effect from June 2025 for vacancy for Specialist Services Care Unit.***		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy	Dedicated discharge coordinators CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Final Report to Board (2024)	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitReps/ Performance Reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2023/24	Developed including out of area plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System Escalation in place
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

Actions (to modify risks)		By When	By Who	Gap	Update
6	Demand and Capacity module to be procured and fully implement	Extended Oct 25	JL	Control	Capacity and flow model now live. Now in an adoption programme into time to care / capacity and flow with full utilisation from end October 2025.
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Extended Sept 25	SC	Control	The 3 Integrated Care Systems and the Trust have appointed PA Consulting to support the risk share review and conclusion. F&P Committee received an update on progress from PA Consulting at its May meeting - noting that there is a shared commitment with work progressing including agreement of resource transfer, drafting MOU, and the development of a mobilisation plan and trajectories for the next three years. Discussions are ongoing, it's a complex programme of work which is impacting timescale. Further extension to Q2 2025. Transition timescales aiming for Sept 2025.
8	Implementation of new operating model	Extended Sept 25	LW	Control	The new Operational Model for Inpatient Services has been rolled with detailed Implementation plan monitored by the Time to Care Steering Group. Progress evident in all ward areas with some achieving 100% chapter implementation. Full implementation is being monitored by the time to care steering group, with a revised timeline of September 2025 for all wards to achieve 100%.
11	Implementation of recommendations following long stay review and system made events across the trust and system	Extended July 25	SG	Control	Themes and recommendations for application across the Trust and Essex wide system to support transfer of care of patients clinically ready for discharge presented to SET SIG. SET SIG to oversee progress against recommendations. Governance and oversight of system delays and escalations reviewed and strengthened with new arrangements commenced in January 2025. Following F&P Committee May 2025 discussion - this action has now been expanded incorporated into the Adult Acute Mental Health Programme led by AG and a ICB executive lead. PID for programme sign off July 2025 at which point this action will closed and replaced by delivery of the Adult Acute Mental Health Programme.
12	Implementation of a clinical and operational prioritisation matrix for bed allocation at locality	Complete	NB	Control	Implemented the shift trust-wide bed allocation to locality based model to ensure local MDT full involvement in discharge planning from the point of admission. This shift to local accountability will improve the management of flow and improve our patient access to inpatient services where needed. Matrix for bed allocation being used and reviewed Complete. We continue to evaluate and reflect through PDSA cycles to optimise the model.

SR5 - Lampard Inquiry (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1- 5 and 7 have been removed from the Board report. **Note 2:** Change of SRO from Nigel Leonard to Denver Greenhalgh. **Note 3:** Maintaining the risk score at 16 following learning from the April hearing and some areas of learning in relation to information submissions to the Inquiry and the potential impact of future requests for both the July hearings and later. **Note 4**: Action 6 is nearing the due date

Executive Responsible Office: Executive Director - Governance Board Committee: Lampard Oversight 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 Browne Jacobson Essex Chambers	Trust Board of Directors	Internal audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry.
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Resources from GW. Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Support for families	Report from HPT to Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee, BOD	Internal audit.
Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

Actions (to modify risks)		By When	By Who	Gap	Update
6	Reviewing resources to ensure (C2) Best value for money; Right skills and resources in place; Operational planning	Extended September '25	GW/GB	Awaiting potential additional Rule 9 Request	We continue to receive clarifications and Rule 9 requests from the Lampard Inquiry. We have in place a procedure for assessing the asks, and the resources needed to deliver. Two Associate Directors have been appointed within the team structure (as per plan) to lead on ongoing disclosure of information and programme manage - complementing the Associate Director already on post for staff support. We will be reviewing the Inquiry provision over the Summer to ensure we continue to have the right skills and resources in place to serve the Lampard Inquiry. Note extension of action inline with this activity.
8	Rule 9 progress	End of July 26	GB	Assurance	Currently nine Rule 9s in draft, 13 finalised and submitted. 2 finalised requiring additional information and 3 to be submitted in draft. We continue to receive clarifications and Rule 9 requests from the Lampard Inquiry.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*3 x 5 = 15*	*C4 x L3= 12*	**Note 1:** Previous reported completed actions 1 - 8 have been removed from the report. **Note 2**: Next reporting period will include a full review of controls to assess what additional safeguards the CAF provides and their associated assurances.

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**
7	Implementation of revised cyber security stratification approach taking into account national NHS cyber risk profile.	Complete	AW	Assurance /Control	DSPT submission for 2025 complete, internal audit assessment complete, audit findings and associated action plan monitored though IGSSC. DSPT audit and submission paper to go July F&P. Action Complete
9	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Extended Oct 2025	AW	Assurance /Control	Of the Seven identified actions - four are now complete, remaining three require project implementation to introduce new technologies, resource capacity and funding to be prioritised though local digital governance resulting in extended timescale for implementation - forecasting 3 months (Oct 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*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	**Note 1:** Previously report completed actions 2 - 4 have been removed from the report. **Note 2:** New Action: Capital Plan for financial year 2025/26

Executive Responsible Office: Executive Chief Finance & Resources Director
Board Committee: Finance and Performance Committee

Key Controls	Controls Assurance 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	Bids submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care as part of 2025/26 capital plan. The Trust has been successful with a number of bids (c£6m). The Capital programme should all bids be approved will total >£36 million – the largest programme the Trust has ever undertaken.
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	F&P Committee receive monthly updates, whilst noted at the July meeting of being behind plan the Committee was assured of plans to recover this position. The Committee also noted that a stocktake of capital priorities would be undertaken in the summer.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	**Note 1:** Previous reported completed actions 1,3 - 5,7-13 has been removed from the report. **Note 2**: Note the IA assurance opinions for consultant job planning.

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	
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2025/26			
Forecast Outturn and risk/ opportunities assessments 25/26			
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team - Downward trend in temporary staffing use seen in month 1 (2025/26).	IA Temporary Staffing (2024/25) Reasonable Assurance Opinion **F&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	Non- recurrent and unfound CIPs incorporated into new year plan. The Finance and Performance Committee were assured that the delivery was currently in line with plan, and noted the challenges to full delivery in 2025/26.
6	Deliver Financial plan for 24/25	Mar '26	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Revenue position Month 3 remains better than planned, however £1.8 million deficit and significantly increased Inquiry resourcing, cost pressure and forecast outturn risk following audit of accounts. The Finance and Performance Committee was assured of progress on temporary staff utilisation, efficiency delivery and MARs programme.

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*	**Note 1:** Previously reported complete action 1-10 have been removed from the report.
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*	

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	Sep-25	AW	Control	Phase 2 to commence April following review and outcome will form Phase 3
12	Implementation of new UEPR	Apr-27	ZT	Control	EPR Programme governance established with reporting lines of assurance up to board

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:** New action 6 regarding implementation of the plan through the lifespan of the People and Education Strategy.

Executive Responsible Office: Executive Director People and Culture
Director Lead: Paul Taylor
Board Committee: People 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 with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025.

SR11: Staff Retention

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note1:** Previously reported completed actions 1 - 5 have been removed from the report.

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 PECC	CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a **breach** low levels of supervision and appraisal.
People and Education Strategy	People Strategy Implementation Plan	Approved by Board of Directors January 2024	
People Promise investment by NHS England	People Promise Manager in post	People & Culture Indicators in IPR with oversight at PECC with emphasis on turnover rates and trends.	Workforce Key Performance Indicators oversight at System People Board

	Actions (to modify risks)	By When	By Who	Gap	Update
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 with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025.

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. **Note 2: N**ew action to deliver the OD and Development Programme

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)
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	New Action: To deliver OD and Development programme	March 26	Director of OD & Culture	Assurance	Following conclusion of the gap analysis (action 4) restructure consultation underway. Proposals for culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years. Procurement is planned for delivery in Autumn 25, year one of a three year plan, with the first cohort planned for Q4. The procurement of a Trust-wide culture review and senior leadership development programme agreed by the Executive Team (May 2025) and now progressing through internal / triple log approval governance and will be subject to a tender process. This will provide the Trust with a clear diagnostic on issues of discrimination, accountability and behaviours which will inform the development of the senior leadership programme.

SR13 - Quality Governance (At a Glance)

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

Likelihood based on: Incidence of repeat incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions from the Care Quality Commission.

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** IA opinion of site visit reasonable assurance provided (this is where adherence of policies at service level is tested). **Note 2:** Assurances provided through the recent CQC inspection report for Adult MH Inpatients and PICU. **Note 3**: Action 8 timeline extension to August to ensure time for Quality Actions Leads meeting to be incorporated into the Quality of Care Group.

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

Key Controls	Controls Assurance Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
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 Patient Safety Incidents Process (2024/25) Reasonable Assurance opinion
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 c/f from 2023/24) Reasonable Assurance opinion IA Care Plans and Risk Assessments (2024/25 c/f from 2023/24) Reasonable Assurance opinion

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
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
1	Develop and implement Quality Dashboard	Complete	RT / AW	Control	The Trust continues working with the Centre of Excellence and attending national workshops to learn and align EPUT's Quality dashboard development to the NHSE principles. The next developmental version has been completed and the action is closed noting this will be a continuous cycle of development going forward.
2	Raise the visibility of senior quality leaders within the Trust (through Back to Practice Visits) and embed.	Complete	AS	Assurance	Back to practice visits (Quality visits) are continuing with one of the Directors of Nursing having a focus on physical health services. Process embedded – action complete (June 2025)
3	Refresh awareness of raising patient safety incidents and reporting.	Complete	MA	Control	Datix system amendments have been made and the Datix Team are creating bite sized recordings to cover different aspects of Datix reporting. Action complete.
4	Continue to full implementation of the eSOP programme (ensuring that all SOPs are reviewed and uploaded to the new SOPHIA system)	Sep '25	RB/RJ	Control	All policies and clinical guidelines have now been uploaded onto the platform. Usage and compliance will be monitored through the SOPHIA reporting tool. The Care Units will review in the Quality and Safety meeting. Condition for full go live (including switching off existing intranet based library) is resolution of the new starter process to ensure there is access to the SOPHIA platform from day one of employment.
5	Deliver Safety Improvement Plans and embedding the learning.	Complete	NA	Control	Learning events were held in April 2025 which included a presentation on SIPs and a focus on improvements and learning. Communications plan in development for all staff to support continuous engagement and dissemination of learning. Governance for SIPs embedded with an oversight group for regular updates. Action closed June 2025

Actions (to modify risks)		By When	By Who	Gap	Update
6	Review the Quality forums from Care Unit to Board and reporting.	Sept '25	AS/DG	Control	A template has been provided to each Care Unit to support local Quality and Safety meetings that reflects experience, effectiveness and safety of care. 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. Note: IA to test the sustainability.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Jul '25	RP	Assurance	Review completed in March '25 - initial findings highlighted some areas of non-adherence to plan. This is being explored to understand the causative factors.
8	To incorporate actions arising from PSII / Homicide Reviews and MHA inspections into the Action Leads Meeting for tracking and evidence assurance.	Extended to Aug '25	NJ/MA/ TM	Control / Assurance	CQC Actions Leads meeting has been reposition to be a Quality Action Leads to oversee a wider set of improvement actions, and has become an integral component of the Executive Quality of Care Group. PFD actions added November '24, following a period of embedding other areas will be added. The timeline has been extended to August to embed the transfer of the Quality Leads Group over and establish its rhythm. The reporting to the Evidence Assurance Group remains in place for closure of actions.

Corporate Risk Register

July 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	Tendale 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, including: Work has been undertaken on performance data leading to the development of a more detailed data set reflecting the demographics of EPUT populations relative to incidents of suicide and self harm, this is now included in the Quality Dashboard and will support focus on specific groups of our patients. The steering group prioritised a series of deep dives areas where assurance was sought regarding the progress of actions intended to deliver improvement (including presentation of from NHS Talking Therapies team and National Rail presentation of a thematic analysis). Achieved target of training 60% of registered staff in STORM training across urgent care. Co produced case for change for the Trusts move from risk stratification to a more personalised approach to risk and safety planning. Year 2 priorities are focusing on : a) self harm reduction inc finalisation case for change to move towards personalised risk assessment and safety planning; b) STORM training, increasing compliance to 95%; c) Reduction in fixed and non-fixed ligatures by 10% and d) Safe Discharges.

CRR45: Mandatory Training

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L5= 20	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note 1:** Previously reported completed actions 1- 4 have been removed from the report. **Note 2:** Risk Assessment has been reviewed and following latest mandatory training compliance rates showing TASI compliance at 85% (substantive staff) and 73% (bank staff) the risk is de-escalated to the People and Culture Risk Register. Risk score is maintained at 12.

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Extended Sept '25	PT	Control	TASI Training compliance currently sits at 86% substantive and 73% for Bank which has improved from the previous month. - Compliance checks are complete to remove inactive bank staff no longer working, which totals over 300. - The training team have compulsory booked TASI training for bank staff following completion of online training, as per policy. All have been contacted to be booked on to face to face courses and support is being offered along with workshops and lunchtime learning Q&A sessions. Bank may take until late summer 25 - noting further extension to achieve action (RAG rated red as second extension). Risk Assessment has been reviewed and following latest mandatory training compliance rates showing TASI compliance at 85% (substantive staff) and 73% (bank staff) it was agreed this risk should be de-escalated to the People and Culture Risk Register. Risk score is maintained at 12.

CRR92: Addressing Inequalities

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	**Note 1:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report. **Note 2:** The controls assurance has been updated to reflect the staff survey results from 2024

Executive Responsible Office: Executive Director People and Culture Director Lead: Paul Taylor Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	HIA4: Addressing Inequalities Staff Survey Results Decrease of 4.93% for “My organisation takes positive action on health and well-being.” (Staff Survey Q11a) Increase of 3.21% for “How often, if at all, do you feel burnt out because of your work?” (Staff Survey Q12b) Increase of 1.88% for “In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?” (Staff Survey Q11b) Increase of 0.75% for “During the last 12 months have you felt unwell as a result of work related stress?” (Staff Survey Q11c) Increase of 3.02% for “In the last three months have you ever come to work despite not feeling well enough to perform your duties? (Staff Survey Q11d)
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (inc. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place HIA2: Evaluation RISE 28.95% of participants achieved their goals completely, 89.47% of participants reported that the programme had a significant personal impact 27% have been promoted	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES / Gender Pay Gap	WRES and WDES plans in place Executive Sponsorship of plans		HIA3: For Pay Gap below the national average of 14.3% and we have seen a reduction of 4.49% over seven years to 2024

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		HAI6: Eliminate Violence, Bullying and Harassment Staff Survey: Increase of 0.02% for “In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers?” (Staff Survey Q14b) Increase of 0.40% for "In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? (Staff Survey Q14c) Decrease of 1.84% for “On what grounds have you experienced discrimination (ethnicity)?" Staff Survey Q16c
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

Actions (to modify risks)		By When	By Who	Gap	Update
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	PT	Control	A three part organisational development plan commences in April with clinical staff across Specialist Services, focussed on unprofessional behaviours and a focus on sexual safety. This will be scaled up across the Trust following the learning and aims to bring to life the behaviour framework, enhance inclusion and safety for our staff. Sexual Safety & Unprofessional Behaviours pilot with Specialist Services to be completed end of May 2025. Learning and impact identified with a plan to then scale up across the Trust. This 3-part workshop addresses sexual safety, incivility and unprofessional behaviours. The sexual safety sub-committee provides management oversight of both patient and workforce issues with a revised agenda/terms of reference to ensure data analytics and compliance against the sexual safety framework/charter. The procurement of a Trust-wide culture review and senior leadership development programme will provide a clear diagnostic on issues of discrimination, accountability and behaviours which will inform the development of the senior leadership programme. Agreed by the Executive Team on 19th May and this will now go through further internal/triple lock approvals and a mini competition procurement process.
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	PT	Control	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. Utilising staff survey data and other relevant data points (Freedom to Speak Up, DATIX), a reset of EPUT specific EDI objectives aligned to this national framework will be agreed in April 2025. These objectives will address the deteriorating scores on the staff survey principally associated with racial discrimination and sexual safety (relates to questions 16b, 17b). The procurement of a Trust-wide culture review and senior leadership development programme will have professional behaviours and accountability as a key line of enquiry and delivery.

CRR98: Pharmacy Resource

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

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note:** Pharmacy vacancies 6.5% dropping to 1.9% with recruitment in the following months. Business continuity plan has been de-escalated as the vacancy rate is below target (10%). The risk is de-escalated to the Nursing and Quality Risk Register. Risk score is maintained at 12 with a view to reduce the score to 8 for closure.

Executive Responsible Office: Executive Chief Operating Officer Director Lead: Tendayi Musundire Leads: Tendayi Musundire Board Committee: Quality Committee	**Controls Assurance**

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

	Actions (to modify risks)	By When	By Who	Gap	
1	Continue with recruitment campaign	Ongoing	HS	Control	Current vacancies 6.5% dropping to 1.9% with recruitment in the following months. BCP is no longer in place and the vacancy rate has normalised. The service is now BAU. Following review with HS in June 2025, risk is being put forward to Executive Team for de-escalation. Risk score is maintained below risk tolerance.

Risk Movement

July 2025

EPUT

Risk Movement and Milestones

Strategic Risk Movement – two year period (July 23 – July 25)

Risk ID	Initial Score	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25
SR1	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	Closed								
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15
SR4	20	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15
SR5	20	15	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	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
SR10	16																New	16	**12**	12	12	12	12	12	12	12
SR11	16																New	16	**12**	12	12	12	12	12	12	12
SR12	16																New	16	**16**	16	16	16	16	16	16	16
SR13	20																	New	**15**	15	16	16	16	16	16	16

Risk Movement and Milestones

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

Risk ID	Initial Score	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
CRR45	12	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	12	16	12	12	12	12	12	D
CRR77	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	8	D							
CRR81	12	16	16	16	16	16	16	16	16	16	12	12	12	12	12	12	12	12	12	D							
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
CRR93	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10	D							
CRR94	16	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	10	D							
CRR98	20	20	20	20	20	20	20	20	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	D

8.2 LEARNING FROM DEATHS

Decision Item | AS | 11:20

REFERENCES

Only PDFs are attached

Learning From Deaths 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 2025

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data Report (2024-2025 Q4)**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, Learning from Deaths Co-ordinator					
Report discussed previously at:	Learning from Deaths Oversight Group (20/05/25) Learning Oversight Sub-Committee (28/05/25) Quality Committee (11/06/25)					
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.	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: • Data relating to deaths recorded on Datix for Q4 2024/25 (1st January – 31st March 2025); • An update on developments being made to mortality reporting and review processes ; • 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); • Outcomes of a thematic review undertaken of 8 non-patient safety incident inpatient deaths;	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note 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 Points

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

2. The final draft report has been refined in format and content from the last report presented to the Board of Directors (Q3) to reflect feedback given by Quality Committee members.

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 Q4 2024/25 data was extracted and analysed as at 13/05/25. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q4 data, which is broadly in line with that of previous quarters. The data (to a greater level of detail) has been presented to the Learning from Deaths Oversight Group (20/05/25) and Learning Oversight Sub-Committee (28/05/25) for consideration and approval for inclusion.

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, Learning Collaborative Partnership and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

5. There continues to be scope to refine and strengthen the mortality reporting, data and review 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 £**			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			
LFD	Learning from deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework		

Supporting Reports / Appendices / for further reading
Learning from Deaths – Quarterly Overview of Learning and Data Report (2024-2025 Q4)

Lead:

Ann Sheridan

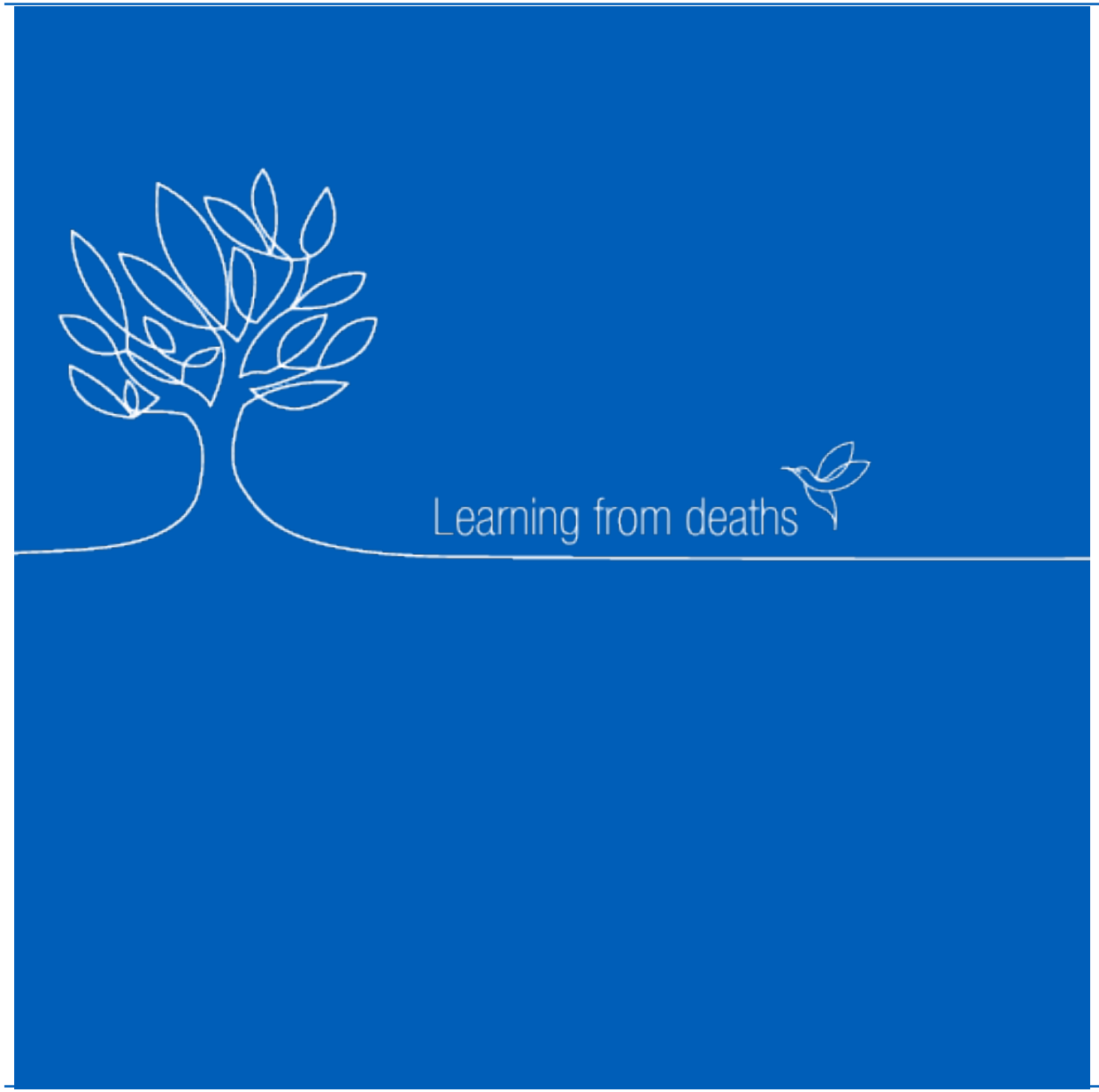
Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 4 - 2024/25

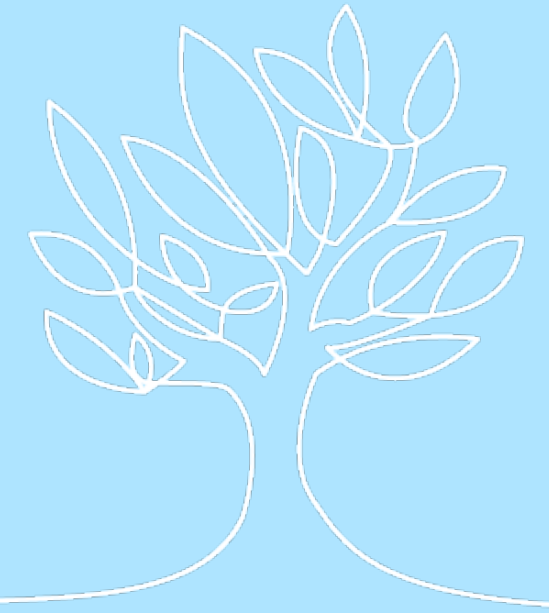


PURPOSE OF REPORT

This report sets out:

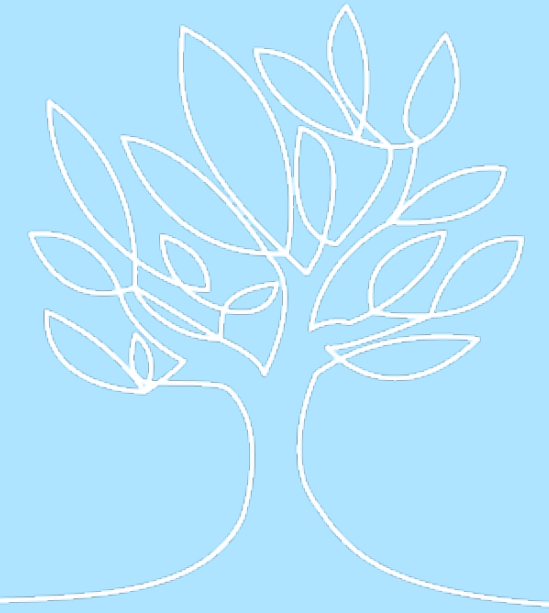
- Data relating to deaths recorded on Datix for Q4 2024/25 (1st January – 31st March 2025);
- An update on developments being made to mortality reporting and review processes ;
- Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to 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);
- Outcomes of a thematic review undertaken of 8 non-patient safety incident inpatient deaths;
- Conclusions and actions required.

Summary of Quarter 4 2024/25 mortality data (as at 13/05/25)



- **Total number of deaths reported:** There were a total of 161 reports of deaths made on Datix, relating to 153 deaths for Q4 2024/25 (including those not falling within the scope for mandatory reporting). To date, a total of 30 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. These figures are within usual parameters for reported death numbers.
- **Inpatient / Nursing Homes deaths:** Of the 153 deaths reported in Q4, 4 were EPUT inpatient deaths and 2 were EPUT nursing home deaths. All of these deaths have been confirmed as due to natural causes.
- **LeDeR reporting validation:** All of the 7 reported Learning Disability deaths have been confirmed as reported to the national LeDeR programme.
- **Stage 1 (Datix) reviews:** To date, a total of 109 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the Q4 deaths. Stage 1 reviews are still actively awaited for 35 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 0 deaths in Q4 have been identified to date for Stage 2 mortality clinical case note review / thematic review.
- **Stage 3 (PSIRF) reviews:** A total of 4 deaths in Q4 have been identified to date for PSIRF review.
- **Problems in care assessment:** There are 0 deaths for Q4 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 consideration 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.

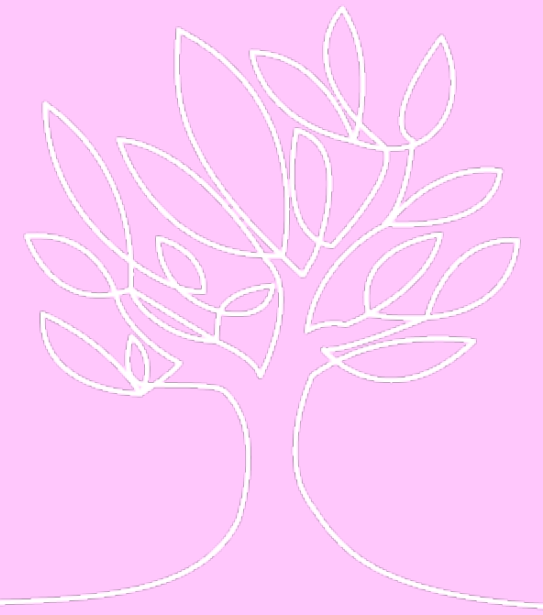
Mortality Data – Update on future developments



- The Trust continues to work on system enhancements whereby all patient deaths will be identified from the "National Spine", a central record fed by GP clinical systems, and included on a dashboard built in-house for Care Units to access on a daily basis for timely notifications of deaths.
- A new initial deceased patient review tool has been built onto all the Trust's main Electronic Patient Records systems. The intention is that this will be completed by service leads for all deaths to provide a record of review of all deaths (including learning) and to determine whether the death falls within the scope of the Trust's policy for report onto Datix.
- The initial technical system enhancement works are completed and a period of testing / piloting commenced. As a result of this, further refinements are being made to the systems and processes prior to launch.
- There are no standard national, regional or local arrangements in place for trusts to have direct access to confirmed causes of death. The Trust is therefore continuing liaison with local Medical Examiners Offices and has also held discussions with Local Authority Registrars (and the Regional Lead in the National Registration Service) about establishing data flows to the Trust on confirmed causes of death for all deaths, not just those referred to HM Coroner. This work continues and will be underpinned by any necessary information governance arrangements.
- Consideration is also being given to:
  - how further automation could be introduced into the process for producing the quarterly mortality data; and
  - the agreement of some Key Performance Indicators to monitor the progress and timeliness of reporting and mortality reviews.

Key learning themes emerging from Stage 1 reviews

March 2025 – May 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 18 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. End of life care has also been the key theme of focus at Integrated Care Board led multi-agency learning from deaths forums this quarter to explore multi-agency learning.
- **Theme 2:** The majority of the deaths reviewed are from **physical health causes** (eg long term conditions, terminal illness, expected deaths of patients receiving end of life care, physical health crisis, deaths in Acute Trust hospitals) (cited in 14 reviews). Again, 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.
- **Theme 3:** For a number of deaths, the **patient was not under the care of EPUT services at the date of death** (cited in 6 reviews). This is most likely to be when the Trust has been notified of a death by HM Coroner and, on undertaking a clinical record review, it is identified that the patient had historic contact with the Trust but was not under the care of services at the date of death. These deaths still provide potential opportunities for learning and thus, if the patient had been under the care of the Trust at any point within the 6 month period prior to death, the Trust review processes are still followed.

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

Key learning themes emerging from Stage 2 Clinical Case Note Reviews

March 2025 – May 2025

STAGE 2 CLINICAL CASE NOTE REVIEWS:

Since the last report to the Board of Directors, there have been two Stage 2 reviews approved. Learning was as follows:

Review 1:

In order to optimise the risk management plan:

- More depth in the mental state examination, considering that the patient demonstrated ambivalence about the reason for their Benzodiazepine overdose.
- Multidisciplinary team involvement and signposting to relevant support should be more evident (particularly related to engagement with Drug and Alcohol Services).
- Family involvement and possible support should be explored.

The above learning, relating to the established Trust Safety Improvement Plan (SIP) / workstream themes of risk assessment, MDTs, dual diagnosis, family / carer involvement and record keeping, has been referred into the relevant SIP / workstream to take into account in action planning.

The review also noted good practice in that risk assessments were comprehensively documented.

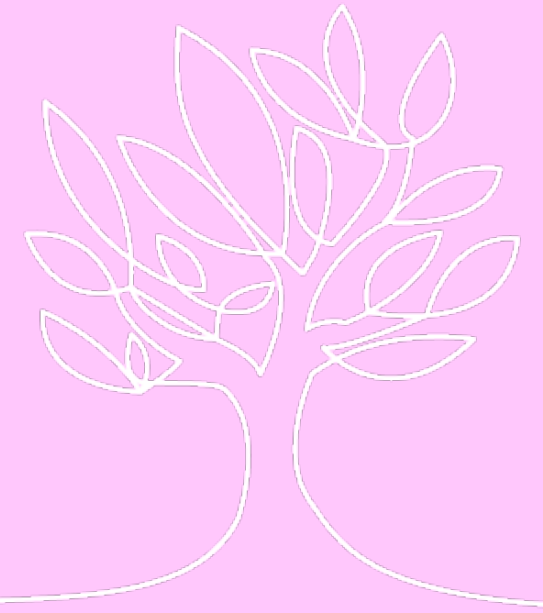
Review 2:

Consider routine X-RAYS on admission for a patient with a history of falls.

This learning has been referred to the Care Unit Clinical Director for consideration as to incorporation into routine practice.

Key learning themes emerging from Stage 3 (PSIRF) reviews

March 2025 – May 2025



Since the last report to the Board of Directors, 10 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 for these 10 death reviews were again:

Theme 1: Clinical care (including for example care planning, risk assessment, multi-disciplinary team (MDT) discussions, observations)

Theme 2: Record keeping (including for example content of clinical notes, timeliness of record keeping, location on Electronic Patient Records for storing information)

Theme 3: Communication (including for example between EPUT teams and with partner agencies)

Other themes identified more than once included policies and processes, disengagement, reviews and training.

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)

Description of death review:

The patient sadly died at home from unnatural causes. They had been under the care of EPUT services shortly prior to death, following presentation at Broomfield Hospital Emergency Department. The death was reviewed using the Multi-Disciplinary Team (MDT) review methodology under PSIRF.

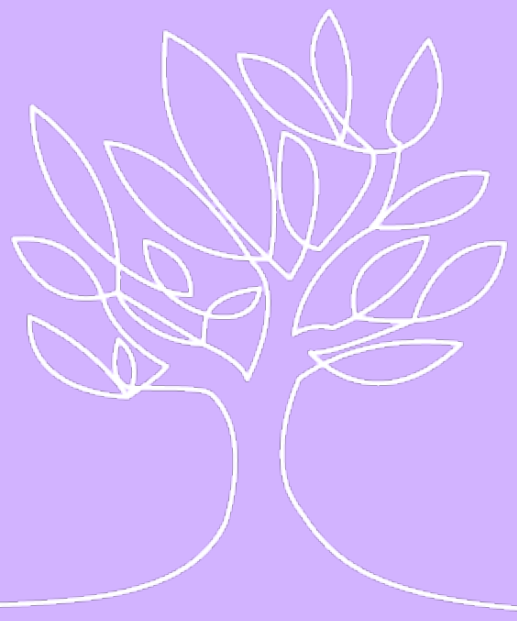
Recommendations	Safety actions to be taken
Liaison between referring teams, where this is part of the teams' policy, should be noted in the patients clinical notes.	Staff in Home First Teams (HFT) and Mental Health Liaison Teams (MHLT) will be reminded via Team Business meeting, individual supervisions and email to document all interactions / intervention as per EPUT Record Keeping policy and NMC codes.
Risk assessments should be undertaken with a deeper focus on events triggering escalations, to allow for better formulation of the patients problems or potential risks. This understanding to be captured and clear within the clinical notes.	This recommendation was reviewed in line with Nice Guidance 2022 for Safety formulations. EPUT Task and Finish Group working towards updating safety formulation process for whole Trust.
Onward referrals by HFT should be made on the day of decision making, given the nature of the support required.	Staff in HFT will be reminded via Team Business meeting, individual supervisions and team email reminding all to document every interaction/intervention as per EPUT policies and Service Operations Procedures.
MHLT assessment/discharge letter was sent to GP approx. 12 days after death, which is outside of the 48hr/7 days stated policy directive.	MHLT to review admin processes in order to ensure work is streamlined for improved management and prioritisation of workload. Monthly assurance audits to be in place to provide clear oversight and assurance of performance.

Outcomes of a thematic review into non-patient safety incident inpatient deaths (1)

In March 2025, the outcomes of a thematic review of 8 physical health related non-patient safety incident deaths of patients who were EPUT inpatients at the time of death or who had been discharged in the 30 days prior to death were presented through the Trust's governance structures. The period of time over which the deaths reviewed occurred was from June 2022 – February 2024. Key findings were as follows:

- The patients within the review were all long term inpatients with significant lengths of stay prior to death.
- With the exception of one death, most deaths occurring in the acute Trust occurred within a reasonable period following transfer to the acute Trust. There was one death which occurred within one day of transfer.
- The two deaths that occurred within the EPUT wards were sudden and unexpected natural causes deaths; and were managed effectively.
- The patients had a wide range of physical health comorbidities some of which were complex.
- The quality of care to all patients was satisfactory and there were no patient safety incidents or significant problems in care identified during the review.
- There were areas of good practice identified such as implementing the national Physical Health competency framework and "Bite size training" teaching sessions
- Areas for development included, accurate completion of physical health observation charts, awareness and training and working closely with family members.

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 Q4 2024/25.
  - An overview of work being undertaken to strengthen the Trust's mortality reporting and review processes.
  - Examples of learning emerging from reviews of deaths being undertaken and actions being taken in response.
- The Board of Directors is asked to:
  - Note 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

11:25

9. STRATEGIC INITIATIVES

9.1 INTENSIVE AND ASSERTIVE COMMUNITY TREATMENT FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS

Discussion Item | MK | 11:27

REFERENCES

Only PDFs are attached

Intensive Outreach Report for 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 2025

Report Title:	**Intensive and Assertive Community Treatment for People with Severe Mental Health Problems**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Molly Pillay, Deputy Medical Director Tsitsi Adiukwu, Associate Director, Mid & South Essex Community Mental Health Services Nina Gough, Deputy Director, West Essex Community Mental and Physical Health Services James Foster, Service Manager for North Essex Community Mental Health Services.					
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	None	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

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

Purpose of the Report		
This report aims to provide an evidence-based comparison of EPUT's current position against the national framework and NHS England directives. It analyses the key challenges and risks from both local and national perspectives to inform the ongoing review and the development of a sustainable, effective, and compliant action plan for assertive outreach services across Essex.	**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 an analysis of Assertive Outreach Team (AOT) services within the Essex Partnership University NHS Foundation Trust (EPUT) footprint, encompassing the Mid and South Essex (MSE), Suffolk and North East Essex (SNEE), and West Essex and Hertfordshire (HWE) Integrated Care Boards (ICBs). The analysis identifies the identified cohort criteria for AOT services, the actual identified cohort in Essex and current service provision across Essex. The analysis identifies challenges and strategic risks to providing a service that is suitable to meet the required cohort criteria.

The Trust developed an action plan following the analysis, which identified 36 actions, of which 19 have been completed. The action plan will continue to be taken forward with ICB colleagues and monitored via accountability framework meetings. The next steps include the wider review of community mental health services, the recruitment of peer support workers to support outreach working and the development of AOT specific training for staff.

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

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

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

Acronyms/Terms Used in the Report

Supporting Reports/ Appendices /or further reading

Lead

Dr Milind Karale
Executive Medical Director

INTENSIVE AND ASSERTIVE COMMUNITY TREATMENT FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS

1.0. INTRODUCTION

This report aims to provide an evidence-based comparison of EPUT's current position against the national framework and NHS England directives. It analyses the key challenges and risks from both local and national perspectives to inform the ongoing review and the development of a sustainable, effective, and compliant action plan for assertive outreach services across Essex.

This report provides an analysis of Assertive Outreach Team (AOT) services within the Essex Partnership University NHS Foundation Trust (EPUT) footprint, encompassing the Mid and South Essex (MSE), Suffolk and North East Essex (SNEE), and West Essex and Hertfordshire (HWE) Integrated Care Boards (ICBs). The analysis is situated within the national context defined by NHS England's directives concerning Assertive Outreach Team (AOT) for individuals with Serious Mental Illness (SMI) who face challenges engaging with services. This national focus stems from heightened concerns regarding patient safety and the recognised need for robust, dedicated community mental health provision for this specific cohort. [1]

EPUT's current AOT landscape is characterised by significant fragmentation and variation across the three ICB areas from close to fidelity or entirely absent. Provision largely deviates from nationally recognised fidelity models for assertive outreach, particularly in context of dedicated team structures and recommended low caseload sizes (typically 15:1 or lower).[1] Existing provision often involves standard care co-ordination within Community Mental Health Teams (CMHTs) managing high caseloads (up to 35:1), or small, sometimes dual-function teams with limited specialist input, falling substantially short of the dedicated, multidisciplinary resources outlined in NHS England guidance.[2]

A primary challenge identified is the tension between the national requirement to ensure appropriate AOT services are in place and the absence of specific, dedicated national funding allocated for implementation within the 2025/26 operational planning guidance.[3] While NHS England guidance stresses the need for dedicated resources for effective AOT [2], the responsibility for funding implementation rests with local systems, requiring ICBs and providers to find efficiencies or reallocate resources from existing budgets, which are already under pressure.

2.0. COHORT IDENTIFICATION AND CURRENT AOT LANDSCAPE WITHIN ESSEX

2.1. Identified Cohort Criteria

EPUT I/AOT Identification Criteria: We adopted a highly rigorous approach to this cohort to maintain model fidelity.

- Patterns of repeated admissions in patient or home treatment and,
- Psychotic symptoms non diagnostic specific and,
- Difficulty engaging/lack of insight/non concordance with treatment plans and
- Currently within services

Rationale: The identified cohort criteria ensure a focused approach, accurately pinpointing the individuals who require this specialised care. We opted not to use the broader criteria outlined in NHS England's guidance to maintain this level of precision.

NHSE Guidance of the cohort: The group under consideration includes individuals who:

- are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- may not respond to, want or may struggle to access and use ‘routine’ monitoring, support and treatment that would minimise harms
- are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- have multiple social needs (housing, finance, self-neglect, isolation etc)
- likely present with co-occurring problems (e.g. drug and alcohol use/dependence)

- may have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- concerns may have been raised by family/carers

2.2. Actual Identified Cohort in Essex

EPUT, through a multi-faceted approach involving electronic health record searches, MaST evaluation, case reviews by CMHTs, analysis of crisis team data, and clinician input, has identified a cohort of 596 individuals across the three ICBs deemed to require Assertive Outreach services.
The distribution is:

- Mid & South Essex (MSE): 437 individuals
- North East Essex (NE): 102 individuals
- West Essex (NW): 57 individuals

The identification methods were similar between the ICBs' footprints and was based on local data systems, the process aimed to capture individuals meeting the broad criteria of SMI with significant engagement challenges. This involved utilising operational data base on frequency of admissions and frequency of contact with crisis services over the last two years. It also involved individual review of caseloads by operational managers. Individuals in North East (NE) who were identified as being a candidate for AOT were verified with NE consultants before submission.

Care plans, risk assessments, and assigned care coordinators are in place or are being actively updated for these identified individuals.

2.3. Current Service Provision across Essex

The current service provision varies across the ICBs:

- **West Essex:** There is no dedicated AOT service team. Patients meeting the threshold for AOT approach are managed within existing Community Mental Health Team or Early Intervention in Psychosis teams with no AOT-specific resources and are therefore offered standard care co-ordination within existing CMHTs. Access to Psychiatrist and other MDT functions is through the existing CMHTs, determined by presenting need. The rest of the identified AOT patient Cohort are managed through the mixed Multidisciplinary team caseload CMHT caseload including the psychiatrist outpatient clinics.

- **North East Essex:** The identified cohort is managed predominantly through standard care co-ordination within existing CMHTs. These teams have high caseload, up to 35 cases per 1 care coordinator. There are two Band 6 members of staff and one band 3 who are fulfilling an 'AOT' role within the mainstay of the team but they also have high caseloads one of 27 and one of 25. The support worker works between the two band 6 care coordinators. These patients are only able to be seen on average monthly unless immediate need determines otherwise.

- **Mid and South Essex**
    - **Thurrock:** A small nurse led team operates under the Recovery and Wellbeing service CMHT. Thurrock assertive outreach team operates a skeletal 7 day service offer, supporting a total caseload of 55 patients with a resource of 2 staff members.

    - **Mid Essex:** There is no dedicated AOT service team. Patients meeting the threshold for AOT approach are managed within existing Community Mental Health Team or Early Intervention in Psychosis teams with no AOT-specific resources and are therefore offered standard care co-ordination within existing CMHTs.

    - **Basildon, Brentwood & Castle Point, Rochford & Southend:** A small, nurse-led Intensive Outreach Team provides both Rehabilitation and AOT functions, with limited Occupational Therapy and psychological input through a Band 7 Nurse Therapists for a total caseload of 52 patients. Access to Psychiatrist and other MDT functions is through the existing CMHTs, determined by presenting need. The rest of the identified AOT patient Cohort are managed

through the mixed Multidisciplinary team CMHT caseload including the psychiatrist outpatient clinics.

3.0. ANALYSIS OF KEY CHALLENGES, RISKS AND STRATEGIC CONSIDERATIONS

3.1. EPUT'S Identified Challenges

Several key challenges have been identified across the localities and formulated into trust wide positions:

- **Lack of Standardisation and Resource Variation:** The absence of a unified AOT model across Essex and its three ICBs, coupled with significant disparities in resource allocation and service delivery between different geographical areas, creates inequity and inefficiency. This has resulted in a "postcode lottery" of AOT delivery.

- **Funding Dependency and Need for Evidence:** Achieving fidelity to the intended AOT model is contingent on securing adequate funding, likely implying a need for investment beyond current levels. Without this, the service risks not meeting the fidelity model and failing to achieve desired outcomes. Whilst creative use of current resource could be considered, this resource being drawn from mainstay services such as CMHTs has been consistently identified by operational managers as posing significant safety issues to the patients who remain under standard CMHT functions.

- **Impact on Existing Services and Staff:** Concerns exist that implementing AOT principles, particularly whilst managing high-needs individuals with existing high caseloads, will divert capacity and resources away from other functions within CMHTs or the few existing outreach programmes. This diversion is anticipated to negatively affect multi-agency working, joint planning, and potentially lead to staff burnout and reduced morale due to unsustainable pressures.

- **Delayed National Guidance:** Progress on EPUT's action plan has been impacted by delays in the anticipated release of detailed national core standards guidelines for AOT, with planning timelines adjusted accordingly. The deadline has been revised in anticipation of the core standards guideline being released by the end of summer 2025.

3.2. Risks and Strategic Considerations

Failure to establish adequate and effective AOT provision carries significant risks, both for service users and the wider system. Additionally, navigating related strategic issues like Out of Area Placements requires careful consideration.

- **Patient Disengagement and Deterioration:** As highlighted in EPUT's history when AOT was last discontinued 10 years ago, discontinuing or failing to provide adequate AOT risks vulnerable individuals becoming 'lost' to services. Disengagement under traditional CMHTs is often pursued for specific periods of time and not indefinitely as it would be under an AOT model. Disengagement is strongly associated with negative outcomes including relapse, deterioration in mental and physical health, increased crisis episodes, homelessness, self-harm, suicide, and, in some cases, risk of harm to others.

- **Impact on CMHTs and System Pressure:** As noted previously, attempting to deliver AOT functions within the currently resourced CMHTs risks diverting attention and capacity away from other service users under their care. This reflects the national strain on CMHTs. Ineffective community support for the highest-need individuals can lead to increased pressure on crisis resolution and home treatment teams (CRHTTs), emergency departments and acute inpatient units. This can potentially drive up costs and demand elsewhere in the system.[5] The assertive outreach model recommends caseloads of no more than 15, whereas most Care Coordinators currently manage caseloads of upwards of 30. With the current provision EPUT cannot drastically cut caseload from those respective CMHTs.

- **Failure to Meet National Mandates:** Failing to provide services aligned with NHS England guidance risks non-compliance with national directives and could attract negative attention from regulators like the CQC, which has already highlighted gaps in community mental health care

quality and safety. However, the 2025/26 operational planning guidance has not allocated any monies to baselines to resource the implementation of the model.

4.0. EPUT ACTION PLAN

The action plan comprises 36 individual actions. A review of the current status indicates that 19 actions are completed. These completed short-term actions include identifying the cohort, ensuring trust policies are reviewed and updated, and establishing governance both internally and with ICB partners. Six actions have not yet commenced, as the core standards guidelines will inform the next steps. The remaining 11 actions are in progress. These include active transformation projects and improving integration with other services, with deadlines from June 2025 onwards.

This action plan is also informed by the key areas for action identified in the NHSE letter from Claire Murdock, which outlines the priorities from the independent review. These areas included: personalised assessment of risk across community and inpatient teams; joint discharge planning arrangements between the person, their family, and inpatient and community teams (alongside other involved agencies); multi-agency working and information sharing; working closely with families; and eliminating Out of Area Placements in line with ICB 3-year plans.

Operational Leads have provided assurance statements confirming that systems and processes are in place to address misalignment regarding patient care across Essex. Several forums exist to facilitate clinical decision-making and resolve disparities. Case reviews and multi-disciplinary meetings are common practice across EPUT and other services for managing complex cases.

EPUT has a Risk Management Assurance Framework, which undergoes annual reviewing. In addition, Trust Accountability Frameworks oversee risk and governance. Significant progress has been made in reducing health inequalities throughout 2024/2025, driven by the Experience of Care strategy's core priority steering groups. The EPUT Carers Framework has received Executive approval and is scheduled for a refresh, with an identified Executive Sponsor. This framework addresses issues raised in the report.

5.0. NEXT STEPS

EPUT is currently undertaking a major review of community mental health services across its footprint. This is a positive development, given the variation in service provision across the Essex operational footprint. This large-scale work program is being established, with the understanding that core standards will ultimately guide the direction of the project. The plan remains to progress incremental change in the repurposing of resources and service delivery.

Seven dedicated Peer Support Worker roles are being introduced In North East Essex ICB (four in Colchester, three in Tendring) to bolster community outreach and assertive outreach support. Notably, SUMMIT Trustees have committed to two of these positions as permanent, enhancing longer-term capacity. These roles will primarily focus on providing essential support to the 102 individuals within NEE identified as benefiting from assertive outreach, and will also extend to newly identified individuals requiring this service. To ensure effective delivery, a comprehensive training program is being established, incorporating existing skills, AOT-specific training from EPUT, shadowing with the Secondary Mental Health Team, and continuous learning opportunities in areas like Drug and Alcohol support and Dual Diagnosis. Robust information sharing processes are also being implemented. Funding for these crucial roles is currently secured for one year.

EPUT will continue to manage and maintain the action plan with all three ICBs. This includes NHSE touchpoint meetings where regional and national progress is shared, and risk/concern areas are discussed.

EPUT is also exploring Triangle of Care implementation, with a meeting planned for Monday, June 2, 2025, involving key stakeholders, including Social Care, Patient Experience, Quality and Safety leads, and family ambassadors.

It is important to note that EPUT cannot provide assurance that the needs of this identified cohort are currently being met without new investment.
References

1. https://docs.cios.icb.nhs.uk/DocumentsLibrary/NHSCornwallAndIslesOfScilly/Organisation/PublicMeetings/BoardMeetings/2425/202503/ICB2425197MentalHealthAssertiveOutreachUpdate.pdf
2. https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/
3. https://hansard.parliament.uk/Commons/2025-01-30/debates/25013042000015/NHSEnglandAndNHSOperationalPlanningGuidance2025-26
4. https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/
5. https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/
6. https://nhsproviders.org/media/700046/otdb-2025-26-planning-guidance.pdf

10. REGULATION AND COMPLIANCE

10.1 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Information Item MK 11:32

REFERENCES

Only PDFs are attached

Safe Working Hours for Resident Doctors 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	06 August 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 for Resident Doctors					
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)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk	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 are safely rostered and that their working hours are compliant with the terms & conditions of their contract.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 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 to the 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. 10 Exception reports were raised in this quarter:
   a) Two trainees stepped down and received payment as per the Trust Acting Down policy.
   b) One trainee raised six exception reports on lack of adequate medical cover on the ward. Clinical tutor has now placed a more senior trainee on the unit. Time off in lieu was given to the trainee.
   c) One trainee worked extra hours on the ward, time off in lieu was given.
   d) No further action required for one exception report raised by a trainee.

4. The Trust was fined a total of £1605.92 in this quarter for two exception reports.

5. Bi-monthly Resident doctor's forum (RDF) is well attended by Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved timely and escalated to Clinical Tutors/DME/Senior Managers where necessary

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	
Impact on patient safety/quality	

Impact on equality and diversity	
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**

Acronyms/Terms Used in the Report			
FY1	Foundation Year 1		
FY2	Foundation Year 2		
DME	Director of Medical Education		
RDF	Resident Doctors Forum		

Supporting Reports/ Appendices /or further reading

Resident Doctors Q1 Guardian Report April-June 2025

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 second quarterly report submitted to the Board on Safe Working of Resident Doctors for the period 1 April to the 30 June 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 10 exception reports were raised in this quarter.

1. 2 April 2025: CT3 raised an exception reports for working extra 1 hour on the ward. Time off in lieu was given.
2. 2 April 2025: CT3 trainee raised an exception report for lack of rest period during the shift. Time off in lieu was given.
3. 3 April 2025: CT3 raised an exception report for unable to complete his psychotherapy records in time due to demand on ward duties. This has been addressed through the tutor.
4. 4 April 2025: CT3 worked an extra 30 minutes on the ward due to excessive workload. Time off in lieu was given.
5. 10 April 2025: ST4 stepped down for 5 hours to help Tier 1 on call doctor to complete the tasks, as the Tier 1 on call doctor was busy due to excessive workload. The trainee will be paid £317.20 as per the Trust's acting down policy. The Trust was fined £472.40
6. 16 April 2025: CT1 worked an extra 1 and a half hours on the ward. Time off in lieu was given
7. 25 May 2025: Exception occurred on 29 March 2025. ST4 had to step down to do on-call duties on site as the Tier 1 doctor was unwell. Trainee was paid as per the Trust acting down guidance. The Trust was fined £1133.52
8. 27 May 2025: FY2 raised an exception report for lack of educational opportunities, as had to attend ward round instead of attending teaching sessions due to staff shortage. No further action as trainee informed he attended ward round voluntarily.
9. 5 June 2025: CT3 trainee worked an extra 35 minutes on the ward due to excessive workload. Time off in lieu was given.
10. 6 June 2025: CT3 trainee worked an extra 40 minutes on the ward due to excessive workload, time off in lieu was given.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 2 April 2025

Doctors in Training Data (Average across reporting period)

Total number of posts EPUT Training Scheme inclusive of foundation and GP	**158**
Total number of psychiatry training posts	**101**

Total number of doctors in psychiatry training on 2016 Terms and Conditions	**99**
Total number of foundation posts	**38**
Total number of GP posts	**19**
Total number of vacancies across all grades	**6**
Total vacancies covered LAS/Agency	**4**
Total gaps	**2**

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	101	101	0	1212.5	1212.5
Total	101	101	0	1212.5	1212.5
Total Cost	**£75,329.38**				

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:

1. The Trust was fined £1133.52 for the exception report raised by a trainee on 25 May 2025.
2. The Trust was fined £472.40 for the exception report raised by a trainee on 10 April 2025.

Issues Arising:

1. The exception report raised on 2, 3, 4 April and 5 and 6 June were raised by the same trainee who works on a specific ward. These exception reports were raised due to a lack of adequate medical staff to complete daily tasks. The Clinical Tutor has now made changes to the trainee's rota and will be placing an FY2 doctor on the ward instead of FY1 from August 2025 onwards to resolve this matter.
2. There has been a poor response from trainees on on-call monitoring activity that was conducted early this year. Following further discussions, another on-call monitoring activity will be held in September 2025, as trainees continue to raise concerns on excessive workload in certain areas of the Trust.

3 Action Required

The Board of Directors is asked to:

1 Receive and note the content of the report

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

On behalf of

Dr Milind Karale
Executive Medical Director

10.2 SAFEGUARDING ANNUAL REPORT

Decision Item AS 11:37

REFERENCES

Only PDFs are attached

Safeguarding Annual Report 06.08.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	6 August 2025

Report Title:	**Safeguarding Annual Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Tendayi Musundire, Deputy Director of Nursing for Safeguarding & MHA					
Report discussed previously at:	Quality of Care Group					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	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 an account of the safeguarding activities undertaken across services and with partners during the year 1 April 2024 to 31 March 2025, and priority areas for 2025/26.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the report for publication
3. Request any further information or action

Summary of Key Issues

Key points:

- The report gives assurance that safeguarding of children, young people and adults is considered to be core business and is a shared responsibility with the need for effective joint working between partner agencies and professionals
- The report outlines how the safeguarding service is performing and promoting best practice
- 2024 – 25 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients
- Safeguarding training meets the national standards as identified in the Intercollegiate Guidance 2019 (Children) and the RCN Intercollegiate Guidance 2018 (Adults)
- The report provides a breakdown of the work undertaken by the safeguarding team during the period 2024 - 2025

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			
	See glossary in main report		

Supporting Reports/ Appendices /or further reading

Safeguarding Annual Report

Lead

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Safeguarding Annual Report

2024-25

Contents

Page Number

Foreword

by Ann Sheridan, Executive Nurse

As a Trust we recognise our continued commitment to demonstrate compliance to safeguarding statutory duties and the continued focus on increasing safeguarding team resources in the year ahead, which will further enhance our arrangements.

I'm pleased to share the 2024/2025 Safeguarding Annual Report for Essex Partnership University NHS Foundation Trust (EPUT). This report is an opportunity to reflect on our safeguarding work over the last year and to look ahead to the priorities we have set ourselves for the coming year. Safeguarding children and adults is at the heart of every service we provide, and we are committed to ensuring that people in our care are always protected from harm. We work closely with our system partners across Essex, Southend and Thurrock, both within the Safeguarding Boards and Partnerships and more widely with partner organisations' services.

Throughout the year, we worked to improve the responsiveness and quality of Section 42 enquiries by analysing cases in each of our Care Units and monitoring against local guidelines, service user experience and compliance with national requirements. We increased capacity in our safeguarding service, clarified contractual requirements with our local authority partners and reviewed and prioritised the role and duties of our Clinical Specialists for Safeguarding. We also reviewed caseloads in each of our Care Units, reporting progress through our safety and safeguarding Board subcommittees, and reviewed our level 3 adult safeguarding training based on the experience of practitioners within our services.

All these initiatives contributed to an increase in case completions and our ability to adopt the national Making Safeguarding Personal approach.

We had a particular focus during the year on domestic violence and abuse, working with our partners Alpha Vesta to deliver dedicated training to staff in all our services. Our staff now have greater understanding and awareness of the issue, both for our patients but also for fellow colleagues who may themselves be experiencing such abuse. Our safeguarding team's roadshow in November 2024 brought the service directly into our clinical sites, joined by agencies and system partners to help share awareness and promote good practice.

In the coming year, safety will remain our top priority, with safeguarding continuing to play a key role in helping us provide safe, high quality care. Our safeguarding approach will also support a renewed focus on the experiences of neurodivergent people, families and carers in our care. I hope the information included in this report demonstrates our continued commitment to the safeguarding agenda and to supporting our teams in delivering its aims.

Local Authority Safeguarding Boards Feedback

Southend Safeguarding Partnership (SSP)

EPUT has been an invaluable member of our partnership, consistently demonstrating a strong commitment to improving mental health services in collaboration with Southend Safeguarding Adult Board (SSAB) partners. As an active participant, they have not only engaged positively with all aspects of our collaborative efforts but also taken on a leadership role by chairing a key sub-group (SSAB – Performance, Audit, Quality and Assurance or PAQA). Their dedication and proactive approach have significantly contributed to the success of our initiatives, fostering a supportive and inclusive environment for all stakeholders. We are grateful for their unwavering support and look forward to continuing our impactful work together.

Essex Safeguarding Adults Board

EPUT continued to be a valued member of the Essex Safeguarding Adults Board (ESAB) throughout 2024/25, regularly attending main Board meetings, and several Sub-Committee meetings, such as the Safeguarding Adult Review Committee (SAR) and the Southend, Essex and Thurrock Multi-Agency Safeguarding Adult Policy and Procedure Group. EPUT's Deputy Director of Nursing for Safeguarding and Mental Health Act continues their role as Chair of ESAB's Prevention and Awareness Sub-Committee, with an ESAB delivery plan focusing on co-production; engagement with Seldom Reached groups and Healthwatch Essex, developing shared knowledge and understanding of the safeguarding challenges that respective groups may face.

ESAB and its partners continued to receive regular updates at its Board meetings, seeking safeguarding assurance and accountability from EPUT, in relation to the implementation, and outcomes, of the EPUT Patient Safety Strategy, and ESAB's Independent Chair, Deborah Stuart-Angus, undertook a number of onsite visits to mental health units within the EPUT portfolio, enabling transparency and mutual understanding of the work on carried out on improving patient safety. This was supported by EPUT continuing to share assurances with ESAB with candour and rigour. ESAB, as a partnership Board continue to support EPUT on its developmental journey to bring about organisational and cultural change, recognising there is still yet more to be done, in the belief that despite challenge, *'together we achieve more*'.

Essex Safeguarding Children's Board

The Essex Safeguarding Children Board (ESCB) formally named Essex Partnership University NHS Foundation Trust (EPUT) as a relevant agency under the updated Multi-Agency Safeguarding Arrangements, in line with Working Together to Safeguard Children 2023.

Key Contributions of EPUT:

Active Participation: EPUT plays a vital role in the Child Safeguarding Practice Review (CSPR) sub-committee, contributing to multi-agency learning reviews and supporting the development of recommendations.

Stay Safe Groups: EPUT regularly attends all four quadrant-based Stay Safe Groups, which focus on local safeguarding priorities, emerging risks, and shared learning.

Ongoing Involvement: EPUT contributes to other ESCB initiatives as needed and has delivered a session in the monthly "Getting to Know You Partners" programme to improve inter-agency understanding.

Impact Reporting: EPUT provides detailed evidence every 6–12 months on how learning from reviews has influenced training, team communication, and broader safeguarding work.

Thurrock Safeguarding Adults Board

EPUT continues to be a fully engaged and active member of the Thurrock Safeguarding Adults Board, providing valuable updates on the work of the Trust as well as expert contributions in policy development enthusiastically and productively.

EPUT members also made an invaluable contribution to the recent highly successful joint conference on transitional arrangements, held by the Thurrock Safeguarding Adults Board and Thurrock Safeguarding Children's Partnership.

Partnership Working

The Trust is actively represented on all the Local Authority Safeguarding Children and Adult Partnerships by executive directors, directors and the Deputy Director for Safeguarding, within the areas where the Trust provides care. This representation is an important part of developing and influencing services for Trust service users and demonstrates the commitment the Trust places on the safeguarding agenda and working relationships with other agencies. These arrangements give assurance and oversight to the safeguarding partners of the work EPUT is involved in. The partners seek help and expertise from the Trust in developing strategies/protocols which include aspects of mental health etc.

Partnership feedback

Alpha Vesta

Since June 2024, we have provided a number of different domestic abuse awareness and training opportunities for employees at EPUT, underpinned with the aim of increasing understanding and awareness and reaching out to either a patient or fellow staff members who could be experiencing it. These sessions were written in line with EPUT's 'Safeguarding Adults Policy' and EPUT's 'Supporting Staff Experiencing Domestic Abuse Toolkit' written in collaboration with Alpha Vesta:

- 2hr Basic Awareness Session and Domestic Abuse Supporting Staff Toolkit
- 2hr Impact of Domestic Abuse on Children and Young People
- 2hr Domestic Abuse Training for Line Managers.

The above sessions were run in June 2024, October 2024 and March 2025 with attendance of over 500 employees across the three sessions.
In addition to this, we have run two hour basic awareness sessions for EPUT's Preceptorship teams with attendance of over 200 employees.

In October 2024, we introduced three new practical sessions for employees around domestic abuse in key areas:

- Managing Routine and Sensitive Enquires around Domestic Abuse
- Effectively Assessing Risk and Need
- Trauma and Suicide Ideation related to domestic abuse.

These sessions included survivor interviews of those that had been impacted not just by domestic abuse, but in those specific areas. These one hour sessions have each been delivered twice (October 2024 and March 2025) with attendance of around 400 employees across the three sessions.

Devon Partnership Trust

Devon Partnership Trust and Essex University Partnership Trust work collaboratively together with regards to sexual safety, with respective deputy directors holding sexual safety and safeguarding within their portfolios (for EPUT and DPT) and attending their counterparts Sexual Safety Committees. This enables constructive sharing of information and comparative analysis of data. The mutual sharing brings benefits to both NHS Trusts.

Essex Adult Police Triage team

The Essex Police Adult Triage team liaise with EPUT Safeguarding team on a daily basis. As a result, we have developed an efficient working partnership and we always appreciate the prompt and informative responses that are received. This enables us all to work together to protect vulnerable adults from harm and we hope this continues going forward.

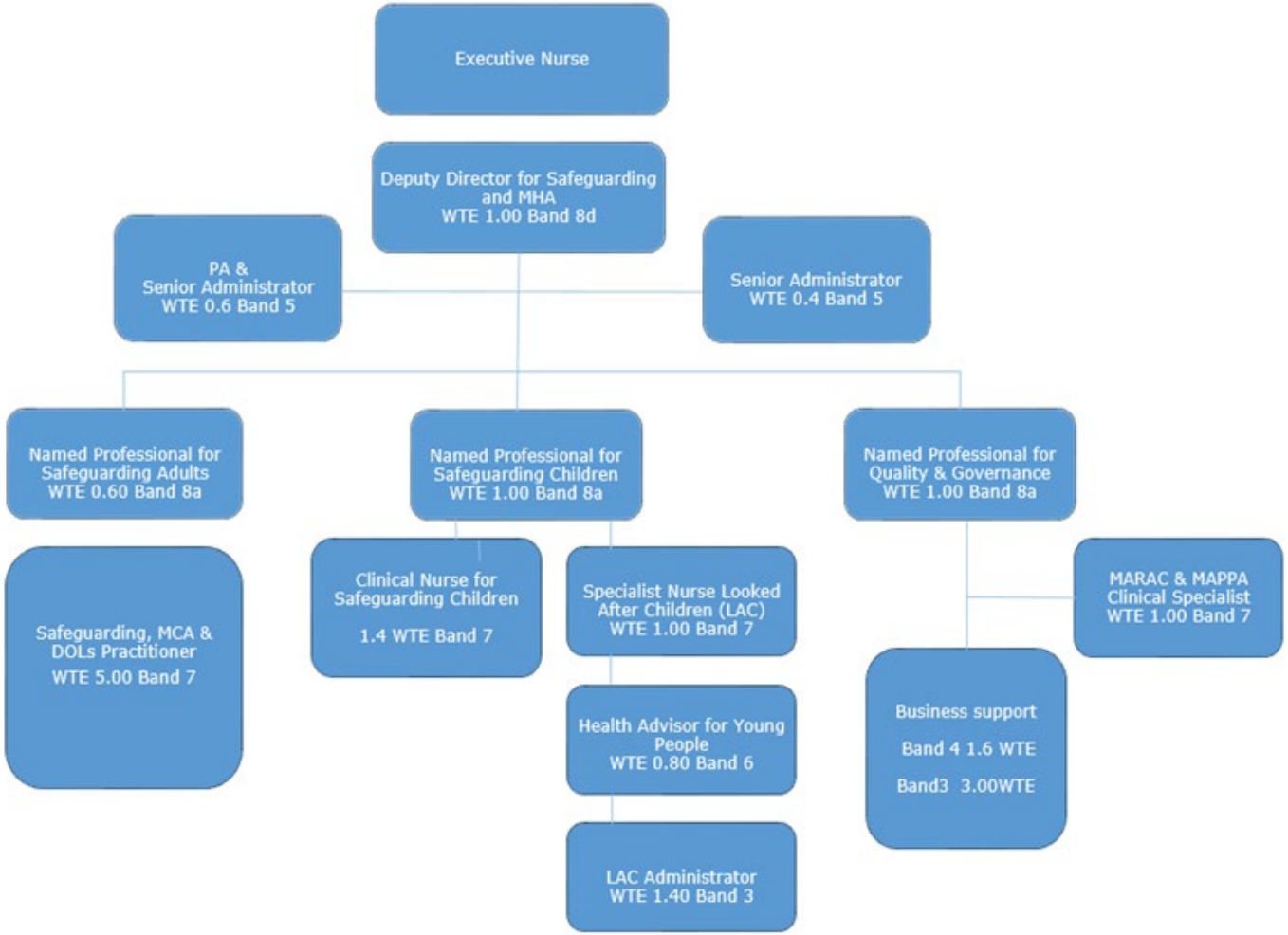
What is the Structure of the Safeguarding team?

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

The Safeguarding Service is led by the Deputy Director of Nursing for Safeguarding & Mental Health Act, covering Mental Health and Community Services across the organisation.

The team has adopted a *'Whole Family'* philosophy and are providing an integrated approach to safeguarding provisions, which is facilitated by joint meetings and peer support.

The team consists of a variety of professionals such as registered general and mental health nurses, health visitors, social workers, midwives and an occupational therapist, all of whom bring additional expertise to the service.



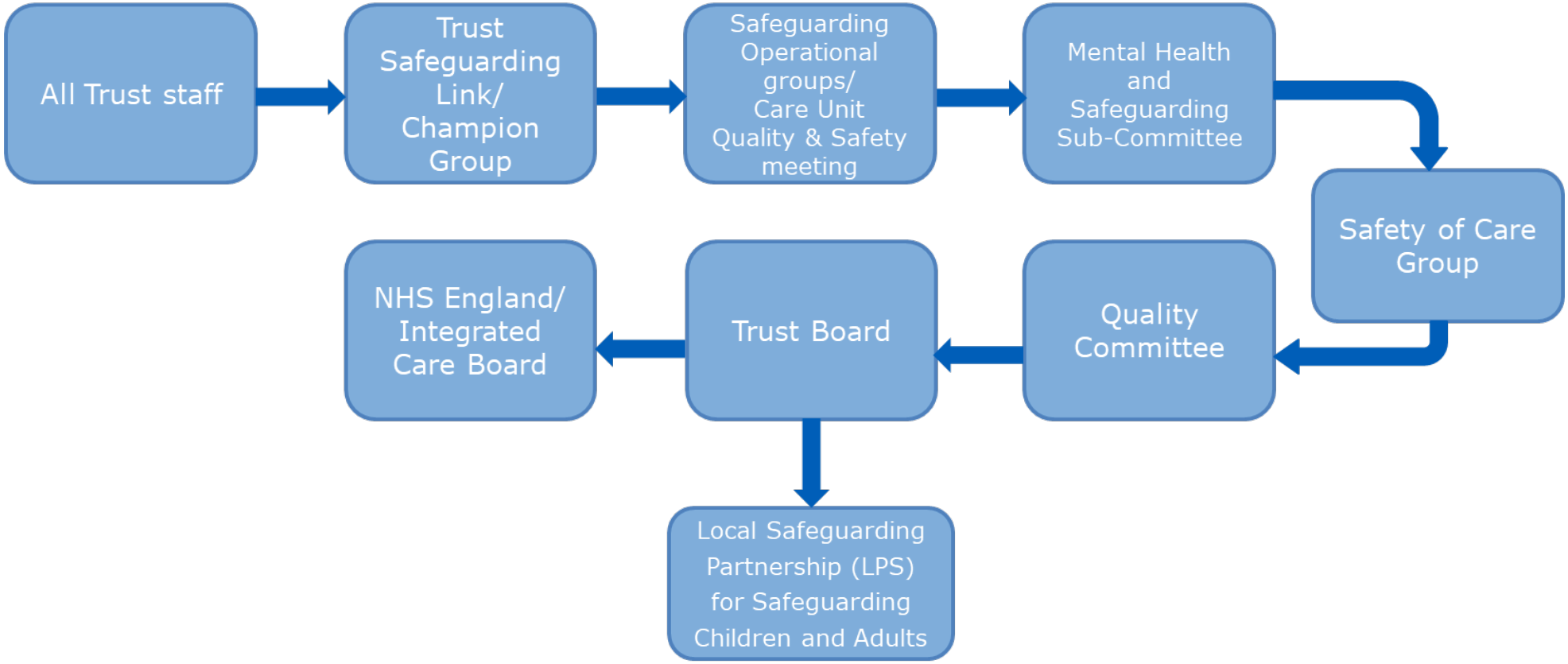
The Integrated adult's and children's Safeguarding team operate a duty system across EPUT between the hours of 9am to 5pm, Monday to Friday.

The Governance Structure for Safeguarding

The diagram illustrates the clear lines of accountability that are in place in relation to the governance pathway for the Safeguarding Service within the Trust.

The Trust has robust reporting systems in place which ensures the Trust Board and associated committees are updated regularly on safeguarding performance, trend analysis and quality issues.

The Trust Safeguarding Service provides regular reports for the Local Authority, Integrated Care group (ICB) and NHS England.



Overview of Safeguarding Activity – Business Support

Initial involvement queries from partner agencies

Business support receive an average of 28 known to service queries per day from both the local authority and police.

Table 1: Number of service queries

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of queries	555	410	445	605	521	526	657	534	653	709	733	805
Average no. per day	25	18	22	26	24	25	29	25	30	31	37	38
Month on month change	-9.1%	-29.3%	+24.8%	+18.2%	-10%	+5.8%	+14%	-11%	+16.7%	+3.9%	+18.9%	+4.6

7,153 queries known to services received, +6% from previous year.

Table 2: Number of queries known to services

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Police	164	46	46	130	142	256	142	37	111	130	121	139
Social Care	391	364	399	475	379	270	515	497	542	579	612	666

Please see Appendix 1 for Business Support functions.

Key Safeguarding Facts

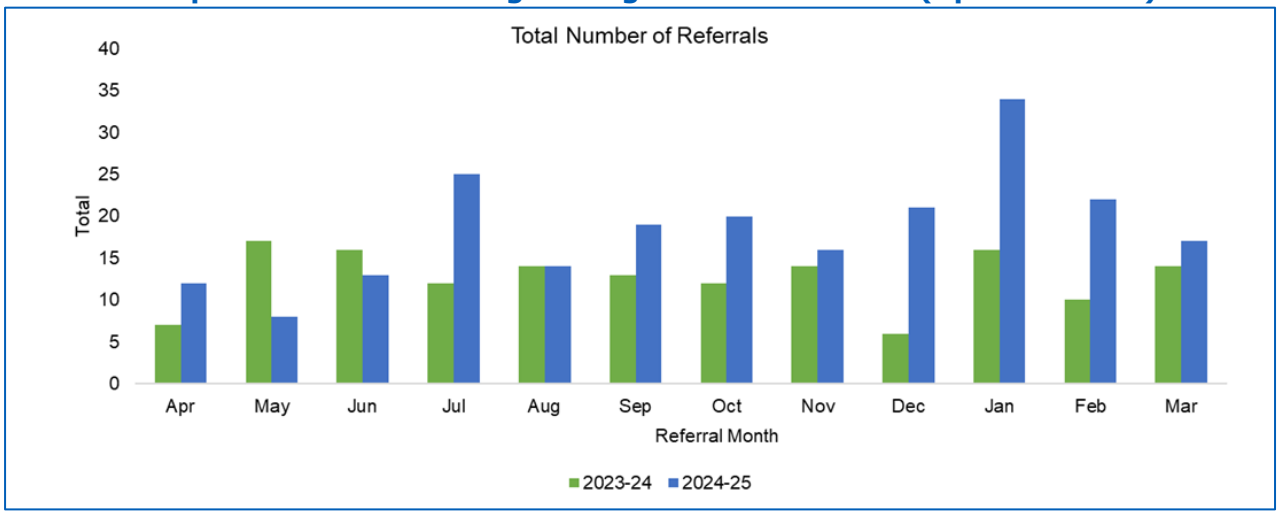
Safeguarding children

Table 4: Trust safeguarding children referrals raised

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
No. of children referrals	7	7	12	23	8	14	14	12	17	17	16	13	160

EPUT continues to provide specialist paediatric services within Essex. EPUT additionally provides tier 4 adolescent inpatient services, Together with Baby, Perinatal Mental Health Service and Mother and Baby inpatient mental health provision in Essex. Children's service practitioners within EPUT receive mandated safeguarding supervision.

Graph 1: Number of safeguarding children referrals (April to March)



Safeguarding adults

2,545 safeguarding concerns received, -20% from previous year this is largely attributed to changes in the reporting of concerns to operational teams that have not reached the threshold for S.42 enquiry.

68% progressed to Section 42 Enquiry

Adult safeguarding referrals

Table 5: Person alleged to have cased harm (top 10)

Self	31%
Partner	10%
Friend	10%
Other professional	9%
EPUT staff member	9%
Stranger	9%
Not known	7%
Neighbour	6%
EPUT service user	5%
Other family member	4%

Table 6: Source of referral

EPUT Mental Health	43%
Other	28%
Police	6%
Ambulance Service	5%
Acute/General Hospital	4%
CQC	3%
GP Surgery	3%
Residential Care Home	3%
Family	3%
Home care agency	2%

Table 7: Category of referral

Self-neglect	20%
Physical	14%
Financial	14%
Psychological	13%
Neglect	11%
Domestic Abuse	9%
Sexual	8%
Not Determined	6%
Organisational	4%
Modern Slavery	1%
Discriminatory	0%
Radicalisation	0%

Table 8: Safeguarding referral outcome

Substantiated	39.9%
Unsubstantiated	18.8%
Partly Substantiated	12.8%
Inconclusive/Not Determined	18.2%
Investigation Ceased at individuals Request	10.3%

Figure 1: Referrals by area

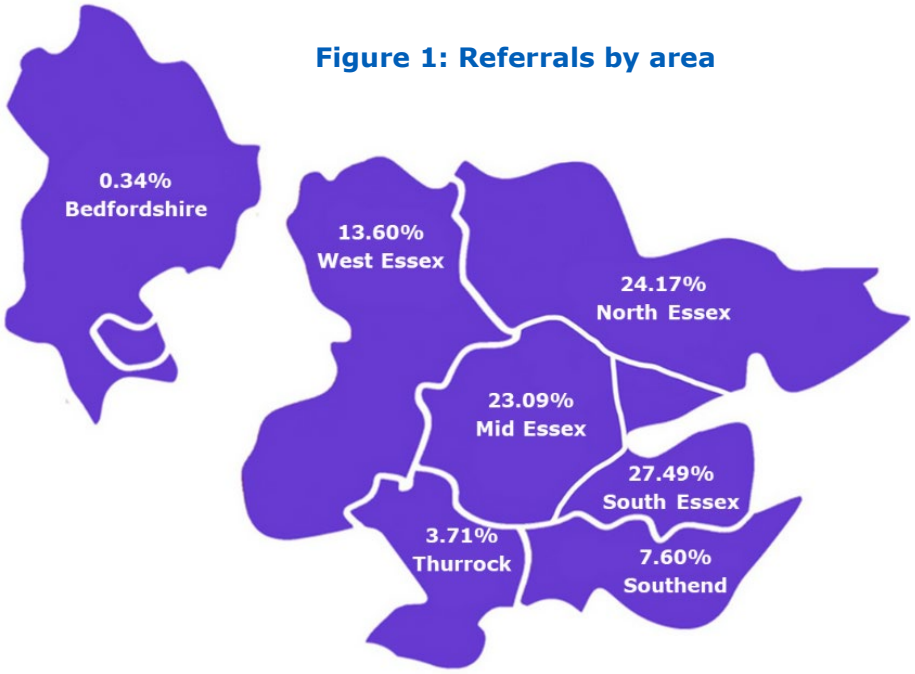


Table 9: Is the vulnerable adult satisfied with the outcome?

Yes	83.7%
Not applicable/known	12.5%
No	3.8%

Table 10: Risk level

Risk reduced	58.0%
Risk removed	28.9%
Risk remains	13.1%

Making Safeguarding Personal

These numbers are for the Enquiries raised for this financial reporting period:

Enquiries

Number of enquiries closed: **920**

Outcome Satisfaction

595 of vulnerable adults were **satisfied** with the enquiry outcome

Safeguarding Referral Outcome

439 of enquiries were recorded as **Substantiated** or **Partly Substantiated**

Desired Outcome

505 of vulnerable adults reported their desired outcome for the enquiry was fully achieved

Service user feedback

54% of service users, family members or advocates provided feedback.
What went well?

- Meeting the alleged perpetrator and reaching a reconciliation.
- Communication between services.
- People listened.
- Adult felt listened to when I agreed to close the safeguard. He explained that he is an adult and able to make arrangements for himself.
- Adult liked that care co-ordinator kept her updated and gave her the time to ask questions without a room full of professionals all the time when discussing this incident.
- Staff co-operation and vigilance to create a safer ward environment.
- Good communication with the perinatal team and every other professional involved in adult's care.
- Adult expressed he now feels educated and empowered about X's needs, admitting he lacked insight into the potential risks identified.
  He is now aware of the information and support he required to continue and sustain his caring role.

Duty System

The service has a safeguarding duty system operating between the hours of 9am to 5pm, Monday to Friday. The duty system has proved invaluable, providing a reflective space to discuss and clarify adult or child safeguarding concerns and to provide support to practitioners on next steps. Safeguarding specialists provide advice to operational teams in cases where the safeguarding threshold has not been met, but operational teams require guidance on forward actions to manage emerging risks.

The service operates a single point of access for all safeguarding matters, which has streamlined processes and supports timely access to specialist safeguarding support.

Themes from Duty System

Safeguarding activity remains high with a total of 1,586 calls reported in 2024/25.

EPUT services have been advised of 332 Child in Need enquiries and 192 Child Protection enquiries for children and young people under the care of EPUT service users during the reporting period.

This highlights the need for practitioners to adopt a 'Whole Family Approach' when working with families to de-escalate potential harm and support positive outcomes for children and young people.

Key themes reported through duty

- Domestic abuse - Insights from staff about domestic abuse in discussions about service users and their relationships with family and partners/ex partners.
- Substance misuse and Dual Diagnosis.
- Self-neglect.
- Patient on patient assaults/altercations/fights on the ward, some of which only require case management however, safeguarding referrals have been made.
- Exploitation/sexual abuse.
- Learning disabilities/neglect.
- Parental mental ill health and substance misuse.
- Increase in reporting of modern slavery cases.

MAPPA

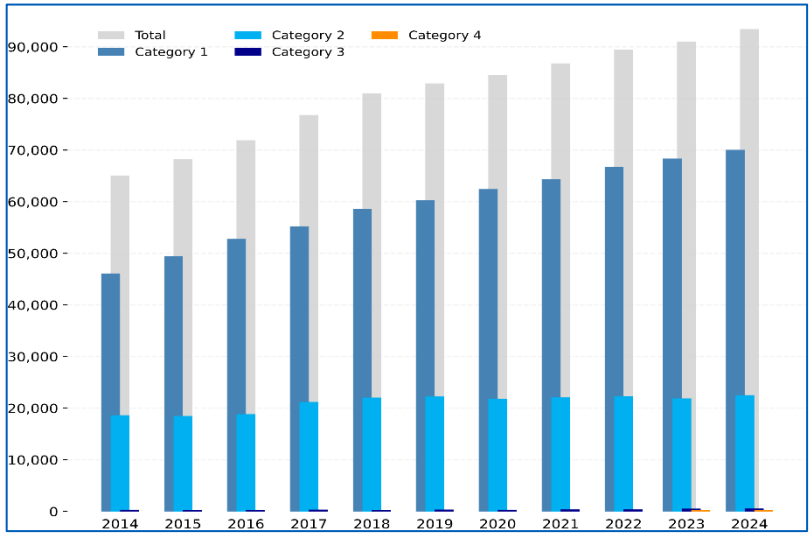
National picture

Multi-Agency Public Protection Arrangements is a framework where various agencies, such as the police, probation, and prison services, collaborate to assess and manage the risks posed by certain sexual and violent offenders. MAPPA produce their annual report in October therefore, the below data has been taken from the 2023 – 2024 reports.

Nationally, the MAPPA population continued to grow and was at 93,436 on 31 March 2024 of which 70,052 Category 1; 22,534 Category 2; 563 Category 3; and 287 Category 4. Within this, 91,873 were managed at Level 1; 1,356 managed at Level 2; 207 managed at Level 3.

There was a 3% increase from the previous year, where there were an additional 2,396 MAPPA offenders, accounted for by an increase of 1,695 in Category 1, 637 in Category 2, 23 in Category 3, and 41 in Category 4.

Graph 1: MAPPA population between 2014 and 2024.



Up until year end date March 2024, there has been an increase of 44% in the MAPPA population since 2014, which is demonstrated in Graph 1.

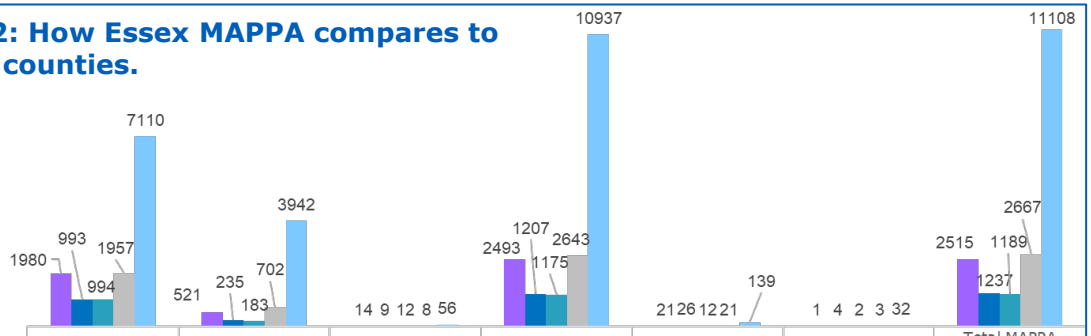
Essex

The Essex MAPPA population continued to grow and was at 2,515 on 31 March 2024 of which 1,980 Category 1; 521 Category 2 and 14 Category 3. Within this, 2,493 were managed at Level 1; 21 managed at Level 2; 1 managed at Level 3.

There was a 5% increase from the previous year, where there were an additional 129 MAPPA offenders, accounted for by an increase of 114 in Category 1, 32 in Category 2, - 17 in Category 3.

Up until year end date March 2024, there has been an increase of 71% in the Essex MAPPA population since 2014.

Graph 2: How Essex MAPPA compares to nearby counties.

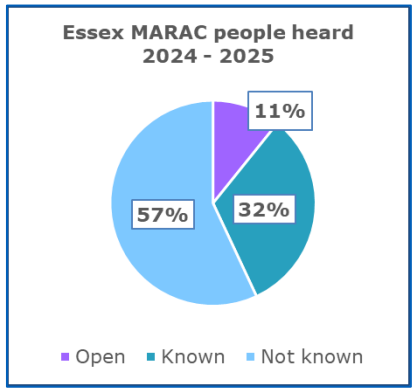


	Category 1	Category 2	Category 3	Level 1	Level 2	Level 3	Total MAPPA offenders
Essex	1980	521	14	2493	21	1	2515
Cambridgeshire	993	235	9	1207	26	4	1237
Suffolk	994	183	12	1175	12	2	1189
Kent	1957	702	8	2643	21	3	2667
London	7110	3942	56	10937	139	32	11108

EPUT themes and challenges - MAPPA

- MAPPA attendance from operational teams has increased from this time last year to 72%.
- There were 33 Level 2 meetings held for MAPPA offenders open to EPUT and 38 Level 3 meetings.
- Figure 1 shows that the category of MAPPA offenders open to EPUT remains largely the same as the previous year, with Category 3 being the greatest at 61% of cases being open.

Figure 2



Graph 3

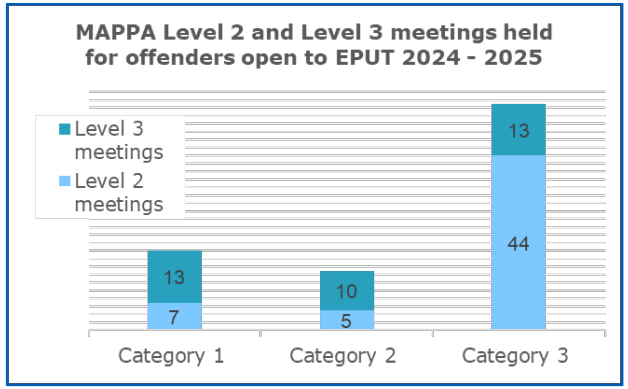
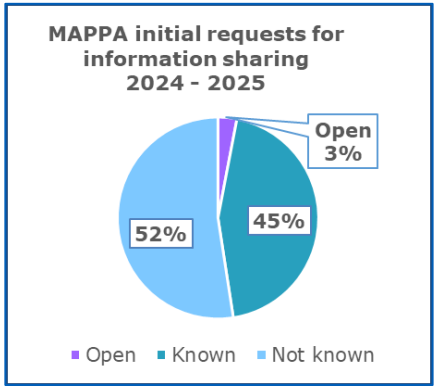


Figure 3



- Figure 3 demonstrates that Category 1 and Category 2 offenders who are open to EPUT are heard at Level 3 more than Level 2; Level 3 is the highest level of MAPPA management, demonstrating the risk and complexity of cases that operational teams are managing.
- The number of MAPPA Initial Requests for Information Sharing remains high, with numbers being consistent to this time last year, which continue to be significantly higher pre 2023.

EPUT themes and challenges -MARAC

Multi-Agency Risk Assessment Conference is a meeting where different agencies collaborate to address high-risk cases of domestic abuse, aiming to protect victims and reduce further harm. MARAC engagement continues to be challenging for operational teams against a significant increase in victims and perpetrators open to EPUT. The number of perpetrators open to EPUT services has increased by 131% in 2024/25.

Figure 4

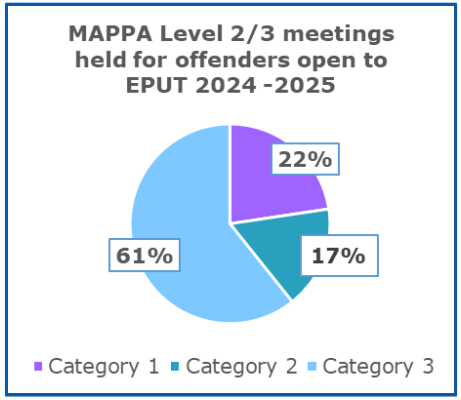


Figure 5

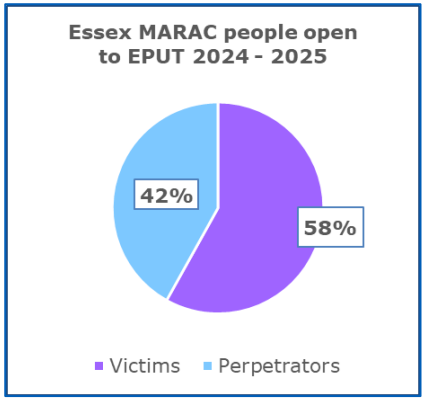
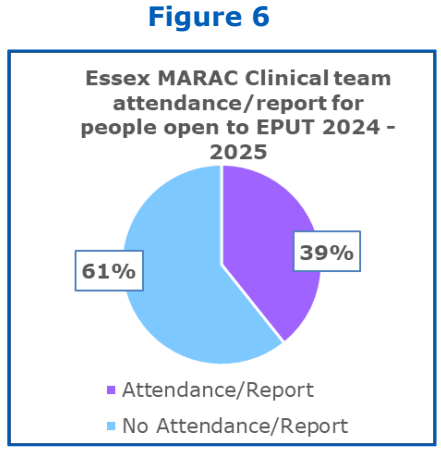


Figure 6



The clinical specialists for safeguarding MARAC and MAPPA continue to offer support and training to operational teams and are working closely alongside MARAC to develop new ways of communication to aid engagement.

Prevent Channel Panels

Prevent is to stop people from becoming terrorists or supporting terrorism. The objectives of Prevent are to:

- tackle the ideological causes of terrorism
- intervene early to support people susceptible to radicalisation.

- A representative from EPUT Safeguarding team attends monthly Prevent Channel Panels as a core member for Essex & Southend and Thurrock. In 2024-25, five service users known to EPUT were presented at Panel.
- The Safeguarding Prevent lead responds to queries from the Prevent Police in addition to the routine information requests in preparation for Channel Panels.
- The Safeguarding Prevent lead and administration team will ensure that any known Prevent information is shared with the clinical teams to inform robust risk assessment.
- A Safeguarding Team Duty clinician or Prevent Lead will triage all Prevent referrals raised by EPUT staff and forward these onto the Prevent Police team if appropriate.
- The Safeguarding Prevent lead attends the Essex Prevent Delivery Group. The purpose of the Essex Prevent Delivery Group (PDG) is to bring together the 'specified authorities' under the Prevent Duty to ensure that Prevent is successfully delivered in Essex.
- Islamist extremism remains the dominant terrorism threat in the UK.
- For 2024-25, there has been four EPUT referrals to Prevent. Referrals in the eastern region from health remains low and education remain the highest referrer.
- The internet has become increasingly prominent in radicalisation pathways and offending over time for convicted extremists in England and Wales.
- Mental health issues, neurodivergence and personality disorder/ difficulties alongside depression and personality disorder/ difficulties have been recorded in a study published by the HM Prison and Probation Service (2022) as the most common types of disorders for those who have primarily been radicalised online.
- All EPUT staff will need to complete HM Government Prevent Duty Training Modules 1 & 2: Prevent awareness & Prevent referrals.

Supervision

There are a variety of models used within EPUT for safeguarding supervision and these include individual, group, peer, as well as pre and post case conference supervision. The safeguarding clinical specialists within the Safeguarding team are trained to offer supervision across the Trust. They receive supervision internally from the named professionals for the clinical skill mix team and the named safeguarding children's nurse receive their supervision externally for themselves through arrangements with the designate professionals.

Children's services are expected to comply with a mandatory safeguarding supervision framework which is monitored closely for compliance. Adult services access supervision sessions through their linked safeguarding clinical specialist, for children or adult concerns as required, if duty advice is not considered sufficient to meet the need of a case. The model offered is a flexible one, with most of the supervision contact taking place via Microsoft Teams or face to face within a community base or inpatient setting.

Table 11: Staff safeguarding supervision

April to March	2021-22	2022-23	2023-24	2024-25
Mandatory 1:1	478	433	269	304
Group (no. of participants)	254	503	395	613
Additional	216	158	12	8
Total	948	1094	676	925

Staff uptake of safeguarding supervision is good with practitioners additionally pro-actively seeking advice when concerned.

Please see Appendix 2 for more information about supervision.

Feedback

South East Perinatal

"I have found my supervision with Safeguarding really helpful, being able to discuss my cases and getting sound guidance has helped. I have learnt a lot as well as I had not had a lot of experience with safeguarding processes before coming into this role. Thank you for giving me a safe space to talk."

Specialist School Nurse

"All the qualified nurses responded that they found supervision sessions helpful. They find the Safeguarding team to be very responsive to any requests for support and the specialist school nurses are never made to feel that they have wasted the supervisors time. Safeguarding sessions result in the nurses being confident with how to proceed with management of a case as appropriate."

Learning from Children's Safeguarding Practice Reviews (CSPR's)

During 2024, the organisation has been involved in six CSPRs (three of which were commissioned in 24/25) and 17 multiagency reviews which although did not meet threshold for CSPR, still provide important system wide learning.

The key themes are:

- Think *'Whole Family'* approach when carrying out assessments/ working with adults with mental health concerns. Be professionally curious - what is the impact on the children?
- Ensuring robust handover/ discharge processes with clear communication of risk.
- Understanding the risk when transitioning services from one organisation to another.
- Use of chronologies in complex cases to aid understanding of cumulative neglect. Consider the benefits of genograms.
- Information sharing – EPUT staff to use the Health Visitor/ School Nurse Notification form when parents are accessing
- mental health services (see our safeguarding intranet page).
- All practitioners to focus on the lived experience of the child and the impact of inconsistent engagement with services. Review the use of "non engagement" or "DNA" and record specific reasons such as "unable to make contact" or "was not brought".
- The impact of trauma – using a trauma informed practice and transition planning.
- Understanding the needs and capabilities of parents, including mental health.
- Capturing the voice of the child in all assessments.
- The use of Mental Capacity Assessments, understanding that this is across the partnership – what is the question? Who is the best person to carry out the MCA?
- How do 'Health' help Partners to understand their concerns around risk of medical neglect.
- Understanding around Child Sexual Abuse – use of the NSPCC 'Traffic Light Tool' and use of resources such as the Centre of Expertise into Child Sexual Abuse.

Safeguarding Adult Reviews

The purpose of a Safeguarding Adult Review (SAR) is to promote effective learning and improvement action, to prevent further deaths and serious harm. SARs are a statutory requirement for Safeguarding Adults Boards (SABs).

In March 2025, the organisation had 64 cases reported within the review work flow to include those referrals currently being scoped, commissioned reviews in progress and multiagency practice reviews. Of these nine reviews had been commissioned during the report period (6 SARs and 3 DARDRS).

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

Learning from all safeguarding reviews is reported through the EPUT Culture of Learning to the Learning Collaborative Partnership and Learning and Oversight Sub Committee. Learning is further disseminated throughout the organisation via the "Five Key Messages" Bulletins, Lessons Identified Newsletter and the Safeguarding Newsletter. Learning also informs topic themes for the Safeguarding Champions Learning Events.

Key Learning Themes That Impacted Practice

Key themes from wider learning

The Safeguarding team, as a member of the Learning Collaborative Partnership, provides specialist expertise to support the Trust's Culture of Learning in the identification of lessons from good practice, safeguarding investigations and reviews.

The Safeguarding team has contributed to the Learning Matters Monthly Event on safeguarding, the "Five Key Messages" Bulletins and Lessons Identified Newsletter.

Key messages identified

Enhancing family risk assessment

A recent child death case highlighted the need for greater professional curiosity in assessing risks within the entire family unit, particularly when a parent is receiving treatment from adult mental health services. The use of the Health Visitor/School Nurse Notification form helps inform relevant professionals within universal children's services of a parent's mental health assessment or treatment, thereby supporting care provision without implying concerns about the child's wellbeing.

Whole family

A greater awareness that a '*Whole Family*' approach is adopted in the assessment of service users, particularly within older adult mental health inpatient units. Staff need to ensure that wider family and community support are investigated to inform assessment of need and risk.

Childhood neglect

Learning from the Essex system-wide Multiagency Thematic Audit on Childhood Neglect that EPUT contributed to, was shared across the organisation, identifying the need to further examine opportunities for early intervention through the tiers of service to strengthen outreach and in reach offers of support to vulnerable children and families at risk of neglect. Families can often struggle with the association of neglect and additionally, when it is used as a 'catch all' term it loses its impact, detail and direct link to harm of the children.

Domestic abuse

Ensure that all frontline staff in all services are aware of the importance of routine enquiry about domestic abuse and appropriate responses to disclosures. This involves ensuring that staff are trained to recognise the indicators of domestic abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. Additionally, the need for greater curiosity and robust documentation regarding significant relationships in a service user's life that could further inform risk and safety planning.

Deprivation of liberty safeguards

When considering a deprivation of liberty; assess and robustly record the patient's mental capacity in the Electronic Patient Record. Mental capacity and restrictions are reviewed weekly, ensuring the least restrictive care plan is in place. Any DoLS applications should be communicated to the patient's relative with a Trust information leaflet. An Independent Mental Capacity Advocate is available if needed and urgent cases with objections will be escalated to the Supervisory Body by the Safeguarding team.

Children in Care

- The Children in Care (CiC) Service operates in alignment with the statutory guidance on Promoting the Health and Well-Being of Children in Care (2015, DFE).
- The Service is tasked with addressing the health needs of children in care and young people in care placed within the South East locality, irrespective of the placing authority. This includes oversight of statutory Review Health Assessments ensuring consistency and quality through rigorous quality assurance processes. Additionally, the team is responsible for coordinating and monitoring the health needs of all children and young people who are looked after and placed by the South East locality and elsewhere in the country.
- The EPUT CiC Service provides frontline support to children and young people in care, particularly those aged 16+ and those not engaged in education or with universal service access. The service further enhances understanding and responsiveness through delivery of accessible and evidence based training to professionals and foster carers, aimed at strengthening clinical practice and awareness of the specific health and developmental needs of this population.
- Provision of evidenced-based training supports the development of practitioner's clinical skills in undertaking robust Review Health Assessments (RHAs), which support a holistic review of the health and developmental needs of the child or young person.

Collaboration remains a key component, with the CiC team actively participating in multi-agency operational groups and working in partnership with the ICB designated nurses to support corporate parenting duties. This includes focused efforts to improve outcomes for those in foster care and residential placements and in planning transitions for care leavers.

The Youth Participation team has also contributed by engaging directly with young people in care, generating meaningful dialogue around the rationale for annual health assessments. This has led to the co-design of user-friendly guidance and a proposed "one-page profile" to better prepare children and young people for their RHAs. Plans are underway to develop further resources tailored for use in both school nursing and CIC contexts, with input from care experienced children to ensure relevance and accessibility.

Local picture

The current CIC caseload held by the service within the South East locality is 760, which is broken down by area as:

Castlepoint & Rochford: 82

Under 18 years of age children

Southend: 322

Under 18 years of age children

Care leavers: 82

18 to 19 years old

Out of Area: 274

Children placed in area that originate from out of area / Children who originate from area placed out of area

Safeguarding Training Update

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

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

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

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

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

In September 2024, the Safeguarding team implemented a hybrid model of both face to face and online learning:

Adults LvL 3

24 Sessions
990 Trained

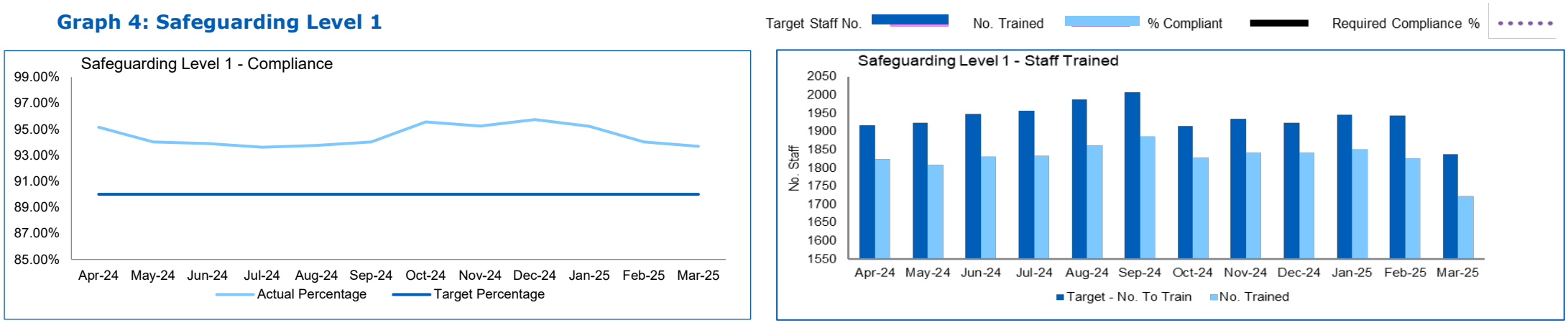
7 Sessions held Face to Face

Children's LvL 3

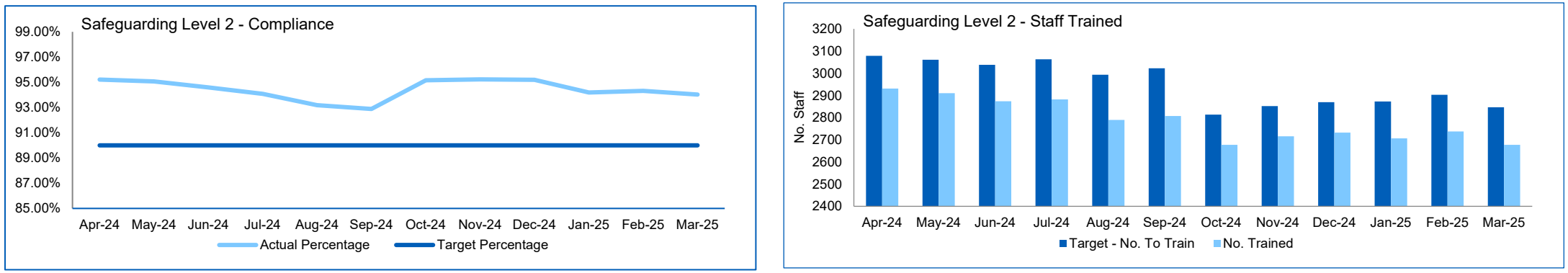
19 Sessions
629 Trained

8 Sessions held Face to Face

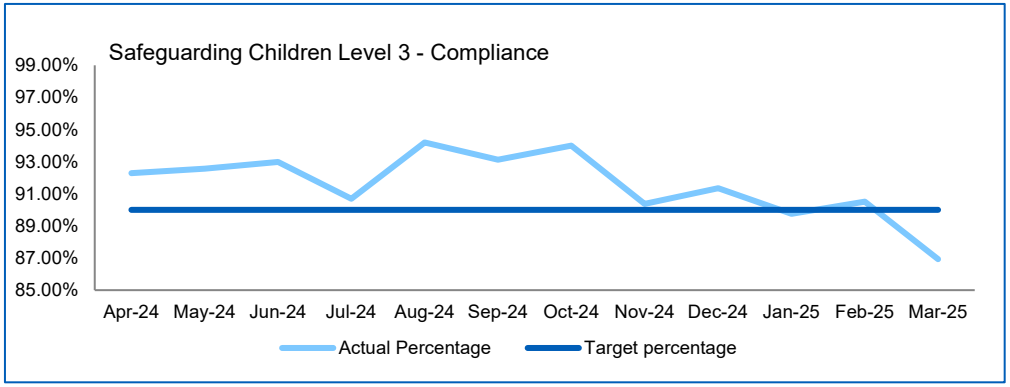
Graph 4: Safeguarding Level 1

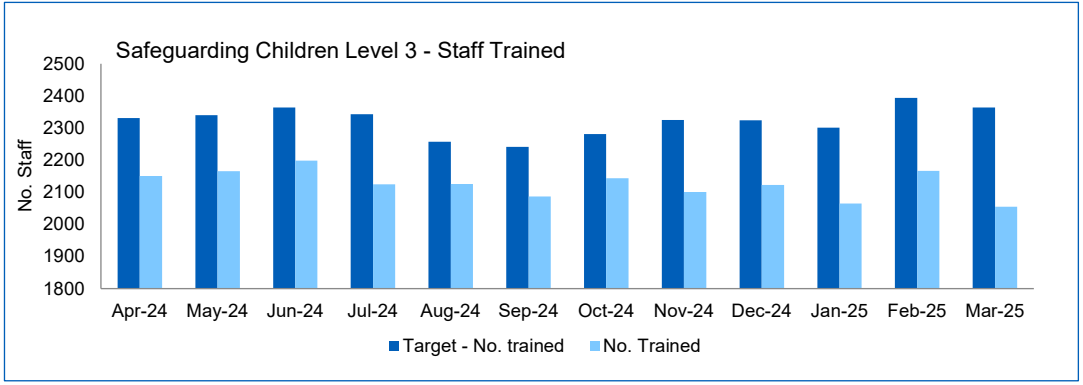


Graph 5: Safeguarding Level 2

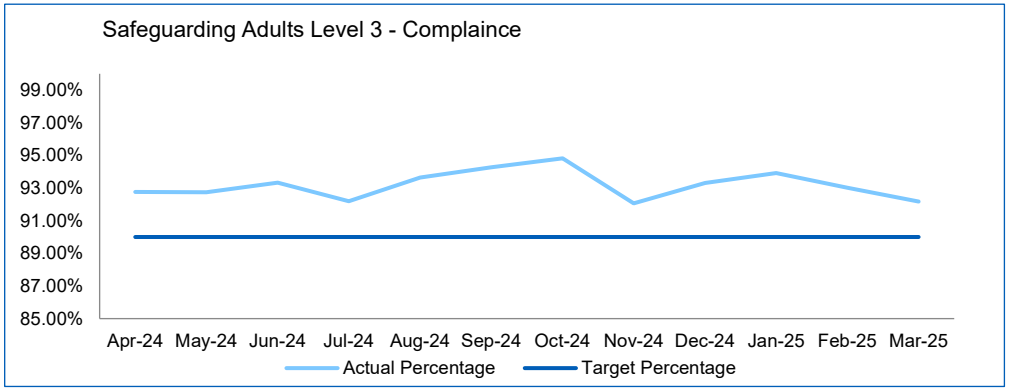


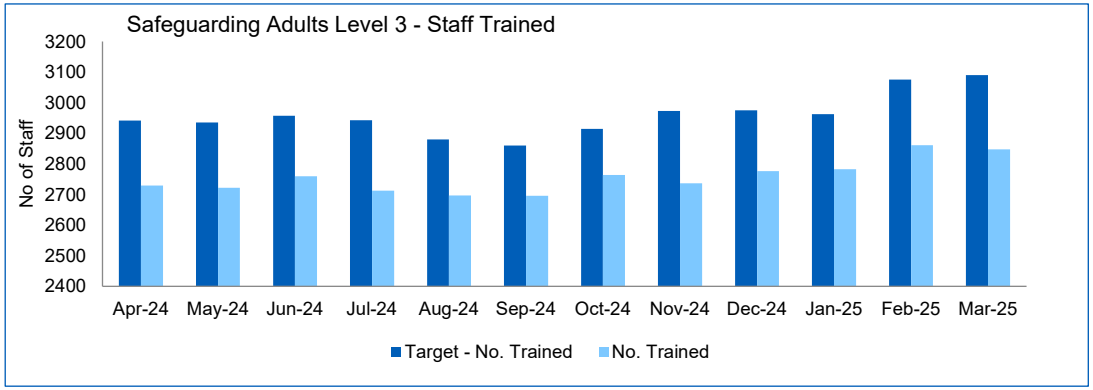
Graph 6: Safeguarding Adults Level 3





Graph 7: Safeguarding Children Level 3





There were dips in Level 3 training for November 2024, due to Safeguarding rolling out face to face training alongside the virtual training. This meant the number of people trained was much lower. We have increased our number of face to face training and added additional virtual classes to address the compliance.

Training feedback

"The case studies were a good way for us to concrete some of our learning from the morning session and use what we already knew about the safeguarding of children. The interaction with other health professionals showed how important an MDT can be if these were actual families we were working alongside.

For me as a newly qualified mental health nurse the knowledge I gathered was invaluable in my role, enabling me to support those in my care appropriately."

"I thought the course was really well presented. The group participation on scenarios was helpful as it made me think about situations presented and offered insight as to how to proceed in given situations. It was very varied which made it easier to focus as it was a long day."

"I particularly liked the way the course leaders acknowledged the potentially emotive subject area and offered support to anyone who was adversely affected and advised us generally about the significance on our emotions of what we had experienced via the case studies within the course."

Feedback post-training actions

1. *"Ensured I continue discuss possible concerns (no matter how small) in MDT setting and supervision*
2. *Remain curious with patients and leaving space for them to open up about any potential difficulties/concerns without judgment but instead to support."*

"Since the training I feel much more confident in raising Safeguarding referrals which includes recognising when a safeguarding referral needs to be made, as well as having confident conversations with families around these when necessary."

Communications

Safeguarding Champions

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

The following Champions events have been held during the reporting period to support this function and are open to safeguarding champions and EPUT practitioners to support best practice in Safeguarding.

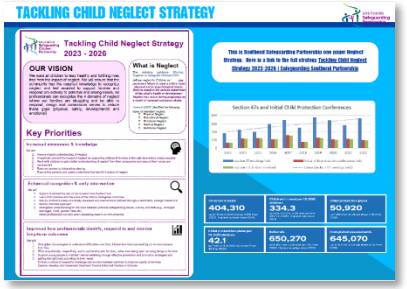
- **April 2024: Next Chapter- What is coercive Control?**
- Attended by 98 staff members.
- **May 2024: MARAC & MAPPA**
- Attended by 154 staff members
- **June 2024: The Role of a Community Mental Health**
- **Clinician Care Coordinator**
- Attended by 58 staff members
- **September 2024: Family Group Conference**
- Attended by 53 staff members
- **September 2024: Alpha Vesta- Basic Awareness & Staff Toolkit**
- Attended by 107 staff members
- **September 2024: DASH Training**
- Attended by 76 staff members
- **October 2024: Alpha Vesta Lunchtime leanings x4 sessions**
- Attended by 209 staff members
- **November 2024: The Change Hub- Stalking Training**
- Attended by 80 staff members
- **March 2025: Alpha Vesta Lunchtime leanings x4 sessions** Attended by 105 staff members

Safeguarding Newsletter

The newsletter is published on a monthly basis and is circulated to all safeguarding champions and operational leads for wider distribution within the organisation.

Topics reported over the past year include:

- Sexual Safety Training
- DASH Training
- Community Safety and Dangerous Dogs
- Child Safety Week
- Rethink and Voiceability
- Pride Month
- The importance of the work of MARAC
- Domestic Abuse- Women in Prison
- Not everyone is Cheering- Euros 2024
- Minute Briefing Child H
- Clare's Law
- Antislavery Partnership Conference
- Online Radicalisation Training
- Staying Safe this Autumn
- Raneem's Law
- Men's Mental Health Awareness Month
- 16 Days of Activism against Gender Based Violence
- Neurodiversity celebration week
- Professional Curiosity and Disguised Compliance
- Tackling Child Neglect.



Safeguarding intranet page

The Safeguarding Adults & Children's Intranet page is the information hub for all aspects that the Safeguarding Team cover including Looked After Children, the Mental Capacity Act and Deprivation of Liberty Safeguards.

Safeguarding homepage: 10k+ views

Sexual Safety homepage: 3,704 views

Safeguarding team roadshow

In November 2024, the EPUT Safeguarding team went out and about across the Trust to celebrate National Safeguarding week. The team visited various sites across Essex, Southend and Thurrock to spread awareness of who we are and what we do.

The team was joined by Next Chapter, VAPR, Health & Safety, Voiceability and the Employee Experience teams.

Challenges and innovations

Challenges

- Increase in both levels of complexity and safeguarding activity requiring specialist oversight from Safeguarding team within operational teams to support timely, robust and rigorous safeguarding enquiries. The safeguarding team successfully recruited a clinical practitioner for safeguarding which was essential in supporting operational teams. We have also increased our presence in operational teams and are offering safeguarding clinics and drop-in sessions.
- DoLS and raising awareness within the organisation regarding the application of the Mental Capacity Act (2005). We have delivered bespoke training sessions on the Mental Capacity Act (2005) and DoLS to operational teams. We have also updated the information and resources available on the safeguarding intranet page so that information is easily accessible to staff. The Mental Capacity Act (2005) has also featured in the Safeguarding Newsletter.
- Patients who have made threats to life and/or serious violence and committed physical violence have not always been reported to the police, leading to an increased risk not being appropriately managed. The Clinical Specialist for Safeguarding MARAC and MAPPA worked closely alongside the operational teams, Essex Police, MAPPA and the Essex Police Mental Health Prevention team to ensure all incidents were reported in the correct manner and emphasised the importance of doing so.
- High turnover of staff has necessitated ad hoc safeguarding training for some of our units.
- Responding and contributing to a high volume of Domestic Abuse Related Death Reviews, Safeguarding Adult Reviews and Child Practice Reviews across the SET Area. The Safeguarding team are working collaboratively with operational teams with regards to EPUT involvement in all reviews. We are sharing responsibility in regards to involvement and reviews.

Innovations and achievements

- Delivery of MHDAP Pilot with Next Chapter to support access for service users and staff to specialist DA services and training for practitioners within Mid and North Localities. The pilot reported a rise in referrals to specialist DA services with a 105% increase in referrals received between Jan 2024 to 16 Dec 2024.
- In partnership with Alpha Vesta, there were commissioned and delivered specialist skills based training programmes to develop practice competency around DA on management of routine and sensitive enquiries, effective assessment of risk and need and connecting with those experiencing trauma and suicidal Ideation.
- A Review of children and adult mandatory training packages to include a hybrid model of delivery via Microsoft Teams and face to face, to support interactive learning.
- Delivery of a programme of safeguarding champions events on key themes.
- Contribution to the ECOL learning matters events and newsletter.
- Delivery of bespoke training packages in response to operational teams training needs to include Mental Capacity Act & Deprivation of Liberty Safeguards, MAPPA/MARAC, S.42 Enquiries.
- Two clinical safeguarding specialists have undertaken and qualified as independent domestic violence advocates. Two safeguarding specialists have become trainers for the Graded Care Profile Two Neglect Tool and to date 85 children's staff within EPUT have undertaken the training. GCP2 is now fully integrated into supervision and children's electronic patient record templates.
- Monthly one to one sessions with Rawreth Court manager to discuss safeguarding cases and closure process. There will be meeting with qualified staff next to upskill them in safeguarding processes. Safeguarding Section 42 closures are starting to be completed within expected time frames.
- Clinical specialist for safeguarding set up group supervision sessions with Therapy for You, which is being well attended and is positively impacting on the need for staff to contact duty. Feedback from staff has been positive.
- Monthly meetings held between the Safeguarding team, Thurrock Safeguarding and Thurrock Community Mental Health team to discuss open safeguarding cases and challenges.
- Bi-weekly meetings between safeguarding clinical specialists and ward matrons/managers to discuss open cases and support with closures.

Looking Back 2024/25 Priorities

Objectives 2024/25	What we have achieved	
Domestic Abuse	Review of clinical DA policy guidance. Review of the DA reporting process on electronic patient records for all initial assessments. Effective utilisation of Staff Toolkit for domestic abuse. DA Training framework implemented with Alpha Vesta (CIC) to include development of 3 skills based training sets. Next Chapter MHDAP Pilot implemented and completed to support access for service users and staff to specialist DA services and training for practitioners within Mid and North Localities. Learning from pilot reported to SETDAB. Learning from DARDR's disseminated via ECOL, safeguarding newsletter and incorporated in L3 training review.	✓
S.42 Enquiries	Review of the current caseload report format presented to care unit and quality and safety meetings. Remedial action plan was instigated to address historical open safeguarding enquiries, resourced through bank provision. Review of Datix reporting mechanism to capture 'justifiable delays'. 1866 enquiries have been closed, with 624 remaining open. 75% of the caseloads have now been closed, exceeding the target of 70% set as an achievement based on Local Authority's data. Successful implementation of the Essex Adult Safeguarding Portal with operational teams for all safeguarding referrals (SETSAF 1/adult concerns forms) for service users residing within Essex.	✓
Children	Learning from local and national safeguarding children reviews summarised and shared within quality and safety meetings, safeguarding champions and the safeguarding newsletter. Relevant publications/legislation updates pertaining to children summarised and disseminated. NSPCC Graded Care Profile 2 neglect tool training delivered to children's services and Perinatal Mental Health Service. Bespoke LADO and MCA for 16 and 17 year olds training delivered to our CAMHS staff and specialist community children's staff.	✓
Learning and Awareness of Safeguarding Agenda	Contributed to Multiagency Thematic Audit (MATA) on Neglect within families & 1 Multiagency Case Audit on Honour Based Abuse in Essex. Learning presented to LOSC, Specialist Children's Services and LCP. Dissemination of Learning and key themes through ECOL from adults and child safeguarding practice Reviews. Delivery of DASH training commissioned from Safer Places (1) for safeguarding practitioners. Delivery of DASH training trust wide by Next Chapter. IDVA training programme completed in September 2024 by two Safeguarding Clinical Specialists. Commissioning of specialist risk assessment training to support operational teams in the care delivery to victims and perpetrators of domestic abuse Commissioning of skills based training re DA to support practitioner competencies within this field. Compliance with safeguarding training L 1, 2,3 & 4 KPI's.	✓

Forward Plan Review 2025/26

Objectives 2025/26	Success Criteria
Whole family Approach	Ensure that development of record templates for the new NOVA patient record system support robust documentation and risks presenting to an individual within a family and community. Contribution to the SET Whole Family Approach working group to ensure EPUT embedded in system wide processes. Ensure learning and practice tools disseminated via EPUT Culture of Learning. Learning themes in relation to Whole Family Approach to be presented to the Trust Learning Collaborative Partnership. Review of learning resources for the Whole Family approach within the safeguarding training, safeguarding newsletter, champions and bespoke discussions with individual teams with a view to arrange a champions event around this subject. Inclusion of Whole Family approach in the agenda for the hybrid model of training delivered to locality teams.
Children's safeguarding	Ensure learning from local and national reviews is shared throughout EPUT via supervision, safeguarding champions, safeguarding newsletter and ECOL. Explore evidence this is embedded into practice. Delivery of champions events around key learning from reviews such as Whole Family Approach, neglect, professional curiosity, impact of mental health on children, child sexual abuse and online harm. Continue to roll out the NSPCC Graded Care Profile 2 tool training to adult teams. Train staff in Brook Traffic Light Tool to support staff to identify harmful sexual behaviour in children. Quarterly meeting with the local authority to identify child protection referrals missing from Datix in order to explore themes/challenges/relevant learning.
Learning	Safeguarding staff events delivered in partnership with external agencies to support identified learning themes. Dissemination of key learning through ECOL-5 key messages, Lessons Identified Newsletter and Learning Matters. Access to L4 safeguarding training for Clinical Safeguarding Specialists. Provision of a hybrid model of training with a focus on localised delivery informed by locality themes. Safeguarding Champions events delivered within localities by clinical safeguarding specialists. Training and awareness to be made available in different modes to include bespoke targeted training to teams - bite size learning, videos and interviews to support different learning styles. Routine support visits by clinical safeguarding specialist to clinical teams. Delivery of audit programme. Compliance to safeguarding training and supervision KPI's.

MCA and DoLS	Review of Mental Capacity Act and DoLS Policy and procedural Guidance MCP2/MCPG2. Audit of the quality of mental capacity act assessments. Development of a training framework for Mental Capacity Act to include Bite size vignettes and team based training. Review of DoLS leaflet for service users and relative/carers. Development of DoLS process chart. Benefit analysis of current reporting mechanisms against Datix functions and reporting to inform dashboard approach.

Closing Remarks

As we move forward into 2025-26, this annual report has been an opportunity to reflect on EPUT's safeguarding journey in the last year. It has enabled the safeguarding service to recognise our achievements and provided the opportunity to focus our efforts for the year ahead. During the course of the reporting period the team was audited by the Trust's independent auditors who provided assurance that the Trust is meeting its statutory responsibilities. The Trust also submitted the SET biannual Safeguarding Self-Assessment Audit, which provided additional assurance to the safeguarding boards.

This report provides assurance to the Trust, its patients and their families, and our partner agencies that safeguarding remains a key priority. During this year, our team has evolved with new staff joining to replace staff that have successfully secured new senior roles in other organisations.

This report demonstrates the enhanced visibility of the service within the Trust with the development of innovative resources and training and development opportunities for staff. The correlation between a workforce that has enhanced safeguarding knowledge and an increase in safeguarding referrals is also a clear observation that is outlined in this report. Colleagues' ability to recognise, respond and escalate safeguarding concerns has contributed to enhanced Trust safeguarding arrangements and a greater ability to keep our patients safe.
There has been positive uptake by staff to additional training provided by the Safeguarding Service through both the Safeguarding Champions Events and additional ward based training with 907 practitioners attending. This has been further demonstrated through training provided in partnership with Alpha Vesta, where 2003 staff have accessed specialist Domestic Abuse training in addition to the mandated training programme. The service was involved in the successful delivery of the Mental Health Domestic Abuse Pilot with Next Chapter to support access for service users and staff to specialist Domestic Abuse services and training for practitioners within Mid and North Localities. The pilot reported a rise in referrals to specialist DA services with a 105% increase in referrals received between Jan 2024 to 16 Dec 2024.

The service has worked closely alongside our Local Safeguarding Partnerships to ensure that the SET learning and development agenda is embedded into practice. Two Safeguarding practitioners are now trained to deliver Grade Care Profile 2 Assessment Tool training for childhood neglect, supporting not only Trust but also system wide training.

The priorities outlined for this reporting year have mostly been achieved and further ambitious priorities are outlined for the year ahead, underpinned by the finer detail outlined within our forward plan. I am confident that the Safeguarding Service will have another productive and proactive year ahead, embedding practice to continuously improve the outcomes for children, young people and adults at risk.

Tendayi Musundire
Deputy Director of Nursing (Responsible for Safeguarding)

Appendix 1

Business support

The Business Support team within the Safeguarding team provide secretarial and administrative support to the safeguarding service. They manage the 'Duty Line' which is a single point of access number and email which feeds into the team. Business support receive a high workflow of enquires as to whether the adult/child is open to our secondary Mental Health Service from:

- Social workers
- Police
- Social care teams
- LA business support teams

Following triage from the duty clinician, business support administer the safeguarding enquiry or case management process, where further action or progression are required to be communicated. Business support manage the booking function that supports provision of mandatory, informal and group safeguarding supervision for practitioners within EPUT.

The administrators also support the child death review process by notifying safeguarding clinicians of the receipt of a child death notification within Essex and the organisation, so that they can identify the relevant practitioners that have been involved in the child's care.

Business support receive, disseminate and manage the Safeguarding Children's inbox. This includes information received or requested from:

- Domestic abuse notifications
- Child Protection Minutes and Invitations
- Children's Social Care
- National Crime Agency
- Essex Police
- Prevent Enquiries
- LADO
- Safeguarding Adult Reviews (SAR)
- Domestic Homicide Reviews (DHR)
- MARAC

The team produce a monthly Safeguarding Newsletter, covering clinical topics identified by the Safeguarding team and administrate the Safeguarding Champion's events.

Appendix 2

Supervision

There are a variety of models used within EPUT for safeguarding supervision and these include individual, group, peer, as well as pre and post case conference supervision. The safeguarding clinical specialists within the Safeguarding team are trained to offer supervision across the Trust. They receive supervision internally from the named professionals for the clinical skill mix team and the named safeguarding children's nurse receive their supervision externally for themselves through arrangements with the designate professionals.

Supervision enables both the supervisor and the supervisee to reflect, scrutinise and evaluate cases where safeguarding concerns have occurred. The process of safeguarding supervision is both educational and supportive, whilst facilitating the supervisee to explore their feelings about the work and the family. Staff will be encouraged to use professional curiosity when discussing their cases and will bring cases for escalation. As a 'Whole Family' organisation, we offer formal supervision to both adult and children's services. The frequency of supervision is mapped to the roles that staff undertake within the organisation. Supervision covers safeguarding concerns in regard to both children and adult safeguarding.

Children's services are expected to comply with a mandatory safeguarding supervision framework which is monitored closely for compliance. Adult services access supervision sessions through their linked safeguarding clinical specialist, for children or adult concerns as required, if duty advice is not considered sufficient to meet the need of a case. The model offered is a flexible one, with most of the supervision contact taking place via Microsoft Teams or face to face within a community base or inpatient setting.

The Safeguarding team also offer joint supervision where practitioners across services are working with the same family. This is actively encouraged in the Trust to support the building of knowledge and skills in practice and the organisation's active ethos of 'Whole Family', both adult and children concerns can be considered and a plan agreed and documented.

Benefits of supervision

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

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

Appendix 3

Glossary of terms

CIC	Children in Care
DA	Domestic Abuse
DARDR	Domestic Abused Related Death Review
DoLS	Deprivation of Liberty Safeguards
ECOL	EPUT Culture of Learning
EHCP	Education Health Care Plan
HEF	Health Executive Forum
ICB	Integrated Care Board
ICS	Integrated Care System
LAC	Looked after Child
LADO	Local Authority Designated Officer
Mace Group	Missing Child Exploitation in Essex Group
MAPPA	Multiagency Public Protection Arrangements
MARAC	Multiagency Risk Assessment Conference
MCA	Mental Capacity Act
MHDAP	Mental Health Domestic Abuse Practitioner
MSE	Mid and South Essex
RHA	Review Health Assessment
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SEND	Special Education Needs
SET	Southend, Essex and Thurrock
SETDAB	Southend, Essex and Thurrock Domestic Abuse Board
SPOC	Single Point of Contact

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11:42

11. OTHER

11.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item HLD 11:45

Verbal

11.2 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item ALL 11:46

Verbal

11.3 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL 11:50

Verbal

11.4 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

Information Item | ALL | 11:55

Verbal

12. ANY OTHER BUSINESS

Information Item ALL 11:56

12.1 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING

12:01

- Risks for escalation to the CRR or BAF
- Risks or issues to be raised with other standing committees

13. QUESTION THE DIRECTORS SESSION

12:02

14. DATE AND TIME OF NEXT MEETING

12:15

Wednesday 1 October 2025 at 10:00, The Lodge Training room 1