

Essex Partnership University NHS Foundation Trust

Annual Report & Accounts

2024-25

EPUT

**Essex
Partnership
University
NHS Foundation
Trust**

***Annual Report &
Accounts***

Presented to Parliament pursuant to
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Contents

Foreword from the Chair and Chief Executive	7
Performance Report.....	11
Performance Overview	11
Performance Analysis.....	22
Financial Review	67
Accountability Report	74
Directors' Report.....	74
Remuneration Report.....	87
Staff Report	107
Glossary.....	149
Annual accounts 2024/2025 index.....	151

Foreword from the Chair and Chief Executive

As we look back on the 2024/25 financial year, it has been another year of changes and developments. After a new Government came to power in July 2024, there then followed announcements of significant changes at the centre of the NHS, as well as to local government. The Lampard Inquiry into deaths in Essex mental health services over a 24 year period held its first hearings in public, bringing an increased focus on the work we need to do to improve mental health services for all. At the same time, we continued to develop our services, recruit more trained colleagues and work closely with the people who use our services, their families and loved ones, and our local partner organisations.

Developing and Improving our Services

Throughout the year, we continued to develop and innovate, working with our patients and partners to introduce new services and improve existing ones. This work has focused on three clear priorities which we believe will improve care for the communities we serve across the full range of our mental health and community health service.

New Electronic Patient Record

Working with colleagues across the mid and south Essex health and care system, we have now signed a contract with Oracle Health to provide our new, first in type, joint electronic patient record system which will operate right across EPUT's mental health and community services and also acute hospital services at Mid and South Essex NHS Foundation Trust.

When it goes live in late 2026/early 2027, the new system will replace ten existing systems, enabling our clinicians to see patients' records across a wide variety of services and improving the

quality, experience and safety of care for our patients who are also involved in the design and development of the new system.

Time to Care

Our Time to Care programme, a five-year programme to transform how we staff and run our inpatient wards, launched earlier in 2024/25 and is focused on releasing more clinical time to care. The changes associated with the programme focus on ensuring that anyone who is admitted to an inpatient mental health bed has a clear reason for admission and care plan agreed with them and their family and loved ones with a path through therapeutic treatment to discharge and onward support in the community. The programme also involves introducing new roles into our ward teams, including activity coordinators, therapists, and for the first time, family and carer ambassadors – people with lived experience of our services who will use their experience to support the families and carers of people being cared for on our adult mental inpatient wards.

Patient and Carer Involvement

One of our most significant areas of focus is involving and working with people who use our services. Listening to people's lived experience brings vital and valuable insight to how we develop services and continue to meet people's needs.

Over the last year, we implemented the first set of priorities from our *Working in Partnership with People and Communities* strategy, which was coproduced with patients and underpinned by NHS England guidance. We have a reward and recognition system at three different levels to encourage people to get involved and to help lead patient involvement. We now have over 300 people working with us who have direct or family experience of using our services who support strategic developments, including our new joint unified electronic patient record programme and the Time to Care programme. They are also working directly with patients, families and staff in our wards and we would like to thank them for the tremendous contribution they make to the Trust and the difference they make to so many of our patients and those using our many services.

Recognition

While we are clear that there is more to do to improve services and care we are delighted that some of the work of colleagues across EPUT has been recognised more widely:

- **Personality Disorder and Complex Needs Service User**

Network (SUN) won the category for Complex Mental Health Needs in the Positive Practice in Mental Health Awards. The network offers peer support, advice and space to share experiences and learning, for people with personality disorders and complex needs, and their families and carers. Members also have the opportunity to shape and design services, work on projects, and support with training staff from EPUT and other organisations to increase understanding and awareness of service users' needs.

- Nicky Richards, who works as a Memory Assessment Nurse at EPUT's Brentwood Memory Service, awarded the prestigious **Queen's Nurse Title** for delivering outstanding care in the community.
- **At the Nursing Times Workforce Awards 2024** Moriam Adekunle, Director of Safety and Patient Safety Specialist, won **Diversity and Inclusion Champion of the Year** for her exceptional work in promoting diversity and inclusion across the Trust. EPUT was also recognised as **Best Employer for Diversity and Inclusion** for its innovative RISE (Resilience, Intelligence, Strength, and Excellence) talent programme, which provides tailored support and development for black, Asian and ethnic minority colleagues, helping to create an inclusive and empowering workplace.

Supporting our Staff

We have over 7,000 permanent staff at EPUT, with a further 1,000 who work with us on an interim basis. Our people are our biggest asset, and we know what a difference a stable workforce and stable teams make to them and to the quality and safety of our services and the care that our patients receive.

Over the last year, we have continued to improve permanent staffing levels on our wards and across the Trust as a whole. Our turnover rate is now at just over nine per cent, back to pre-pandemic levels, and our vacancy rate is around 12 per cent, down from nearly 19 per cent two years ago. In 2024, 151 new healthcare assistants and 132 newly qualified nurses joined the Trust and we know they are making a great contribution to our services and the care we provide.

We also continued to invest in support for colleagues, including our dedicated *Here for You* emotional support programme and introducing a new employee assistance programme which provides free practical and emotional support for anyone working at EPUT.

The Lampard Inquiry

The Lampard Inquiry held its first set of public hearings in September and November 2024, covering some of the background to the Inquiry and hearing very moving commemorative statements from family members who have lost loved ones in the care of Essex mental health services. Attending the hearings was a moving and humbling experience, and our thoughts remain with those affected. All of us across healthcare have a responsibility to work together to improve care and treatment for all and to build on the

improvements that have already been made over the last 24 years.

The Year Ahead

As we look ahead to 2025/26, we will continue to embed our Time to Care programme, focus on a similar programme of reviewing and transforming our community mental health services and work with our partners to deliver our new electronic patient record. We will start to see the impact of planned changes within NHS England, to local government and integrated health and care systems and will continue to work strongly in partnership with colleagues locally and nationally. We will also continue to do all we can to support the work of the Lampard Inquiry into Mental Health Deaths in Essex.

Looking back on the last year also gives us a further opportunity to thank our outgoing Chair, Professor Sheila Salmon, who stood down at the end of March 2025 after nearly eight years in the role. During her time with us, Sheila has overseen considerable changes in our services and teams and has been a steady and supportive influence at the Trust and within the wider systems in which we operate. We wish her well for the future.

Finally, we would like to thank our colleagues, volunteers, supporters, patients, families and carers and everyone who is involved with and contributes to the Trust and to the work we do every day to support the 100,000 people who are in our care at any one time.

Hattie Llewelyn-Davies.

Hattie Llewelyn-Davies
Chair
24 July 2025

A handwritten signature in black ink, appearing to read 'P. Scott', with a stylized, overlapping flourish at the end.

Paul Scott
Chief Executive
24 July 2025

Performance Report

Performance Overview

This overview provides information on the Trust, our history and purpose. Information is included about our services, where we provide them and the population we serve, and we highlight our performance, achievements and key risks for the past year.

Performance Overview from Paul Scott, Chief Executive

As CEO my reflection on EPUT's performance over 2024/25 is one where our people have shown resilience and dedication to supporting the people and communities that rely on us, in challenging times. I am proud of how we have adapted our services to reflect changing circumstances and to continue providing the best possible care, all with a relentless focus on patient safety, learning lessons and driving forward to continuously improve.

About EPUT

Essex Partnership University NHS Foundation Trust (EPUT) was formed on 01 April 2017 following the merger of South Essex Partnership University NHS Trust and North Essex Partnership University NHS Foundation Trust.

EPUT provides community health, mental health, learning disability and social care services to over 3.2 million people across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk. We employ more than 7,000 staff who work across around 200 sites. At any one time, we care for more than 100,000 people.

The Trust's turnover has increased by £69m compared to 2023/24 from £543m to £612m. The main increases related to the part year effect of the Trust taking on Lead Provider status for the Mid and South Essex Community Collaborative £33m. Other key increases included, Tariff uplifts including pay awards £17m, National

Pension contribution 9.4% (previously 6.3%) £9m and funding increases in Adult Secure Provider Collaborative and the implementation of the Time to Care model of Care.

Our Services

We provide a wide range of community health, mental health, learning disability and social care services. Our approach is underpinned by our aim to provide individualised care that supports people to live independently and within their own homes for as long as possible.

Community health services: Our diverse range of community health services provide support and treatment to both adults and children. We deliver this care in community hospitals, health centres, GP surgeries, and in people's homes.

Mental health services: We provide a wide range of treatment and support to adults and older people and children

and adolescents experiencing mental health illness within primary care, community and in secure and specialised inpatient care settings. We deliver a range of tertiary services, including forensic services and specialist health outreach services to marginalised communities.

Learning disability services: We provide inpatient learning disability services, working in partnership with Hertfordshire Partnership University NHS Foundation Trust.

Social care: We provide individualised social care to people with a range of needs, including people with learning disabilities or mental illness, supporting people to live independently. Essex County Council has a Section 75 Partnership Agreement in place with us which mean some statutory social care responsibilities are delegated to EPUT and some functions are delivered in partnership. Each year we agree performance targets with them for each nationally-defined social care indicator. Whilst in Thurrock we share a Partnership Director for local authority, community mental health and community health services for the area, enabling close working relationships.

In 2024/25, we:

- Received **479,804** referrals into our services
- Delivered **1,526,113** face to face contacts
- Carried out **40,837** digital face to face contacts
- Held **233,003** telephone contacts
- Cared for **158,773** patients / service users, of whom **3,530** were inpatients.

Our Partnerships

EPUT is part of four Integrated Care Systems (ICSs):

- Hertfordshire and West Essex
- Mid and South Essex
- Suffolk and North East Essex
- Bedfordshire, Luton, and Milton Keynes.

At a more local level, we are actively involved in place-based Alliances in:

- North East Essex
- West Essex
- Mid Essex
- Basildon and Brentwood
- Thurrock
- South East Essex (including Southend).

We work in partnership with Essex County Council, Thurrock Council, Southend-On-Sea City Council and local district and borough councils.

We also work closely with other providers of NHS services including GP practices and primary care networks, acute trusts, mental health and community trusts, voluntary, community and social enterprise organisations and independent sector providers.

We have established specific collaborative arrangements with other providers in NHS services in:

- **Mid and South Essex** – the Community Collaborative brings together providers delivering community health services hosted by EPUT as principal provider.

- **North East Essex** – the Community Collaborative brings together providers delivering community health services (and is hosted by East Suffolk and North Essex NHS Foundation Trust).
- **East of England** – the Regional Specialist Mental Health Commissioning Collaborative brings together mental health providers across the region. It focuses on specialist services, such as children and young people's inpatient services, and forensic services, which are led by EPUT within the East of England provider collaborative.
- **Hertfordshire and West Essex** – the Community Collaborative in Hertfordshire and West Essex brings together providers delivering community health services in an informal arrangement with the objective of standardising a high quality community services offer to local communities across the system.
- **Southend, Essex and Thurrock All Age Mental Health Strategy 2023-8** – EPUT partners with three local authorities, three Integrated Care Partnerships, NELFT and Essex Police on a programme of work to improve:
 - Prevention and early intervention
 - Acute and crisis services
 - Supporting recovery.

We provide education and training for students from Anglia Ruskin University and the University of Essex as well as training placements for junior doctors. We are continuing to build our academic partnerships to support

innovation and research that will benefit our services. Our strategic partnership with Anglia Ruskin University has commissioned a joint research project to investigate the provision, accessibility and navigability of self-harm and suicide prevention services in the coastal communities of North East Essex, which commenced in March 2025. We have joint clinical academic partnerships with University College London and University of Cambridge. EPUT's success is judged against our contribution to the objectives of the integrated care systems in which we operate, in addition to our existing duties to deliver safe, effective care and effective use of resources. *EPUT collaborates with partners across three main Integrated Care Systems on the delivery of Joint Forward Plans for 2024-29 and Integrated Care Strategies, overseen by local Health and Wellbeing Boards.*

EPUT is committed to engaging consistently in shared planning and decision making; to taking collective responsibility with partners for delivery of high quality and sustainable services; and taking responsibility for delivery of agreed system improvements and decisions.

EPUT executives are active partners within our local integrated care systems, with several executives sitting on local integrated care boards and partnership boards. Our business model enables our leadership teams to actively participate with partners in the systems and place-based partnerships (Alliances).

As detailed above we have established specific collaborative arrangements with other providers to develop shared plans and priorities.

The Mid and South Essex System has operated a System Investment Group, chaired by EPUT since October 2021. This forum has been used to discuss and recommend major investment cases to the System Finance Investment Committee (also the forum at which capital allocations and plans are reviewed and agreed). EPUT delivers services across four integrated care systems and shares information about the capital plan and initiatives through finance and estates networks.

In a first of type in the UK, people across Essex and beyond will benefit from a new Electronic Patient Record (EPR) Information Technology system

in a £65m contract award to Oracle Health, a global leader in healthcare systems. The new system will build on current digital investments to create a single patient record system across hospitals, mental health and community services, delivered by Mid and South Essex Foundation Trust (MSEFT) and EPUT, in partnership with Oracle Health. The new system is expected to launch in 2026/27.

It will improve how clinicians access patients' comprehensive health and care information in real-time and enhance patients' experiences by not having to re-tell their health or care history whenever they see a health professional. The approval of the full business case and investment in the EPR system is part of the NHS commitment to modernising healthcare services through digital technology, improving patient care and increasing system-wide efficiency.



Our Vision, Values and Purpose

People are at the heart of everything we do, and our strategy is focused on providing high quality, safe, individualised care and supporting people to live well throughout their lives. Our approach is underpinned by partnership working, championing lived experience and co-production, continuous development, and a caring, learning, and empowering culture.

The Trust's vision, values, purpose, and strategic objectives create the framework whereby through engagement with our staff, partner organisations and representatives of the communities that we serve, we have set out a clear and exciting strategy for our services aligned to national and local strategies.

Recognising that we are part of a complex system of health, care and wellbeing services and that we have a key role to play in making sure that service users can receive joined up care.

We carried out extensive engagement with our service users, and their carers and families, as well as our staff and partners, to look at what we need to do to achieve those goals over the coming years.

Our Strategic Plan for 2023 to 2028 is the result of that work, and sets out our priorities and commitments, and how we will work together to deliver our vision.

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

For more information, visit our website to see our strategic plan:

[Strategic Plan for 2023 to 2028](#)



Our Performance

The Trust delivers a wide range of services commissioned by different Integrated Care Systems and specialist commissioners. A number of mandated, contractual and locally identified key performance indicators (KPIs) are used to monitor the performance and quality of services.

The key ways in which the Trust measures performance include:

- NHS Oversight Framework
- Performance against contract targets
- Performance against national targets
- Performance in national staff and patient surveys
- Quality measures under the domains of patient safety, clinical effectiveness and patient experience
- Key financial and workforce targets
- Service user and carer experience
- Outcomes of Care Quality Commission Inspections.

The Trust has an established system of measurement to track progress in delivery of strategy, and priorities for improvement. Progress in these areas is monitored by the receipt and scrutiny of reports at care units, executive, committee and Trust Board level in the form of quality and performance scorecards.

In our Quality Account for 2024/25, we provide further details of our performance against a range of quality related performance metrics and our Quality of Care Strategy.

Key Issues, Opportunities and Risks

As part of good governance, EPUT continues to identify issues, opportunities and risks that could affect delivering our objectives to achieve future success and sustainability.

Key issues

- The population we serve is growing
- Like many other trusts, we are in underlying financial deficit, despite consistently delivering financial results. The Trust continues to face increasing financial challenges.
- National inflationary pressures and cost of living remains high, including fuel, energy and utilities.
- Delivery of recruitment plans and the full identification and recurrent delivery of efficiency schemes.
- Financial constraints with the Mid and South Essex Integrated Care System (MSE ICS).
- National standards for clinical services quality continue to rise and maintaining compliance is challenging in some areas e.g. compliance with CQC quality statements.
- Changing landscape of the NHS with the merger of NHS England back into the Department of Health and Social Care.
- Resourcing of our core participation with the Lampard Inquiry.
- The likely changes to Integrated Care Board responsibilities and structures. This creates a risk for the Trust in terms of how this is taken forward, but also provides an opportunity in terms of our focus on delivery of services and

strategic commissioning. This also includes government reform and the further development of place-based care.

- The effective recruitment that is aligned with our partners in education to ensure we maintain opportunities with our local communities.

Opportunities

- The identification and implementation of new ways of working with our lived experience ambassadors and co-production with our service users, their families and carers.
- The insights gained from the Lampard Inquiry for improving services.
- We operate in systems that continue to develop strong partnerships with other health and care providers. There is the opportunity to develop relationships with strategic partners, particularly in digital to enhance patient safety, e.g. SOPHIA (online standing operating procedures system) and the NOVA new electronic patient record system.
- There are efficiency opportunities, both internally to the Trust, and those from greater collaboration with system partners, such as: out of area placement reduction, workforce development, commercial innovations and potential site rationalisation.
- We are partners in the specialist mental health collaborative.
- We are lead for a partnership in contracts for community services in

both Mid and South Essex and North Essex. Provider collaboration arrangements with maturity continuously developing.

- The National Partnership Agreement, Right Care Right Person, which sets-out a framework for ensuring that vulnerable people get the right support from emergency services.
- We are currently on a journey to transform mental health inpatient services, using the Time to Care programme and the Community First programme for mental health community services.
- The Trust potential to become a centre of excellence for clinical research in mental health.
- The ability for the Trust to support local economic development through procurement and inclusive employment opportunities.
- Developing leadership skills that are aligned to our strategic priorities and supports a culture of excellence, quality and compassion.
- The undertaking of a reflective cultural review and understanding where we can improve.

Risks

The Trust captures its principal risks in its Strategic Risk Register (SRR) and high level operational risks within its Corporate Risk Register (CRR). The causes of the risks and mitigating actions are described in more detail in the annual governance statement. In brief, the principal risks to the Trust's strategic objectives are:

- SR3: 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 its safety, quality and compliance ambitions.

- SR4: If EPUT does not effectively address demands, then our resources may be overstretched resulting in an inability to deliver high quality safe care, transform, innovate and meet its partnership ambitions.
- SR5: If EPUT is not open and transparent, with the correct governance arrangements in place then it will not serve the Lampard Inquiry effectively or embed learning from past failings resulting in undermining its safety ambitions.
- SR6: If EPUT experiences a cyber-attack then it may encounter system failures and downtime resulting in a failure to achieve its safety ambitions, compliance, and consequential financial and reputational damage.
- SR7: If EPUT does not have sufficient capital resource, e.g. digital and EPR, then it will be unable to undertake essential works or capital dependent transformation programmes, resulting in non-achievement of some of its strategic and safety ambitions.
- SR8: If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources, then it may not meet its financial control total, resulting in potential failure to sustain and improve services.
- SR9: If EPUT does not have the required capability and expert knowledge to deliver the digital

and data strategy, then the Trust may fail to achieve strategic ambition.

- SR10: 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 its ability to provide high quality of care to our services users.
- SR11: If EPUT does not effectively and efficiently manage a coherent staff retention strategy, then it will continue to effect staff and skills shortages in certain professions resulting in associated skills deficit, impact on staff morale and its ability to provide high quality of care to services users.
- SR12: If EPUT does not have in place effective organisational development support to address cultural development and management of change, then it may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.
- SR13: 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 its 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.

The Trust's high-level operational risks are:

- CRR11: Suicide prevention – Delivery of the Suicide Prevention Framework as aligned to the Quality of Care Strategy, priorities for year two having an emphasis on a) self-harm reduction; b) STORM training; c) introduction of safety plans; and d) safe discharges.
- CRR45: Mandatory training – Fully recovered TASI training for substantive staff following the pandemic and continuing to roll out to temporary staff on the Trust bank register with a trajectory of achieving 90% in early 2025/26.
- CRR92: Addressing inequalities – Continuing to implement the Equality Diversity and Inclusion (EDI) framework aligned with the NHS England EDI plan. Implementation of the sexual safety charter now having clear reporting mechanisms in place for staff to recognise, report and address sexual safety issues; and the leadership behavioural toolkit having been in place for over a year and incorporated into training development.
- CRR98: Pharmacy resource – Significant progress has been made in year and we continue with the recruitment campaign. Following commencement of all candidates who have been offered roles the vacancies will be down to 2.2 whole time equivalents and all business continuity plans will be lifted.

Closed risks in year:

- SR1: If EPUT does not invest in safety or effectively learn lessons from the past then it may not meet its safety ambitions resulting in a possibility of experiencing avoidable harm, loss of confidence and regulatory requirements. This was reviewed in recognition that the Safety First Safety Always Strategy had concluded and had established the safety team. To align with the new Quality of Care Strategy the risk was reframed to encompass ward/ service to Board quality governance and the two remaining open actions were incorporated into the new risk SR13 Quality Governance.
- SR2: If EPUT does not adequately address and manage staff supply and demand then it may not have the right staff, with the right competencies, in the right place at the right time to deliver services, resulting in potential failure to provide optimal patient care / treatment and the resultant impact on quality of care (safety, effectiveness and experience). The risk was formally closed after review and superseded by the three new risks SR10 – Organisational Development; SR11 – Staff Retention; and SR12 Workforce Sustainability.
- CRR77: Medical devices – Following a significant programme of work there is now a robust asset register for medical devices, a medical devices management contract in place and medical devices policies and standard operating procedures. The risk actions achieved a good level of system control reducing the risk

score to 8 and therefore de-escalated from Board reporting.

- CRR81: Ligature reduction – A significant programme of work undertaken and continues to be overseen by a Ligature Risk Reduction Group (LRRG). In recognition of the work to decrease fixed-point ligatures and evidence from incidents, the risk was reduced to 8. The risk CR11 Suicide Prevention addresses the risk of alternative forms of self-harm.
- CRR93: Continuous learning - Risk rating reviewed following discussion with the Executive Nurse. It was agreed the risk rating target score had been achieved. Continuous learning mechanisms / structure within EPUT, developed through the Culture of Learning Programme will form controls with the new SR13 risk going forward.
- CRR94: Observation and engagement - The Risk assessment had been reviewed and following the review of tenable audit data and Internal Audit review (Recording and monitoring of therapeutic observations) it was assessed that the risk score had reduced to 10. And, consistently achieving training compliance of 97% for substantive staff and 84% for bank staff.
- CRR96: Loggists (the staff who capture decisions and management action during the course of a major incident) – The Trust Emergency Preparedness, Resilience and Response Manager has been trained as a trainer and has been delivering targeted training. The

trust achieved an appropriate number of trained loggists for delivery of a 24/7 response following declaration of an incident and the risk was closed in November 2024. We will continue to provide logistic training to sustain this position as business as usual.

- CRR99: Safeguarding referrals – Context is the need to manage the increase in safeguarding referrals and their subsequent time resource. We worked with system partners and embedded improved systems of working (including change over to the local authority portal and having safeguarding forms within the patient record system). This risk has now been de-escalated from the CRR and will be monitored through the Nursing and Quality Risk Register going forward.

Emergent risks:

- Ongoing changes arising from the introduction of Integrated Care Systems and statutory arrangements.
- Thematic risks arising from our use of the Patient Safety Incident Response Framework – with the identification of nine key learning priorities for system improvement.
- Change in risk profile of ligature risks moving from reduced fixed ligature to other forms of self-harm.
- Capacity to service the Coroners Court both efficiently and effectively.

Going Concern Disclosure

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the Trust's continued funding and provision of services. The interim financial plan for 2025/26 was approved on 20 March 2025 with the final submission made on 30 April 2025. The plan shows an adjusted breakeven position. The plan includes the continued provision of services by the Trust and/or within the WGA boundary. No circumstances were identified which caused the Directors to doubt the continued provision of NHS services.

Against the adjusted financial performance measure for 2024/25, the Trust has reported a deficit of £10,434k for the current financial year (2023/24: £21,474k deficit).

Our going concern assessment is made up to the end of June 2026. The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period which shows sufficient liquidity for the Trust to continue to operate during that period.

In conclusion, and after making enquiries, the Directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance Analysis

The performance analysis provides a detailed performance summary of how we measure our performance, providing more detailed integrated performance analysis and long-term trend analysis for some areas.

Care Quality Commission (CQC) Registration

Essex Partnership University NHS Foundation Trust is registered with the Care Quality Commission and is registered to provide the following regulated activities:

- Family planning
- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Surgical procedures
- Diagnostic and screening procedures.

The Trust has the following conditions in relation to Clifton Lodge and Rawreth Court Nursing Homes:

- A requirement to have a registered manager for each site.
- A maximum of 35 beds at each site.

In 2024/25, the Care Quality Commission completed an unannounced inspection of Clifton Lodge on 9 January 2025.

The inspection found that the home delivers person-centered, high-quality care and that staff actively engaged with people and their families to create detailed care plans, incorporating their preferences and support needs.

It was also found that the service tailored activities to meet people's needs and interests. Staff arranged structured activities for people to join in, to keep them stimulated and engaged throughout the day. They also made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

The CQC published its report in February 2025. The service has an improved rating of 'GOOD'. The full report for the inspection can be viewed on the CQC website: <https://www.cqc.org.uk/location/R1LJ3/reports>

Overview	
Safe	Good ●
Effective	Good ●
Caring	Good ●
Responsive	Good ●
Well-led	Good ●

As reported in the 2023/24 Report, the CQC undertook an unannounced core service inspection of our Forensic / Secure wards in March 2024. The CQC published its report on 25 April 2025. The report highlighted that the wards had enough qualified, skilled and experienced staff to ensure people’s safety and meet their needs in a secure setting. It established that:







- The service had a proactive and positive culture of safety and minimised the use of restrictive practices.
- Staff assessed risks to patient's health and safety and mitigated those risks.
- Staff ensured medicines were managed safely.
- The service provided a range of treatments suitable to the needs of the patients cared for on a forensic ward.
- Staff actively sought information and listened to patients.

- The service valued a diverse workforce and worked towards an inclusive and fair culture by improving equality for staff.
- The Trust fostered a positive culture where staff felt that they could speak up.
- Leaders worked well with their partners across the local system.
- Concerns about safety were listened to by senior leaders and safety events were investigated and reported thoroughly.

One area of concern was identified pertaining to a breach of the legal regulation as people were not always involved in planning their care and staff did not always maintain patients’ privacy.

The service has maintained its rating of ‘GOOD’, meaning that it is performing well and meeting the CQC’s expectations. The full report for the inspection can be viewed on the CQC website.

Ratings - Forensic inpatient or secure wards

Overall	<u>Good</u> 
Safe	<u>Good</u> 
Effective	<u>Good</u> 
Caring	<u>Good</u> 
Responsive	<u>Good</u> 
Well-led	<u>Good</u> 

The full matrix of ratings for the services provided by EPUT are provided here:

Ratings for Community Health Services	Safe	Effective	Caring	Responsive	Well-Led	Overall
Community health services for adults (Jul 2018)	Good	Good	Good	Good	Good	Good
Community health services for children and young people (Jul 2018)	Good	Good	Outstanding ☆	Good	Good	Good
Community health inpatient services (Jul 2018)	Good	Good	Good	Good	Good	Good
Community end of life care (Oct 2019)	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Overall (Oct 2019)	Good	Good	Outstanding ☆	Good	Good	Good
Ratings for Mental Health Services	Safe	Effective	Caring	Responsive	Well-Led	Overall
Child and adolescent mental health wards (Jul 2022)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Wards for people with a learning disability or autism (Jul 2023)	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Acute wards for adults of working age and psychiatric intensive care unit (Jul 2023)	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Wards for older people with mental health problems (Jul 2023)	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Forensic inpatient or secure wards (Apr 2025)	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults (Oct 2019)	Good	Requires improvement	Good	Good	Good	Good
Community-based mental health services of adults of working age (Jul 2023)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-places of safety (Jul 2018)	Requires improvement	Good	Good	Good	Good	Good
Substance misuse services (Jul 2023)	Good	Good	Good	Good	Requires improvement	Good
Community mental health services for people with a learning disability or autism (Jul 2018)	Good	Good	Outstanding ☆	Good	Good	Good
Community-based mental health services for older people (Jul 2018)	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Ratings for Nursing Homes	Safe	Effective	Caring	Responsive	Well-Led	Overall
Clifton Lodge (Feb 2025)	Good	Good	Good	Good	Good	Good
Rawreth Court (Sept 2023)	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement

We continue to progress our improvement plan following the publication of the CQC inspection report in July 2023 which related to the comprehensive inspection carried out in November 2022. Progress is monitored on a weekly basis, along with local system support through an evidence assurance group, which reviews our evidence of sustainability of actions taken to address the concerns raised.

As at the end of 2024/25:

- 96% of actions in response to the CQC recommendations have been reported as complete by the action owners.
- Of these, 55% have been through the Evidence Assurance Process and closed. Note: closure of actions has a lag phase from actions complete as we look to provide evidence of both achievement of actions and sustainability of impact.
- Two actions are ongoing and on track for delivery.

We have two actions past their original stated timelines, both of which are additional actions proposed by the Trust

and not directly linked to the CQC findings:

1. The review with ICB colleagues of the service specification and aligned CQC registration for our nursing homes. This was an action the Trust took rather than a direct result of the CQC inspection to clarify whether the registration under social care was the correct one. Discussions continue.
2. The replacement of the current CCTV retrieval process to one that is more accessible to designated staff at each site to improve the access time. This requires a change over from an external contract to an in-house solution utilising new IT software. The software has passed our cyber security tests and is now part of business planning prioritisation.

Further to this, the CQC undertook an unannounced core service inspection of our Adult Acute and Psychiatric Intensive Care Unit (PICU) services in November and December 2024. The Trust is awaiting the final report from the CQC following this inspection.

Our Performance

Table 1: Summary of 2024/25 performance against key quality of care and outcomes metrics, operational metrics and leadership and workforce metrics that are set-out in the NHS Oversight Framework (NHS OF).

Quality of Care and Outcomes	NHS Oversight Framework target	Year End (Mar) Position
CQC Rating of Good or Above	Good or Above	Overall "Requires Improvement"
Written complaint rate per 100 WTE	No target set	3.8
National Quarterly Pulse Survey	No target set	The results for 2024/2025 for the 9 core questions show an improvement in the motivation theme (I am enthusiastic about my job). The other 8 questions show a decline.
Never Events	0	0
There will be 0 Safety Alerts breaches	0	0
CQC community mental health patient survey	No target set	Two questions scored in the highest 20% of trusts, 26 questions in the intermediate 20% and seven in the lowest 20% of trusts
I Want Great Care	No target set	89.5% positive score
People on Care Programme Approach (CPA) are followed-up within 72-hrs of discharge from hospital	80%	91.5%
Clients in settled accommodation	No target set	69% (Local Authority Target 70%)
Clients in employment	No target set	35.1% (Local Authority Target 7%)

Operational Metrics	NHS Oversight Framework target	Year End (Mar) Position
Potential under reporting of patient safety incidents	No target set	62.4 (MH Benchmark >44.3)
Admission to adult facilities of patients under 16 years old	0	0
People with first episode of psychosis (FEP) begin treatment with a NICE-recommended care package within two-weeks of referral	60%	81%
Data Quality Maturity Index (DQMI) – MHSDS dataset	95%	91.8% (latest published data Dec-24)
Improving Access to Psychological Therapies (IAPT) / Talking therapies a) 52% of people completing treatment who move to recovery	52%	52.2%
Improving Access to Psychological Therapies (IAPT) / Talking therapies b) Waiting time to begin treatment i) 75% within 6-weeks ii) 95% within 18 weeks	75% 95%	6-weeks: 100% 18-weeks: 100%
Continued reduction inappropriate Out of Area Bed days to 0	Reduction	19,378 inappropriate out of area bed days

Leadership and Workforce	NHS Oversight Framework target	Year End (Mar) Position
Staff Sickness Rates	No target set	4.7% (MH benchmark of <5%)
Staff Turnover	No target set	8.7% (Local target based on national benchmarking <12%)
Proportion of Temporary Staff (Agency)	No target set	0.9%
Staff Survey	No target set	The results for 2024 compared to the benchmarking average mostly show a decline in the People Promise scores. There was an area of improvement in the We are always learning theme. The three worse areas were: Staff Engagement, Morale and We are safe and healthy.

In addition to the performance against the NHS Oversight Framework detailed above, this section summaries performance innovation against a small number of other targets over 2024/25. Further information on these, and a range of other indicators, is contained with the Quality Account 2024/25.

Service Developments in 2024/25

We continued to innovate and develop services throughout the year, working together with patients, their families and carers, our staff and partner organisations. Highlights include:

West Essex Hospital at Home is operated by a team of doctors, advanced clinical practitioners, nurses, pharmacists and paramedics who monitor patients every day using a combination of home visits, remote monitoring equipment and phone calls. The service provides hospital care for people who can be safely treated at home or in their usual place of residence

to prevent admission to hospital and to support early safe discharge. The innovative remote monitoring equipment complements in-person care, enabling staff to safely and effectively monitor patients and intervene quickly if their health deteriorates.

The Hospital at Home team works in partnership with Doccla, who provide the remote monitoring equipment, and a wide range of system partners including GPs, Princess Alexandra Hospital in Harlow, the East of England Ambulance Trust, Essex County Council's Adult Social Care, care homes, and domiciliary

care providers. This innovation has been shortlisted in the 2025 HSJ Digital Awards for Improving Out of Hospital Care through Digital.

EPUT and Vita Health Group have been working in partnership to provide an improvement to the **Primary Care Mental Health Practitioner service in Basildon and Brentwood** which has helped reduce health inequalities and improved patient access to mental health professionals across the two areas.

Changes to the service and the introduction of a single digital system have driven a sustained reduction in patient waiting times from over nine days to below one day, with patient satisfaction recorded above 80 percent. Our innovative approach has also reduced health inequalities by improving the mobility and agility of our workforce, ensuring more efficient and effective care delivery.

This innovation has been shortlisted for the HSJ Digital Award 2025 in the category of Reducing Health Inequalities Through Digital. Since April 2024, the service has provided over 17,000 primary care mental health appointments to the Basildon and Brentwood area. Utilisation of these appointments by the involved Primary Care Networks was over 90 percent.

The **Complex Housing Intervention Programme (CHIP) in Thurrock** offers intensive support for a group of people who have complex needs linked to severe or enduring mental health illness, and/or chronic drug or alcohol use. They are all Thurrock Council tenants, who are at risk of eviction and are not receiving treatment from

mainstream health care services.

The CHIP staff work with each person to understand their individual needs and life experiences so they can get them the right support, using their specialist skills and connections with organisations across Thurrock and Essex. This includes working closely with mental health care coordinators, Thurrock Council's housing team, charities and voluntary groups. The CHIP is a collaboration between EPUT, Thurrock Council, Mid and South Essex NHS Foundation Trust, and the Forward Trust, a charity which empowers people to break the cycles of addiction or crime.

The service was commissioned in 2023 and has been extended in November 2024 for a further two years as it has had a positive impact in areas such as reducing admissions to hospital, police and criminal justice interactions, and anti-social behaviour reports.

The **Older People's Community Mental Health team in Thurrock** set up the two groups at Grays Town Park Café last August after listening to feedback from patients and their loved ones. The Community Coffee Group is aimed at carers and offers a place for them to meet others and get support and advice.

The Older People's Community Mental Health team is made up of professionals from EPUT and Thurrock Council, who provide care for people who are mainly aged over 65, and have a mental health condition and cognitive impairment, such as dementia. The team often support those who have been discharged from a mental health or general hospital, and, by engaging with them and their carers about the best

way to address their needs, they are often able to prevent any further unplanned hospital admission.

Lighthouse Child Development Centre

The Trust has been delivering the Lighthouse Child Development Centre service since March 2022 and has made excellent progress in improving the service. The service wait times have improved and have worked towards developing a “waiting well-call” to ensure parents of children receive support whilst waiting for the service.

The service now provides additional pathways, including ADHD, autism and neurodiversity, which ensures patients are seen on the right pathway at the time of their appointment. The service has also co-produced the “My Care Bridge” website for parents to keep informed of the progress of their child’s referrals and help in understanding the decisions and diagnoses made by the service.

The Lakes Electroconvulsive Therapy (ECT) Clinic National Accreditation

The Electroconvulsive Therapy (ECT) clinic at The Lakes received ECTAS accreditation from the Royal College of Psychiatrists. This accreditation verifies

that ECT clinics are providing services to the highest standard. The clinic received special commendation for its safe environment, thorough documentation and good patient experience. This is the first time the clinic has received ECTAS accreditation and means that all three of EPUT’s ECT clinics are now ECTAS accredited.

Fishing Programme in Great Oakley

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

Service Visits

Governors, non-executive director and ICB colleagues undertake service visits across the Trust, speaking with patients and staff. The Trust launched a revised Quality Assurance Visit programme in 2024/25 as a pilot. The aim of the programme was to undertake coordinated visits with a range of colleagues.

In 2024/25, 19 Quality Assurance Visits were undertaken, including governors, non-executive directors and ICB colleagues. In addition, 13, visits were completed by non-executive directors and 20 by executive directors. There were also a number of visits from key stakeholders and MPs which were supported by executives within the year.

Overseas Operations

The Trust did not undertake any overseas operations during the year 2024/25.

Mid and South Essex Community Collaborative

The Mid and South Essex Community Collaborative (MSECC) is a partnership between EPUT, Provide Community and North East London NHS Foundation Trust. Between the Collaborative partners, we provide community physical health services across the mid and south Essex area. This way of working helps us to better support the overall health and care system and improve patient experience and outcomes by providing services in the right place for them. EPUT hosts the contract for the collaborative and the delivery is overseen by a Committee in Common together with partners.

Our efforts this year to enhance system capacity, improve productivity and address health inequalities have shown the power of collaboration in achieving better outcomes for patients, staff, and partners. Highlights across the collaborative include:

- We now deliver over 70,000 patient contacts every month in our community nursing teams. A 36% increase in activity over the past two years.
- Referral to treatment (RTT) waits. Adults seen within 18 weeks maintained over last two years. Long waits over 52 weeks eradicated.
- Frailty Virtual Wards have supported over 3000 patients so far, saving over 31,500 occupied beds (beds in the hospital).

- Urgent Community Response teams have seen almost 12,000 contacts with patients from January 2024 to January 2025, saving around 88,000 hospital bed days (Measured from 0-7 days after contact).
- Intermediate Care (IMC) Beds: Length of Stay (LOS) reduction by an average of 30% to 20 days.
- We employ 1,750 Full-Time Equivalent (FTE) clinical members of staff.
- The vacancy rate has dropped in 18 months from 11.34% to 5.82%. Clinical vacancies are down to 4.18%, reduced from a peak of over 13% in early 2023.



Case Study: A collaborative approach in Community Beds: Supporting more people in the community.

Over the past year, we've seen the power of collaboration and operational alignment in enhancing staff and patient experiences, easing system pressures. Strong leadership has unified the operational vision for community beds with a single pathway and point of contact. This clarity is reducing duplication and enabling clinical teams to focus on delivering high-quality patient care. Multi-disciplinary huddles have been instrumental in fostering stronger relationships and a shared sense of priorities across teams. These meetings address challenges collectively and staff feel aligned and supported.

Rebecca Boyes leads on community beds for the collaborative and reflects on the progress:

"The changes we've implemented have brought much-needed grip and control. Everyone knows what's happening and who is responsible, ensuring that our efforts are unified and focused."

This collaborative approach is further supported by active engagement with partners and stakeholders, reinforcing a system wide commitment to improving patient flow and experience. Through this work, and supported by system-wide initiatives, the Intermediate Care Beds Length of Stay (LOS) was reduced by an average of 30% to 20 days. While challenges, such as data accessibility, persist, the collective determination to address them underscores the progress made and the ongoing potential for improvement.

Mid and South Essex Ageing Well Stewardship

The Ageing Well Stewardship Group brings together clinical and professional leaders dedicated to improving care for older adults and those living with frailty, dementia, and end-of-life needs. They recognise frailty as a long-term condition in its own right and use a strategic framework to drive transformation across Mid and South Essex.

Rooted in the NHS Triple Aim to improve personal outcomes, population health, and value for money, the group is central to shaping a more proactive, person-centred care model in the face of rising demand and limited resources.

Over the past year, the Ageing Well

Stewardship Group has made significant contributions to system priorities aligned with national and regional frameworks such as the Fuller Stocktake and Darzi Review. Their work has supported elective care recovery, financial sustainability, and improved service coordination, particularly through a focus on prevention, urgent care, and complex needs.

Proactive Preventative Care

Proactive care is at the heart of the strategy. The group has led the way regionally in dementia care, setting the benchmark for diagnosis rates and contributing to the National Dementia Toolkit Pilot. Working across multiple local authorities, the group has

informed national thinking on best practice.

We are particularly proud of our leadership in dementia care, where we've set the **regional benchmark for dementia diagnosis rates**. Our participation in the **National Dementia Toolkit Pilot** has further supported this, with the complexities of working across multiple local authorities in MSE informing national considerations. This work has positioned us as leaders in dementia care, ensuring timely diagnosis and care that helps prevent more complex health needs down the line.

Complex Care: Early Intervention and Recovery

The group's early intervention work is helping manage frailty, dementia, and long-term conditions before they escalate. The **Frailty Hotline** has become a vital tool, taking **400–600 calls per month**. 86% of calls from **UCRT** and East of England **paramedics** at the scene, preventing hospital admissions in 81% of cases within seven days, and 64% within 90 days.

Around **70% of patients** supported by the hotline benefit from step-up care, including many in their last year of life, a level that is not seen anywhere else in our region. Frailty Scores have been completed for over 4,000 patients, enabling earlier, more appropriate interventions.

The **Virtual Ward initiative**, built on **seven high-impact actions**, is improving care quality, supporting step-down care, and easing pressure on hospital beds by promoting home-first principles. These changes directly contribute to elective recovery and

system efficiency. This aligns with the system's goals of reducing reliance on hospital beds and promoting **home-first principles**, aligning with national best practice. The latest performance data highlights the success of this initiative in managing patients outside traditional hospital settings, thus supporting both elective recovery and the wider system's efforts to optimise resources.

Urgent and Emergency Care (UEC)

The **Frailty Hotline** is just one part of our broader contribution to **urgent and emergency care (UEC)**. Embedding the consultant-led frailty hotline into **UCRT's Single Point of Access (SPoA)** and the **Urgent Care Coordination Hubs (UCCHs)** has provided clinicians with real-time access to expert advice, which has improved care coordination and reduced unnecessary delays. This integration is supporting system resilience by preventing avoidable admissions and ensuring frail patients receive timely, appropriate care outside of hospital settings.

The Enablers: Frailty, End of Life and Dementia Assessment and Review (FrEDA), Electronic Frailty Care Coordination System (eFraCCS), Electronic Palliative Care Coordination System (ePaCCS) and Training

Key digital tools (**FrEDA, eFraCCS, and ePaCCS**), alongside targeted training, have been vital enablers of personalised, proactive care. FrEDA is enhancing digital care planning, and alignment with NHS Elect and GIRFT is helping us learn from best practice and apply it locally.

The group appointed a new Chair this year, following the departure of a

valued member. Despite this transition, the group remained visible and influential, presenting at the **NHS Confederation Conference** and actively participating in the **Stewardship Expo** and **Stewardship Summit**, as well as attending other regional and national platforms.

Collaboration has been key to our success this year. Our work with other stewardship groups, such as developing a **Fracture Liaison Service** and working alongside **Cancer Stewards** on personalised care plans and shared decision-making, exemplifies how we have effectively combined resources and expertise to deliver better care pathways.

These achievements are the result of stewardship, effective collaboration, and a shared commitment to improving the health and care outcomes for the population we serve. As we move forward, we will continue to leverage these strengths to tackle new challenges and seize opportunities for further improvement across the Mid and South Essex health system.

What's Next?

The Ageing Well Stewards are committed to securing measurable improvements in outcomes for older people across Mid and South Essex. In the year ahead, they will continue to

drive collaboration, foster accountability, and refine their strategy through inclusive planning and reflective practice in line with the Medium Term Plan and changing NHS landscape. Their forthcoming Away Day will be pivotal in assessing progress, shaping priorities, and finalising the Implementation Plan for 2025 and beyond.

To advance our commissioning objectives, we are seeking senior support to prioritise the following key initiatives over the next year:

1. **Expansion of FrEDA and eFraCCS** – Both tools are central to delivering proactive, person-centred care, and their continued development is critical to enhancing service quality for individuals with frailty.
2. **Advancing Dementia Care** – We aim to enhance dementia care pathways through the recommendations of the National Dementia Review and insights gained from our pilot programme.
3. **Aligning with NHS Elect** – Partnering with NHS Elect will enable us to refine our strategy and ensure our initiatives contribute to wider system priorities and deliver impactful, measurable results.

Prevention of Future Death Reports

The Trust has received six prevention of future death reports in 2024/25. Actions taken in response are subject to a quality review to provide assurance that changes to practice are embedded and sustained. The Board of Directors receive reports on the prevention of future deaths issued, the responses and

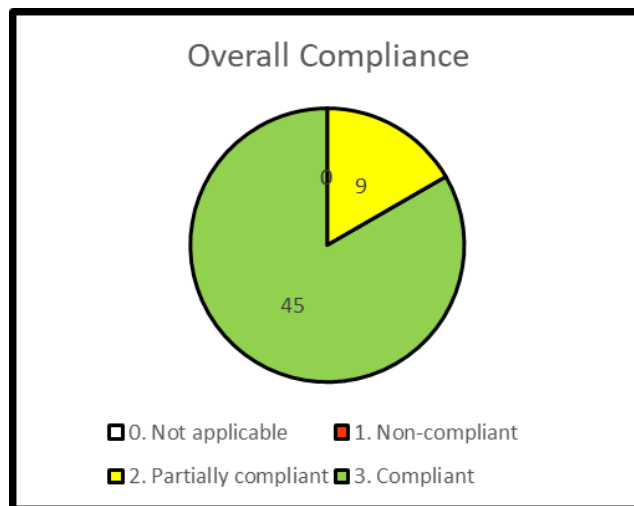
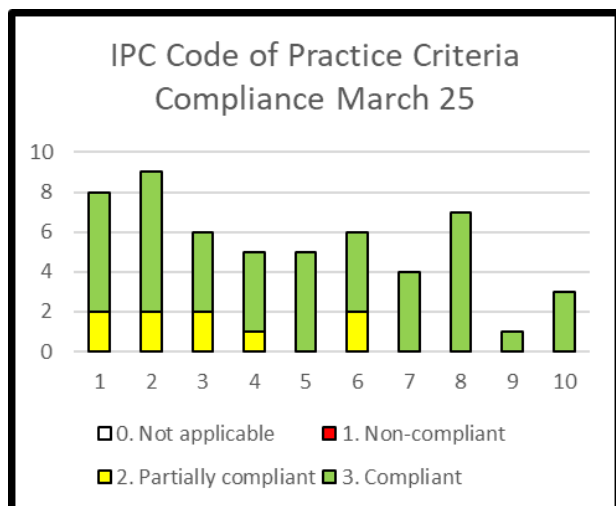
the process in place to ensure action is taken and wider learning shared. In 2024/25, we incorporated the process for responding to these report into our CQC action leads meeting, bringing actions together in one master action plan.

Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) and Infection Prevention and Control (IPC) team have continued to provide specialist advice to all levels of the organisation and to the Mid and South Essex Community Collaborative.

Assurance on policy provided through regular self-assessment reporting against the Infection Prevention and Control Board Assurance Framework through our Quality Committee.

Figure 1- Overall compliance with IPC Board Assurance Framework (March 2025):



The Trust has an overall compliance of 45 out of 54 key lines of enquiry, which is an 18% improvement on last year.

- Criteria 1: Systems to manage and monitor the prevention and control of infection:** The Trust does not have a formal IPC surveillance system. This is mitigated by our collaborative arrangements and contracts with all acute hospital

services pathology systems in our locality, as well as clinical teams having in place systems by which they alert the IPC team to individual cases of infection. An overarching IPC audit tool for in-patient services was implemented

during 2024 on the Tendable audit platform and is for self-audit by clinical teams. Once inpatient auditing is fully established the Trust plans to move towards the inclusion of community-based settings. Commissioning colleagues have undertaken several assurance visits receiving very positive feedback.

- **Criteria 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections:**

Environmental audits are carried out by the IPC team on a yearly basis who aim to complete a full audit of all sites each year. Audits are fed back directly to teams and other colleagues who work in collaboration, such as Estates and Facilities and are followed up to monitor progress on action plans and provide expert advice and support to colleagues in relation to clinical practice or the patient environment. There has been a positive improvement in each care unit over the last year, with some individual areas demonstrating significant improvement during the year. In addition, clinical teams providing inpatient care complete an overarching self-audit of IPC practice on a quarterly basis; with ongoing assurance provided by the completion of Ward Manage and Matron Audits. The Trust Facilities team completes audits on environmental cleaning, based on National Cleaning Standards, and have reported an average of 95% over the last year.

- Over 10,000 estates tasks have been completed over the year, as well as planned preventative maintenance. The ventilation systems in some parts of the Trust estate require an upgrade. This is being monitored and managed via the Ventilation Safety Group.
- **Criteria 3: Ensure appropriate antimicrobial stewardship:** The Trust does not currently have an antimicrobial pharmacist in post. As a result of national funding discrepancies between acute and community organisations, a business case requires submission.
- **Criteria 4: Provide suitable and accurate information on infection to patients/service users, visitors/carers and any person concerned with providing further support:** Through service user support and co-production, the patient information leaflets (including roles and responsibilities) have undergone review.
- **Criteria 5: Systems and processes are in place to ensure that patient placement decisions are in line with National Infection Prevention and Control Manual (NIPCM) and Criteria 7: Provide or secure adequate isolation precautions and facilities:** Self-Assessed as fully-compliant.
- **Criteria 6: Systems are in place to ensure all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection:** The Infection Prevention

and Control team continue to provide expert training for staff as part of their induction as well as ad hoc training in the workplace as a result of learning identified when managing investigations. This is also supported by mandatory training requirements. The Trust has a number of trained fit testers in care units and have recently recruited a fit tester due to join the Trust in April 2025 to support fit testers in care units and increase the provision of the service.

- **Criteria 8:** Provide secure and adequate access to laboratory/

diagnostic support as appropriate: Self-assessed as fully compliant.

- **Criteria 9:** Have and adhere to policies designed for the individual's care that will help to prevent and control infections: Self-assessed as fully compliant.
- **Criteria 10:** Have a system in place to manage the occupational health needs and obligations of staff in relation to infection: Self-assessed as fully compliant.

Table 2: Infection control cases:

Clostridium difficile: Clostridium difficile incidence is assessed as cases detected after three days of admission (these are considered to be attributable to an infection acquired in a healthcare setting). The system of reviewing cases determines whether cases were associated with or without breaches of local protocols, the latter being deemed unavoidable.	Six cases in total were detected after three days of admission. One of these also had several relapses.
MRSA bacteraemia: MRSA incidence is assessed as cases detected more than 48 hours after admission, which are considered to be attributable to an infection acquired in hospital, or cases where MRSA is considered to be a contaminant.	Achieved target to have zero cases of MRSA bacteraemia.
Gram-negative blood stream infections: E. coli bloodstream infections represented 55% of all gram-negative blood stream infections. Approximately three-quarters of these cases occur before patients are admitted to hospital, and the Trust continues to contribute to a system wide plan to support improvements across the health economy.	Zero cases reported.
Hand hygiene monitoring: We monitor compliance with best practice for hand hygiene through monthly audits by our clinical inpatient teams.	Overall compliance 99.6%.
Covid-19 Outbreaks: EPUT have been committed to following the guidance issued by Public Health England (PHE). All staff have had the opportunity to undertake a risk assessment ensuring their health and safety within the workplace. Staff have access and training regarding the use of personal protective equipment (PPE).	19 outbreaks.

Patient-Led Assessment of the Clinical Environment (PLACE)

Patient-led assessments of the care environment are an appraisal of the non-clinical aspects of NHS healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of two patient assessors.

PLACE assessments provide a framework for assessing quality against common guidelines and standards:

- **Cleanliness:** the domain covers all items commonly found in healthcare premises, including patient equipment. Examples are baths, toilets and showers, furniture, floors and fixtures and fittings.
- **Food and Hydration:** the domain includes a range of organisational questions relating to catering services available for patients, for example choice of food, 24-hour availability, meal times and access to menus. It also includes an assessment of food at ward level, including taste, texture and appropriateness of serving temperature.
- **Privacy, Dignity and Wellbeing:** the domain includes infrastructure and organisational aspects such as the provision of

outdoor and recreational areas, changing and waiting facilities and access to television, radio, internet and telephones. It also includes the practicality of male and female services e.g. sleeping, bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.

- **Condition, Appearance and Maintenance:** the domain includes various aspects of the general environment including décor, condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, the external appearance of the buildings and the maintenance of the grounds.
- **Dementia and Disability:** this domain ensures assessments for the other domains are made with a view to the needs of a person living with dementia or a disability, for example wheelchair access, hearing loops and accessible information.

The following tables detail the Trust's scores against the national average benchmark from 2024, based on the 1,093 assessments undertaken in 2024 – figures from NHS England.

Table 3: The Trust performed well against the national average for the following domains:

Domain	EPUT	National Average
Ward Food	92.65%	91.38%
Privacy, Dignity and Wellbeing	94.99%	88.22%
Dementia	91.94%	83.66%
Disability	89.30%	85.20%

Table 4: Areas for improvement include:

Domain	EPUT	National Average
Cleanliness	96.79%	98.31%
Condition, Appearance and Maintenance	95.21%	96.36%

There is no strong correlation between the cleanliness score and infection prevention and control, the lower scores mainly related to surface damage, including scratches to windows and marring décor. This is reflected in the lower score for condition, appearance and maintenance.

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

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

PLACE remains a good example of how effectively EPUT is continuing to work with families and carers to improve patient care.



Patient artwork at Poplar Ward. Child and Adolescent Mental Health inpatient service at Rochford Hospital.

Sustainability and Environmental Stewardship

Leadership and Engagement

We recognise that climate change is a significant global issue with widespread impacts on the environment, economy, and human health, with the most vulnerable in society at increased risk. Scientific evidence overwhelmingly indicates that human activities, particularly the release of greenhouse gases, are the primary driver of the observed warming of the Earth's climate. The Intergovernmental Panel on Climate Change (IPCC) states that it is "unequivocal" that human influence has warmed the atmosphere, ocean, and land. This warming has led to more frequent and intense extreme weather events, rising sea levels, and other significant consequences.

In recognition of the consequence of climate change including discharging our responsibilities under statutory requirements and the impact on the delivery of healthcare to the communities we serve, we have developed our new Green Plan, which will be published by the autumn of 2025. The Plan sets out our commitment to reducing the impact of our operations on our communities and the environment, discharging our regulatory duties as well as aligning with the NHS goal of achieving net zero by 2040.

Green Plan

Essex Partnership University NHS Foundation Trust has been on a sustainability journey to reduce the impact of our operations on the environment and the communities we serve. We remain committed meeting the sustainability challenge and achieve net zero in accordance with our

statutory obligations by learning, listening and innovating so that we deliver the highest quality and safest care possible sustainably.

The Trust's current Green Plan (2021) is coming to the end of its useful life and as a consequence the Trust has developed a new Green Plan, which is strategically aligned to the Trust's Corporate Plan and the delivery of four primary objectives:

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

As we look to the future, the role of our estate is critical in supporting our vision of being the leading health and wellbeing service in the provision of mental health and community care. Our green plan therefore serves as a road map supporting our commitment to delivering high quality, accessible and sustainable health care services.

The delivery of the Trust's Corporate Plan is underpinned by the Trust's Estates strategy and the delivery of eight key objectives:

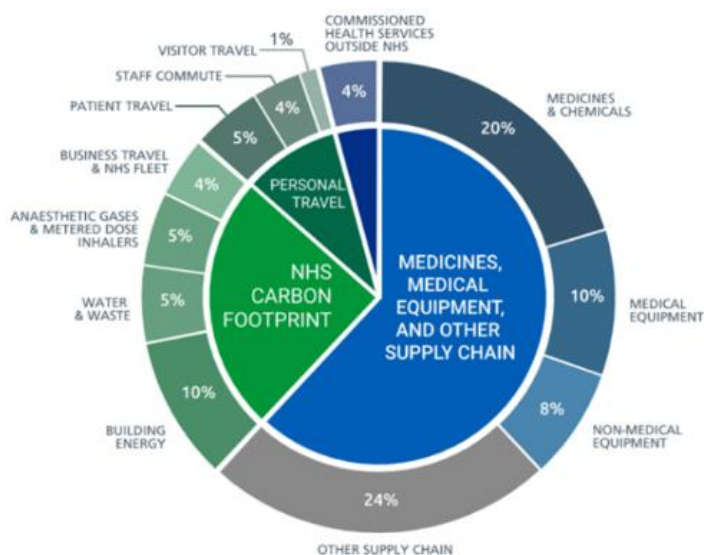
- Enhance the quality of care provided
- Improve Accessibility of services
- Drive efficiencies

- Enable smart use of the estate via digital enablers
- Work with system partners
- Rationalise and consolidate estate where appropriate
- Optimise our estate as community assets
- Create a sustainable estate.

Our second Green Plan supports the overarching estate strategy which is a comprehensive forward-thinking plan that sets out how we will develop our estate over the next 10 years, ensuring that it is fit for purpose and aligns with our strategic goals. As we navigate the complexities of modern healthcare, our estate must not only respond to current needs but also anticipate future challenges, including climate change mitigation and adaptation.

Our new Green Plan embraces our enabling strategies including digital, quality of care, social impact and working in partnership with people and communities. We have also embraced the principles of sustainability, recognising our responsibility to incorporate sustainable development

Figure 2: NHS Carbon footprint



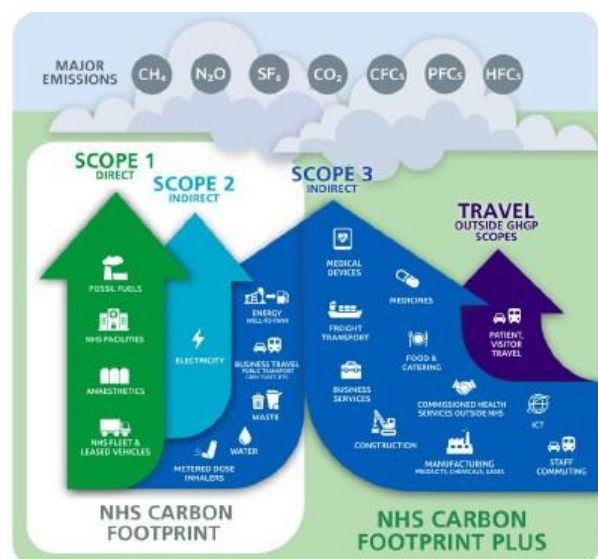
aiming to reduce energy consumption, minimise waste and enhance the overall environmental performance of our estate.

The new Green Plan focuses the following key themes:

- Green spaces and biodiversity
- Waste reduction
- Decarbonisation
- Climate change mitigation and adaptation
- Water conservation
- Sustainable procurement.

Under each of the key themes there is a supporting strategy and action plan, which supports the delivery of the Estates strategy and the Trust Corporate Plan. Our Green Plan is a living document and is underpinned by the estate decarbonisation and travel and transport strategies which together are designed to evolve as we grow and adapt to new sustainability and climate change challenges, as well as aligning with NHS England's strategic aims and objectives.

Figure 3: Greenhouse gas emissions



Care Quality Commission

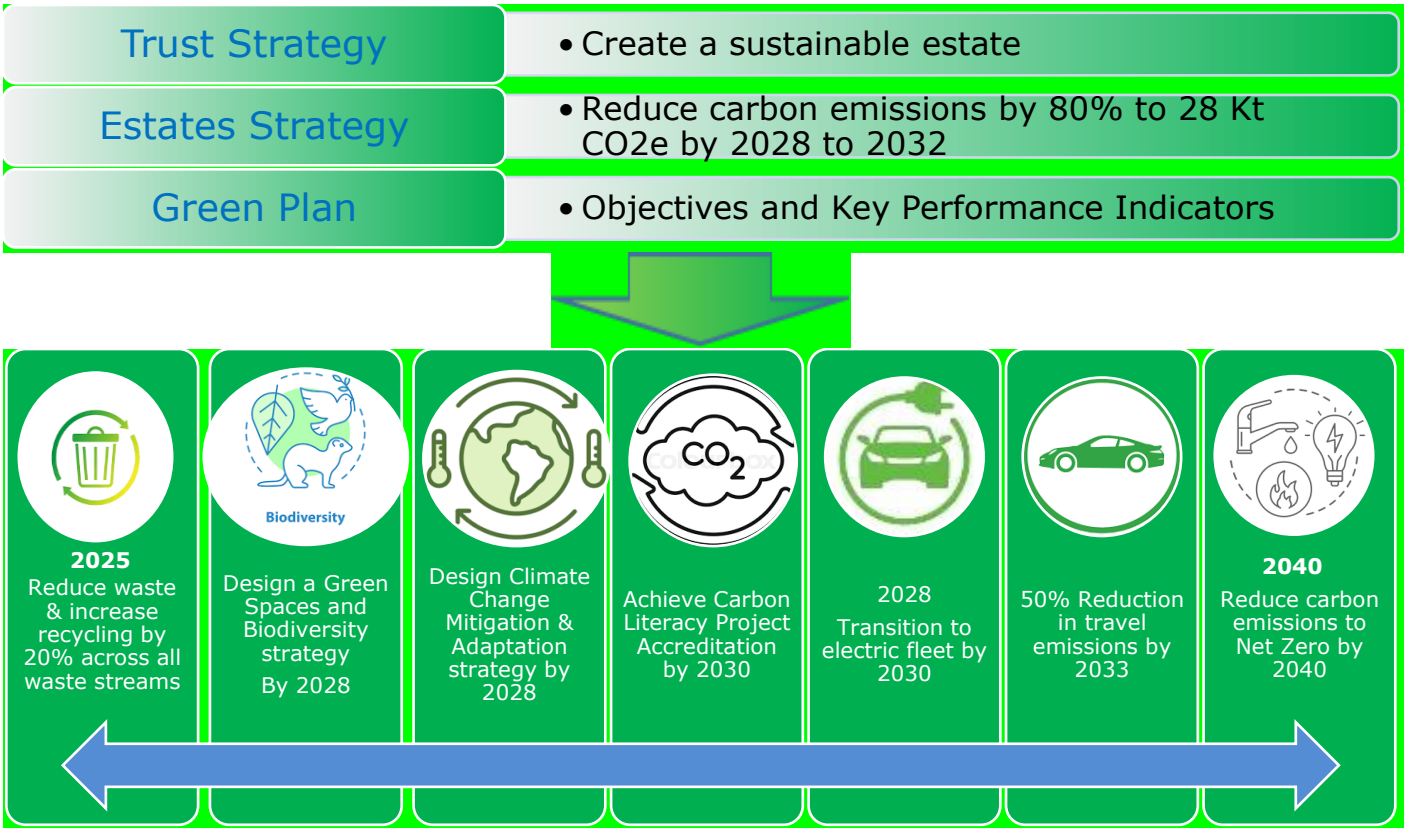
The Trust is subject to the rigors of the Care Quality Commission (CQC), whose single assessment framework includes assessment of environmental sustainability and development, under the heading of “Well-Led”.

One of the key question asked of the Trust during assessment is “We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same”.

The Trust’s new Green Plan, the associated action plan and progress report addresses this question and provides supporting evidence on progress made to limit the impact of Trust activities on its communities and the environment.

Figure 4 below demonstrates the relationship between the Trust’s strategies and the associated key performance indicators.

Figure 4: Measuring Success Green Plan 2025:



The Trust has a range of metrics to demonstrate good governance in respect of the discharging our regulatory obligations as well as our obligations to our communities, which

are captured in the Green Plan. We continue to work with trusted partners across our integrated care systems to deliver the best possible outcomes for our communities.

Sustainability – Governance

Task Force on climate-related disclosures (TFCD)

NHS Foundation trusts including EPUT are required to follow the 'task force on climate-related financial disclosure' requirements on a comply or explain basis. From 2024/25 trusts should disclose how they identify, assess and manage climate related risks as part of their risk management pillar. Metrics and target used in assessment and management of climate issues should be disclosed. These are outlined in the Trust's new Green Plan (2025 to 2028).

For 2024/25 this includes the governance pillar detailed below with reference to relevant information sources (internal and external), including but not limited to the Estates Return Information Collections report and NHS England's analysis of Trust sustainability performance, including but not limited to climate change risk, greenhouse gas emissions and waste. The Trust is not required to disclose scope 1, 2, 3 greenhouse gas emission under TFCD requirements as these are produced nationally by NHS England.

Governance

The Trust recognises that having a leadership team with clear and specific responsibility for climate related risk and opportunities is essential to good governance and financial planning. There is a clear governance structure in place which provides oversight, challenge and accountability for the delivery of the Trust's green plan and associated activities, including but not limited to climate change risk, climate change adaptation and business continuity planning, which puts patient and staff safety and wellbeing at the heart of the organisation risk

management and decision making process.

Leadership and oversight is provided by the Executive Chief Finance & Resource Officer, a non-executive director with dedicated responsibility for sustainability, and the Senior Director of Estates and Facilities, supported by the Associate Director of Estates, the Head of Sustainability and senior managers from across the Trust who are responsible for service delivery.

Operational oversight is provided through the Sustainability and Environmental Management Committee, co-chaired by the Executive Chief Finance and Resource Officer and the Senior Director of Estates and Facilities, which meets four times a year. The committee reports to the Finance and Performance Committee (a standing committee of the Board of Directors).

Climate change risks, operational and strategic risks are recorded in the Estates and Facilities Risk Register, which underpins the Trust's Corporate Risk Register.

Further to the above, and falling within the corporate governance framework for managing and mitigating operation risk. The Emergency Planning and Risk Management team, support service delivery with emergency planning, for example dealing with extremes of heat, all incidents relating to "safety" are recorded on the Trusts Risk Management System Datix and reported through the various risk management committees to the risk, for example Infection Prevention and Control, Water Management Committees.

Climate change mitigation and adaptation

Our climate is rapidly changing. With six of the last 10 years (2014-2023) ranking among the [warmest on record](#) since 1884, the impacts are already proving costly to both society and the NHS, with future costs expected to rise.

While estimating the full extent is challenging, heat-related mortality in England alone costs [£6.8 billion annually](#), likely to increase to £14.7 billion per year by the 2050s. These figures underscore the urgent need for action ([NHS England 4th health and climate adaption report 2023](#)).

The Trust's assessment of climate change risk is consistent with the Health and Climate Adaptation Report 2023, with key strategic and operational risks identified as:

- The East of England is particularly vulnerable to climate change risks, including temperature increases, leading to more frequent and intense heatwaves
- Wintertime will not be much warmer but will likely face an increase in rainfall, with heavier and more concentrated storms, leading to surface water flooding, impacting on infrastructure, transport and patient services.

The Trust serves communities across the East of England delivering healthcare from circa 152 sites. The predicted increases in average temperature for the East of England are higher than the rest of the UK, with some predictions significantly higher than the national average.

The Trust has a robust incident

monitoring and risk management system (Datix). We are pleased to report that in the previous 12 months April 2024 to March 2025, there were no reported incidents of extreme weather events which could be directly attributable to climate change, or weather events that impacted on the provision of healthcare services to the communities the Trust serves.

Climate change risk

In October 2023 the Trust completed the first of its mitigation and adaption risk assessments, specifically assessing the risk to infrastructure and services provision that may be impacted by flooding. In October 2024 NHS England undertook its own assessment of healthcare providers flood risk, both assessments (EPUT & NHSE) highlight the main areas of concern and assessed flood risk as follows:

- **Surface water** (extreme weather – flash floods)
 - **High Risk – 36 locations;**
Medium Risk 7 locations
- **Rivers and sea** (sea level rises, extreme weather)
 - **High Risk – 2 locations;**
Medium Risk 1 location
- **Reservoirs** (Collapse, overflowing/ extreme weather)
 - **Unqualified Risk – 3 locations**
- **Ground water** (water table rises/prolonged extreme weather)
 - **Unlikely (we have no properties at risk).**

The Trust has a defined system, policies and procedures in place to address any incident that could impact on the delivery of its services, which are managed by the Trust's Emergency

Planning and Reporting team. Operational teams with the support of the Emergency Planning team have robust plans to deal with issues that could impact patients and staff including extremes of heat for example. The Trust undertaken an initial risk

Our People

Staff engagement in sustainability agenda

In developing our new green plan, we have engaged with stakeholders including, staff and system partners. Their insights and experiences have been central in shaping our revised plan and has helped us with our mission in being a leading sustainable health and wellbeing service.



The Trust continues with its strategy of engaging and involving staff in sustainability. Our Green

Champions, a network of staff passionate about the environment and sustainability. Green Champions meet every month to discuss issues pertaining to sustainability, encompassing waste management and opportunities to reduce the impact of the Trust's operations on the environment.

The Trust continues to provide green spaces to promote health and wellbeing of patients and staff. In January 2025 the Trust was provided by NHS Forests

assessment for surface water flooding and has identified sites which are at risk. Further work will be undertaken to assess urban and onsite drainage systems to ensure that they are capable of supporting the delivery of key services across the Trust's estate.

40+ trees to enhance our green spaces and improve biodiversity, the saplings were planted in and around the Thurrock Community Hospital site. The planning of trees improves the quality of air, and the long-term they will provide shading and reduce ambient temperature, they make a positive contribution to reducing CO2 emissions and improving air quality.

Energy and direct consumption

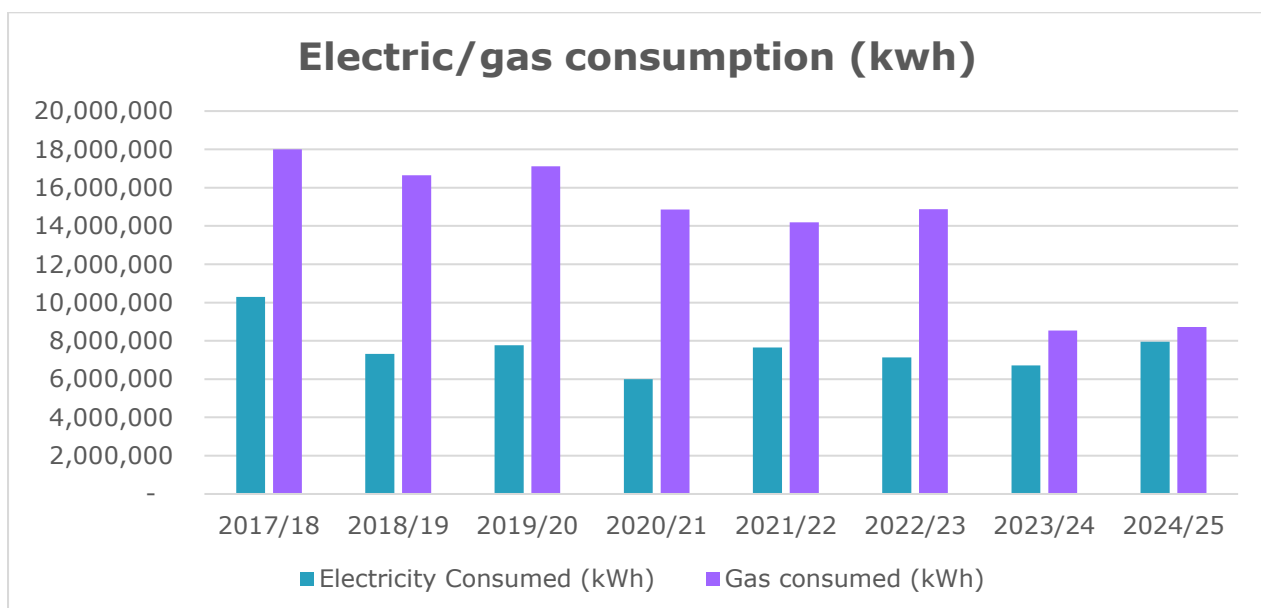
Table 5 and Figure 5 below illustrate the Trust's energy consumption from a baseline year of 2018/19. The amount of energy the Trust consumes (gas and electric) have a direct impact on the amount of carbon emissions the Trust produces, as does the milder winters. The Trust purchases its electricity through Crown Commercial Services (CCS) using the new NHS England energy purchasing strategy. Whilst the Trust will not see a reducing in greenhouse gas emissions from using the NHS England purchasing strategy, we should see a reduction in energy costs.

Table 5: Energy consumption (kWh)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Occupied Floor area (m²)	151,100	146,180	141,254	139,913	139,913	139,664	123,413	123,413
Electricity Consumed (kWh)	10,287,236	7,319,779	7,773,231	5,996,494	7,645,126	7,140,470	6,707,435	7,949,105
Gas consumed (kWh)	17,998,670	16,651,433	17,122,441	14,857,677	14,191,374	14,872,663	8,529,744	8,726,963
Renewable Energy - Electricity (kWh)	5,642,162	4,121,485	6,745,958	4,985,055	7,645,126	7,140,470	6,707.44	7,949,105
Site energy consumed per occupied floor area (kWh/m²)	187	164	176	149	156	158	123	135

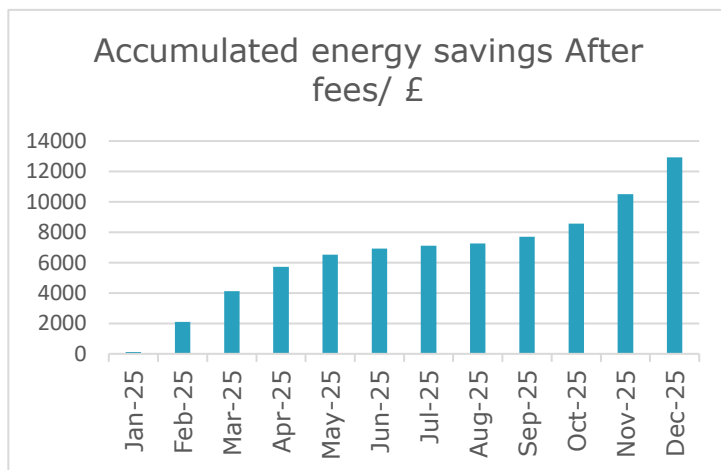
Table 5 above and Figure 5 below indicate that there has been an increase and electricity and gas consumption for 2024/25, despite the relatively milder winter. This in part may be attributable to the addition of properties whose gas and electricity were included in the

lease agreements, the increase use of electric vehicle charging facilities and or changes in occupancy levels and or how individual spaces are used, including the expansion of services offered by the Trust to our communities.

Figure 5: Energy consumption (kWh)

Notwithstanding the above, during 2024/25 the Trust undertook a number of invest to save projects, including one to reconfiguration some of the Building Management Systems (BMS), with the objective of reducing energy consumption. Initial finds have indicated that some savings have been

Figure 6: Energy savings



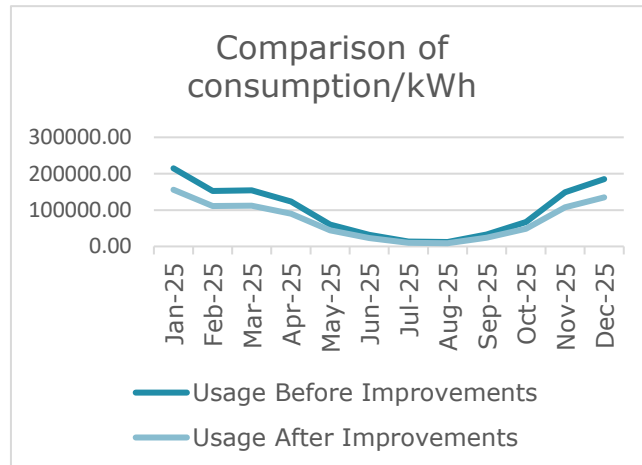
The financial year 2025/2026 will see the completion of three major energy reduction projects, with photovoltaics being installed at two Trust's sites, and LED lighting being installed at one of the Trust's larger community hospital sites. It is anticipated that these three projects will reduce greenhouse gas emissions by 274,239.00 kg of CO₂.

Water Consumption

In 2023 the Trust changed its provider of water and wastewater services. Subsequently the Trust introduced an 'invest to save' project, the objectives of which were to improve water and wastewater data, reduce water consumption and wastewater to foul. To

made. Furthermore, the Trust received funding from NHS England to upgrade some BMS systems and it is anticipated that this will also result in lower energy consumption and as a consequence a reduction in greenhouse gas emissions attributable to the Trust's operations.

Figure 7: Energy consumption



date, 10 sites with high levels of water consumption have had automatic meter readers installed and a further six are planned in the coming year. Water consumption reduction technology introduced at 17 sites.

Notwithstanding the above, it can be seen from Figure 8 and 9 below that there has been increase in water consumption and wastewater to foul. This may be attributable to a number of factors including, but not limited to improved data collection, change in site occupancy, activity levels, undetected water leaks and or an increase in the services provided by the Trust to its communities.

Figure 8: Water consumption

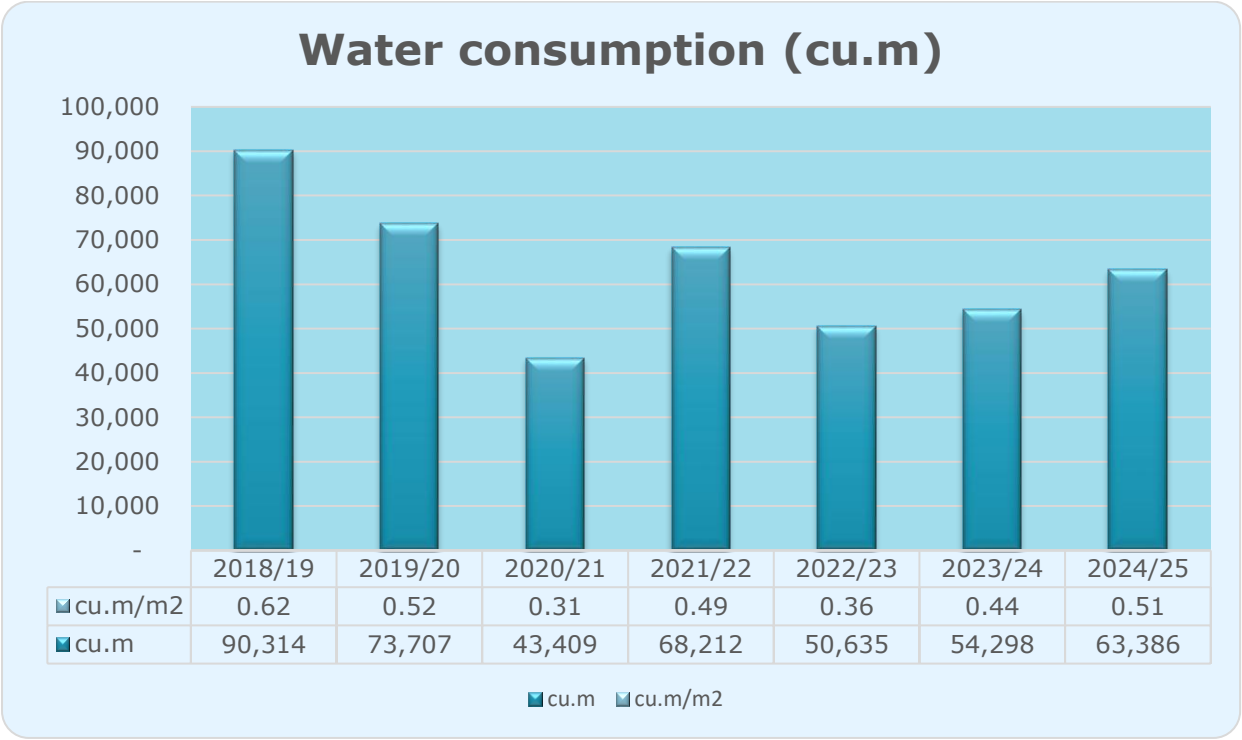
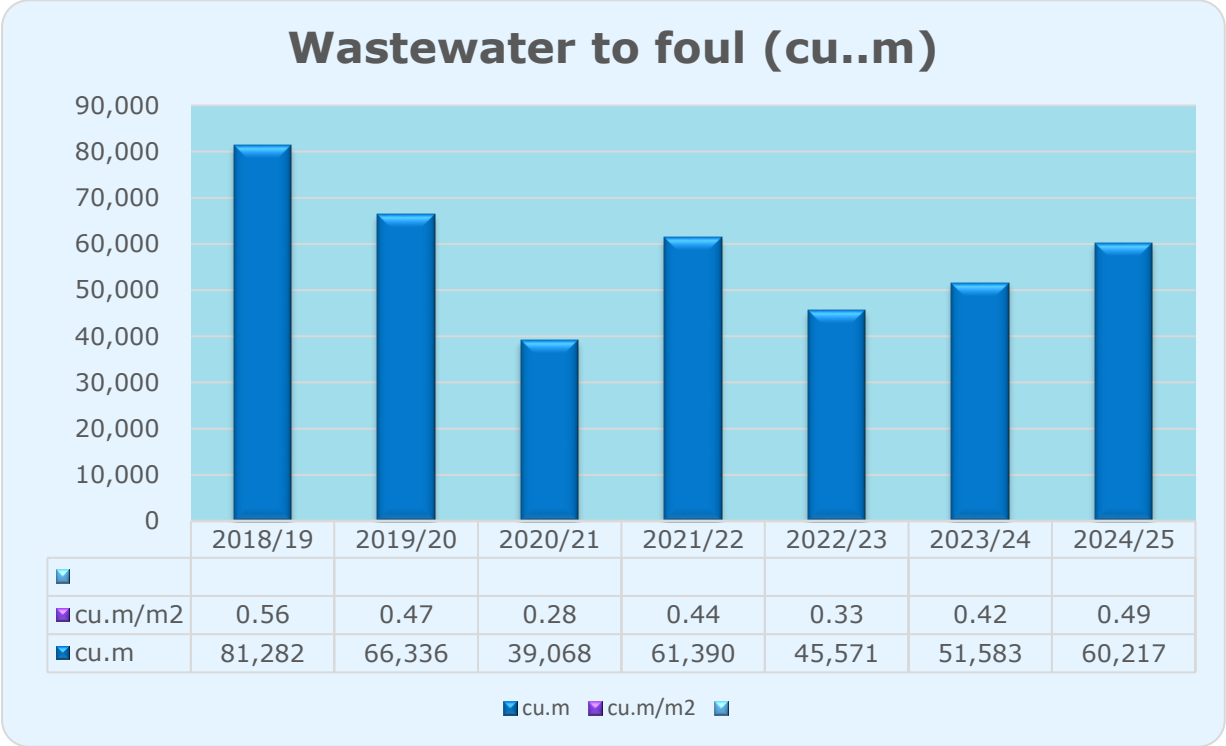


Figure 9: Wastewater to foul



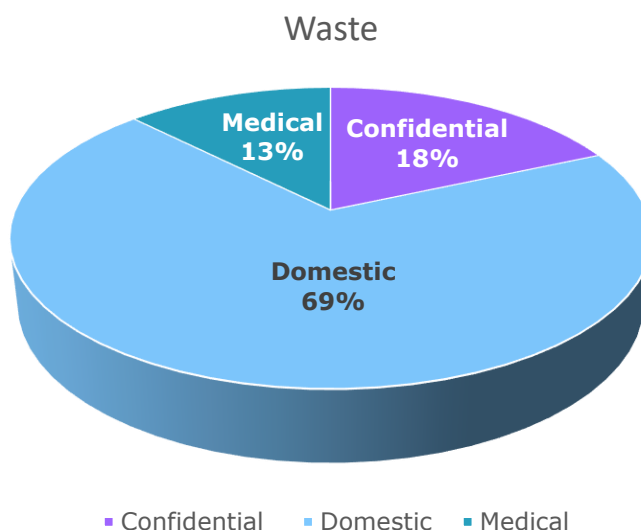
Waste and recycling

The Trust has a statutory obligation to process waste in accordance with the relevant waste regulations, which now include accounting for food waste. All food waste must be handled and treated in compliance with [the animal by-products \(SBP\) regulations](#). All other waste produced by the Trust is handled in accordance with the guidance issued

by NHS England in the [Health Technical memorandum HTM 01-07 \(2023\)](#). The Trust produces a range of waste, the majority of which falls into one of the following categories:

- General mixed waste
- Confidential (paper) waste
- Medical waste.

Figure 10: Waste Produced by category



The Trust makes every effort to avoid sending waste to landfill:

- Mixed domestic waste (plastic, glass, and metal) recycled avoiding 87 tonnes of waste going to landfill each year.
- Confidential waste is shredded and recycled avoiding around 275 tonnes of waste going to landfill each year.
- Clinical waste is diverted for alternative treatment and or sent for incineration, which generates heat and power for use by other businesses
- Over 1,577 items of electrical and electronic equipment has been recycled and repurposed diverting 9,666 kg of waste from landfill and

reducing CO2e emission by and estimated 216 tonnes.

In October 2024 the Trust moved away from the recycling platform know as [Warp-It](#), an on-line self-service facility to be used by staff to promote the reuse of surplus assets. The Trust instigated an 'invest to save' project to reduce the burden on teams for recycling assets and to improve the number of assets recycled across the Trust. We now use a managed service and have achieved the following results between December 2024 and March 2025:

- 925 unused assets re-used via 3rd part placement, of which 518 assets went to support registered charities.

- 694 unused assets recycled with zero waste going to landfill.
- 326 assets in storage for recycling, reuse or repurposing within the Trust.
- 39 assets reused within the Trust.

Consequently the Trust avoided 81,314 kg of CO₂e emissions attributable to waste produced and prevented circ. 46,998 kg of waste going to landfill.

Procurement

We are committed to sustainable procurement across all our operations in accordance with national policies, and NHS England's [procurement regulations](#). Our tender specifications detail our sustainability requirements, specific to each service. We make specific reference to minimising waste, reducing vehicle movements and innovation using appropriate technology to support procurement solutions.

We remain committed to delivering the aims and objects of the NHS England Net Zero supplier Roadmap as detailed below in figure 11 below.

Figure 11: NHS England Net Zero Supplier Roadmap



Travel and transport

The [NHS England Net Zero Travel and Transport Strategy](#) states that emissions from staff travel must be reduced through shifts to more sustainable forms of travel and the electrification of personal vehicles. Our staff, patients, visitors and supply chain undertake a significant amount of

business related travel each year, contributing to the amount of carbon dioxide emissions attributed to our direct and indirect activities.

We encourage staff to use public transport where possible, but the geographic distribution of our services means we face a significant challenge in

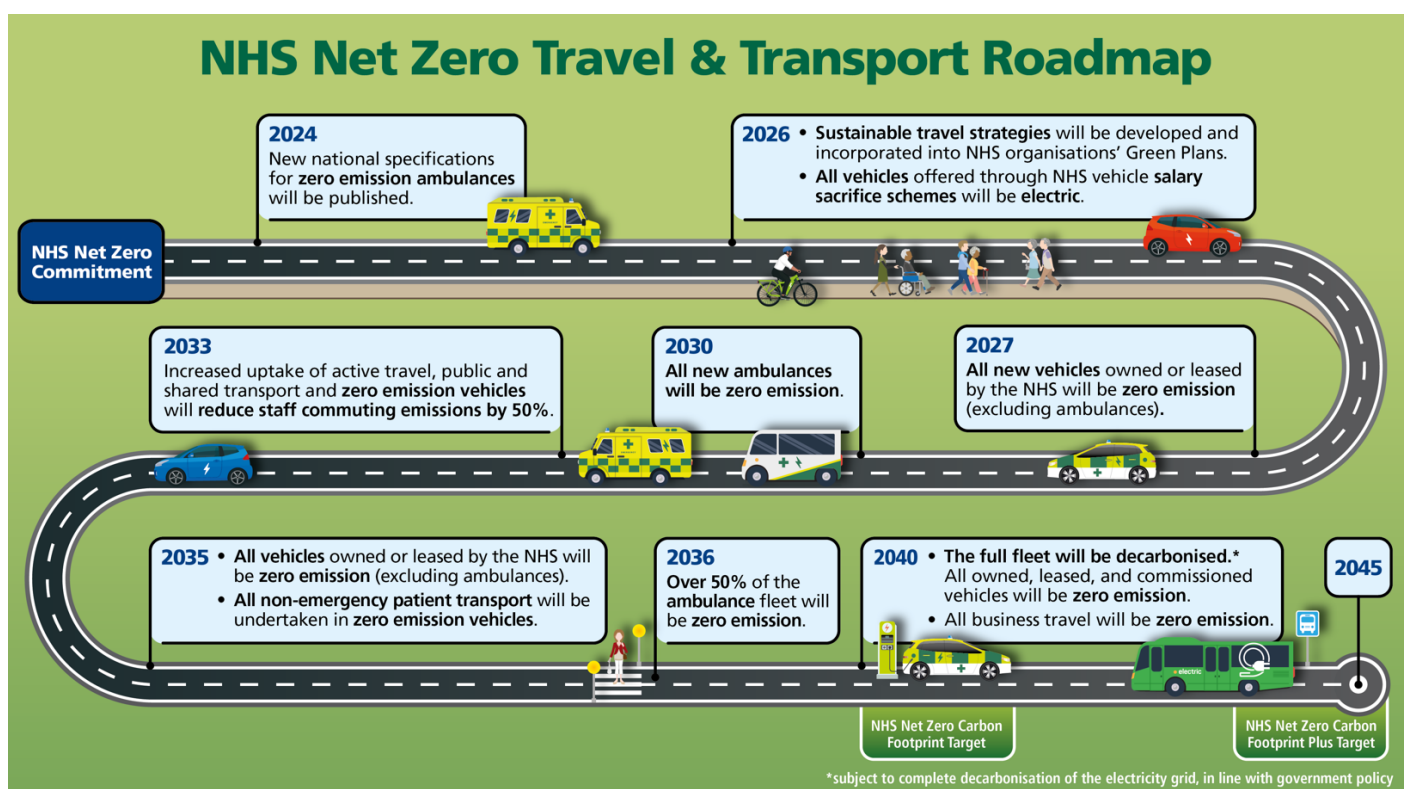
reducing emissions from staff commuting to and from work. However, we remain committed to reducing the impact and have a number of initiatives in place, including:

- Public transport season ticket loans
- Electric vehicle charging facilities
- Cycle shelters

- Access to cycle purchasing schemes, including Love to Ride Essex
- Hybrid working.

The Trust is committed to transition to zero emissions vehicles and is adhering to the NHS England Travel and Transport Roadmap, in Figure 12 below.

Figure 12: NHS England net zero travel and transport roadmap

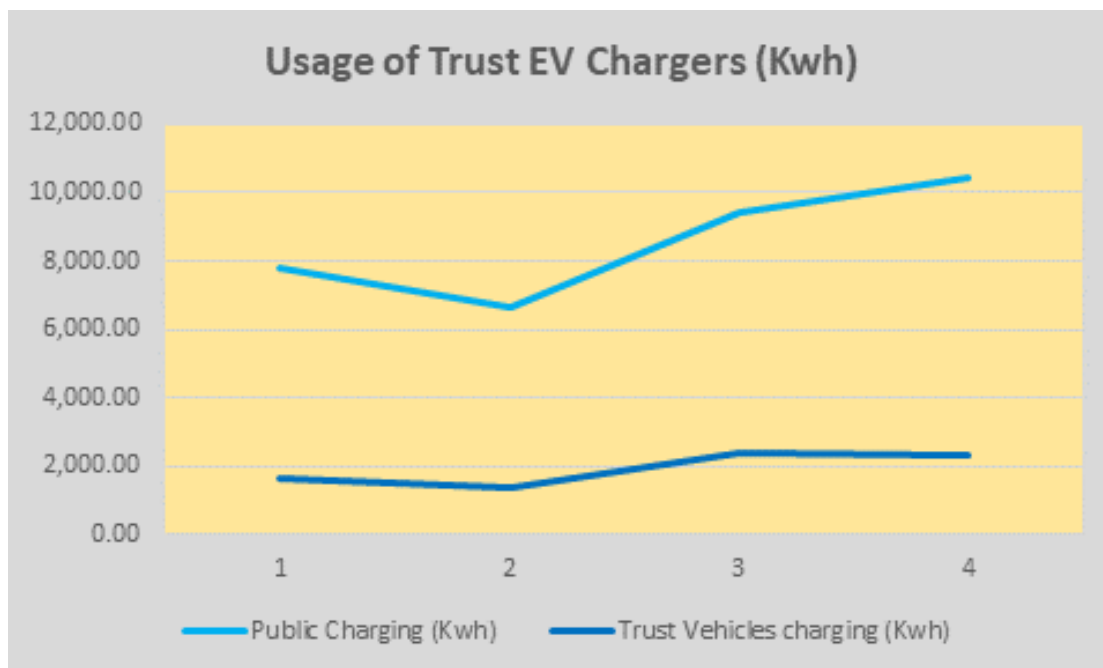


The Trust has a small fleet of vehicles, of which 21% are hybrid or electric. 88% of Trust vehicles are leased and as leases come up for renewal, the replacements will be required to comply the NHS England Travel and Transport Strategy, which states that all new vehicles owned or leased by the Trust will be zero emissions on or before 2027.

The Trust provides staff with the opportunity to engage in the lease vehicles salary sacrifice scheme.

Currently there are 354 vehicles operating within this scheme of these vehicles 212 (60%) are hybrid or electric.

Figure 13 below indicated in Kwh the demand for electric vehicle charging, including from Trust vehicles. Between April 2024 and March 2025, Trust electric vehicle charging facilities would support a 17 to 30% reduction from travel emissions from vehicles by staff, the public and the Trust own vehicles.

Figure 13: Electric charger use by consumption (Kwh) 2024 to 2025

From 2026 the vehicles offered through the salary sacrifice scheme will only be electric, this will result in the majority of private leased vehicles through salary sacrifice being hybrid/electric before 2030, which will increase the demand for publically available EV charging facilities.

New charging facilities at Clough Road Colchester

The Trust continues to expand its electric vehicle charging facilities, with three new chargers installed at the Clough Road, Colchester site. The



chargers were installed in preparation for the delivery of a number of hybrid electric vans for the Estates and

Facilities team. The Trust's electric vehicles charging network has increased from 27 charge points to 36. This includes three "fast" chargers. All the Trust EV chargers can be used by staff and the majority of chargers can be used by the general public. This provides a modest income for the Trust and supports the maintenance of the EV charging network.

The removal of diesel engine vehicles and the transitioning to hybrid and electric vehicles makes a positive contribution to reduce carbon emissions, removing particulate emission from the air, which improves internal and external air quality, which together makes a contribution to reducing the impact of Trust operations on the environment, staff, patients, visitors and the communities in close proximity to our facilities.

Travel survey

Towards the latter end of the financial year 2024/25, the Trust launched its staff travel survey. 565 employees from across the Trust completed the survey (Figure 14 to 16). The results from the 2024/25 staff survey will shape the Trust’s longer term travel and transport strategies, with the objective of reducing staff travel emissions by 50% on or before 2033. The Trust will look

to support a model shift change, prioritising active travel for health and wellbeing, public and shared transport and the promoting of zero emissions vehicles through the salary sacrifice schemes offered to staff by the Trust.

Figure 14 depicted the initial findings of the staff travel survey revealing that the majority of staff who did the survey travelled by car to work.

Figure 14: Transport modes for commuting

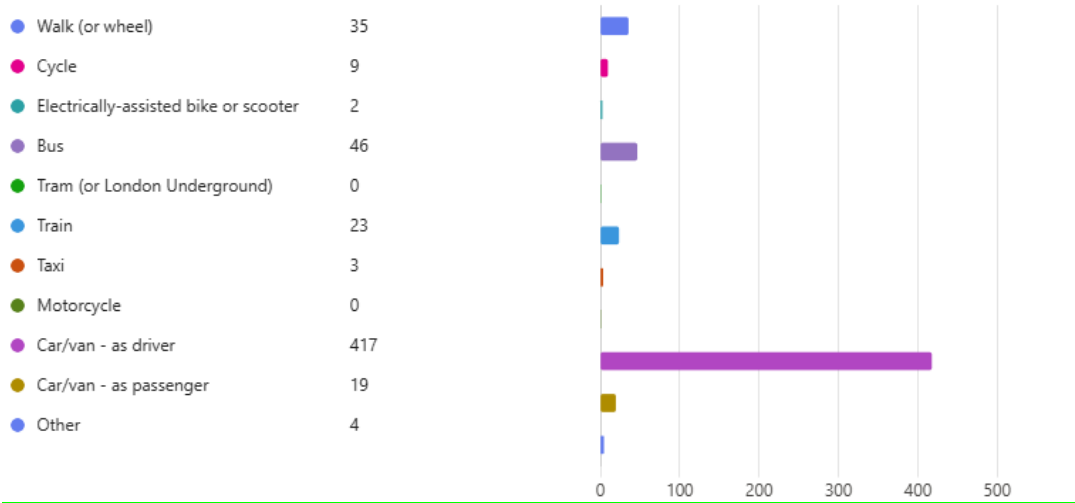


Figure 15 indicates why staff use their primary choice of transport, which is varied, but not unexpected, given the primary choice is by vehicle.

Figure 15: Staff preferences for commuting

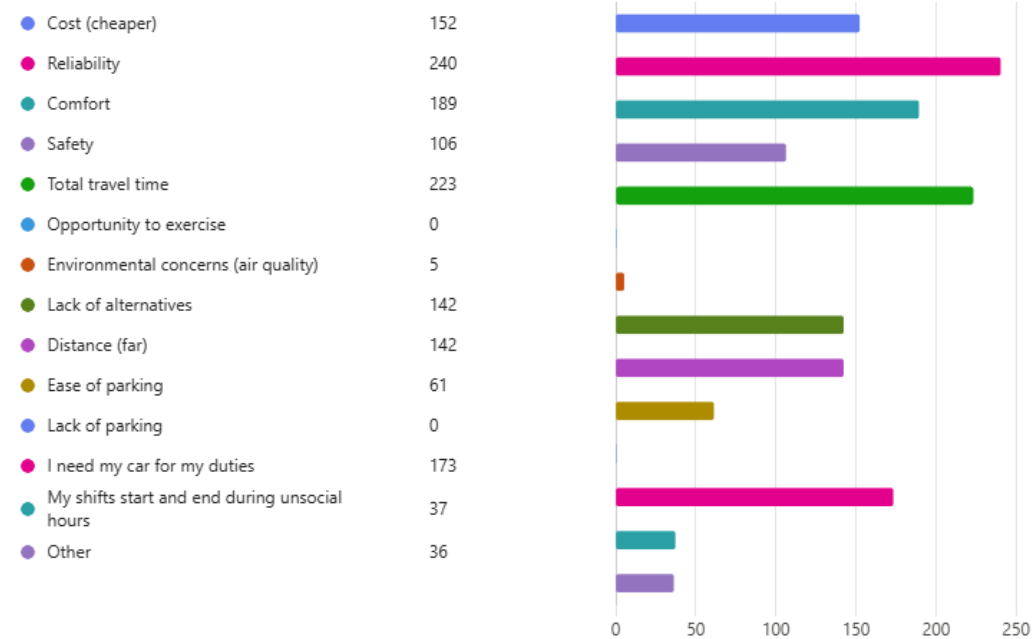
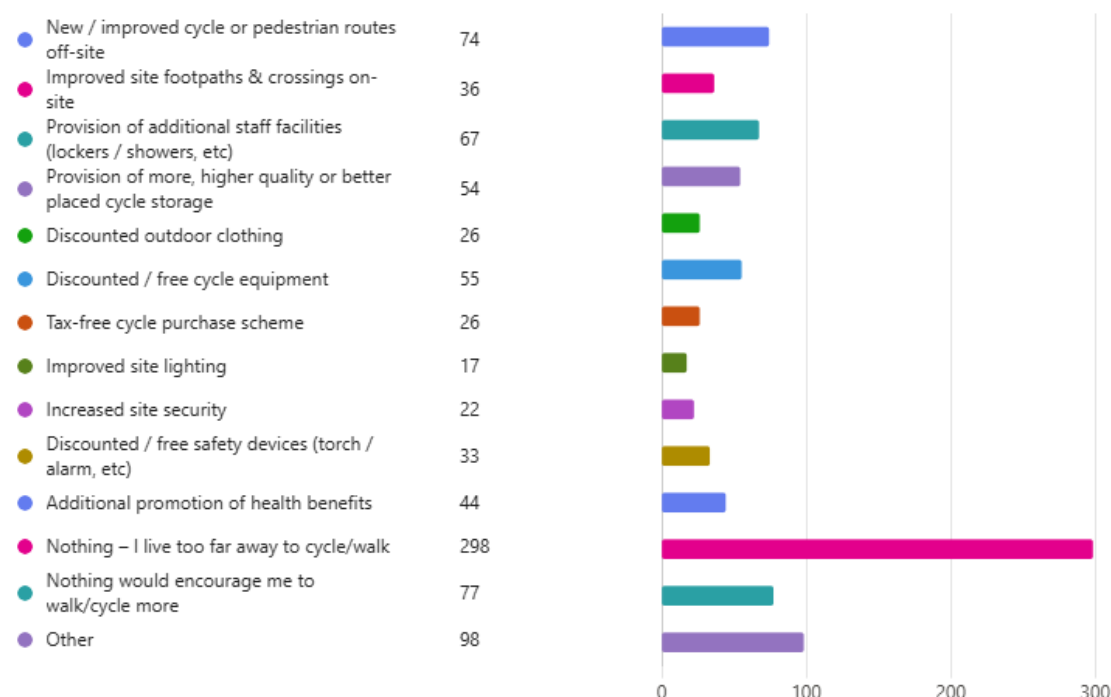


Figure 16 shows what would encourage staff to walk or cycle to work, over half of the staff surveyed said nothing, which needs to be qualified in the context of the distance they travel to work and the reliability of public transport, for example.

Figure 16 - what actions would support a modal shift in commuting preferences



Patient and Public Involvement

The Trust has the ambition to ensure the people and communities we serve are involved with key decisions and engaged in driving forward meaningful change; putting the lived experience of people at the heart of everything we do. In order to achieve this, the Trust must consistently involve the people we work with in shared decision-making, and co-delivery across all our services. This is a golden thread throughout the Trust's strategy but most evident in Strategic Objective 3, where the Trust believes that working in partnership with the people and communities that use our services is crucial to driving forward improvements and maintaining the high quality standards we set ourselves.

In 2024/25, we have continued to implement our 'Working in Partnership with People and Communities' strategy launched in January 2024. The strategy set out three guiding principles:

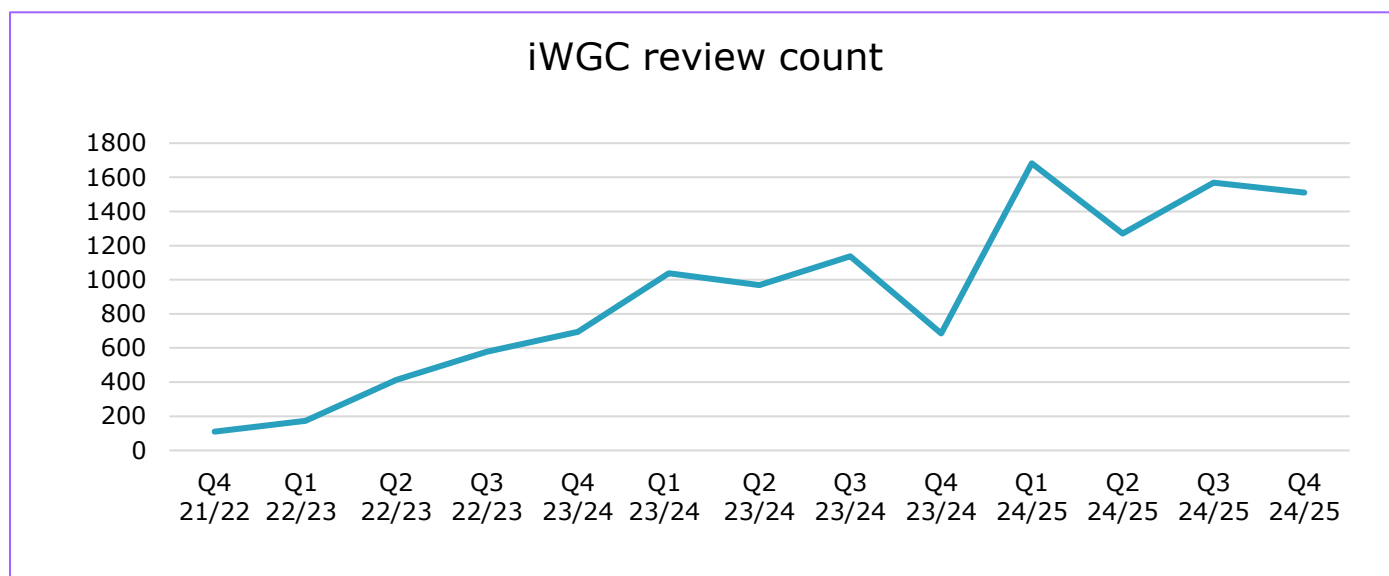
- **Equitable partnerships at every level of the organisation:** with people using our services, sharing power around decision making, whilst maintaining our responsibility to care for people.
- **Lived experience practice is what we do, it is in our DNA:** Our lived experience is invaluable, and the Trust celebrates it and harnesses it to drive meaningful change.
- **Co-production first:** Everything we do, we do in partnership with

people using our services, actively seeking and encouraging feedback, good or bad.

- The implementation of the strategy has seen the following key areas during the year:
- The team continue to be approached by colleagues across the NHS, system partners and ICB colleagues to understand and adopt best practice from our Reward and Recognition policy. We have maintained an increase in the utilisation of the policy and increased the number of involvement activities and hours contributed by Lived Experience Ambassadors.
- We have enhanced our staff induction offer and significantly increased the amount of different Lived Experience Ambassadors taking part.
- The team established the People Participation Group of the new Unified Electronic Patient Record by utilising the Reward and Recognition policy.
- The three different rates of involvement continue to work well with an increasing amount of Lived Experience Ambassadors becoming quality priority meeting group co-chairs; facilitating and monitoring the progress of end of life care, promoting neurodiversity and reducing health inequalities groups into executive oversight groups. This provides assurance people with lived experience have increasing influence in key decision making at Board level.
- The remit and utilisation of the (previously named) PIPE (Patient Information in Plain English) group has continued to grow and is routinely included in the development and review of patient facing documents with a supporting standard operating practice including the Marketing and Communications teams. Members of the PIPE group decided they would like to rename the group to SUM (Simple, Understandable, Meaningful).
- Our iWantGreatCare (iWGC) feedback response rates have increased significantly. Whilst we still strive to include data collection in business as usual processes, this provides assurance that our patients, their families and carers have increasing influence in key decision making across the trust. Such feedback identifies best practice, acts as an early warning system for complaints and is utilised with Lessons Learnt team.

Table 6: Volunteers, LEA, and involvement growth since April 2024

	Apr 2024	Apr 2025	Difference
Volunteers	484	483	-0.2%
Lived Experience Ambassadors	217	308	+42%
Involvement activities	26	55	+112%
Hours of involvement	955.5	5388	+464%

Figure 17: iWGC responses by quarter since its launch in January 2022**Table 7:** Comparison scores for March 2024 and March 2025**March 2024**

Essex Partnership University NHS Foundation Trust EPUT		Date
Your average score for all questions this period		01 March - 31 March
		Reviews this period
4.81		389
Your Experience Scores		
5 star score	% Positive experience	% Negative experience
4.78	93.3%	3.3%

After the successful pilot program last year, iWGC volunteers are now working across inpatient units to support and encourage patients, families, and carers to leave reviews of their care. The entirety of our iWGC volunteering cohort are health and social care students. By recruiting to this post with our local universities we are helping to deliver transferable skills to our local community and potentially provide our future workforce with invaluable experience. We plan to reapply this method for further roles next year.

March 2025

Essex Partnership University NHS Foundation Trust EPUT		Date
Your average score for all questions this period		01 March - 31 March
		Reviews this period
4.75		450
Your Experience Scores		
5 star score	% Positive experience	% Negative experience
4.72	85.6%	4.0%

Patients can complete feedback through both digital and paper methods. This personalised outreach method has led to patients reporting an increase in confidence to

provide feedback, with volunteers being seen as “more relatable” and able to rephrase questions when needed.

This method also increases accessibility as volunteers can help patients fill out surveys or feedback forms, especially for those who may face barriers to completing them independently, such as language, literacy, or physical limitations. The support provided by volunteers has led to a 76% increase in feedback rates for services with an iWGC volunteer, compared to those

without. This suggests utilising our volunteering function to support and facilitate feedback collection, we are better placed to create an environment where patients feel supported and more inclined to share their thoughts, leading to improved feedback rates. Additionally, the physical presence of volunteers on the wards has helped to increase visibility and awareness of the feedback process.

Volunteer, Ekaete writes:

“As a volunteer, I find immense fulfilment in being able to make a positive impact on people's lives. Volunteering has given me the opportunity to connect with others, learn new skills, improve my communication skills and gain valuable experience. It's incredibly rewarding to see the difference I can make, no matter how small it is.

I believe volunteers are invaluable in gathering feedback from patients. As an impartial and empathetic listener, volunteers can provide a safe space for patients to share their concerns and suggestions. Patients often feel better at ease sharing their honest opinions with someone who isn't directly involved in their care. This helps to ensure that their voices are heard, resulting in significant advances in patient care and services or the healthcare services.”

Co-production Conference 2024

The 2024 Co-production Conference was a great success. The conference celebrated the valuable contribution that people with personal experience of using health services are making to shape the care we deliver.

More than 120 people attended the event. Guests included staff, volunteers and senior leaders from EPUT, partner organisations, and NHS service providers and commissioners in Essex.

We were pleased to welcome guest speakers Lady Julie Jaye Charles CBE and Jan Hutchinson, who spoke about how organisations can work more

effectively and meaningfully with patients, families and carers to improve services.



Patient Advice and Liaison Service (PALS) and Complaints

Patient Advice and Liaison Service (PALS) and Complaints are fundamental in giving the people and communities

that use our services a platform for being heard and seeking improvements.

Table 8: Concerns and complaints

	2023/24	2024/25
Formal complaints	275	249
PALS concerns	537	603
MP concerns	69	73
Locally Resolved concerns	60	59
Compliments	1,344	1,545

Within the year, there were 77 complaints referred to the Parliamentary and Health Services Ombudsman (PHSO), which was a 20% increase on the previous year (64). For the second consecutive year, none were progressed for detailed investigation by the PHSO, but were all concluded at

their assessment stage for various reasons including ‘Out of Remit’, ‘Withdrawn’ or where referrals were made to the PHSO without first approaching the Trust. No detailed investigations were completed by the PHSO during the year for the Trust.

Equality and Inclusion

Equality of service delivery

The EPUT strategic plan was co-produced with stakeholders and partners and informed by an analysis of known inequalities. In our plan, we have committed to reducing health inequalities in access, experience and outcomes and are committed to developing and expanding our health outreach services for communities that experience challenges in accessing healthcare.

These plans are further set out in our strategies relating to Quality of Care and Working in Partnership with People and Communities. We will have deep and meaningful connections with our local faith communities to identify gaps in health inequality and work collaboratively to close these gaps.

Similarly, Trust operational plans and service developments are designed and evaluated using an inequalities assessment framework and with reference to the Joint Strategic Needs Assessments produced by Essex, Southend and Thurrock councils.

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. In

2022 EDS was relaunched by NHS England with 3 domains:

1. Commissioned or provided services
2. Workforce health and wellbeing
3. Inclusive leadership.

The Patient Experience team lead on domain and work with service users and carers to understand the performance of a service based on the following key areas:

- Levels of access to the service
- Individual health needs being met
- Using the service free of any harm
- Reporting positive experiences of the service.

Each area is scored by people who use the service, and then collated into an overall score which then determines whether the service is 'underdeveloped', 'developing', 'achieving' or 'excelling'. Whatever the outcome of the review, the service is left with an action plan for improvement moving forward. Further given the annual and rolling nature of the EDS, the guidance is that each ICB or provider selects three services to review per year.

In 2024, EPUT worked with its partners across three Essex Integrated Care Systems to identify and address health inequalities in access, experience and outcomes through the EDS framework by undertaking a service user led deep dive into the experience of care for three services, this is known as domain 1 within the EDS.

Evidence was collated for Lived Experience Ambassadors this year to assess how our Diabetes and Learning

Disability teams can demonstrate patients have required levels of access to the service, patients health needs are met, patients that use the service are free from harm and patients report positive experiences of the service. A MSE system panel inclusive of patient stakeholders took place in December which collectively scored EPUT as "achieving" across all criteria's. However, EDS is not the only national framework we use to monitor, identify, and address inequity in our services. We are engaged in a range of national initiatives designed to address health inequalities including the Patient and Carer Race Equality Framework (PCREF).

The PCREF is a national framework which is a key recommendation from the independent review of the Mental Health Act 2018 and has significant reporting requirements. It applies to all **mental health pathways** for older adults (65 plus), adults (18-64) and children and young people (0-25), although as a Trust any learning and best practice will be shared across all services (not just mental health).

The aim of the framework is to eliminate the racial disparity in the Access, Experience and Outcomes (AEO) of Black, Asian and minority ethnic communities and to significantly improve their trust and confidence in mental health services.

The framework has been launched in 2023 and trusts were expected to develop localised plans by the end of 2023/24. The Trust developed a plan in line with this timescale.

EPUT was an early adopter of the PCREF and so have been working to

embed its principles since July 2022, however, in 2024 the PCREF became the number one priority in the Trust's reducing health inequalities work which led to the following developments:

- Appointing two lived experience coproduction leads for the programme who chair our PCREF Task and Finish Group and the Trust's Reducing Health Inequalities Steering Group.
- Made race equity our priority within our reducing health inequalities annual plan.
- Created a Business Intelligence data dashboard to better comply with our public sector equality duty.
- Collaborated with chaplaincy to establish baseline standard of multi faith spaces in our wards.
- Co-designed cultural awareness training with the University of East Anglia which will be available to healthcare staff.
- Introduced our coproduction lived experience leads to the EPR programme to ensure race equity remains priority in these conversations.

In addition to the PCREF and EDS, EPUT is ambassador for the national Core20Plus5 programme, and works to ensure that all the relevant areas are including within the Trust's health equity improvement work. Further throughout 2023 and 2024, EPUT supported Mid & South Essex Integrated Care System as one of seven national accelerator sites for the national CORE20PLUS5 programme. The focus for this work was on physical health checks for people with severe

mental illness with a view to helping increase life expectancy. In addition to this, we worked with ICS colleagues to apply a PCREF lens to this work, so that we can better understand, identify, and address any disparities in service provision for the global majority. Whilst we recognise that there is more work to do, we have seen an improvement in the uptake of physical health checks across the mid and south Essex area, with a greater uptake for people who identify as white British, Black and Asian.

Another opportunity for the Trust to leverage national guidance and best practice to improve equity across our services is the Learning Disability Improvement standard. We provide a range of services for people with learning disabilities and autistic people and have embedded a range of new practices in the last year to address the inequitable outcomes we know people can face:

- Ask Listen Do sessions have been embedded and evolved to include specific forms for learning disability and neurodiversity.
- We marked Learning Disability Week with an information session attended by 120 staff.
- We have started the rollout of Oliver McGowan learning disability and autism awareness training to all relevant staff at EPUT, with 84% of staff now trained.
- Our new Quality of Care strategy has a focus on promoting neurodiversity and reducing restrictive practice for all patient groups to address identifiable areas of inequity.

A final area of focus for the Trust in ensuring equitable care is the national Accessible Information Standard. The Accessible Information Standard (AIS) is a legal requirement for organizations providing NHS care and publicly-funded adult social care in the UK, ensuring individuals with disabilities or sensory loss receive information in an accessible format and with appropriate communication support. It mandates a consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication needs of these individuals. The Trust reports on this annually against three areas:

1. Level of implementation
2. Accountability and monitoring
3. Recommendations from the 'Sigh Health Review'.

Within each area there are detailed requirements to monitor progress against, and the below is a list of some of the trusts progress in 2024 against the AIS:

- The AIS is included with the Trust's EDI toolkit and training pack
- The AIS is included as a general condition of standard contracts with suppliers
- The Trust has a dedicated lead for the AIS, along with a lived experience lead.
- The Trust's complaints procedure, and supporting policies is accessible for those who have a disability, impairment or sensory loss.
- The Trust has an ongoing contract with a 3rd party specialist to provide interpretation and

translation services, with British Sign Language (BSL) included.

- In 2024 the Trust facilitated 172 non-spoken face-to-face bookings for BSL with a total of 13,020 minutes interpreted. This forms part of close to 3000 interpreting requests received by the Trust, all of which were facilitated with no gaps.

Equality Impact Assessments

The Trust has a robust Equality Impact Assessment (EIA) process, which ensures EIAs are completed for all policies and key decision making. We are currently reviewing our approach to ensure it provides the right balance of rigour and ease of implementation.

Equality monitoring policies

The Trust is committed to deliver against national requirements for ethnicity monitoring for both patients and staff - DSCN 02/2001, DSCN 03/2001 and DSCN 21/2000. This also follows national sexual orientation monitoring standards to ensure requests for data from staff and patients is undertaken in an inclusive manner. These policies are supported through our Equality Monitoring Policy and Procedure.

Equal opportunities (P50)

Our strategic objectives and the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan shape our approach to EDI. Helping our communities thrive requires us to understand the experiences of people from marginalised groups, both in our workforce and our local communities.

TRAC is our online recruitment system to help ensure job applications are fair

and inclusive. Personal details such as an applicant's name or protected characteristics are withheld during the shortlisting process, mitigating bias and allowing decisions to be based purely on merit and potential. In 2024, we introduced an inclusive recruitment and selection toolkit, developed collaboratively with Mid and South Essex ICS. The toolkit encouraging interview panels to mitigate potential bias and ensure decisions are fair.

Reasonable adjustments are promoted and offer on arrival within the Trust, which is a Disability Confident Leader. In line with our Workforce Race Equality Standard (WRES) goals, interview panels for senior positions at (Agenda for Change Bands 8a+) include Inclusion Ambassadors, volunteer staff members who advocate for inclusive practice, sharing their lived experience to ensure that cultural differences are taken into account during recruitment.

Chaplaincy and Spiritual Care

We have worked closely with our chaplaincy services throughout this period, with focus on providing guidance to staff members on ways they can observe their faith and spirituality in work. Our Chaplaincy service have provided helpful advice and support in ensuring the Trust meets spiritual and faith needs of patients and service users.

Interpreting and Translation Services

The Trust has a contract in place with Language Empire to provide interpreting and translation services for patients and service users. This service helps bridge potential language and/or cultural barriers between our patients and the Trust as a healthcare provider. It also allows services users to communicate accurate information to their clinicians and practitioners.

Social Impact Strategy

The Board approved a five-year Social Impact strategy in September 2023. Delivery of this strategy represents one of the main ways in which we will fulfil our strategic ambition to help our communities thrive. Overall, the implementation of the Social Impact strategy is proceeding to plan and social impact has become a strong theme running through the Trust. For example, the Estates strategy published in January 2025 described the Trust as a community enabler and lists a range of short and longer term priorities for leveraging our estate to help our communities thrive e.g. through community garden projects, hosting estates and facilities apprentices and using our buildings to accommodate community hubs.

Similarly, the Pharmacy & Medicines Optimisation strategy published in August 2024 describes how we will help our communities thrive through reduction of medicines wastage through patient-centred optimisation and recycling of medicines-related items as well as inclusive recruitment from local communities where possible.

EPUT has a number of Tier 1 and Tier 2 initiatives in planning or delivery stages which are starting to show measurable impact, though some areas require further focus. In the second half of 2024/25, the Social Impact Leadership Group has been generating and qualifying Tier 3 initiatives.

Table 9

Tier	Examples of initiatives in planning or delivery
1: Things we are already doing or could start without much material change to maximise positive impact in our local communities.	<ul style="list-style-type: none"> • Programme of inclusive recruitment events • Review of standard recruitment documentation • Accommodation of Voluntary and Community Sector (VCS) partners on EPUT sites where possible and safe to do so.
2: Medium scale projects for the next 1-3 years, likely grant funded and delivered in partnership with local authority and VCSE.	Multiply programme being delivered across Essex, Thurrock and Southend in the community, and now in inpatient and prison settings.
3: Larger scale ambitions with five year time horizon that might attract commercial investment.	Plans in development.

Delivery across the social impact pillars for 2024/25 includes:

- Commitment to adopt principles of community resilience into collaborations with voluntary sector partners.
 - Programme of inclusive, local recruitment events across Essex in partnership with colleges and higher education institutions to bring down barriers to high quality work in more deprived areas.
 - 89% of EPUT staff live and work in same county during 2024/25, up from 81% in M8 of the prior year.
 - 22% of purchase order value was placed with suppliers in Essex,
- Bedfordshire or Suffolk, same as in the first half of the year.
 - Launched GoGreen Management service as furniture, fittings and equipment re-use programme which will help save money and reduce environmental impact.
 - Hosting 221 apprentices, using 29% of apprenticeship levy with plans in development to increase usage further.
 - Positioning social impact as key theme of other enabling strategies e.g. people and education (local apprenticeships), estates (community assets), pharmacy and medicines optimisation (medical waste reduction).

The following case studies demonstrate the work of the Social Impact strategy which continued throughout 2024/25:

Multiply: supporting adults in Essex with numeracy skills

Multiply is a government-funded initiative aimed at improving numeracy skills and building confidence in using numbers in daily life, work, and learning. It supports individuals, families and communities to become more confident with maths and numeracy. The programme aims to empower people with their finances, leading to a positive impact on their health and wellbeing.

Since the beginning of 2024, Enable East (hosted by EPUT) has been awarded £343k of grant funding from Southend, Essex and Thurrock councils to deliver Multiply, a numeracy skills programme for adults that do not have mathematics GCSE. The team has created and delivered interactive Financial Wellbeing and Resilience Courses for community organisations, targeting those in underserved groups.

Since the start of the programme in January 2023, Enable East has supported over 1,238 people to improve their numeracy skills which we know to be a wider determinant of health outcome, of which 986 in 2024/25, showing the sustained growth in this social impact intervention and the strategic importance of Enable East as a delivery function in the last year.

With additional grant funding from Essex County Council, Enable East mobilised delivery of Multiply within EPUT's inpatient wards as part of therapeutic offer upskilling them ready for discharge. The pilot was quickly extended from one to eight wards and over 175 learners have been supported to date.

In addition, Enable East secured a grant to expand and tailor its delivery of Multiply to

Chelmsford prison starting from November 2024; 62 learners supported to date for reintegration back into society.

The programme has now ended and has won the Innovation Award presented by Essex County Council for innovative delivery to inpatient and prison cohorts in January 2025.

Inclusive recruitment for local people

During National Careers Week (3-8 March 2025), EPUT worked with the Department for Work and Pensions to support people into rewarding careers in the NHS. A recruitment event held in Epping on 4 March helped 25 people secure interviews for healthcare assistant roles at St Margaret's Hospital, which provides inpatient services for older adults with mental illness.

This was the third recruitment event held jointly between EPUT and local Job Centres, with previous successful events having taken place in Basildon and Colchester. Six new healthcare assistants recruited at the Basildon event in October 2024 will start working at Brockfield House in March 2025, having completed their initial training.

The sessions aim to support people into rewarding careers within their local NHS services and offer applicants the opportunity to hear from current staff working in community and mental health on the qualities needed for the role, the importance of patient safety, and the benefits of working in the NHS. During the event, candidates also heard from people with lived experience of mental health services on some of the activities and therapeutic engagement which can provide patients with a positive care experience. The initiative is supported by the HCA Academy, a programme from the Mid and South Essex Integrated Care Board which aims to develop the skills of healthcare assistants.

Potential applicants are also able to find out about career support on offer through the HCA Academy and opportunities to study further healthcare qualifications through apprenticeships with EPUT.

EPUT's Recruitment team also recently ran a recruitment event at Harlow College and were able to offer roles to health and social care students to join St Margaret's Hospital in the summer.

EPUT continues to refine its approach to measurement of social impact through exploration of the "distance travelled" metrics and combining this with aspects of UCL Partner's "How Strong Is Your Anchor?" model.

Consultation with local groups and organisations

Throughout the year, we continued to engage with local Members of Parliament, relevant local authority

committees and other key stakeholders. Following the UK general election in July 2024, a number of new MPs were elected to seats in Essex, Bedfordshire and Suffolk. We sent individual welcome messages and briefings to all new Essex MPs, and in the following months we either met or held online briefings with many new MPs. We also maintained contact with and regular briefings for existing MPs.

During the year, we issued five routine written updates to MPs, covering routine operational and strategic issues and re-sharing recent news stories we had sent to local and trade media. All MPs also routinely receive copies of press releases when they are issued to the media. We welcomed several MPs on visits to our services, which our operational teams enjoy. Such visits are a valuable opportunity to demonstrate the work of the Trust, to increase MPs' understanding of our services and any local issues and priorities and to deepen our relationships with them.

Following local elections in May 2024, there were a number of changes amongst elected members of local authorities, including health scrutiny committees, relevant cabinet leads and health and wellbeing boards. Following the elections, we continued with our programme of routine attendance at and briefings for the health scrutiny

committees of the three Essex upper tier local authorities – Essex County Council, Southend City Council and Thurrock Council. We also offered and provided online and face to face briefings for members and senior officers at Southend City and Thurrock Councils during the Lampard Inquiry hearings in late 2024, as well as providing written updates for all three committees following the publication of the three-year report of our Safety First, Safety Always strategy.

During the year, we introduced a separate routine written briefing for a range of stakeholders, including Healthwatch, local voluntary sector organisations, safeguarding boards, local NHS organisations, higher education institutions and other partners. Three such briefings were sent during the year and were well received.



Financial Review

Overview

This part of the Performance Report provides commentary on the financial results and performance. The Trust's annual report and accounts cover the period of 1 April 2024 to 31 March 2025. Annual Accounts have been prepared in accordance with directions issued by NHS England (NHSE) under the National Health Service Act 2006. Accounts are also prepared in accordance with International Financial Reporting Standards (IFRS) and are designed to give a true and fair view of the Trust's financial activities.

Financial Performance

During the financial year the Trust agreed an adjusted deficit plan (which performance is measured against) with NHSE of £10.5 million. Against this target the Trust delivered an actual adjusted deficit of £3.8 million after receiving £14.1m of non-recurrent deficit support funding and accounting for a Prior Period Adjustment (PPA) of £8.7 million. The PPA is in respect of provisions held within the Statement of Financial Position as at the end of 31 March 2024.

The Trust's adjusted deficit includes technical adjustments relating to impairments associated with the impact of the full valuation of the Trust's estate, local government pension scheme and accounting treatment for PFI, and donated and peppercorn assets.

The tables below provide a summary of the Trust's performance on its Statement of Comprehensive Income and the Statement of Financial Position.

Table 10: Summary of statement of comprehensive income

	2024/25 £000	Restated 2023/24 £000
Total Income	608,683	538,739
Operating Expenses	(637,044)	(548,800)
Finance Costs / Other Gains and Losses	(10,180)	(11,732)
Deficit for the year from continuing operations	(38,541)	(21,793)
Exclude: I & E Impairments / (Reversals)	27,515	4,622
Exclude: IFRS16 PFI Conversion	-	4,245
Exclude: IFRS to UK GAAP PFI accounting	(239)	-
Exclude: Local Government Pension Scheme	86	98
Exclude: I & E Impact from Donated/Peppercorn assets	(1,293)	5
Impact of prior period adjustment	8,651	
Adjusted Deficit for the year ^{1,2}	(3,821)	(21,474)

¹ The 2024/25 adjusted deficit includes deficit support funding of £14.1m.

² For the purpose of the above table the impact of the PPA of £8.651m is reflected in 2024/25 results with the 2023/24 adjusted deficit displayed as reported in 2023/24.

Income from healthcare activities

Total income from all sources was £608.7m million, of which income received from patient care activities totalled £581.7 million with other income of £27 million. Income is reported in line with the requirement of section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Section 43 (3A) of the NHS Act 2006 also requires NHS Foundation Trust's to provide information on the impact that other income it has received on the provision of the health service in England. The majority of other income relates to education and training income for our staff of £18.4m. This has no impact on the provision of goods and services for the purposes of the health service in England.

Operating expenditure

The total operating expenditure was £637 million. The largest area of direct spend related to staff costs of £414.5 million (65.1%).

Efficiency

The Trust achieved savings of £23.3 million through a combination of both recurrent and non-recurrent measures.

Finance costs

The Trust is required to pay the Treasury dividends in respect of Public Dividend Capital (PDC). Dividends are determined at a rate set by Treasury (currently 3.5%) on the average relevant net assets of the Trust. Dividends are paid twice a year in September and March. Average relevant net assets are based on the opening and closing balances of the Statement of Financial Position, and therefore a debtor or creditor may exist at year end between the Trust and

Treasury. For the 2024/25 financial year, the Trust paid dividends of £5.7 million, with a debtor balance of £0.7 million.

In addition, the Trust incurred finance costs in respect of PFI obligations for the Trust's properties at Rawreth Court, Clifton Lodge and Brockfield House. This included interest charges of £2.5 million and remeasurement of the lease liability from change in RPI / indexation of £1.8 million. The Trust also holds loans of £2m with the Department of Health which incurred in-year interest costs of £47k.

The Trust also paid finance costs in respect of the right of use assets of £0.4 million during the year.

Local Government Pension Scheme (LGPS)

On an annual basis the Trust is required to obtain an actuarial valuation on the Local Government Pension Scheme (LGPS) which relates to social workers employed by the Trust under Section 75 agreements. This is based on figures provided by the actuary at Essex Pension Fund and subsequently verified by the Trust's External Auditors.

The operational cost, finance income, and finance costs of the scheme for 2024/25 have been reflected in the Trust's Statement of Comprehensive Income and reduced the Trust's adjusted deficit position by £86k. At the end of the year, the Trust is recording a net defined asset of £21k within the Trust's non-current assets.

Revaluation of investment property

In accordance with accounting guidelines, the Trust has undertaken an annual revaluation of its investment properties. This has resulted in a net

decrease in the overall value of the Trust's investment properties of £0.8 million in 2024/25. This decrease is reported as part of the Statement of Comprehensive Income within other gains and losses.

Impaired value of land and property

During 2024/25, the Trust instructed Montagu Evans LLP to undertake a full valuation of the estate, including a right of use peppercorn asset and assets held for sale. This resulted in a net decrease in land and buildings of £21.9 million which has been reflected in the Trust's

Statement of Financial Position.

This net position includes a number of revaluations (increase in values) and impairments (reduction in values) which are chargeable to either the Statement of Comprehensive Income as part of operating expenses, or taken to the Revaluation Reserve in the Statement of Financial Position. Any impairment reported within the Statement of Comprehensive Income is excluded as a technical item in the adjusted financial position against which the Trust is monitored and for the 2024/25 financial year totalled £27.5 million.

Table 11: Summary of statement of financial position

Summary of Statement of Financial Position	2024/25 £000	Restated 2023/24 £000
Non-Current Assets	281,337	301,202
Current Assets (excluding cash)	24,221	21,224
Cash and Cash Equivalents	28,077	43,378
Current Liabilities	(74,448)	(68,913)
Non-Current Liabilities	(80,805)	(89,196)
Total Assets Employed	178,380	207,695
Total Taxpayers Equity	178,380	207,695

Capital investment

During the year, the Trust invested £17.1 million on capital expenditure, of which £3.5m was funded from Department of Health and Social Care Public Dividend Capital. This performance was consistent with forecast outturn expectations. The Trust continues to heavily invest to improve facilities, estates, digital infrastructure and equipment requirements. Investments are prioritised on a risk based approach with clinical and operational leadership driving these priorities. The total capital spend for the year included the following:

- £3.5m on ward environment upgrades at The Lakes, Kings Wood Centre, The Linden Centre and Byron Court. As well as environmental upgrades these included sensory and family spaces for patients;
- £2.2m on estates safety backlog schemes including electrical works, asbestos removal, door and window replacements, fire safety works, roof repairs and boiler replacements;
- £0.7m investment in medical equipment including profiled beds

replacement programme to support improved patient safety;

- £0.6m on sustainability schemes including a Building Management System and installation of LED lighting on the Thurrock Hospital site;
- £2.2m on Electronic Patient Record Project (EPR), including preparation for business case, and EPR readiness schemes;
- £0.8m on Electronic Prescribing and Medicines Administration (EPMA);
- £2.2m on ICT including cyber security, wifi infrastructure, Windows 11 preparedness, business intelligence and the shared care record;
- £0.5m on other improvements to Trust estate.

Within non-current assets on the face of the Statement of Financial Position, the Trust now holds intangible assets, plus property, plant and equipment totaling £224.2 million as at the end of March 2025.

Right of use assets

In addition to property, plant and equipment, a further £44.4 million of right of use assets are also held within non-current assets.

In line with other property, plant and equipment, the right of use assets are depreciated in-year which is charged to the Statement of Comprehensive Income within operating expenses. The Trust also incurred an interest charge on the lease liability of £0.4 million, which is charged as part of finance expenditure.

Investment property

The Trust also holds a number of investment properties within the classification of non-current assets totaling £12.6 million. These properties are leased out to various organisations including other NHS bodies, housing associations and private individuals.

Assets held for sale

As at the end of the 2024/25 financial year, the Trust held one asset in preparation for disposal. This relates to number 4 The Glades based in Bedfordshire. This was revalued during the year, and decreased in value by £45k.

Non-current liabilities

In line with International Financial Reporting Standard (IFRS) 16 Leases, the liabilities held in respect of the PFI properties were remeasured during the year increasing by £1.8 million. The Trust's other leases which are supported by a right of use asset, were similarly remeasured and increased in value by £1.7 million.

Capital repayments against the PFI liability and lease liability for the year totalled £5.7 million.

Working capital and liquidity

The Trust has robust cash management and forecasting arrangements in place and is required to periodically submit cash projections to NHSE. The Trust also routinely reports cash position into its Finance and Performance Committee. This Committee was chaired by a Non-Executive Director, and included further Non-Executive Directors and the Executive Chief Finance Officer.

The Trust invests surplus cash on a day-to-day basis in line with the Operating Cash Management Policy and Procedure and has maximised interest generated from cash management activities by placing longer term investments with the National Loans Fund (a government bank). During the year the Trust earned interest of £2 million.

Policy and payment of creditors

The Non NHS Trade Creditor Payment Policy of the NHS is to comply with both the Confederation of British Industry (CBI) Prompt Payment Code and government accounting rules. The government accounting rules state: "The timing of payment should normally be stated in the contract. Where there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later". As a result of

this policy, the Trust ensures that:

- a clear consistent policy of paying bills in accordance with contracts exists and that finance and purchasing divisions are aware of this policy;
- payment terms are agreed at the outset of a contract and are adhered to;
- payment terms are not altered without prior agreement of the supplier;
- suppliers are given clear guidance on payment terms;
- a system exists for dealing quickly with disputes and complaints;
- bills are paid within 30 days unless covered by other agreed payment terms.

The Trust's performance on its creditor payments for the 2024/25 financial year is detailed below:

Table 12: Performance on creditor payments 2024/25

	NHS		Non-NHS		Total	
	Number of Invoices	Value £000	Number of Invoices	Value £000	Number of Invoices	Value £000
Invoices paid within 30 days	759	53,929	67,459	233,469	68,218	287,398
Invoices paid in excess of 30 days	265	16,225	7,440	17,742	7,705	33,967
Total invoices that were or should have been paid in 30 days	1,024	70,154	74,899	251,211	75,923	321,365
	74.1%	76.9%	90.1%	92.9%	89.9%	89.4%

The Trusts combined performance on the payment of suppliers is 89.9% based on the number of invoices.

During the year, the Trust incurred actual interest charges on the late payment of invoices of £140.

Taxpayers' equity

As at the end of 2024/25, the Trust holds Public Dividend Capital of £148.3 million including new PDC capital received during the year of £3.5 million to support capital investment.

Taxpayers equity also includes reserves for income and expenditure surpluses and deficits generated over the years, and from asset revaluations or impairments arising from the impact of the valuations of the Trusts estate. The total of these represents the level of taxpayers' equity in the Trust of £178.4 million.

Accounting policies

The Trust has detailed accounting policies which comply with the NHS Foundation Trust Annual Reporting Manual. These have been thoroughly reviewed by the Trust and agreed with External Auditors. Details of the policies are shown on pages 178 to 226 of the 2024/25 annual accounts.

Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury.

NHS pensions and directors' remuneration

The accounting policy in relation to employee pension and retirement benefits and the remuneration report is set out on pages 201 to 205.

Charitable funds

The Trust has a registered charity in the name of Essex Partnership University NHS Foundation Trust Charities (number 1053793) which has resulted from fund raising activities, donations and legacies received over many years.

The Charity consists of a number of restricted funds which are used to purchase equipment and other services in accordance with the purpose for which the funds were raised or donated, as well as unrestricted (general purpose) funds which are more widely available for the benefit of patients and staff.

The Trust is extremely grateful for all donations and further details around the charity and how to donate can be found at www.eput.nhs.uk/get-involved/charitable-funds/.

The Board of Directors act as Corporate Trustee for the Charity and is further supported by the Charitable Funds Committee. The Committee consists of two Non-Executive Directors, (one of which is the Chair), the Executive Chief Finance Officer and Executive Director of Major Projects and Programmes. Due to materiality, the charity accounts are not consolidated into the Trust's main accounts for the 2024/25 financial year.

A copy of the charity's Annual Report and Accounts for 2024/25 will be available from January 2026 upon request to the Executive Chief Finance Officer.

Political donations

The Trust did not make, nor receive any political donations from or to its exchequer or charitable funds during 2024/25.


Financial risk management

The Trust's financial performance is assessed by NHS England, based on the NHS Oversight Framework. This framework looks at six themes, of which one is the Trust's performance on

finance and use of resources.

The Trust has a robust risk

management process into which any identified financial risks are included and monitored on a regular basis.

A handwritten signature in black ink, appearing to read 'P. Scott', with a large, stylized flourish at the end.

Paul Scott
Chief Executive
24 July 2025

Accountability Report

Directors' Report

The Directors' Report comprises the details of the individuals undertaking the role of director during 2024/25 and the statutory disclosures required to be part of that report. It is presented in the name of the following directors who occupied positions during the year.

Our Board of Directors provides overall leadership and vision to the Trust. It is ultimately and collectively responsible for the Trust's strategic direction, its day-to-day operations and all aspects of performance, including safety, clinical and service quality, financial and governance. The powers, duties, roles and responsibilities of the Board are set out in the Board's Standing Orders, Scheme of Reservation and Delegation.

The main roles of the Board are to:

- Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Set the Trust's strategic objectives, taking into consideration the views of the

Council of Governors, ensure that financial resources and staff are in place for the Trust to meet its objectives and review management performance.

- Ensure the quality and safety of all healthcare services, education and training delivered by the Trust and to apply the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.
- Ensure compliance by the Trust with its provider license, its constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations, and regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

Non-Executive Directors



Professor Sheila Salmon
Trust Chair

Appointment: 01 November 2017

Term of Office: Expired 31 March 2025

A voting member of the Board, Sheila chaired Mid Essex Hospitals NHS Trust from 2010 – 2017 and was also the Founding Chair of the Joint Working Board (2016 – 2017), forged through the collaboration of Mid Essex Hospitals with Basildon and Thurrock University Hospital Foundation Trust and Southend University Hospital Foundation Trust within the Mid and South Essex Strategic Transformation Partnership.

Sheila was previously Chair of the North East Essex Primary Care Trust (2006 – 2010) and prior to that, chaired the Essex Ambulance Service, before being appointed to the Board of the East of England Ambulance Regional Service.

Coming with a strong clinical background, she has built significant and diverse senior leadership experience in health and social care. And in the University sector, where she led the establishment of a Regional Faculty of Health and Social Care, and has represented the Nursing and Midwifery Council on numerous quality and standards visits to British Universities and their partner NHS Trusts.



Dr. Mateen Jiwani

Non-Executive Director / Senior Independent Director

Appointment: 31 December 2020

Term of Office: Expires 31 December 2026

A voting member of the Board, Mateen is a practicing GP in London and Essex and previously worked as Medical Director at Barking, Havering and Redbridge University Hospitals NHS Trust, and NHS Enfield Clinical Commissioning Group.

He has a passion for technology and innovation, is a regular broadcaster on new and innovative healthcare approaches and sits on a number of boards including the Royal College of General Practitioners.



Diane Leacock
Non-Executive Director

Appointment: 04 December 2023

Term of Office: Expires 31 December 2025

A voting member of the Board, Diane's career has spanned several industries. She has held Finance Director roles at various commercial organisations in the information and publishing, insurance broking and legal sectors where she has streamlined, grown and transformed business units.

Diane has a keen interest in healthcare and people issues and served as a non-executive director within the NHS for 10 years prior to joining the board of EPUT.

Currently, Diane is a fractional Chief Financial Officer, working with growing businesses. She is also a non-executive director at the Royal Papworth Hospital NHS Foundation Trust and sits on the Board of Trustees at the East of England's award-winning contemporary visual arts gallery, Firstsite.

An Economics graduate of the University of Waterloo (Canada), Diane holds a Masters in Business Administration from Henley Business School and is a Fellow of the Association of Chartered Certified Accountants.



Dr. Rufus Helm
Non-Executive Director

Appointment: 24 July 2018

Term of Office: Expired 31 July 2024

A voting member of the Board, Rufus originally trained as a doctor, specialising in obstetrics and gynaecology before making the transition to management consultancy. Starting his consultancy career with Arthur Andersen Consulting, he helped establish Andersen's consultancy offering in healthcare before moving on to commercial roles with Serco and Circle Health. Here he concentrated on the design and implementation of new service models focusing on improving the management of long-term conditions and, in particular, the interface between acute and community settings.

Rufus joined the British Medical Journal (BMJ) as their Head of Business Development in 2012 where he focused on how digital resources can drive clinical improvement in areas such as clinical decision support, shared decision making and the delivery of evidence based medicine.

More recently, he helped Health Navigator implement its innovative tele-coaching model as their Chief Operating Officer / Chief Medical Officer and now provides freelance consultancy to health organisations countrywide



Loy Lobo

Non-Executive Director / Vice Chair (From March '24)

Appointment: 31 March 2021

Term of Office: Expires 31 March 2027

A voting member of the Board, Loy is a leader in healthcare innovation. Before working exclusively in healthcare, he worked for 11 years for a management consultancy, leading technology-enabled business transformation programmes for multi-national companies.

Over the past decade, Loy has introduced a number of healthcare innovation and is president of the Royal Society of Medicine's Digital Health Council. He has launched a UK social enterprise start up in wellness and was the founder of the telehealth business at BT Global Health.

Loy has served on a number of high profile government panels and academic collaborations to promote the adoption of technology and decision science in healthcare. He runs a health innovation company that applies design, digital, and decision science to transform healthcare.



Elena Lokteva

Non-Executive Director / Chair Audit Committee

Appointment: 01 July 2023

Term of Office: Expires 23 May 2026

A voting member of the Board, Elena's executive career was in private equity. At SI Capital, she was a partner responsible for the financial and legal affairs of the firm, lead international teams handling acquisitions and exits across continental Europe and the Middle East. She also worked as a restructuring CEO in portfolio companies.

Elena has more than twenty years of board level experience in executive and non-executive capacities. Her current NED portfolio includes North Middlesex University Hospital NHS Trust and Northampton General Hospital NHS Trust. Elena also served as an Associated NED at EPUT from February 2023 prior to taking up her role. Elena has seven years of front line and board level volunteering at mental health charities, including Bipolar UK, Herts Mind and St Andrew's Healthcare.

Elena is a qualified accountant and a Fellow at the Chartered Institute of Management Accountants.



Jenny Raine

Non-Executive Director (until October '24) and then Associate Non-Executive Director (from October '24)

Appointment: 02 January 2024

Term of Office: Expired 31 May 2025

A voting member of the Board (until October '24), Jenny qualified as a Chartered Accountant with PwC before a career in Executive roles in the NHS in Cambridgeshire. This included ten years at Cambridgeshire and Peterborough Mental Health Foundation Trust as well as a period as Director of Finance and Improvement at Cambridgeshire Clinical Commissioning Group.

Jenny is now the Bursar at Corpus Christi College Cambridge and sits on the Joint Wellbeing Committee for the collegiate University, which oversees the implementation of the recently agreed Mental Health Strategy.

Jenny has also worked in an executive role for Place2Be, a charity that provides mental health services in schools. She is currently a Trustee of Red Balloon Educational Trust, which provides alternative educational opportunities for young people who have self-excluded from school as a result of bullying.



Dr Ruth Jackson

Associate Non-Executive Director (until August '24) and then Non-Executive Director (from August '24)

Appointment: 12 February 2024

Term of Office: Expires 31 August 2027

A Non-voting member of the Board (from August '24), Ruth began her career in clinical practice as a nurse before becoming a midwife working in Colchester. She moved into higher education in Anglia Ruskin University where she completed a Masters and a Doctorate. During this time she held a range of senior roles including Director of the Post Graduate Medical Institute and Pro Vice Chancellor and Dean Faculty of Medical Science. Ruth was the Pro Vice Chancellor for the development of the School of Medicine at Anglia Ruskin University working with colleagues across Essex, regionally and nationally to establish a new medical school Chelmsford in 2018.

Ruth returned to the NHS in 2020 where she held the role of Executive Chief People Officer for the Mid and South Essex Integrated Care

Board, here she led on workforce and educational strategy for the system.

Ruth has a passion for education and research and the benefits they can bring for our staff and the health and wellbeing of our population. Her understanding of systems and the importance of cross sector collaboration gives her a unique perspective on the challenges and opportunities that lie ahead.

Executive Directors



Paul Scott
Chief Executive Officer
Appointment: September 2020

A voting member of the Board, Paul has extensive experience at board level and across the NHS. He held the position of Chief Financial Officer at Cambridge University Hospitals Foundation Trust, where he also led system development and integration. Prior to this, he was Executive Director of Finance, Strategy and Performance at The Ipswich Hospital NHS Trust, where he was responsible for leading long-term partnerships as well as information and IT.

He previously held senior roles in the East of England Ambulance Service and at Mid Essex Hospital Services NHS Trust. Paul is motivated by improving the way our health and care services work in partnership to deliver improvements to the services we provide.

Paul represented mental health and community services at the Mid and South Essex Integrated Care Board.



Alex Green
Executive Chief Operating Office (Deputy CEO)
Appointment: December 2020

A voting member of the Board, Alex Green was appointed as Executive Chief Operating Officer in December 2020.

Her portfolio of services includes mental health services, community physical health and learning disabilities across the Trust.

Previously she was the Director of Health and Care Delivery for West Essex at EPUT and Essex County Council. She has a wealth of experience having worked in health and social care for more than 25 years.

Alex represents EPUT on the Hertfordshire and West Essex

Integrated Care Partnership.



Dr. Milind Karale
Executive Medical Director
Appointment: August 2017

A voting member of the Board, Dr Karale is a Consultant Psychiatrist, the Trust's Caldicott Guardian and Executive Medical Director on the Board of Directors for EPUT.

After completing his specialist training in Psychiatry from Cambridge and Eastern Deanery, Dr Karale joined as a Consultant Psychiatrist in 2007. He has worked as a Consultant Psychiatrist in various services including Inpatient Psychiatric Unit, Assertive Outreach team, Mental health Assessment Unit, Community Mental Health Team, Crisis team, Essex rTMS service and he currently provide clinical input into the Community Mental Health Team in Loughton, Essex.

Dr Karale is a Fellow of the Royal College of Psychiatrists and has a Postgraduate Diploma in Clinical Forensic Psychiatry (merit) from the Institute of Psychiatry at Maudsley. He has been involved in medical management for the last twelve years, working as Clinical Director for Clinical Governance, Deputy medical Director and Medication Director from 2012. As the Responsible Officer, he is responsible for the performance of doctors with prescribed connection to EPUT.



Nigel Leonard
Executive Director of Major Projects and Programmes
Appointment: August 2017

A voting member of the Board, Nigel Leonard is Executive Director of Major Projects and Programmes on the Board of Directors for EPUT.

Nigel has worked in the NHS for over 30 years in a variety of planning, governance and project management roles in acute, community and mental health organisations. He has work as a Programme Director delivering changes in mental health services in Essex and recently led the roll out of the Covid-19 Vaccination Programme across Mid & South Essex and Suffolk & North East Essex Clinical Commissioning Groups.

Nigel is a qualified company secretary and has an MSc in project management. He is also a member of the Association of Project Management.



Andrew McMenemy
Executive Chief People Officer
Appointment: May 2024

Prior to joining EPUT, Andrew was Chief People Officer at West Hertfordshire Teaching Hospitals NHS Trust for over four years. Andrew has extensive experience in the health and care service with a career spanning over 28 years, where he has worked on four trust boards in an executive role. He is a graduate of law and human resource management at University in Scotland and the US.

Andrew is passionate about developing inclusion, well-being and staff development in the NHS. His portfolio includes Human Resources, Organisational Development, Payroll, Medical Staffing, Training and Development, Workforce Planning and Equality and Diversity.



Ann Sheridan
Executive Chief Nurse
Appointment: 01 August 2023

A voting member of the Board, Ann brings a wealth of experience to EPUT, with a dual qualification in general and mental health nursing, an MSc in Social Work and more than 30 years' experience working in a range of health and care settings.

Ann joins us from Central and North West London Foundation Trust where she was Managing Director of Divisional Mental Health Services.



Trevor Smith
Executive Chief Finance and Resource Officer (Deputy CEO)
Appointment: September 2020

A voting member of the Board, Trevor has worked as an executive director across a range of NHS services for more than 22 years.

Before joining EPUT, Trevor was Deputy Chief Executive and Chief Finance Officer at Princess Alexandra Hospital NHS Trust (PAH). During his time there Trevor actively supported PAH's financial and quality improvements as well as securing funding for the hospital redevelopment.

Trevor's portfolio includes business development, contracting, finance, estates and facilities.



Denver Greenhalgh
Senior Director of Governance and Corporate Affairs
Appointment: February 2022

A non-voting member of the Board, Denver has worked in the NHS for 30 years. She began her career as a newly qualified podiatrist and then, working as a senior clinician specialising in clinical biomechanics.

Her first leadership role was as a District Chief Podiatrist in 2002, since then she has worked in operational management and leadership roles in both community and hospital based services. Denver has an MSc in Integrated Healthcare Governance and has been a Director of Governance for the past 9 years. Prior to joining EPUT, she was Director of Governance at East Suffolk and North Essex NHS Foundation Trust.



Zephan Trent
Executive Director of Strategy, Transformation and Digital
Appointment: April 2022

A non-voting member of the Board, prior to joining EPUT Zephan was Director of Strategy Transformation / Locality Director at NHS England, where his responsibilities included the regional mental health programme, the regional learning disability and autism programme, Integrated Care System development, and Strategic change.

Zephan has a wide range of experience from senior roles in the NHS including strategy and policy development, strategic finance, transformation, analytics and business intelligence (information).

Zephan has a joint role with Mid and South Essex Foundation Trust Board of Directors as a non-voting Chief Strategy and Transformation Officer.



Marcus Riddell
Interim Executive Director of People and Culture
Appointment: 01 January 2024 – 12 May 2024

A voting member of the Board, Marcus held the position of Interim Chief People Officer at Essex Partnership University NHS Foundation Trust, having previously served as Deputy Chief People Officer/Director of Workforce and Senior Director for Organisational Development.

Prior to this, he was Director for Strategic Partnerships at NHS Professionals, a role that followed a series of Deputy Director roles at NHS England and NHS Improvement. During the pandemic, Marcus was Head of the Covid-19 Risk Assessment Delivery Unit, Head of Staff Covid-19 vaccinations uptake, and Head of Equality and Inclusion – Evidence and Policy.

All Board members are required to disclose their relevant interests as defined in the Trust's constitution. These are recorded in a publicly available register. A copy of the register is available on our website, by contacting the Trust Secretary's Office at Trust Head Offices, The Lodge, Lodge Approach, Wickford, Essex, SS11 7XX or by emailing epunft.trust.secretary@nhs.net

Responsibilities of directors for preparing the Annual Report and Accounts

The Directors are required under the NHS Act 2006, and as directed by NHS England, to prepare accounts for each financial year. NHS England, with the approval of HM Treasury, directs that these accounts shall show and give a true and fair view of the NHS Foundation Trust's gains and losses, cash flow and financial state at the end of the financial year.

NHS England further directs that the accounts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury. In preparing these accounts, the Directors are required to:

- Apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Annual Reporting Manual issued by NHS England
- Make judgements and estimates which are reasonable and prudent, and ensure the application of all

relevant accounting standards and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts

The Directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for published accounts.

The Directors are responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors are required to confirm that:

- As far as they are aware, there is no relevant information of which the Trust's auditor is unaware

- They have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the auditor is aware of that information.

The Directors confirm, to the best of their knowledge and belief, they have complied with the above requirement in preparing the accounts.

The Directors consider that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

NHS England's Well Led Framework

The Well-led Framework distils the favourable characteristics required to ensure the provision of quality services.

As part of the system support associated with our oversight rating an independent well-led development review was conducted by NHS England's National Recovery Support team, to provide the Trust with an objective view against the CQC well-led quality statements detailed in the Single Assessment Framework published in April 2024. This review occurred between April and July 2024. It encompassed the governance arrangements and made the following recommendations under each quality statement:

- **Shared direction and culture**
Continue to focus on culture across the organisation with a focus on the areas which are outliers and

consider how best to undertake a culture review.

To ensure adequate visibility across the services provide a clear feedback loop to staff and publish a calendar of visits / walkabouts so that staff know about the visits.

Ensure the narrative on senior management decisions pertaining to improving the trust's financial position is clearly communicated, with messaging balancing clarity around the trust's financial position and articulating how given changes will support improvements.

- **Capable, compassionate and inclusive leaders**

In line with continuing to mature care units, develop a robust development plan for care unit leaders, including succession planning.

Consider whether there is a need to review and provide further clarity on roles and responsibilities for quality, workforce and operational duties within care units (following the introduction of leadership triumvirate).

Review and streamline communication to staff.

- **Freedom to Speak Up (FTSU)**

In line with planned work, improve the follow through and feedback of FTSU concerns to staff.

- **Workforce equality, diversity and inclusion**

In order to retain its diverse workforce, the trust should work collaboratively with system partners to design and implement a campaign to raise awareness and

promote 'zero tolerance to racism' against NHS staff. With further opportunities to review the trust induction programme and include awareness around cultural sensitivities.

Consider working with system partners to expand the roll out of the RISE programme.

Review the content of training programme for middle managers and ward managers to enhance impact of sessions delivered to make it more meaningful.

- **Governance, management and sustainability**

Strengthen the accountability framework meetings, supported with clear data and outcome measures; and ensuring consistent attendance at these meetings.

Foster a culture of using data to drive continuous improvement at every level of the organisation. Continue aligning an IPR to the new quality of care strategy, enabling data driven discussions at the relevant meetings.

Review induction packs to ensure training on incident reporting is included for new starters.

- **Partnerships and communities**

Review and continue to extend the scope of peer support workers. Ensure there is clarity of where peer support workers are placed and how their well-being is maintained. Ensure this is communicated to staff.

Consider including patient and carers in quality service reviews,

including in co-producing a meaningful set of patient experience metrics.

To strengthen the patient voice within the organisation, consider extending the care group leadership team to include a service user representative.

Share the good examples of system working, especially falls care and new EPR development.

- **Learning, improvement and innovation**

Review the organisational QI strategy, including capability, capacity, training and support to care units to drive improvement initiatives.

Have mechanisms to regularly design/develop and test the implementation of actions and policies and ensure this is shared with staff and leaders.

- **Environmental sustainability – sustainable development**

No recommendations made for this quality statement.

An action plan was developed and progress will be monitored twice a year through Board seminar.

We continue to use the accountability framework introduced in 2021/22 as an executive management system to oversee performance and gain assurance in an integrated, consistent and transparent way of our operational service directorates. The framework covers five domains:

- Quality and safety
- Operational performance

- Workforce and culture
- Finance and use of resources
- External relations.

We hold our teams to account for being Well-led through the Accountability Framework and throughout 2024/25 we continued to mature this approach.

Remuneration Report

Introduction

This section covers the remuneration of the most senior managers of the Trust – those people who have the authority and responsibility for controlling the major activities of the Trust. In effect, this means the Board of Directors, including both executive directors (including the Chief Executive Officer), non-executive directors (including the Chair) and any other director in attendance at Board meetings.

Information is also provided about the Remuneration Committees, the policy on remuneration and detailed information about the remuneration of the Executive and non-executive directors of the Trust.

Annual Statement on Remuneration

Executive directors (including the Chief Executive Officer)

The Board of Directors Remuneration and Nominations Committee has delegated responsibility to review and set the remuneration, allowances and other terms and conditions of the executive directors (including the Chief Executive Officer). The Trust's executive directors have the authority and responsibility for directing and controlling major activities of the Trust.

The remuneration policy for the executive directors ensures remuneration is consistent with market rates for equivalent roles in other NHS foundation trusts of comparable size and complexity. It also takes into account the performance of the Trust, comparability of employees holding national pay and conditions of employment, pay awards for senior roles elsewhere in the NHS and pay/price changes in the broader economy and any changes to individual roles and responsibilities, as well as overall affordability. Decisions regarding individual remuneration are made with due regard to the size and complexity of the senior managers' portfolios of

responsibility. In setting the remuneration levels, the Committee balances the need to attract, retain and motivate directors of the quality required.

The executive directors' salary is a 'spot' salary within an agreed remuneration framework.

The Trust follows the NHS England guidance of pay for very senior managers (VSMs) in NHS Trusts and Foundation Trusts issued in March 2018.

The Trust does not make termination payments to Executive Directors which are in excess of contractual obligations. There have been no such payments during the past year.

The Committee refers to the NHS Providers' annual salary benchmarking survey analysis, together with publicly available information about trends within the NHS and the broader economy.

Non-executive directors (including the Chair)

The Council of Governors Remuneration Committee has delegated responsibility to recommend to the Council of Governors the remuneration levels for the non-executive directors (including the Chair), including allowances and the other terms and conditions of office in accordance with all relevant legislation and regulations. The remuneration levels for all appointments take into account the NHS England remuneration structure for non-executive directors (November 2019).

In reviewing the remuneration of the Chair and non-executive directors, the Committee balances the need to attract, retain and motivate directors of the quality and with the appropriate skills and experience required on the Board to meet current and future business needs without paying more than is necessary and at a level which is affordable to the Trust.

The remuneration policy for the Trust's non-executive directors is to ensure remuneration is consistent with market rates for equivalent roles in foundation trusts of comparable size and complexity, taking account of NHS Providers' annual salary benchmarking survey analysis and NHS England guidance. It also takes into account the pay and employment conditions of staff in the Trust, the performance of the Trust, and the time commitment and responsibilities of the non-executive directors and Chair, as well as succession planning requirements.

The Chair and non-executive directors are entitled to receive remuneration only in relation to the period for which they hold office; there is no entitlement to compensation for loss of office.

Decisions made during 2024/25

During the year, the Board of Directors Remuneration and Nominations Committee agreed (in respect of remuneration business):

- Approval of the quarterly contractual payments for the Chief Executive Officer on the basis of achievement of objectives
- Approval of the joint appointment of the Executive Director of Strategy, Transformation and Digital to the role of Chief Strategy and Transformation Officer at Mid and South Essex Foundation Trust (MSEFT) as a secondment for a 12-month period. This included approval of a responsibility allowance for the duration of the secondment to be equally paid by EPUT and MSEFT.
- Approval of a 5% pay award for Very Senior Managers as recommended by NHS England.

During the year, the Council of Governors Remuneration agreed (in respect of remuneration business):

- Approval of the remuneration of the incoming Chair of the Trust, due to commence in post from the 1 April 2025.



Hattie Llewelyn-Davies

Trust Chair
24 July 2025

On behalf of Professor Sheila Salmon, Trust Chair and Chair of the Board of Directors Remuneration and Nominations Committee and Council of Governors Remuneration Committee Essex Partnership University NHS Foundation Trust 2024/2025.

Senior Managers' Remuneration Policy

Remuneration package components

The executive directors' (including the Chief Executive Officer) remuneration package consists of salary and the entitlement to NHS pension benefits or a Retention Bonus Scheme should they have reached their lifetime allowance and opted to withdraw from the NHS Pension Scheme. The Chief Executive Officer's remuneration package includes an annual earn back component which the Remuneration and Nomination Committee will be required to authorise on a quarterly basis. Executive directors pay is inclusive of other payments such as overtime, long hours, on-call and stand by payments which do not feature in executive directors' remuneration.

Non-executive directors (including the Chair) are remunerated for an agreed number of days' work per month. There is no entitlement to the NHS pension scheme.

Remuneration package

Each executive director's salary is a 'spot' salary within an agreed remuneration framework. The salary levels are set to attract and retain appropriately skilled executives. In 2024/25, the Trust employed six executive directors on Very Senior Manager (VSM) terms and conditions who are paid more than £150,000.

In 2024/25, the Trust applied a five per cent salary increase to executive director salaries in line with the NHS England 2024/25 annual pay increase recommendation for Very Senior Managers (VSMs).

Remuneration package framework for executive directors (including the Chief Executive Officer)

The Trust follows the NHS England guidance on pay for Very Senior Managers (VSMs) in NHS Trusts and Foundation Trusts issued in March 2018. Thus, for any new appointments above the threshold of £150,000 per annum, the provisions within that guidance relating to "earn-back" and performance pay bonuses aligned to achievement of objectives agreed by the Board have been enacted.

Executive director contracts stipulate that if monies are owed to the Trust, the post-holder will agree to repay them by salary deduction or by any other method acceptable to the Trust. The Trust may withhold payment in circumstances of unauthorised absence. This policy applies to all executive directors. For the 2024/25 financial year, there are no instances of monies owed to or by the Trust in respect of executive directors.

Where an individual reached their lifetime allowance based on their NHS Pension entitlement the Trust operated a Retention Bonus Scheme. The scheme remains operating for previously approved and eligible staff, however, due to changes in lifetime allowance thresholds no new entrants to the scheme have been approved in the reporting period. Where eligible, the Trust makes a retention payment of 7.5% of an individual's basic salary which is taxable. Also as part of the scheme the Trust will award an additional five days paid annual leave earned in arrears for each six months of continued employment up to a maximum of ten days per financial year.

The key differences between the Trust's policy on executive directors' remuneration and its general policy on employees' remuneration are:

- **Salary** - The Trust appoints executive directors on a range of spot salaries within an agreed remuneration framework, i.e. salaries with no incremental progression.
- **Notice period** - Executive directors are expected to give six months' notice of termination of employment. This is in recognition of the need to have sufficient time to recruit a replacement or alternatively to appoint to a different post.
- **Pay review** - the Board of Directors Remuneration Committee determines whether or not to award cost of living pay awards to executive directors.

Chief Executive Officer remuneration terms includes a non-recurrent "earn-back" which is subject to achieving objectives set and overseen by the Board of Directors Remuneration and Nomination Committee.

Non-executive directors (including the Chair)

The remuneration policy for the Trust's Non-executive directors is to ensure remuneration is consistent with market rates for equivalent roles in Foundation Trusts of comparable size and complexity. The policy takes into account the *Structure to align remuneration for chairs and non-executive directors of NHS trusts and foundation trusts* published by NHS England in November 2019, whilst maintaining the ability for governors to

set the remuneration levels of the Chair and non-executive directors. The remuneration levels take into account the pay and employment conditions of staff in the Trust, the performance of the Trust and the time commitment and responsibilities of non-executive Directors and Chair, as well as the skills, knowledge and experience required of the Board to meet business needs and succession planning.

Service contract obligations

The Trust is obliged to give executive directors six months' notice of termination of employment, which matches the notice expected of executive directors from the Trust. The Trust does not make termination payments beyond its contractual obligations, which are set out in the contract of service and related terms and conditions. Executive directors' terms and conditions, with the exception of salary, shadow the national Agenda for Change arrangements, inclusive of sick pay and redundancy arrangements and do not contain any obligations above the national level.

Policy on payment for loss of office

Executive directors' service contracts contain a requirement for the Trust to provide six months' notice of termination to directors. In turn, it requires Executive directors to provide six months' notice to the Trust if they resign from its service. The Trust retains the right to make payment in lieu of the notice period, be it in part or for the whole period, where it considers it is in the Trust's interest to do so. Any decision would be taken by the Board of Directors Remuneration and Nominations Committee.

Executive directors are covered by the same policy in terms of conduct and capability as other Trust staff. If found to have engaged in gross misconduct or committed any act or omission which breaches the trust and confidence of the Trust, they can be summarily dismissed, i.e. their contract would be terminated without notice and/or compensation. In cases of termination due to organisational change, Executive Directors are covered by the national Agenda for Change arrangements for redundancy for NHS staff. This states that one month's pay will be provided for each complete year of reckonable service in the NHS without a break of 12 months or more. Limits are set on this payment. A month's pay for this purpose is subject to a total annual earnings floor of £23,000 and a cap of £80,000. The payment cannot exceed a maximum of 24 months' pay.

Statement of consideration of employment conditions elsewhere in the Trust

The Trust's Board of Directors Remuneration and Nominations Committee carries out an annual review of pay and terms and conditions for executive directors. This includes having regard to salary and the remuneration package as a whole. Salary levels are set taking into account the need to recruit and retain able directors and balancing that against a proper regard for use of public funds. In setting salary levels, the Remuneration Committee satisfies itself that the salary is competitive with other NHS providers of a similar constitution. The Remuneration and Nominations Committee will also review the pay progression framework in light of the current and emerging economic environment. There is no performance

based progression in place in the Trust, although performance is managed by a robust appraisal and supervision framework. Executive directors are subject to capability arrangements including annual appraisal and 360 degree appraisal feedback.

Annual report on remuneration

This section covers the remuneration of the most senior managers of the Trust – those people who have the authority and responsibility for controlling the major activities of the Trust. In effect, this means the Board of Directors, including both executive directors (including the Chief Executive Officer), non-executive directors (including the Chair) and those in attendance at the Board.

Information is also provided about the Remuneration Committees, the policy on remuneration and detailed information about remuneration of the executive and non-executive directors of the Trust.

The Trust has two Remuneration Committees - the Board of Directors Remuneration and Nominations Committee and the Council of Governors Remuneration Committee.

Board of Directors Remuneration and Nominations Committee

Membership of the Committee wholly comprises non-executive directors who are viewed as independent, having no financial interest in matters to be decided. The Committee is chaired by the Trust Chair. The Chief Executive Officer will attend meetings of the Committee if invited to do so by the Chair of the Committee but may not receive any papers in relation to or be present when their remuneration or

conditions of service are considered. The Executive Chief People Officer will normally attend the meetings in an advisory capacity as required, depending on the agenda items to be discussed. The Senior Director of Corporate Governance (or their deputy) is the Committee Secretary. The Committee may commission independent professional advice if considered necessary. No consultants were commissioned during 2024/25 in respect of remuneration business. The Board of Directors Remuneration

and Nominations Committee has the responsibility for setting the remuneration of the executive directors. Details are included in the section above on Senior Managers Remuneration Policy.

The Committee meets when necessary but at least annually.

Members of the Committee and the number of meetings attended by each member during the year are set out below.

Table 13: Board of Directors Remuneration and Nominations Committee Membership and Meeting Attendance 2024/25

Name	Role	Meetings Attended (actual/possible)
Professor Sheila Salmon	Chair	4/4
Dr Rufus Helm	Non-Executive Director	0/1
Dr Ruth Jackson	Non-Executive Director	3/3
Dr Mateen Jiwani	Non-Executive Director	4/4
Diane Leacock	Non-Executive Director	4/4
Loy Lobo	Non-Executive Director	4/4
Elena Lokteva	Non-Executive Director	3/4
Jenny Raine	Non-Executive Director	1/3

The Committee was attended by the following individuals, who provided support and advice to the Committee during the year:

- Paul Scott, Chief Executive Officer
- Denver Greenhalgh, Senior Director of Governance and Corporate Affairs
- Andrew McMenemy, Executive Chief People Officer.

In addition to the considerations by the Committee listed under the Annual Statement of Remuneration on page 88 the Committee also:

- Received and noted the outcome of appraisals completed for the Executive Team (including the Chief Executive Officer), including the achievement of objectives and the establishment of new objectives for 2024/25.
- Received and noted the outcome of mid-year reviews completed for the Executive Team (including the Chief Executive Officer), including progress with achieving objectives for 2024/25.
- Received and noted action taken by the Chair in accordance with

Clause 3.5 of the CEO contract of employment, regarding approving direct engagement of the CEO in another business. This related to the setup of a limited company for taking forward their level 2 Integrated Development Coach qualification into practice.

- Received and noted the release of the Senior Director of Corporate Governance to undertake a secondment to the East of England Ambulance Service to provide governance support.

Council of Governors Remuneration Committee

The Council of Governors has delegated responsibility to its Remuneration Committee for assessing and making recommendations to the Council in relation to the remuneration, allowances and other terms and conditions of office for the Chair and all non-executive directors.

In addition, the Committee leads on the process to receive assurance on the performance evaluation of the Chair, working with the Senior Independent

Director, and Non-Executive Directors, working with the Chair.

The Committee is chaired by the Lead Governor and may, as appropriate, retain external consultants or commission independent professional advice. In such instances, the Committee will be responsible for establishing the selection criteria, appointing and setting the terms of reference for remuneration consultants or advisers to the Committee.

No consultants were commissioned during 2024/25. At the invitation of the Committee, the Executive Chief People Officer and Senior Director of Corporate Governance will attend the meeting in an advisory capacity.

The Assistant Trust Secretary is the Committee Secretary. The Committee meets when necessary but at least annually.

Members of the Committee and the number of meetings attended by each member during the year are set out below.

Table 14: Council of Governors Remuneration Committee Membership and Meeting Attendance

Name	Role	Meetings Attended (actual/possible)
John Jones	Lead Governor	3/3
Dianne Collins	Public Governor	2/3
David Finn	Public Governor	3/3
Paula Grayson	Public Governor	3/3
Pam Madison	Public Governor	3/3

In addition to the considerations by the Committee listed under the Annual Statement of Remuneration on page 88 during the year the Council of Governors Remuneration Committee:

- Received assurance that the end of year appraisal process for Non-Executive Directors for 2023/24 had been satisfactorily completed in line

with the performance review process agreed by the Council of Governors.

- Received assurance that appropriate objectives for 2024/2025 for the Chair and non-executive directors were in place.
- Approved a recommendation to the Council of Governors for a non-executive director to act as non-executive director of another NHS Body.
- Approved the procedure for the establishment of levels of remuneration of the Chair and Non-Executive Directors.

Table 15: Service contracts: Executive directors

Name	Role	Contract Start Date at Predecessor Trusts	Interim Board Contract Start Date	Substantive Board Contract Start Date
Paul Scott	Chief Executive Officer	n/a	n/a	24-Aug-20
Alex Green	Executive Chief Operating Officer	n/a	n/a	10-Dec-20
Denver Greenhalgh	Senior Director of Governance	n/a	n/a	14-Feb-22
Dr Milind Karale	Executive Medical Director	30-Jul-12	01-Apr-17	25-Aug-17
Nigel Leonard	Executive Director of Major Projects and Programmes	01-Feb-14	01-Apr-17	25-Aug-17
Andrew McMenemy	Executive Chief People Officer	n/a	n/a	13-May-24
Marcus Riddell	Interim Executive Director of People and Culture (contract end 12/05/2024)	n/a	n/a	n/a
Ann Sheridan	Executive Nurse	n/a	n/a	09-Feb-24
Trevor Smith	Executive Director of Finance and Resources	n/a	n/a	18-Sep-20
Zephan Trent	Executive Director Strategy, Transformation and Digital	n/a	n/a	01-Apr-22

Table 16: Service contracts: Non-executive directors

Name	Role	Period of Office	Start Date	End Date
Professor Sheila Salmon	Chair	7-years	01-Nov-17	31-Mar-25
Dr Rufus Helm	NED	6-years	24-Jul-18	30-Jul-24
Dr Ruth Jackson	NED (Associate until 01-Aug-24)	3-years	12-Feb-24	12-Feb-27
Dr Mateen Jiwani	NED	6-years	18-Jan-21	18-Jan-27
Diane Leacock	NED	2-years	04-Dec-23	04-Dec-25
Loy Lobo	NED / Deputy Chair	6-years	31-Mar-21	31-Mar-27
Elena Lokteva	NED	3-years	20-Feb-23	20-Feb-26
Jenny Raine	NED (Associate from 03-Oct-24)	1 year, 4-months	02-Jan-24	31-May-25

Table 17: Non-executive directors' remuneration

Name	Role	Remuneration £0	Working Days	Additional Fees £0
Professor Sheila Salmon	Chair	51-55	11 per month	Nil
Dr Rufus Helm	NED	15-20	4 per month	Nil
Dr Ruth Jackson	NED (Associate until 01-Aug-24)	15-20	4 per month	Nil
Dr Mateen Jiwani	NED	15-20	4 per month	Nil
Diane Leacock	NED	15-20	4 per month	Nil
Loy Lobo	NED / Deputy Chair	15-20	4.5 per month	Nil
Elena Lokteva	NED	15-20	4.5 per month	Nil
Jenny Raine	NED (Associate from 03-Oct-24)	15-20	4 per month	Nil

Executive directors participating in Trust’s Retention Bonus Scheme

Table 18

		Total Pay including salary and pension benefits		
Nigel Leonard	Executive Director of Major Projects and Programmes	24/25	23/24	22/23
		185-190	170-175	165-170

Executive and non-executive directors’ expenses

Total Executive and Non-Executive Directors expenses paid by the Trust during 2024/25 was £10,879 and were claimed by 16 directors (2023/24: £9,660 claimed by 16 directors).

Table 19: Senior Managers Pay (Subject to audit)

		2024/25							
		Salary1	Other Remuneration2	All Taxable Benefits	Annual Performance Related Bonus3	Long Term Performance Related Bonuses	All Pension Related Benefits4	Exit Package	Total
		£000	£000	£	£000	£000	£000	£000	£000
Paul Scott	Chief Executive	210 - 215	0	700	10 - 15	0	62.5 - 65.0	0	285 - 290
Alexandra Green	Executive Chief Operating Officer	170 - 175	0	0	0	0	45.0 - 47.5	0	220 - 225
Trevor Smith	Executive Chief Finance Officer	175 - 180	0	0	0	0	15.0 - 17.5	0	190 - 195
Dr Milind Karale	Executive Medical Director	230 - 235	20 - 25	900	0	0	180.0- 182.5	0	430 - 435
Nigel Leonard	Executive Director of Major Projects & Programmes	185 - 190	0	0	0	0	0	0	185 - 190
Ann Sheridan	Executive Director of Nursing	145 - 150	0	0	0	0	62.5 - 65.0	0	210 - 215
Zephan Trent	Executive Director of Strategy, Transformation & Digital (from 01/09/24, shared post with MSEFT 50:50)	120 - 125	0	0	0	0	40.0 - 42.5	0	160 - 165
Marcus Riddell	Acting Executive Director of People & Culture (until 12/05/2024)	15 - 20	0	0	0	0	22.5 - 25.0	0	35 - 40
Andrew McMenemy	Executive Director of People & Culture (from 13/05/2024)	135 - 140	0	0	0	0	185.0 - 187.5	0	325 - 330
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	145 - 150	0	0	0	0	12.5 - 15.0	0	160 - 165
Professor Sheila Salmon	Chair	50 - 55	0	0	0	0	0	0	50 - 55
Loy Lobo	Vice Chair	15 - 20	0	0	0	0	0	0	15 - 20
Diane Leacock	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Dr Mateen Jiwani	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Dr Ruth Jackson	Non-Executive Director	10 - 15	0	0	0	0	0	0	10 - 15
Elena Lokteva	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Jenny Raine	Associate Non-Executive Director	5 - 10	0	100	0	0	0	0	10 - 15
Rufus Helm	Non-Executive Director (until 01/08/2024)	5 - 10	0	0	0	0	0	0	5 - 10

Table 20: Comparative table showing salary and allowances of senior managers

		2023/24							
		Salary1	Other Remuneration2	All Taxable Benefits	Annual Performance Related Bonus3	Long Term Performance Related Bonuses	All Pension Related Benefits4	Exit Package	Total
		£000	£000	£	£000	£000	£000	£000	£000
Paul Scott	Chief Executive	200 - 205	0	0	5 - 10	0	0	0	205 - 210
Alexandra Green	Executive Chief Operating Officer	160 - 165	0	0	0	0	37.5 - 40.0	0	200 - 205
Trevor Smith	Executive Chief Finance Officer	165 - 170	0	0	0	0	0	0	165 - 170
Dr Milind Karale	Executive Medical Director	205 - 210	15 - 20	0	0	0	202.5 - 205.0	0	430 - 435
Nigel Leonard	Executive Director of Major Projects & Programmes	170 - 175	0	0	0	0	0	0	170 - 175
Ann Sheridan	Executive Director of Nursing (from 09/02/2024)	20 - 25	0	0	0	0	70.0 - 72.5		90 - 95
Frances Bolger	Interim Executive Director of Nursing (01/08/2023 to 31/03/2024)	65 - 70	0	0	0	0	17.5 - 20.0	0	85 - 90
Zephan Trent	Executive Director of Strategy, Transformation & Digital	160 - 165	0	0	0	0	35.0 - 37.5	0	195 - 200
Sean Leahy	Executive Director of People & Culture (until 02/07/2023)	40 - 45	0	0	0	0	0	0	40-45
Marcus Riddell	Acting Executive Director of People & Culture (April 2023, January to March 2024)	45 - 50	0	0	0	0	42.5 - 45.0	0	90 -95
Susan Young	Acting Executive Director of People & Culture (16/08/2023 to 14/02/2024)	60 - 65	0	0	0	0	27.5 - 30.0	0	90 - 95
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	140 - 145	0	0	0	0	0	0	140 - 145
Professor Sheila Salmon	Chair	50 - 55	0	0	0	0	0	0	50 - 55
Loy Lobo	Vice Chair	15 - 20	0	0	0	0	0	0	15 - 20
Diane Leacock	Non-Executive Director (from 04/12/2023)	5 - 10	0	0	0	0	0	0	5 - 10
Dr Mateen Jiwani	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Elena Lokteva	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20

		2023/24							
		Salary ¹	Other Remuneration ²	All Taxable Benefits	Annual Performance Related Bonus ³	Long Term Performance Related Bonuses	All Pension Related Benefits ⁴	Exit Package	Total
		£000	£000	£	£000	£000	£000	£000	£000
Jenny Raine	Associate Non-Executive Director (from 02/01/2024)	0 - 5	0	0	0	0	0	0	0 - 5
Rufus Helm	Non-Executive Director	15 - 20	0	0	0	0	0	0	15 - 20
Manny Lewis	Non-Executive Director / Vice Chair	15 - 20	0	0	0	0	0	0	15 - 20
Janet Wood	Non-Executive Director (until 30/09/23)	5 - 10	0	0	0	0	0	0	5 - 10
Professor Stephen Heppell	Non-Executive Director (until 11/03/24)	10 -15	0	0	0	0	0	0	10 -15

Note 1 - Due to the demands and challenges placed on the NHS many staff, although encouraged to do so, were unable to take their full annual leave entitlement. The Trust made the decision to give staff the opportunity to sell some of their annual leave, which two executive directors opted to do so (2023/24: two directors). This has increased their salary in excess of the agreed pay award.

Note 2 – The Medical Directors salary has been split to show the value of clinical excellence awards separately to salary.

Note 3 - When appointed in August 2020, the externally agreed salary package for the Chief Executive contained a contractual non-pensionable quarterly element of £2,500 dependent upon successful delivery against objectives, as determined by review undertaken by the Board of Directors Remuneration and Nominations Committee.

During the year, the Remuneration Committee reviewed the performance of the CEO against agreed objectives, and approved the payment of contractual non pensionable pay totalling £12,500 including £5,000 for the previous financial year.

Note 4 - The value of pension benefits accrued during the year (column entitled 'all pension related benefits' in the Senior Manager Pay Table above), is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Total pension entitlement

Table 21: Total pension entitlement (subject to audit) 2024/25

		2024/25						
		Real increase in pension at pension age £000	Real increase in lump sum at pension age £000	Total accrued pension at pension age at 31 March 2025 £000	Lump sum at pension age related to accrued pension at 31 March 2025 £000	Cash equivalent transfer value at 31 March 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2025 £000
Paul Scott	Chief Executive	2.5 - 5.0	5.0 - 7.5	60 - 65	165 - 170	1,212	0	1,171
Alexandra Green	Executive Chief Operating Officer	2.5 - 5.0	0	30 - 35	0	431	41	522
Trevor Smith	Executive Chief Finance Officer	0.0 - 2.5	0	85 - 90	230 - 235	1,955	34	2,141
Dr Milind Karale	Executive Medical Director	7.5 - 10.0	15.0 - 17.5	70 - 75	185 - 190	1,423	201	1,748
Ann Sheridan	Executive Director of Nursing	2.5 - 5.0	0	35 - 40	0	526	58	639
Zephan Trent	Executive Director of Strategy, Transformation & Digital	0.0 - 2.5	0	5 - 10	0	67	6	108
Marcus Riddell	Acting Executive Director of People & Culture (until 12/05/2024)	0.0 - 2.5	0	10 - 15	0	134	0	160
Andrew McMenemy	Executive Director of People & Culture (from 13/05/2024)	7.5 - 10.0	15.0 - 17.5	55 - 60	140 - 145	947	163	1,215
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	0.0 - 2.5	0	60 - 65	160 - 165	1,294	20	1,424

Table 22: Comparative table showing total pension entitlement 2023/24

		2023/24 (Restated)						
		Real increase in pension at pension age £000	Real increase in lump sum at pension age £000	Total accrued pension at pension age at 31 March 2025 £000	Lump sum at pension age related to accrued pension at 31 March 2025 £000	Cash equivalent transfer value at 31 March 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2025 £000
Paul Scott	Chief Executive	0	17.5 - 20	50 - 55	150 - 155	952	138	1212
Alexandra Green	Executive Chief Operating Officer	2.5 - 5.0	0	25 - 30	0	308	70	431
Trevor Smith	Executive Chief Finance Officer	0	35.0 - 37.5	80 - 85	220 - 225	1612	157	1955
Dr Milind Karale	Executive Medical Director	7.5 - 10.0	70.0 - 72.5	55 - 60	150 - 155	875	433	1423
Ann Sheridan	Executive Director of Nursing (from 09/02/2024)	0.0 - 2.5	0.0 - 2.5	20 - 25	55 - 60	441	8	558
Frances Bolger	Interim Executive Director of Nursing (01/08/2023 to 31/03/2024)	0.0 - 2.5	0	0 - 5	0	0	6	23
Zephan Trent	Executive Director of Strategy, Transformation & Digital	2.5 - 5.0	0	5 - 10	0	24	20	67
Marcus Riddell	Acting Executive Director of People & Culture (April 2023, January to March 2024)	0.0 - 2.5	0	10 - 15	0	74	11	134
Susan Young	Acting Executive Director of People & Culture (16/08/2023 to 14/02/2024)	0.0 - 2.5	0	10 - 15	0	159	8	209
Denver Greenhalgh	Senior Director of Governance & Corporate Affairs	0	30.0 - 32.5	55 - 60	155 - 160	980	193	1294

The table of Senior Officer Total Pension Entitlements for 2023/24 has been restated as the format of the prior year disclosure did not meet the requirements of the NHS Foundation Trust Annual Reporting Manual. The restatement does not change the overall value of pension entitlements reported for senior officers, but it does separately disclose the increase in pension and pension lump sum, and the value of accrued pension and related lump sum to increase transparency of pension movements.

Fair pay multiple (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. HM Treasury guidance states that for the purpose of fair pay disclosures, 'employees' includes substantive, agency and other temporary staff, but not consultancy.

The banded remuneration of the highest paid Director in the Trust in the financial year 2024/25 was £250,000 to £255,000 (2023/24: £225,000 to £230,000). This is an increase between years of 10.4% (2023/24: 0.2% increase).

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value

of pensions.

For employees of the Trust as a whole, the range of annualised full time remuneration in 2024/25 was from £4,000 to £315,000 (2023/24: £3,000 to £276,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is an increase of 9.9%. Eleven employees (of which 9 are agency staff) have calculated remuneration in excess of the highest-paid director in 2024/25 (2023/24: 5 employees of which 2 are agency).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid Director (excluding pension benefits) and each point in the remuneration range for the Trust's workforce.

Table 23: 2024/25 pay ratio

	25 th Percentile	Median	75 th Percentile
Salary component of pay	£25,674	£32,324	£46,148
Total pay and benefits excluding pension benefits	£25,674	£32,324	£46,148
Pay and benefits excluding pension: pay ratio for highest paid director	10:1	8:1	5:1

Table 24: 2023/24 pay ratio

	25 th Percentile	Median	75 th Percentile
Salary component of pay	£24,336	£28,407	£42,618
Total pay and benefits excluding pension benefits	£24,336	£28,976	£42,894
Pay and benefits excluding pension: pay ratio for highest paid director	9:1	8:1	5:1

Loss of office payments (subject to audit)

The Trust did not make any payments to senior managers in respect of loss of office during 2024/25.

A handwritten signature in black ink, appearing to read 'P. Scott', with a stylized flourish at the end.

Paul Scott Chief Executive

Essex Partnership University NHS FT

24 July 2025

Staff Report

Staff Costs (Subject to audit)

During 2024/25, the Trust incurred total staffing costs of £414.2 million which can be analysed as follows between permanent staff and other staff:

Table 25: Staff costs 2024/25

	Permanent Staff £000	Other Staff £000	Total Staff £000
Salaries and Wages	303,191	4,368	305,263
Social Security Costs	32,417	-	32,417
Apprenticeship Levy	1,512	-	1,512
Pension Cost (employer contributions to NHS Pension Scheme)	35,356	-	35,356
Pension Cost (employer contributions paid by NHSE on provider's behalf at 9.4%)	23,114	-	23,114
Termination Benefits	93	-	93
Temporary Staff – agency / contract staff	-	16,524	16,429
Total Staff Costs	395,683	20,892	416,575

These total staff costs are categorised in note 6 to the annual accounts between employee expenses (staff and executive directors), research and development, education and training and redundancy and notes 10 and 11 as part of intangible assets and property, plant and equipment costs for the year.

Average Staff Numbers (subject to audit)

During 2024/25, the Trust employed an average of 7,508 staff as shown below.

Table 26: Average staff numbers 2024/25

	Permanent staff (WTE*)	Other staff (WTE*)	Total staff (WTE*)
Medical and Dental	296	81	377
Ambulance Staff	7	-	7
Administration and Estates	1,810	17	1,827
Healthcare Assistants and Other Support Staff	2,107	31	2,138
Nursing, Midwifery and Health Visiting Staff	2,042	93	2,135
Nursing, Midwifery and Health Visiting Learners	5	-	5
Scientific, Therapeutic and Technical Staff	873	19	892
Social Care Staff	125	2	127
Total average staff numbers	7,265	243	7,508

* WTE (Whole Time Equivalent) denotes the total number of hours of all post holders in the staff group (whether part-time or full-time) divided by the full-time hours of a role in the staff group. For example, a member of staff contracted to work 18.75 hours per week in a role with full time hours of 37.5 would constitute 0.5WTE.

Workforce Analysis

Our workforce profile is similar to many NHS Foundation Trusts in that 46 per cent of our staff are over the age of 46 and our workforce is predominantly female. This is detailed further in the table below:

Table 27: Workforce profile

Staff group:	Total	Gender		Age			
		Female	Male	<25	26-45	46-65	>65
Board of directors	16	8	8	0	2	13	1
Senior managers	47	30	17	0	13	31	3
Doctors and dentists	333	166	167	1	208	110	14
Nursing	2063	1648	415	65	896	1057	45
Other healthcare staff	2853	2238	615	189	1493	1118	53
Support staff	1889	1485	404	94	704	977	114
All employees	7201	5575	1626	349	3316	3306	230
Percentage		77.4%	22.6%	4.8%	46.0%	45.9%	3.2%

Table 28: Ethnic diversity

Percentage difference between Board voting members and its overall workforce			Percentage difference between the Board Executive membership and its overall workforce		
	White	BME		White	BME
Board Members	69.2%	30.8%	Board Members	88.9%	11.1%
Overall Workforce	66.4%	32.1%	Overall Workforce	66.4%	32.1%
Percentage Difference	2.8%	1.3%	Percentage Difference	22.5%	20.9%

Sickness Absence

In accordance with Treasury guidance, all public bodies must report sickness absence data on a consistent basis per calendar year, in order to permit aggregation across the NHS. The Trust is required to use the published

statistics, which are produced using data from the Electronic Staff Record (ESR) Data Warehouse. The latest publication, covering the period to November 2024, is available from the [NHS Digital Website](#).

Table 29: Sickness absence

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital	
Average FTE 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days
10,387	76,182	7.3	3,791,249	123,584

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2024

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

An average of 7.3 working days were lost per staff member in a 12-month period. This is a decrease on the previous year’s reported figures which reported an average of 18.9 days per FTE. The figures have been calculated on a 12-month basis between January 2024 to December 2024 based on the latest data available from NHS Digital. This data therefore does not fully align to the Trust’s financial year, which starts on 1st April 2024 and ends on 31 March 2025.

The Trust retains a focus on supporting the health and well-being of our

colleagues, with a dedicated page on the Trust’s intranet detailing the range of health and well-being resources available to colleagues and managers. The Trust has a Health and Well-being Toolkit for managers and colleagues to support self-care and compassionate manager conversations, individual wellness plans are a composite part of the Trust’s 1:1 Support Policy.

Where colleagues are absent from work for reasons of ill health, the Trust’s Management of Sickness and Ill Health Procedure ensures that arrangements are in place for the management of ill

health, and other absence, from work in a manner that minimises the impact of ill-health on both the worker and Trust services.

The Trust has a reasonable adjustments procedure and passport in place to ensure it meets its legal, moral and social obligations to make reasonable adjustments for people who are disabled or have a long term health condition in accordance with the requirements of the Equality Act 2010. Line managers are required to undertake sickness absence training as part of the Trust's management development programme, regular Sickness Task and Finish Groups are held within operational services, which are supported by a member of the Human Resources team to support managing employee wellbeing and sickness absence.

Turnover

For further details on the Trust's average turnover in 2024/25 please refer to data on the [NHS Digital Website](#).

Workforce Equality and Inclusion

We are committed to equality and inclusion within our services, as this is vital in supporting our diverse workforce and providing high quality care in EPUT:

- We are implementing the NHS EDI Improvement Plan, which outlines actions to enhance equality, diversity and inclusion within the NHS (2023 – 2026). This is also outlined in our People and Education strategy (2024 - 2028) with targets to improve the experiences of marginalised

populations within our organisation.

- Our Behavioural Framework supports this commitment to EDI and promotes an inclusive and equitable culture to all staff.
- Our Director of Organisational Development and Culture leads the delivery of EDI in EPUT, championed by our Executive Team who sponsor the implementation of actions in their services and each have EDI objectives within the organisation.
- A bi-monthly Equality and Inclusion Committee throughout the year drove inclusion across the Trust, with input from our five staff equality networks and senior leads across the organisation. The committee reported into our People and Culture Committee (PECC) for assurance, with key reports and interventions being raised and approved at Board level.
- We updated our Equality, Inclusion and Human Rights policy and procedure to provide additional guidance on how we as an organisation support marginalised groups, including staff:
 - Who are transgender, non-binary or undergoing gender reassignment
 - Who are experiencing racial abuse or discrimination
 - Who require reasonable adjustments for a disability or long-term condition
 - Who are unpaid carers alongside their role in EPUT.
- EPUT's Equality Advisor is part of the Conduct Concerns Panel in the Trust, ensuring that any formal disciplinary or formal capability are

reviewed to ensure that bias or discrimination do not influence the decisions of the Employee Relations team.

- Equality Impact Assessments are mandatory as part of EPUT policy and procedure and were approved by the Equality Advisor in EPUT.
- In line with the Public Sector Equality Duty, we publish workforce data and demographics, as well as regularly submit reports to NHS England and ensure this data is available to members of the public and our commissioners. The reports listed below are all available in full on our Trust internet page:
 - **WRES:** We have seen improvement in six out of the nine WRES Metrics.
 - **WDES:** We have seen improvement in nine out of the ten WDES Metrics.
 - **EDS:** We were graded a “developing organisation” with a possible 20 points out of 33 by stakeholders (patients, staff, external review).
 - **PSED:** We publish our workforce demographic data on a yearly basis.
 - **Pay Gap Reporting:** Our Gender Pay Gap has reduced by 4.5% from 2017 to present and is now 12.41%, EPUT is performing well in comparison with neighbouring providers, and our gap is below the national average.
- We updated our training in line with the Behavioural Framework to adopt an Active Bystander approach, empowering staff to recognise discrimination, challenge

it and support those affected. Our management training also provides guidance on supporting the protected characteristics of staff under the Equality Act, and ways that they can foster allyship within their teams.

Involvement and Recognition

The Trust is strengthening established recognition schemes, and introducing new initiatives to better recognise our workforce. 2024/25 has seen our thousandth nomination for the quarterly Staff Recognition Awards, where any member of staff can nominate a colleague or team in one of five categories. The Quality and Excellence awards were also held this year, recognising the dedication of our workforce in its efforts to deliver high quality patient care.

Our long service and retirement schemes are undergoing review, with a view of improving how we mark major milestones for colleagues with longer service in the NHS.

Efforts have also been made to raise the profile and recognition of individual teams, through ‘Living the NHS People Promise’ profiles. These have been well received and shared out through all-staff communications, and act as an additional mechanism for recognising how teams demonstrate the NHS People Promise.

The Trust has five active staff equality networks, with dedicated Communications, Employee Experience support, and Executive Sponsor who champions the network and supports its goals. These networks are key to us engaging our whole workforce in our ambition for an inclusive culture:

- Faith and Spirituality
- Ethnic Minority and Race Equality (*EMREN*)
- Disability and Mental Health (*including long term conditions and neurodiversity*)
- Lesbian, Gay, Bi, Trans and any other gender or sexual identity (*LGBTQ+*),
- Gender Equality (*GEN*).

Our Networks work collaboratively with the Equality Advisor to achieve the following in EPUT:

- Supporting our work to mitigate discrimination, harassment, and victimisation within the organisation, through sharing lived experience of staff members and encouraging participation.
- Advancing equality of opportunity by participating in focus groups and discussions to improve career development, flexible working and shortlisting of marginalised staff members. Collaboratively developing resources to empower and foster inclusive management of marginalised employees.
- Fostering good relations in our organisation by adopting an Active Bystander approach to challenging inappropriate or discriminatory behaviour, holding events throughout the year (*LGBTQ+ Pride, Black History Month, Disability History Month, NHS EDI Week*) to raise awareness of these groups, the difficulties they face and the importance of an inclusive workforce.

Staff Concerns

The Trust believes in the importance of raising concerns at work and is committed to encouraging workers to raise concerns openly and transparently as part of normal day to day practice and feels that this mechanism plays an important role in improving quality of service user support and patient safety, ensuring high quality and compassionate care is delivered.

It is an expectation that all staff will raise any concerns about safety, clinical practice, malpractice or wrong doing which may affect patients, the public, other staff or the organisation itself. At EPUT every manager has a duty to ensure that staff are able to express their concerns through all levels of management of the organisation. Managers must ensure that any staff concerns are dealt with thoroughly and fairly and that the staff member raising the concern does not receive any detrimental treatment as a result of raising their concern. Individual members of staff in the Trust have an obligation to safeguard all confidential information to which they have access, particularly information about individual service users or clients, which under all circumstances is strictly confidential, in line with the General Data Protection Regulation, 2016 (GDPR).

Freedom to Speak Up

At EPUT we aim to cultivate a working environment where we can all speak up about issues that concern us.

The Freedom to Speak Up (FTSU) movement supports the development of a safe, open culture for people to raise concerns about patient / worker safety or any issues getting in the way of performing ones role.

An additional FTSU Guardian has recently joined the trust to help support the Principal Freedom to Speak Up Guardian and service; which is an additional safety net to other day-to-day reporting routes. The Guardian is supported by an executive director, non-executive director and senior leaders.

As the message around the importance of Speaking Up, 'everyone has a voice' and 'what we do together matters' becomes embedded, so too has the number of people speaking up through the FTSU service and the type of issues they are raising.

Table 30: Freedom to Speak Up activity 2024/25

	People Speaking Up	Patient Safety	Worker Safety / well-being	Bullying & Harassment	Inappropriate Behaviours / attitudes	Spoke Up as Anonymous
Q1	59	9	22	7	29	11
Q2	72	12	24	6	20	24
Q3	70	14	34	2	36	22
Q4	63	15	20	11	26	20
Total	264	50	100	26	111	77

NB: Other issues are raised through FTSU than the broad themes captured here

Informing and Consulting with Staff

The Trust has in place a Joint Partnership Agreement that establishes the principles of partnership working between the Trust and its recognised Trade Unions and local staff side representatives. The agreement provides a recognised means of consultation and negotiation to ensure co-operation between the parties on matters of mutual concern with a view to the promotion of the best interests of our workforce.

The Trust informs, listens and negotiates with its recognised Trade Unions through a Joint Partnership Committee (JPC), which meets monthly, and a Joint Local Negotiating Committee (JLNC), for medical and dental staff, which meets bi-monthly.

Both committees have local and regional representative attendance and discuss the strategic overview of the

workforce, policies, quality service delivery and service transformation. The Trust also has in place a Policy Sub-Committee, which meets monthly to review and agree policies and procedures in partnership for ratification.

The Trust has in place a robust Organisational Change Policy, reviewed and updated in March 2024 in partnership with staff side representatives, which establishes a framework for common understanding of the change management process for management, staff and staff side representatives. The core principles, which underpin the Trust's practice in the management of organisational change, are:

- Consulting and communicating in meaningful way
- Maximising staff involvement and participation in the process of change

- Ensuring decision making is based on clear, consistent and fair criteria
- Implementing measures aimed at avoiding redundancy wherever possible
- Ensuring equality of opportunity for staff, through the application of best practice in relation to employment law
- Recognising the abilities, range of experience and competencies of all staff
- Providing opportunities for support and development of staff.

NHS Staff Survey

The NHS Staff Survey, is conducted annually, benchmarks EPUT against other NHS Trusts of a similar type. Survey questions align to the seven elements of the NHS People Promise, with engagement and morale as two additional elements.

In 2024, response rate was 41.47% against a median of 54% for peer organisations in our Benchmark Group.

This is a decrease in response rate compared with prior years (2021: 46.41%, 2022: 42.11%, 2023: 43.67%).

Scores for each indicator together with that of the survey benchmark group (Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts) are presented below (Table 31).

Indicators (‘People Promise’ elements and themes)	2024/25		2023/24		2022/23	
	Trust Score	Benchmark Group Score	Trust Score	Benchmark Group Score	Trust Score	Benchmark Group Score
People Promise:						
We are compassionate and inclusive	7.46	7.55	7.56	7.58	7.49	7.50
We are recognised and rewarded	6.31	6.35	6.37	6.41	6.22	6.30
We each have a voice that counts	6.86	6.94	6.99	7.01	6.90	7.00
We are safe and healthy	6.30	6.40	6.46	6.39	6.23	6.20
We are always learning	5.97	5.93	5.96	5.93	5.74	5.70
We work flexibly	6.78	6.83	6.85	6.84	6.77	6.70
We are a team	7.11	7.15	7.21	7.18	7.09	7.10
Staff engagement	6.97	7.07	7.17	7.11	7.04	7.00
Morale	6.13	6.20	6.29	6.17	6.12	6.00

Of the nine Staff Survey elements, EPUT performed below average compared with the Benchmark Group Average, and performed above average in the NHS People Promise 'We are Always Learning'. Of the nine Staff Survey elements, EPUT performed below average compared with the Benchmark Group Average, and performed above average in the NHS People Promise 'We are Always Learning'.

Five priorities have been identified to improve staff experience across all areas of the organisation:

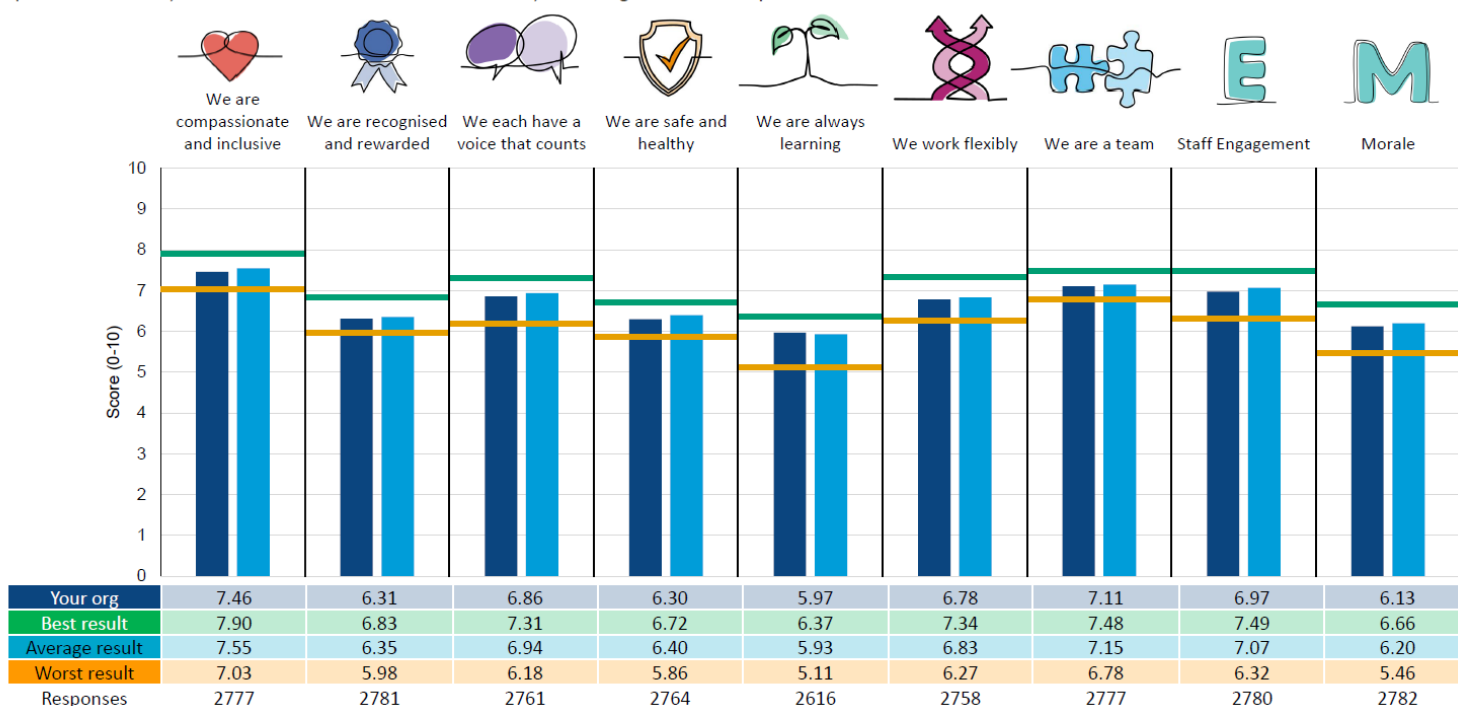
1. Compassionate and inclusive leadership and management
2. Celebrating and recognising staff
3. Addressing workload and factors leading to burnout
4. Improving psychological safety and a culture of safety
5. Enhancing appraisals and clinical supervision.

The five areas identified are areas where the Trust is currently trending below our benchmarked group average. The approach taken for this financial year was to identify local actions through care units / corporate business units to review the results and identify improvement actions that could be taken in the local area. The actions were presented to a Senior Leadership Group meeting for reflection and the identified local actions will be monitored through the Accountability Framework.

Operational oversight on progress with Trust plans will be provided through the Executive Team and assurance through the People Committee and Board of Directors across the year. This will include updates on the National Quarterly Pulse Surveys results, the five priority Trust actions and outputs from the 'You Said, We Did' campaign. This will ensure clear line of sight between workforce feedback and the continuous improvements that need prioritising and delivering against.

Figure 18: 2024 People Promise Results

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



In addition to these broad priorities, 2024/25 has seen improved HR business partnering approaches with care units, helping leaders digest and respond to the results from staff voice in their areas. A dedicated Staff Survey Senior Leadership Group (SLG) meeting was held, at which leaders reflected on their local results, and shared plans for improvement over the coming year.

National Quarterly Pulse Survey (NQPS)

The National Quarterly Pulse Survey (NQPS) takes place three times per year and is a consistent and standardised internal and external measure of staff experience. The survey is open for one month in Q1, Q2 and Q4, with Q3 being the NHS Staff Survey. The survey consists of the nine questions, grouped into themes of motivation, advocacy, and involvement.

Table 32: Survey response rates

NQPS Window	2024/25 Response	2023/24 Response
Q1 (April)	390	315
Q2 (July)	696	605
Q4 (January)	492	587

NQPS results are communicated across the organisation via all-staff communication channels.

Our Engagement Champions Network has continued to hold meetings bi-monthly throughout 2024/25. This group comprises of colleagues across the Trust who are committed to

increasing engagement, with a focus on promoting the NHS People Promise ‘We each have a voice that counts’.

2024/25 was EPUT’s first full year of using the People Pulse platform to complete the NQPS. This platform is used by many NHS Trusts and allows results to be compared with other providers. People Pulse has provided improved functionality, including the addition of themed questions which can be compared with results from other organisations.

Gender Pay Gap

As a Trust, we work to reduce the Gender Pay Gap for our employees, and publish our reporting for this on our website: [Gender Pay Gap Report](#).

Health and Safety

We recognise the need for the effective management of health, safety and security. Day-to-day management is undertaken by service managers with expert support from the Health and Safety / Violence Abuse Prevention and Reduction (VAPR) team and staff according to their level of responsibility.

The Trust’s Corporate Statement and Policy on Health and Safety (RM01), which has been reviewed this year, demonstrates a clear organisational structure for the management of health and safety. It sets out how the Board of Directors fulfils its statutory obligations and ensures the identification of control measures to suitably reduce health, safety, security and ligature risks so far as is reasonably practicable and as required by the following legislation:

- Health and Safety at Work Act 1974

- Management of Health and Safety at Work Regulations 1992
- Workplace (Health, Safety, and Welfare) Regulations 1992
- Violence Prevention and Reduction Standards 2021.

The Health Safety and Security Committee co-ordinates the implementation and management of health, safety and security across the Trust. The committee includes wide representation from both operational and support services and receives assurance from local Quality and Safety Groups.

The Trust has a range of policies and procedures in place to support compliance with health and safety requirements:

- Corporate Statement and Policy on Health and Safety
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment Policy
- First Aid Policy
- General Work Place Risk Assessment Policy
- Adverse Incident Policy
- Lone Worker Safety Policy
- Health and Safety of Young Persons Policy
- Ligature Environmental Risk Assessment and Management Policy
- Manual Handling Policy
- Search Policy
- Work-related Driving Policy

- Criminal Behaviour within a Health Environment (Zero Tolerance) Policy
- Therapeutic and Safe Interventions and De-escalation Policy (TASID)
- Latex Policy
- Safety Alert Bulletin Policy
- Fire Safety Policy
- Violence Abuse Prevention and Reduction (VAPR) Policy
- Employee Well-being, sickness and Ill Health Policy.

The Trust follows the Plan – Do – Study – Act process for health, safety and security management.

To enable staff to understand their roles and responsibilities, the Trust has health and safety training programmes which includes a fit for work e-learning programme. As at 31 March 2025, 87 per cent of staff had completed this training.

In line with the Trust's Corporate Statement and Policy on Health and Safety (RM01) and the legislative requirements placed upon them, it is the role of the Health and Safety/VAPR team to develop and undertake a programme of work which specifically relates to health and safety inspections at individual sites. Inspections are undertaken by the Health and Safety/VAPR team on a two yearly programme and are designed to ensure the continued health, safety, security and welfare of staff, patients and visitors within the Trust. They are undertaken against strict criteria, with any identified risks escalated immediately, accompanied by a reporting process which includes any recommended actions needed in order

to mitigate the risk and rectify the issue.

56 health and safety site inspections were completed between 1 April 2024 and 31 March 2025, in accordance with Trust policy and in line with legislation and guidance. Inspection results were shared with staff and corrective action identified to minimise risk.

In line with health and safety legislation, all managers have a responsibility for the health and safety of their staff, including completing general workplace risk assessments for their services. Expert support is provided by the Health and Safety/VAPR team and any risks identified as part of the assessment are mitigated or escalated where support is required through local quality and safety groups and to the Health Safety and Security Committee.

In line with the Trust's Ligature Risk Assessment and Management Policy (CP75) it is the role of the Health and Safety/VAPR team to facilitate a programme of ligature inspections and follow up visits across inpatient mental health services. All applicable wards receive a full annual ligature inspection which assesses risks against the Trust's environmental standards.

The ligature inspection process aims to assess the risk posed by potential ligature anchor points. Inspections are carried out jointly between the Health and Safety/VAPR Team, a representative from each ward and the Estates Team, taking joint responsibility for highlighting and managing risk posed. Each ward receives a full report detailing assessed risks for each room and an action plan to address concerns. Potential risks identified are either removed, replaced with a reduced

ligature solution or included in a capital works programme.

Risks which cannot be addressed in this way are highlighted to staff to allow them to mitigate those risks, taking them into account when planning care for vulnerable patients.

Community based services, including mental health A&E liaison teams, are required to consider ligature anchor points as part of their general work place risk assessment.

A separate support visit is undertaken six months after each full inspection, led by a senior clinical lead with support from the Health and Safety/VAPR team and Estates team and with a representative from the ward. These visits focus on:

- Coaching, support and education of staff on ligature risks
- Following up outstanding actions from ligature inspections
- Auditing compliance with policy, procedure and appendices
- Following up any gaps in processes from previous ligature assessment inspections.

85 ligature risk assessment inspections (annual and follow up visits) were completed between 1 April 2024 and 31 March 2025.

The Trust continues to regularly review and develop agreed risk reduced environmental standards based on both internal and national learning, including national safety alerts. The standards inform the Trust's ligature risk assessment inspections, investment and patient safety improvement work programme and are overseen by the

Ligature Risk Reduction Group.

The Health and Safety/VAPR team support the Trust's capital projects programme, providing expert advice and support with refurbishment and improvement works across multiple sites to ensure health and safety is at the forefront of any works.

A clear structure is in place to prevent and reduce violence and abuse against Trust staff, based on the national Violence Prevention Reduction Standards (VPRS) introduced by NHS England in 2021. The standards were revised in December 2024. During the year, we focused on implementing the new Violence Abuse Prevention and Reduction policy, reviewing the Trust Datix system to enable more comprehensive reporting of VAPR related incidents, in order to better quantify data obtained and continuing to support staff engaged in violence or abusive incidents. By 31 March 2025, the Trust was meeting 73.2% the (VPRS) standards, estimated to rise above 90% by the end of 2025/26.

Work continued during the year with partner agencies to provide a safer and more secure environment for staff, patients and visitors through greater understanding of the core issues around violence prevention and reduction. In the event that a member of staff is a victim of violence and aggression, the Health and Safety VAPR Team offer support and guidance to staff, and run clinics with Essex Police and the Trust's TASI training

team.

Essex Police have signed up to implementing the 'Right Care Right Person' strategy. This strategy looks to ensure that the correct organisation is responsible for attending/dealing with needs specific to their purpose. A memorandum of understanding and best working practices have been developed in partnership across Essex. This will help create a seamless transition and understanding between our organisations, to ensure the continuation of the best level of care and service is provided to both staff and patients within the Trust.

Lone worker devices and body worn cameras are used to enhance safety and security for patients and staff. Managers have access to data for monitoring staff usage and activity which is analysed on a monthly basis.

In the coming year, we will focus on digitisation of: ligature audits (utilising the Tendable audit platform); a review and pilot of new style lone worker devices; and the establishment of a standalone Violence Prevention Safety Group.

Further to this we will continue to work with people with lived experience to engage with patients to identify potential triggers for violence and aggression to help reduce / prevent incidents. Findings will help shape behaviour pledges for both staff and service users.

Staff Health and Wellbeing

The health and wellbeing of workforce is fundamental to the delivery of high quality care for patients and service users. We are committed to supporting staff health and wellbeing, with support

in place to cover all seven domains of the NHS Health and Wellbeing Framework. A positive health and wellbeing culture improves workforce measures such as retention and

engagement, as well as the service provided to patients.

Health and wellbeing support includes:

- Weekly staff mindfulness sessions for staff
- Act for You Training, open to any staff member
- Menopause awareness training and events for staff and managers
- A neuro-inclusive café, for staff to support one another with strengths and challenges associated with neurodivergence
- Psychological and emotional support through our award-winning psychological support service, 'Here for You'
- Wellbeing conversation training for managers, as part of our Management Development Programme (MDP)
- Access to fast track physiotherapy support
- A comprehensive health and wellbeing toolkit for all staff, and dedicated health and wellbeing intranet resources
- Regular communications and staff events, to connect on shared
- An employee assistance programme (EAP) and managed occupational health service, both provided through PAM
- A newly revised support document for managers and staff on flexible working requests

Expenditure on Consultancy

During 2024/25, the Trust spent £0.2 million on consultancy expenditure in respect of the provision of objective

- Newly revised reasonable adjustments passport guidance
- Domestic abuse toolkit and support pathway
- Staff sexual safety helpline and support process
- A range of staff benefits to support financial wellbeing, including cycle to work schemes, car loan schemes and the opportunity to buy and sell annual leave.

Charitable funds have also supported the facilitation of wellbeing roadshows delivered in 2024, and remaining funds are being reallocated to ensure staff are supported at a local level with their health and wellbeing needs.

Occupational Health and Employee Assistance Programme

Occupational health and Employee Assistance Programme (EAP) provision is available through People Asset Management Group Ltd. (PAM). Service includes pre-employment checks, workplace adjustments guidance, physiotherapy fast-track support, advice for workplace-adjustments for colleagues with a neurodivergence, needle stick/sharp injuries helpline, short-term counselling, computerised cognitive behavioural therapy (CBT), and more.

PAM and EPUT hold monthly and quarterly review meetings to review performance and the health of our workforce.

advice and assistance to the Trust in delivering its purpose and objectives.

Off Payroll Arrangements

In line with HM Treasury guidance, the Trust has put controls in place around the use of off-payroll arrangements. These engagements are only entered into on the basis of the provider's relevant skills, experience and knowledge and are supported by

individual contracts. All contracts are signed by both parties and include such terms as services to be provided, amount payable per day and responsibility for tax and national insurance contributions.

Table 33: Highly-paid off-payroll worker engagements as of 31 March 2025 earning £245 per day or greater.

Number of existing engagements as of 31 March 2025	1
Of which	
Number that have existed for less than one year at time of reporting.	0
Number that have existed for between one and two years at time of reporting.	1
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

Table 34: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2025	1
Of which...	
Not subject to off-payroll legislation.*	0
Subject to off-payroll legislation and determined as in-scope of IR35.*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35.*	1
Number of engagements reassessed for compliance or assurance purposes during the year.	0
Of which: number of engagements that saw a change to IR35 status following review.	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 35: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements.	10

Staff Exit Packages (subject to Audit)

During the year the Trust has incurred termination costs of £317k in respect of 7 individuals. There were no special severance payments that required HM Treasury approval made in the year.

Table 36: Staff exit packages in 2024/25.

	2024/25					
	Compulsory redundancies		Other departures agreed		Total termination costs	
	Number	£000	Number	£000	Number	£000
< £10,000	1	9	-	-	1	9
£10,001 - £25,000	1	21	-	-	1	21
£25,001 - £50,000	3	113	-	-	3	113
£50,001 - £100,000	2	174	-	-	2	174
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
Total	7	317	-	-	7	317

Table 37: Staff exit packages in 2023/24.

	2023/24					
	Compulsory redundancies		Other departures agreed		Total termination costs	
	Number	£000	Number	£000	Number	£000
< £10,000	1	7	1	9	2	16
£10,001 - £25,000	1	24	-	-	1	24
£25,001 - £50,000	1	27	-	-	1	27
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	1	138	-	-	1	138
£150,001 - £200,000	-	-	-	-	-	-
Total	4	196	1	9	5	205

Staff Exit Packages – non-compulsory departure payments

This note discloses the number of non-compulsory departures which attracted an exit package and the value of payments by individual types.

Table 38: Non-compulsory departure payments in 2024/25

	2024/25	
	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HM Treasury approval*	-	-
Total	-	-
Of which: Non contractual payments requiring HM Treasury approval made to individuals where the payment value was more than 12 months of their annual salary	-	-

Table 39: Non-compulsory departure payments in 2023/24

	2023/24	
	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HM Treasury approval*	1	9
Total	1	9
Of which: Non contractual payments requiring HM Treasury approval made to individuals where the payment value was more than 12 months of their annual salary	-	-

Trade Union (Facility Time Publication Requirements) Regulations 2017

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require NHS employers to publish certain information on trade union officials and facility time on their website as follows:

- The number of employees who were relevant union officials during the relevant period and the number of full time equivalent employees
- The percentage of time spent on facility time for each relevant union official
- The percentage of pay bill spent on facility time

- The number of hours spent by relevant union officials on paid trade union activities as a percentage of total plain facility time hours.

For these purposes, 'facility time' is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Schedule 2 – The Trade Union (Facility Time Publication Requirements) Regulations 2017.

The detail of trade union activity for 1 April 2024 to 31 March 2025 is as below.

Table 40: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent trade union representatives	Full-time equivalent employee number
29	27.39	6355.84

Table 41: Percentage of time spent on facility time - The number of employees who were relevant union officials employed during the relevant period and spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	8*
1-50%	20*
51%-99%	1*
100%	0*

Table 42: Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£59,222.26*
Total pay bill	£416,575,000
Percentage of the total pay bill spent on facility time	0.014%

Table 43: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	1.39%*
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**Disclaimer; Please note the information is correct based on returns received from trade union officials. Nil returns have been received and therefore may be subject to change. This information will be updated upon receipt of additional information.*

Code of Governance for NHS provider trusts

Essex Partnership University NHS Foundation Trust has applied the principles of the Code of Governance for NHS Providers on a comply or explain basis. The Code of Governance, most recently revised in October 2022, is based on the principles of the UK Corporate Governance Code issued in 2012.

The purpose of the Code of Governance is to assist NHS provider boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements. This Annual Report includes all the disclosures required by the Code.

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest standards of corporate governance and support and agreed the principles set out in the Code.

For the period 1 April 2024 to 31 March 2025, the Trust deviated from Code Provision B.2.7 that provides for *at least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent*. The Board of Directors composition is seven non-executive directors (excluding the Chair) and seven executive directors in a voting capacity. In year, we operated with a reduced non-executive director establishment as a consequence of a non-executive director stepping down due to ill health (March 2024) and another stepping down due to a change of circumstance (October 2024). The

Chair took an active decision to hold these positions for recruitment pending the new Chair appointment. We mitigated this in our Board Committees with the use of associate non-executive directors and made provisions for occasions where a board vote may be required. In year, there were no such circumstances where a vote was required.

The Trust was compliant with all other provisions of the Code of Governance for the same period.

Note: The Trust Chair served longer than six years, with a 12-month extension to their term of office agreed through appropriate governance with NHS England and a further period to enable recruitment of the new chair. This extension is not considered to have impaired the Chair's independence as a non-executive director of the Board.

NHS Oversight Framework

NHS England's NHS Oversight Framework oversees systems including providers and identifies potential support needs. NHS organisations are allocated to one of four 'segments'.

A segment decision indicates the scale and general nature of support needs, from no specific support (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving to another segment are met. These criteria have two components:

- a) Objective and measurable eligibility criteria based on performance against six oversight themes using the relevant oversight metrics (the

themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

- b) Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will only be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

NHS England confirm that EPUT is in segment 3 (from March 2024), with mandated support provided to enable the Trust to address key challenges associated with our Care Quality Commission report (published 2023). This segmentation information is the Trust's position as at 31 March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>.

The support provided by local partners from our Integrated Care Board included:

- **Supporting the establishment of an Evidence Assurance Group to provide external oversight and test robustness and sustainability of improvement.**

The Evidence Assurance Group continued throughout 2024/25, with 59% of improvement actions having been closed (as at April 2025). For more information on our CQC improvement actions see page 25.

Feedback from our ICB colleagues is that they welcome the transparency of the Trust and involvement in the process.

- **Support with the development and enhancing of Quality improvement capacity by commissioning and delivering of NHS Impact 'QSIR' training.**

Quality Service Improvement and Redesign (QSIR) training has seen 6 staff trained to QSIR Practitioner status. This is a five-day course which builds on the fundamentals course and provides participants with the skills and knowledge they need to lead and manage service improvement projects. These staff are members of the Transformation team and will support QI organisationally. A further 23 staff completing the one-day course providing an introduction to the QSIR programme and to its tools and techniques. These staff will support operational QI activity within our care units, alongside the Deputy Directors of Quality & Safety and Deputy Medical Directors in targeting priority areas identified through quality planning cycles. As at the end of 2024, we had 167 active users of the LifeQI system, and 68 active projects.

- **Support to review and establish the governance framework for oversight and delivery of the improvement plan.**

The new governance has been in place throughout 2024/25, and utilises SEIPS (System Engineering Initiative for Patient Safety) approach. This approach in conjunction with weekly progress meetings is grounded in local engagement to ensure causes and process challenges are understood to facilitate improvement actions that are both corrective and

sustainable. This approach has enhanced local ownership for improvement and shared learning. The governance brings together all inspection reports and associated actions (and more recently actions arising from Prevention of Future Death Reports) into one master tracker. From this we are able to provide progress reports.

- **Support external stakeholder involvements in quality assurance visit programme to test improvements in care.**

In support of our new governance and to proactively deliver on our commitments to deliver safe and effective care we developed the Quality Assurance Framework. The framework consists of four quadrants:

- Quality Planning
- Quality Improvement
- Quality Control
- Quality Assurance.

In 2024, we piloted our new Quality Assurance Visit Framework, with the aim of implementing a programme of joint Quality Assurance Visits between EPUT and our ICBs. The pilot has now concluded and an evaluation session held (attended by ICB, NED, and Governor Representatives with members of the Compliance Team who coordinate the programme). Further comments were received verbally / via emails which was also taken into the evaluation.

Overall, the feedback from the pilot is that this a positive approach to seeking assurance from patients, their families and staff. It also, reduced

duplication of visit from both internal and ICB colleagues separately. As with all new processes continuous reflection and adaptation is required, with some feedback received felt that there needed to be clearer understanding of roles and responsibilities for leading a visit and to guard against being conducted as a 'tick box' approach.

Changes to the process for the 2025/26 programme:

- To ensure an information pack is consistently provided in advance of a visit.
- Inclusion of training and supervision data within the information pack and to ensure there is a balance of both positive and areas of challenge for the service.
- A review of the Framework to ensure it sets the correct tone with a focus on assurance and make clear roles and responsibilities.
- RAG to be added to the visit tool for capture opinions, with a clear definition being developed to support this request.
- Liaising with the Patient Experience team to discuss inclusion of lived experience ambassadors (being mindful of the initial feedback to keep the size of attendees to a minimal as to avoid raising

tensions within service users and disruption to staff duties).

- Developing feedback measure for the impact of visits on services.

Recommendations from visits are provided back to teams and then followed up via the Accountability Framework meetings. Once we have completed a significant sample of visits we will undertake a thematic review which we would be happy to share with Council members.

- **Support a well-led development review of leadership and governance to establish a baseline.**

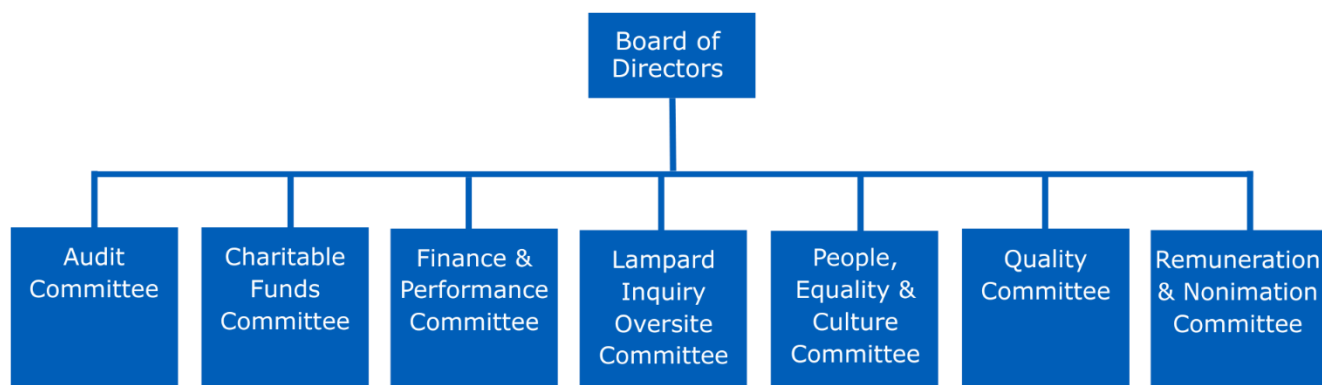
An independent well-led development review was conducted by NHS England's National Recovery Support team, to provide the Trust providing an objective view against the CQC well-led quality statements detailed in the Single Assessment Framework published in April 2024. This review occurred between April and July 2024. For more information on well-led see page 85.

The Trust welcomes and thanks system partners for their support with our improvement journey.

Board of Directors

In 2024/25, the Board of Directors operated with the structure below:

Figure 19



In addition to the above standing committees of the Board, in 2024/25 the Board established a Committee (known as the Lampard Inquiry Oversight Committee) chaired by a non-executive director with the sole function of providing oversight to the serving of the Lampard Inquiry and establishing health and wellbeing support to anyone impacted.

The Board of Directors functions as a corporate decision making body. The duty of the Board and of each director individually is to ensure the long-term success of the Trust in delivering high quality healthcare. As a Board, all voting directors have the same status as non-executive and executive sitting on a single Board, operate on the principle of a 'unitary board'.

All the powers of the Trust shall be exercised by the Board of Directors on behalf of the organisation. The rules and regulations within which the Board is expected to operate are captured in the Trust's corporate governance documents, which include the constitution (which contains the

standing orders for the Board of Directors), its schedule of matters reserved for Board decision, standing financial instructions and scheme of delegation. These documents explain the respective roles and responsibilities of the Board of Directors and the Council of Governors, the matters which require Board and / or Council approval and matters that are delegated to committees or executive management.

Collectively the Board of Directors have responsibility for:

- Providing leadership to the organisation within a framework of prudent and effective controls.
- Supporting an appropriate culture, setting strategic direction, ensuring management capacity and capability and monitoring and managing performance.
- Facilitating the understanding on the part of the governors of the role of the Board and the systems supporting its oversight of the organisation.

Disagreements between the Board of Directors and Council of Governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken which involves a resolution discussion at a Board meeting.

The Board takes active steps to ensure it interacts appropriately with the Council of Governors. Governors attend regular informal meetings with the Trust Chair and are regular observers of the Board assurance committees. Non-executive directors are invited to attend the Council of Governors meetings and Council of Governor members attend the public Board meetings.

The limitations set on the delegation to executive management require that any executive action taken in the course of business does not compromise the integrity and reputation of the Trust and takes account of any potential risk, health and safety, patient experience,

finance and working with partner organisations.

The executive directors manage the day-to-day running of the Trust while the Chair and non-executive directors provide operational and Board level experience gained from other public and private sector bodies; among their skills are accountancy, audit, clinical, commercial, digital technology, education, human resources, quality and risk. The Board includes members with a diverse range of skills, experience and backgrounds that incorporate the skills required of the Board.

The Board has a Vice-Chair and a Senior Independent Director. All non-executive directors are considered independent taking into account character, judgement and length of tenure.

During the course of the year, the Board met eight times. Six of these meetings were held in public.

The attendance record of all meetings for the Board of Directors for the year ended 31 March 2025 is as follows:

Table 44: Attendance at the Board of Directors 2024/25

Name	Role	Meetings Attended (actual/possible)
Professor Sheila Salmon	Chair	8/8
Paul Scott	Chief Executive Officer	8/8
Alexandra Green	Executive Chief Operating Officer / Deputy CEO	7/8
Denver Greenhalgh	Senior Director of Corporate Governance	8/8
Dr Rufus Helm	Non-Executive Director	3/3
Dr Ruth Jackson	Non-Executive Director	6/8
Dr Mateen Jiwani	Non-Executive Director / Senior Independent Director	5/8
Dr Milind Karale	Executive Medical Director	7/8
Diane Leacock	Non-Executive Director	6/8
Nigel Leonard	Executive Director of Major Projects & Programmes	6/8
Loy Lobo	Non-Executive Director / Deputy Chair	8/8
Elena Lokteva	Non-Executive Director	7/8
Andrew McMenemy	Executive Chief People Officer	7/7
Jenny Raine	Non-Executive Director / Associate Non-Executive Director	4/8
Marcus Riddell	Interim Executive Director of People and Culture	1/1
Ann Sheridan	Executive Nurse	8/8
Trevor Smith	Executive Chief Finance Officer / Deputy CEO	8/8
Zephan Trent	Executive Director of Strategy, Transformation and Digital	6/8

Board of Directors appointments

The Trust has a formal, rigorous and transparent procedure for the appointment of both executive and non-executive directors. Appointments are made on merit and based on objective criteria.

Executive directors are permanent appointments, while non-executive directors are appointed to a three-year term of office.

The reappointment of a non-executive director after their first term of office will be subject to a satisfactory performance appraisal. Any term beyond six years is only supported in exceptional circumstances and with the

support of NHS England, and takes into account the need for progressive refreshing of the Board.

Both the Chair and non-executive directors are appointed by the Council of Governors who may also terminate their appointment as set out the Trust's constitution.

Appointment of executive directors

The Board of Directors Remuneration and Nominations Committee has delegated responsibility to oversee the appointment of executive directors to the Board of Directors, including approving successful candidates and establishing remuneration for new appointments.

The recruitment of executive directors is completed using a robust selection process, including stakeholder panels and a formal interview panel. Candidates are interviewed by a range of individuals, including ensuring diversity at both stakeholder and interview panel level.

During 2024/25, the Trust did not appoint any executive directors, however, Andrew McMenemy, Executive Chief People Officer commenced in post in May 2024, following a recruitment process completed in 2023/24.

Appointment of non-executive directors

The appointment of non-executive directors to the Board of Directors is undertaken by the Council of Governors Nomination Committee on behalf of the Council of Governors. Non-executive directors on a term of three-years. The non-executive director may be appointed for a further three-year term following a re-appointment process. Any term beyond six years will be subject to rigorous review and satisfactory annual performance appraisal, taking into account the need for progressive and refreshing of the Board. From February 2021, any new non-executive director appointments have been appointed for a three-year term with a probationary review completed after one year, to review the non-executive director has performed satisfactorily in the role to serve the remaining two-years of their first term.

The Trust constitution sets-out the circumstances that disqualify an individual from holding a Directorship. Should any of those circumstances become applicable to a non-executive director, their appointment will be

terminated. In addition, either party shall be entitled to terminate that agreement by giving at least one month's notice in writing to the other. The appointment may be terminated with immediate effect if the non-executive director becomes disqualified for appointment or membership. This is set-out in the Terms and Conditions signed by the non-executive director on appointment.

The non-executive director will leave their post at the completion of their term of office unless re-appointed by the Council of Governors for a further term.

The terms of office for one non-executive director ended during 2024/25:

- Dr Rufus Helm (31 July 2024)

The Council of Governors appointed the following non-executive directors during 2024/25:

- Hattie Llewelyn-Davies, Chair (due to commence in post 1 April 2025)

The Council of Governors utilised the expertise of an external recruitment company, Hunter Healthcare, and completed a robust selection process overseen by the Nominations Committee and in line with internal procedures. The Council of Governors approved the appointment of the new Chair.

In addition, Dr Ruth Jackson, Associate Non-Executive Director transitioned into the role of Non-Executive Director in August 2024 and Jenny Raine, Non-Executive Director transitioned into an Associate Non-Executive Director in October 2024.

Chair's significant commitments

Professor Sheila Salmon has no other significant commitments other than to the Trust. However, she has declared her involvement with Anglia Ruskin University where she is the Emeritus Professor of Health Services Development which is a non-remunerated role.

Independence of the non-executive Directors

Following consideration of the Code of Governance, the Board takes the view that all non-executive directors are independent. All non-executive directors declare their interest and, in the rare likelihood that such interest conflicts with those of the Trust, then the individual would be excluded from any discussion and decision relating to that specific matter.

Balance, completeness and appropriateness of the membership of the Board of Directors

The current Board of Directors comprises eight non-executive directors (including the Trust Chair) and eight executive directors (including the Chief Executive Officer, seven voting). In year, the Trust operated with a lower number of non-executive directors as described in the Code of Governance section above.

Taking into account the wide experience of the whole Board as well as the balance and completeness of membership, and the use of associate non-executive directors the composition of the Board is considered to be appropriate for the requirements of the business and future direction of the Trust.

Board of Directors performance evaluation

The Trust has put in place processes for

an annual performance evaluation of the Board and its Directors in relation to their performance. An evaluation of the Board of Directors Standing Committees is currently underway for 2024/25 using an online evaluation form. The Trust also commissioned an independent Well-Led Review conducted by NHS England in 2024/25.

All members of the Board receive a full and tailored induction on joining the Trust and undertake a personal induction programme during the first 12 months of appointment. All directors will undergo an annual performance review against agreed objectives, skills and competences and agree personal development plans for the forthcoming year. In addition, the Chair will annually review and agree the Chief Executive's and executive directors' training and development needs as they relate to their role on the Board.

The performance evaluation of the executive directors is undertaken by the Chief Executive Officer whose performance is appraised by the Chair. The outcomes are reported to the Board of Directors Remuneration and Nominations Committee.

The Chair conducts the annual performance evaluation and appraisal of each non-executive director. The Senior Independent Director conducts the annual performance evaluation and appraisal of the Chair, having met with all other non-executive directors and received feedback from governors. Detailed consideration of the results of the performance evaluation of the Chair and non-executive directors for 2022/23 was undertaken by the Council of Governors Remuneration Committee in line with the process agreed by the Council and a report from the Committee made to the Council of

Governors. All submissions for the outcome of the Chair's performance evaluation were submitted to NHS England, as required.

Board performance is also evaluated through focused discussions at Board Development / Seminar sessions and ongoing in-year review of the Board. Assurance Framework. The Framework provides clear information and enables a continuous and comprehensive review of the performance of the Trust against

Nominations Committees

The Trust has two Nominations Committees: the Board of Directors Remuneration and Nominations Committee and the Council of Governors Nominations Committee.

Board of Directors Remuneration and Nominations Committee

The Board of Directors Remuneration and Nominations Committee is constituted as a standing committee of the Board. It has the statutory responsibility for identifying and appointing suitable candidates to fill executive director positions on the Board of Directors, ensuring compliance with any mandatory guidance and relevant statutory requirements.

This Committee is also responsible for succession planning and reviewing Board structure, size, composition and diversity, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

The Committee is chaired by the Trust's Chair with membership comprising all non-executive directors. The Chief Executive Officer will attend when the Committee is considering appointments

agreed plans and objectives, linked to the Strategic Objectives.

All Directors meet the criteria for being a fit and proper person as prescribed by the Trust's Provider Licence and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust is following the new Fit and Proper Persons Tests framework published in 2024.

to executive director positions other than the post of Chief Executive Officer. At the invitation of the Committee the Executive Chief People Officer (or their deputy) will normally attend (depending on the agenda items to be discussed) in an advisory capacity. The Senior Director of Corporate Governance (or their deputy) is the Committee Secretary.

The Committee's terms of reference are reviewed annually in line with good practice. The Committee meets at least annually or as and when required to undertake its roles and responsibilities.

The Committee met nine times during the year. The appointment processes considered by the Committee are as described on page 134. During the year, the Board of Directors Remuneration and Nominations Committee did not make any decisions in respect of nominations business. Members of the combined Remuneration and Nominations Committee and the number of meetings attended by each member during the year is detailed at Table 13 earlier in this report.

Council of Governors Nominations Committee

The Council of Governors Nominations Committee is responsible for establishing a clear and transparent process for the identification and nomination of suitable candidates that fit the criteria set out by the Board of Directors Remuneration and Nominations Committee for the appointment of the Trust Chair and non-executive directors, for approval by the Council.

The Committee is chaired by the Trust's Chair with membership comprising elected and appointed governors. If the Chair is being appointed or not available, the Vice-Chair, Senior Independent Director, one of the other non-executive directors who is not standing for appointment or the Lead Governor will be the Chair. When the Trust Chair is being appointed, the Committee comprises only governors who will elect a Chair of the Committee from amongst its members. The Assistant Trust Secretary is the Committee Secretary.

The Committee's terms of reference are reviewed annually in line with good practice. The Committee meets at least annually or as and when required to undertake its roles and responsibilities.

The Committee undertook a recruitment process to appoint a new Chair of the Trust. The Committee completed a robust selection process which included an executive search, shortlisting process and stakeholder / interview panel. The Committee agreed to recommend the appointment of the Chair as detailed earlier in this report.

Support and advice was provided to the Committee as part of this process by Hunter Healthcare and the Executive Chief People Officer. The company does not have any other connection with the trust or individual directors. In line with the Code of Governance for Provider Trusts, the Committee was further supported by an external independent chair and a senior representative from NHS England.

Members of the Committee and the number of meetings attended by each member during the year are set out below.

Table 45: Attendance at the Council of Governors Nominations Committee 2024/25

Name	Role	Meetings Attended (actual/possible)
Professor Sheila Salmon	Chair	2/2
Loy Lobo	Deputy Chair	2/2
Zisan Abedin	Staff Governor	2/4
Paula Grayson	Public Governor	3/4
John Jones	Public Governor	3/4
Stuart Scrivener	Public Governor	4/4
Helen Semoh	Staff Governor	1/1
Biliaminu Yesufu	Public Governor	0/4

Audit Committee

The Audit Committee comprises solely of independent non-executive directors who have a broad set of financial, legal and commercial expertise to fulfil the

Committee's duties. Members of the Committee and the number of meetings attended by each member during the year are set out below:

Table 46: Membership and attendance at Audit Committee meetings

Name	Role	Meetings attended
Elena Lokteva	Chair of Committee	5/5
Dr Rufus Helm	Non-Executive Director	2/3
Dr Mateen Jiwani	Non-Executive Director	2/2
Jenny Raine	Non-Executive Director / Associate Non- Executive Director	5/5

At the request of the Committee Chair, each meeting is attended by the Executive Chief Finance and Resources Officer, Director of Finance, Senior Director of Governance and Corporate Affairs, Head of Financial Accounts, an External Audit representative, an Internal Audit representative, and the Local Counter Fraud Specialist. In addition, the Chief Executive presents the Annual Governance Statement on an annual basis.

Internal audit

The Trust has an internal audit function which forms an important part of the organisation's internal control environment. During the year, this function was provided by TIAA. The functions of the internal audit service are to provide an '*independent, objective assurance and consulting activity designed to add value to an organisation's activities*'. This means that the role embraces two key areas:

1. The provision of an independent and objective opinion to the Accounting Officer, the governing body and the Audit Committee on the degree to which risk management, control and governance support the

achievement of the organisations agreed objectives

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Anti-Crime Specialist

During 2024/25, TIAA also provided the Trust with a dedicated counter fraud service. TIAA agrees a detailed counter fraud work plan with the Trust, based on guidance received from the NHS Counter Fraud Authority. The Trust also has a counter fraud policy and response plan which has been approved by the Board of Directors. Anyone suspecting fraudulent activities within the Trust's services should report their suspicions to the Executive Chief Finance and Resources Officer or telephone the NHS Counter Fraud Authority confidential hotline on 0800 028 4060.

All NHS funded services are required to provide assurance against the NHS Counter Fraud Authority (NHSCFA) Requirements of Government Functional Standards 013: Counter fraud. The Audit Committee oversees

this return and in May 2024 the Trust submitted an overall rating of **GREEN** for 2023/24.

External audit

The 2024/25 financial year represents the third year of a three-year contract (with option to extend for a further two years) with Ernst and Young. This appointment was approved by the Council of Governors in August 2023.

The value of the external audit contract for 2024/25 was £203k (excluding VAT). There was no non-audit work undertaken during the year.

Work of the Audit Committee

During the year, the Committee considered a number of significant issues including the impact of the

Council of Governors

Our Council of Governors is an integral part of the Trust. Our governors bring the views and interests of the public, service users and patients, carers, our staff and other stakeholders into the heart of our governance. This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments in order to help improve the quality of services and care for all our service users and patients.

Role of the Council of Governors

The roles and responsibilities of the Council of Governors are set out in our Constitution. The Council of Governors' statutory responsibilities include:

- To hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors

current inquiry and the planning regime.

Further matters relating to the 2024/25 annual accounts, which were discussed by the Committee, were as follows:

- Accounting for ongoing costs of servicing the inquiry in the 2024/25 accounts with costs met from internal Trust resources
 - Accounting treatment for Collaborative arrangements
 - Restatement in annual leave accrual;
 - Revaluation and impairment of property, plant and equipment;
 - Accounting treatment for the Local Government Pension Scheme; and
 - Losses and special payments.
-
- To represent the interests of the members of the Trust as a whole and the interests of the public
 - To amend/approve amendments to the Trust's constitution
 - To appoint/remove the Chair and other non-executive directors
 - To approve the appointment of the Chief Executive
 - To determine the remuneration, allowances and other terms and conditions of office of the Chair and non-executive directors
 - To appoint/remove the Trust's external auditor
 - To provide views to the Board of Directors in the preparation of the Trust's Annual Plan
 - To receive the Trust's Annual Report and Accounts and any report of the auditor on them

- To take decisions on significant transactions and on non-NHS income.

The Council of Governors is required to meet a minimum of four times a year.

The Health and Social Care Act 2012 requires the Board of Directors to empower Governors by:

- Holding open Board meetings

- Sending a copy of the agendas to the Council before holding a Board meeting
- Sending copies of the approved minutes to the Council as soon as practicable after holding a Board meeting
- Ensuring that governors are equipped with the skills and knowledge they need to undertake their role.

Composition of the Council of Governors

The Council is led by the Chair of the Trust. The composition of the Council of Governors is in accordance with the Trust's constitution as below.

Table 47: Council of Governors Composition

Constituency		Number of Governors
Public	Essex Mid & South	9
	North East Essex & Suffolk	3
	West Essex & Hertfordshire	5
	Milton Keynes, Bedfordshire, Luton & Rest of England	2
Staff	Clinical	4
	Non-Clinical	2
Appointed	Essex County Council	1
	Southend Borough Council	1
	Thurrock Council	1
	Anglia Ruskin & Essex Universities*	1
	Voluntary/Third Sector	1

*joint appointment

Board relationship with the Council of Governors

The Trust Chair is responsible for the leadership of both the Council of Governors and the Board of Directors. The Chair has overall responsibility for ensuring that the views of the Council and Trust members are communicated to the Board as a whole and considered as part of decision-making processes and that the two bodies work effectively together.

The Chair works closely with the Lead and Deputy Lead Governors and meets with them prior to Council meetings to set the agenda and review key issues.

The non-executive directors attend each meeting of the Council, presenting agenda items and taking part in open discussions that form part of each meeting. The executive directors attend meetings to present specific items or provide support for any presentations on a theme related to their portfolios. Standing agenda items include reports from the Chief Executive Officer and

executive directors on Trust performance, finance and quality matters, a report from the Chair and national and local systems updates. Non-executive chairs of each Board standing committee also present a summary report of the committees' deliberations on a rotational basis.

The Senior Independent Director pursues an effective relationship between the Council and the Board. Governors can contact the Senior Independent Director if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive Officer or Executive Chief Finance and Resources Officer. There are a number of procedures in place to guide key processes for the involvement of the Council of Governors, including in situations where the Council disagrees with or rejects a proposal made by the Board of Directors. This includes criteria by which the Council may reject or disagree with a recommendation from the Board and action that should be taken. A formal policy and procedure is also in place which sets-out the relationship between the Board and Council, included how any disagreement or dispute will be resolved.

Board of Directors meetings are held in public and governors can and do attend, having the opportunity to ask questions of the Board on matters relating to agenda items. In addition, the Trust establishes working groups of Board and Council representatives to take forward specific work.

Both the Board of Directors and the Council of Governors are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective

way possible.

The Board values the relationship it has with the Council and recognises that its work promotes the strategic aims and assists in shaping the culture of the Trust. Both the Board and the Council are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible.

Awareness of governors' and members' views

The Board recognises the importance of maintaining good relations with stakeholders, and in particular that there is dialogue with members, patients and local communities. The Trust regularly consults and involves governors, members, patients and local communities and supports governors in representing the interests of Trust members and the public, through seeking their views and keeping them informed.

During the year, the Board was kept informed of the views of governors and members through a variety of means, including:

- Attendance and agenda item presentations by executive directors and non-executive directors at all quarterly Council meetings, where governors can ask questions and provide feedback
- Council meetings held in public
- Quarterly informal non-executive directors and governors meetings
- Constituency meetings for governors and their representative non-executive directors
- Quarterly Chief Executive Officer briefing sessions with governors

- Regular Lead and Deputy Lead Governors meetings with the Trust Chair and Trust Secretary's Office
- Attendance by governors at Board of Director meetings
- Public "Your Voice" member meetings across Trust constituencies, enabling members and the public to meet with the Chair, Chief Executive Officer, directors, senior managers and governors

- Annual Members Meeting
- The Trust's website - www.eput.nhs.uk.

The Trust fosters an 'open door' policy where issues, queries and feedback can be raised with the Chair, the Chief Executive and any Board member as appropriate, either on a face-to-face basis or via email.

Table 48: Council of Governors Meeting Attendance 2024/25

Name	Term		Attendance at Council of Governor Meetings (actual/possible)
Public: Milton Keynes, Bedfordshire and Luton			
Paula Grayson	3 term: 3 years	Jun 2022 – Jun 2025	5/5
John Jones (Lead Governor)	3 term: 3 years	Jun 2022 – Jun 2025	5/5
Public: Essex Mid and South			
Dianne Collins	2 term: 2 years, 9 months	Jun 2022 – Mar 2025	4/5
Mark Dale	2 term: 2 years, 4 months	Jun 2022 – Oct 2024	2/2
Gwyn Davies	1 term: 3 years	Sep 2023 - Sep 2026	4/5
Kingsley Edore	1 term: 3 years	Sep 2023 - Sep 2026	1/5
David Finn	1 term: 3 years	Sep 2023 - Sep 2026	5/5
Megan Leach	1 term: 3 years	Jun 2022 – Jun 2025	4/5
Pamela Madison	3 term: 3 years	Sep 2023 - Sep 2026	5/5
David Norman	1 term: 3 years	Sep 2023 - Sep 2026	2/5
Stuart Scrivener	2 term: 3 years	Jun 2022 – Jun 2025	5/5
Public: North East Essex and Suffolk			
Susan Tivy-Ward	1 term: 2 years, 6 months	Jun 2022 – Dec 2024	0/4
Cort Williamson	1 term: 3 years	Jun 2022 – Jun 2025	5/5
Public: West Essex and Herts			
Joanna Androulakis	1 term: 1 year, 2 months	Sep 2023 – Nov 2024	0/3
Nat Ehigie-Obano	1 term, 3 years	Jun 2024 – Jun 2027	3/4
Jason Gunn	1 term: 3 years	Jun 2022 – Jun 2025	4/5

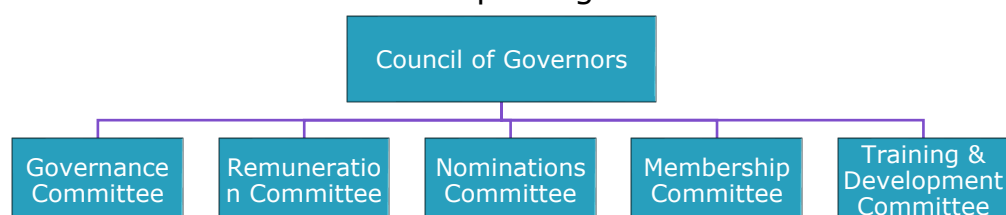
Name	Term		Attendance at Council of Governor Meetings (actual/possible)
Biliaminu Yesufu	1 term: 3 years	Sep 2023 - Sep 2026	1/5
Staff: Clinical			
Alivia Bray	1 term: 1 year, 3 months	Sep 2023 – Dec 2024	3/3
Ibraheem Lateef	1 term: 3 years	Sep 2023 - Sep 2026	1/5
Marie Newland	1 term: 8 months	Jul 2024 – Mar 2025	1/4
Oladipo Ogedengbe	1 term: 1 year, 9 months	Dec 2024 – Sep 2026	1/1
Edwin Ugoh	1 term: 3 years	Jun 2022 – Jun 2025	1/5
Staff: Non-Clinical			
Zisan Abedin	1 term: 3 years	Sep 2023 - Sep 2026	4/5
Helen Semoh	1 term: 3 years	Jun 2024 – Jun 2027	3/4
Essex County Council			
Jaymey McIvor	1 term: 1 year	Jul 2023 – Jul 2024	0/1
Holly Whitbread	1 term: 1 year, 10 months	Aug 2024 – Jun 2026	1/3
Southend on Sea Council			
Maxine Sadza	2 term: 3 years	Jul 2024 – Jul 2027	1/4
Thurrock Council			
Neil Speight	1 term: 3 years	May 2024 – May 2027	3/4
Anglia Ruskin and Essex Universities			
Nicky Milner	1 term: 2 years, 10 months	Aug 2022 – Jun 2025	0/5

Council of Governors Committees

The Council's committee governance framework is designed to ensure it robustly supports and enables the Council to fulfil its duties, roles and responsibilities effectively. The Committees do not have any delegated

authority. All responsibilities are undertaken in support of the Council, as it is the Council of Governors that holds the responsibility for decisions relating to all issues covered by the Committees.

Figure 20: Committee structure underpinning Council of Governors



In line with good governance practice, an effectiveness review of the Council of Governors and its sub-committee structure was completed and results presented to the Council of Governors in May 2024. The Council of Governors structure provides robust coverage of its statutory responsibilities. The sub-committees provide support for the Council of Governors by taking forward key statutory tasks and making recommendations to the Council of Governors to consider.

The Council of Governors Training and Development Committee is a subcommittee of the Council which ensures effective and robust training and development arrangements are in place to develop Governors' skills, knowledge and capabilities.

During the year, the Trust has hosted or provided governors with access to a range of training and development opportunities with the purpose of enhancing their knowledge and understanding of the organisation.

All governors have undertaken a comprehensive induction programme, which is regularly reviewed and updated, taking account of best practice from the national and local sources. This includes a Governor Induction Handbook based on handbooks developed by NHS Providers, which provides new Governors with information about the Trust and their role as governors.

Annual Report of the Council of Governors

We are pleased to write this report to members from the Council of Governors of Essex Partnership University Trust (EPUT).

Governors are kept regularly informed through direct emails. Knowledge is kept up to date through the sharing of best practice and centrally published information. In addition, the Chief Executive Officer provides a briefing in private prior to each Council meeting.

Council of Governors Register of Interests

All members of the Council of Governors have a responsibility to declare relevant interests as defined in the Trust's Constitution. Declarations made are entered into a register which is [available online](#) and is updated in real time.

Governor expenses

Whilst governors do not receive remuneration, they are entitled to claim travel and other expenses in line with Trust policy. Eight governors in place during the year claimed expenses, with all claims totalling £1,815.34.

Contacting our governors

Our governors can be contacted through our Membership Office:

Email: epunft.membership@nhs.net

Freephone: 01268 739739

Post: Freepost RTRG-UCEC-CYXU

Trust Secretary's Office

The Lodge, Lodge Approach

Wickford

SS11 7XX

We have taken our role as 'critical friend' seriously, questioning the directors regularly so as to satisfy ourselves that proper process has been undertaken and that the interests of the patients and carers have been

uppermost in any decisions which have been made.

Changes in senior management have brought a new look to the Board with new ideas. We welcome these and recognise that it means that any changes proposed must be in the interests of the patients and carers.

The two new non-executive directors we appointed this year, Sarah Teather and Richard Spencer, we hope will bring a new perspective and fresh ideas from their wealth of experience. They replace Jenny Raine and Manny Lewis who we thank for their hard work and dedication.

At the end of March 2025, we said goodbye to our Chair (for the past 7 years) Professor Sheila Salmon. The governors have all enjoyed working with her and appreciate the support which she has given to the Council. She will be a hard act to follow so we have high expectations of our newly appointed Chair, Hattie Llewelyn-Davies, who took up her post on 1st April.

We did undertake some quality visits during the past year. These allowed us to find out how our patients feel about the level of service which they receive, and how those changes, which have been made, have bedded in and improved the level of care.

Those governors who were able to attend the Council meetings every quarter have appreciated the private session before the main meeting in which the Chief Executive, Paul Scott, holds an informal discussion on matters of immediate interest. These have been very helpful, enhancing, as they do, the close working relationship between the governors and the Chief Executive.

We can give you, our members, assurance that EPUT complies with the *Code of Governance*. This guidance helps Trusts to deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients and service users.

We always make sure that there are governors present at public Board meetings to provide us with an insight into how the non-executive directors and the executive directors interact as well as to ask questions on your behalf. A record of these questions can be found in the Minutes of the Board of Directors' meetings on the Trust's website which shows the wide variety of subjects on which we have asked questions.

We are mindful that we are elected or appointed to represent you, the members of our Trust, and to satisfy ourselves on your behalf that service users'/patients' needs are always the top priority and that the services provided are safe and of high quality, while at the same time maintaining independence from executive decisions.

This year has not been easy for staff and we know that you would wish us to thank them all for the hard work and dedication which they have shown in mental and community health, and learning disability services. This is against a background of the Mental Health Statutory Inquiry currently in progress and which has involved staff and management in considerable additional work.

Finally, we hope that you, as members, have been satisfied with the representation which we, as governors, have been able to provide during the

past year. If you have any questions which you wish to ask us then feel free

John Jones

Lead Governor

to send us these, through the Trust Secretary's Office.

Stuart Scrivener

Deputy Lead Governor

Membership

Foundation trust membership aims to give local people, service users, patients and staff a greater influence in how the Trust's services are provided and developed. The benefits to the Trust in developing an effective membership and providing active engagement include:

- Wider engagement with and improved access to the views of the populations and communities we serve.
- Improved and more representative feedback from the local population as a whole.
- A better understanding of service user/patients' views in identifying particular service needs/gaps in services and feedback on how well services are meeting the requirements of local communities, improving the quality of care.
- Continuing to build good and trusting relationships.
- The ability to inform/consult with local communities on the work of the Trust, including service developments.

Membership is important in helping to make the Trust more accountable to the people we serve, to raise awareness of

mental health, community health and learning disabilities and helps the Trust to work in partnership with our local communities.

The membership structure for the Trust is made up of two categories of membership:

- Public Members - Anyone aged 12 and over living in England can become a member. Public membership is sub-divided into four constituencies which reflect the areas within which the Trust delivers services, one of which - Bedford, Luton, Milton Keynes - also includes the rest of England.
- Staff Members - All staff who are on permanent or fixed term contracts that run for 12 months or longer automatically become members, unless they opt out. Staff who are seconded from our partnership organisations and are working in the Trust on permanent or fixed term contracts that run for 12 months or longer are also automatically eligible to become members. Staff are members of one of two sub-groups which are linked to their different fields of work – clinical or non-clinical.

Membership size and breakdown

Our aim is to establish and maintain a broad and engaged membership that is evenly spread geographically across the areas we serve and reflects the ages and diversity of our local population.

Table 49: Membership Breakdown

Membership size and movements	
Public constituency	Last Year (2024/25)
At year start (April 1)	4,832
New members	27
Members leaving	794
At year end (March 31)	4,065
Staff constituency	Last Year (2023/24)
At year start (April 1)	10,099
New members	476
Members leaving	3,635
At year end (March 31)	6,940

Analysis of current membership	Last Year (2023/24)
Analysis of current membership	
Public constituency	Number of members
Age (years):	
0-16	1
17-21	1
22+	3,599
Ethnicity:	
White	3,099
Mixed	83
Asian or Asian British	361
Black or Black British	259
Other	13
Socio-economic groupings*:	
AB	1,052
C1	1,188
C2	860
DE	912
Gender Analysis	
Male	1,594
Female	2,371

The analysis section of this report excludes:

- 464 public members with no dates of birth, 338 members with no stated ethnicity and 100 members with no stated gender.

Membership strategy

During the year, the Trust continued to implement its Membership strategy. The strategy was approved by the Board in November 2023 and by the Council of Governors in December 2023. It runs for three years until 2026 and includes the following priorities:

- Establish a membership that is representative of the population served by EPUT
- Communicate effectively with members and ensure their views are represented within EPUT
- Develop a process to ensure membership engagement operates across the system and with Integrated Care Boards.

Each priority has key milestones to be achieved for each year of the strategy and a series of sub-actions have been identified to achieve each milestone. The sub-actions are detailed in an implementation plan which is overseen by the Council of Governors' Membership Committee.

The strategy completed its first year of implementation in March 2025, with the following key achievements:

- A phone audit of postal members to determine if individuals wished to remain as members. This helped improve the analysis of demographical data by reducing the number of inactive members.
- Researched available demographical data to best represent the population served by EPUT. The most accurate source of data available was the Census 2021 data.

- Reviewed and amended demographical information collated via the Civica Membership database to ensure data could be directly compared with the census, where categorisation was different.
- Incorporated data into metric report to the Membership Committee and Council of Governors to allow analysis of gaps in membership for targeted communication.
- Communication Plan developed providing a plan for the next financial year on the communication with members, including regular newsletters and engaging with local groups.
- Communication Plan divided into sections to provide clear detail of the "who, what, where, when" of the plan.
- Governor pack developed providing key information for governors to use when engaging with members outside the Trust. This included a leaflet providing details of the services provided by EPUT.

The second year of the strategy is now underway.

Engagement and recruitment of members

The Membership strategy includes a priority to establishment a membership that is reflective of the population served. This includes comparing membership demographics with national data to identify areas of under-representation for targeted attention.


During 2024/25, the Trust held a series of Your Voice meetings, both face-to-face and virtually, as a primary method

of engagement. Meetings were chaired by a member of the Council of Governors and included a short presentation on new innovations, services and plans followed by an open forum allowing members to ask questions of and express views to senior staff in the Trust.

Meeting attendance fluctuated during the year and therefore the Trust trailed collocating a Your Voice session in October 2024 alongside the Co-Production Conference which was met with some success. The Trust is now developing a plan for 2024/25 which will incorporate feedback from the event in October 2024.

Members are also kept up to date with developments at the Trust by:

- Direct communication
- The Trust's website
- Following the Trust on social media
- Attending public meetings of the Board of Directors and Council of Governors
- Attending locality based patient/carers events
- Attending the Annual Members' Meeting
- Attending Patient Forums.



Paul Scott
Chief Executive

Essex Partnership University NHS FT
24 July 2025

Glossary

AIS	Accessible Information Standard	IPC	Infection Prevention and Control
BMS	Building Management Systems	IPCC	Intergovernmental Panel on Climate Change
CCS	Crown Commercial Services	KPI	Key Performance Indicator
CHIP	Complex Housing Intervention Programme	LEA	Lived Experience Ambassador
CQC	Care Quality Commission	LGPS	Local Government Pension Scheme
CRR	Corporate Risk Register	MSECC	Mid and South Essex Community Collaborative
DHSC	Department of Health and Social Care	NHSCFA	NHS Counter Fraud Authority
DDQI	Data Quality Maturity Index	NQPS	National Quarterly Pulse Survey
ECT	Electroconvulsive Therapy	PALS	Patient Advice and Liaison Service
EDI	Equality, Diversity and Inclusion	PCREF	Patient and Carer Race Equality Framework
EDS	Equality Delivery System	PDC	Public Dividend Capital
EIA	Equality Impact Assessment	PFI	Private Finance Initiative
eFraCCS	Electronic Frailty Care Coordination System	PHSO	Parliamentary Health Service Ombudsman
ePaCCS	Electronic Palliative Care Coordination System	PICU	Psychiatric Intensive Care Unit
EPMA	Electronic Prescribing and Medicines Administration	PIPE	Patient Information in Plain English
EPR	Electronic Patient Record	PLACE	Patient-Led Assessment of the Care Environment
ESR	Electronic Staff Record	PSED	Public Sector Equality Duty
FEP	First Episode of Psychosis	QSIR	Quality Service Improvement and Redesign
FTE	Full-Time Equivalent	RISE	Resilience, Intelligence, Strength and Excellence
FTSU	Freedom to Speak-Up	RTT	Referral to Treatment
FreDA	Frailty, End of Life and Dementia Assessment	SEIPS	System Engineering Initiative for Patient Safety
GIRFT	Getting it Right First Time	SOPHIA	A system for the maintaining of operational procedures
IFRS	International Financial Reporting Standard	SR	Strategic Risk
		WTE	Whole Time Equivalent



Annual accounts 2024/2025 index

Section A: Certificate for annual accounts

Page no

Index	151
Statement of the Chief Executive's Responsibilities as the Accounting Officer of the Trust	152
Annual Governance Statement 2024/25	153
Independent Auditor's Report	167

Section B: Annual accounts and notes to the accounts

	Foreword to the Accounts	172
	Statement of Comprehensive Income (SoCI)	173
	Statement of Financial Position (SoFP)	174
	Statement of Changes in Taxpayers Equity	175
	Statement of Cash Flows	177
Note 1	Summary of Accounting Policies and Other Information	178
Note 2	Operating Income from Patient Care Activities	196
Note 3	Other Operating Income	197
Note 4	Additional Information on Revenue from Contracts	198
Note 5	Operating Lease Income	198
Note 6	Operating Expenses	200
Note 7	Employee Benefits	201
Note 8	Finance Income, Expenditure and Late Payments of Commercial Debt (interest) Act 1998	205
Note 9	Other gains and losses	206
Note 10	Intangible Assets	206
Note 11	Property, Plant and Equipment	208
Note 12	Operating Leases	213
Note 13	Investment Property	215
Note 14	Inventories	215
Note 15	Trade Receivables and Other Receivables	216
Note 16	Non-Current Assets Held for Sale	216
Note 17	Cash and Cash Equivalents	217
Note 18	Third Party Assets Held by the Trust	217
Note 19	Trade and Other Payables	217
Note 20	Other Liabilities	218
Note 21	Borrowings	218
Note 22	On-SoFP PFI	220
Note 23	Provision for Liabilities and Charges	221
Note 24	Capital Commitments	221
Note 25	Events after the Reporting Period	222
Note 26	Contingent Liabilities	222
Note 27	Related Party Transactions	222
Note 28	Financial Instruments	223
Note 29	Losses and Special Payments	225
Note 30	Prior Period Adjustment	226

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Essex Partnership University NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Essex Partnership University NHS Foundation Trust (the Trust) to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Paul Scott, Chief Executive
24 July 2025

Annual governance statement for the year ended 31 March 2025

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Essex Partnership University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently and economically. The system of internal control has been in place in Essex Partnership University NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risks

The overall responsibility for risk management within the Trust rests with me and the Executive Management team, along with the requirements to meet all statutory requirements and adhere to the guidance issued by NHS England and the Department of Health and Social Care in respect of governance. As the Accounting Officer, I am accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. I have overall responsibility for the management of risk and for maintaining a sound system of internal control.

Leadership arrangements for risk management are detailed in the Trust's Risk Management Framework, supported by the Board Assurance Framework and individual job descriptions. The Risk Management Framework outlines our approach to risk and the accountability arrangements including the responsibilities of the Board and its committees, Executive Directors and all staff.

Active leadership from all managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance.

The Senior Director of Corporate Governance has delegated responsibility for the Trust's Board Assurance Framework and for ensuring the implementation of the risk management framework within services. All Executive Directors have responsibility to identify and manage risk within their specific areas of control in line with the management and accountability arrangements in the Trust. Directorates and Care Units have identified leads for risk management. Risks and mitigations are considered at all Accountability Framework meetings. The Trust also has a monthly Risk Oversight Group with multidisciplinary membership at a senior level.

The Board and its committees receive and scrutinise the risks to achieving our strategic objectives through the Board Assurance Framework. The Audit Committee has delegated responsibility for developing, maintaining and monitoring the risk management and assurance systems within the Trust and specifically the Board Assurance Framework. Care Units and corporate directorate team meetings review their Risk Registers the Trust's Executive Operational Group regularly reviews the Corporate Risk Register. All members of staff have an important role to play in identifying, assessing and managing risk.

The Trust engenders a fair, open environment and does not seek to apportion blame. Where staff feel that raising issues or concerns may compromise them or may not be effective, they are encouraged to follow alternative feedback mechanisms, including through the Freedom to Speak-Up Guardian and / or the Trust's Freedom to Speak-Up / Whistleblowing policy.

The Trust ensures that staff are equipped to manage risk in a variety of ways and at different levels of strategic and operational function. Staff are trained in various aspects of risk management, including as part of the on-boarding process for new staff. The training is designed to provide an awareness and understanding of the risk management framework, the risk management process and to give practical experience of completing risk assessments. Additional training is made available to all levels of staff covering areas such as fire safety, health and safety, moving and handling, resuscitation and first aid. The Trust regularly shares information and with all staff to support learning from good practice, experience and lessons learnt from incidents or near misses. The Trust uses Quality Improvement (QI) methodology to encourage staff to learn from good practice. Local improvement data is shared and visible to teams so that they can learn from, scale-up and spread what works well.

The Risk and Control Framework

Key elements of the risk management framework

The Trust considers risk management to be an intrinsic part of our governance and quality frameworks and an essential element of the entire management process and not a separate entity. The management of risk underpins the achievement of the Trust's strategic objectives, and effective risk management is imperative to provide a safe environment and improved quality of care for service users and staff.

Risk management including clinical, non-clinical, corporate, business and financial risks is intrinsic in the operational and strategic thinking of every part of service delivery within the organisation and applies to all staff. Risk management processes involve the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals to reduce the incidence and impact of the risks they face.

The Trust Risk Management Framework details our risk management arrangements. Potential risks are identified from a variety of sources, including risk assessments, risk registers, incidents, safety alerts, management, complaints, claims, internal / external reviews and staffing trends. The framework overarches both clinical and non-clinical risk management, and defines risk and identifies individual collective responsibility for risk management within the organisation. It also sets-out the Trust's approach to the identification, assessment, scoring, management and monitoring of risk. The framework also includes the Trust's risk appetite statement for the levels and types of risk the Trust is prepared to accept in pursuance of its strategic priorities by considering the Trust's position against a range of factors including national policy, system requirements, local plans and pressures.

The Trust manages its most significant current and future potential risks to the achievement of our strategic objectives through the Board Assurance Framework that provides a structure for the effective and focused management of principal risks. Risks are assessed by using a 5 x 5 (Likelihood x Consequence) risk matrix where the total score is an indicator as to seriousness of the risk. Each risk is allocated an Executive Director lead and a lead committee of the Board, and these risks are reviewed at committee meetings. The Board reviews the complete Board Assurance Framework at its meetings in public.

Quality Governance

The Trust has an accountability framework in place as an executive management system to oversee performance and gain assurance in an integrated, consistent and transparent way, including through care units and corporate directorates. The framework covers five domains:

1. Quality and Safety
2. Operational Performance
3. Workforce and Culture
4. Finance
5. External Relations

Maintaining an effective quality governance system supports our compliance with national standards and we are committed to continuous improvement of our systems. The Trust introduced a new risk to the Board Assurance Framework relating to quality governance (SR13) to ensure there are effective quality governance processes in place to provide thorough insight into quality risks. The risk noted the importance of the development and embed governance and reporting (including triangulating a range of quality and performance information) to ensure there is consistent understanding of key risks and mitigating actions, leading to the consistency of standards across the Trust.

The Quality Committee is the key governance committee, which is a standing committee of the Board that is chaired by a Non-Executive Director. The Committee seeks assurance that high standards of care are provided, that quality improvement and learning is embedded in the Trust, and ensures that adequate and appropriate governance structures, processes and controls are in place across the organisation. The Committee receives regular assurance reports focused on safer staffing, learning from deaths. NICE compliance safeguarding, medicines management, infection control and health & safety.

Performance matters are overseen by the Trust's Performance and Finance Committee.

The Board receives regular quality and performance reports at its meetings in public. The quality report provides the Board with assurance related to quality across the Trust, incorporating two domains of quality assurance and quality improvement. Quality control is covered in the quality and performance scorecard report that contains quality measures at an organisation level and provides an oversight of strategic performance and risk issues. The quality of performance information is assessed through the Data Security Protection Toolkit.

The Trust aspires to provide care of the highest quality, working with people who use our services. The aspiration is supported by our quality management system, which includes quality planning, quality control, quality assurance and quality improvement. We embrace continuous improvement and learning through our established quality improvement programme. We provide training for all staff to help them develop the skills they need to lead change and deliver improvements to patient experience and outcomes, focusing on what matters most to our service users and staff.

The Trust is registered with the Care Quality Commission (CQC) and is fully compliant with the CQC's registration requirements. Additional conditions of registration are placed on the Trust's services for accommodation for persons who require nursing or personal care at both Clifton Lodge and Rawreth Court Nursing Homes, specifically,

A requirement to have a registered manager for each site.

A maximum of 35 beds provision at each site.

The CQC published one report pertaining to the Trust's services in 2024/25:

February 2025 – Clifton Lodge Nursing Home (from an inspection completed in October 2024) achieving an overall rating of 'Good', with a 'Good' rating in all domains.

The CQC also carried out an unannounced focused inspection of our forensic / secure wards at Brockfield House in March 2024, and published its report in April 2025. The service was rated as 'Good' in all domains.

In year, the CQC undertook an unannounced focused inspection of Adult Acute and Psychiatric Intensive Care Units (PICU) in November / December 2024. The inspection focused on the safe and well-led domains, for which the report is awaited.

The Trust is overall rated as 'Requires Improvement' by the CQC, with the rating for the caring domain being 'Good'.

The Trust continues to progress the improvement plan, in response to inspections. The plan is monitored on a weekly basis and by a regular evidence assurance meeting including Integrated Care Board (ICB) colleagues, to provide evidence that actions have been completed and improvements sustained. As at the end of 2024/25:

- There were 348 actions addressing 78 'must do' / 'should do' recommendations made by the CQC.
- 96% of actions in response to the CQC recommendations have been reported as complete by action owners.
- 55% have been through the evidence assurance process and closed with the support of our ICB colleagues.

As at 31 March 2025, there are two sub-actions past the original stated timelines, both being additional actions proposed by the Trust (see CQC section in report) have required a reassessment and subsequent extension to the initial timelines.

Oversight is through the Executive Operational Committee on a monthly basis and to the Board of Directors and System partners.

Embedding risk management in the activity of the organisation

Risk management is embedded throughout the Trust's operational structures, with emphasis on ownership of risk within the care units and directorates support by the Risk and Compliance Team. Directorates are responsible for maintaining their own risk registers that feed into the Trust's Corporate Risk Register. Local Risk Registers are reviewed at monthly care unit meetings and shared with the assurance team. Directorate representatives attend key committees of the healthcare governance framework ensuring formal channels of reporting, wide staff involvement and sharing of learning. The implementation of incident management and other risk-related policies and procedures throughout the Trust ensures the involvement of all staff in risk management activity.

The Trust has published on its website an up-to-date register of interests (via an online portal), including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

Trust major risks

The Board Assurance Framework includes eleven risks that align with the Trust's strategic objectives. Some risks and target scores reflect multi-year programmes. The standing committees of the Board review and discuss the controls and assurance for each of their assigned risks, including the actions identified to address gaps and whether there should be any changes to the current and / or target scores. The Audit Committee has responsibility for ensuring the Trust has good risk management processes in place, which operate effectively. To avoid duplication, the Audit Committee does not discuss in detail any risks that are the responsibility of other committees.

As at 31 March 2025, the Trust identified the most significant risks to the achievement of its strategic objectives as being:

SR3: 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. The Trust continued its strategy towards the ambition of being the leading health and wellbeing service in the provision of mental health and community services. A key part of this is the Trust Estates Strategy, approved in October 2024, which is now being implemented to support the delivery of the clinical care model. (Risk Score 15)

SR4: If EPUT does not effectively address demands, then its resources may be over stretched, resulting in an inability to deliver high quality safe care, transform, innovate and meet partnership ambitions. The Trust is implementing a new target operating model to enhance place-based care and is implementing a demand and capacity module which will allow predictive modelling and an inpatient dashboard enabling visibility of patient-level data. The Trust continues to collaborate with system partners to improve patient flow and capacity. (Risk Score 15)

SR5: 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 the undermining of the Quality of Care Strategy. The Trust is fully cooperating with the Inquiry team and has in place a project team to ensure timely and effective responses are provided. This is overseen by a Committee reporting directly to the Board to provide assurance the Inquiry is being served appropriately and highlight any potential risk directly to the Board. The Trust has continued to take action to ensure the systematic and sustained embedding of learning. (Risk Score 16)

SR6: If EPUT experiences a cyber-attack, then it may encounter system failures and downtime, resulting in a failure to achieve safety ambitions, compliance and consequential financial and reputational damage. The Trust continues to hold cyber essentials plus accreditation and has implemented a new cyber security framework, taking into account national NHS cyber risk profile. The Trust has business continuity plans in place for IT disruption. (Risk Score 15)

SR7: If EPUT does not have sufficient capital resource, e.g. digital and electronic patient records, then it will be unable to undertake essential works or capital dependent transformation programmes, resulting in non-achievement of some of its strategic and safety ambitions. The Trust has a prioritised capital plan in place and tracks key strategic investments to monitor the impact on the plan. The Trust actively horizon scans to maximise opportunities for both regional and national investment and is engaged within the system finance meetings where accountability for capital resources are held. A range of applications for additional capital have been submitted covering Critical Infrastructure, Mental Health Urgent Care and Out of Area placements (Risk Score 20)

SR8: If EPUT (as part of Mid and South Essex Integrated Care System) 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. The Trust has a number of internal policies and processes to manage and monitor effective and efficient management of resources, including standing financial instructions, scheme of delegation and accountability framework meetings. The Trust has also implemented additional oversight and support for areas of highest spend, such as the use of temporary staffing, and identified through an Investigate and Intervene Programme options for improving the use of resources. The Executive Chief Finance Officer and deputies continue to be actively involved and engaged within the system finance meetings. The Trust recognises the challenges and associated risks that exist at both local, ICS and national levels and has enhanced pay and non-pay controls measures in places. The Trust has also introduced a Transformation and Efficiency Group chaired by the CEO... (Risk Score 20)

SR9: If EPUT does 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 mid-set and culture, which may result in limitations in its ability to procure and implement the appropriate

technology to support the integration of care close to where service users live, and support staff to undertake their duties effectively; threaten the development of patient facing technologies to support service users, families and carers; and stall its capability and agility to use data to inform both direct care and insight driven decision making. The Trust has successfully implemented phase one of its digital target operating model and has the ambition of completing phase two during 2025/26. The Trust is currently engaged in a major digital product to deliver a unified electronic patient record. (Risk Score 15)

SR10: 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 its ability to provide high quality of care to service users. The Trust has been formerly part of the People promise initiative alongside NHS England. This alongside effective workforce planning has resulted in reduction in turnover, lower vacancies and a reduction in staff absence therefore indicating enhanced levels of staff morale. (Risk Score 12)

SR11: If EPUT does not effectively and efficiently manage a coherent staff retention strategy, then it will continue to effect staff and skills shortages in certain professions resulting in associated skills deficit, impact on staff morale and the ability to provide high quality of care to service users. The Trust has implemented a People and Education Strategy, to ensure greater focus on staff retention. The Trust is demonstrating positive trends in staff turnover as well as a reduction in vacancy rates alongside significant reduction in temporary staff use. (Risk Score 12)

SR12: If EPUT does not have in place effective organisational development support to address cultural development and management of change, then it may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care. The Trust completed a gap analysis of organisational development skills to determine what is required to be effective and sourced external support for senior leadership development and a cultural reviews. (Risk Score 16)

SR13: 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 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. The Trust has a Quality of Care Strategy, which is supported by a range of other policies and processes, such as a Quality Assurance Framework, quality visits programme and a number of information driven oversight arrangements. (Risk Score 15)

The Trust has a number of processes whereby risks are identified such as, risk assessments, clinical benchmarking, audit data, clinical and non-clinical incident reporting, complaints, claims, patient and public feedback, stakeholder and partnership feedback, national and regional risk registers held by NHS England / local Integrated Care Systems and internal / external assessment, including Care Quality Commission inspection reports.

At Essex Partnership University NHS Foundation Trust, we believe that every incident offers an opportunity to learn. The reporting of incidents is a fundamental building block in achieving an open, transparent and fear-free way of fulfilling this aim. Our structures and frameworks promote learning, escalation, treatment and mitigation of, or from, risk.

We recognise the rapidly changing health and social care landscape – both nationally and locally – combined with wider system pressure poses potential risks to the sustainability of high quality service provision for the populations we serve and our financial sustainability, as well as providing opportunities for further improvement.

The Board continuously reviews the risks that may affect the Trust's achievement of its strategic priorities.

NHS Foundation Trust licence condition compliance.

The Trust's risk and governance frameworks as described in this statement ensures that the organisation can confirm validity of its governance arrangement as required under NHS provider licence section 4 (NHS2 Governance arrangements). The Trust Executive team undertakes an annual review of its compliance with these principles, systems and standards of good corporate governance and flags for the Board's attention those areas where action is required. The Board of Directors reviews the Corporate Governance Statement itself, with a summary of evidence supporting it.

During the year, the Board used a number of mechanisms to gain positive assurance that the Trust continued to comply with those requirements, in preparation for the making of the statement. These included regular reporting from Board Committees regarding the level of assurance in respect of the matters that they were delegated to oversee, receiving patient and staff stories to hear directly about the quality of care provided to patients; regular reviews of the Board Assurance Framework and reviewing the risks recorded within it; and regular consideration of key business plans, and updates on progress for the various projects within the Trust's strategic and transformation programme.

A self-assessment of compliance against the Trust's licence is undertaken by the Senior Director of Corporate Governance and reviewed by the Finance and Performance Committee. The Trust also has a programme of internal audit in place aligned to key areas of potential financial and operational risk. The Board has not identified any principle risks to compliance with provider licence section.

Involvement of stakeholders

The interests of our patients, carers, staff, members and local partner organisations are embedded in our values and demonstrated in our ways of working. Our Working in Partnership with People and Communities Strategy continues to be implemented and sets-out our ambition for involving stakeholders across all functions.

The Trust has a continuing positive relationship with stakeholders and staff through the delivery of strategic plans and delivering performance against contracts.

Risks to public stakeholders are managed through formal review processes with NHS England and local commissioners through joint actions on specific issues, such as emergency planning and learning from incidents, and through scrutiny meetings with upper tier local authorities' Health and Overview Scrutiny Committees. We work across the local health economy, including integrated care systems, particularly on the delivery of integrated care pathways. This way of working has been particularly effective in our collaborative working arrangements for specialist mental health services and community services.

The interests of our patients are overseen by the Director of Patient Experience through various forums and by including representatives in the coproduction of services, quality improvement initiatives and other patient-led programmes. The Council of Governors represents the interests of members (both public and staff) as well as appointing organisations, and has a role in holding the Non-Executive Directors both individually and collectively to account for the performance of the Board.

The Trust workforce

Staffing

During the year, the Trust's workforce planning has continued to focus on ensuring our operational care units are able to recruit and retain the staff required to ensure high quality, safe care can be provided. Supported by the Time to Care programme, there has been a focus on our inpatient services with a novel approach to staffing and updates to our operating model, which has implemented a comprehensive plan to increase staffing levels for critical clinical roles. The plans include initiatives such as the enhanced recruitment of additional Health Care Assistants in order to reduce the high vacancy factor.

The work undertaken during 2024/25 has led to the successful appointment of staff to the following positions:

- 201 Qualified Nurses
- 65 Allied Health Professionals
- 14 Substantive and 5 NHS Locum Consultant Psychiatrists
- 169 Health Care Assistants

The work undertaken has led to a Trust-wide vacancy rate of 11.4 percent and a turnover rate of 8.7 percent in March 2025, compared to 9.1 percent for both vacancy and turnover in March 2024.

The Trust has collaborated closely with Care Unit management teams and clinical leaders to establish safe staffing levels for each ward and unit. The new governance arrangements enables us to review staffing levels to ensure the delivery of high quality, safe care for our patients while operating efficiently. These efforts will help us continue to drive improvements in care and services across the Trust. The Trust has effective systems and processes in place to assure the Board that staffing is safe, sustainable, effective and supports provision of a quality service. The Trust regularly reviews staffing establishments, ensuring the right number and skill mix of staff are available to meet the needs of people using our services. These reviews include use of evidence based tools where available, national guidance, reviews of quality measures, quality outcomes and professional judgement.

The Trust has been successful in its efforts to reduced reliance on temporary staffing including Executive led oversight meetings. This work has seen a reduction in temporary staffing costs of £14.5m (18%) between 2023/24 and 2024/25. The work undertaken has seen a proportion of agency staff spend reduce annually from 7.2% (£28.1m) of the total pay bill to 3.9% (£16.4m). Whilst this remains outside of the National 3.2% target it is a reduction of 3.3 percent from March 2024.

On a daily basis, professional teams undertake daily staffing reviews in line with standard operating procedures, taking into account staff numbers, skill mix and competencies, patient acuity, dependency and activity. Where indicated, staff are used flexibly to provide cover and risks are formally escalated for action.

The Trust completed a full establishment review in August 2024, providing the Board with assurance safer standards were being met. The Trust electronic roster system for nursing staff details the type and number of staff required to meet patient care and treatment needs. Rotas for trainee doctors are monitored for compliance with oversight from the Guarding of Safe Working and the People, Equality and Culture Committee (PECC). All changes to skill mix and new roles undergo a quality impact assessment which is signed off by the Executive Nurse and Executive Medical Director. The PECC also oversees the Trust's wider talent management, leadership development and training initiatives, which are all designed to create resilience and capacity within the workforce.

During the early part of 2024/25, the Trust responded to industrial action by junior doctors, using emergency planning protocols to establish cover rotas and agree pay and escalation procedures.

The Trust continued to implement its Time to Care programme in 2024/25. The programme had seen the development of a new innovative therapeutic operating model that would enable quality and safety consistency across all wards; ensuring purposeful admission which an ambition of an average length of stay of 30 days and a range of other improvements, including trauma informed care, integrated working with urgent and community services to support safe local discharge; all to improve the experience of patients, families and carers.

The Trust mobilised its new Therapeutic Acute Inpatient Care Operating model during 2024/25, which was supported by the investment and recruitment of the Time to Care Workforce, training schedule, Standard Operating Policy, International Fundamentals of Care and a new Quality of Care Framework.

The aims and objectives of the model are to:

1. Set out the acute inpatient care operating model for adults and older adults.
2. Current and incoming Time to Care staff understand how care is to be delivered in our organisation and be empowered and equipped with the skills to deliver care in line with the operating model.

The project scope set out the plan for the mobilisation of the model:

- Plan and Design the operating model for acute inpatient care for adults and older adults from admission, through inpatient stay and to discharge (joined up with Community Services / families & carers.).
- Identify priority pathways
- Development of implementation plan (yr. 1,2,3 priorities)
- Communicate the operating model to the organisation, working with relevant stakeholders
- Work with stakeholders to ensure change management activities are in place to enable to implementation of the operating model
 - **Work with the Time to Care Programme** to ensure that the operating model is reflected in the work being delivered by the recruitment and marketing, communications, and initiative leads work streams
 - **Commence implementation** in priority pathways
 - **Review the success** of the operating model and make revisions as appropriate

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity and human rights legislation

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. In addition, strategies are in place to further equality, diversity and inclusion.

Financially viable programmes are subject to Quality Impact Assessment and Equality Impact Assessment as necessary, ongoing monitoring to ensure that efficiencies do not adversely impact on the quality of service delivery.

Climate change obligations

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance from the Greener NHS programme. The Trust ensures that obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of the economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I have responsibility for ensuring economy, efficiency and effectiveness of the use of resources and am supported by my Executive team who are responsible for overseeing the day-to-day operations of the Trust. Performance in this area is monitored by the Board on a regular basis and through assurance reports from its standing committees. The Board discusses and approves the Trust's strategic and annual plans and budgets, taking into account the views of the Council of Governors.

The Board receives regular finance, financial viability, quality and performance reports which enable it to monitor progress in implementing the annual plan, and strategic objectives. The quality and performance scorecard presented to Board provides assurance on the delivery of Trust-wide performance, finance and

compliance matters and seeks to demonstrate how the Trust is improving quality of life for the communities it serves.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively centre on a robust budget-setting and control system which includes activity related budgets and periodic reviews during the year. These are considered by the Executive Directors, the Finance and Performance Committee and the Board.

The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and financial approval limits. Due to the challenged financial environment in which the Trust operates, internal systems of control have been enhanced including reviewing all non-pay spend to ensure the budgets are being utilised economically and the Trust is getting best value-for-money for any non-pay spend. Furthermore, Vacancy Control Panels operate across the Trust and the Trust has been working to Triple Lock Control arrangements with System and Regional colleagues. During 2024/25 the Trust also participated in the National Investigate and Intervene Programme with its System partners to support the delivery of its financial efficiency programme and financial targets. It also refined its Transformation and Efficiency Group to provide further oversight and support on efficiency and financial improvement.

The Trust's Audit Committee supports the Board and me as the Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management and control environment. The scope of the Audit Committee's work is defined in its Terms of Reference and encompasses all the assurance needs of the Board and the Accounting Officer. The Audit Committee is involved with the work of internal and external audit, and is chaired by a Non-Executive Director.

Information Governance

The Trust recognises the vital importance of data security and protection, as we hold sensitive personal data related to a large number of individuals, both patients and staff. The Trust has appropriate data security arrangements in place, including password restricted access to systems and information, and systems to record all access to records. Staff receive regular update training on information governance and security measures, and the Trust takes appropriate disciplinary action against staff who have improperly accessed information.

The Executive Director of Strategy, Transformation and Digital is the Executive-lead for information governance and is supported by staff within the Data Protection Officer Office, Information Governance Team and directorate leads.

The Trust nominated Caldicott Guarding is the Executive Medical Director and the Executive Director of Strategy, Transformation and Digital is the Senior Information Risk Owner (SIRO).

The Trust has policies in place which are compliant with NHS guidelines, and incident-reporting procedures are in place and utilised by staff. An Information Governance Steering Committee forms part of the Trust's healthcare governance framework and the Board receives reports on compliance with the Data Security and Protection Toolkit (DPST). The arrangements are in place to manage and control risks to information and data security and the Board has been assured by the SIRO, in the annual DSPT assessment that these are effective.

The Trust regularly reviews and updates its cyber assurance approach to align with the NCSC Cyber Assurance Framework (CAF).

There were no reportable incidents via the Data Security Incident Reporting Tool in 2024/25 that met the threshold for notification to the Information Commissioner's Office.

Ongoing training and awareness programmes are undertaken with individuals, teams and Trust-wide to reiterate the Trust's commitment to maintain the confidentiality of personal information.

Data Quality and Governance

A fundamental requirement for the Trust to deliver safe, high quality care is the provision of timely and effective monitoring reports, using complete data. Key performance indicators are reported regularly to the Board as part of performance monitoring arrangements. Scrutiny of the information contained within the indicators and its implications for clinical outcomes, patient safety and patient experience takes place at the Board committees.

Reviews of data quality and the accuracy, validity and completeness of Trust information fall within the remit of the Audit Committee, which is informed by the review of internal and external audit management assurances.

The Trust achieved an average Data Quality Maturity Index (DQMI) score of 93.4% for Q1, and 91.1% for Q2, and achieved an average Data Quality Maturity Index (DQMI) of 91.9% for the most recent reporting period (Q3 2024/25) which is 18% above the national average (noting that Q4 is yet to be published).

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Essex Partnership University NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by the comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other committees of the board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Progress against actions are monitored by the Executive Team and the Audit and Quality Assurance Committees. The following processes have been applied in maintaining and review the effectiveness of the system of internal control:

- The Board met five time in public during 2025/25 and received a report at each meeting relating to finance, performance and quality, inviting scrutiny and challenge.
- A structure of standing committees beneath the Board provides a layered approach to monitoring, scrutiny and challenge of systems of internal control.
- A comprehensive quality, assurance and risk structure is in place.
- The Board has identified strategic risks facing the Trust that are included in the Board Assurance Framework, has monitored the controls in place and the assurance available to ensure that these risks are being appropriately managed. The Board received the Board Assurance Framework at each meeting as well as assurance reports from all standing committees.
- Executive Directors ensure that key risks have been identified and monitored within their directorates and the necessary action taken to address them. They are also directly involved in monitoring and reviewing the Board Assurance Framework, and attend the assigned lead committees to report on risk with their areas of control.
- The Audit Committee provides the Board with an independent and objective view of arrangements for internal control and risk management within the Trust and ensures the internal audit service complies with mandatory audit standards. It approves the annual audit plans for internal and external audit activities, receives regular progress reports and individual audit reports, and ensures that recommendations arising from audits are actioned by Executive management.
- The Quality Committee receives internal audit reports at each of its meetings pertaining to quality related updates. A Non-Executive Director member of the Quality Committee is also a member of the Audit Committee.

- A clinical audit programme is in place to drive-up quality standards. The Quality Committee considers the clinical audit plan, and management ensures that appropriate action is being taken to address any areas of under-performance. An annual report of results is produced.
- The Trust has a local anti-crime and investigation service in place. The Audit Committee receives regular reports from the local anti-crime specialist.
- Internal audit services are outsourced to an organisation called TiAA who provide an objective and independent opinion on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Individual audit reports include a management response and action plan. Internal audit routinely follow-up actions with the management to establish the level of compliance, and the results are reported to the Audit Committee.
- The comprehensive programme of internal audit is aligned to key areas of potential financial and operational risk. My review is also informed by the work through the year of the Board of Directors and of Board standing committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by the Audit Committee and the action plans resulting to address areas for improvement.

Head of Internal Audit Opinion

In accordance with the Public Sector Internal Audit Standards (PSIAS), internal audit provides the Trust with an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

Internal Audit issued 13 reports in 2024/25 – see table below:

	Audit	Opinion	Status
1.	Recording and Monitoring of Therapeutic Observations	Reasonable	Final
2.	Care Plans and Risk Assessments	Reasonable	Final
3.	Core Financial Assurance	Substantial	Final
4.	Temporary Staffing	Reasonable	Final
5.	Cyber Security	Reasonable	Final
6.	E-Rostering	Limited	Final
7.	Mortality Review Process	Reasonable	Final
8.	Patient Safety Incidents Process	Reasonable	Final
9.	Consultant Job Planning	Limited	Final
10.	Falls Management	Reasonable	Final
11.	Payroll including Salary Overpayments	Reasonable	Final
12.	Assurance Framework and Risk Management	Substantial	Final
13.	Compliance with Policies – Site Visits	Reasonable	Final

Consultant Job Planning – The internal audit review focussed on effectiveness and compliance with consultant job planning process. The auditors concluded that while a consultant job planning process exists, audit testing has noted improvements are required to the existing arrangements to strengthen controls over the operation and management of the process hence limited assurance provided. Management action is being taken to address the ten recommendations made by the auditors and internal audit will routinely follow up to establish levels of compliance and report to the Audit Committee.

E-Rostering - The internal audit limited assurance review noted that establishment figures and the numbers of hours being owed to the Trust by members of staff needed reviewing. There were a number of cases where system calculations resulted in errors on the rosters, and Trust wide reports relating to rostering for Community Teams were not available due to the lack of reporting functionality in the rostering system. Management action is being taken to address the six recommendations made by the auditors and internal audit will routinely follow up to establish levels of compliance and report to the Audit Committee.

The framework for monitoring and review of action in response to internal audit reports is established and status for each reported at each Audit Committee meeting.

Head of internal audit's annual opinion

TIAA is satisfied that, for the areas reviewed during the year, Essex Partnership University NHS Foundation Trust has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by Essex Partnership University NHS Foundation Trust from its various sources of assurance.

My Review confirms that the Trust has an adequate and effective system of internal control and in considering any significant issues, the following has been recognised:

- Lampard Inquiry is considered a significant matter for EPUT, both in regards to resourcing including the direct servicing, administration, access to and the retrieval of historic documentation over 24 years together with associated clinical, operational, staffing, financial impacts and its reputational implications.
- Mental Health inpatient demand and acuity driving temporary staffing levels and out of area placements is considered a significant matter with the potential to prejudice the achievement of the Trust's priorities to deliver safe and effective care and a positive patient / carer experience.
- The Mid and South Essex Integrated Care System financial challenge is considered a significant matter for EPUT, in regards to the financial management and the Trust's contribution to the system control total and the potential to prejudice the achievement of the Trust's priorities to sustain and improve services – for example, capital resourcing requirements, addressing the underlying deficit, efficiency requirements and reducing cash balances.
- The CQC rating of our acute mental health wards for adults and our adult psychiatric intensive care unit (published April '23 and in July 2023) is considered to be an ongoing significant internal control issue for EPUT (until there is CQC re-inspection). We have made significant progress in delivering our quality improvement plan, working with our system partners, to provide quality assurance for both impact and sustainability.

A handwritten signature in black ink, appearing to read 'P. Scott', is positioned within a light gray rectangular box.

Paul Scott

Chief Executive Officer

Essex Partnership University NHS Foundation Trust

24 July 2025

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ESSEX PARTNERSHIP NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Essex Partnership University NHS Foundation Trust for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 30, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Essex Partnership University NHS Foundation Trust as at 31 March 2025 and of Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on Foundation Trust's ability to continue as a going concern for a period to 31 July 2026.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of the Chief Executive's responsibilities as the accounting officer of Essex Partnership University NHS Foundation Trust', the Chief Executive is the accounting officer of Essex Partnership University NHS Foundation Trust. The accounting officer is responsible

for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the Foundation Trust, or have no realistic alternative but to do so.

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.
- We understood how Essex Partnership University NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit, those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.
- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper

recognition of revenue and omission of expenditure) and management override of controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue and omission of expenditure, we reviewed transactions recorded in the ledger and payments received into the bank account post year-end, to confirm that expenditure had been recognised in the correct period, we reviewed significant contracts for patient care income to check that income was recognised in line with the agreements and tested accrued income and expenditure balances at the year-end back to supporting evidence.
- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

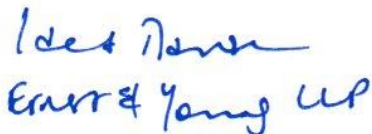
We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Essex Partnership University NHS Foundation Trust.

Use of our report

This report is made solely to the Council of Governors of Essex Partnership University NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. Our audit work has been undertaken so that we might state to the Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.



Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
28 July 2025

Foreword to the accounts

Essex Partnership University NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Essex Partnership University NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

If you require any further information on these accounts, please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268 366000



Paul Scott
Chief Executive
24 July 2025

Statement of Comprehensive Income

		2024/25	Restated 2023/24
	Note	£000	£000
Operating income from patient care activities	2	581,711	507,277
Other operating income	3	26,972	31,462
Operating expenses	6,7	(637,044)	(548,800)
Operating (deficit) from continuing operations		(28,361)	(10,061)
Finance income	8.1	3,137	4,296
Finance expenses	8.2	(7,618)	(10,369)
PDC dividends payable		(5,011)	(5,113)
Net finance costs		(9,492)	(11,186)
Other gains / (losses)	9	(688)	(546)
(Deficit) for the year from continuing operations		(38,541)	(21,793)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	11.5	(44,557)	(6,258)
Revaluations	11.5	50,175	12,748
Remeasurements of the net defined benefit pension scheme liability / asset	7.4.8	(6)	(375)
Other reserve movements		146	70
Total comprehensive income / (expense) for the period		(32,783)	(15,608)

The notes on pages 178-226 form part of these accounts. All income and expenditure derives from continuing operations.

	2024/25	2023/24
Adjusted financial performance (unaudited)	£000	£000
(Deficit) for the period	(38,541)	(30,444)
Remove net impairments not scoring to the Departmental Expenditure Limit	27,515	4,622
Remove capital donations / grants / peppercorn lease I&E impact	(1,293)	5
Prior period adjustments	8,651	-
Remove impact of technical PFI adjustment	(239)	4,245
Remove non-cash element of on-SOFP pension costs	86	98
Adjusted financial performance (deficit)	(3,821)	(21,474)

The Trust is monitored by NHS England on the basis of adjusted financial performance. This is based on the reported surplus / (deficit) for the year, and is adjusted for a number of agreed items. For the financial year ending 31 March 2025, the Trust's adjusted financial performance was a deficit of £3,821k which includes the impact of the prior period adjustment (note 30). Prior period adjustments score against the in-year performance with the previous years adjusted performance remaining unaffected by the adjustment.

Statement of financial position

		31 March 2025 £000	Restated 31 March 2024 £000
	Note		
Non-current assets			
Intangible assets	10	14,184	11,756
Property, plant and equipment	11	209,992	227,098
Right of use assets	12.1	44,378	43,985
Investment property	13	12,585	18,085
Receivables	15	176	166
Other assets	7.4.3	21	113
Total non-current assets		281,336	301,202
Current assets			
Inventories	14	411	489
Receivables	15	23,310	20,190
Non-current assets for sale and assets in disposal groups	16	500	545
Cash and cash equivalents	17	28,077	43,378
Total current assets		52,298	64,602
Current liabilities			
Trade and other payables	19	(51,227)	(50,669)
Borrowings	21	(12,781)	(9,058)
Provisions	23	(9,199)	(7,576)
Other liabilities	20	(1,825)	(1,610)
Total current liabilities		(75,032)	(68,913)
Total assets less current liabilities		258,601	296,891
Non-current liabilities			
Trade and other payables	19	-	(282)
Borrowings	21	(72,887)	(78,299)
Provisions	23	(7,334)	(10,615)
Total non-current liabilities		(80,221)	(89,196)
Total assets employed		178,380	207,695
Financed by			
Public dividend capital		148,329	144,861
Revaluation reserve		98,853	78,104
Other reserves		21	113
Income and expenditure reserve		(68,823)	(15,383)
Total taxpayers' equity		178,380	207,695

The financial statements on pages 173-177 were approved by the Board on 24 July 2025 and signed on its behalf by:



Paul Scott
Chief Executive
24 July 2025

Statement of changes in taxpayers equity for year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 (restated) - brought forward	144,861	78,104	113	(15,383)	207,695
(Deficit) for the year	-	-	-	(38,541)	(38,541)
Adjustment to revaluation reserve *		15,012		(15,012)	-
Other transfers between reserves	-		(86)	86	-
Impairments	-	(44,557)	-	-	(44,557)
Revaluations	-	50,175	-	-	50,175
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	(6)	-	(6)
Public dividend capital received	3,468	-	-	-	3,468
Other reserve movements	-	119	-	27	146
Taxpayers' and others' equity at 31 March 2025	148,329	98,853	21	(68,823)	178,380

* During the year, and following a five year revaluation of estate the Trust has reviewed the basis of offsetting revaluation gains and losses between revaluation and income and expenditure reserves. This review has led to an 'in year' adjustment to ensure revaluation gains and losses are represented on a component basis consistent with Accounting Policy. The Trust has assessed it is impractical to unwind adjustment to prior years on the basis that for the adjustment to be reliable it would need to revert to beyond pre-merger conditions and it is impracticable to determine period specific effects with enhanced accuracy. Management has selected it is more practicable to adjust impacts from balances recorded at 01 April 2024. The transfer of reserve results in a movement from revaluation reserves to income and expenditure reserves totalling £15m. The adjustment does not change the overall equity position of the Trust or impact 'in year' adjusted performance results and is assessed as not qualitatively material.

Statement of changes in taxpayers equity for year ending 31 March 2025 (restated)

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	141,550	71,534	586	19,673	233,343
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	(13,351)	(13,351)
(Deficit) for the year	-	-	-	(21,793)	(21,793)
Other transfers between reserves	-	10	(98)	88	-
Impairments	-	(6,258)	-	-	(6,258)
Revaluations	-	12,748	-	-	12,748
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	(375)	-	(375)
Public dividend capital received	3,311	-	-	-	3,311
Other reserve movements	-	70	-	-	70
Taxpayers' and others' equity at 31 March 2024	144,861	78,104	113	(15,383)	207,695

Statement of cash flows

	Note	2024/25 £000	Restated 2023/24 £000
Cash flows from operating activities			
Operating (deficit)		(28,361)	(10,061)
Non-cash income and expense:			
Depreciation and amortisation	6.1	15,556	14,787
Net impairments	11.5	27,515	4,622
Income recognised in respect of capital donations	3	(1,380)	-
Non-cash movements in on-SoFP pension liability		86	98
(Increase) / decrease in receivables and other assets		(3,106)	13,030
(Increase) / decrease in inventories		78	(40)
Increase / (decrease) in payables and other liabilities		1,728	(13,716)
Increase / (decrease) in provisions		(3,354)	(6,992)
Net cash flows from operating activities		8,762	1,728
Cash flows from investing activities			
Interest received		2,035	3,182
Purchase of intangible assets		(4,657)	(4,762)
Purchase of PPE and investment property		(10,885)	(11,345)
Sale of PPE		2	-
Net cash flows (used in) investing activities		(13,505)	(12,926)
Cash flows from financing activities			
Public dividend capital received		3,468	3,311
Movement on loans from DHSC		(400)	(400)
Capital element of lease rental payments		(2,926)	(3,706)
Capital element of PFI, LIFT and other service concession payments		(2,611)	(1,754)
Interest on loans		(51)	(59)
Interest paid on lease liability repayments		(421)	(450)
Interest paid on PFI, LIFT and other service concession obligations		(2,537)	(2,598)
PDC dividend (paid)		(5,080)	(5,709)
Net cash flows (used in) financing activities		(10,558)	(11,365)
(Decrease) in cash and cash equivalents		(15,301)	(22,563)
Cash and cash equivalents at 1 April - brought forward		43,378	65,941
Cash and cash equivalents at 31 March	17	28,077	43,378

Notes to the accounts

1 Summary of Accounting Policies and Other Information

1.1 General Information

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Presentation of Financial Statements

When preparing the financial statements the Trust will in normal circumstances follow the standard format. However, where it is determined that the standard format is not representative in reflecting the true performance of the Trust, the presentation of the primary statements may be amended accordingly.

1.2.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Going Concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the Trust's continued funding and provision of services. The interim financial plan for 2025/26 was approved on 20 March 2025 with the final submission made on 30 April 2025. The plan shows an adjusted breakeven position. The plan includes the continued provision of services by the Trust and/or within the WGA boundary. No circumstances were identified which caused the Directors to doubt the continued provision of NHS services.

Against the adjusted financial performance measure for 2024/25, the Trust has reported a deficit of £3,821k for the current financial year. This includes the impact of the prior period adjustment in 2023/24 which scores against 2024/25 performance (2023/24: £21,474k deficit).

Our going concern assessment is made up to the end of July 2026. The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period which shows sufficient liquidity for the Trust to continue to operate during that period.

In conclusion, and after making enquiries, the Directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable

future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.4 Income

1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations, which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods / services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods / services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year-end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2024/25, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements termed Aligned Payment and Incentive (API) contracts. These payments are accompanied by a variable element to adjust income for actual activity delivered.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred, and other income top-ups to support the delivery of services, for example reimbursement of variable activity.

Mental health and community provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism, and community services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. For the full period covered by these accounts, the Trust has been the lead provider for the East of England Adult Secure Provider Collaborative. During the 2024/25 financial year, the Trust took over as lead provider for the Mid & South Essex Community Collaborative. As lead provider for both of these Collaboratives, the Trust is accountable to NHS England and Mid & South Essex ICB respectively, and as such recognises the income and expenditure associated with the commissioning of services from other providers in these accounts. Where the Trust is the provider of commissioned services, this element of income is recognised in respect of the provision of services, after eliminating internal transactions. The Trust accounts for these transactions as a principal, in accordance with IFRS 15.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied.

In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.4.2 Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.4.3 Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 Expenditure on Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded, defined benefit schemes

that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

NEST Pension Scheme

A small number of employees are members of the NEST (National Employment Savings Trust) Scheme. NEST is a defined contribution scheme. This means that the contributions paid in by the employer, the employee, and anyone else are invested and used to build up the employee's own pension pot in accordance with the Scheme's policies.

The contributions are managed by the NEST Corporation, who are a Trustee body representing the employees. The employer shares no gain or loss on those funds. The employer is responsible only for its pension cost contributions and nothing else and does not bear the risks related to the plan rather those risks are borne by employees.

Employer's pension cost contributions are charged to operating expenses as and when they become due. The current year's contributions are in note 7.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme, i.e. the Essex Pension Fund, which is administered by Essex County Council. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

To assess the value of the Employer's liabilities at 31 March 2025, the liabilities have been recalculated from the latest full funding valuation carried out at 31 March 2022, using financial assumptions compliant with IAS19.

To calculate the Employer's asset share, the actuaries have rolled forward the assets allocated to the Employer at the latest valuation date allowing for investment returns (estimated where necessary), contributions paid into, and estimated benefits paid from the Fund by and in respect of the employer and its employees.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.6 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant & Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative services;
- it is probable that future economic benefits will flow to, or service potential be provided to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- they form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Tenant Improvements

Property, plant and equipment are capitalised where they are tenant improvements made on leased properties that cost at least £5,000 and add value to the leased property such that it is probable that future economic benefits will flow to the Trust for more than one year over the remaining lease term.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7.2 Measurement

Valuation

All property, plant and equipment assets are initially measured at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- land and non-specialised buildings – market value for existing use;
- specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity, meeting the location requirements of the services being provided. Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

HM Treasury recommends Land and Building assets are valued every five years, with an interim valuation at the end of the intervening third year. The financial year 2024/25 represents the fifth year of the recommended period for valuations. The Trust uses Montagu Evans LLP who are professionally qualified valuers and work in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The Trust instructed Montagu Evans LLP to undertake a full assessment of the asset carrying amounts at the end of the financial year and reflected these within the financial statements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees and borrowings costs, where capitalised in accordance with IAS 23. Assets are subsequently revalued/assessed for revaluation and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The Trust applies the following useful lives to property, plant and equipment assets. The lives applied to building assets from 31 March 2025 are based on the latest valuations received from Montagu Evans LLP where assets have been revalued. Prior to this date, the lives applied were based on those provided by the District Valuer for the 2024/25 financial year.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset, or for buildings, the life at latest revaluation as at start of the financial year. The range of useful lives are shown in the table below:

Main Asset Category	Sub Category	Minimum Useful Life (in years)	Maximum Useful Life (in years)
Buildings - owned	Structure	3	78
	Engineering and installations	5	35
	External works	12	78
Buildings - PFI schemes	Structure	59	62
	Engineering and installations	17	29
	External works	37	43
Plant, machinery and equipment	Medical and surgical equipment	5	15
	Office equipment	5	5
	IT Hardware	5	10
	Other engineering works	5	30
Furniture and fitting	Furniture	5	10
	Soft furnishings	5	7
Motor vehicles		7	7

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition / Assets Held for Sale

Assets intended for disposal, are reclassified as 'held for sale' once the following criteria in IFRS 5 are

met: the sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the net sale proceeds and the carrying amount and is recognised in the income statement. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment, which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated Assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Private Finance Initiative (PFI)

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM are accounted for as 'On-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and life cycle replacement components of the asset.

Initial Recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent Measurement

Assets are subsequently accounted for as property, plant and equipment as appropriate. The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI liabilities in these financial statements with effect from 1 April 2023 in accordance with national guidance. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

1.9 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Intangible assets are capitalised when they are capable of being used in Trust activities for more than one year; they can be valued; and have a cost of at least £5,000.

Internally generated intangible assets

Internally generated goodwill, mastheads, publishing titles, consumer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost, or the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Purchased computer software licences and internally generated assets are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the useful economic life or licence term.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

		Useful Economic Life	Useful Economic Life
Main	Sub Category	Minimum	Maximum
Asset Category		(in years)	(in years)
Intangible assets - purchased	Software	2	15
Intangible assets – internally generated	IT	5	5

1.10 Inventories

Inventories are stated at the lower of cost or net realisable value. The cost of inventories is measured using the weighted average cost method.

For the financial periods from 2020/21 to 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

1.11 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, to support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

The Trust currently has properties which are leased to housing associations, other NHS organisations and private tenants, following the decommissioning of the services that were previously rendered from these properties.

The Trust instructed Montagu Evans LLP, who are professionally qualified valuers and work in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, to undertake a valuation on the Trust's investment properties as at the end of the financial year.

1.12 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Cash, bank and overdraft balances are recorded at current value. These balances exclude monies held in the Trust's bank account belonging to patients (see 'third party assets' above). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts, and interest charged on overdrafts is recorded as 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.13 Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, are impaired. Financial assets are impaired, and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows from the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Provision for debtor impairment

A provision will be provided against the recovery of debts, where such a recovery is considered doubtful. Where the recovery of a debt is considered unlikely, the debt will either be written down directly to the Statement of Comprehensive Income, or charged against a provision to the extent that there is a balance available for the debt concerned, and thereafter charged to operating expenses.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.14.1 The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments.

Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.14.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as an operating lease.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the head lease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the lease. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the lease.

Operating leases

Income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2025.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23, but is not recognised in the Trust's accounts.

Non clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events where existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an income of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events where existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at: <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set

out in the pre-audit version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.18 Taxation

The Trust is a Health Service body within the meaning of s519A of the Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519 A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. There is no corporation tax liability arising in the current financial year.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury's FReM.

1.21 Capital commitments

For ongoing capital projects at the balance sheet date, the value of capital commitments will be based on the value of contracted work not yet completed at the balance sheet date. The value of the capital commitment is disclosed at note 24.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. The value of losses and special payments is disclosed in Note 29.

1.23 Key Sources of Judgement and Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Provisions

Provisions have been made in line with management's best estimates and in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

The Trust's post-employment benefits are rebased periodically subject to life expectancy assumptions as issued by Government Actuary Department. The real discount rate issued by the HM Treasury

annually is also applied to the balance to determine the provision required as at the end of the financial year. The real discount rate applicable on 31 March 2025 was 2.40% (the previous year's rate was 2.45%).

The Trust also holds provisions in respect of its obligations to service the Lampard Inquiry into Mental Health Deaths in Essex. This was announced in November 2020 initially as an Independent Inquiry, and later given statutory powers on 1 November 2023 and relaunched as The Lampard Inquiry. On 10 April 2024 Terms of Reference for The Lampard Inquiry were published. In line with IAS37, the Trust monitors and undertakes annual cost reassessments as the Inquiry progresses. The real discount rate applicable on 31 March 2025 was 4.03% (the previous year's rate was 4.26%).

Apart from the above provisions, the Trust has no other material provisions, or provisions which may change materially as a result of any underlying uncertainty.

Pensions

The valuations of the NHS Pensions Scheme liability and the Local Government Pension Scheme are carried out by the schemes' actuaries. These involve a degree of actuarial and financial assumption and estimation.

Assumptions regarding valuation of Investment Properties, Land and Buildings

The Trust's Investment Properties, Land and Buildings are valued by Montagu Evans. This involves a significant degree of judgement and estimation: the results reflect the specialist professional assessment of the conditions within the external property market.

Assumptions regarding depreciation of Property, Plant and Equipment and Intangible Assets

The depreciation of Buildings is based on the value and life of the assets as periodically determined by Montagu Evans.

The depreciation of other assets is based on the value and life of the assets in line with the accounting standard, IAS 16 Property, Plant and Equipment. The Standard requires that the useful life of an asset be reviewed regularly and, if expectations differ from previous estimates, any change is accounted for prospectively as a change in estimate under the Accounting Standard, IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors.

The following are the judgements, apart from those involving estimations (see above) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Consolidation of the EPUT Charity Accounts with the Trust Accounts

The accounting standards require consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. The Trust is a corporate trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund, and the purpose of the Charity is to assist Trust NHS patients, hence the Trust has control over and benefits from the Charity's activities, so the requirements of the relevant accounting standards would be applicable in the preparation of the Trust Accounts.

However, In line with IAS 1, Presentation of Financial Statements, specific disclosure requirements set out in individual accounting standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity is approximately 0.5% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trust's wider accounts. As such, the Board of Directors have noted and approved that the Charity's Accounts will not be consolidated into

the main Trust Accounts for 2024/25. This is subject to an annual materiality review each financial year.

1.24 Operating Segments

Under International Financial Reporting Standards, operating segments are components of an entity that engage in separate revenue earning activities, have discrete financial information available, and whose results are reviewed separately by the entity's Chief Operating Decision Maker. Activities or departments of an organisation that earn no or incidental revenues would not be operating segments.

Operating segments are reported in a manner consistent with the internal reporting to the Chief Operating Decision Maker of the Trust. The Chief Operating Decision Maker of the Trust is the Trust Board.

The Trust's activities constitute a single segment of healthcare activity provided wholly in the UK, subject to similar risks and rewards, and all assets are managed as one central pool. This is consistent with the monthly financial report to the Trust Board.

1.25 Limitation of auditors' liability

In line with guidance from the Financial Reporting Council, the Trust's external auditor, Ernst & Young LLP, have limited their liability in respect of their external audit work. The limitation on auditors' liability for external audit work is £2m.

1.26 Accounting standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods: A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £201m and £44m respectively as at 31 March 2025. There are no assets valued on an alternative site basis as at 31 March 2025.

1.27 Transfer by absorption

For functions that have been transferred to the Trust from another NHS/local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the combined cost and accumulated depreciation/amortisation from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS/local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

In 2024/25, there were no transactions required to be accounted for as a transfer by absorption.

1.28 Prior Period Adjustment

Prior period adjustments may arise from a change in accounting policy or in correcting a material error.

Changes in accounting policies are only made when required by proper accounting practices or when the effect of the changes will provide more reliable or relevant information regarding the impact of transactions, other events and conditions on the Trust's financial position or financial performance.

Where a change is made, it is applied retrospectively (unless stated otherwise), by adjusting opening balances and comparative amounts for the prior period as though the new policy had always been applied.

Material errors identified in prior period amounts are corrected retrospectively by amending opening balances and comparative amounts for the prior period.

New or updated information may give rise to reclassifications between balances in the Statement of Financial Position, thereby leading to the restating of their opening balances under the new classifications.

During 2024/25, the Trust accounted for one prior period adjustment (note 30).

Note 2 Income

All income from patient care activities relates to contract income recognized in line with accounting policy 1.4.

Note 2.1 Income from patient care activities (by nature)

	2024/25 £000	2023/24 £000
Mental health services		
Income from commissioners under API contracts*	264,185	234,929
Services delivered under a mental health collaborative	30,083	28,741
Income for commissioning services in a mental health collaborative	63,958	60,823
Clinical partnerships providing mandatory services (including S75 agreements)	3,749	3,516
Other clinical income from mandatory services	20,875	21,171
Community services		
Income from commissioners under API contracts*	134,202	106,809
Income from other sources (e.g. local authorities)	23,158	23,251
Other services		
Private patient income	7	-
National pay award central funding**	406	89
Additional pension contribution central funding***	23,114	14,060
Other clinical income	17,974	13,888
Total income from activities	581,711	507,277

*Aligned Payment and Incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation – <https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

** Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	118,411	110,258
Integrated care boards	408,146	345,674
Other NHS providers	30,438	26,445
Local authorities	19,335	18,696
Non-NHS: private patients	7	-
Injury cost recovery scheme	17	4
Non NHS: other	5,357	6,200
Total income from activities	581,711	507,277

Note 3 Other operating income

	2024/25			2023/24		
	Contract	Non-	Total	Contract	Non-	Total
	income	contract		income	contract	
	£000	income	£000	£000	income	£000
Research and development	593	-	593	671	-	671
Education and training	18,370	-	18,370	22,745	-	22,745
Non-patient care services to other bodies	-	-	-	1	-	1
Income in respect of employee benefits accounted on a gross basis	1,231	-	1,231	1,919	-	1,919
Receipt of capital grants and donations and peppercorn leases	-	1,380	1,380	-	-	-
Charitable and other contributions to expenditure	-	37	37	-	108	108
Revenue from operating leases	-	2,570	2,570	-	2,086	2,086
Other income	2,791	-	2,791	3,932	-	3,932
Total other operating income	22,985	3,987	26,972	29,268	2,194	31,462

Note 3.1 Analysis of other contract income

	2024/25 £000	2023/24 £000
Catering	99	103
Pharmacy sales	3	56
Staff accommodation rental	42	133
Non-clinical services recharged to other bodies *	1,832	2,862
Staff contribution to employee benefit schemes	273	274
Other income not already covered (recognised under IFRS15)	542	504
	2,791	3,932

* This includes income for IT and Estates services provided to other organisations.

Note 4 Additional information on income**Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period**

	2024/25 £000	2023/24 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,513	3,382

Note 4.2 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25 £000	2023/24 £000
Income from services designated as commissioner requested services	581,711	507,277
Total	581,711	507,277

Note 5 Operating leases – Trust as lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor. The Trust applies IFRS16 to account for lease arrangements.

Note 5.1 Operating lease income

	2024/25 £000	2023/24 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	2,570	2,086
Total in-year operating lease income	2,570	2,086

Note 5.2 Future lease receipts

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due in:		
- not later than one year	2,151	2,050
- later than one year and not later than two years	431	423
- later than two years and not later than three years	232	221
- later than three years and not later than four years	127	128
- later than four years and not later than five years	112	100
- later than five years	415	483
Total	3,468	3,405

Note 6 Operating expenses

	2024/25 £000	Restated 2023/24 £000
Purchase of healthcare from NHS and DHSC bodies	60,794	40,569
Purchase of healthcare from non-NHS and non-DHSC bodies	56,298	40,941
Staff and executive directors costs	410,855	381,934
Remuneration of non-executive directors	163	179
Supplies and services - clinical (excluding drugs costs)	7,002	5,530
Supplies and services - general	6,582	7,266
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,697	5,372
Consultancy costs	210	1,074
Establishment	2,456	2,721
Premises	21,470	20,629
Transport (including patient travel)	5,195	4,856
Depreciation on property, plant and equipment	13,236	12,420
Amortisation on intangible assets	2,320	2,367
Net impairments	27,515	4,622
Movement in credit loss allowance: contract receivables / contract assets	3	(49)
Increase/(decrease) in other provisions	66	(6,322)
Change in provisions discount rate(s)	(1,169)	(1,073)
Fees payable to the external auditor audit services- statutory audit	321	216
Internal audit costs	121	167
Clinical negligence	3,023	2,848
Legal fees *	903	5,066
Insurance	634	598
Research and development	567	613
Education and training	5,734	6,140
Expenditure on short term leases	1,175	359
Expenditure on low value leases	140	1,321
Redundancy	420	196
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,318	2,111
Car parking & security	611	1,758
Hospitality	32	56
Losses, ex gratia & special payments	70	91
Other services, e.g. external payroll	4,207	4,233
Other	75	(9)
Total	637,044	548,800

* Legal fees for 2023/24 include the impact of the Lampard Inquiry.

Note 7 Employee benefits

	2024/25	Restated 2023/24
	Total	Total
	£000	£000
Salaries and wages	307,559	280,138
Social security costs	32,417	30,465
Apprenticeship levy	1,512	1,417
Employer's contributions to NHS pensions	58,470	46,384
Termination benefits	93	169
Temporary staff (agency)	16,524	28,176
Total gross staff costs	416,575	386,749
Costs capitalised as part of assets	(2,066)	(1,490)
Total staff costs *	414,509	385,259

* Total staff costs include costs shown within Research and Development, and Education and Training in note 6.

Note 7.1 Retirements due to ill-health

During 2024/25 there were four early retirements from the Trust agreed on the grounds of ill-health (five in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £496k (£310k in 2023/24). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 7.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 7.3 Director Remunerations and Staff Costs

The analysis of directors' remunerations and pension benefits for the year ended 31 March 2025 are in the Remuneration Report section of the Annual Report.

The analysis of staff costs, average staff numbers and staff exit packages for the year ended 31 March 2025 are in the staff report section of the Annual Report.

Note 7.4 Employee retirement benefit obligation

Note 7.4.1 Amounts recognised in the SoCI

	2024/25 £000	2023/24 £000
Current service cost	(75)	(107)
Interest expense / income	5	27
Administration expenses	(16)	(18)
Total net (charge) / gain recognised in SOCI	(86)	(98)

Note 7.4.2 Principal actuarial assumptions

	2024/25	2023/24
	%	%
Discount rate	5.75	4.90
Pension increases (CPI)	2.90	2.90
RPI inflation	3.20	3.25
Rate of increase in salaries	3.90	3.90

Note 7.4.3 Amounts recognised in the Statement of Financial Position

	31 March 2025	31 March 2024
	£000	£000
Present value of the defined benefit obligation	(11,651)	(13,017)
Plan assets at fair value	23,956	23,674
Impact of asset ceiling	(12,284)	(10,544)
Net defined benefit (obligation) / asset recognised in the SoFP	21	113

Note 7.4.4 Reconciliation of asset ceiling

	31 March 2025	31 March 2024
	£000	£000
Opening impact of asset ceiling	(10,544)	(7,972)
Interest on asset ceiling	(517)	(383)
Actuarial (gains)	(1,223)	(2,189)
Closing impact of asset ceiling	(12,284)	(10,544)

Note 7.4.5 Change in benefit obligation

	2024/25	2023/24
	£000	£000
Present value of the defined benefit obligation at 1 April	(13,017)	(13,114)
Adjustment to Plan liabilities at fair value at 1 April 2023	-	11
Current service cost	(75)	(107)
Interest cost	(625)	(617)
Contribution by plan participants	(23)	(34)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial losses	1,535	289
Benefits paid	554	555
Present value of the defined benefit obligation at 31 March	(11,651)	(13,017)

Note 7.4.6 Change in fair value of plan assets

	2024/25 £000	2023/24 £000
Plan assets at fair value at 1 April	23,674	21,672
Adjustment to Plan assets at fair value at 1 April 2023	-	(11)
Administrative expenses	(16)	(18)
Interest income	1,147	1,027
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	(318)	1,525
Contributions by the plan participants	23	34
Benefits paid	(554)	(555)
Plan assets at fair value at 31 March	23,956	23,674

Note 7.4.7 Analysis of fair value of plan assets

	2024/25 £000	%	2023/24 £000	%
Equities	13,630	57%	12,995	55%
Gilts	359	2%	420	2%
Property	1,767	7%	1,679	7%
Cash / Temporary investments	452	2%	634	3%
Alternative investments	3,482	15%	3,585	15%
Other managed funds	4,266	18%	4,361	18%
Plan assets at fair value at 31 March	23,956	100%	23,674	100%

Note 7.4.8 Remeasurement in other comprehensive income

	2024/25 £000	2023/24 £000
Returns on funds in excess of interest	(318)	1,525
Change in financial assumption	1,494	192
Change in demographic assumptions	29	168
Experience gain / (loss) on defined benefit obligation	12	(71)
Change in impact of asset ceiling	(1,223)	(2,189)
Remeasurement of the net asset / (defined liability)	(6)	(375)

Note 7.4.9 Projected pension expenses

	2024/25 £000
Service costs	61
Net interest on defined asset	(1)
Administration expenses	15
	75
Employer contributions	-
Total	75

Note 7.4.10 Sensitivity analysis

Adjustment to discount rate	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	10,907	11,496	11,651	11,809	12,479
Projected service cost	54	59	61	62	68
Adjustment to long term salary increase	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	11,694	11,660	11,651	11,643	11,609
Projected service cost	61	61	61	61	61
Adjustment to pension increases and deferred revaluation	+0.5%	+0.1%	0.0%	-0.1%	-0.5%
Present value total obligation	12,456	11,805	11,651	11,500	10,926
Projected service cost	69	62	61	59	54
Adjustment to life expectancy assumptions	+1 year		None	-1 year	
Present value total obligation	12,008		11,651	11,305	
Projected service cost	63		61	59	

Note 8 Finance income, expenditure and late payment of commercial debt

Note 8.1 Finance income

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,990	3,269
Other finance income	1,147	1,027
Total finance income	3,137	4,296

Note 8.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	Restated 2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	47	57
Interest on lease obligations	421	450
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	2,537	2,598
Remeasurement of the liability resulting from change in index or rate	1,804	5,059
Total interest expense	4,809	8,164
Unwinding of discount on provisions	1,639	1,149
Other finance costs	1,170	1,056
Total finance costs	7,618	10,369

Note 8.3 The late payment of commercial debts (interest) Act 1998

There was a total interest payment (including administration charges) of £140 relating to the late payment of commercial debts in the year ended 31 March 2025 (2023/24: £350).

Note 9 Other gains / (losses)

	2024/25 £000	2023/24 £000
Gains on disposal of right of use assets	108	-
Losses on disposal of plant, property and equipment	(16)	(11)
Total (losses) on disposal of assets	92	(11)
Fair value (losses) on investment properties	(780)	(535)
Total other (losses)	(688)	(546)

Note 10 Intangible assets

Note 10.1 Intangible assets – 2024/25

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	22,681	579	4,089	27,349
Additions	1,525	368	2,764	4,657
Reclassifications	141	-	(50)	91
Valuation / gross cost at 31 March 2025	24,347	947	6,803	32,097
Amortisation at 1 April 2024 - brought forward	15,477	116	-	15,593
Provided during the year	2,204	116	-	2,320
Amortisation at 31 March 2025	17,681	232	-	17,913
Net book value at 31 March 2025	6,666	715	6,803	14,184
Net book value at 1 April 2024	7,204	463	4,089	11,756

Note 10.2 Intangible assets – 2023/24

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023 - as previously stated	21,648	579	360	22,587
Additions	1,033	-	3,729	4,762
Valuation / gross cost at 31 March 2024	22,681	579	4,089	27,349
Amortisation at 1 April 2023 - as previously stated	13,226	-	-	13,226
Provided during the year	2,251	116	-	2,367
Amortisation at 31 March 2024	15,477	116	-	15,593
Net book value at 31 March 2024	7,204	463	4,089	11,756
Net book value at 1 April 2023	8,422	579	360	9,361

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment – 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	48,903	166,263	739	4,110	6,249	296	10,707	934	238,201
Additions	-	7,838	-	128	232	-	1,153	419	9,770
Impairments	(21,234)	(53,324)	(233)	-	-	-	-	-	(74,791)
Reversals of impairments	209	2,555	-	-	-	-	-	-	2,764
Revaluations	6,202	36,050	417	-	-	-	-	-	42,669
Reclassifications	1,575	5,208	-	(3,025)	8	0	761	102	4,629
Disposals / derecognition	-	-	-	-	-	(33)	-	-	(33)
Valuation/gross cost at 31 March 2025	35,654	164,590	923	1,213	6,489	264	12,621	1,455	223,209
Accumulated depreciation at 1 April 2024 - brought forward	-	-	-	-	4,519	275	5,862	447	11,103
Provided during the year	-	5,776	44	-	403	4	1,575	147	7,949
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(5,776)	(44)	-	-	-	-	-	(5,820)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	(15)	-	-	(15)
Accumulated depreciation at 31 March 2025	-	-	-	-	4,922	264	7,437	594	13,216
Net book value at 31 March 2025	35,654	164,590	923	1,213	1,567	-	5,184	861	209,993
Net book value at 1 April 2024	48,903	166,263	739	4,110	1,730	21	4,845	487	227,098

Note 11.2 Property, plant and equipment – 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	50,290	167,284	759	2,192	6,171	296	8,070	864	235,926
Additions	-	5,122	-	3,444	163	-	2,637	70	11,436
Impairments	(1,625)	(9,864)	-	-	-	-	-	-	(11,489)
Reversals of impairments	-	639	-	-	-	-	-	-	639
Revaluations	238	1,556	(20)	-	-	-	-	-	1,774
Reclassifications	-	1,526	-	(1,526)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(85)	-	-	-	(85)
Valuation/gross cost at 31 March 2024	48,903	166,263	739	4,110	6,249	296	10,707	934	238,201
Accumulated depreciation at 1 April 2023 - as previously stated	-	5,208	45	-	4,179	270	4,686	324	14,712
Provided during the year	-	5,676	45	-	413	5	1,176	123	7,438
Revaluations	-	(10,884)	(90)	-	-	-	-	-	(10,974)
Disposals / derecognition	-	-	-	-	(73)	-	-	-	(73)
Accumulated depreciation at 31 March 2024	-	-	-	-	4,519	275	5,862	447	11,103
Net book value at 31 March 2024	48,903	166,263	739	4,110	1,730	21	4,845	487	227,098
Net book value at 1 April 2023	50,290	162,076	715	2,192	1,992	26	3,384	540	221,214

Note 11.3 Property, plant and equipment financing – 31 March 2025

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under constructi £000	Plant & machinery £000	Transport equipment £000	Informatio n technology £000	Furniture & fittings £000	Total £000
Owned - purchased	35,654	126,069	924	1,213	1,567	-	5,184	861	171,472
On-SoFP PFI contracts and other service concession arrangements	-	38,230	-	-	-	-	-	-	38,230
Owned - donated/granted	-	291	-	-	-	-	-	-	291
Total net book value at 31 March 2025	35,654	164,590	924	1,213	1,567	-	5,184	861	209,993

Note 11.4 Property, plant and equipment financing – 31 March 2024

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	48,903	131,209	740	4,110	1,730	21	4,845	487	192,044
On-SoFP PFI contracts and other service concession arrangements	-	34,933	-	-	-	-	-	-	34,933
Owned - donated/granted	-	121	-	-	-	-	-	-	121
Total net book value at 31 March 2024	48,903	166,263	740	4,110	1,730	21	4,845	487	227,098

Note 11.5 Revaluation and impairments

In line with accounting policy and International Accounting Standard (IAS16) the Trust is required to undertake a five year full revaluation of Estate. This is to ensure the value of assets do not differ materially from their fair value at the Statement of Financial Position date. As such, the Trust instructed Montagu Evans LLP to conduct a revaluation of its land and buildings including an asset held as a right of use peppercorn asset (note 12.1) and assets held for sale (note 16) in 2024/25.

The impact of the revaluation was a reduction in the value of assets of £21,897k. This consists of a £23,538k reduction in land and buildings, an increase of £1,686k in right of use assets and a reduction of £45k in assets held for sale.

Of the £21,897k, a net gain of £5,618k has been recognised against the Revaluation Reserve in the Statement of Financial Position with the remaining £27,515k charged to the Statement of Comprehensive Income (note 6).

	Revaluation Reserve Surplus	Revaluation Reserve Impairment	Net Impairment in Operating Expenditure	Total
	£000	£000	£000	£000
Land and Buildings	48,489	(44,557)	(27,470)	(23,538)
Right of Use Peppercorn Asset	1,686	-	-	1,686
Asset Held for Sale	-	-	(45)	(45)
Total 2024/25	50,175	(44,557)	(27,515)	(21,897)

	Revaluation Reserve Surplus	Revaluation Reserve Impairment	Net Impairment in Operating Expenditure	Total
	£000	£000	£000	£000
Land and Buildings	12,748	(6,258)	(4,592)	1,898
Asset Held for Sale	-	-	(30)	(30)
Total 2023/24	12,748	(6,258)	(4,622)	1,868

Note 11.6 Remaining economic lives of property, plant and equipment

	Minimum useful life (years)	Maximum useful life (years)
Buildings excluding dwellings	0	45
Dwellings	35	35
Plant and machinery	0	27
Transport equipment	0	0
Information technology	1	5
Furniture and fittings	2	9

Note 11.7 Assets under PFI contract

	2024/25 £000	2023/24 £000
Valuation/gross cost		
Valuation/gross cost at 1 April	34,933	33,654
Additions	2,013	-
Revaluations	7,995	1,279
Impairment	(7,393)	-
Reclassifications	682	-
Valuation/gross cost at 31 March	38,230	34,933
Accumulated depreciation		
Accumulated depreciation at 1 April	-	801
Provided during the year	843	801
Revaluations	(843)	(1,602)
Accumulated depreciation at 31 March	-	-
Net book value at 31 March	38,230	34,933
Net book value at 1 April	34,933	32,853

Elderly Mentally Ill (EMI) Homes – PFI

In 2004, two homes were opened for the provision of care for the EMI, one in Rawreth and one in Westcliff-on-Sea. These homes have since been re-designated under CQC registration as Nursing Homes. The construction has been financed by a private finance initiative, between the Trust, legacy South Essex Partnership Trust (the grantor) and Ryhurst (the operator), under a public private service concession arrangement.

The term of the arrangement is 30 years, over which the grantor will repay the financing received from the operator, ending in 2033. At the end of the financing period legal ownership will pass from Ryhurst to the Trust.

During the period of the arrangement the grantor will have full and sole use of the properties to provide the health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract. No material capital expenditure is included in the contract arrangement.

Maintenance costs payable to the operator are subject to annual increases based on the Retail Price Index (RPI).

There are no changes in the arrangement over the contract period.

Forensic Unit - PFI

In November 2009 a new forensic unit was opened to provide low and medium secure services. The construction of the new facility has been financed by a private finance initiative between the Trust, legacy South Essex Partnership Trust (the grantor) and Grosvenor House (the operator), under a public private service concession arrangement.

The term of the arrangement, over which the grantor will repay financing received to the operator, is

29 years ending in 2037. At the end of the financing period legal ownership will pass from Grosvenor House to the Trust.

During the period of the arrangement the grantor will have full and sole use of the unit to provide health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract.

Maintenance costs payable to the operator are subject to annual increases based on the Retail Price Index (RPI).

There are no changes in the arrangement over the contract period.

Note 12 Leases – the Trust as a lessee

This note details information about leases for which the Trust is a lessee. The Trust applied IFRS 16 to account for lease arrangements from 1 April 2022.

Note 12.1 Right of use assets – 2024/25

	Property (land and buildings) £000	Transport equipment £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	52,775	278	-	53,053	48,244
Additions	2,186	188	492	2,866	1,380
Remeasurements of the lease liability	1,707	-	-	1,707	1,547
Movements in provisions for restoration / removal costs	58	-	-	58	-
Revaluations *	1,605	-	-	1,605	1,605
Disposals / derecognition	(637)	-	-	(637)	(637)
Valuation/gross cost at 31 March 2025	57,694	466	492	58,652	52,139
Accumulated depreciation at 1 April 2024 - brought forward	8,955	113	-	9,068	7,911
Provided during the year	5,191	84	12	5,287	4,519
Revaluations *	(81)	-	-	(81)	(81)
Accumulated depreciation at 31 March 2025	14,065	197	12	14,274	12,349
Net book value at 31 March 2025	43,629	269	480	44,378	39,790
Net book value at 1 April 2024	43,820	165	-	43,985	40,333
Net book value of right of use assets leased from other NHS providers					9,184
Net book value of right of use assets leased from other DHSC group bodies					30,606

* Revaluation relates to Lighthouse Children's Development Centre held as a right of use peppercorn asset and revalued by Montagu Evans LLP.

Note 12.2 Right of use assets – 2023/24

	Property (land and buildings) £000	Transport equipment £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	45,234	138	-	45,372	40,815
Additions	-	140	-	140	-
Remeasurements of the lease liability	7,503	-	-	7,503	7,391
Movements in provisions for restoration / removal costs	38	-	-	38	38
Valuation/gross cost at 31 March 2024	52,775	278	-	53,053	48,244
Accumulated depreciation at 1 April 2023 - brought forward	4,041	45	-	4,086	3,549
Provided during the year	4,914	68	-	4,982	4,362
Accumulated depreciation at 31 March 2024	8,955	113	-	9,068	7,911
Net book value at 31 March 2024	43,820	165	-	43,985	40,333
Net book value at 1 April 2023	41,193	93	-	41,286	37,266
Net book value of right of use assets leased from other NHS providers					8,966
Net book value of right of use assets leased from other DHSC group bodies					31,367

Note 12.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 21.1.

	2024/25 £000	2023/24 £000
Carrying value at 1 April	45,078	41,141
Lease additions	1,486	140
Lease liability remeasurements	1,707	7,503
Interest charge arising in year	421	450
Early terminations	(745)	-
Lease payments (cash outflows)	(3,347)	(4,156)
Carrying value at 31 March	44,600	45,078

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are disclosed in operating expenditure. These payments are disclosed in note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 12.4 Maturity analysis of future lease payments

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year;	8,962	8,089	5,912	5,317
- later than one year and not later than five years;	21,497	18,640	20,083	18,069
- later than five years.	16,461	15,258	19,083	18,002
Total gross future lease payments	46,920	41,987	45,078	41,388
Finance charges allocated to future periods	(2,320)	(1,894)	-	-
Net lease liabilities at 31 March 2025	44,600	40,093	45,078	41,388
Of which:				
Leased from other NHS providers		9,286		9,367
Leased from other DHSC group bodies		30,807		32,021

Note 13 Investment property

	2024/25 £000	2023/24 £000
Carrying value at 1 April - brought forward	18,085	18,620
Movement in fair value	(780)	(535)
Reclassifications to PPE *	(4,720)	-
Carrying value at 31 March	12,585	18,085

* During the year, Mountnessing Road properties and Oakley Court were reclassified from Investment Property to PPE. They are no longer held for income generation or capital appreciation purposes.

Note 14 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	114	168
Wheelchairs	297	321
Total inventories	411	489

Note 15 Trade and other receivables

Note 15.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	18,507	15,349
Allowance for impaired contract receivables / assets	(27)	(24)
Prepayments (non-PFI)	2,378	2,606
Interest receivable	171	216
PDC dividend receivable	726	657
VAT receivable	861	1,278
Other receivables	694	108
Total current receivables	23,310	20,190
Non-current		
Other receivables	176	166
Total non-current receivables	176	166
Of which receivable from NHS and DHSC group bodies:		
Current	13,519	10,544
Non-current	176	166

Note 15.2 Allowances for credit losses

	2024/25 Contract receivables and contract assets £000	2023/24 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	24	456
New allowances arising	3	12
Reversals of allowances	-	(61)
Utilisation of allowances (write offs)	-	(383)
Allowances as at 31 March 2025	27	24

Note 16 Non-current assets held for sale and assets in disposal groups

	2024/25 £000	2023/24 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	545	575
Impairment of assets held for sale	(45)	(30)
NBV of non-current assets for sale and assets in disposal groups at 31 March	500	545

As at 31 March 2025, the Trust held one property for sale: 4 The Glades, Bedfordshire.

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25 £000	2023/24 £000
At 1 April	43,378	65,941
Net change in year	(15,301)	(22,563)
At 31 March	28,077	43,378
Broken down into:		
Cash at commercial banks and in hand	270	607
Cash with the Government Banking Service	27,807	42,771
Total cash and cash equivalents as in SoFP	28,077	43,378

Note 18 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025 £000	31 March 2024 £000
Bank balances	381	337
Total third party assets	381	337

Note 19 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	11,805	13,740
Capital payables	1,943	3,180
Accruals	24,421	21,360
Social security costs	4,034	4,153
Other taxes payable	4,034	3,637
Pension contributions payable	4,990	4,599
Total current trade and other payables	51,227	50,669
Non-current		
Accruals	-	282
Total non-current trade and other payables	-	282
Of which payables from NHS and DHSC group bodies:		
Current	15,172	9,994
Non-current	-	-

Note 20 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	1,825	1,610
Total other current liabilities	1,825	1,610

Note 21 Borrowings and liabilities arising from financing activities

Note 21.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	411	415
Lease liabilities	8,962	5,912
Obligations under PFI, LIFT or other service concession contracts	3,408	2,731
Total current borrowings	12,781	9,058
Non-current		
Loans from DHSC	1,604	2,004
Lease liabilities	35,638	39,166
Obligations under PFI, LIFT or other service concession contracts	35,645	37,129
Total non-current borrowings	72,887	78,299

The Trust is responsible for ensuring that it is able to repay its borrowings and any associated interest charges. As at the financial year ending 2024/25 the Trust holds one single currency term loan from the Secretary of State as follows:

Amount Outstanding (Current) £000	Amount Outstanding (Non- Current) £000	Interest Rate £000	Repayment Date £000
411	1604	2.17%	March 2030

Note 21.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	2,419	45,078	39,860	87,357
Cash movements:				
Financing cash flows - payments and receipts of principal	(400)	(2,926)	(2,611)	(5,937)
Financing cash flows - payments of interest	(51)	(421)	(2,537)	(3,009)
Non-cash movements:				
Additions	-	1,486	-	1,486
Lease liability remeasurements	-	1,707	-	1,707
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,804	1,804
Application of effective interest rate	47	421	2,537	3,005
Early terminations	-	(745)	-	(745)
Carrying value at 31 March 2025	2,015	44,600	39,053	85,668

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	2,821	41,141	23,204	67,166
Cash movements:				
Financing cash flows - payments and receipts of principal	(400)	(3,706)	(1,754)	(5,860)
Financing cash flows - payments of interest	(59)	(450)	(2,598)	(3,107)
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	13,351	13,351
Additions	-	140	-	140
Lease liability remeasurements	-	7,503	-	7,503
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	5,059	5,059
Application of effective interest rate	57	450	2,598	3,105
Carrying value at 31 March 2024	2,419	45,078	39,860	87,357

Note 22 On-SoFP PFI arrangements

Note 22.1 On-SoFP PFI obligations

The following obligations in respect of the PFI are recognised in the Statement of Financial position:

	31 March 2025 £000	31 March 2024 £000
Gross PFI liabilities	55,241	57,774
Of which liabilities are due		
- not later than one year;	5,656	5,157
- later than one year and not later than five years;	18,709	18,277
- later than five years.	30,876	34,340
Finance charges allocated to future periods	(16,188)	(17,914)
Net PFI obligation	39,053	39,860
- not later than one year;	3,408	2,731
- later than one year and not later than five years;	10,808	10,192
- later than five years.	24,837	26,937

Note 22.2 Total on-SoFP PFI obligations

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI arrangements	77,737	80,606
Of which payments are due:		
- not later than one year;	6,998	6,464
- later than one year and not later than five years;	27,026	25,856
- later than five years.	43,713	48,286

Note 22.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operation:

	2024/25 £000	2023/24 £000
Unitary payment payable to service concession operator	6,757	6,463
Consisting of:		
- Interest charge	2,537	2,598
- Repayment of balance sheet obligation	2,854	1,754
- Service element and other charges to operating expenditure	1,270	1,680
- Capital lifecycle maintenance	48	-
- Revenue lifecycle maintenance	48	431
Total amount paid to service concession operator	6,757	6,463

Note 23 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other * £000	Total £000
At 1 April 2024 (restated)	3,645	1,719	151	27	12,649	18,191
Change in the discount rate	(411)	(339)	-	-	(419)	(1,169)
Arising during the year	266	86	75	202	118	747
Utilised during the year	(491)	(166)	(15)	(120)	(1,740)	(2,532)
Reversed unused	(141)	(6)	(80)	-	(115)	(342)
Unwinding of discount	500	386	-	-	753	1,639
At 31 March 2025	3,368	1,680	131	109	11,246	16,534
Expected timing of cash flows:						
- not later than one year;	476	163	131	109	8,320	9,199
- later than one year and not later than five years;	1,750	614	-	-	2,781	5,145
- later than five years.	1,142	903	-	-	145	2,190
Total	3,368	1,680	131	109	11,246	16,534

* During the reporting period financial provisions relating to the Lampard Inquiry have been reassessed. Following reassessment some aspects of the provision have been revisited with a closing 2024/25 provision reduced to £8.6m. The reduction in provision recognises the impact of both the cost reassessment exercise and 'in year' utilisation of the provision.

The closing £8.6m provision remains inclusive of items meeting recognition criteria under IAS37. The Trust has endorsed its commitment to serve the Inquiry by publicly announcing to fulfil obligations and duties throughout the expected duration of the Inquiry and has created valid expectations of these commitments. Costs remaining within the provision include; external incremental legal costs to support the Inquiry and employees. Cost estimates are based on reliable assessments from management and are judged as appropriate in order to settle obligations. Timings of provision outflows have been estimated with main uncertainties reliant on progress of the Inquiry procedures.

In order to reflect the nature of the impact of the reassessment exercise the Trust has made a prior period adjustment of £8.7m under IAS 8 (see Note 30). This adjustment includes reassessment of provision costs for internal project management and communications teams assessed by management as not meeting the criteria for recognition as a provision, along with restatement of prior period comparators. Note 30 outlines the extent to which the adjustment impacts financial statements with reduced operating expenses of £8.7m in 2023/24.

The total value of clinical negligence provisions carried by NHS Resolution on the Trust's behalf as at 31 March 2025 was £18,915k (2023/24: £17,379k). This figure is not included in the above table, and does not form part of the Trust's financial position.

Note 24 Capital commitments

The value of the capital commitments under expenditure contracts at 31 March 2025 was £nil on Property, Plant and Equipment, and £9,100k on Intangible Assets, giving a total capital commitment of £9,100k (2023/24: total £857k).

Note 25 Events after the Reporting Period

The Trust's Annual Accounts were authorised for issue by the Chief Executive / Accounting Officer on 24 July 2025.

Note 26 Contingent Liabilities

As at 31 March 2025, the Trust had contingent liabilities in respect of the Liabilities to Third Parties Scheme and Property Expenses Scheme totaling £65k (2023/24: £93k).

Note 27 Related Party Transactions

The Trust is a body corporate established by the Secretary of State. NHS England and other Foundation Trusts are considered related parties. The Department of Health and Social Care is regarded as a related party as it exerts influence over a number of transactions and operating policies of the Trust. During the year ended 31 March 2025 the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

During the year and at the period end, the Trust had material transactions with other NHS bodies, namely NHS Mid & South Essex ICB, NHS Suffolk & North East Essex ICB, NHS Hertfordshire & West Essex ICB, Hertfordshire Partnership University NHS Foundation Trust, Norfolk & Suffolk NHS Foundation Trust, North East London NHS Foundation Trust, and NHS England.

During the year and at the period end, the Trust had material transactions with other public sector bodies namely Essex County Council, His Majesty's Revenue and Customs and NHS Pensions.

Other than those disclosed under note 27.1 and 27.2, during the year none of the Board Members, Governors or members of the key management staff or parties related to them and Department of Health and Social Care (DHSC) related parties (i.e. DHSC Ministers, senior officials and entities controlled or influenced by them) has undertaken any material transactions with the Trust.

The Governors appointed to the Council of Governors may also be members of Boards and Committees of local stakeholder organisations. Local stakeholder organisations can nominate an individual as a Governor on the Council under the following arrangements.

Three Local Authority Governors, one each appointed by:

- Essex County Council;
- Southend on Sea Borough Council;
- Thurrock Council.

Two Partnership Governors appointed by partnership organisations, one each appointed by:

- Essex University and Anglia Ruskin University (joint appointment);
- Third Party / Voluntary Sector

The Trust is the Corporate Trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund. During the year ended 31 March 2025, the Trust received income of £31,316 from the Charity for administrative services provided by the Trust on behalf of the Charity. The Trust did not receive any capital payments. All the members of the Corporate Trustee are also members of the Trust Board.

Note 27.1 Director's Interests

Ruth Jackson (Non-Executive Director) provides consultancy, education and workforce services to the University of Essex. During the 2024/25 financial year, the Trust incurred expenditure of £256,037 in respect of course and conference fees. Trust income for the year includes £23,449 from the University of Essex in respect of teaching fees and staff secondments. At 31 March 2025, the Trust owed the University of Essex £32,000. This expenditure and income was not initiated by Ruth Jackson.

Elena Lokteva (Non-Executive Director) is a Non-Executive Director at North Middlesex University Hospital NHS Trust. The Trust's total expenditure in the 2024/25 financial year was £62,786 in respect of staff secondments. This expenditure was not initiated by Elena Lokteva.

Dr. Milind Karale (Medical Director) is an investigator / clinical adviser at Niche Health and Social Care Consulting. The Trust's total expenditure in the 2024/25 financial year was £27,600 in respect of independent investigations. At 31 March 2025, the Trust owed Niche Health and Social Care Consulting £13,800. This expenditure was not initiated by Dr. Milind Karale.

Professor Sheila Salmon (Chair) is the Emeritus Professor of Health Development at Anglia Ruskin University. During the 2024/25 financial year, the Trust incurred expenditure of £175,176 in respect of course fees. At 31 March 2025, the Trust owed Anglia Ruskin University £73,726. Trust income for the year includes £64,273 in respect of staff secondment fees and conference income. At 31 March 2025, the Trust was owed £3,025 by Anglia Ruskin University. This expenditure and income was not initiated by Professor Sheila Salmon.

Zephan Trent (Executive Director of Strategy, Transformation and Digital) was seconded to Mid and South Essex NHS Foundation Trust as Chief Strategy and Transformation Officer for 0.5WTE from September 2024. During the year, the Trust incurred expenditure of £2,933,785 in respect of various clinical and non-clinical services, and of staff secondment fees. As at 31 March 2025, the Trust owed £551,598 to Mid and South Essex NHS Foundation Trust. Trust income for the year includes £1,112,029 in respect of various clinical and non-clinical services, and staff secondment fees. As at 31 March 2025, the Trust was owed £1,032,369 by Mid and South Essex NHS Foundation Trust. This expenditure and income was not initiated by Zephan Trent.

Note 27.2 DHSC related parties

The Trust had transactions with the following organisations identified by the DHSC as a related party to Government Ministers and senior officials:

During the 2024/25 year, the Trust received income of £67,159 from Macmillan Cancer Support. As at 31 March 2025, the Trust was owed £27,673 by Macmillan Cancer Support.

During the year, the Trust incurred expenditure of £16,800 with NHS Confederation.

During the year, the Trust incurred expenditure of £4,354 with Currys Plc.

Note 28 Financial Instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the entity is exposed at the end of the reporting period. Due to the continuing service provider relationship that the Trust has with the local Integrated Care Board and the way those Integrated Care Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the limited companies to which IFRS 7 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Over 90% of the Trust's income is from contracted arrangements with commissioners. As such any material credit risk is limited to administrative and contractual disputes.

Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from cash made available from prior year surpluses; and Public Dividend Capital funding that may be available from the Department of Health and Social Care to fund particular projects. The Trust has also funded two of its buildings through Private Finance Initiative scheme. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest, it is not, therefore, exposed to significant interest rate risk.

Foreign currency risk

The Trust has nil foreign currency income and expenditure.

Note 28.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	19,521	19,521
Cash and cash equivalents	28,077	28,077
Total at 31 March 2025	47,598	47,598

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non-financial assets	15,815	15,815
Cash and cash equivalents	43,378	43,378
Total at 31 March 2024	59,193	59,193

Note 28.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	2,015	2,015
Obligations under leases	44,600	44,600
Obligations under PFI	39,053	39,053
Trade and other payables excluding non-financial liabilities	35,833	35,833
Provisions under contract	11,486	11,486
Total at 31 March 2025	132,987	132,987

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	2,419	2,419
Obligations under leases	45,078	45,078
Obligations under PFI	39,860	39,860
Trade and other payables excluding non-financial liabilities	35,477	35,477
Provisions under contract	12,827	12,827
Total at 31 March 2024	135,661	135,661

Note 28.3 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	59,422	53,636
In more than one year but not more than five years	44,591	46,110
In more than five years	47,482	53,829
Total	151,495	153,576

Note 29 Losses and special payments

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	26	12	5	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	5	7	-	-
Stores losses and damage to property	1	-	2	1
Total losses	32	19	7	2
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	1
Extra-contractual payments	-	-	-	-
Ex-gratia payments	14	51	13	80
Special severance payments	-	-	1	9
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	14	51	15	90
Total losses and special payments	46	70	22	92

Note 30 Prior period adjustment

For year ended 31 March 2025, the Trust recorded a prior period adjustment in respect of provisions held within the Statement of Financial Position as at the end of 31 March 2024. The adjustment reduced operating expenditure and net finance costs within the Statement of Comprehensive Income by £8,651k in 2023/24 and reduced the reported deficit for the year from £30,444k to £21,793k as follows:

	2023/24 as originally stated £000	Adjustment £000	2023/24 restated amount £000
Operating income	538,739		538,739
Operating expenditure	(557,196)	8,396	(548,800)
Net finance costs	(11,441)	255	(11,186)
Other gains / (losses)	(546)		(546)
Surplus / (deficit) for the year	(30,444)	8,651	(21,793)

The value of the Trusts provisions held in the Statement of Financial Position similarly reduced by £8,651k as at 31 March 2024 as follows:

	31 March 2024 as originally stated £000	Adjustment £000	31 March 2024 restated amount £000
Provisions (current)	(11,576)	4,000	(7,576)
Provisions (non current)	(15,266)	4,651	(10,615)
Income and expenditure reserve	(24,034)	8,651	(15,383)

All primary financial statements and supporting notes (including note 23 on provisions for liabilities and charges analysis) have been updated to reflect restated amounts.

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