Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

1 October 2025

10:00 GMT+1 Europe/London

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

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

0# Part 1 BoD Agenda Oct 2025 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 1 October 2025 at 10:00

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

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

AGENDA

1	**APOLOGIES FOR ABSENCE**	HLD	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	HLD	Verbal	Noting
West Essex EPUT Community Delivery for Neighbourhood Health Nicole Rich, Director of West Essex Community Delivery & Partnerships				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 6 August 2025	HLD	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	HLD	Attached	Noting
5	Chairs Report (including Governance Update)	HLD	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	Workforce Race Equality Standard (WRES)	AM	Attached	Approval
7.5	Workforce Disability Equality Standard (WDES)	AM	Attached	Approval
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	Mental Health Act Annual Report	AS	Attached	Approval
8.3	Infection and Control Annual Report	AS	Attached	Approval

Questions taken from the General Public				
9	**STRATEGIC INITIATIVES**			
9.1	Participative Culture Inquiry & Senior Leadership Development Programme	AM	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
10.1	A Framework of Quality Assurance Responsible Officers & Revalidation Annual Report and Statement of Compliance	MK	Attached	Approval
Questions taken from the General Public				
11	**OTHER**			
11.1	Correspondence circulated to Board members since the last meeting.	HLD	Verbal	Noting
11.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.4	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 3 December 2025 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** 4 February 2026 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item HLD 10:00

2. DECLARATIONS OF INTEREST

Standing item | HLD | 10:02

PRESENTATION: WEST ESSEX EPUT COMMUNITY DELIVERY FOR NEIGHBOURHOOD HEALTH

Information Item 10:04

Nicole Rich, Director of West Essex Community Delivery & Partnerships

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 6 AUGUST 2025

Decision Item HLD 10:19

REFERENCES

Only PDFs are attached

Board of Directors Part 1 Minutes 06.08.2025 (Draft) V3 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 07 August 2025
Held Virtually via MS Teams

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Paul Scott	PS	Chief Executive Officer
Anna Bokobza	AB	Director of Strategy (for Zephan Trent)
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director
Dr Milind Karale	MK	Executive Medical Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Non-Executive Director / Vice Chair
Elena Lokteva	EL	Non-Executive Director
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Richard Spencer	RS	Non-Executive Director
Sarah Teather	ST	Non-Executive Director

IN ATTENDANCE:

Bryony Dale	BD	Service User Network Manager, Specialist Personality Disorder and Complex Needs Team
Chris Jennings	CJ	Assistant Trust Secretary
Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Martine Munby		Director of Communications
Janice Scott	JS	Freedom to Speak Up Guardian (for item 085/25)
Clare Sumner	CS	Trust Secretary Administrator

There two Governors present.

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

The meeting commenced at 10am.

075/25 APOLOGIES FOR ABSENCE

Denver Greenhalgh, Executive Director of Corporate Governance
Zephan Trent, Executive Director of Digital, Strategy and Transformation

076/25 DECLARATIONS OF INTEREST

There were no declarations of interest relating to any items for discussion on the agenda.

077/25 PRESENTATION: HERE COMES THE SUN: PAVING THE PATH TO EMPOWERMENT AND SERVICE INNOVATION

Members of the Service User Network (SUN) team delivered a presentation regarding the Psychological Services Service User Network, highlighting the following:

- The SUN is a network where service users can seek peer support, share reviews on improving services and actively seeking and valuing the service user voice. This combination provides a demonstration of patient-led care.
- The network was integrated into a project, facilitated by an external consultant, regarding improving experiences for people living with personality disorders and complex needs (PDCN). The involvement of those with lived experience was a fundamental part of the project. The aim of the project was to have skilled employees who were able to meet the needs of service users. The services would also be more relevant, timely and cost effective.
- The presentation detailed benefits provided by Service User Networks, including mutual learning, designing services that are fit for purpose and tackling health inequalities.
- The next steps were to continue to deliver the network's objectives and seeking substantive funding for the teams.

Questions and Discussion

- DL asked how service users are encouraged to participate in the network. BD advised service users are encouraged to join through awareness and other peer support groups. There are also links with other programmes to help promote the network and the use of social media.
- AM agreed to speak with the team outside of the meeting regarding the recruitment strategy and how the network could provide input and give insight on how recruitment opportunities can be created in the Trust.
- ST asked whether the network worked with other organisations, to consider co-production and learning for key areas, such as individuals with personality disorders spending longer times on inpatient units. BD confirmed the service and network collaborates with partner organisations around enhancing involvement and supporting the development of services.
- AG highlighted the importance of the network during the winter period, looking at giving people better experiences and managing demand during the difficult winter months.
- PS commented the presentation solidified the importance of co-production and what can be achieved through responding to what service users want, bridging the gap between services and service users. There was a risk that service user involvement becomes a word rather than a practice and asked whether the Trust was a service user led organisation. CP felt the Trust had made good progress, but there was still more work to be done. The SUN provided mutual benefit, by showing staff what helped individuals accessing services, and showing service users the pressures and challenges faced by staff. The importance was to ensure service user involvement at all parts of a process, rather than at the end or as a member of a panel, which can become tokenistic.
- LL asked whether there was a view on what "great" looked like and what needed to be done to reach this point. BD felt "great" would be achieved by having the network model across all services. There are currently around 200 service users involved in the network and if this was replicated across the Trust, this would have a significant impact. AS agreed to discuss this outside of the meeting, looking at how existing programmes, such as peer support workers etc. could be utilised.
- EL commented on the importance of ensuring these types of programmes and projects can be sustainably funded.

HLD thanked the members of the SUN team for the presentation and the excellent discussion which had taken place.

078/25 MINUTES OF THE PREVIOUS MEETING HELD ON 04 JUNE 2025

The Board of Directors reviewed the minutes of the meeting held on 04 June 2025.

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

079/25 ACTION LOG AND MATTERS ARISING

The action log for the meeting held on the 4 June 2025, noting two closed actions and one future action in progress. The Board agreed for action 048/25 be updated to clarify the project referred to in the action related to the ligature risk reduction project at Longview Ward.

Action:

1. **Amend the action 048/25 on the action log to clarify the project referred to in the action related to the ligature risk reduction project on Longview Ward. (CJ)**

080/25 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

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

- The positive outcome of recent CQC inspections for Brockfield House and Clifton Lodge, which both achieved a rating of *Good*.
- Changes to the Council of Governors, including the stepping-down of John Jones, Paula Grayson, Dianne Collins and David Norman, formally thanking them for their contribution on behalf of the Board.
- Congratulations and thank you to Stuart Scrivener, for undertaking the role of Lead Governor.

The Board of Directors:

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

081/25 CEO REPORT

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

- Changes to the Board of Directors, including the retirement of Nigel Leonard. PS thanked NL for his extraordinary service to the NHS over many years and the positive legacy he has left the Trust.
- The CQC inspection report and improved ratings had shown that tangible improvements had been made and identified clear areas of focus going forward. It was positive to note the inspection report aligned with the Trust's own assessment on the actions it needs to take going forward. PS thanked those involved in the response to the CQC inspection report.
- The Annual Report and Accounts for 2024-25 had been signed off. PS thanked the Chair of the Audit Committee and Finance colleagues for their work in this area.
- The launch of the new NHS Oversight Framework would focus on performance, including use of resources and access to services. This will be important during the winter period and remained high on the EPUT agenda.
- The Government's new ten-year plan had a number of factors, such as the restructuring of ICB's. The development of a greater Essex ICB would make coordination of health and care services across Essex easier. There was a focus

on neighbourhood and place-based care and an opportunity to engage with partners across the sector. There was still uncertainty as to how the plan would be implemented, but EPUT was in a strong position to provide leadership in working with communities and partners.

Questions and Answers

- LL highlighted the importance of digital infrastructure in interfacing with partners, such as the new electronic patient record. It would be important to ensure any developments are co-produced and consent sought from patients for sharing information with partners involved in their care. PS agreed and noted the importance of ensuring there is rigour in sharing information with more partners involved in people's care.
- DL asked how contingencies developed for recent industrial action had worked and whether there were any challenges for the Trust. PS advised the consultant body had responded and coordinated well during the industrial action. MK advised there had been clear instruction not to cancel appointments and there had been enough support through additional rotas from consultants and medical managers with little disruption to patient services.

The Board of Directors:

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

082/25 QUALITY AND PERFORMANCE SCORECARD

PS presented a report providing the key performance and quality metrics. AG provided a summarised focus on operational performance as this was a high area of focus for the Trust. AG highlighted the following:

- There continued to be challenges with patient flow through inpatient services. This has an impact on other areas such as accessibility, financial outcomes and out of area placements.
- There was a focus on mental health flow and capacity, which had resulted in small improvements in June, but this remained a challenge which continued throughout July. There had been a request from the ICB for a remedial action plan for the inappropriate out of area placement trajectory plan.
- The recent industrial action had been managed internally, however, there was an external impact to consider for acute services, which had an impact on community health services.
- Winter planning had started early, and a workshop would be convened in September for Board members to have meaningful conversations about patient flow, including the actions being implemented to manage winter pressures.

Questions & Discussions

- MK provided assurance on the action taken to manage out of area patients, such as weekly clinical involvement to review the appropriateness of the placement and a focus on repatriation or discharge. There was also the implementation of a new operating model, utilising the Community First programme to increase proactive services for patients before a crisis is reached.
- RJ asked if there are any organisations performing above the expected level of patient flow from which the Trust could learn. AG advised that we have reviewed how other organisations manage patient flow, but that the biggest challenge for EPUT was length of stay. There was an improvement network being developed for the East of England which would include organisations with better positions on length of stay.
- EL highlighted the importance of understanding system level barriers, which could help manage patient flow prior to patients needing to be admitted to an inpatient

bed. AG advised there was a prevention workstream and work was being undertaken as part of the Community First model. The discharge system delays had remained unchanged, with a focus placed on internal management of patient flow to ensure the Trust owns the issue.

- RS asked whether Opel 4 status provided value and positive responses from system partners. AG advised there was some inequality between acute and mental health services, but that we have seen better attendance from senior colleagues at the Trust escalation call. This now needed to be sustained.
- LL highlighted a process undertaken by industries when looking at a complex issue such as flow and capacity, which is the development of a simulation to allow a constructive conversation to be held with system partners. AG welcomed a conversation with LL to take this forward. The focus currently would be on ensuring the winter plan is developed and immediate actions were undertaken, but the development of a simulation may be helpful as a medium-term plan.

The Board of Directors:

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

Actions:

1. **Establish a workshop in September to review and discuss the EPUT Winter Plan (AG/CJ)**
2. **Discuss the development of a simulation for flow and capacity. (AG/LL)**

083/25 COMMITTEE CHAIRS' REPORT

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

The Board of Directors:

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

084/25 CQC ASSURANCE REPORT

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

- There had been an unannounced inspection of Byron Court (learning disability inpatient service), which had involved a day/night visit and the submission of requested information. The outcome of the inspection was now awaited.
- The outcome of the Brockfield House inspection with an overall rating of *Good*. The Trust was not required to submit an action plan, but areas such as patient involvement and ensuring care plans are patient friendly would be taken forward.
- The Trust received the final report following the CQC unannounced focused inspection for the safe and well-led domains for mental health acute and psychiatric intensive care unit (PICU) inpatient services. The service had achieved an improved rating of *Requires Improvement*. The CQC inspectors saw demonstrable improvements, such as in staffing (particularly pharmacy and psychology), restrictive practice and a learning culture.
- The Trust received formal notification that the S29A warning notice, issued after the Dispatches programme aired in 2022, had been lifted as the CQC had received suitable assurance in relation to the areas of concern identified at the time.
- The Trust's overall CQC implementation plan was now at 94% of completed actions having been agreed through the evidence assurance process. It was proposed that the current version of the action plan is archived, with open actions

moved forward to a new plan, including any areas for improvement from recent inspections.

Questions and Discussion:

- RS asked if there had been progress with pharmacy staffing and the embedding of the electronic prescribing system since the inspection. AS advised that the Trust had employed additional pharmacy staff. There would be a focus as part of the action plan to ensuring practice is compliant with relevant policies.

The Board of Directors:

1. **Received and noted the contents of the report for assurance of oversight of progress against the CQC improvement plan.**
2. **Approved the archiving of the CQC improvement plan and a refresh to create a version to include residual open actions and new actions arising from recent inspection activity.**

085/25 FREEDOM TO SPEAK UP ANNUAL REPORT

JS presented the report which provided an update on the Freedom to Speak Up (FTSU) service activity for the period 1 April 2024 to 31 March 2025, including assurance on the FTSU arrangements with identified strengths and areas for improvement. JS highlighted the following:

- There was a slight increase in overall reporting levels, with inappropriate behaviour and attitudes the highest. There had also been an increase in anonymous reporting, partly due to staff utilising the confidential reporting form, but this may also be an indicator of staff fearing repercussions.
- The key developments for the year included the undertaking of staff engagement visits to listen to staff in their work environment. This has allowed the development of a more comprehensive view of the culture of speaking up in different areas.
- The next steps are the re-introduction of champion roles and continuing to raise awareness of the service, including routes to speak up. The informal resolution process would continue to be utilised, which can empower a person speaking up by feeling they have control of the process.
- The next steps mentioned above and the increased visibility of the team will likely contribute to a rise in the number of staff speaking up, with time needed to build trust in the process and demonstrate to staff that they were being listened to and noticeable changes had been made.

Questions & Discussions

- DL noted the number of anonymous concerns raised which often made it difficult to fully resolve issues, but added that the engagement visits was a positive development. DL asked if there was any action which could be taken to demonstrate to staff that the Trust wishes to learn and there would be no repercussions from speaking up. JS advised the engagement visits from Board members would be helpful in demonstrating open and honest communication with no blame.
- RS welcomed the approach and the pragmatism in the reporting of recognising the journey. RS asked if there were any stories which could be shared where staff had raised a concern which had led to a positive outcome. RS also suggested asking a question at the end of the process as to whether the staff member would raise a concern again, which could provide a good measure. AS agreed, and felt it was good to show staff that the Trust had acted as a result of concerns that had been raised. JS advised the feedback form could be developed to identify staff who may be interested in participating in a case study to share their story.

- AB commented on the need to normalise providing honest feedback, which may reduce the need for escalation to F2SU. AM advised this was part of the leadership development programme, with support from F2SU in encouraging managers to find resolutions to concerns raised.

The Board of Directors:

1. **Noted the contents of the annual report.**
2. **Agreed in principle next steps set out under 'priorities for service development 202526".**
3. **Supported greater collaborative work around Speak Up routes across the Trust.**

086/25 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

Cllr. Elizabeth Rigby, Appointed Governor, Thurrock Council, asked whether the impact on EPUT of the changes to the ICBs was known. PS advised the move to an Essex footprint would work well in streamlining conversations and decision making. The resource changes and what may be allocated to provider organisations was unclear, but this would become clearer moving forward.

087/25 BOARD ASSURANCE FRAMEWORK

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

- The BAF should be considered within the context of the strategy and the discussions held at the Board today.
- The Trust is currently undertaking a review of the strategic plan, which would also lead to a review of the BAF once completed.

Questions and Discussion

- TS advised the recent external audit reassessment of Inquiry provision as part of the annual accounts sign-off had impacted Strategic Risk 8: Use of Resources. This related to the Inquiry resources, cost provision and financial outturn.

The Board of Directors:

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

088/25 LEARNING FROM DEATHS

AS presented a report which provided data relating to deaths recorded on Datix for Q4 2024/25 (01 January to 31 March), provided an update on developments being made to mortality reporting and review processes, including key learning identified.
AS highlighted the following:

- Work had continued to improve the monitoring, data and review processes across the Trust, including the development of a dashboard and reviewing the inclusion of a tool in the EPR system.

Questions & Discussions

- In relation to the improvements mentioned, LL asked if there had been any progress in developing a list of quality improvement programmes for tracking by the Board. AS advised the list was currently being collated and would be taken through the Quality Committee prior to presentation to the Board.

The Board of Directors:

1. **Noted the information presented.**

2. **Noted the assurance provided by the content of this report that the Trust has robust processes in place which are line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high-quality services.**

089/25 INTENSIVE AND ASSERTIVE COMMUNITY TREATMENT FOR PEOPLE WITH SEVERE MENTAL HEALTH PROBLEMS

MK presented a report which provided an evidence-based comparison of EPUT's current position against the national framework and NHS England directives. MK highlighted the following:

- The Assertive Outreach service is for individuals with chronic illnesses and frequent admissions to psychiatric units. There had been a national move to review services for the patient cohort, and the report provided key challenges locally and nationally.
- An analysis of AOT services identified fragmentation across Essex, due to the challenges associated with meeting local requirements and funding.
- The analysis identified around 600 patients and associated challenges, such as in West Essex where there is no AOT, with CMHTs managing the caseload with additional pressure, whilst in Thurrock and Basildon, Intensive Outreach Teams are in place. This demonstrated the difference in commissioning across Essex.
- The analysis identified a number of actions and recommendations which are currently being progressed. These include the wider review of community services, the recruitment of peer support workers for outreach and AOT specific training for staff.

Questions & Discussions

- LL suggested providing a position on what best practice would look like for the patient cohort and an outline business case on what it would take to be able to deliver a service. RS suggested linking this with the Community First strategy to understand how this would fit with outreach services. AS advised the Community First project would be brought to a future seminar session – it includes individuals with complete emotional and assertive outreach needs as part of the pathway.
- DL commented the paper raised concerns and did not provide a solution, suggesting understanding what the Trust can do next in this area. MK advised the paper was presented to raise awareness. The assurance is currently limited, but there was good oversight of the cohort of patients and action being taken.

The Board of Directors:

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

Action:

1. **Develop session for the Board as part of a seminar / development session for Community First and Assertive Outreach, including how the Trust can resolve the issues outlined in the paper. (MK / AS)**

090/25 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

MK presented a report which provided assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract. MK highlighted the following:

- There had been ten exception reports within this period, which had resulted in two fines for the Trust.
- The on-call monitoring activity had not received the response anticipated and it has been agreed this would be repeated in September as concerns continued to be raised regarding workload.

Questions and Discussions:

- In answer to a query regarding whether there was a risk that doctors are not raising concerns, MK advised there was a clear process in place which was closely monitored by the guardian of safe working, working closely with tutors to ensure any breaches are addressed.

The Board of Directors:

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

091/25 SAFEGUARDING ANNUAL REPORT

AS presented a report which provided an account of the safeguarding activities undertaken across services and with partners during the year 01 April 2024 to 31 March 2025 and priority areas for 2025/26. AS highlighted the following:

- The report provided the activity undertaken by the Safeguarding Team during the year, noting the increased referrals year-on-year, which is similar nationally.
- Significant work has been undertaken in partnership around children and adult safeguarding reviews. There had been an increase in reviews due to changes in domestic abuse criteria and guidance.
- The report demonstrated evidence of visibility of safeguarding and how well EPUT's safeguarding processes and personnel are regarded by partners.

Questions & Discussions

- MK commented positively on the safeguarding lead and team, noting they were well regarding by the medical staff.

The Board of Directors:

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

092/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

093/25 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

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

094/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

HLD reflected on the importance of the Trust's commitment to equalities which was a broad framework in a complex organisation, with the presentation providing a good example.

AG highlighted the discussions around patient flow and the resulting experiences for people, including the conversations around assertive outreach and people who were seriously unwell.

095/25 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIREMENT)

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

096/25 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING RISKS FOR ESCALATION TO THE CRR OR BAF, RISKS OR ISSUES TO BE RAISED WITH OTHER STANDING COMMITTEES

There were no items for escalation.

097/25 ANY OTHER BUSINESS

LL advised he had represented EPUT on the East of England Mental Health Collaborative, but that following a Board restructure, it would no longer include NED representation. The Board will now be CEO-led.

098/25 QUESTION THE DIRECTORS SESSION

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

099/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 01 October 2025.

The meeting closed at 12:15.

Signed: Date: 2025

Hattie Llewelyn-Davies, Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 098/25)

Governor / Member of the Public	Query	Response
Ekoh West, Public Governor, Essex Mid & South	Comment regarding the development of a simulation for flow and capacity. The choice of approach should depend on the nature of the problem, the desired level of detail and the goals of analysis. In addition, could a combination of methodologies or a hybrid approach be considered? This can provide a more comprehensive, sustainable and adaptive approach for complex systems.	Thank you for the comments. Your points will be incorporated into the discussion regarding the development of a simulation model and tracked through the Board action plan.

4. ACTION LOG AND MATTERS ARISING

Standing item | HLD | 10:21

REFERENCES

Only PDFs are attached

Action Log Part 1 01.10.2025.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 6 August 2025

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG	Chris Jennings	CJ	Loy Lobo	LL
Scott Huckle	SH	Dr Milind Karale	MK	Ann Sheridan	AS

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
079/25 August	Amend the action 048/25 on the action log to clarify the project referred to in the action related to the ligature risk reduction project on Longview Ward.	CJ	October 2025	Action amended.	Closed	
082/25 August	Establish a workshop in September to review and discuss the EPUT Winter Plan	AG / CJ	September 2025	Workshop held on the 3 September 2025.	Closed	
	Discuss the development of a simulation for flow and capacity.	AG / LL	September 2025	Conversation to be held.	Open	
089/25 August	Develop session for the Board as part of a seminar / development session for Community First and Assertive Outreach, including how the Trust can resolve the issues outlined in the paper	MK / AS	November 2025	Included on the Board Seminar schedule for November 2025	Future Action	
048/25 June	Provide a further presentation / report to the Board of Directors in six months, providing further information on the impact of the ligature risk reduction project at Longview Ward and any feedback from young people on their experiences.	AS/SH	December 2025	This has been added to the Board Schedule.	Future Action	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | HLD | 10:23

REFERENCES

Only PDFs are attached

Chairs Report 01.10.2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

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

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

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

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Chair's Report (including Governance Update)

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

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Recent National and International Events

Many will have seen coverage in the media and social media about events in the US and closer to home and may be worried about the impact of those. At EPUT we are proud of the diversity of our workforce, with more than 90 nationalities represented at the Trust. It is important that everyone is respected, feels valued and feels confident to report any issues or concerns. Our Chief Executive has sent a personal message to colleagues to reinforce that there is no room for racism in our Trust and reminded all of the support available. This includes reaching out to a trusted peer or manager; our Employee Assistance Programme which is available 24 hours a day, seven days a week; the Here for You service, and our EPUT Chaplains to name but a few. Colleagues are also encouraged to raise concerns through the Freedom to Speak Up service, and can remain anonymous if preferred. No one should experience any form of racism or discrimination, and this will not be tolerated at EPUT.

2.2 Changes to Board of Directors and Council of Governors

I would like to formally congratulate Stuart Scrivener on his appointment to the Lead Governor role. Stuart has been an active member of the EPUT Council of Governors for some time and I look forward to working closely with him as Lead Governor.

I would also like to formally welcome Doug Field to the Trust in the role as Associate Non-Executive Director. Doug is an accomplished Non-Executive Director and Chair with extensive experience in private, public and charity sectors and is a welcome addition to our Board.

2.3 NHS Oversight Framework 2025/26

NHS England has published the updated 2025/26 Oversight Framework, which outlines the new approach to assessing NHS trusts. The framework introduces revised performance metrics with a greater emphasis on transparency and consistency. Key focus areas include waiting times, mental health access, quality of care, and financial sustainability. This links to annual effectiveness (capability) self-assessment issued through NHS England with the domains of Strategy, Quality of Care, People & Culture, Access & Delivery of services, Productivity & Value for Money, Financial Performance and Oversight

2.4 Research and Innovation

As part of our work in research and innovation, I was delighted to open our first joint research conference with colleagues at Anglia Ruskin University on 05 September. The event was an opportunity to celebrate our current research work and present on a number of programmes in which both organisations are involved. Presentations were heard around dementia and diagnosis, the mental health impacts of hyperemesis gravidarum (extreme morning sickness) in pregnant women, the impact of offering psychological therapies for patients admitted to an acute hospital with a physical health condition and using cognitive stimulation therapy to encourage and support people with dementia to engage in different activities. EPUT also became the first UK location to begin recruiting patients for a major clinical trial to test whether a specific blood test can improve early and accurate diagnosis of Alzheimer's disease. The landmark study is being led by University College London (UCL) and is recruiting people from memory clinics across the UK.

2.5 National Recognition

EPUT have been recognised for work in supporting newly qualified allied health professionals (AHPs) who have recently joined our services, scoring highly in the NHS England AHP Preceptorship Organisational Self-Assessment Tool. We scored highly for organisational culture,

quality and oversight of preceptorship, empowering preceptees and delivering preceptorship programmes.

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

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

Congratulations to all for their well-deserved national recognition.

2.6 Board Development Programme

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

3.0 Legal and Policy Update

3.1 Mental Health Bill [HL] 2024-2025 Progress of the Bill

This briefing provided an overview of the progress of the Bill through the House of Commons prior to report stage. **For Information:** CBP-10317.pdf

3.2 Enhanced Therapeutic Observation and Care Developing a Local Policy

Please see the link below for a copy of the guide designed to support trust develop and implement their enhanced therapeutic observation and care (ETOC) policy published on 28 August 2025. Trusts create ETOC polices that are living documents, enabling ongoing implementation and continuous improvement that responds to local needs. **For Information: NHS England » Enhanced therapeutic observation and care: developing a local policy**

3.3 Online Safety Laws to Strengthen to Protect People of all Ages from Devastating Self-Harm Content

Please see the link below for a copy of the report published on 8 September 2025. The Government has announced urgent action to toughen the Online Safety Act by putting stricter legal requirements on tech companies to hunt down and remove material that encourages or assists serious self-harm, before it can destroy lives and tear families apart. **For Information: Online safety laws to strengthen to protect people of all ages from devastating self-harm content - GOV.UK**

3.4 Planning Framework For the NHS in England

Please see the link below for a copy of Version 1 of the report published on 8 September 2025. The 10 Year Health Plan sets out the need for a significant change to the way we organise, deliver and fund services. To support this, a new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services. **For Information: NHS England » Planning framework for the NHS in England**

3.5 Assessing Provider Capability : Guidance for NHS Trust Boards

Please see the link first below for a copy of the guidance published on 26 August 2025 As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. The second links is a copy of the provider capability self-assessment template. **For Information:** **NHS England » Assessing provider capability: guidance for NHS trust boards** **Provider-capability-self-assessment.xlsx**

3.6 Standard Alternative Provider Medical Services Contract

Please see the link below for a copy of the report published on 21 August 2025.This document is the standard alternative provider medical services contract variation notice for 2025/2026. **For Information:** **Standard Alternative Provider Medical Services (APMS) Contract 2025/26**

3.7 Health and Care Sector Latest Developments

Please see the first link below for a copy of the report published on 11 September 2025 outlining the pressure on the NHS as waiting lists grow. The second link is a copy of Smart Glass and AI Apps to help mental health. **For Information:** **Health and care sector latest developments | NHS Confederation** **Smart glasses and AI filter apps among new tech to transform the mental health of millions - GOV.UK**

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 10:28

REFERENCES

Only PDFs are attached

CEO Report 01.10.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

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

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

Purpose of the Report		
This report provides an update on news and developments.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the content of the report.

Summary of Key Points

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

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

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

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

Acronyms/Terms Used in the Report			
BMA	British Medical Association	ICS	Integrated Care System
ICO	Integrated Care Organisation	EPR	Electronic Patient Record
CQC	Care Quality Commission	ARU	Anglia Ruskin University
WTE	Whole Time Equivalent	JEG	Job Evaluation Group
MARS	Mutually Agreed Resignation Scheme	GMC	General Medical Council
NMC	Nursing Midwifery Council		

Supporting Reports and/or Appendices

Chief Executive Officer Report.

Executive/ Non-Executive Lead / Committee Lead:

Paul Scott
Chief Executive Officer

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 **NHS Oversight Framework 2025/26**

NHS England has published the updated 2025/26 Oversight Framework, which outlines the new approach to assessing NHS trusts. The framework introduces revised performance metrics with a greater emphasis on transparency and consistency. Key focus areas include waiting times, mental health access, quality of care, and financial sustainability. This links to annual effectiveness (capability) self-assessment issued through NHS England with the domains of Strategy, Quality of Care, People & Culture, Access & Delivery of services, Productivity & value for money, Financial performance and oversight

1.2 **National Neighbourhood Health Implementation Programme (NNHIP)**

NNHIP is rolling out pilots focused on improving care for patients with multiple long-term conditions, including mental health. The programme promotes integrated care closer to communities with partnerships between NHS providers, primary care, and the voluntary sector. Three submissions were made across our Essex geography with West Essex and North East Essex selected to join phase one of the programme. We are delighted to be a key partner in both roll outs. These sites will play a crucial role in testing and refining models of community-led, preventative, and personalised care, as outlined in the 10 Year Health Plan

1.3 **NHS League Tables Launch**

NHS England published new league tables showing performance across mental health provision at trust level. The tables are reflected in three parts acute hospital trusts, non-acute trusts and ambulance trust. EPUT is included in the rankings of non-acute trusts and is placed 36 out of 61 non-acute provider trusts. Our scores for the individual domains in the ratings place us in the top performing trusts for access to services and for managing variance from our financial plan, although we scored less well in other areas, including the length of time patients stay in our acute mental health inpatient wards and our financial performance. I welcome information which allows our patients and communities to know more about how health services are performing, we are focussed on continually improving the care that we provide and performance monitoring plays and important part.

1.4 **NHS Payment Scheme 2025/26 Updates**

The NHS Payment Scheme for 2025/26 introduces a number of important updates, including the expansion of the Activity & Payment Incentive (API) model. This extended approach now applies more broadly across both mental health and community services, reflecting a national shift towards more outcomes-focused and transparent funding mechanisms.

These developments were reviewed in detail by our Finance and Performance Committee, who welcomed the direction of travel and recognised the strategic importance of preparing for future implementation milestones. In particular, the Committee highlighted the need to strengthen our coding and data infrastructure to ensure readiness for the 2027/28 financial year.

1.5 **National Maternity Services Investigation**

A national investigation has been launched into a number of NHS trusts regarding toxic cultures within maternity services. While not directly related to mental health services, this underscores wider NHS concerns regarding organisational culture and speaking up. EPUT remains firmly committed to fostering an open, transparent and inclusive culture where all staff feel empowered to raise concerns without fear of reprisal. This commitment is underpinned by robust Freedom to Speak Up and whistleblowing arrangements, which are designed to ensure that every voice is heard, respected, and acted upon appropriately.

We continue to strengthen our internal processes to support staff in speaking up, including:

- **Clear and accessible reporting pathways**, with dedicated Freedom to Speak Up Guardians and confidential whistleblowing channels.
- **Regular training and awareness campaigns** to build confidence and understanding around raising concerns.

- **Visible leadership support**, reinforcing that speaking up is a valued and protected part of our organisational culture.
- **Timely and transparent responses** to concerns raised, with feedback loops to ensure staff feel acknowledged and informed.

These measures are integral to maintaining a psychologically safe workplace, where staff are not only encouraged but feel genuinely supported to speak up about any issues that may impact patient safety, staff wellbeing, or organisational integrity.

The Board recognises that a strong speaking up culture is essential to continuous improvement and learning. We will continue to monitor and enhance our arrangements to ensure they remain effective, inclusive, and responsive to the needs of our workforce.

2. UPDATES

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

Our Trust wide winter plan has now been submitted to all 3 Essex system and will form an integral part of the system based integrated plans and our teams have participated in a number of system winter planning events.

To ensure the recent improvements in inpatient mental health flow are sustained, we have engaged subject matter expertise to undertake a 15 day systematic review. Timely recommendations for flow improvement will be provided to the Executive Team.

Falls Prevention Awareness Week took place from 15th-19th September, with the West Essex Falls Car highlighted for supporting over 2,500 patients in its first 2 years of operation.

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

Extensive planning framework activities are underway and have been the subject of discussion at the Finance and Performance Committee

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Health Inequalities and Patient Experience Team

The Trust's patient experience team, along with the support of Mid and South Essex (MSE) ICB, are working with community mental health services to launch an innovative and new approach to keeping young, black, Asian, and minority ethnic men out of hospital. Key to the model is advocacy, peer support, and creating opportunities for young men to move forward. The project is taking a population health approach to understand and address some of the wider determinants that impact the health of people in our communities.

Fundamentals of Care Event

The second year of Fundamentals of care was launched on the 19th September 2025 at the Crystal Centre in Chelmsford. This programme offers opportunities to minimise the theory / practice gap, and ensure evidence based practice supports gold standard person centred care within the Trust. The event began with a presentation of the Trust's journey so far with the International learning collaborative. A number of QI projects planned as part of the Fundamentals of Care fellowship programme were presented. The event hosted key note speaker, Dr Devin Carr, Chief Nurse, from Maine Health, Portland, USA. Devin spoke of how he has led the improvements in quality of care at Maine Health by fully adopting and weaving the Fundamentals of Care framework in the delivery of care.

The Safewards Squad

The Inpatient Deputy Director for Quality and Safety has been invited to Nottingham Health Care NHS Foundation Trust to talk at their Nursing and Co-Production Conference, with the CEO of Safewards about the work the Trust is doing in relation to Safewards. This is an evidence-based model for reducing conflict and containment on inpatient wards and consists of ten simple interventions that improve both patient and staff experience and reduce restrictive practice as well as friction and abuse between patients and staff.

'The Safewards Squad' which is a co-produced way for inpatients currently receiving care to be empowered to be part of the implementation of Safewards, which creates a more therapeutic environment and therapeutic benefit for themselves. This is expanding and is already having an incredible impact on patient experience and recovery. Examples of feedback from patients-

Maxine said: 'This project helped me ignore the voice telling me how useless I am all the time. I want to do more of this, it really helps me feel better'.

Eunice said: 'I've learnt a lot about myself, and I just wanted to say thank you all' …. 'I feel like my talent and artistic expression is very strong and has been valued through Safewards'.

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

Flu Planning
Winter 2025/2026 - Plans are in place ahead of the winter season to support the winter flu campaign. This year NHSE has requested organisations strive to achieve an additional 5% update from last year's campaign. The Trust's Occupational Health provider (OH) PAM will provide flu clinics for staff during October, November and December 2025.

In EPUT the second highest reason for absence in EPUT during last year was flu, with the equivalent of 14,453 FTE days lost. An increase of flu vaccination will therefore support the reduction of absenteeism due to flu and provide enhanced protection to prevent spread to infection to colleagues and patients. A communication and engagement strategy to support this campaign is being finalised.

National Staff Survey
Last month, we were encouraged to see a 53% increase in engagement with our National Quarterly Pulse Survey (NQPS) compared to the previous quarter. This positive momentum of staff engagement provides a strong foundation as we prepare for the launch of the National Staff Survey on 24 September.

To maximise participation, we will introduce a range of targeted incentives and engagement activities, ensuring that every member of our workforce can share their views. The Executive Team and Board of Directors remain fully committed to listening to our staff and acting on their feedback. The impact of last year's survey is already evident, with several initiatives now underway to address staff wellbeing, sexual safety, and to strengthen retention and leadership across the organisation.

Culture & Leadership Development
This month marks the beginning of a significant partnership with two highly respected national organisations: BRAP, a leading equalities charity, and The King's Fund, an independent health and care charity. Over the next year, both organisations will work closely with EPUT to conduct a comprehensive culture review and design a bespoke leadership development programme. This collaboration will deepen our understanding of cultural dynamics within the Trust and enhance our leadership capability and capacity, ensuring we are well-equipped to meet the needs of our staff and the communities we serve.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item | PS | 10:33

REFERENCES

Only PDFs are attached

Quality and Performance Scorecard 01.10.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	01 October 2025

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

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the report 2 Request any further information or action

Full Report

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

Summary of Key Points

Mental Health Inpatient Capacity:

- Adult Occupancy increased to 100.9%, remaining out of target (an increase from 98.5% in July) - Target <93%
- PICU Occupancy has increased to 88.9%, out of target (an increase from 72.5% in July) – Target <88%
- Specialist Occupancy has decreased to 71.2%, out of target (a decrease from 73.5% in July) - Target >95%
- Older Adult Occupancy has decreased to 94.8%, remaining out of target (a decrease from 98% in July) – Target <86%

Data accuracy is contributing to some of the issues. The ward bed base numbers used in the IPR are currently being validated by the Inpatient service leads, alongside existing challenges with recording discharges where documents cannot be backdated if they require sign off post discharge, the MH Information Team is working with Wards, Operational Productivity and Systems team to correct these issues.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (excluding Assessment unit) reduced to 48.05 days (down from 59.84 in July) - Target <35
- 96 discharges in August - 20 long stays (60+ days).
- Adult ALoS (Including the Assessment Unit) reduced to 40.15 days (down from 46.82 in July) - Target <35

August represented the lowest ALoS since September 2024 and represents a below average ALoS over the past 24 months, this is the second consecutive month of reporting within the new NHS oversight target of 60 days.

There is a flow recovery plan in place, we are also moving towards completion of Time to Care. There are 3 patients currently waiting for a bed as of 12/09:

- **Mid & South –** 1 Male on AMU at SUHFT
- **North Essex –** 2 Females on Acute Ward at CGH

Older Adult Average Length of Stay on Discharge

- Increased in August to 133.78 days (up from 129.20 in July) - Target <74
- 40 discharges in August - 22 long stay (60+ days).
- Older Adult current inpatients ALoS has reduced to 104.6 days - target of <80. The new Oversight Framework also changes the Older Adult target length of stay to 90 days (we are still at variance against this new target). 8 patients were discharged who had stays over 200 days which can result in an inflated ALoS figure in month.

PICU average length of stay

- Increased in August to 92.3 days (from 82.3 in July) – Target <50
- Five discharges from PICU in August,
    - Hadleigh – 3 discharges (1x 291 days and 1x 145 days)
    - Christopher – 2 discharges (both were long stays of 60+ days)

Adult and Older Adult wards are seeing reduced lengths of stay with this trend predicted to continue.

Rates of Patients Clinically Ready for Discharge:

Patients with a delayed transfer of care on PICU, Older Adults and Specialist wards all continue to report well within their respective target limits. Adults are seeing a small increase in the delayed transfer of care. This is due to the long stay inpatients that are experiencing system delays.

Inappropriate Out of Area Placements:

- There was a reduction and increase in the number of placements in August
  - Adult reduced by 15
  - PICU increased by two

- 29 repatriations in August
  - Adult – 25
  - Older Adult - 2
  - PICU - 2
- 53 remain OOA (46 Adult and 7 PICU)

The number of OOA remaining at month end is down from July, (66 to 53). Decreased by 2 older adults and 12 adults. However, PICU increased by 1.

Cardio Metabolic:

The indicator for health checks for SMI patients in Early Intervention Psychosis services continues to report good compliance, but not yet reaching target of >90%. August reports 68.29%

- Twelve inpatient wards fully compliant in August (439 Ipswich Road, Ardleigh, Henneage, Tower, Chelmer, Kitwood, Stort, Ruby, Meadowview, Edward House, Larkwood and Wood Lea).
- Overall compliance improved compared to July.

Nursing staff are completing the BMI, BP, Drink and Smoking sections to near 100%. We are working with the medics to improve the recording of lipids and glucose for which they are responsible and are sending out communications and escalating for discussion at their upcoming ward away days.

SMI patients in the Community Teams under 1 year overall compliance position has seen a slight decrease in performance with 58.6% reported in August.
Annual health checks in the community for SMI patients is being added to the risk register for the MSE care unit due to demand v capacity impacting further progress. SystmOne access is being given to teams so they can identify the Health Check gaps to be undertaken. A tracking report used by our teams was offline for a period and reinstated mid-august, performance is expected to improve since the report became available again.

NHS Talking Therapies:

The Talking Therapies services in the South East are currently reporting against historical Access Rates until these are replaced by commissioners with a greater focus on reliable improvement, recovery and 2nd appointments. The recovery rate continues to report above the 50% target at 58% in August.

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

No Harm / Low Harm Incident Rates:

August MH Services reported below target for No/Low patient harm but saw an increase from the position reported in July. As a Trust we encourage incident reporting and expect a high percentage of all incidents to be of no harm or low harm, this indicates a healthy reporting culture and limited harm being experienced by our patients.

Workforce:

The sickness absence rate continued to rise in August, reaching 5.4% and remaining above the established threshold. This trend mirrors the national picture, where NHS sickness absence rates have also seen an upward shift. Benchmarking data indicates that the Trust is performing relatively well across professional groups, with the majority positioned in quartile 2—reflecting mid-range performance among NHS organisations. To address the increase, proactive monitoring has been implemented through dedicated sickness task and finish groups, aimed at supporting targeted reduction efforts.

In preparation for the winter period, the Trust is actively promoting maximum uptake of the flu vaccine as a preventative measure to help mitigate seasonal-related absences.

Staff turnover has continued its downward trend, currently reported at 8.4%—the second-lowest rate recorded in the past 12 months. Benchmarking activity is underway and has identified the Trust as performing within quartile 2, indicating a mid-range position relative to National position.

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

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

Income & Expenditure
In-month deficit £0.3m, YTD deficit £3.1m (£1.8m excluding excess Inquiry costs). Whilst the overall position is £0.9m off plan after allowing for the excess costs of Inquiry it would be slightly better than planned. The second half of the year is increasingly challenging and the Trust has put in place a number of actions and mitigations to support the delivery of the forecast outturn.

Efficiency
Delivery in month £3m, YTD is £10.7m, £0.2m below plan. This includes is over-performance of temporary staffing spend and under performance on Out Of Area Placements.

Capital
Capital spend YTD £3.5m, £3.5m ahead of plan. Actions are in place to increase the rate of spend in the second half of the year.

Cash
Cash balance £32.7m, this includes deficit support funding and lower than expected capital spend.

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

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

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

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

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

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Information Item Chairs 10:47

REFERENCES

Only PDFs are attached

Committee Chairs Report Part 1 BoD Oct 25 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

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

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

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

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

Summary of Key Points
The Board of Directors regularly delegates authority to the standing committees of the Board in line with the Trust's Governance arrangements (SoRD, SFIs etc). Standing Committees present regular reports to the Board of Directors, providing assurance on the key items discussed and progress made to resolve any identified issues. For each Board meeting, Chairs of standing committees will provide details of meetings held and report: • Assurance – any key assurances to be provided to the Board. • Information – any issues previously identified which have now been resolved, including lessons learned. • Alert – any issues / hotspots for escalation to the Board. • Action – any issues where the Standing Committee is requesting action from the Board. The attached report provides updates in relation to the following Standing Committees: 1. Finance & Performance Committee (Diane Leacock) 2. People, Equality & Culture Committee (Ruth Jackson) 3. Quality Committee (Dr Mateen Jiwani)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report

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

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors

1 October 2025

EPUT

INTRODUCTION

Purpose of the report

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

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

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

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

NHS
Essex Partnership University
NHS Foundation Trust

1. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 18 September 2025

Assurance

Performance Report

• Assurance on the Trust's performance during August 2025 included the following areas:
- Crisis call response times.
- Inpatient mental health capacity.
- Mental health readmissions within 28 days for adults.
- Adult and older adult average length of stay on discharge.
- PICU average length of stay.
- Rates of Patients clinically ready for discharge.
- Inappropriate out of area placements.
- Admissions under the Mental Health Act.
- OPEL Status.
- Cardio Metabolic.
- Virtual Ward Occupancy.
- Routine mental health referrals seen within 28 days.

Financial Report

• The Committee received an update and considered the Trust's Month 5 Revenue and Capital results. This included key cost drivers, risks and mitigations, underlying deficit, cash impact of Inquiry and NHSE rules regarding Deficit Support Funding.

Estates & Facilities Report

• The Committee received an update on key areas of the estate, including:
- Estates strategy and property disposals.
- Catering services.
- Capital programme and operational estates.

Board Assurance Framework Report

• The Committee Received the BAF risks aligned with the Committee.

Information

NHS England Attendance

• The Deputy Director of Finance, NHSE, attended the meeting to observe and answer any questions.

Action

Escalate increased concern and risk to future cash balance from Inquiry Costs and Deficit Support Funding which is subject to System Financial Plan delivery.

Alert

No Alerts for the Board

NHS
Essex Partnership University
NHS Foundation Trust

2. PEOPLE COMMITTEE

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

Committee meeting held: 28 August 2025

Assurance

Workforce Disability Equality and Workforce Race Equality Standards
- An informal meeting of the People Committee has been arranged to discuss Workforce Disability Equality and Workforce Race Equality Standards in more detail.

People & Culture Risk Register
- Committee members agreed that the People & Culture Risk Register should be shared at future People Committee meetings for transparency and assurance.

Assurance Reports
- The following assurance reports were received by the Committee:
  - Board Assurance Framework
  - Education Strategy
  - Employee Relations Activity
  - Equality, Diversity & Inclusion
  - Lived Experience & Volunteers Workforce
  - People Promise
  - Time to Care
  - Workforce Key Performance Indicators
  - Workforce Disability Equality Standard
  - Workforce Race Equality Standard

Information

Staff Survey
- At the time of the meeting, the Staff Survey was expected to be launched on 24 September.
- A suggestion to make charitable donations in place of nominal staff rewards for completing the survey was being explored.

Appraisal Process
- The appraisal process is undergoing review, with the intention to change the window to November in line with Corporate Operational schedule.

Clinical Engagement
- Medical and clinical engagement is currently a priority area.
- The former Chief Medical Officer of a neighbouring Trust is assisting on an advisory basis.

Cultural Review
- EPUT is working with BRAP and Kings Fund to organise a cultural review of the Trust to support in the development of an OD programme of leadership development in line with our commitment to staff to provide support and career development.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

3. QUALITY COMMITTEE

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

Committee meeting held: 11 September 2025

Assurance

Assurance Reports:

- The Committee received the following Assurance Reports:
  - Board Assurance Framework
  - Development of a Patient Safety Culture
  - Emergency Preparedness Resilience & Response
  - Falls Prevention & Management
  - Infection Prevention & Control Annual Report 2024/25
  - Management of the Deteriorating Patient
  - Patient Safety Incident Response Framework
  - Patient & Service User Experience
  - PCREF Plan Including Health Inequalities
  - CQC & PFD
  - Quality of Care Performance Dashboard
  - Quality Senate
  - Safeguarding Annual Report 2024/25
  - Suicide Prevention
  - Transforming Community Mental Health Teams

Information

Oxevision Update

- The Committee received a verbal update on the use of Oxevision at the Trust.
- Refreshed Standard Operating Procedures and monthly audits have been implemented.
- Committee members requested that a Deep Dive Report be presented at the November 2025 meeting.

Launch of New Care Plan

- The Committee received a verbal update on the new Care Plan, which will be launched on 1 December 2025.
- The initiative will incorporate a range of system partners, working together to provide quality and safe care using existing resources.
- A detailed report will be presented to the Committee prior to the launch.

Updated Quality of Care Committee Work Plan 2025/26

- The Committee approved the updated Quality of Care Sub-Committee Work Plan 2025/26.
- The Quality Committee Work Plan 2025/26 has been revised accordingly, and is presented to the Board of Directors for approval.

Action

Updated Quality Committee Work Plan 2025/26

- The Board of Directors is requested to approve the Updated Quality Committee Work Plan 2025/26.

Alert

No Alerts for the Board.

7.3 CQC ASSURANCE REPORT

Information Item AS 10:57

REFERENCES

Only PDFs are attached

CQC Assurance Report 01.10.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

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

Risk Assessment of Report		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	✓
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	NA	
Describe what measures will you use to monitor mitigation of the risk	NA	

Purpose of the Report		
This report provides the Board of Directors with 1. An update on CQC related activities that are being undertaken within the Trust. 2. An update and escalations made against the Trust CQC improvement plan. 3. Assurance against the CQC Quality Statements.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the contents of the report.

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- No further activity has been undertaken by the CQC following their unannounced inspection of LD Inpatients (Byron Court), with the draft report pending.
- The new CQC/PFD improvement plan 2025 (v02) which includes actions from both the Forensic inspection and MH Adult Acute and PICU inpatient inspection has been opened. There are currently thirteen CQC concerns being taken forward, this includes three must do actions previously issued by the CQC, four Regulation Breach actions (RA) and six Improvement Actions (IA).
- There were fourteen CQC enquiries raised during the reporting period.

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

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

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

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

Supporting Reports/ Appendices /or further reading

- CQC Assurance Report
- Appendix 1 – CQC Action Plan 02 Update Report September 2025

Lead

Ann Sheridan

Ann Sheridan
Executive Chief Nurse

CQC ASSURANCE REPORT - OCTOBER 2025

1. Purpose of the report

This report provides the Board of Directors with:

- An update on CQC related activities undertaken within the Trust.
- An update and escalations as required on progress made against the Trust CQC action plan v02.
- Internal assurance of CQC Quality Statements.

2. CQC Registration Requirements

EPUT is fully registered with the Care Quality Commission.

3. CQC Inspections and Improvement Plans

3.1. Inpatient MH Adult and PICU inspection Report Published 11 July 2025

Following receipt of the final report for the CQC inspection of Adult Acute and PICU Services (MH), an approved improvement plan is in place.

The improvement actions are associated with:

- Medicines optimisation and the clinical governance oversight and management
- Governance and oversight of supervision and appraisal
- Patient involvement in the development of their care plan

The Improvement Plan has been submitted to CQC by the Compliance Team and will be monitored through the CQC/PFD actions governance process.

3.2. CQC Unannounced inspection LD Inpatients (Byron Court) 16 July 2025

No further activity undertaken by the CQC following their unannounced inspection of Learnng Disability Inpatients (Byron Court). The Trust awaits the draft report.

3.3. CQC Improvement Plan

As reported to Board in August 2025, version 01 of the improvement plan is archived with three ongoing actions transferred to a new Improvement Plan version 02.

- M6 - associated with improving the accessibility of CCTV footage.
- M21 – associated with Medicines Management training.
- M15 – associated with patient autonomy and informal rights.

New actions developed to bring together actions agreed following CQC inspection reports received in 2025 (Forensic Services and Adult Acute & PICU Services).

This plan will include any future CQC or PFD actions developed in 2025. By bringing together core CQC and other related plans into one document we will ensure consistency of delivery, avoidance of duplication and assurance oversight.

CQC Improvement Plan v02 Overview (September 2025):

There are currently 13 CQC concerns, these being three must do actions previously issued by the CQC, four Regulation Breach actions (RA) and six Improvement Actions (IA) – a total of 56 sub-actions.

- 0 (0%) complete, with no new actions being due until November 2025
- 2 are in recovery (CCTV / Informal rights) – carried forward from v01.
- 44 are on track.
- 9 reported as complete and pending evidence.
- 1 requires update (Enhancing systems for risk assessment review following an incident)

The Improvement Plan v02 monitoring has transferred to the monthly Quality of Care Group chaired by the Executive Chief Nurse. (Noting this replaces the weekly CQC action leads meeting). Further to this, the Evidence Assurance Group function has transferred to the Learning Oversight Committee.

3.4. CQC Enquiries

During the reporting period, the CQC raised fourteen (14) enquiries as outlined below.

Received	Service	Enquiry related to
09/07/2025	Dune Brockfield House, Wickford	Ground Leave
10/07/2025	Mental Health Urgent Care Department Basildon	Lack of Community Support
14/07/2025	Mental Health Urgent Care Department Basildon	Unhappy with Treatment
23/07/2025	Mid First Episode Psychosis Service the Gables	Patient Relationship
24/07/2025	Cedar Ward Rochford Hospital	Mental Health Act Detention
24/07/2025	Willow Ward Rochford Hospital	Mental Health Act Detention
30/07/2025	Christopher Unit (PICU) The Linden Centre	Medication
06/08/2025	Beech Ward (Rochford) Rochford Hospital	Mental Health Act Detention

Received	Service	Enquiry related to
06/08/2025	Specialist Mental Health Team the Gables	Medication
07/08/2025	Stort Ward Derwent Centre	Ground Leave
07/08/2025	Galleywood Ward The Linden Centre	Mental Health Act Detention
11/08/2025	Galleywood Ward The Linden Centre	Lack of Support - Inpatient
13/08/2025	Hadleigh Unit (PICU) Basildon Mental Health Unit (MHU)	Unhappy with Treatment
26/08/2025	Kelvedon Ward Basildon Mental Health Unit (MHU)	Poor communication between professionals

3.5. CQC Notifications

During the reporting period the Trust has made twenty-six (26) notification submissions to the CQC including:

- Death of a detained MH patient (2)
- Absent without leave (2)
- Death of a person using the service (3)
- Allegations of abuse (13)
- Serious injury to a person using the service (6)

4. Independent Assurance against CQC Quality Statements

4.1. Internal Assurance (Annual Assurance Visit Programme)

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

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

4.2. Internal Assurance (Quality Statements Assurance Framework)

A Trust Quality Statement Assurance Framework has been developed to provide an assurance map at a Trust level of compliance with the Quality Statements. All 34 Quality Statements are mapped to relevant policies/guidelines, governance forums, feedback methodology, performance indicators, audit data and outcomes.

A review of the Trust Quality Statements Assurance Framework is continuing in 2025 including a refresh of the template to mirror the Trust Board Assurance Framework. This change has been well received by staff within the Trust.

4.3. Quality Assurance Visits

The Quality Assurance Visits continued in July and paused in August as per the Framework. Visits will recommence in September.

5. Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report.

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Ann Sheridan
Executive Chief Nurse

Appendix 1

CQC Action Plan Update

September 2025

Introduction

The purpose of this report is to provide an update on key CQC compliance requirements including implementation and assurance status against those actions within the CQC action plan v02.

Version 01 of the plan has been closed following completion of improvement actions and version 2 is being opened and includes:

- CQC report Core Services and Well Led (published July 23) – 3 actions remained open at closure of version 01 and have been carried forward
- CQC report Forensic Services (published April 2025)
- CQC report Acute Wards for Adults and PICU (published July 2025)

Level of Assurance: Level 1

Key Messages

CQC Activity

No new CQC inspections.

CQC Improvement Plan v02 (2025)

There are currently thirteen CQC concerns being taken forward, this includes three must do actions previously issued by the CQC, four Regulation Breach actions (RA) and six Improvement Actions (IA). As at September 2025, 56 sub-actions have been developed to address the improvements required, of which:

- 0 (0%) of the Must do / Regulation Breach/ Improvement Actions are complete, with no new actions being due until November 2025.
- 2 is in recovery (CCTV/Informal Rights) – carried forward from v01
- 44 are on track
- 9 reported as complete and pending evidence
- 1 requires update

The Improvement Plan v02 monitoring has transferred to the monthly Quality of Care Group chaired by the Executive Chief Nurse. (Noting this replaces the weekly CQC action leads meeting). Further to this, the Evidence Assurance Group function has transferred to the Learning Oversight Committee.

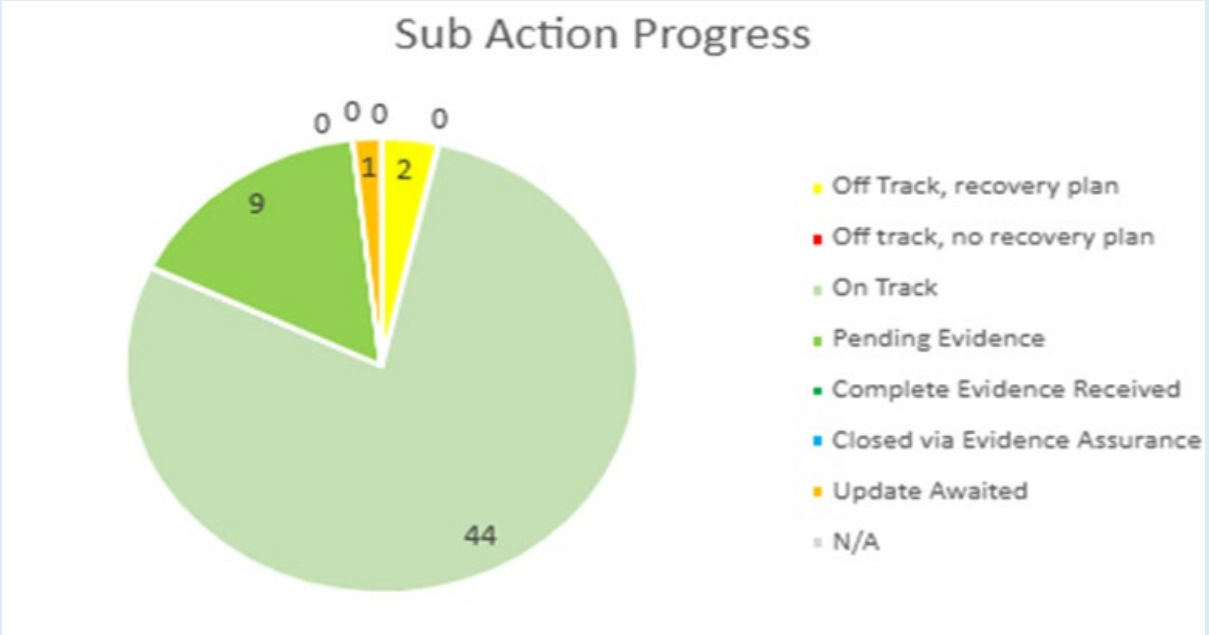
CQC action progress

Summary of key activities completed in the reporting period

Actions completed (pending evidence) in the period:

- Implementation of ePMA since the CQC inspection has supported with a number of actions including completion of PRN important details and allergy information recording)
- Pharmacy have set up a weekly report that goes to ward inbox showing administration omissions for the previous week and address gaps by having regular reviews for each ward. This started in April 2025.
- All medicines related audits, whether undertaken as part of the medicines management audit plan, within the POMH-UK programme or by individual/groups of junior medics to be reviewed by the Medicines Management Group and action plans agreed.
- Circulated staff communication to staff at Brockfield house reminding them of the Trust Behaviour Framework and of the importance to maintain patients' dignity and respect.
- Brockfield House has recruited to vacant activity coordinator roles and are now fully established with 10 in post
- Brockfield house has implemented activity programme

Progress



CQC Action Recovery Plan

Action Recovery Plan

CQC Concern	Sub-Action past timescale	Current Position	Recovery Plan	Lead
M6: (July 2023) The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts' policies and procedures for the recording and reporting of incidents	M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning	Work continues for remote access can be uploaded to current ward IT equipment. New software identified and has passed cyber security processes. Identifying funding options to take forward. Current mitigation of access at current location in place.	The CCTV software procurement decision has been escalated to Director of Estates for a decision. Final stages of discussions with Estates, Operations, and Digital to assign ownership of CCTV management to Operations for future downloading. This initiative aims to streamline the process, significantly reducing the time required to respond to requests compared to the existing system. Once the software is approved and implemented, training will be provided to designated staff members through Operations to ensure compliance with Trust policies for the downloading footage. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona
M15 (July 2023 The Trust must support the autonomy of the patients in line with their needs and states preferences. Patients admitted informally must be fully informed of their rights and be able to leave the ward safely	Education with staff and patients regarding informal patients' rights to leave at any time	**(Re-opened 28 July 2025)** Evidence assurance presentation did not sufficiently evidence that this change has been fully embedded	Re-audit to be undertaken September 2025	Katy Scott / Lianne Joyce

7.4 WORKFORCE RACE EQUALITY STANDARD (WRES)

Decision Item AM 11:02

REFERENCES

Only PDFs are attached

Workforce Race Equality Standard (WRES) Oct 2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

Report Title:	**Workforce Race Equality Standard (WRES)**					
Executive/ Non-Executive Lead:	Andrew McMenemy – Executive Chief People Officer					
Report Author(s):	Gary Brisco – Equality Advisor Paul Taylor – Director of OD & Culture					
Report discussed previously at:	Executive Operational Committee - 5th August 2025 People Committee - 28th August 2025					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	• If the Trust does not address issues of inequality in the experience of BME staff in comparison to their white counterparts, staff will experience poorer outcomes, including poor morale and engagement, higher turnover rates and reduced psychological safety leading to burnout and stress. • If the Trust does not develop specific actions associated with formal disciplinary outcomes, bullying and harassment and career progression and development for BME staff, it will lead to poorer patient outcomes, regulatory compliance risks and deepen inequity of access to opportunities across the Trust.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	
	Area	Who / When

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

Purpose of the Report		
This report provides the findings of the EPUT WRES 2025 data, measuring performance. It provides a detailed breakdown and comparison of EPUT's indicators to the previous year with a breakdown of key data (Appendix A). This data has been presented to EPUT Stakeholders to develop an action plan (Appendix B) that will be delivered in EPUT with the goal of improving the experience of working in EPUT for our Black, Asian and minority Ethnicity (BME) workforce.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the data in Section 4 and Appendix A
- Note the proposed actions in Appendix B for delivery in 2025-26.
- Approve the publication of the WRES.

Summary of Key Issues

There remains a disparity in the negative experience of BME staff in all indicators in comparison to their White counterparts. This inequality is seen in our data for discrimination and bullying from staff and patients, as well as the following themes:

- BME staff entering the formal disciplinary process. **(WRES Indicator 3)**
- BME Staff accessing non-mandatory training and CPD. Belief that the organisation provides equal opportunities for progression or promotion. **(WRES Indicator 4 & 7)**
- Staff experiencing harassment, bullying or abuse from patients, relatives, or the public **(WRES Indicator 5)**
- Staff experiencing harassment, bullying, discrimination or abuse from staff. **(WRES Indicator 6 & 8)**

A minor improvement is noted across the following domain:

- 1.5% improvement in BME staff experiencing harassment, bullying or abuse from patients / service users, relatives, or the public in last 12 months since 2024.

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

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

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

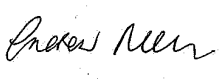
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality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

Acronyms/Terms Used in the Report			
BME	Black, Asian and Minority Ethnicity	DCF	Data collection Framework
EMREN	Ethnic Minority and Race Equality Network	AfC	Agenda for Change
ESR	Electronic Staff Record	WRES	Workforce Race Equality Standard

Supporting Reports/ Appendices /or further reading

- Workforce Race Equality Standards 2025 Report
- Appendix A: Breakdown of WRES Data
- Appendix B: WRES Action Plan 2025 - 26

Lead



Andrew McMenemy –
Executive Chief People Officer

WORKFORCE RACE EQUALITY STANDARD 2025

1 INTRODUCTION

1.1 The Workforce Race Equality Standard (WRES) was created to lead the race equality agenda in the NHS and for organisations to improve their performance. The goal is for employees from Black, Asian and Minority Ethnicity (BME) backgrounds to have equal access to opportunities and receive fair treatment in the workplace. This is measured using both NHS Staff Survey data and workforce data from our Electronic Staff Record (ESR) across ten "WRES Indicators." These indicators cover areas including representation throughout the organisation, recruitment, involvement in formal disciplinary processes, bullying, harassment and career progression.

1.2 This report shares the findings of the EPUT WRES 2025 data, measuring our performance. It provides a detailed breakdown and comparison of EPUT's indicators to our previous year with a breakdown of key data in Appendix A. This data has been presented to EPUT Stakeholders to develop an action plan (Appendix B) that will be delivered in EPUT with the goal of improving the experience of working in EPUT for our Black, Asian and minority Ethnicity (BME) workforce.

2 EXECUTIVE SUMMARY

2.1 EPUT has seen improvements in two out of the nine WRES indicators. with the remaining eight being close to national averages.

2.2 The latest WRES data states that 32.1% of the Trust's workforce are from a BME background. This is an increase of 2.9% from the previous year's report. EPUT data shows that whilst the Trust have seen some improvements, there remained a disparity in the negative experience of BME staff in all indicators in comparison to their White counterparts. This inequality is seen in the Trust data for discrimination and bullying from staff and patients, as well as the likelihood of entering formal disciplinary processes and access to career progression in comparison to their White counterparts.

3 PERFORMANCE AGAINST WRES INDICATORS

3.1 This data is taken from the ESR (1 April 2024 – 31 March 2025) and the EPUT 2024 Staff Survey results which has been shared with NHS England's Mandated Standards Team via a Data Collection Framework (DCF). These findings are presented below with progress against these indicators and comparisons against the national averages where available:

3.2 **Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (Very Senior Managers) including Executive Board members compared with the percentage of staff in the overall workforce.**

3.3 Performance against this indicator has improved by 2.9%, with 308 BME staff joining the Trust since the previous reporting period. 32.1% of our staff are from a BME background. The BME non-clinical workforce has seen an increase in staff at bands 2, 3, 4, 6, 7 and 8a in comparison to the previous report. The majority of BME staff however remain in bands 2 – 4, with fewer BME staff working at bands 7, 8, 9 and VSM in comparison to their White counterparts.

3.4 The BME clinical workforce (non-medical) has also seen significant growth in bands 3, 6, 7 and 8a, this data shows fewer BME staff working at bands 7, 8, 9 and VSM in comparison to their White counterparts. The medical and dental workforce has a significantly larger proportion of BME staff in comparison to their White counterparts. This section has seen growth at Consultant and Trainee grades.

3.5 **<u>Indicator 2</u>: Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.**

3.6 Performance against this indicator has decreased. In 2024, the relative likelihood ratio of 1.27 showed that BME staff were less likely to be appointed from shortlisting compared to their White counterparts during that period. The latest data shows that this is now 1.44 which highlights that White staff were more likely to be appointed during this period (based on shortlisting and appointment figures in Appendix A).

3.7 When reviewing the data, we can see that whilst the number of BME shortlisted applicants was higher, the percentage of successfully appointed staff members was lower than their White counterparts (with BME staff having a 17.2% success rate during this period and White staff having a higher 24.8%). This reinforces the raise in disparity ratio.

3.8 **<u>Indicator 3:</u> Relative likelihood of BME staff entering the formal disciplinary process compared to White staff.**

3.9 The likelihood of BME staff entering formal disciplinary processes compared to their White counterparts has decreased from a disparity ratio of 3.47 to 3.32, whilst this is an improvement, it still shows that BME staff were significantly more likely to enter this process.

3.10 When reviewing this significant disparity with the Employee Relations Team, their annual reporting showed an increase overall in cases entering formal conduct proceedings, with the majority of these within the MH Inpatient and Urgent Care directorates (which have significantly higher levels of BME staff). This will continue to remain a priority until the Trust can reduce this ratio to a balanced score (1).

3.12 **<u>Indicator 4</u>: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.**

3.13 The likelihood of BME staff accessing non-mandatory training and CPD compared to White staff has declined from the previous year, showing that BME staff were less likely to access these opportunities than their White counterparts during this period, with the disparity ratio rising from 1.07 in 2024's WRES report to 1.41 in 2025.

3.14 When comparing this to the figures in Appendix A, 17.4% of BME staff engaged in comparison to 24.5% of White staff. Whilst the bespoke RISE program for BME staff receives a positive reception in EPUT, other methods to encourage and empower this group into non-mandatory training and career progression should be considered.

Symbol	Key
▲▼	Improvement / Increase
▼▲	Decline / Decrease
-	No Change
	Current data for BME staff experience at time of reporting.

Workforce Indicators (Data taken from ESR, ER and Recruitment teams, April 2024 – March 2025)		EPUT Progress				
		EPUT 2024	EPUT 2025	24 - 25 Diff.	NHS Avg.	EPUT vs. Avg.
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. *(full breakdown in **Appendix A**)* *Higher % = Improvement*	**29.2%**	**32.1%**	**▲ 2.9%**	**28.6%**	**Higher**
2	Relative likelihood of White staff being appointed from shortlisting compared to BME staff. *Higher = Worse, "1" being equal likelihood. Figure below 1 means that BME Staff are more likely than White staff.*	**1.24**	**1.44**	**▲ 0.44**	**1.62**	**Lower**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff. *Lower Ratio = Better, with "1" being equal likelihood.*	**3.47**	**3.32**	**▼ 0.15**	**1.09**	**Higher**
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff. *Lower Ratio = Better, with "1" being equal likelihood. Figure below 1 means that White staff are less likely than BME Staff.*	**1.07**	**1.41**	**▲ 0.07**	**1.06**	**Higher**

3.15 Indicators 5-8: Staff Experience

3.16 This data is taken from EPUT's NHS Staff Survey results, published in March 2024. Some figures may show discrepancies in comparison to previous WRES reports due to a National Staff Survey data collection issue which has since been resolved. To rectify this, we used the most recent Staff Survey benchmark data to ensure this report remains accurate. The following should be considered:

- **These percentages represent staff who completed the NHS Staff Survey**, not the total for EPUT or the NHS.
- Our current results are near average for an NHS organisation, with our scores being within 5% of NHS Staff Survey 2024 averages.
- We have seen positive reductions in indicator 5 (*Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives, or the public in last 12 months.*) for both White and BME staff, with a reduction in the gap between the two groups.
- Indicators 5, 6 and 8 continue to show a significant disparity in the reported experience of BME staff in comparison to their White counterparts.
- This gap is akin to the previous year with the largest being for indicator 7 *(Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.)*

Symbol	Key
▲▼	Improvement / Increase
▼▲	Decline / Decrease
-	No Change
	Current data for BME staff experience at time of reporting.

Staff Survey Indicators (data taken from NHS Staff Survey 2024)		EPUT 2023	EPUT 2024	23 / 24 Diff.	Staff Survey Avg. (2024)	EPUT vs Avg.
5	Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives, or the public in last 12 months. *Lower % = Improvement*	White 21.98%	White 21.49%	▼0.49%	White: 21.29%	**Higher**
		BME: 33.14%	**BME: 31.64%**	▼1.50%	**BME: 31.64%**	**Equal**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. *Lower % = Improvement*	White 19.70%	White 19.97%	▲0.27%	White 16.48%	**Higher**
		BME: 20.72%	**BME: 21.91%**	▲1.19%	**BME: 21.23%**	**Higher**
7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. *Higher % = Improvement*	White: 63.68%	White: 60.90%	▲2.78%	White 60.99%	**Lower**
		BME: 53.29%	**BME: 50.23%**	▼3.06%	**BME: 51.05%**	**Lower**
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months. *Lower % = Improvement*	White: 6.59%	White: 7.78%	▲1.19%	White 6.08%	**Higher**
		BME: 13.58%	**BME: 14.58%**	▲1.00%	**BME: 13.23%**	**Higher**

3.17 Indicator 9 – Percentage difference between the organisations' Board voting membership and its overall workforce

There have been reductions in the number of BME board members and BME executive members in EPUT, which has led to a decrease in the representation in each of these areas.

However, when reviewing the data in Appendix A, we can see that EPUT currently has fourteen Board members, with three (21.4%) members of BME staff. Whilst this still does not reflect the 32.1% of BME staff in the wider Trust, we still see representation at senior levels.

Workforce Indicators (Data taken from April 2023 – March 2024)		EPUT Progress		
		EPUT 2024	EPUT 2025	Difference Gap 2024 - 2025
9i	Percentage difference between the organisations' Voting Board membership and its overall workforce *A score of 0 = equality of representation between membership and workforce* *Minus numbers caused by larger percentage in overall workforce*	White *(60% - 68.7%)* -8.7%	White *(66.7% - 66.4%)* 0.3%	**Narrower**
		BME *(33.3% - 29.2%)* **4.1%**	**BME** *(25% - 32.1%)* **-7.1%**	**Wider**

Workforce Indicators (Data taken from April 2023 – March 2024)		EPUT Progress		
		EPUT 2024	EPUT 2025	Difference Gap 2024 - 2025
9ii	Percentage difference between the organisations' Exec Board membership and its overall workforce *A score of 0 = equality of representation between membership and workforce. Minus numbers caused by larger percentage in overall workforce*	White *(80% - 68.7%)* 11.3%	White *(100% - 66.4%)* 33.6%	**Wider**
		BME (*20% - 29.2%*) **-9.2**	**BME** (*0% - 32.1%*) **-32.1%**	**Wider**

4 PEOPLE AND EDUCATION STRATEGY AND EDI DELIVERY PLAN

4.1 The EPUT **People and Education Strategy (2024 - 2028)** uses the data from Indicators 5 – 8 (based on 2024 Staff Survey data) to gauge performance as an organisation in achieving race equality and preventing discrimination or disparities. The information below shows our current progress in comparison to the targets set by these indicators.

- A 1.50% increase in the percentage of BME staff reporting experiences of harassment, bullying or abuse from patients / service users, relatives, or the public.
  - This is currently at 31.64%, above EPUT's PES target of 30%.
- A 0.19% increase in the percentage of BME staff reporting experiences of harassment, bullying or abuse from staff.
  - This is currently at 21.91%, above EPUT's PES target of 20%.
- A 3.06% decrease in the percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion.
  - This is currently at 50.23%, below EPUT's PES target of 60%.
- A 1% increase in the percentage of BME staff reporting experiences of discrimination at work from a manager / team leader or other colleagues.
  - This is currently at 14.58%, above EPUT's PES target of 10%.

5 ENGAGING STAKEHOLDERS AND PRIORITIES

5.1 An all-staff stakeholder session was held on 17 July 2025, as part of the Ethnic Minority and Race Equality Network (EMREN) to discuss how these indicators have developed, as well as the Trust's current initiatives. This collaboration was then used to develop the WRES action plan (Appendix B) with the following themes:

- BME staff entering the formal disciplinary process. **(WRES Indicator 3)**
- BME Staff accessing non-mandatory training and CPD. Belief that the organisation provides equal opportunities for progression or promotion. **(WRES Indicator 4 & 7**
- Staff experiencing harassment, bullying or abuse from patients, relatives, or the public **(WRES Indicator 5)**
- Staff experiencing harassment, bullying, discrimination or abuse from staff. **(WRES Indicator 6 & 8)**

5.2 This data has also been used to establish priorities as part of an overarching EDI delivery plan across 2025-27 and will be facilitated by an EDI working group. Racism and disproportionate treatment of BME staff has been agreed as a theme following engagement with key stakeholders within the organisation.

6 CONCLUSION

6.1 Whilst we as the Trust endeavours to improve the experiences of BME staff in comparison to their White counterparts, this report continues to highlight areas for improvement. The Trust will continue to support BME staff across the Trust as well as working in collaboration with our EMREN, their executive sponsor and the People and Culture Directorate to drive improvement and facilitate the voices of our staff from these groups. The WRES action plan and delivery of the EDI Delivery Plan will also facilitate this, with updates provided to the Executive Team as these actions are implemented.

7 NEXT STEPS

Presented to Executive Team for approval	Tuesday 5 August 2025
Presented to PECC for assurance	Thursday 28 August 2025
Presented to Board of Directors for approval	Tuesday 1 October 2025
Deadline for Publication	Friday 31 October 2025

8 ACTION REQUIRED

The Board of Directors is asked to:

- Note the data in Section 4 and Appendix A
- Note the proposed actions in Appendix B for delivery in 2025-26.
- Approve the publication of the WRES.

Report prepared by:

Gary Brisco
Equality Advisor

Paul Taylor
Director of Organisational Development and Culture

On behalf of:

Andrew McMenemy
Executive Chief People Officer

APPENDIX A: BREAKDOWN OF WRES DATA

1a) Summary of Key Figures Taken from WRES DCF	WRES 2023	WRES 2024	WRES 2025
Number of White staff in overall workforce	4489	4712	4783
Number of BME staff in overall workforce	1677	**2004**	**2312**
Number of staff (ethnicity unknown on ESR)	190	139	107
Total substantive (permanent) workforce	6356	**6855**	**7202**
Number of shortlisted applicants (White)	2603	2921	**2431**
Number appointed (White)	693	657	**603**
Percentage of successful appointments (White)	26.6%	22.5%	24.8%
Number of shortlisted applicants (BME)	1994	**2379**	2760
Number appointed (BME)	744	**430**	474
Percentage of successful appointments (BME)	37%	**18.1%**	17.2%
Number of shortlisted staff (ethnicity unknown on ESR)	186	158	246
Number appointed (ethnicity unknown in ESR)	116	25	20
Percentage of successful appointments (ethnicity unknown on ESR)	62%	15.3%	16.2%
Number of White staff entering formal disciplinary process	19	23	27
Number of BME staff entering formal disciplinary process	13	**34**	**43**
Number of staff (ethnicity unknown on ESR) entering formal disciplinary process	1	0	1
Number of White staff accessing non-mandatory training and CPD	543	1023	1170
Number of BME staff accessing non-mandatory training and CPD	146	**406**	**402**
Number of staff (ethnicity unknown on ESR) accessing non-mandatory training and CPD	27	71	153
White Total Board Members	12	12	11
White Executive Board Members	8	8	8
BME Total Board Members	4	**5**	**3**
BME Executive Board Members	1	**2**	**0**
(Ethnicity unknown on ESR) Total Board Members	1	1	1
(Ethnicity unknown on ESR) Executive Board Members	0	0	0

1b) Non-Clinical Workforce						
	2023		2024		2025	
NHS Banding (AfC)	White	BME	White	BME	White	BME
Band 1	No Staff in Band 1 or below					
Band 2	265	56	261	61	266	**66**
Band 3	485	52	522	56	534	**58**
Band 4	346	35	364	43	368	**59**
Band 5	156	15	157	15	160	**14**
Band 6	107	14	105	20	118	**24**
Band 7	72	11	86	15	91	**16**
Band 8a	41	7	44	8	46	**12**
Band 8b	23	5	20	6	19	**6**
Band 8c	14	3	21	5	22	**4**
Band 8d	11	2	11	3	13	**3**
Band 9	5	0	6	0	8	**0**
VSM	24	3	22	2	21	**0**

1c) Clinical Workforce (of which Non-Medical)			
	2023	2024	2025

NHS Banding (AfC)	White	BME	White	BME	White	BME
Band 1	**Band 1 Removed from Grading System (No Staff in Band 1 or below)**					
Band 2	18	3	10	3	1	**1**
Band 3	581	319	582	394	562	**515**
Band 4	378	129	420	86	418	**90**
Band 5	309	298	308	421	32	**411**
Band 6	752	302	784	367	801	**481**
Band 7	526	152	574	178	581	**210**
Band 8a	185	46	202	58	209	**65**
Band 8b	85	25	94	27	91	**23**
Band 8c	28	4	28	3	29	**10**
Band 8d	14	5	14	7	18	**7**
Band 9	2	0	3	0	4	**0**
VSM	2	1	2	1	2	**1**
1d) Clinical Workforce (of which Medical and Dental)						
Consultants	28	66	29	79	31	**81**
Of which, Senior Medical Manager	0	1	0	1	0	**1**
Non-Consultant, Career Grade	12	46	12	56	13	**59**
Trainee Grades	31	74	31	90	21	**89**
Other	7	8	0	0	4	**2**

APPENDIX B: WRES ACTION PLAN 2025-26

WRES indicators – 3, 4, 5, 6, 7, 8
People Promise Themes – *We are Compassionate and Inclusive, we are Safe and Healthy*
NHS EDI High Impact Actions – 1, 2, 4, 6

Priority Area	Actions	Leads	KPI's
FORMAL DISCIPLINARY PROCESS Reduce number of BME Staff members undergoing the formal disciplinary procedure.	• Engage with volunteers from the Ethnic Minority and Race Equality Network to review current processes and help mitigate potential bias. **(Ongoing)** • Develop training for staff to build cultural awareness, share benefits of inclusion and cultural competency in workplace interactions and conflict resolutions. **(March 2026)** • Collaboratively work with the EMREN volunteers with positive and negative accounts of resolving incidents in inpatient settings, using lived experience to identify cultural barriers whilst evoking emotional shifts that are fundamental to behaviour change. **(June 2026)**	Debbie Prentice *Employee Relations Lead* Nicky Reeves: *Organisational Development Lead* Gary Brisco: *Equality Advisor*	**WRES 3:** Relative Likelihood reduced significantly to "1". Reduction in BME staff accessing formal disciplinary processes (<43)

WRES indicators – 3, 4, 5, 6, 7, 8 **People Promise Themes –** *We are Compassionate and Inclusive, we are Safe and Healthy* **NHS EDI High Impact Actions –** 1, 2, 4, 6			
Priority Area	**Actions**	**Leads**	**KPI's**
ACCESS TO NON-MANDATORY TRAINING AND CPD Increase the numbers of BME staff members accessing career development and mentoring.	• Launch internal "speed mentoring" sessions aimed at BME staff **(January 2026)** • Develop "Career Clinic" sessions aimed at BME staff, where staff can access advice on their own career progression and development. **(December 2025)** • Promote apprenticeships, career progression and development opportunities **(Ongoing)** • Work alongside national NHS to develop a pilot for BME nurses (including internationally educated nurses) **(September 2026)**	Nicky Reeves: *Organisational Development Lead* Kim Russell *Communications Lead* Andrew McMenemy *EPUT Chief People Officer, Pilot Lead*	**NHS Staff Survey Q15 & Q24B:** Improvement in scores regarding career progression and development for BME staff. **WRES 3:** BME staff entering NMD and CPD. **WRES 7:** Improved perception of equal opportunities for career progression or promotion. **Workforce Promotions Data:** Increased rate of promotion for BME staff (PSED Report 2025)
BULLYING AND HARASSMENT FROM SERVICE USERS Increase reporting of instances of bullying, harassment, and discrimination from service users. Decrease instances of this behaviour against BME staff.	• Develop clear guidelines on managing situations where patients or carers are racially abusing staff members, and how the Trust should challenge this. **(April 2026)** • Introduce ways to capture how staff are supported following a reported DATIX incident by their manager, and to confirm that this is done appropriately with discussion on how to prevent this happening again. **(April 2026)**	Deputy Directors of Quality and Safety Adam Mack *VAPR Lead* Phil Stephens *DATIX Lead*	**WRES 5**: Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. **DATIX:** Incidents where Racial Abuse was listed as a contributing factor and manager support was received

WRES indicators – 3, 4, 5, 6, 7, 8 **People Promise Themes –** *We are Compassionate and Inclusive, we are Safe and Healthy* **NHS EDI High Impact Actions –** 1, 2, 4, 6			
Priority Area	**Actions**	**Leads**	**KPI's**
BULLYING, HARASSMENT AND DISCRIMINATORY BEHAVIOUR AGAINST STAFF Reduce instances of discriminatory behaviour from managers, team leaders or other colleagues by BME Staff.	• Cultural awareness training to be delivered in areas with high rates of incident reporting, encouraging staff to challenge discriminatory behaviour and empowering them to report and discuss this in the workplace. **(Ongoing)** • Develop resources to educate teams and managers on the positive benefits from inclusion. **(January 2026)** • Board and VSM's clearly and regularly communicate the organisation's values as an anti-racist Trust, and the consequences of racial discrimination, bullying, harassment, or abuse. **(Ongoing)**	Nicky Reeves: *Organisational Development Lead* Gary Brisco: *Equality Advisor* Kim Russell *Communications Lead*	**WRES 6**: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. **WRES 8:** Percentage of BME staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

7.5 WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

Decision Item | AM | 11.10

REFERENCES

Only PDFs are attached

Workforce Disability Equality Standard (WDES) Oct 2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

Report Title:	**Workforce Disability Equality Standard (WDES)**					
Executive/ Non-Executive Lead:	Andrew McMenemy – Executive Chief People Officer					
Report Author(s):	Gary Brisco – Equality Advisor Paul Taylor – Director of Organisational Development and Culture					
Report discussed previously at:	Executive Operational Committee – 5th August 2025 People Committee – 28th August 2025					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	• If the Trust does not address issues of inequality in the experience of disabled staff in comparison to their non-disabled counterparts, staff will experience poorer outcomes, including poor morale and engagement, higher turnover rates and reduced psychological safety leading to burnout and stress. • If the Trust does not develop specific actions associated with formal disciplinary outcomes, bullying and harassment and career progression and development for BME staff, it will lead to poorer patient outcomes, regulatory compliance risks and deepen inequity of access to opportunities across the Trust.		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability	✓	
	SR11 Staff Retention	✓	
	SR12 Organisational Development	✓	
	SR13 Quality Governance		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates	Area	Who	When
	Executive Director	Andrew McMenemy	5th August 2025

etc.) and the Executive Director with SRO function accountability.	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the findings of the EPUT WDES 2025 data, measuring performance. It provides a detailed breakdown and comparison of EPUT's Metrics to the previous year with a breakdown of key data (Appendix A). This data has been presented to EPUT Stakeholders to develop an action plan (Appendix B) that will be delivered in EPUT with the goal of improving the experience of working in EPUT for staff with Disabilities (as well as long-term conditions and neurodiversity).	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the data in Section 4 as well as Appendix A
- Note the proposed actions in Appendix B for delivery in 2025-26.
- Approve the publication of the WDES.

Summary of Key Issues

EPUT data shows that there continues to be a disparity in the negative experience of staff with disabilities in comparison to their non-disabled counterparts. In particular:

- Staff experiencing harassment, bullying or abuse from other colleagues **(WDES Metric 4a iiii)**
- Staff believing that the Trust provides equal opportunities for career progression or promotion. **(WDES Metric 5)**
- Staff who have felt pressure from their manager to come to work, despite not feeling well enough **(WDES Metric 6)**
- Staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. **(WDES Metric 8)**.

The following metrics have shown some minor improvements since 2024:

- 1.5% improvement of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
- A 0.54% decrease in the percentage of disabled staff members reporting harassment, bullying or abuse from Managers.
- 1% improvement of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

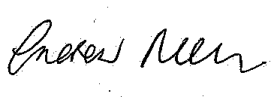
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital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

Acronyms/Terms Used in the Report			
WDES	Workforce Disability Equality Standard	DCF	Data collection Framework
ESR	Electronic Staff Record	AfC	Agenda for Change

Supporting Reports/ Appendices /or further reading

- Workforce Disability Equality Standards (WDES) Report
- Appendix A: Breakdown of WDES Data
- Appendix B: WDES Action Plan 2025 - 26

Lead



Andrew McMenemy –
Executive Chief People Officer

WORKFORCE DISABILITY EQUALITY STANDARD 2025

1 INTRODUCTION

1.1 The Workforce Disability Equality Standard (WDES) was created to support staff with disabilities in the NHS and to encourage organisations to improve their performance in this area. The goal is for staff members with disabilities to have equal access to opportunities and receive fair treatment in the workplace. This is measured using both NHS Staff Survey data and workforce data from our Electronic Staff Record (ESR) across ten "WDES Metrics." These metrics cover areas including representation throughout the organisation, recruitment, involvement in formal capability processes, bullying, harassment and career progression.

1.2 This report shares the findings of our WDES 2025 data, measuring our performance. It provides a detailed breakdown and comparison of EPUT's Metrics to our previous year with a breakdown of key data in Appendix A. This data has been presented to EPUT Stakeholders to develop an action plan (Appendix B) that will be delivered in EPUT with the goal of improving the experience of working in EPUT for our staff with disabilities (including long-term conditions and neurodiversities).

2 EXECUTIVE SUMMARY

2.1 EPUT has seen improvement in three out of the ten WDES Metrics, with the remaining seven being close to national averages.

2.2 The latest WDES data states that 8.84% of staff are recorded as declaring a disability on our Electronic Staff Record (ESR). This is an increase of 1.28% from the previous year's report. EPUT data also shows that there continues to be a disparity in the negative experience of staff with disabilities in comparison to their non-disabled counterparts. This inequality is seen in data for discrimination and bullying from colleagues, difficulty accessing accessibility improvements (reasonable adjustments) and beliefs regarding career progression and promotion.

3 PERFORMANCE AGAINST WDES METRICS

3.1 This data is taken from the ESR (1 April 2024 – 31 March 2025) and our 2024 Staff Survey results which has been shared with NHS England's Mandated Standards Team via a Data Collection Framework (DCF). These findings are presented below with progress against these metrics and comparisons against the national averages where available

3.2 **Metric 1: Percentage of staff in AfC (Agenda for Change) pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.**

3.3 Performance against this indicator has improved with an additional 119 staff declaring a disability via ESR, an increase of 1.28%. Disabled staff now make up 8.84% of the Trust's workforce, and whilst there has been increases in staff with disabilities in both clinical and non-clinical roles, there were few additional staff joining at senior levels in the Trust (Appendix A).

3.4 **Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.**

3.5 This Metric remains close to equal for both groups, only slightly declining from the previous year. With a relative score of 0.91, this shows both were near-equal in the likelihood of being appointed from shortlisting, with the data slightly skewed in favour of disabled staff during this period. There is near-equal likelihoods of being appointed from shortlisting for both staff with disabilities as well as their non-disabled counterparts during this period (Appendix A).

3.6 Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

This Metric shows that staff with disabilities did not disproportionally enter formal capability proceedings during this period. This remains at zero due to all entries (18 non-disabled staff and 4 disabled staff) being listed as entered "*…under the grounds of ill health*", which is the same for both groups. It should also be noted that there were 8 staff entering this process who have not declared their status via ESR, listed as "*Unknown Status*". With the potential that some of these staff may have disabilities, effort should be made to encourage all EPUT staff to share this information where possible to ensure these figures are an accurate representation of the Trust.

Symbol	Key
▲▼	Improvement
▼▲	Decline
-	No Change
	Current data for Disabled staff experience at time of reporting.

	Workforce Metrics (Internal Data, April 2023 – March 2024)	EPUT Progress				
		EPUT 2024	EPUT 2025	23 - 24 Diff.	NHS Avg.	EPUT Vs Avg.
1	Percentage of staff in AfC (Agenda for Change) pay bands and very senior managers (including Executive Board members) with disabilities compared with the percentage of staff in the overall workforce. *(full breakdown in **Appendix A**)* *Higher % = Improvement*	Disabled **7.56%**	Disabled **8.84%**	▲**1.28%**	5.7%	**Higher**
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts. *"1" being equal likelihood. Figure below 1 means that Disabled staff are more likely in comparison.*	**0.92**	**0.91**	▼**- 0.02**	0.98	**Lower**
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. *(excluding entry under the grounds of ill health)* *"1" being equal likelihood, Data taken as an average across two years.*	**0**	**0**	-	2.04	**Lower**

3.7 Metrics 4 – 9: Staff Experience

This data is taken from EPUT's NHS Staff Survey results, published in March 2024. Some figures may show discrepancies in comparison to previous WDES reporting due to a National Staff Survey data collection issue which has since been resolved. To adjust for this, we used the most recent Staff Survey benchmark data throughout this document to ensure this report will line-up with future reporting of this data. This data shows us the following:

- **These percentages represent staff who completed the NHS Staff Survey**, not the total for EPUT or the NHS.
- Performance against 4aii, 4b, 6 and 7 for staff with disabilities improved during this period.
- Our current results are near average for an NHS organisation, with scores being within 5% of NHS Staff Survey averages.

- There was a significant decline in staff with disabilities reporting belief that EPUT offers equal opportunities for career progression or promotion, with a similar decline for non-disabled staff. EPUT is now close to the average score in this area.

A breakdown of these Metrics is available below with additional data available in Appendix A:

Staff Survey Metrics (data taken from NHS Staff Survey 2024)		EPUT 2023	EPUT 2024	23 / 24 Diff.	Staff Survey Avg. (2024)	EPUT vs Avg.
4ai	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from service users, their relatives or other members of the public in last 12 months. *Lower % = Improvement*	Non-Dis 22.70%	Non-Dis 22.25%	▼0.40%	Non-Dis 21.60%	**Higher**
		Disabled 27.81%	**Disabled 28.55%**	**▲0.74%**	**Disabled 26.64%**	**Higher**
4aii	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers in last 12 months. *Lower % = Improvement*	Non-Dis 6.64%	Non-Dis 7.31%	▲0.67%	Non-Dis 6.07%	**Higher**
		Disabled 13.41%	**Disabled 12.87%**	**▼0.54%**	**Disabled 11.49%**	**Higher**
4aiii	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in last 12 months. *Lower % = Improvement*	Non-Dis 14.10%	Non-Dis 13.81%	▼0.29%	Non-Dis 11.81%	**Higher**
		Disabled 20.77%	**Disabled 22.75%**	**▲1.98%**	**Disabled 17.96%**	**Higher**
4b	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. *Higher % = Improvement*	Non-Dis 65.97%	Non-Dis 64.29%	▼1.68%	Non-Dis 64.98%	**Higher**
		Disabled 62.14%	**Disabled 63.16%**	**▲1.02%**	**Disabled 62.98%**	**Higher**
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. *Higher % = Improvement*	Non-Dis 61.95%	Non-Dis 58.99%	▼2.96%	Non-Dis 60.75%	**Lower**
		Disabled 59.18%	**Disabled 55.12%**	**▼4.06%**	**Disabled 55.13%**	**Lower**
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. *Lower % = Improvement*	Non-Dis 14.79%	Non-Dis 14.43%	▼0.36%	Non-Dis 11.86%	**Higher**
		Disabled 20.00%	**Disabled 19.63%**	**▼0.37%**	**Disabled 17.91%**	**Higher**
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. *Higher % = Improvement*	Non-Dis 54.49%	Non-Dis 53.23%	1.26%	Non-Dis 54.37%	**Higher**
		Disabled 45.37%	**Disabled 46.93%**	**▲1.56%**	**Disabled 44.33%**	**Higher**

8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. *Higher % = Improvement*	**81.29%**	**75.39%**	**▼5.9%**	79.60%	**Lower**
9a	The staff engagement score for disabled staff, compared to non-disabled staff. *Higher % = Improvement*	Non-Dis 7.32	Non-Dis 7.12	▼0.20	Non-Dis 7.20	**Lower**
		Disabled 6.88	**Disabled 6.61**	**▼0.27**	**Disabled 6.74**	**Lower**

3.8 Metric 9b: What actions have you taken action to facilitate the voices of Disabled staff in your organisation to be heard?

As part of the data supplied to NHS England's Mandated Standards Team, a survey requested details of the ways that staff with disabilities have been supported in EPUT, the following was included.

- Executive Sponsors attend Staff Networks, which allows the Network to share feedback and concerns directly with the Board.
- Staff Network Sessions are held virtually, with access to subtitles / transcribing tools to ensure they are as accessible as possible for attendees.
- Staff can raise concerns anonymously through our Freedom to Speak Up Guardians, as well as raise issues about their accessibility via our Employee Relations and Employee Experience functions. The Equality Advisor can also provide managers or employees with guidance and support in these areas.
- We have worked closely with our Transformation Team to ensure the Disability and Mental Health Network has clear goals for the year and is able to measure their own progress via SMART KPI's.
- Disability and Mental Health Network meetings are attended by senior leads, our NHS People Promise Manager and our Equality Advisor, to ensure feedback is heard and acted upon.

3.9 Metric 10: Percentage difference between the organisation and total Board:

When comparing representation at senior levels in EPUT, the WDES encourages Trusts to compare the percentage of staff with a disability at Board level against the overall workforce. Three comparisons have been made below at Total, Voting and Executive Board membership.

All three of these metrics show that despite the loss of one disabled member on the Executive Board (Appendix A) since the previous year, these gaps have narrowed. Showing improved representation within the organisation at a senior level.

Workforce Metric (ESR Data from April 2023 – March 2024)		**EPUT Progress**		
		EPUT 2024	**EPUT 2025**	**Difference Gap 2024-25**
10	Percentage difference between the organisation's Total Board membership and its organisation's overall workforce, *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce*	Non-Dis 88.9% - 78.3% 10.6%	Non-Dis 86.67% - 79.80% 6.87%	**Narrower**
		Disabled 11.1% - 7.6% 3.5%	**Disabled 13.33% - 8.84% 4.49%**	**Wider**

Workforce Metric (ESR Data from April 2023 – March 2024)	EPUT Progress		
	EPUT 2024	EPUT 2025	Difference Gap 2024-25
Percentage difference between the organisation's voting Board membership and its organisation's overall workforce, *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce*	Non-Dis 93.3% - 78.3% 15%	Non-Dis 91.67% - 79.80% 11.87%	**Narrower**
	Disabled **6.7% - 7.6%** **-0.9%**	**Disabled** **8.33% - 8.84%** **-0.51%**	**Narrower**
Percentage difference between the organisation's Executive Board membership and its organisation's overall workforce, *A score of 0 = equality of representation. Minus numbers caused by larger percentage in overall workforce*	Non-Dis 90% - 78.3% 11.7%	Non-Dis 87.50% - 79.80% 7.7%	**Narrower**
	Disabled **10% - 7.6%** **2.4%**	**Disabled** **12.50% - 8.84%** **3.66%**	**Wider**

4 PEOPLE AND EDUCATION STRATEGY METRICS

4.1 The EPUT **People and Education Strategy (2024 - 2028)** uses the data from Indicators 5 – 8 (based on 2024 Staff Survey data) to gauge performance as an organisation in achieving race equality and preventing discrimination or disparities. The information below shows our current progress in comparison to the targets set by these indicators.

- A 0.74% increase in disabled staff reporting harassment, bullying or abuse from patients / service users, their relatives or other members of the public.
  - This is currently at 28.55%, above EPUT's PES target of 28%.
- A 0.54% decrease in the percentage of disabled staff members reporting harassment, bullying or abuse from Managers.
  - This is currently at 12.87%, above EPUT's PES target of 10%.
- A 1.98% increase in the percentage of disabled staff members reporting harassment, bullying or abuse from other colleagues.
  - This is currently at 22.75%, above EPUT's PES target of 20%.
- A 4.06% decrease in disabled staff reporting that the Trust provides equal opportunities for career progression or promotion.
  - This is currently at 55.12%, below EPUT's PES target of 62%.

5 ENGAGING STAKEHOLDERS AND PRIORITIES

5.1 An all-staff stakeholder session was held on 7 July, 2025, as part of the Disability and Mental Health Network to discuss how these metrics have developed, as well as the Trust's current initiatives, this collaboration was used to develop the WDES action plan (Appendix B) with the following themes:

- Staff experiencing harassment, bullying or abuse from other colleagues **(Metric 4aiii)**
- Staff believing that the Trust provides equal opportunities for career progression or promotion. **(Metric 5)**
- Staff who have felt pressure from their manager to come to work, despite not feeling well enough **(Metric 6)**

- Staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. **(Metric 8)**

5.2 This data has also been used to establish priorities as part of an overarching EDI delivery plan across 2025-27, this will be facilitated by an EDI working group. Support for Disabled and Neurodiverse staff have been agreed as themes following engagement with key stakeholders within the organisation.

6 CONCLUSION

6.2 Whilst the Trust endeavours to improve the experiences of Disabled staff in comparison to their non-disabled counterparts, this report continues to highlight areas for improvement. The Trust will continue to support Disabled staff across the Trust as well as working in collaboration with the Disability and Mental Health Network, their executive sponsor and the People and Culture Directorate to drive improvement and facilitate the voices of our staff from these groups. The WDES action plan and delivery of the EDI Delivery Plan will also facilitate this, with updates provided to the Executive Team as these actions are implemented.

7 WDES NEXT STEPS

Presented to Executive Operational Team for approval	Tuesday 8th August 2025
Presented to People Committee for assurance	Thursday 28 August 2025
Presented to Board of Directors for approval	Tuesday 1 October 2025
Deadline for Publication	Friday 31 October 2025

8 ACTION REQUIRED

The Board of Directors is asked to

- Note the data in Section 4 as well as Appendix A
- Note the proposed actions in Appendix B for delivery in 2025-26.
- Approve the publication of the WDES.

Report prepared by:

Gary Brisco
Equality Advisor

Paul Taylor
Director of Organisational Development and Culture

On behalf of:

Andrew McMenemy
Executive Chief People Officer

APPENDIX A: BREAKDOWN OF WDES DATA

1a) Summary of Key Figures Taken from WDES DCF	WDES 2023	WDES 2024	WDES 2025
Number of Non-disabled staff in overall workforce	4894	5366	5747
Number of disabled staff in overall workforce	404	518	**637**
Number of staff in overall workforce whose status is recorded as unknown	1066	971	818
Total workforce	6364	6855	7202
Number of shortlisted applicants (Non – dis) Number appointed (Non – dis) Percentage of successful appointments	4173 1446 (35%)	4769 958 (20%)	4680 958 (20.5%)
Number of shortlisted applicants (disabled) **Number appointed (disabled)** **Percentage of successful appointments**	403 107 (27%)	480 105 (22%)	488 110 (22.5%)
Number of shortlisted applicants (unknown status) Number appointed (unknown status) Percentage of successful appointments	212 37 (17%)	200 49 (25%)	269 29 (10.8%)
Number of Non – dis staff entering formal capability process (on the grounds of ill health)	8	0	13
Number of disabled **staff entering formal capability process** (on the grounds of ill health)	0	2	**4**
Number of (unknown status) staff entering formal capability process (on the grounds of ill health)	0	25	8
Non – dis Total Board Members	14	16	13
Non- dis Executive Board Members	8	9	**7**
Disabled Total Board Members	3	2	**2**
Disabled Executive Board Members	1	1	**1**
(Unknown status) Total Board Members	0	0	0
(Unknown status) Executive Board Members	0	0	0

Cluster (Bandings)	1b) Disabled Staff (Non-Clinical Workforce)		
	2023	**2024**	**2025**
C1 (1-4)	71	**96**	**123**
C2 (5-7)	23	**33**	**41**
C3 (8a / 8b)	7	**4**	**9**
C4 (8c +)	2	**3**	**3**
Cluster (Bandings)	**1c) Disabled Staff (Clinical Workforce)**		
	2023	**2024**	**2025**
C1 (1-4)	92	**103**	**127**
C2 (5-7)	162	**225**	**271**
C3 (8a / 8b)	32	**36**	**46**
C4 (8c +)	4	**5**	**6**
1d) Clinical Workforce (of which Medical and Dental)			
C5 (Consultants)	1	**2**	**2**
C6 (Career Grade)	1	**4**	**4**
C7 (Trainees)	8	**7**	**5**

For the WDES, AfC bandings are grouped into “clusters” on the request of the Mandated Standards Team.

APPENDIX B: WDES ACTION PLAN

WDES metrics – 4aiii, 5, 6, 8
People Promise Themes – *We are Compassionate and Inclusive, we are Safe and Healthy*
NHS EDI High Impact Actions – 1, 2, 4, 6

Priority Area	Actions	Leads	KPI's
ACCESS TO NON-MANDATORY TRAINING AND CPD Increase the numbers of disabled staff members accessing career development and mentoring.	• Launch internal "speed mentoring" sessions aimed at staff with disabilities and neurodiversities **(January 2026)** • Provide "Career Lounge" sessions for disabled and neurodiverse staff as part of Disability and Mental Health Network. **(November 2025)** • Develop open office hours "Career Clinic" sessions aimed at staff with disabilities and neurodiversities. Supporting staff with advice on their own career progression and development. **(December 2025)** • Develop and promote digital resources for staff with disabilities and neurodiversities wishing to independently develop their careers. **(November 2025)**	Nicky Reeves: *Organisational Development Lead* Gary Brisco *Equality Advisor* D&MH Network Chairs	**NHS Staff Survey Q15 & Q24B:** Improvement in scores regarding career progression and development for Disabled Staff **WDES 5:** Improved perception of equal opportunities for career progression or promotion. **Workforce Promotions Data:** Increased rate of promotion for Disabled staff (PSED Report 2025)
BULLYING AND HARASSMENT FROM COLLEAGUES Increase reporting of incidents, Decrease instances of this behaviour against disabled staff.	• Training to be delivered in areas with high rates of incident reporting, encouraging staff to challenge discriminatory behaviour and proper conduct when supporting those with disabilities or neurodiversities. **(Ongoing)** • Develop resources to educate teams and managers on the positive benefits from inclusion. **(January 2026)** • Board and VSM's clearly and regularly communicate the importance of supporting staff with disabilities and neurodiversities in EPUT. **(Ongoing)**	Nicky Reeves: *Organisational Development Lead* Gary Brisco *Equality Advisor* Kim Russell *Communications Lead*	**WDES 4aiii**: Percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues. **DATIX:** Incidents of discriminatory behaviour against staff where incidents have "Disability / Ableism as a contributing factor. **WDES 6*:*** Percentage of disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough.

WDES metrics – 4aiii, 5, 6, 8 **People Promise Themes –** *We are Compassionate and Inclusive, we are Safe and Healthy* **NHS EDI High Impact Actions –** 1, 2, 4, 6			
Priority Area	**Actions**	**Leads**	**KPI's**
ACCESS TO REASONABLE ADJUSTMENTS IN THE WORKPLACE Improve access to reasonable adjustments and support to staff who have a disability or long-term condition in the workplace.	• Improve staff and manager guidance on implementing reasonable adjustments for disabilities and neurodiversities, including access to work processes**. (November 2025)** • Review reasonable adjustments process to remove potential barriers (*i.e., Non-Pay Panels*). (**April 2026)** • Record funding / spend on reasonable adjustments via E-Procurement, report this to the EDI Working Group. **(December 2025)** • Launch guidance for developing Neuroinclusive Workspaces in EPUT sites, with DDQS's facilitating the launch of low-stimuli spaces in the organisation for staff. **(April 2026)** • Expand reasonable adjustments process to include neurodiverse staff members and provide clear guidance to managers on how to best implement this. **(April 2026)**	Debbie Prentice *Operational HR Lead* Ama Duryea *Retention Lead* (TBC) *Procurement Lead* *Fiona Benson* *(Estates and Facilities Lead)*	**WDES 8:** Improved access to reasonable adjustments (informal or via Access to Work) Number of Successful Reasonable Adjustments

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11:18

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 11:15

REFERENCES

Only PDFs are attached

BAF Report 01.10.2025 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	01 October 2025

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Denver Greenhalgh Senior Director - Governance					
Report Author(s):	Nicky Jones, Director of Risk and Compliance					
Report discussed previously at:	Executive Board Assurance Framework Meeting Board of Directors Standing Committees					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the report 2. Request any further information of action

Summary of Key Issues

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

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

The Board of Directors is asked to note:

- Board Assurance Framework dashboard providing an oversight of the reporting period.
- The following level 3 assurances provided for through the 2025/26 National Oversight Framework rating:
    - EPUT has been placed in Segment 3 defined as 'The organisation and/or wider System are off track in a range of domains or are in financial deficit'. The Trust is rated 36 out of 61 non acute trusts.
- There have been no changes in risk score
- There has been one risk refocused in this reporting period:
    - **CRR45 Mandatory Training** – Risk has been refocused with a change of title and description to focus on achieving continuous compliance with mandatory training requirements. New actions have been added consisting of undertaking a review of mandatory training against the new national framework; review of the Trust Education Group governance; and the development of targets for each Care Unit / Directorate. The People Committee will oversee this risk.
    - As indicated in the last report to Board the CRR92 Addressing Inequalities is being refocused to capture the cultural review programme and will report to the People Committee in October 2025, and to the next Board meeting.
- There has been no risk agreed for closure
- Strategic Risk register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer
- Corporate Risk register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

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

Acronyms/Terms Used in the Report			
SR	Strategic Risk	CR	Corporate Risk
BCP	Business Continuity Plan		

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Executive Director – Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

August 2025

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

Aug-25

EPUT

Strategic Risk Register at a Glance

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

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

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

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

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR3	All	Infrastructure	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	ERIC and PAM groups have been established; this has identified that additional work is needed and underway to pull into one consolidated action plan. EPUT has been allocated £6m from the Estates Safety Fund to address infrastructure items.
SR4	All	Demand and Capacity	AG	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The Demand, Capacity and Length of Stay Programme is in initiate stage with the first Steering Group planned for late September. This will feed into the Adult Acute Mental Health Programme and incorporates the Winter Plan (agreed at Board Seminar on 3 September 2025) and the Flow Recovery Plan (FRP) hosted by EPUT, with a System wide approach/leadership. The FRP looks to implement intensive actions to manage out of area use closely and permanently unblock system issues that prevent timely discharge. Monthly MADE sessions are led by ICB colleagues with all wards planned to be complete by October 2025. Length of stay has improved over the previous two months and OOA placements are within the MTP trajectory.
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	We will be reviewing the Inquiry provision to ensure we continue to have the right skills and resources in place to serve the Lampard Inquiry. The significant number of new Rule 9 requests from the Inquiry in the period (25), with an expectation that this will be mirrored following the October hearings. Indexing is nearly complete and continue to work with Alan Bradshaw to complete the remaining mapping. Netwrix Search Software - two members of the team are piloting the search function with some positive results. Netwrix search functions shows the information and its location, but does not allow download of source document of you do not have permission for the file. We therefore need to arrange the IG governance to enable access to all folders or ask IT to carry out this aspect of the pulling of source documents.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR6	All	Cyber Security	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Of the Seven identified actions - four are now complete, remaining three require project implementation to introduce new technologies, resource capacity and funding to be prioritised though local digital governance resulting in extended timescale for implementation - forecasting 3 months (Oct 25).
SR7	All	Capital	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20	20 20 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	Bids submitted for additional capital resources for critical infrastructure, out of area placements and mental health urgent care, as part of 2025/26 capital plan have been successful with the allocation of £6m from the Estates Safety Fund. F&P Committee receive monthly updates, whilst noted at the September Finance and Performance Committee YTD £3.5m. Actions are in place to increase expenditure including additional procurement resources focusing on capital projects.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20	20 20 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	The Finance and Performance Committee have been updated on the Month 4 efficiency performance including key risks and mitigation actions. YTD delivery £10.7m (£0.2m behind plan). Focus remains on indent ying opportunities and mitigations to deliver with PMO supporting on a number of workstreams. Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. The Finance and Performance Committee have been assured of progress, noting: The YTD deficit is £3.1m with the deficit rate slowing from M 4 2 8 m) The position is £0.9m behind plan but includes £1.3m of unplanned Inquiry expenditure associated with the impact of the external audit of 24/25 Accounts. Excluding Inquiry costs the Trust would be favourable to plan. Focus remains on mitigating actions including reassessment of Inquiry costs, temporary staffing controls/escalations, lock down of underspends and a clinically and operationally led flow recovery action plan
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation	Phase 2 to commence April following review and outcome will form Phase 3. EPR Programme governance established with reporting lines of assurance up to board
SR10	All	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025. In the process of revising the governance arrangements for the People and Culture Directorate. There will be clear lines of escalation to the Executive Operational Committee and matters of assurance to the People Committee. Terms of reference drafted with agreed outline and structure. Formal launch to take place in October 2025. Consultation meetings held with stakeholders both internal and external to develop a clear recruitment plan to support sustainability going forward and to be aligned to the People Strategy. This includes aims to have full recruitment for HCA and band 5 nurses as an early area of focus. It also looks at developing a recruitment plan that supports career development and is aligned to our learning and education priorities.

SR11	All	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025. Note: Links to SR10 and SR12 Work is underway to develop a mechanism to review exit information for trends and to revise the new starter experience.
ID	**SO**	**Title**	**Lead**	**Impact**	**CRS**	**Risk Movement (Last 3 months)**	**Context**	**Key Progress**
SR12	All	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=16	16 16 16	The risk of not addressing cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	Following conclusion of the gap analysis restructure consultation underway. This will create new roles and changes to roles in order to have an OD & Culture team that is able to meet the needs of the organisation within this remit. Proposals for culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years. Procurement is planned for delivery in Autumn 25, year one of a three year plan, with the first cohort planned for Q4
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15	15 15 15	Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	Note IA opinion of site visit reasonable assurance provided (this is where adherence of policies at service level is tested). And, Assurances provided through the recent CQC inspection report for Adult MH Inpatients and PICU. Four actions have been completed to achieve active controls and assurance covering: development of the quality dashboard; raising the visibility of senior quality leaders; refreshed the raising of patient safety incidents and reporting; and put in place governance for SIPs. Review of the Quality Control Audits (Tendable) one year post implementation has been completed - initial findings highlighted some areas of non-adherence to plan. This is being explored to understand the causative factors. CQC Actions Leads meeting has been reposition to be a Quality Action Leads to oversee a wider set of improvement actions, and has become an integral component of the Executive Quality of Care Group. PFD actions added November '24, following a period of embedding other areas will be added. The timeline has been extended to August to embed the transfer of the Quality Leads Group over and establish its rhythm. The reporting to the Evidence Assurance Group remains in place for closure of actions. The Trust has now held two learning events to share patient safety areas of focus, which have been well attended by staff, service user, system colleagues and CQC.

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
2	0	0	0

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

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

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

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	MK	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	The Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25, including: Work has been undertaken on performance data leading to the development of a more detailed data set reflecting the demographics of EPUT populations relative to incidents of suicide and self harm, this is now included in the Quality Dashboard and will support focus on specific groups of our patients. The steering group prioritised a series of deep dives areas where assurance was sought regarding the progress of actions intended to deliver improvement (including presentation of from NHS Talking Therapies team and National Rail presentation of a thematic analysis). Achieved target of training 60% of registered staff in STORM training across urgent care. Co produced case for change for the Trusts move from risk stratification to a more personalised approach to risk and safety planning. Year 2 priorities are focusing on : a) self harm reduction inc finalisation case for change to move towards personalised risk assessment and safety planning; b) STORM training, increasing compliance to 95%; c) Reduction in fixed and non-fixed ligatures by 10% and d) Safe Discharges.
CRR45	All	Mandatory Training	PT	Safety	4x3=15	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Risk has been refocused with a change of title and description to focus on achieving continuous compliance with mandatory training requirements. New actions have been added consisting of undertaking a review of mandatory training against the new national framework; review of the Trust Education Group governance; and the development of targets for each Care Unit / Directorate. The People Committee will oversee this risk.

Strategic Risk Register

August 2025

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previous reported completed actions 1- 5 and 7 have been removed from the report. **Note 2**: The completed action 6 development of an action plan for PAM. This will be removed from future reporting. **Note 3**: Note the allocation of £6m Estates Safety Fund to EPUT to addresss infrastructure capital items.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs ERIC and PAM Groups Established £6m - Estate Safety Capital Fund allocated 25/26	Premises Assurance Model in place with assessment	
6-Facet Survey	Review of core premises undertaken through the Estates Strategy	6- Facet Survey completed	6-Facet Survey
Business Continuity Plans	Business continuity plan in place		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
6	Develop action plan for Premises Assurance Model (PAM) outstanding tasks	Complete	MM	Control	ERIC and PAM groups have been established; this has identified that additional work is needed and underway to pull into one consolidated action plan. Action plans completed. PAM submission on track for September 2025

8	Deliver action plan from Premises Assurance Model (PAM) self-assessment	Sep-26	MM	Control	Preparation has taken place for the September 2025 self-assessment submission. EPUT has been allocated £6m from the Estates Safety Fund to address infrastructure items.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-5, 8-10 and 12 have been removed from the report. **Note 2**: Action 6, 7, 8 and 9 RAG rated amber as timeline is extension to the originally stated timeframe, noting system programmes and progress being made. **Note 3:** New Action: Demand and Capacity Length of Stay Programme **Note 4**: Note EPUT NOF 3 rating for which service performance metrics are a key component.

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

Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

Actions (to modify risks)		By When	By Who	Gap	Update
6	Demand and Capacity module to be procured and fully implement	Extended Oct 25	JL	Control	Capacity and flow model now live. Now in an adoption programme into time to care / capacity and flow with full utilisation from end October 2025.
7	Model Out of Area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer.	Extended Dec 25	SC/JW	Control	The 3 Integrated Care Systems and the Trust have appointed PA Consulting to support the risk share review and conclusion. F&P Committee received an update on progress from PA Consulting at its May meeting - noting that there is a shared commitment with work progressing including agreement of resource transfer, drafting MOU, and the development of a mobilisation plan and trajectories for the next three years. Discussions are ongoing for this complex programme of work including assessment of interventions and ICBs dependancies that will impact on OOA demand which is impacting timescale. Note further extension to Q3 2025 (action continues to Amber RAG rated due to the extension).
8	Implementation of new operating model	Extended Sept 25	LW	Control	The new Operational Model for Inpatient Services has been rolled with detailed Implementation plan monitored by the Time to Care Steering Group. Progress evident in all ward areas with some achieving 100% chapter implementation. Completion of the roll out is a condition of satisfaction for the programme to transition to business as usual and expected by the end of September 2025.
11	Implementation of recommendations following long stay review and system made events across the trust and system	Complete	SG	Control	Governance and oversight of system delays and escalations reviewed and strengthened. Now incorporated into the Adult Acute Mental Health Programme led by AG and a ICB executive lead. Action complete - see new action 13 delivery of the demand and capacity length of stay programme.
13	**New Action:** Demand and Capacity Length of Stay Programme	Oct-25	AG	Control	The Demand, Capacity and Length of Stay Programme is in initiate stage with the first Steering Group planned for late September. This will feed into the Adult Acute Mental Health Programme and incorporates the Winter Plan (agreed at Board Seminar on 3 September 2025) and the Flow Recovery Plan (FRP) hosted by EPUT, with a System wide approach/leadership. The FRP looks to implement intensive actions to manage out of area use closely and permanently unblock system issues that prevent timely discharge. Monthly MADE sessions are led by ICB colleagues with all wards planned to be complete by October 2025.

SR5 - Lampard Inquiry (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1- 5 and 7 have been removed from the Board report. **Note 2:** Updates for September 2025 - Note the appointment of the final 2 associate directors bringing the team to full complement. Also, note the vacancy at Project Director position with recruitment underway to fill the post through a fixed term appointment by November 2025. **Note 3**: Following the external audit of the Inquiry financial provision the resultant cost pressure impact to the end of 2026. **Note 4**: The significant number of new Rule 9 requests from the Inquiry in the period (25), with an expectation that this will be mirrored following the October hearings.

Executive Responsible Office: Executive Director - Corporate Governance
Board Committee: Lampard Inquiry Oversight Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment and reporting in place.		
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Denver Greenhalgh) Project Director (Vacancy) 3 Associate Directors Inquiry Project Team (27 wte) Browne Jacobson Essex Chambers		
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial allocation £8.6m to end of 2026.	Finance reports to Finance & Performance Committee	External audit of provision for the Inquiry completed for 2024/25 (Note additional cost pressure to the end of 2026 as consequence of accounting treatment)
Inquiry Response Governance	Inquiry Project Team leadership through 3 ADs Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee	

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Monitoring of Rule 9 Requests	Project Team Tracking: September 2025: 49 Rule 9 requests have been made to date, of which: 33 submitted as final 7 submitted in draft for Inquiry review 28 in progress (of which 25 received since the 01 August 2025).	SitRep Report to Lampard Inquiry Oversight Committee	
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group Executive Team	Lampard Inquiry Oversight Committee Quality Committee	

Support for staff	Here for Your Service service use Staff Feedback	Lampard Inquiry Oversight Committee	
Support for families	Report from HPFT to Project Working Group	Lampard Inquiry Oversight Committee	
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee	
Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Reviewing resources to ensure (C2) Best value for money; Right skills and resources in place; Operational planning	Complete	GW/GB	Awaiting potential additional Rule 9 Request	We continue to receive clarifications and Rule 9 requests from the Lampard Inquiry. We have in place a procedure for assessing the asks, and the resources needed to deliver. We now have three Associate Directors appointed within the team structure (as per plan) to lead on ongoing disclosure of information, programme manage and staff support.
8	Rule 9 progress	Ongoing	DG	Assurance	45 Rule 9 requests have been made to date, of which: 25 submitted as final 7 submitted in draft for Inquiry review 31 in progress (of which 21 received since the 01 August 2025). 3 of the recent Rule 9's are complex and broad in scope and cover the entire period under review.
9	Recruitment of a new Project Director to ensure we have the right skills and resources in place to service the Lampard Inquiry requests.	November '25	DG	Control	The Project Director has stepped back to their substantive position within the Trust (from August 2025) and recruitment is underway for a replacement on a fixed term basis. Timeline for this recruitment is November 2025, note change of timeline.

Actions (to modify risks)		By When	By Who	Gap	Update
10	Implement Netwrix Search Software	Extended September '25	DG	Control	Indexing is nearly complete and continue to work with Alan Bradshaw to complete the remaining mapping. IT have worked through issue with permissions and two members of the team are piloting the search function with some positive results. Netwrix search functions shows the information and its location, but does not allow download of source document of you do not have permission for the file. We therefore need to arrange the IG governance to enable access to all folders or ask IT to carry out this aspect of the pulling of source documents.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L4 = 20	*C 3 x L5 = 15*	*C4 x L3= 12*	**Note 1:** Previous reported completed actions 1 - 8 have been removed from the report. **Note 2**: Next reporting period will include a full review of controls to assess what additional safeguards the CAF provides and their associated assurances.

Executive Responsible Office: Executive Director Strategy Transformation and Digital
Board Committee: Finance and Performance Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC IA Cyber Security (2024/25) **Reasonable Assurance**	NHS Digital Data Security Protection Toolkit (DSPT/CAF)
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; IA Cyber Security (2024/25) **Reasonable Assurance**	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT/CAF Action plan Implementation following TIAA audit
Business Continuity Plans and National Cyber Team processes	BCP in place	Successfully managed Cyber incident	Annual Testing as part of DSPT/CAF NHS Digital Data Security Centre, Penetration Testing,
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DSPT/CAF Action plan Implementation following TIAA audit

	Actions (to modify risks)	By When	By Who	Gap	Update
9	Implementation of the enhancements to DSPT, (Cyber assurance framework - CAF)	Extended Oct 2025	AW	Assurance /Control	Of the Seven identified actions - four are now complete, remaining three require project implementation to introduce new technologies, resource capacity and funding to be prioritised though local digital governance resulting in extended timescale for implementation - forecasting 3 months (Oct 25).

SR7- Capital (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	**Note 1:** Previously report completed actions 2 - 4 have been removed from the report. **Note 2:** Note the allocation of £6m from the Estates Safety Fund

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital funding allocation 2025/26	Capital Project Group forecasting	Capital Planning Group reporting to ET and onto Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources secured	Capital Planning Group reporting to ET and onto Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB; Chairing System Investment Group	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2025/26 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	FBC Agreed, contract signed.
Tracking EPR Investments			

Actions (to modify risks)		By When	By Who	Gap	Update
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing for financial year	JD	Control	Estates Safety Funding of £6m has been approved, therefore financial risk mitigated for the capital schemes, including UEC. Business cases are preemptively being developed for future potential investment streams, e.g. Estates and Digital national funding for 2026/27.The Trust is working through the profile of a number of property disposals as agreed in the Estates Strategy.
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	F&P Committee receive monthly updates, whilst noted at the September Finance and Performance Committee YTD £3.5m. Actions are in place to increase expenditure including additional procurement resources focusing on capital projects.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	**Note 1**:Previous reported completed actions 1,3 - 5,7-13 has been removed from the report. **Note 2**:Note new external assurance of National Oversight Framework rating of 3 linked to the receiot of deficit funding and system financial performance.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment IA Core Financial Assurance (2024/25) Substantial Assurance Opinion IA Payroll including Salary Overpayments (2024/25) - Reasonable Assurance opinion	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).IA E-rostering - Limited Assurance opinion.IA Consultant Job Plans - Limited Assurance opinion.
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	**National Oversight Framework/ RONDA: 3** (Cohort Non acute trusts placed 36/61)
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2026/27	Mutidisplinary team stood up	Finance and Workforce Committees	**National Oversight Framework/RONDA: 3** (Cohort Non acute trusts placed 36/61)
Forecast Outturn and risk/ opportunities assessments 25/26	Forecast outturn reports including risks and mitigations	Accountability Framework reporting and F&P	
Enhanced controls in place for approval of temporary staffing use and recruitment to Corporate roles.	Management reports to Executive Team - Downward trend in temporary staffing use seen in month 1 (2025/26).	IA Temporary Staffing (2024/25)Reasonable Assurance OpinionF&P Committee July '25 - Reasonable assurance that temporary staffing controls were working as expected.	

Actions (to modify risks)		By When	By Who	Gap	Update
2	Deliver Financial Efficiency Target	Mar '26	TS	Control	The Finance and Performance Committee have been updated on the Month 4 effciency performance including key risks and mitigation actions. YTD delivery £10.7m (£0.2m behind plan). Focus remains on indentying opportunities and mitigations to deliver with PMO supportng on a number of workstreams.
6	Deliver Financial plan for 24/25	Mar '26	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. Revenue position Month 4 is £0.6m behind plan with a £2.8m deficit including the impact of increased Inquiry resourcing, cost pressure and forecast outturn risk following audit of accounts. The Finance and Performance Committee have been assured of progress, noting: The YTD deficit is £3.1m with the deficit rate slowing from M4 £2.8m. The position is £0.9m behind plan but includes £1.3m of unplanned Inquiry expenditure associated with the impact of the external audit of 24/25 Accounts. Excluding Inquiry costs the Trust would be favourable to plan. Focus remains on mitigating actions including reassessment of Inquiry costs, temporary staffing controls/escalations, lock down of underspends and a clinically and operationally led flow recovery action plan.

SR9- Digital and Data Strategy (At a Glance)

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

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

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

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

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
11	Digital Target operating model implementation - phase 2	Extended Dec 25	AW	Control	Phase 2 to commence April following review and outcome will form Phase 3. Outcomes of MARS and delays in recruitment have influenced phase 2 timescales, potential delay forcasted. RAG rated amber due to extended timeline for action to December 2025.

12	New Action: Implementation of new UEPR	Apr-27	ZT	Control	EPR Programme governance established with reporting lines of assurance up to board

SR10: Workforce Sustainability

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3= 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1 - 5 have been removed from the report. **Note 2:** Note new actions 7 and 8 putting place revised governance arrangements in the People and Culture Directorate; and delivery of trust wide recruitment plan.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Delivery the People and Education Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 2025.
7	To operationalise revised governance arrangements for the People and Culture Directorate.	Oct '25	Executive Director of People and Culture	Control	Three distinct but aligned groups covering Staff Experience, Recruitment & Retention and Education that will all feed into a People & Culture Group. There will be clear lines of escalation to the Executive Operational Committee and matters of assurance to the People Committee. Terms of reference drafted with agreed outline and structure. Formal launch to take place in October 2025.
8	Deliver the Trust recruitment plan.	Dec '25	Associate Director of People - Resourcing	Control	Consultation meetings held with stakeholders both internal and external to develop a clear recruitment plan to support sustainability going forward and to be aligned to the People Strategy. This includes aims to have full recruitment for HCA and band 5 nurses as an early area of focus. It also looks at developing a recruitment plan that supports career development and is aligned to our learning and education priorities.

SR11: Staff Retention

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note1:** Previously reported completed actions 1 - 5 have been removed from the report. Note 2: New actions 7 and 8 associated with gaining a deeper intelligence from exit interviews; and a refreshed new starter experience.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Delivery the People and Eductaion Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee with most recent iteration in June 2025. The People & Culture team plan to review and refine strategy in September with presentation of revised draft at Executive Committee and People Committee in October 202
7	To develop a mechanism to review exit information and identify clear trends; and triangualted with pulse and annual staf survey information to better understand interventions to reduce staff turnover.	Dec-25	Director of OD & Culture	Assurance	The OD & Culture team are looking at options that will be presented to the People & Culture Senior Leadership Team for consideration including internal and external solutions to the recording of exit interviews and developing effective interventions.
8	Delivery of People Promise objectives with an empahsis on new starter experience.	Jan '26	Director of OD & Culture	Assurance	The team are currently revising the new starter experience with proposal associated to improving the induction process as well as enhancing support for new staff within the first 6-12 months of commencing in their new role.

SR12: Organisational Development

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L4= 16*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1-6 have been removed from the report. **Note 2:** New action to deliver the OD and Development Programme

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
7	To deliver OD and Development programme	March 26	Director of OD & Culture	Assurance	Following conclusion of the gap analysis restructure consultation underway. This will create new roles and changes to roles in order to have an OD & Culture team that is able to meet the needs of the organisation within this remit.
8	Culture Review and Leadership Development Programme.	March 26	Director of OD & Culture	Assurance	Proposals for culture review and leadership received and delivery of programmes to commence from September '25 and will run for three years. Procurement is planned for delivery in Autumn 25, year one of a three year plan, with the first cohort planned for Q4.

SR13 - Quality Governance (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note 1:** Previously reported completed actions 1-3 and 5 have been removed from the report.

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Lead roles and subject matter experts	Nursing and Quality Structure Medical Directorate Structure Care Unit Leadership Triumvirate (Including DDQS)		IA Safeguarding (outcome detail to be added)
Patient Safety Incident Management Team	Team Established		IA PSIRF (outcome detail to be added)
Clinical (Quality) Governance Structure	Each meeting annual work plan, annual report and effectiveness reviews.		CQC inspection report for Adult MH Inpatient Wards and PICU (July '25) identified a breach in governance as a consequence of not having adequate oversight of the breaches within the Safe domain.
Learning Collaborative Partnership	Forum attendance and effectiveness review.		CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Learning information communications plan			CQC inspection report for Adult MH Inpatient Wards and PICU provided positive assurance of learning from incidents.
Patient Safety Dashboard			
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports 2024 - 2025 for Clifton Lodge, Brockfield House and Adult MH Inpatients and PICU provided positive assurance.
ESLMS			

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Patient Incident Response Plan			IA Falls Management (2024/25) Reasonable Assurance opinion IA Recording and Monitoring of Therapeutic Observations (2024/25) Reasonable Assurance opinion IA Care Plans and Risk Assessments (2024/25) Reasonable Assurance opinion
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA Compliance with policies - Site Visits (2024/25) Reasonable Assurance opinion.IA Board Assurance and Risk Management – Substantial Assurance opinion.
Clinical Audit Programme	Annual Plan and Outputs	Quality Committee Oversight	National Audits / Confidential Inquiries Reports and Organisational reports
Quality Assurance Framework: Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits Compliance Reviews (Clinical Audit Plan / Compliance Team Reviews)	Quality of Care Strategy Quality Control Audits (Tendable) Quality Assurance Visits		IA Mortality Review Processes 2025 - Reasonable assurance opinion. CQC inspection reports 2024 - 2025 for Clifton Lodge (Good) , Brockfield House (Good) and Adult MH Inpatients and PICU (RI - an improved rating) provided positive assurance.

	Actions (to modify risks)	By When	By Who	Gap	Update
4	Continue to full implementation of the eSOP programme (ensuring that all SOPs are reviewed and uploaded to the new SOPHIA system)	Extended Oct '25	RB/RJ	Control	All policies and clinical guidelines have now been uploaded onto the platform. Usage and compliance will be monitored through the SOPHIA reporting tool. The Care Units will review in the Quality and Safety meeting. Condition for full go live (including switching off existing intranet based library) is resolution of the new starter process to ensure there is access to the SOPHIA platform from day one of employment.

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Review the Quality forums from Care Unit to Board and reporting.	Sept '25	AS/DG	Control	A template has been provided to each Care Unit to support local Quality and Safety meetings that reflects experience, effectiveness and safety of care. Now in a period of monitoring for impact and sustainability, with a view to closing the action in September and moving to an active control. Note: IA to test the sustainability.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Extended Oct '25	RP	Assurance	Review completed in March '25 - initial findings highlighted some areas of non-adherence to plan. This is being explored to understand the causative factors.
8	To incorporate actions arising from PSII / Homicide Reviews and MHA inspections into the Action Leads Meeting for tracking and evidence assurance.	Extended Dec '25	NJ/MA/ TM	Control / Assurance	CQC Actions Leads has been replaced by Care Unit CQC/PFD operational meetings, with oversight now taking place monthly through the Executive Quality of Care Group. The Evidence Assurance Group function has been transferred to the LOSC where all actions are reviewed in one place. Extension of timeline to enable review of new governance in 3 months time.

Corporate Risk Register

August 2025

EPUT

CRR11 - Suicide Prevention

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

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

Executive Responsible Office: Executive Medical Director Director Lead: Dr Nuruz Zaman Deputy Medical Director Leads: Alan Hewitt, Deputy Director of Quality and Safety Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Electronic observations recording tool	In trial phase		
Ward level oversight	Tendale Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos	STORM training (achieved year one target of 60% of registered staff)		
Self Harm Clinical Guideline Ligature Environmental Risk assessment and Management Policy		Suicide Prevention Group (Co-chaired with a Lived Experience Ambassador) Ligature Risk Reduction Group	
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	The Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25, including: Work has been undertaken on performance data leading to the development of a more detailed data set reflecting the demographics of EPUT populations relative to incidents of suicide and self harm, this is now included in the Quality Dashboard and will support focus on specific groups of our patients. The steering group prioritised a series of deep dives areas where assurance was sought regarding the progress of actions intended to deliver improvement (including presentation of from NHS Talking Therapies team and National Rail presentation of a thematic analysis). Achieved target of training 60% of registered staff in STORM training across urgent care. Co produced case for change for the Trusts move from risk stratification to a more personalised approach to risk and safety planning. Year 2 priorities are focusing on :a) self harm reduction inc finalisation case for change to move towards personalised risk assessment and safety planning; b) STORM training, increasing compliance to 95%; c) Reduction in fixed and non-fixed ligatures by 10% and d) Safe Discharges.

CRR45: Mandatory Training

Risk Description: If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in adverse events and potential for regulatory action.

Likelihood based on: Complinace reports at professional and subject level.
Consequence based on: Outcomes from patient & staff indicents including coroners.

Current Risk Score C4 x L3 = 12	*Current Risk Score C4 x L3 = 12*	*Target Score C3 x L2 = 6*	**Note 1:** Risk has been refocused with a change of title and description to focus on achieving continuous compliance with mandatory training requirements. New actions have been added consisting of undertaking a review of mandatory training against the new national framework; review of the Trust Education Group governance; and the development of targets for each Care Unit / Directorate. The People Committee will oversee this risk.

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Training Team	Established – current resource 8.5WTE TASI trainers increased		12 month TASI accreditation from BILD
Induction and Training Policy	Policy and Procedure in Place		
Training Tracker	Management Check	Accountability. F&PC and PC, SMT and TB	

	Actions (to modify risks)	By When	By Who	Gap	Update
1	To review mandated training alongside new national framework.	Oct-25	Mandatory Training Manager	Control	The review has been undertaken with some revisions enacted therefore this is on track.
2	To establish revised governance arrangements with refresh of Trust Education Group.	Oct-25	Director of OD and Culture	Assurance	This is on track to establish Education Group where areas associated to Mandatory Training will be reported. This will include recommendations for new and revised training for a decsion to made at Executive Committee based on recommendations.
3	Develop compliance targets for each Care Unit at accountability framework meetings over a 3 month period.	Oct-25	Mandatory Training Manager and HRBPs	Assurance	Complinace targets were set in September 2025 with update to be provided at October 25 Accounatability Framework meetings leading to compliance across all subjects and within all proffessional groups targeted for December 2025.

Risk Movement

August 2025

EPUT

Risk Movement and Milestones

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

Risk ID	Initial Score	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25
SR1	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	Closed									
SR3	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15
SR4	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15
SR5	20	20	20	20	20	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	16	16	16	16	16	16	16
SR6	12	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15
SR7	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20	20	20	20	20	20	20
SR8	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20	20	20	20	20	20	20
SR9	20						New	20	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15
SR10	16															New	16	**12**	12	12	12	12	12	12	12	12
SR11	16															New	16	**12**	12	12	12	12	12	12	12	12
SR12	16															New	16	**16**	16	16	16	16	16	16	16	16
SR13	20																New	**15**	15	16	16	16	16	16	16	16

Risk Movement and Milestones

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

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

8.2 MENTAL HEALTH ACT ANNUAL REPORT

Decision Item | AS | 11:20

REFERENCES

Only PDFs are attached

Mental Health Annual Report 2024-25.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	01 October 2025

Report Title:	**Mental Health Act Annual Report 2024/25**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Tendayi Musundire, Deputy Director of Nursing for Safeguarding and Mental Health					
Report discussed previously at:	Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with assurance that the Trust has delivered a robust, proactive and effective Safeguarding and Mental Health Act service, as well as providing an overview of activity throughout 2024/25 and developments and challenges anticipated in 2025/26.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the content of the report
- Approve the report for publication
- Request any further information or action

Summary of Key Issues

This is the eighth annual report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee and sets out the framework within which it operates.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April 2024 to 31st March 2025 and provides an overview of the work undertaken in the administration of the Mental Health Act 1983.

The Mental Health Act team continues to monitor Mental Health Act activity across the Trust, including the number and type of detention (i.e. Section 5(4), Section 5(2), etc.) . The Mental Health Act team also monitor detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range.

The CQC carried out seventeen Mental Health Act focused inspections during the period April 2024 – March 2025. Overall, the feedback from the inspections was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of good practices.

The target compliance figure of 85% (this threshold is set out nationally via core skills framework and NHS England) for Mental Health Act mandatory training, covering both registered and un-registered staff, was met for the period April 2024 – March 2025.

The Mental Health Act team continue to provide Mental Health Act administration support to several local acute care partners for patients detained to them under a Service Level Agreement. As part of the agreement, the team also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Going forward, work will continue to address and streamline the functions of the Mental Health Act administration, ensuring compliance under the Mental Health Act.

The Mental Health Act team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	

Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	
Impact on patient safety/quality	
Impact on equality and diversity	
Equality Impact Assessment (EIA) Completed	~~**YES**~~**/NO**

Acronyms/Terms Used in the Report			
MHA	Mental Health Act	SLA	Service Level Agreement
SPC	Statistical Process Control	CQC	Care Quality Commission
CTO	Community Treatment Order	IMHA	Independent Mental Health Advocate
AWOL	Absent without leave	CAMHS	Child and Adolescent Mental Health Services
PICU	Psychiatric Intensive Care Unit	OT	Occupational Therapy
OTA	Occupational Therapy Assistant	DoLS	Deprivation of Liberty Safeguards
AHM	Associate Hospital Manager	ERA	Employments Rights Act
EPR	Electronic Patient Record		

Supporting Reports/ Appendices /or further reading

Attached Annual Report

Lead

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Mental Health Act Annual Report

2024/2025

EPUT

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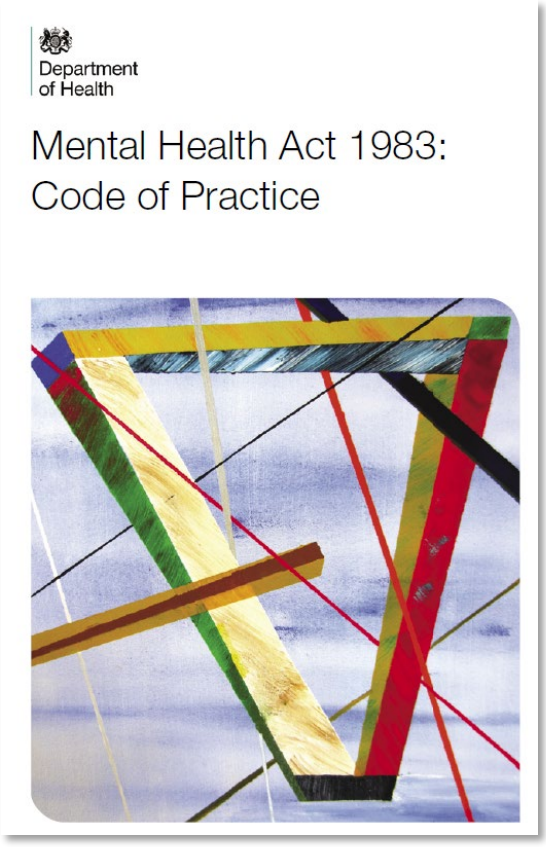


Foreword

By Ann Sheridan, Executive Nurse

I am delighted to introduce this year's Mental Health Act Administration Annual Report (2024/25) which sets out our performance in relation to the Mental Health Act and highlights our plans and priorities for the coming year.

Providing high quality, safe and compassionate care remains our priority as we continue on our journey of transformation and improvement. Over the last 12 months we have taken great strides towards achieving our vision 'to be the leading health and wellbeing service in the provision of mental health and community care."

Central to this is our Quality of Care Strategy which sets out our guiding principles for delivering great care and putting people at the heart of everything we do. The strategy is shaped by what our staff, people with lived experience and partners have told us quality of care means to them and focuses on safety, effectiveness and people's experiences as the three foundations for delivering consistent and reliable care.

We are focused on providing the best inpatient care, building a stable and skilled workforce to provide that care, and safe and therapeutic environments in which to do so. In 2024/25, we welcomed more than 910 permanent new colleagues and continue to make improvements to our wards.

Widespread changes have been made across wards to reduce the risk of self-harm and create the best environment for care and recovery.

2024/25 has been a busy year and one in which we have made great progress in helping people in mental health crisis get the right care at the right time.

All that we have achieved is testament to the hard work and dedication of our staff and I would like to take this opportunity to thank everyone at the Trust as well as our system partners for their continued support.

#WhatWeDoTogetherMatters

Executive Summary

This is the eighth Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Sub-Committee operates, provides an overview of its activities in 2024/2025 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2025/2026.

The Board recognises that high standards of governance throughout the Trust are essential for the delivery of the identified strategic objectives, the safety of its services, the quality of service user and carer experience, and the long-term protection of stakeholder interests. Good governance emanates from the Board but pervades the entire organisation, being reflected in its operating practices, policies and procedures.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April, 2024 to 31st March 2025. It provides an overview of the work undertaken in the administration of the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

The Mental Health Act team continues to monitor Mental Health Act activity across the Trust, including the number and type of detentions (i.e. Section 5(4), Section 5(2), etc.) and instances of detained patients absent without leave, as well as monitoring detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years.

The Care Quality Commission (CQC) carried out seventeen Mental Health Act inspections during the period 1st April 2024 – 31st March 2025. Overall, the feedback from the CQC inspections was positive with a small number of points of learning/themes identified and addressed.

The Trust's target compliance figure of 85% for Mental Health Act mandatory training, covering both registered and unregistered staff, was met for the period 1st April 2024 – 31st March 2025.

The Mental Health Act team continue to provide Mental Health Act administration support under a Service Level Agreement to local acute care partners. As part of the agreement, the Mental Health Act team also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Work will continue going forward in continuing to address and streamline the functions of the Mental Health Act administration, ensuring compliance under the Mental Health Act.

The Mental Health Act team remains committed to providing a quality, supportive function to EPUT clinicians to ensure we work collectively to ensure that those individuals detained under

the Act are in receipt of their rights as a detained patient. The Trust will continue to support the key functions of the Associate Hospital Managers (AHMs) in considering patients requests for discharge from detention under certain sections of the Mental Health Act in accordance with Section 23 of the Act, including Community Treatment Orders, and review detentions following renewal of such sections or following the barring by a Responsible Clinician of an application for discharge by the patient's Nearest Relative.

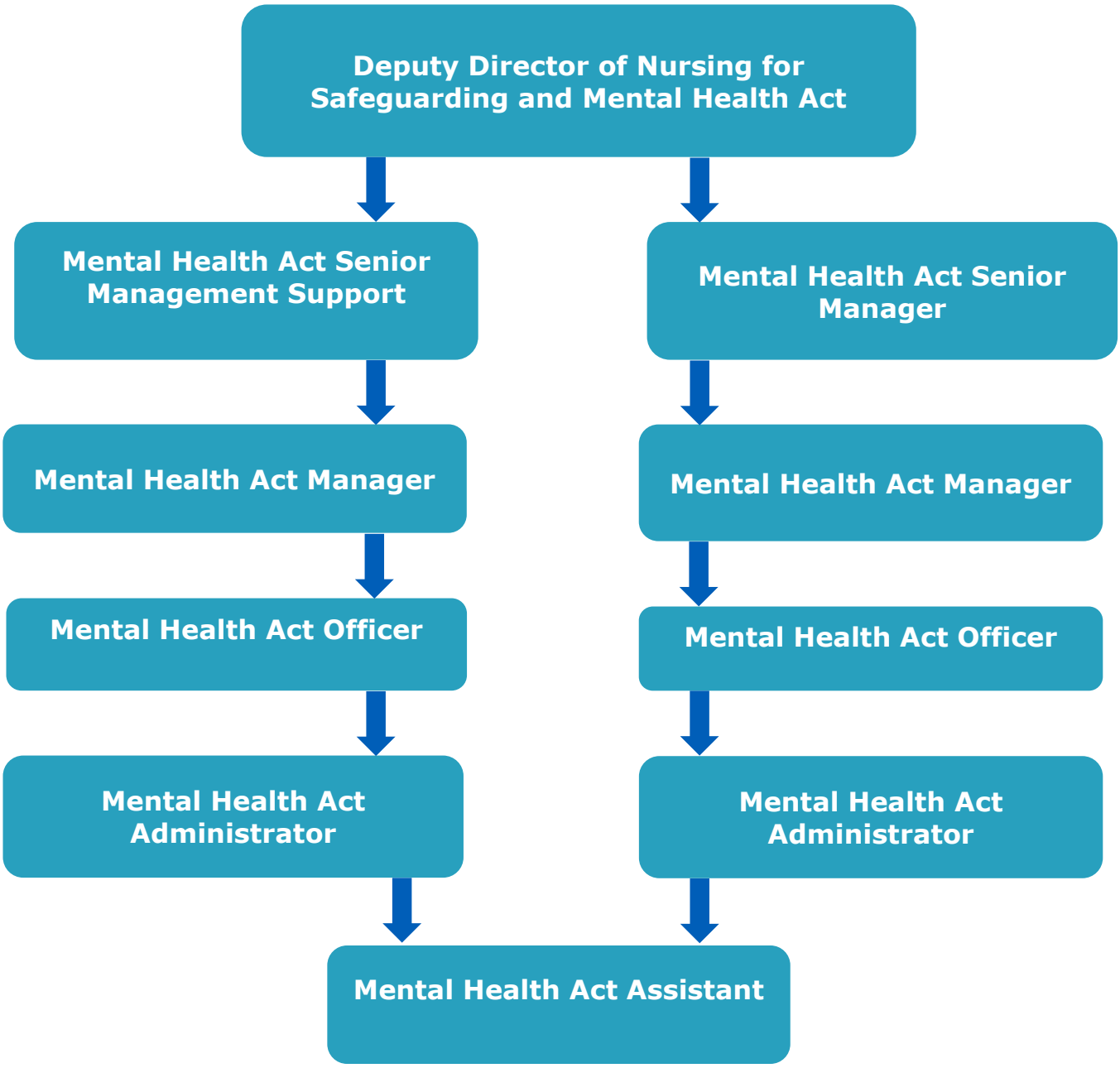
EPUT Governance

Mental Health Act Team

Within Essex Partnership University NHS Foundation Trust (EPUT), the Executive Nurse is responsible for the delivery of the Mental Health Act administration service, led by the Deputy Director of Nursing for Safeguarding and Mental Health Act.

The Mental Health Act team operate an administration service between 8am and 5pm, Monday to Friday, excluding bank holidays.

Mental Health Act Team Structure



Mental Health Act Administration Service Pathway

The diagram below demonstrates the reporting pathway for the Mental Health Act administration service within the Trust.

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

Mental Health Act Team Development

As an organisation, EPUT supports the development of its workforce and supports staff to offer the best positive care to our patients and service users.

Members of the Mental Health Act team have continued to enhance their knowledge of the Mental Health Act by receiving regular distributions regarding changes to the Mental Health Act through Mental Health Law Online, Care Quality Commission, London Mental Health Network and the Law Society. This knowledge enhances the skills within the team and helps to ensure the team can support clinicians to continue to provide high quality care within the legal framework of the Act.

Senior management within the Mental Health Act team have introduced "focused" Mental Health Act training to all members of the team to support their knowledge and learning. In addition, and to support the development of the Mental Health Act managers, practice development forums are now in place with senior managers where discussions and views regarding recent case law, high court judgements and day-to-day anomalies with the Mental Health Act team are discussed.

Senior managers regularly review the career pathways of the team during annual appraisals.

Detentions under the Mental Health Act 2024-2025

Data Source

As there are currently two clinical systems being used for the administration of the Mental Health Act in the Trust; Mobius in Basildon/ Rochford/Thurrock area and Paris in the Chelmsford/Colchester/Harlow area, this report provides details for both systems, which are provided by the Trust's Information and Performance team.

People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.

National data

Mental Health Act statistics – Annual Figures 01 April 2024 to 31 March 2025. Published 18 September 2025.

In 2024/25, there were 52,731 recorded detentions under the Mental Health Act, however the overall national total will be higher as not all providers submitted data and some submitted incomplete data. Trend comparisons are also affected by changes in data quality. For the providers that submitted good quality detentions data in each of the last eight years, it is estimated that there was an increase in detentions of 4.9% from last year. Comparisons can still be made between groups of people using populations based rates even though the rates shown are based on incomplete data.

Detention rates by gender

Known detention rates were higher for males (90.1 per 100,000 population) than females (80.0 per 100,000 population).

Detention rates by age group

Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (132.2 detentions per 100,000 population) were around 69% higher than those age 65+ (78.4 per 100,000 population).

Detention rates by ethnicity

A more detailed breakdown of the five broad ethnicity groupings shows that the detention rate was highest for those with 'Any Other Black Background', which forms part of the 'Black or British' group. At 780.3

detentions per 100,000 people, this was twelve times the rate for the White British group (64.9 detentions per 100,000 people) in 2024-25. The 'Any Other Mixed Background' had the second highest rate of detention (306.1 detentions per 100,000 population) followed by the Caribbean group at 250.4 detentions per 100,000 population.

How EPUT Compares to National Picture

EPUT detained 1,915 people between 1 April 2024 and 31 March 2025. This was lower than the previous year (2,102), whereas the national picture shows an increase in detentions.

Detention rates by gender

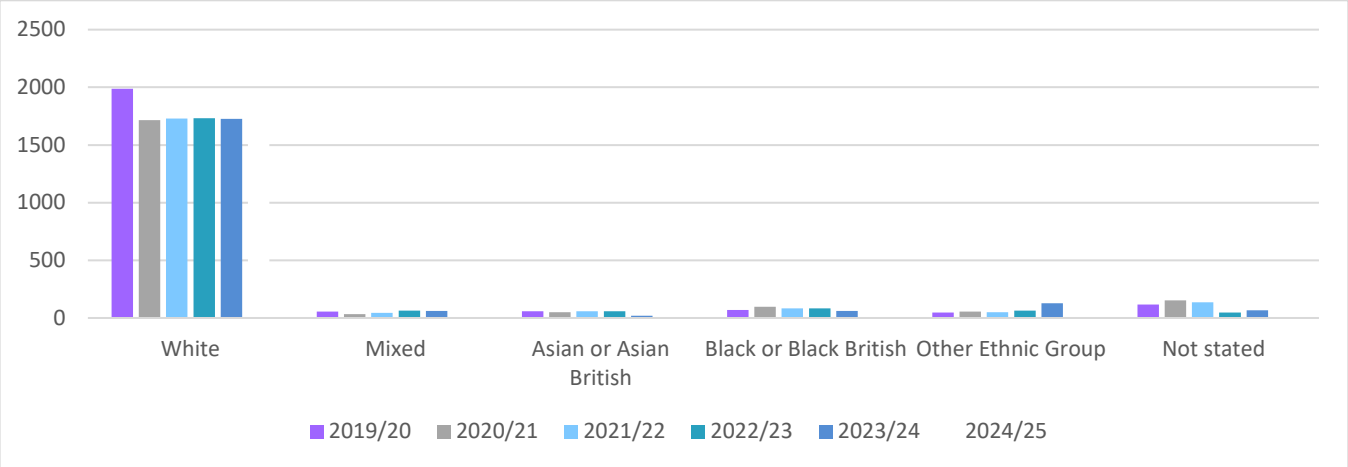
EPUT saw more men (51%) were detained than women (48%), 1% were other gender. This is similar to the national picture.

Detention rates by age group

EPUT sees more detentions in the 35 to 64 age group (39%) which is slightly different to the national picture of 18 to 34. (This age group was second for EPUT with 34%). This is indicative of the local demographic where there are more adults of working age.

Detention rates by ethnicity

The majority of detained people are of a white ethnic origin for 2024/25 (82%). This has been the trend over the years. The graph below details the ethnic grouping of detained patients in receipt of care from EPUT. Although the data indicates a slight increase in the detentions of black individuals and a slight increase in the detention of white individuals, the data, as in previous years, remains relatively stable and appears to be consistent with the demographic profile of EPUT's geographical area.



Graph 1: Detention rates by ethnicity, over time. Data provided by EPUT's Information Department.

EPUT Mental Health Act Detention Activity Data

Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated to understand the context and circumstances; and remedial action taken as appropriate.

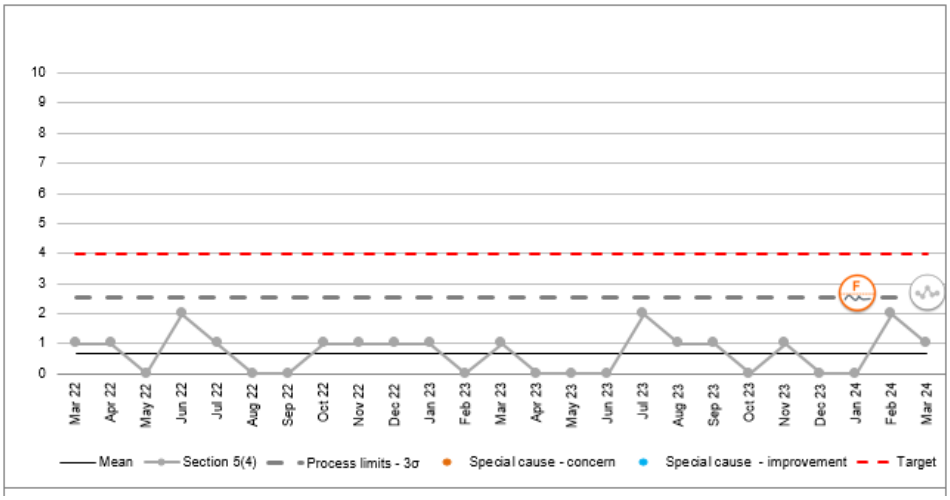
The below SPC charts provides an overview of Mental Health Act Activity. Whilst there is some fluctuation in the use of some of the detentions it is consistent with previous years.

Section 5(4)

A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the register indicates that their field of practice is either mental health or learning disability.

A Section 5(4) lasts for up to six hours or until the doctor attends to assess the patient to ascertain if the patient requires further detention. The use of Section 5(4) whilst fluctuates remains low and within single figures.

The low numbers in the graph for EPUT show that fewer people are being admitted as informal patients requiring the application of Section 5(4). There are no trends with regards to areas where the holding powers are being used.



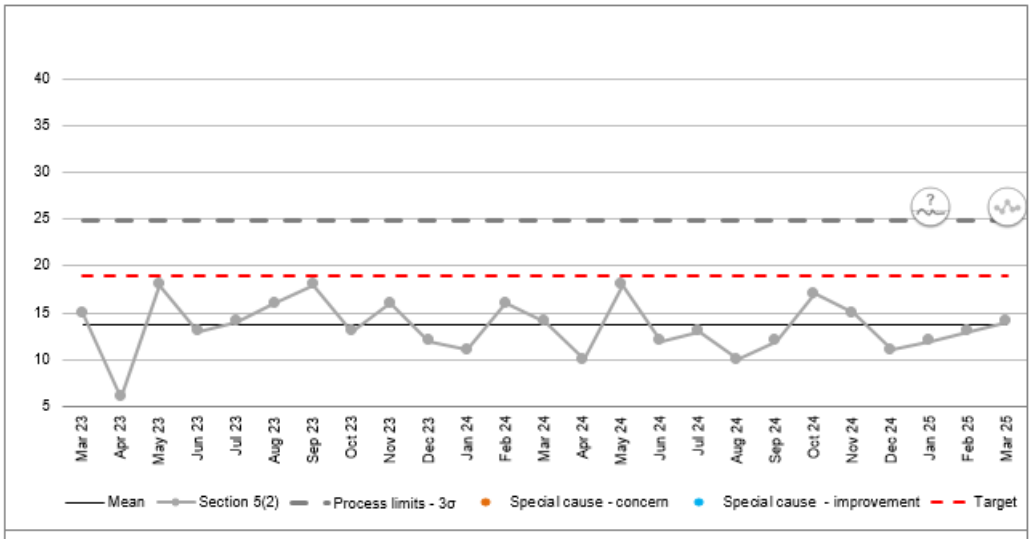
Graph 2: Use of Section 5(4). Data provided by EPUT's Information Department.

Section 5(2)

Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983. The purpose of a Section 5(2) is to prevent the person from discharging themselves before there is time to arrange an Mental Health Act assessment for a Section 2 or Section 3. The usage of a 5(2) can therefore fluctuate from month to

month demonstrated as common variation.

The graph shows that the number is low but higher than the 5(4) which is expected as all those detained under 5(4) will be considered for 5(2). There are no clear trends of where the Section is being utilised within the Trust. The numbers are low as most of the patients admitted on the wards would have already been detained.

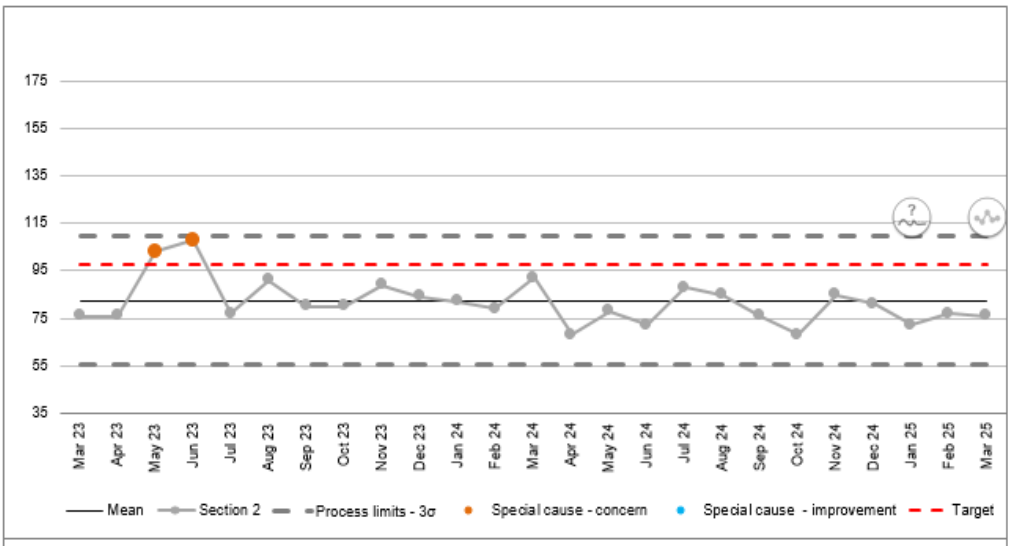


Graph 3: Use of Section 5(2). Data provided by EPUT's Information Department.

Section 2

Section 2 allows for the compulsory admission and detention for assessment of someone with a mental disorder. The mental disorder must be of a nature or degree which warrants the detention of the person in hospital and that they ought to be detained in the interests of their own health, safety or with a view to the protection of other persons. The Section 2 is for detention up to 28 days and cannot be renewed.

There are no obvious trends, as shown in the graph below, as the number of people detained under Section 2 fluctuates. There are various interventions being undertaken by community teams prior to hospital admission.

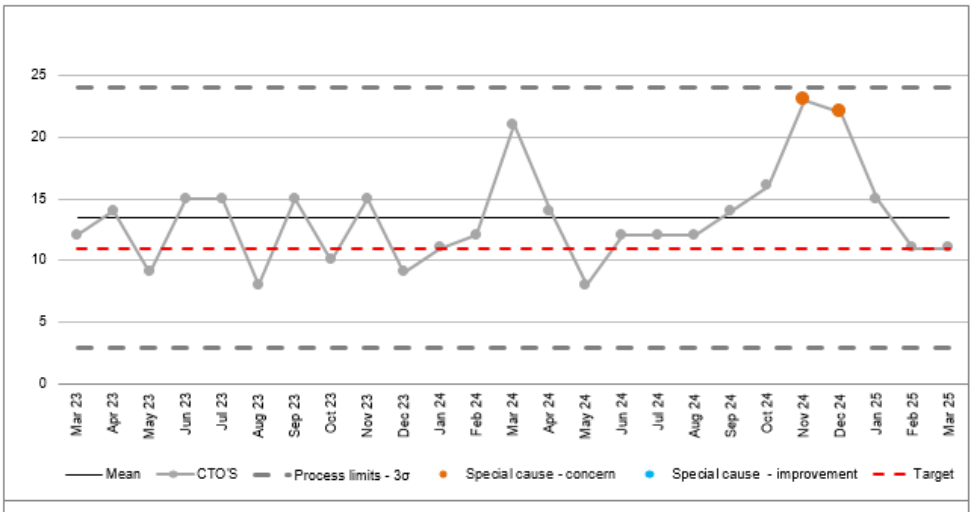


Graph 4: Use of Section 2. Data provided by EPUT's Information Department.

Section 3

Section 3 allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature or degree which warrants the detention of the person in hospital and that they ought to be detained in the interests of their own health, safety or with a view to the protection of other persons. The Section 3 is for detention up to six months; this can be renewed if the criteria is still met for a further six months and then yearly after that.

The graph shows an increase over time of people being detained under Section 3.

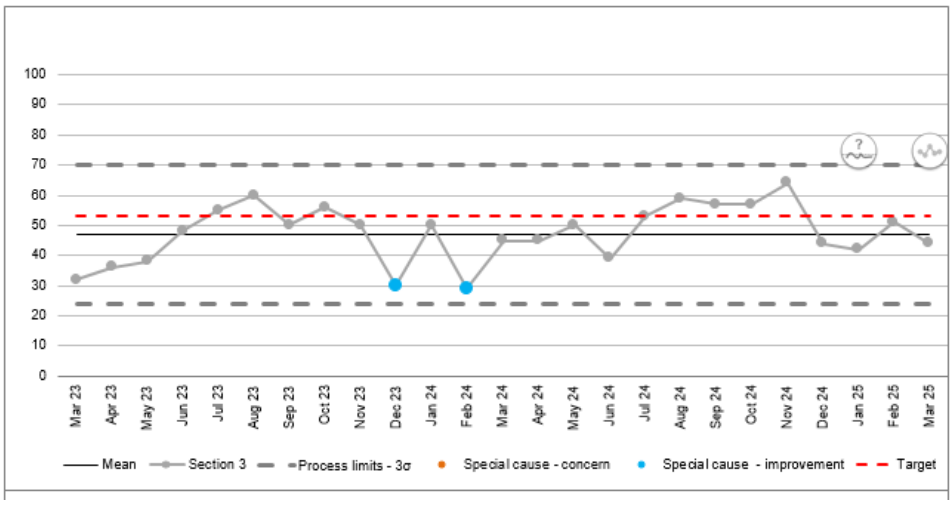


Graph 5: Use of Section 3. Data provided by EPUT's Information Department.

Community Treatment Order (CTO)

A Community Treatment Order (CTO) allows for a patient on a qualifying section to be discharged into the community. The Responsible Clincian has the power to recall the patient to hosptial if needed. The CTO is for up to six months, renewable at six months and then yearly.

There has been an increase in the number of people detained under CTO which is expected as we have an increase in the number of people detained under Section 3.



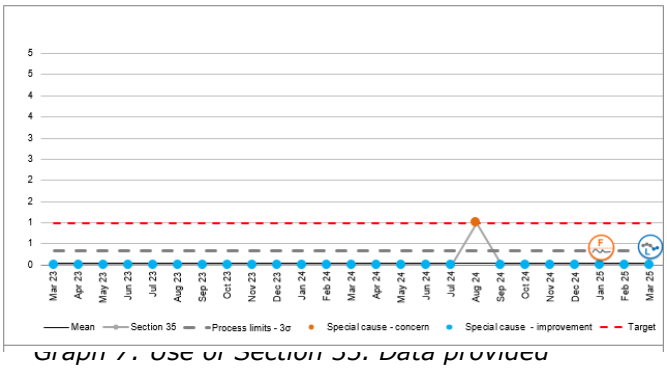
Graph 6: Use of a Community Treatment Order. Data provided by EPUT's Information Department.

Part Three of the Mental Health Act

Patients have been admitted to hospital under what is called a Part 3 or Forensic Section. These Sections are placed on someone to bring them to hospital in one of two ways. The first way is from a Court of Law. The second way is from a Prison.

Section 35

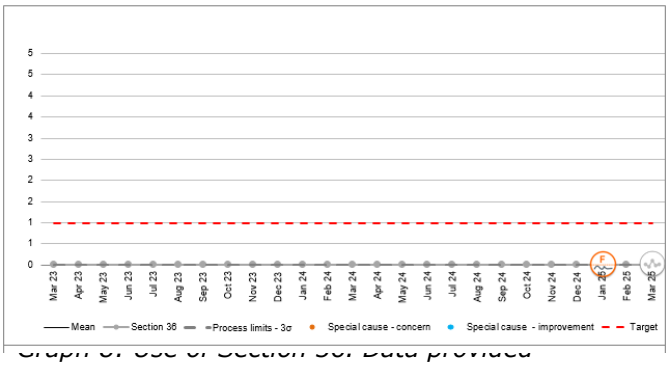
Section 35 is a remand to hospital for assessment for up to 28 days, it can be renewed for a further 28 day period, for up to 12 weeks.



Graph 7: Use of Section 35. Data provided by EPUT's Information Department.

Section 36

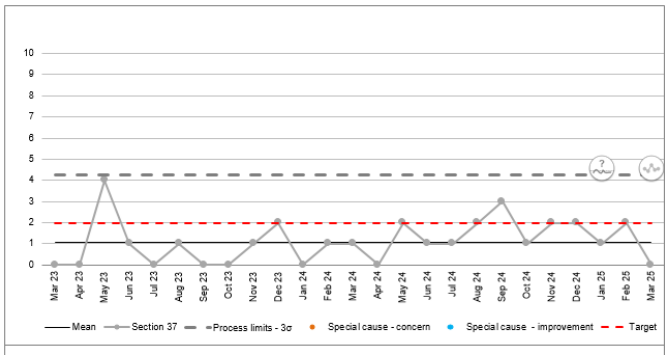
Section 36 is a remand to hospital for treatment for up to 28 days, it can be renewed for a further 28 day period, for up to 12 weeks.



Graph 8: Use of Section 36. Data provided by EPUT's Information Department.

Section 37

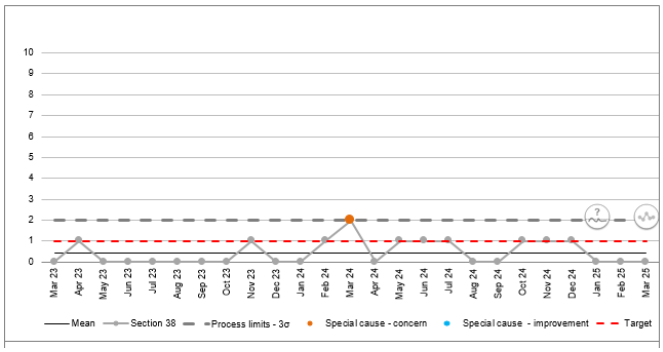
Section 37 is a Hospital Order for the admission of an offender to hospital who is suffering from a mental disorder. Section 37 is for up to six months, renewable at six months and then yearly.



Graph 9: Use of Section 37. Data provided by EPUT's Information Department.

Section 38

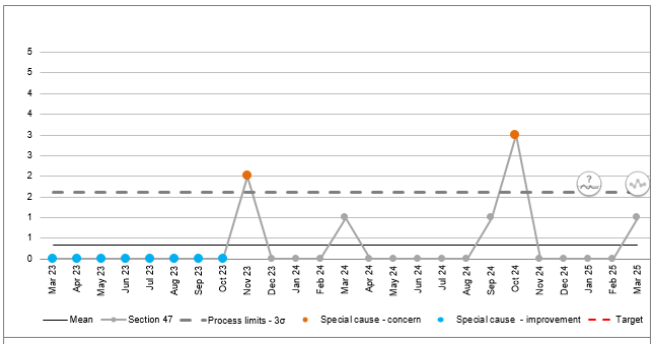
Section 38 is an interim hospital order to assess an un-sentenced prisoner and is for up to 12 weeks.



Graph 10: Use of Section 38. Data provided by EPUT's Information Department.

Section 47

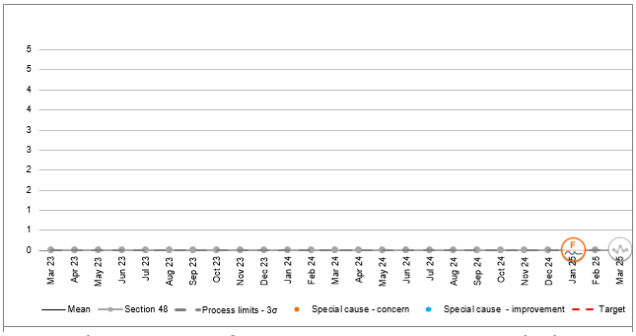
Section 47 is the transfer of a sentenced prisoner to hospital who is suffering from a mental disorder. A Section 47 is for up to six months, renewable at six months and then yearly.



Graph 11: Use of Section 47. Data provided by EPUT's Information Department.

Section 48

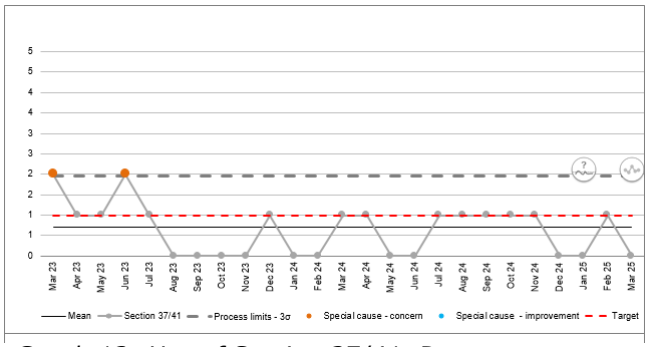
Section 48 is the transfer of an un-sentenced prisoner in need of urgent treatment. The Section has no limit of time.



Graph 12: Use of Section 48. Data provided by EPUT's Information Department.

Section 37/41

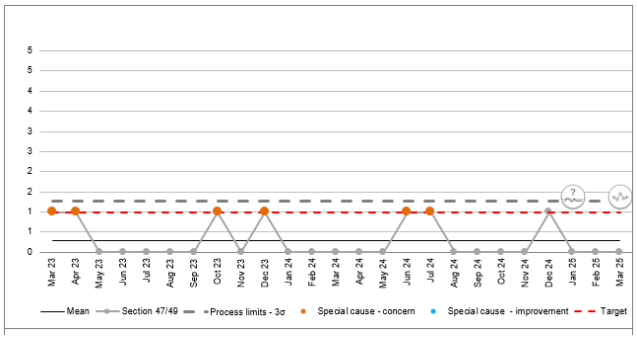
Section 37/41 is a Hospital Order with restrictions. The Section has no limit of time.



Graph 13: Use of Section 37/41. Data provided by EPUT's Information Department.

Section 47/49

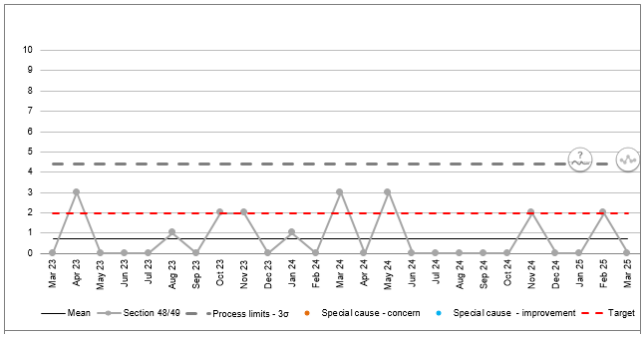
Section 47/49 is the transfer of a sentenced prisoner to hospital who is suffering from a mental disorder with restrictions.



Graph 14: Use of Section 37/41. Data provided by EPUT's Information Department.

Section 48/49

Section 48/49 is the transfer of an un-sentenced prisoner in need of treatment.



Graph 15: Use of Section 48/49. Data provided by EPUT's Information Department.

Service Level Agreements with Other Providers

The Trust continues to have in place Service Level Agreements with Princess Alexandra Hospital (Harlow), East Suffolk and North Essex NHS Foundation Trust (who are responsible for services in Colchester General Hospital) and Mid & South Essex NHS Foundation Trust (who are responsible for services in Broomfield Hospital, Basildon General Hospital and Southend General Hospital). The Service Level Agreements provide Mental Health Act administration expertise and support with patients detained to an acute hospital under the Mental Health Act. Two Service Level Agreements have been renewed for another year by

Princess Alexandra Hospital (PAH) and Mid & South Essex NHS Foundation Trust (MSE). The Service Level Agreement with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) is due for renewal in October 2025.

A vital part of the Service Level Agreement is the provision of Mental Health Act training to our acute care colleagues, all of which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Feedback Received

Over the last year we have continued to receive support from the EPUT Mental Health Act team through the Service Level Agreement. This has been vital in supporting us as an organisation in meeting our responsibilities when patients receiving care in Colchester Hospital have been detained under section of the MHA. Although the number of people this applies to has increased in the last year, these are comparatively small numbers so acute hospital staff do not undertake these processes as part of their usual day to day care. The approach by the team is mindful of this and we have found them to be understanding and patient, whilst also ensuring that teams are aware of what is required and so that patients are not subject to unlawful practice. The relationships we have are valuable, it is helpful to be able to have a point of contact to consult with when there are particular complex factors impacting upon the use of the Act to ensure the right routes are followed. Additionally, the offer of training and education for colleagues is helpful, particularly around the use of section 5(2).

Tara Brown, Senior Lead for Safeguarding and Complex Health, East Suffolk and North Essex NHS Foundation Trust

The Mental Health Act team at EPUT provides support to PAH in the administration of the MHA at PAH. They

advise our staff on correct completion of the paperwork, advice and guidance on the proper implementation of the MHA and best practice, support to ensure that our service users have all the access they require to information on their rights and legal or advocacy advice, they offer monthly training sessions to our staff on the MHA and its use and implementation in an acute setting, and also support and offer guidance at every step for the appeals and Tribunals process.

The Team is always readily available and on hand to offer guidance and support in a friendly and professional manner. They are also happy to contribute to discussions around service development and improvement.

Vivienne Narburgh, Lead Nurse for Mental Health, Mid and South Essex NHS Foundation Trust

EPUT's Mental Health Act team continue to deliver regular training which is available to all MSE staff as part of the Service Level Agreement. The training now incorporates more information around Section 5(2) and Section 136 in response to feedback from attendees.

The team are highly responsive to queries on all aspects of the Mental Health Act; staff across the acute general hospitals often have limited knowledge regarding the requirements when patients are detained to the hospitals. The Mental Health Act team offer timely guidance and support where corrections are necessary on Section papers or where additional information is needed.

Wendy Hill, Mental Health Lead Nurse, Prevent Lead & Safeguarding Group, Mid and South Essex NHS Foundation Trust

Care Quality Commission

Monitoring the Mental Health Act in 2024/2025 Report

The CQC's monitoring of the Mental Health Act in 2023/2024 Report was published on 13th March 2025. The report is based on the findings from 823 monitoring visits carried out during 2023/2024. This involved speaking with 4634 patients (3343 in private interviews and 1291 in more informal situations) and 1435 carers. The CQC also spoke with advocates and ward staff. In addition, the CQC carried out a series of interviews with people who have lived experience of being detained under the Mental Health Act or of caring for someone who has been detained.

The key points identified by the CQC were:

Workforce

In 2023/24 there were continuing problems with workforce retention and staff shortages, as well as concern around training and support for staff. Although the mental health workforces have grown by nearly 35% since 2019, shortages in both medical and support roles continue to have a negative impact on patient care.

Shortages of doctors also continue to affect the delivery of their Second Opinion Appointed Doctor (SOAD) service. They remain concerned about the long-term sustainability of the service, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions.

Environment

Through their Mental Health Act monitoring visits, the CQC found that the quality of inpatient environments continues to vary. They are concerned about the impact of poor-quality environments on patients seen examples of how ageing and poorly designed facilities affect people's care.

Being able to go outside brings therapeutic benefits for patients, but access to outdoor facilities varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, they found examples of unwelcoming gardens and at some services patient's access to outdoor space was limited. This issue was also raised by members of our Service User Reference Panel.

Inequalities

They are concerned that some of the key issues raised in the reports, including access to mental health support, are particularly challenging for certain groups of people, such are people from ethnic minority groups and those living in areas of deprivation. They identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.

There was variation in how well services met people's needs. While many provided access to spiritual leaders, they remain concerned about gaps in the knowledge of staff around caring for autistic people.

Children and young people

Children and young people continue to face challenges in accessing mental health care. Increasing demand is leading to long waits for beds and increases the risk of being place in inappropriate environments and/or being sent to hospitals miles away from home. Once in hospitals, they are concerned that access to specialist staff is being affected by low staffing levels, leading to patients' needs not being met. In addition, the quality of physical environments for children and young people varies; access to food and drink

Challenges in transitions of care between children and young people's mental health services and adult mental health services remain, with many young people still falling through the gaps and not getting the care and support they need.

Monitoring the Mental Health Act in 2023/24 - Care Quality Commission

Care Quality Commission Mental Health Act Focused Visits to EPUT

The Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. They do this by looking across the whole patient pathway experience from admission to discharge.

The Mental Health Act team provides a supportive process for the wards to help co-ordinate the visit. In the main during the last year, visits from the CQC have been unannounced. The Mental Health Act team provide support to the ward staff for any responses that may be required to the CQC, during or following their visit. To date this has proved very successful.

CQC Mental Health Act Reviewers undertook the following:

The CQC have given formal provider action statements and monitoring reports detailing the outcome of the visit indicating any points where they would expect action to be taken. The CQC made seventeen visits to the Trust from the 1st April 2024 to the 31st March 2025:

Fuji Ward	03/04/2024
Alpine Ward	03/04/2024
Larkwood Ward	10/04/2024
Robin Pinto Unit	24/04/2024
Beech Ward	24/04/2024
439 Ipswich Road	12/06/2024
Tower Ward	03/07/2024
Hadleigh Unit	09/07/2024
Poplar Ward	30/07/2024
Topaz Ward	23/09/2024
Kelvedon Ward	07/01/2025
Willow Ward	28/01/2025
Kitwood Ward	04/02/2025
Ruby Ward	25/02/2025
Byron Court	04/03/2025
Aurora Ward	19/03/2025
Meadowview	26/03/2025

Overall, feedback from CQC reviews was positive however, several themes were identified. The general themes identified have been shared at the Mental Health Act Business meeting, Safety of Care Group and MHA & Safeguarding Sub-Committee, and action taken to mitigate against recurrence. It was pleasing to note that in addition to areas for improvement a number of positive general comments from patients, relatives, carers and IMHAs were provided to the CQC Reviewers during their visits.

Some of the themes identified were:
IMHA Services:

- Lack of information around the ward
- Lack of referring detained patients that have no capacity

Section 132 Rights:

- No evidence of rights being given
- Delay in giving rights

Capacity to Consent to Treatment Assessments:

- No evidence in the ward review electronic form, that capacity to consent to treatment has been assessed

Care Plans:

- No evidence of patient involvement
- Patients not being given copies of their care plans

Consent to Treatment:

- Treatment forms (T2/3 & Sec 62) not attached to the medication chart/ not available on the eMPA system or hard copies available

All areas identified have a comprehensive action plan in place and shared with the CQC and monitored via the care unit structures.

Actions taken to address the themes identified during the CQC visits:

- All staff reminded of the requirements of the Act and its Code of Practice

Observations from the CQC:

Feedback from the CQC following the Mental Health Act inspection visits are as follows:

There was a beverage bay where patients could make hot and cold drinks throughout the day. This was a recent installation and was proving very popular. ***(Robin Pinto Unit, Secure Services)***

There was good evidence that young people were regularly involved in care planning, key workers spend time with young people discussing care plans. "My Care My Recovery" plans were also used to enable dialogue around young people's thoughts and wishes. ***(Larkwood Ward, CAMHS)***

Informal patients were provided with information about their rights to leave the ward. There was a rights poster in reception and in the communal space on the ward, patients were also provided with a leaflet. ***(Beech Ward, Elderly Services)***

We observed patients being spoken to with kindness, respect, and dignity. ***(Tower Ward, Elderly Services)***

Patients were aware of their legal status and had knowledge of up-and-coming MHA hearings. ***(439 Ipswich Road, Adult Rehabilitation)***

Records showed that rights advice was provided. Section 2 rights information was provided on initial detention then once a week. Section 3 rights information was provided on detention and then monthly. Patients were referred to the IMHA if they lacked capacity to understand their rights. ***(Hadleigh Unit, PICU)***

Discussion with patients:

All patients we spoke with said staff were supportive and approachable. One patient said "they could speak to staff day or night". One patient said they "had a lot of trust in the staff". ***(Fuji Ward, Secure Services).***

We spoke with one young person in private who explained they understood the section under which they were detained. They said they had their rights read to them regularly. Staff explained each time medication was given, what it was and how it would help them ***(Poplar, CAMHS)***

All the patients we spoke with enjoyed the food provided on the ward and said that there was a good variety of food available. Patients had observed staff providing meals outside of mealtimes if a patient had missed this. ***(Ruby Ward, Elderly Services)***

The ward was sufficiently recovery-orientated. One Occupational Therapy Assistant (OTA), supervised by a qualified Occupational Therapist (OT), was available on the ward. Activity Coordinators and a Gym instructor were also in post. In addition, Clinical Psychologists were available as requested by the multidisciplinary team, and a Discharge Coordinator was also in post. ***(Topaz Ward, Adult Acute)***

All three patients said they got on with their Responsible Clinician and felt listened to in ward review meetings. ***(Kelvedon Ward, Adult Acute)***

Patients we spoke with told us they felt safe on the ward. They said that staff intervened well with disturbances that took place, and protected patients. In addition, patients spoke highly of the staff and how they supported them. They said, "The staff are kind and supportive." ***(Willow Ward, Adult Acute)***

Discussion with carers:

Carers had been able to meet with their relatives on the ward and described flexibility around visiting times. Carers praised the activities that were available. One carer said their relative was non-verbal but was still encouraged by staff to participate in activities. ***(Meadowview, Elderly Services)***

We heard positive feedback from carers about staff and the treatment on the ward. Carers said that staff were friendly, supportive and responsive to requests. Carers described improvements in their relatives and said that staff ensured that physical needs and personal care were managed well. ***(Kitwood Ward, Elderly Services)***

The carer said that visiting their relative was made easy and was well-facilitated by staff. When their relative had been more unwell at the beginning of their admission, staff made sure that calls from the carer were put through to them. This was appreciated by the carer. ***(Kelvedon Ward, Adult Acute)***

Carers said they felt the staff were really good, and supported their relatives very well. They felt well informed by the staff about incidents and any other significant issues. Carers could ring the ward if they had any concerns, and staff always responded. ***(Topaz Ward, Adult Acute)***

Carers attended the weekly meetings with the doctors and they felt that their views were listened to and welcomed. The diagnosis and treatment were explained and discussed very thoroughly. Carers felt that it was good that carers had time with the doctors before the patient was invited to the meeting and carers views were listened to. ***(Hadleigh Unit, PICU)***

Carers spoke positively about support they received from the family carers'

champion. ***(Willow Ward, Adult Acute)***

All the staff had been very friendly and welcoming. Explanations were provided for the procedures for visiting. Carers are able to arrange visits with the patient. They only had to sign in/out of the building for fire safety purposes. ***(439 Ipswich Rd, Adult Rehab)***

Discussions with the IMHAs:

The IMHA said that staff routinely referred all new admissions to their service. They were also able to support patients subject to DoLS as their service provided Independent Mental Capacity Advocates. ***(Byron Court, Specialist Services)***

Mental Health Act Training in EPUT

Mental Health Act training is an online training module and is mandatory to both registered and unregistered staff. Compliance with training requirements is monitored monthly and where compliance falls below target, this is escalated at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. The Trust compliance figure is 85%.

Training needs are highlighted through results from ongoing Mental Health Act audits, Mental Health Act CQC visits and requests from Ward Managers to address team or individual needs. Where training needs are identified, the Mental Health Act team provided bespoke training either via Microsoft Teams or supported one to one telephone discussions.

	Overall Competence		
	Total Target	Trained	
		No	%
Mental Health Act All Registered Staff	2223	2015	91%
Mental Health Act All Non-Registered Staff	1477	1425	96%

Table 1: Number of staff trained. Data provided by EPUT Information Department.

Mental Health Act Training Delivered by Mental Health Act team

The Mental Health Act team has devised a rolling programme of Mental Health Act training which can be accessed by all members of staff within the Trust on a monthly basis. These monthly sessions provide an opportunity for learning as well as sharing current CQC themes arising from Mental Health Act focused CQC visits.

Staff Group	Numbers
EPUT Staff	91
EPUT Preceptorship Group	116
Service Level Agreement - Acute Hospital Staff	28
Total	**235**

Table 2: Number of staff trained by group 2024/25. Data provided by EPUT

Audits 2024/25

Audits are undertaken annually, bi-annually and monthly to monitor EPUT's compliance with the Mental Health Act and to ensure that patients are legally detained and their rights protected.

Associate Hospital Manager Audit

Associate Hospital Managers (AHM) are independent individuals appointed by NHS trusts to review whether a person's detention under the Mental Health Act should continue. They have the legal authority to discharge patients under Section 23 of the Act and typically conduct reviews as part of a panel of three. Their role involves ensuring decisions comply with the Mental Health Act and Code of Practice, considering human rights implications, and safeguarding the rights of detained individuals. They respond to requests for discharge, including those from patients and their Nearest Relatives, and maintain independence from clinical teams. AHMs also participate in regular training and development to stay informed about legal and procedural updates.

The Independent Chair of the AHMs, in conjunction with the Mental Health Act team, undertake two audits a year: a decision form audit and a full panel audit.

Decision Form Audit

This audit involves scrutinising a number of decision forms (12 in total) to ensure that the forms gave sufficient evidence to justify the decision to discharge or not, the patients' detention under the Mental Health Act. The decision form audit took place during December 2024 and January 2025. The twelve decision forms audited were dated between the periods April 2024 to December 2024. In the vast majority of cases, forms were completed in line with expectations. The following observations were made at the conclusion of the audit:

1. AHMs to be reminded, that patient's insight and/or capacity should be automatically questioned when considering evidence under the Nature/Degree criterion area, or in assessing their contribution towards risks, treatment compliance and other associated factors.
2. AHMs to be reminded that graded Section 17 Leave is a key component of therapeutic treatment, particularly as the patient nears discharge, as community safety is a necessary element for accommodation providers who cannot provide a secure setting.
3. Decision forms need to be seen as a standalone document which records evidence of the statutory criteria for continued detention. Some of the decision forms did not

cite detailed evidence that demonstrated continued detention of Community Treatment Order (CTO) criteria, even though these may have been identified from the reports or within the hearing process.

Full Panel Audit

The purpose of the audit is to reflect on what has occurred within hearings in order to learn lessons and improve practice and procedures within EPUT. The Audit team will seek to ensure that the process of the hearing complied with the principles of clinical governance and that the rights of the patient were considered and, where appropriate, protected.

This includes ensuring that reports were received in a timely fashion and were of an appropriate standard, that the AHM Decision Form from the hearing was clear and comprehensive and to discuss and identify any best practice points for clinicians, administrators and AHMs.

The Full Panel audit took place on 6th December 2024. The Audit team looked at the case of a patient who was detained on Section 3. The Responsible Clinician Report, Social Circumstances Report and the Nursing Report were reviewed as part of the audit process.

It was evident during this audit that there were elements of the reports that could have provided more in-depth detail for the AHMs to support their responses to the questions raised. To support professionals in the completion of their report guidance, notes on the completion of reports are provided to report authors to enable them to include the relevant evidence in their report.

Tendable Report

A monthly audit is undertaken at ward level by Ward Managers or Nominated Person, to ensure the ward's individual compliance with the Mental Health Act. Tendable, the audit tool designed to assist health and care professionals to own patient safety and conduct quicker and more efficient quality audits, is used to facilitate this audit and has proved effective in helping monitor compliance.

Audits are undertaken on a monthly basis, the results of which are produced and viewed through an Inspection Summary. The Inspection Summary is made up of various components containing previously agreed questions that are required to be asked of individual wards regarding compliance.

The Mental Health Act team review the Inspection Summary each month. Based on the findings of these audits, specific support training is offered to the ward and, where applicable, individual clinicians.

The results of the Mental Health Act Tendable audits are a standing agenda item at the Mental Health Act Bi-Monthly Business Meeting as well as the Mental Health Act & Safeguarding Sub-Committee. Any emerging themes and points of learning are

discussed, escalated if necessary, and any remedial action taken, for example, bespoke training, review of online training and review of policies and procedures.

Mental Health Act Documentation Audit

When someone is detained under a section of the Mental Health Act, certain section documentation is required in regard to the admission of and continued detention and, treatment under the Act.

The role of the Mental Health Act team is to scrutinise documents for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention. The Mental Health Act team has developed processes and procedures to aid compliance with the Mental Health Act, the Mental Health Act Code of Practice and guidelines issued by the CQC.

The aim of the audit was to provide assurance that the Trust is compliant with the legal requirements of the Mental Health Act which could lead to patient safety risks and reputational damage due to inaccurate completion and retention of appropriate section papers, as well as provide assurance that patients detained under the Mental Health Act with the Trust were detained lawfully and being treated within the parameters of Section 58 of the Mental Health Act.

The audit demonstrated that the Mental Health Act team on the whole operate a good sound system of Mental Health Act administration processes and procedures. However, it was identified that there were a few instances of non-compliance with processes and procedures which were addressed through learning and training.

Associate Hospital Managers

Section 145 of the Mental Health Act gives the designated Hospital Managers various powers and duties. In an NHS Trust or NHS Foundation Trust, the Hospital Managers will be the Trust or Foundation Trust as a body. In practice, many duties within the Act for which Hospital Managers are responsible will be delegated.

Delegation is authorised within the Mental Health Act Regulations and in the case of discharge powers, under Section 23 of the Act. Many of the functions will usually be delegated to the Mental Health Act team. Organisations may delegate the Section 23 role to a group of people referred to as “Associate Hospital Managers” (AHMs). Hospital Managers retain overall responsibility for any delegated duties. AHMs are lay individuals who work on a voluntary basis and they receive a small remuneration for their

time.

The key function of the AHMs is to consider patients' requests for discharge from detention under certain sections of the Mental Health Act in accordance with Section 23 of that Act, (including from Community Treatment Orders) and reviewing detention following renewal of such sections or following the barring by the Responsible Clinician of an application for discharge by the patient's Nearest Relative.

The Trust currently has twenty AHMs who undertake Hospital Manager hearings, and to ensure that their Mental Health Act knowledge remains current, they participate in regular relevant learning sessions.

The Mental Health Act team, in conjunction with the Independent Chair and Vice Chair, regularly review the number of AHMs to ensure there is sufficient capacity to facilitate hearings in a timely manner. Currently the Mental Health Act team are in the process of recruiting a number of new AHMs who are expected to be in post by autumn 2025.

The AHMs meet three times per year to discuss business pertaining to their role. Guest speakers are invited to provide an overview of their specialist area and expertise in regards to their individual roles within the organisation, which underpins the knowledge and expertise of the AHMs.

Associate Hospital Manager Review of Performance

The Mental Health Act Code of Practice requires trusts to complete an evaluation of satisfactory performance for each AHM prior to the renewal of their agreement. AHMs two-year agreement includes elements that they must fulfil to ensure renewal, of which the performance review is a primary element. These reviews are used to determine learning requirements, both specific to the individual as well as learning in general. AHM performance reviews were all concluded to a satisfactory standard. A new schedule of reviews will be devised to meet the conditions of the renewal of AHM agreements on 1st May 2027. (See Case Law – Appendix 2).

The Trust would like to acknowledge the hard work and commitment of all past and current AHMs during 2024/2025.

Associate Hospital Managers Meetings and Supportive Learning

The AHMs have met on a regular basis through the year and have received bespoke training, one example being the presentation from the Clinical Director of Psychological Services on the role of the Multi Professional Approved Clinician.

Innovations and Achievements

Mental Health Act Training

To promote continuing knowledge and understanding of the Mental Health Act, a rolling Mental Health Act Training Programme has been introduced to capture staff from all disciplines to enhance their working knowledge of the Mental Health Act. Following discussions with Matrons, it was agreed that the training will be delivered on the third Thursday of every month. The up take on training has been fruitful and the feedback from staff has been complimentary.

Service Level Agreement Bespoke Package

To promote partnership working, a Mental Health Act training package has been devised and tailored to reflect the needs of the acute hospitals who have an SLA with the Trust. In the case of one of our acute hospitals colleagues, have had a training package devised which has been specifically personalised to meet their individual needs in regards to "walking through" the relevant Mental Health Act section papers that they were unfamiliar with, and making them aware what must be included in the paperwork and who should be completing this. It is our intention to share this package with our other acute colleagues.

NOVA – Unified Electronic Patient Record

Essex Partnership University NHS Foundation Trust and Mid and South Essex Foundation NHS Trust are working together to implement Nova, a new single Electronic Patient Record (EPR) system across the services.

The implementation of a unified EPR through the NOVA Programme will transform how the Trust will collaborate and work as a single health system to deliver quality and safe care to patients and services across acute, community and mental health sectors.

The Mental Health Act team has been instrumental in the development of process maps for the legal requirements of the Mental Health Act and reviewing the forms. The Mental Health Act team continue to attend meetings, workshops and Mental Health Act localisation patient flow walk-throughs.

Challenges

Amendments required to section paper to meet the requirements of Section 15 (rectification of application and recommendations) of the Mental Health Act

Section 15 allows for rectification of an application and medical recommendations within a period of 14 days from the start of the section. It is accepted that mistakes do happen when completing section paperwork which Section 15 allows for. The challenge arises in sending the paperwork to the author for any necessary amendments as these amendments require completion within this 14 day window. There have been occasions when the paperwork has not been amended within this window and unfortunately these sections were deemed to be unlawful. To mitigate these occurrences, a robust administrative procedure is in place utilising the Mental Health Act team diary with timely notifications to remind Mental Health Act team staff of the impending return of the section paperwork.

Forward Plan

As in previous years, work will continue to address and streamline the functions of the Mental Health Act administration, ensuring compliance under the Mental Health Act for all patients detained within EPUT.

The Mental Health Act Senior team members will meet every three months to discuss areas of practice, anomalies in regards to the Mental Health Act, along with shared learning around the approach to dealing with complex queries and issues.

Delivery of Mental Health Act training will continue across the Trust and to colleagues in the acute sector which has proved very successful in the main and have been enhanced by the introduction of the Mental Health Act training rolling programme, which provides support to individuals and teams.

Work will continue to improve the content of the completed provider action statement with the introduction of agreed guidelines to help staff with the completion of these detailed statements. In addition, and following completed provider action statements to the CQC, staff will be requested to provide an update to the initial responses made to the CQC three months after the CQC visit to provide assurance of actions taken to the response made.

As part of the Mental Health Act team objectives for 2025/2026 and to enhance their individual knowledge of the Mental

Health Act, protected time has been allocated to individual team members as part of their personal objectives to expand their knowledge of the Mental Health Act Code of Practice and the Mental Health Act Manual (Jones 26th Edition)

Conclusion

As we move into 2025/26, this annual report has provided a valuable opportunity to reflect on the work of EPUT's Mental Health Act team over the past year. It has allowed us to acknowledge our achievements, assess challenges, and set a clear direction for the year ahead.

The report offers assurance that the Trust continues to operate within the legal framework of the Mental Health Act 1983, supported by robust systems, comprehensive policies, and a strong commitment to training. We also recognise the dedication of Mental Health Act team staff, whose work is central to ensuring that mental health services are delivered lawfully, ethically, and with continuous improvement.

Despite facing challenges related to the acuity and volume of admissions, the Mental Health Act team has successfully fulfilled its statutory responsibilities. We have addressed staffing gaps through recruitment and have invested in upskilling new team members to strengthen our capacity and resilience.

We continue to support AHMs in their statutory roles by providing high-quality learning and guidance aligned with the Mental Health Act and the Code of Practice (2015). Our collaboration with the advocacy provider has also been enhanced, particularly in relation to Independent Mental Health Advocacy (IMHA), with improved data sharing and a renewed focus on promoting advocacy engagement across our hospitals.

Strategic Priorities for 2025/26

- Preparing for the implementation of the new Mental Health Act
- Maintaining and reviewing Service Level Agreements to ensure operational effectiveness
- Evaluating and strengthening the Mental Health Act team structure
- Enhancing engagement with advocacy services, with a focus on accessibility and impact
- Review Mental Health Act training

Tendayi Musundire
Deputy Director of Nursing
(Responsible for Mental Health Act)

Appendix 1

A reflective analysis of the demographics of detained patients over the past four years

In some cases the percentages have been rounded up or down.

Total number of detentions by ethnic background

Ethnicity	2021/22		2022/23		2023/24		2024/25	
		%		%		%		%
White	1731	84%	1735	86%	1752	83%	1562	82%
Mixed	45	2%	64	3%	62	3%	58	3%
Asian / Asian British	58	3%	58	3%	70	4%	68	3%
Black / Black British	86	4%	82	4%	132	6%	116	6%
Other	50	3%	67	3%	63	3%	71	4%
Not stated	88	4%	17	1%	23	1%	40	2%
Total	**2058**		**2023**		**2102**		**1915**	

Data provided by EPUT's Information Department

Total number of detentions by gender

Gender	2021/22		2022/23		2023/24		2024/25	
		%		%		%		%
Female	1032	50%	967	48%	1042	49%	922	48%
Male	1024	49%	1035	51%	1048	50%	978	51%
Non-Binary	2	1%	21	1%	12	1%	10	0.5%
Other	0	0%	0	0%	0	0%	5	0.5%
Total	**2058**		**2023**		**2102**		**1915**	

Data provided by EPUT's Information Department

Total number of detentions by age

Age	2021/22		2022/23		2023/24		2024/25	
		%		%		%		%
18	77	4%	129	6%	124	6%	105	5%
18 -34	716	35%	637	31%	670	32%	644	34%
35 - 64	815	40%	804	40%	847	40%	754	39%

65+	450	22%	453	23%	461	22%	412	22%
Total	**2058**		**2023**		**2102**		**1915**	

Data provided by EPUT's Information Department

Total number of detention by section

Source	Section	2021/22	2022/23	2023/24	2024/25
Inpatient ward	5(4)	5	10	8	9
	5(2)	159	169	167	157
AMHP Assessment	2	1156	1049	1082	927
	3	554	584	638	606
	4	0	0	0	0
Court	35	1	0	0	1
	36	4	2	0	0
	37	16	13	11	17
	38	4	2	6	5
	45a	1	1	0	1
	47	4	3	5	5
	48	2	2	4	0
	37/41	7	18	7	7
	47/49	7	7	3	6
	48/49	15	18	11	4
Community	CTO	123	145	161	170
Total		**2058**	**2023**	**2102**	**1915**

Data provided by EPUT's Information Department

The data indicates over the last four years that there has been little change in the number of detained patients across the Trust.

Appendix 2

Lancashire and South Cumbria NHS Foundation Trust v Ms Moon

The ruling in the Lancashire and South Cumbria NHA Foundation Trust v Ms R Moon [2024] - essentially, the case looked at whether AHMs have any rights or protections under employment law.

Under Section 23 of the Mental Health Act, the Hospital Managers can delegate their statutory power to discharge from detention to panels of AHMs, none of whom can be an Executive Director or an employee of the Trust. People do not become employees or officers simply because they are paid a fee for serving on managers' panels." There is, however, a lack of statutory definition of the term 'employee' in the Mental Health Act and no detail underpinning how people are appointed to Hospital Managers' Panels and how the relationship with the appointing organisation works.

The AHMs involved in the Moon case had an honorary contract with the Trust for a fixed 3 year term and was paid a flat fee on a per session basis, with a specified minimum number of sessions expected to be undertaken per year and some requirements around training and appraisal. In our experience, this is an entirely standard arrangement for AHMs across the country.

Ms Moon argued in the employment tribunal that, despite her not being an existing Trust 'employee' in the sense meant in Section 23(6) MHA or in the narrow sense of Section 230(a) Employment Rights Act 1996 (ERA) – being an individual employed under a contract of service - she should have certain employment rights and protections. The mental health trust involved disagreed, pointing to the importance of AHMs being independent from the Trust, hence the statutory restriction on who can be authorised to exercise the Section 23 Powers of Discharge.

The employment tribunal found in favour of Ms Moon, concluding that the fact an AHM cannot be an 'employee' of the detaining organisation in the narrow sense does not mean they are inevitably without employment rights or protection. The mental health trust appealed this decision to the Employment Appeals Tribunal.

In its recent ruling, the Employment Appeals Tribunal upheld the Tribunal's original decision, agreeing that the independent decision-making required of AHMs does not mean they should be denied all employment rights or protections. Specifically, the Tribunal had been entitled to conclude that there was a contractual relationship between the AHM and the Trust and that there was nothing in the Mental Health Act or elsewhere to preclude her from being a 'worker' under the ERA and an 'employee' in the broader sense of the Equality Act 2010.

Following this ruling, the Trust sought advice from their solicitors whom on reviewing all the facts of the case concluded that the AHMs are of "worker" status which entitled AHMs to certain rights, these are:

- Protection against unlawful deduction from wages
- An itemised pay statement (if began work on or after 6 April 2020)
- National minimum wage
- Paid annual leave
- Rest breaks
- Maximum working week
- Right to be accompanied at a disciplinary or grievance hearing
- Protection for making a protected disclosure (Whistleblowing)
- Vicarious liability of the employer for the employee's tortious acts
- Protection under the Data Protection Act 2018
- Right to pension contributions from employer under the auto-enrolment scheme
- Protection under discrimination legislation

The Trust on recognition of AHMs being of worker status, revised the amount of remuneration they receive for the duties they undertake for the role of AHM to comply with the national minimum wage along with an uplift of 12.07% in respect of paid annual leave for each session undertaken. These changes came into effect as of the 1st May 2025.

Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex
SS11 7XX

Tel: 0300 123 0808
Email: epunft.marketing@nhs.net
Online: www.EPUT.nhs.uk

8.3 INFECTION AND CONTROL ANNUAL REPORT

Decision Item | AS | 11.25

REFERENCES

Only PDFs are attached

Infection Prevention and Control AR Oct 2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS Part 1	01 October 2025

Report Title:	**Infection Prevention & Control Annual Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Katheryn Hobbs Head of Infection Prevention and Control and Angela Wade Director of Nursing, Director of Infection Prevention and Control					
Report discussed previously at:	Quality of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with assurance that the Trust has delivered a robust, proactive and effective Infection Prevention and Control (IPC) service; and can demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the content of the report
- Approve the report for publication
- Request any further information or action

Summary of Key Issues

The purpose of this annual report is to provide assurance that the Trust has delivered a robust, proactive and effective Infection Prevention and Control (IPC) service; and can demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance. This assurance also extends to the Care Quality Commission's quality statements.

The aim of the IPC service is to ensure that all our patients are provided with care in a clean, safe environment by staff members who are competent and engaged with IPC practices.

The report outlines the achievements and activities in relation to IPC across the organisation during the year, giving focus to the national Code of Practice Board Assurance Framework.

Trust compliance with the Code of Practice Board Assurance Framework rose by 18% during the reporting period compared to the previous year.

The IPC team has continued to provide specialist advice to all areas of the organisation including clinical and non-clinical colleagues during the year.

Assurance of compliance with the Code of Practice has been provided through regular updating of the IPC Board Assurance Framework, which has been reviewed quarterly, and reported through the Quality Committee.

The IPC team are committed to ensuring learning from individual cases and outbreaks of health care associated infection. Learning is shared not only within the Trust, but also more widely across the health care system. Reflections and learning have been shared directly with those involved in cases, as well as via the Trust Learning Culture Platform and the monthly IPC Newsletter.

In order to provide assurance of compliance with the Hygiene Code, an audit programme is undertaken each year in part by the IPC team members, and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, environmental and equipment cleaning, and mattresses are audited.

The IPC team play an active role in essential safety meetings and groups including Water Quality, Ventilation Safety, Medical Devices and Harm Free Care. A quarterly Infection Prevention and Control Steering Group (IPCG) meeting is held as part of the wider clinical governance structures within the organisation, which includes engagement of key stakeholders.

Our commitment to closer working with our care system partners has seen us have regular discussion and policy alignment with our partners in the Mid and South Essex (MSE) Community Collaborative, taking into consideration differing needs of the sovereign organisations. The desired outcome is to maintain standards and reduce variation of practice, foster collaboration and provide consistency for patients across Essex. EPUT is the lead provider for IPC within our Mid and South Essex (MSE) Community Collaborative and continue to work closely with commissioning and provider colleagues across the whole geographical area of the Trust on a regular basis.

The team have maintained the provision of IPC training for staff as part of the Trust Induction Programme with ongoing mandatory training provided via E-learning through the national IPC training resources. Additionally, ad-hoc training sessions have been delivered by IPC team members within their care units, to support direct care needs and continuous learning and development opportunities.

Following the recognition of increased incidence of Group G strep, during the early part of 2024, the Head

of IPC and the Director of IPC delivered training to a forum of regional Deputy Chief Nurses, to share the lessons learned from the situation and its system wide management. A poster presentation was also delivered at the national Infection Prevention Society Conference on the same subject.

The team held a successful IPC Conference in autumn 2024, for colleagues from inpatient and community services, with over 60 colleagues in attendance. Delegates demonstrated a high level of engagement and commitment to supporting improvement in IPC in their workplace.

The Trust agreed IPC quality priorities during 2024 as part of the Trust's three-year Quality of Care delivery programme.

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

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

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

Acronyms/Terms Used in the Report			
IPC	Infection Prevention and Control		

Supporting Reports/ Appendices /or further reading
Infection Prevention and Control Annual Report 2024/25

Lead

Ann Sheridan

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control

ANNUAL REPORT 2024-2025

EPUT

CONTENTS

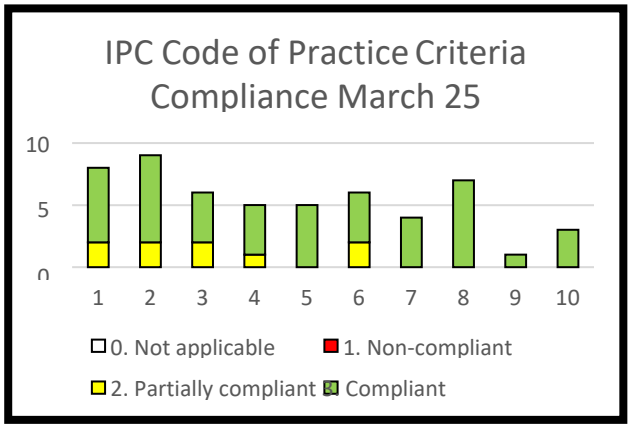
EXECUTIVE SUMMARY

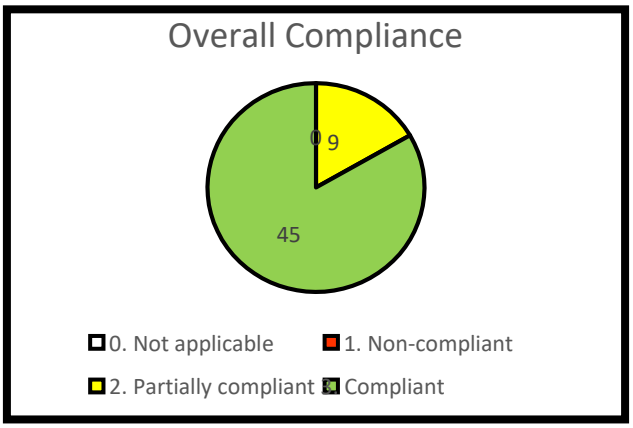
This annual report is presented using the National Code of Practice Board Assurance Framework domains for Infection Prevention and Control; there are 10 criterion within this code of practice and aligns to the National Infection Prevention and Control Manual.

The purpose of this report is to provide assurance that the Trust has delivered a robust, proactive and effective Infection Prevention and Control (IPC) Service; and can demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance, including the Care Quality Commission's quality statements.

The report outlines the achievements and impact in relation to IPC practice across the organisation during the year.

Trust compliance with the Code of Practice Board Assurance Framework improved by a further 18% during the reporting period compared to the previous year. The Trust is now fully compliant in 45 of the 54 (83%) elements of the IPC Code of Practice Criteria.





The areas assessed as partially compliant are summarised:

- Criteria 1: Systems to manage and monitor the prevention and control of infection: Yearly mandatory training is amber at 80%: **Action to move to full compliance** - Mandatory training compliance is monitored in care groups Accountability Framework meetings chaired by the Executive team who will work with care groups to ensure compliance with training.
- Criteria 2: The provision and maintenance of a clean and appropriate environment **Action to move to full compliance** - Plan in place to continue the environment maintenance programme. Water maintenance programme identified areas that required urgent work which has been completed.
- Criteria 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance **Action to move to full compliance** - Systems and processes are

in place and while the Trust does not have a permanent Antimicrobial Specialist Pharmacist, the responsibilities have been delegated to the inpatient pharmacy with oversight from the Trust senior pharmacy team.

- Criteria 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion: **Action to move to full compliance** - The IPC team to continue to produce information and the Patient Information Group are working with the team to support information in Plain English with people with lived experience, this will be possible when the development of the IPC dashboard is completed and provides quality assurance data. The expected timeline for this is by the end of 2025.
- Criteria 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection: Infection control audits have seen an increase in compliance across all care groups with the target of over 85% compliance being reached by all care groups. **Action to move to full compliance** - The compliance with mandatory training and local audits will be monitored through the care group's Accountability Framework meetings supporting the road to compliance.

Introduction

The aim of the IPC service is to ensure that all our patients are provided with care in a clean, safe environment by staff members who are competent and engaged with IPC practices.

The IPC team have continued to provide specialist advice to all areas of the organisation including clinical and non-clinical colleagues during the year.
Assurance of compliance with the Code of Practice has been provided through regular updating of the IPC Board Assurance Framework, which has been reviewed quarterly, and reported through the Quality Committee.

The IPC team are committed to ensuring learning from individual cases and outbreaks of health care associated infection. Learning is shared not only within the Trust but also more widely across the health care system. Reflections and learning have been shared directly with those involved in cases, as well as via the Trust Learning Culture Platform and the monthly IPC Newsletter.

In order to provide assurance of compliance with the Hygiene Code, an audit programme is undertaken each year, in part by the IPC team members and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, environmental and equipment cleaning, and mattresses are audited.

The IPC team play an active role in essential safety meetings and groups including Water Quality, Ventilation Safety, Medical Devices and Harm Free Care. A quarterly Infection Prevention and Control Steering Group (IPCG) meeting is held as a part of

the wider clinical governance structures within the organisation, which includes engagement of key stakeholders.

Our commitment to closer working with our care system partners has led to regular discussion and policy alignment with our partners in the Mid and South Essex Community Collaborative, taking into consideration the differing needs of the sovereign organisations. The desired outcome is to maintain standards and reduce variation of practice, foster collaboration and provide consistency for patients across Essex. EPUT is the lead provider for IPC within our Mid and South Essex (MSE) Community Collaborative and continues to work closely with commissioning and provider colleagues across the whole geographical area of the Trust on a regular basis.

The team have maintained the provision of IPC training for staff as part of the Trust Induction Programme with ongoing mandatory training provided via E-learning through the National IPC Training Resources. Additionally, ad-hoc training sessions have been delivered by IPC team members within their care units, to support direct care needs and continuous learning and development opportunities.

Following the recognition of increased incidence of Group G strep, during the early part of 2024, the Head of IPC and the Director of IPC delivered training to a forum of regional Deputy Chief Nurses to share the lessons learned from the situation and its system wide management. A poster presentation was also delivered at the National Infection Prevention Society Conference on the same subject.

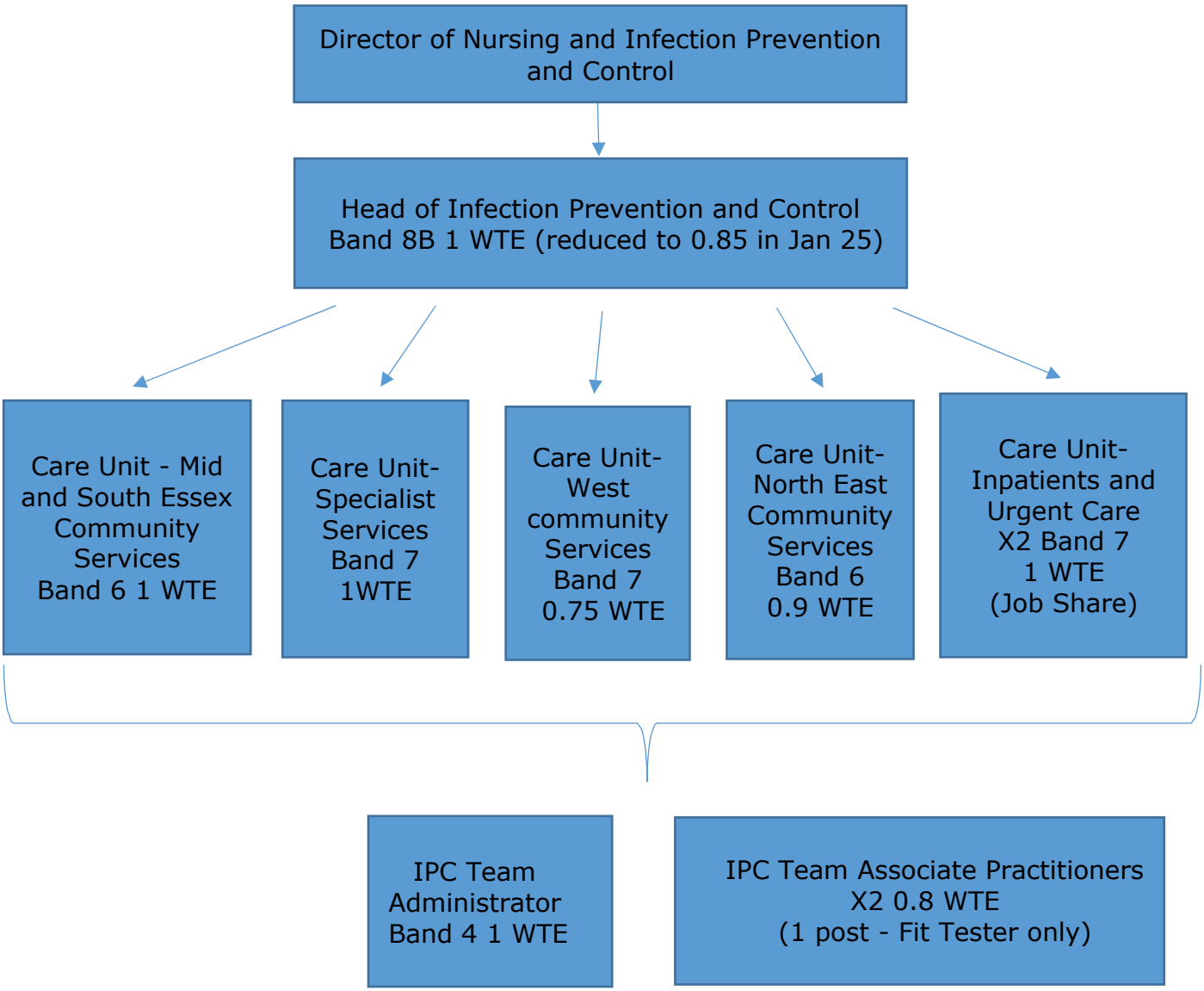
The team held a successful IPC Conference in autumn 2024, for colleagues from inpatient and community services, with over 60 colleagues in attendance. Delegates demonstrated a high level of engagement and commitment to supporting improvement in IPC in their workplace.

The Trust agreed IPC quality priorities during 2024 as part of the Trust's three-year Quality of Care delivery programme. Summary of planned activity can be seen in appendix 1 with evidence provided in the main body of the annual report; this programme of work will continue into 25/26.

REPORT
Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

The Trust has acknowledged the key role that the IPC team play in the provision of safe care for patients and reduction of risk to staff. As a result, the structure of the team aligns with the organisation strategy of a care unit/ specialty approach.



The IPC team members within the care units, work in collaboration with the Deputy Directors of Quality and Safety (DDQS), establishing a good understanding of the services provided in the care unit and building positive working relationships with the staff in order to increase staff engagement and therefore, quality of care.

A Service Level Agreement continues with a Consultant Microbiologist who works within the local acute trust and provides expert clinical advice to the organisation and on an individual basis when required.

A quarterly Infection Prevention and Control Steering Group is chaired by the Director of IPC or Head of IPC with key Trust and system partner stakeholder attendance and engagement, including clinical, occupational health and estates and facilities representation, and provides oversight and assessment of IPC assurance across the Trust. Meetings are also attended by the three commissioning boards.

IPC Information Training and Supervision:

The IPC team deliver induction training as part of the Trust Corporate Induction Programme.

Mandatory training is provided for all staff using the Oracle Learning Management Platform. The Trust has procured IPC training via the National Skills for Health Programme to ensure training is updated in a timely manner as changes in national guidelines are made, as well as to align with our partner community Trust organisations.

As of the end of March 2025, the Trust's Training Department has reported compliance with IPC mandatory training as follows:

1 Yearly Mandatory Training Compliance (Level 2)	3 Yearly Mandatory Training Compliance (Level 1)
80%	94%

Ad-hoc training is delivered in the workplace by the IPC team as required, following audit, site visits or as part of lessons learned following incidents of health care associated infection or nosocomial outbreaks.

The monthly IPC Newsletter is available on the Intranet focusing on education relating to topics e.g. measles identification and management. It is an opportunity to promote IPC events, share good IPC practice from clinical areas, and share learning points from IPC incidents or site visits. It is circulated via EPUT's weekly communications once a month to reach as many staff as possible. An example of the newsletter can be seen by clicking on the link below.

IPC Newsletter January 2025 .pdf

Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Water Management:

This is important because water systems can be a reservoir for pathogens; failures can lead to serious infections among vulnerable inpatients. Ensuring safe water protects patients, staff, and visitors.

All Water Risk Assessments (WRA), which expired during the year, have an agreed completion programme. Following discussions and engagement with the Water Quality Group (WQG), IPC, Estates and Water Authorising Engineer (AE), a new frequency tool has been completed and implemented to enable WRAs to be completed on buildings based on the risk profile

Thermostatic mixing valves (TMVs) are an integral part of the Trust's water systems ensuring water temperatures are regulated to water outlets and are required to have a comprehensive pre-planned maintenance programme to negate the build-up and release of biofilm. The Trust has a rolling programme of works for completion of 6 monthly failsafe tests to ensure compliance and yearly strip down and disinfections.

The Trust's Ventilation Safety Group (VSG) continues to meet on a quarterly basis.

The Estates & Facilities team undertook a comprehensive Legionella Awareness training programme in line with the Trust's Water Policy - frequency of 3 years. Overall, 93% of Estates & Facilities team and IPC staff have been trained on legionella awareness and renewal of training will be programmed in for the coming year

There is a comprehensive programme in place to address any water concerns identified following sampling with oversight from the WQG. Evaluation of data from the Trust's water monitoring system identifies risks, such as temperature control monitoring within plant and outlets allowing for water pre planned maintenance.

Estates Capital Projects 2024/2025 Programme:




The 2024/2025 Capital Works Programme focused on delivering environmental upgrades at The Lakes, Linden Centre and Kingswood Centre:

- Kingswood Centre - Henneage and Peter Bruff
- The Lakes – Ardleigh and Gosfield
- The Linden Centre - Finchingfield and Galleywood

Works were identified on all six wards through collaborative engagement with our Estates and Facilities colleagues, as well as clinical teams to address areas of concern and enhance the care environment.

The scope of works included the replacement of vinyl flooring and Trovex wall cladding in bathroom and WC areas which had damaged flooring and damp bath frames. These elements were fully renewed as part of the works.

Kitchen and beverage bay areas were also upgraded with new flooring, Trovex wall cladding and the installation of washable cabinets. At The Lakes, a damp en-suite and bedroom was fully stripped out with new vinyl flooring and stud wall with Trovex wall cladding. Corridors and bedrooms across the facilities were redecorated using Dulux Sterishield paint, which contains an in-film bactericide proven to inhibit the growth of harmful bacteria including MRSA and E. coli.

Additionally, new washable curtains were installed in the bedrooms at both The Lakes and Kingswood Centre. These curtains are manufactured using Panaz Shieldplus anti-microbial fabric. Two sets per bedroom were provided to enable regular laundering without disrupting patients.

Finally, the food storage area at The Lakes was refurbished with hygienic, wipe-clean finishes, including high-gloss storage units, Trovex wall cladding and cap-and-cove vinyl flooring to ensure the Facilities team can clean to a high standard.

Kitchen improvement works were also undertaken on Kitwood and Roding wards.

Clinical teams and patients were involved in some of the decision-making processes with regard to refurbishments.

Facilities:

The EPUT Facilities team are responsible for ensuring that the Trust is delivering a high quality and safe environment that meets the needs and expectations of patients, the staff and public, contributing to the overall patient experience and high quality patient centered care.

Facilities deliver a high-quality Soft Facilities Management (FM) healthcare service that aims to ensure that all Soft FM related risks are identified, minimised and managed on a consistent and long term basis in line with Risk Management and Infection Prevention and Control regulations.

Domestic Services staff work across all areas of the Trust making sure that all facilities and environments are clean and safe places where staff can care for patients while reducing the risk of infection.

The Domestic Services staff provides a routine and responsive service in accordance with the National Standards of Healthcare Cleanliness. Staff are trained and adhere to robust methods statements and IPC guidance.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the new national standards. Feedback is given to staff on the areas from these audits.

We have introduced a star rating scheme for all inpatient wards as recommended in the national cleaning standards. These are displayed at or near ward entrances.

Facilities Managers have undertaken the cleaning efficacy audits to measure the effectiveness of our cleaning service.

Annual Summary of cleaning efficacy audits 2024/2025	North	South	West	Averages
Functional Risk Cat 2	96%	98%	97%	97.00%
Functional Risk Cat 3	96%	96%	95%	95.66%
Functional Risk Cat 4	94%	96%	97%	95.66%

Catering

All healthcare organisations have a responsibility to provide the highest level of care possible for their patients, staff and visitors. This includes the quality, nutritional value and the sustainable aspects of the food and drink that is served, as well as the overall experience and environment in which it is eaten.

EPUT recognises the intrinsic value in the view of 'food as medicine' and remains a prevalent subject on the Trust agenda.

The standards describe the methods by which organisations must ensure the quality and sustainability of their food and drink provision for patients, staff and visitors and how they should be applied and monitored, as well as recommending future improvements, aspirations and actions.

The Trust has implemented a number of measures to comply with the National Standard of Healthcare – Food and Drink including:

- A specific tailored food safety training has been successfully rolled out and is accessible to all staff on a shared drive
- Random food spot checks across the Trust are now embedded into daily routines at all sites
- Food auditing firmly in place will all Environmental Health Officer inspections awarded at the highest mark of 5 star, including revisits
- 100% of all main sites are meeting or surpassing the minimum 90% standard set by the Trust on all food audits

- A food safety league table has been created.
- EPUT has instigated a quartiles supplier meeting to review all aspects with partners
- EPUT has instigated a tendering process across all food supply partners
- EPUT continues to work closely with the Food Agency on food safety alerts across the country

Progress continues to be monitored via internal departmental meetings.

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Stewardship (AMS) is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. Antibiotics should never be prescribed or supplied for viral infections.

Antimicrobial prescribing continues to be audited within the organisation on an annual basis as part of the Code of Practice, which supports compliance with the Health and Social Care Act (2008). All prescriptions of antimicrobials within the organisation are governed by national and local prescribing guidelines, which advocate the use of specific antimicrobials for a specified period of time. Non-formulary antimicrobials are only available following advice from consultant microbiology colleagues in the local acute trusts. These are not dispensed by Pharmacy unless assurances are received that the prescription has been discussed and agreed. Prescriptions for inpatient settings are clinically screened by a Pharmacist for:

- Appropriateness including route, dose, duration and frequency taking into account patient co-morbidities
- Selection of antimicrobial according to guidelines for specific clinical indications and any microbiological samples
- Length of treatment and potential switches from IV to oral (only applicable in community health service settings)

Education relating to AMS is promoted by the annual audit of antimicrobial prescribing and taught in the mandatory Medicines Management training courses for both medical and nursing staff.

In 2023, an Antibiotic Stewardship Group was formed which sits separately to the existing IPC Group. The group reports directly to the Medicines Management Group with a responsibility to feed any relevant decisions into the IPC Group. Membership includes the Director of IPC, Microbiologist, Pharmacist Lead, Head of IPC, Quality Leads and representation from nursing and medical teams.

The Medicines Management has allocated the Antimicrobial Specialist Pharmacist responsibilities to an inpatient pharmacist who will support this agenda.

The remit of the group aligns with the Health and Social Care Act 2008, Criterion 3: antimicrobial use, and focusses on:

- Monitoring the use of antimicrobials across the Trust to ensure inappropriate and harmful use is minimised, drawing on local or national guidance where appropriate
- Education and training to medical, nursing /pharmacy staff, promoting constant review of prescriptions and embedding an awareness in the Trust
- Promotion of European Antibiotic Awareness Day

Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The IPC team has developed patient information leaflets on MRSA, clostridioides difficile, norovirus, hand hygiene and general advice for patients and visitors, to ensure that those we care for have access to appropriate information relating to common infections and how to assist in preventing their transmission.

The Patient Information and Plain English (PIPE) Group has been actively involved in the review and an integral part of the development process.

Criterion 5

There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

IPC Policy and Clinical Guideline Reviews undertaken in 2024-2025:

All IPC policies are reviewed on a three yearly basis or when national guidance changes. In the reporting period, the following sections of ICPG1 were reviewed:

- ICPG1 Infection Prevention and Control Procedural Guidelines – Section 9: Prevention and Management of Sharps Injuries and Contamination Incidents
- ICPG1 Infection Prevention and Control Procedural Guidelines - Section 6: Management of Clostridioides Infection

Cases of Reportable Health Care Associated Infection in 2024/25:

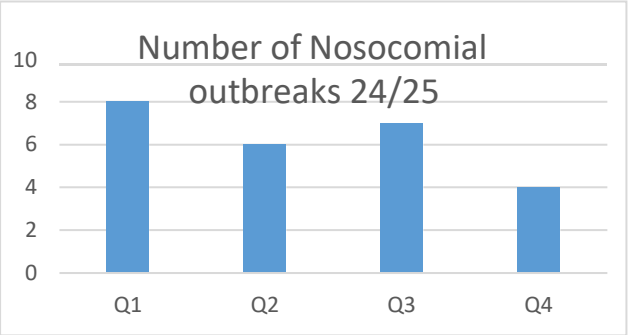
All cases of mandatory reportable healthcare associated infection are fully investigated with the clinical team involved and a post infection review processto identify any learning follows:

Clostridioides *difficile* – C. *difficile* incidence is assessed as cases detected after 3 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.	5 cases in total were detected after 3 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 attributed to the Trust.
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.

This shows sustained achievement of zero cases of MRSA bacteraemia and Gram-negative blood stream infections over the past 2 years. There has been an increase in C.difficile incidence from 2023/34 from 2 to 5 cases, each case has been reviewed with the clinical teams to identify learning for practice improvement.

Outbreak Management:

The definition of outbreak is two or more connected cases of infectious disease in either patients, staff or visitors. The prevalence rate within services often has been commensurate with community prevalence rates. The number of outbreaks has reduced significantly in the previous two years and is attributable to the ending of the COVID-19 pandemic.



The IPC team has continued to ensure that all outbreaks have been reported in line with local and regional requirements. Lessons learned have been identified and shared with teams involved and via the Trust governance meetings and Learning Culture Partnership.

Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

All Trust job descriptions have IPC responsibilities included within them as detailed below:

The post holder is accountable and responsible for the prevention of healthcare associated infections by complying with all Infection Prevention & Control policies and procedures in line with legislation (Health Act 2006; Code of Practice for the Prevention and Control of Healthcare Associated Infections).

All staff are encouraged to professionally challenge colleagues and be challenged themselves if they are not compliant with IPC policies. Additional training for staff is provided by the IPC team ad-hoc within the workplace as a need is identified to support best practice

As per Criterion 1, all staff attend Trust Induction where an IPC session is delivered by the IPC team, and all staff are to complete online mandatory training (clinical and non-clinical) - National Skills for Health E-learning module, which is automatically updated if national changes in practice occur; ensuring the programme is current.

All staff can access IPC contact details, guidance and policies on the IPC page on the Intranet.

The IPC team celebrated Global Hand Hygiene Day in May 2024 with increased site visits to staff from all specialties including those who support clinical colleagues. The focus being on the use of gloves to ensure hand hygiene was performed appropriately as well as thinking about the environmental impact of using gloves at inappropriate times. Two members of the IPC team also delivered training on these issues at a number of forums across the organisation.

IPC Link Champions:

IPC is seen at EPUT as an important patient safety and quality element for high quality patient outcomes together with staff engagement and work satisfaction. Therefore, during 2024, work continued to develop the IPC Link Champions monthly forum to provide education and Q&A opportunities drawing from the learning from recent incidents and audits, queries to the IPC team, national and local outbreaks, together with emerging points of interest. These included sharps management awareness; outbreak management; oral health; MRSA; Group A streptococcus infection; Facilities & Estates team function and how this supports best practice.

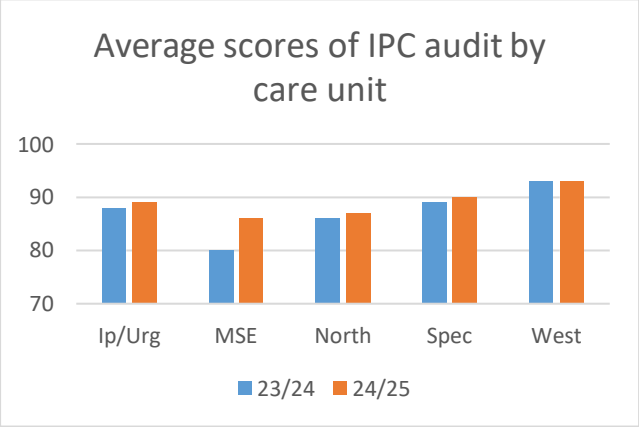
An IPC Conference was held in November 2024 with delegate numbers exceeding sixty. The feedback was positive, and staff were able to engage and network with each other as well as external colleagues who supported the event with educational displays.

Audit Programme:

Environmental audits are carried out on an annual basis by the IPC team and involve revisits to areas to reassess any deficits highlighted in the audit.

The audit is based on the Infection Control Nurses Association (ICNA) Audit Tool, which has been amended to take into account mental health settings and is carried out using the ICAT Electronic Auditing Platform. This is an extremely stringent and thorough audit that assesses every room in each clinical area, thus providing a comprehensive and in-depth view of cleanliness, status of fixtures, fittings, furniture and infection control procedures and processes.

A comparison between 23/24 and 24/25 can be seen below for each care unit, which shows a positive improvement over the last year. Overall, the target of over 85% compliance has been reached in each care unit.



The enhanced cleaning audits are addressed by the action plan, and any training identified by the current themes are incorporated into both formal and informal training sessions.

The IPC team has continued to provide additional support in between formal audits by way of ad-hoc site visits.

The IPC team encourage communication and partnership working with other providers and building landlords in order to address areas for improvement and have worked closely with EPUT's Estates and Facilities team as well as care unit colleagues in order to identify areas of concern and support resolution. The addition of the DDQS role within care units has also reinforced the need for accountability and provide the additional experiential support for clinical teams to take timely improvement action.

Quality Assurance Visits (QAV):

As the year has progressed, the IPC team has been involved in peer review visits between EPUT and Norfolk and Suffolk Foundation Trust to share best practices and identify elements for improvement in some of our sites. This has proved to be beneficial to both organisations, with further peer reviews planned for the coming year.

Mid and South Essex commissioning colleagues have undertaken several QAVs with the most recent in Basildon MH Unit receiving very positive feedback:

"First impression of all areas visited was a minimalist environment which was clean, tidy, calm and well organised. In summary, the visit provided assurance with good IPC standards across the hospital. There was evidence that staff from top down are invested in providing good effective clean and safe care for their patients. All staff engaged with were able to discuss their IPC practices, demonstrating sound IPC knowledge. A very positive visit".

Themes highlighted that wards require more storage facilities, cleaning of fans, inappropriate use of "I am clean" stickers, hand gel to be in wall mountable dispensers, remove tape, evidence or replacing/cleaning curtains schedule required. Full reports have been shared to address recommendations made which are monitored through the care unit quality and safety meetings.

Internal QAVs are undertaken by a team of colleagues led by the Compliance team, supported with audit and action planning information supplied by the IPC team. These visits have assisted in further escalation of certain environmental concerns previously raised; but have also highlighted some of the good clinical practices seen.

Self-Audit within Inpatient Wards:

The Inpatient IPC Audit Tool is designed for completion on a quarterly basis and is carried out using the Tendable electronic auditing platform. It is a means of self-audit and a way of capturing IPC practices as well as environmental standards. Ongoing assurance is provided by the use of Ward Manager and Matron Audits also available on the Tendable platform.

Audit results are now shared in the Quality and Safety Dashboard. Development of the IPC Dashboard, in collaboration with the Performance team, is progressing. The initial aim is to include both inpatient team self-audits and IPC team environmental audits.

Fit Testing for FFP3 Masks:

Fit testing of FFP3 masks is an essential element of long-term preparedness, not only for future pandemics, but also for use with patients who are suspected or known to have diseases of high consequence and other infections transmitted by the respiratory route such as Influenza, Measles, and Chicken Pox. Relevant staff should be fit tested every two years if organisations are to evidence they are protecting staff in accordance with National Health and Safety Guidelines.

The IPC team continue to provide some level of fit testing for relevant staff as part of the wider work stream; and have provided external accredited training for twenty-two staff within the care units to encourage active support of the programme.

During the last two years, 26% of relevant staff have been seen for fit testing (1309) out of a denominator of 5052 (including bank staff). In the coming year, the aim is to report on compliance via care units with the addition of a quarterly denominator to enable accurate data production.

The IPC team has recruited a Fit Tester (joining in April 2025) to assist in the development of fit testing as an ongoing project, as well as providing practical fit testing and support for those colleagues already trained. Additionally, the IPC team has seen several changes in personnel over the last year and by the end of March 2025, had a fully staffed team recruited, including this team member recruited to support the fit testing of FFP3 masks for relevant staff.

Criterion 7

The provision or ability to secure adequate isolation facilities.

Trust inpatient services are provided using bays of beds and individual side rooms, many of which have ensuite bathrooms. This means that patients who require isolation can be accommodated. However, it must be noted that not all side rooms are ensuite and individual risk assessments should be carried out by the clinical team to ensure a safe approach is taken in situations where patients require isolation due to infectious reasons.

A further point to note is that due to the provision of rehabilitation services provided across the Trust, EPUT inpatient services have communal social, activity and eating areas allowing patients to participate in active rehabilitation. However, if a patient is required to isolate due to infection, provision is made for them as individuals following a risk assessment undertaken by the clinical team with the support of the IPC nurses.

Ward closure decisions may be made as part of outbreak management. Outbreak meetings specify that wards will not admit patients during the emerging and critical stages of an outbreak of infection. However, it is acknowledged that for a variety of clinical reasons the risk of not admitting would be greater than the risk of transmission of infection. A clinical risk assessment is to be carried out and fully documented by the clinical team with support of the IPCT if required.

Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

Contracts are in place with accredited pathology services, provided by acute NHS trusts, across the geographical area.

Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

An overarching IPC Policy is accessible to all staff via the Intranet page which includes the following subject matters:

- Common infectious diseases
- Standard precautions
- Infection control in clinical practice
- Communicable diseases and outbreak control
- Prevention and management of MRSA
- Prevention and management of *clostridioides difficile*
- Prevention and management of tuberculosis
- Prevention and management of infestations
- Prevention and management of sharps injuries and contamination incidents
- Pets and pests
- Care and decontamination of mattresses
- MPox

Each policy is subject to review on a three yearly cycle or as national guidance changes. Each policy is informed by the National Infection Prevention and Control Manual for England.

All policy and guideline reviews include comment from expert colleagues who form the Infection Prevention and Control Group

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Occupational Health (OH) Services:

The Trust Employee Occupational Health (OH) Service are contracted via an external provider which commenced in June 2024.

Staff can access their services and advice using a range of methods including via telephone, posters, guidance on the Intranet page. Line managers can signpost information to their staff as well as access to make referrals and view reports for their team members via the OH portal. OH policies and procedures can be accessed on the Intranet pages.

The Trust Human Resources team work together with OH in relation to the organisation Sickness Policy and the IPC team provide general principles relating to staff becoming unwell during the delivery of the Trust Induction Programme, and these are also covered in the National Mandatory Training Skills for Health E-learning Module that all staff undertake.

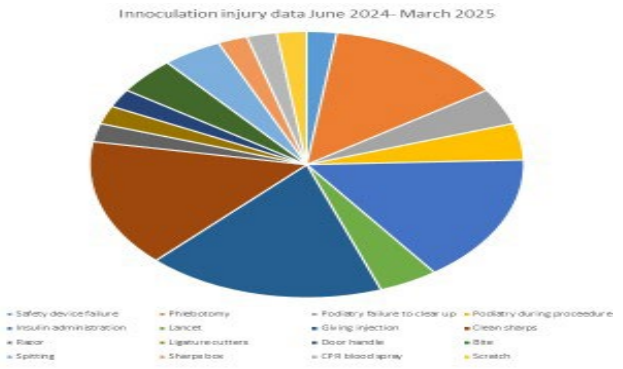
Sharps Injuries:

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 are a key piece of legislation in the NHS UK that aims to protect healthcare workers from the risk of sharps injuries. These regulations require healthcare employers to take steps to prevent healthcare staff from being exposed to infectious agents from sharps injuries, so far as it is reasonably practicable to do so.

Key points include:

- Definition of Sharps: Sharps are defined as objects or instruments necessary for healthcare activities that can cut, prick, or cause injury, including needles and scalpels.
- Risk Assessment: Employers must assess the risks associated with sharps use and implement appropriate control measures.
- Training and Information: Employers are required to provide training and information to employees on the safe handling and disposal of sharps.
- Record Keeping: Employers must maintain records of sharps incidents and investigate them as necessary.
- Safer Sharps: Employers must use safer sharps where possible and ensure that any sharps used are not capped after use unless necessary.
- The Trust's OH provider lead on risk assessments and providing expert advice for staff sustaining sharps injuries, calling on the IPC team if required. An in-hours and out-of-hours telephone numberis provided for staff to call, should they sustain a sharps or bodily fluid contamination injury.

A review of inoculation injuries has been undertaken by the IPC team and OH provider to assist in the identification of lessons learned and training opportunities for the year ahead, and lessons identified have been taken forward with clinical teams and Estates and Facilities as a result.

When?	• Data from the datix system and OH records was reviewed from June 2024 (when new OH contract commenced) until end of March 2025
Findings	• A total of 37 datix reports were completed- of these 4 were near misses and 2 were incidents affecting a patient • A further 15 staff members contacted Occupational Health reporting injuries that were not reported via the datix system
Themes	• 2 students had a clean injury and 1 student had a dirty injury • 4 injuries sustained in podiatry services. At least 2 of these were as a result of failure to clear up immediately after use of a sharp • 5 injuries were sustained during/ after insulin administration • 6 injuries were sustained during phlebotomy procedure • 4 were linked to post injection administration • 2 linked to use of razors (1 of these was a patient) • 7 were identified as clean sharps and therefore low risk
Themes identified	
"SO what now what"/ Lessons learned	• Review/ scoping of safer sharps in use with procurement to include insulin needles • IPC to link in with waste manager to review progress of audit and on-site training in relation to sharps disposal to ensure best practice

Staff Swabbing During Outbreaks of Infection:

The Trust continues to use the services of an external contractor as part of the ICB contract for the swabbing of staff in outbreaks of infection such as Group A strep as these services are not currently provided by the current Occupational Health service provider.

Immunisations:

Our Occupational Health provider team, collect and keep records of staff immunisations as part of the New Joiner Risk Based Screening Assessment. Any immunisation recommendations made by them align with the National Green Book. Although a regular review of immunisation status is not currently undertaken, if staff members change their role whilst working with the organisation, immunisation status is checked again at that point by OH services as part of the recruitment service.
Patients who were being cared for as inpatients during the winter season were offered Influenza vaccination as well as those who met the criteria for COVID-19 vaccination.

All staff were offered a free Influenza vaccination each year and were also offered all relevant Covid vaccinations as part of the national vaccinations' programmes. Vaccinations were provided by the Trust Vaccination service, with support from the OH services and IPC team.

Quality Priority

The Trust agreed IPC focused quality priorities during 2024 as part of the Trust's first year of the Quality of Care delivery programme to report through the annual Quality Account.

Infection Prevention and Control Safety Priority 2

Why was this a priority?

The statutory requirements of the Health & Social Care Act (2010) Regulation 12, as detailed in the Code of Practice for the Prevention & Control of Infections, and compliance assessed against the NHS England IPC Board Assurance Framework was the foundation of this priority, outlining our ongoing commitment to promote best practice in IPC and sustaining a low number of Health Care Acquired Infections (HCAIs) across our services. Led by our specialist IPC team, through expert knowledge and guidance, development of strong collaborative relationships, not just with other key EPUT teams, but with those external to the organisation, to assist in the delivery of improved practice and environments for the safety of our patients.

What did we say we would do?

5 priority areas were agreed during the planning phase using the Trust's Quality assurance framework approach (see appendix 1). Review of practices in community settings through standardisation of practice across the Trust, including training in aseptic non-touch technique, update and adhering to clinical guidelines, undertaking environmental checks and increasing IPC Champions. Measuring through performance data monitored against IPC standards compliance, peer review visits and appreciative inquiry with patients and staff. Our expected outcome aim was a 10 % improvement in IPC standards in care and environment by year end.

Did we achieve this?

EPUT has continued to make sustained progress in achieving the key IPC priority; review of practice in community settings.

For the year ending March 2025, EPUT declared IPC standards in care and environment compliance at 83% which is an improvement of 18% from last year.

Reviews of practice in community settings continue on an ongoing basis. The IPC team has recruited an IPC nurse to work closely with the teams in Mid and South Essex (MSE) to replace a colleague who left the organisation in Quarter 3.

This review work will continue into the coming year.

A large-scale quality improvement project in relation to Aseptic Non-Touch Technique (ANTT) has now been agreed to be taken forward as part of the Mid and South Essex (MSE) community collaborative; a collaborative which includes the three provider organisations who deliver community health services in that

locality, to standardise care and practice approaches through collaboration and ensure quality standards are achieved consistently for the population, reducing unwarranted variation across service provision. To date, a review of community practices in relation to ANTT and discussions with community collaborative colleagues have identified the need to provide staff with increased education and competency assessment in the management of wounds as well as other invasive procedures. The IPC Community Collaborative Group, led by EPUT, are in the early stages of formulating a shared proposal. This piece of work will roll over into 25/26 and will involve key stakeholders from the community collaborative members to take the QI project forward.

Our IPC Link Practitioner forums have had variable attendance rates and so are under review for the coming year to make the sessions more meaningful as well as encourage greater engagement. Through the introduction of IPC Link Champions in the community setting, we were able to create a psychologically safe forum environment that the identification of increased incidence of Group G Strep was identified. The learning identified through system partner review, including the ICB and UKHCA, led to presentations locally, regionally and nationally.

As the year has progressed, the IPC team has been involved in peer review visits between EPUT and Norfolk and Suffolk Foundation Trust to share best practices and identify elements for improvement in some of our sites. This has proved to be beneficial to both organisations, with further peer reviews planned for the coming year.

Internal quality assurance visits are undertaken by a team of colleagues led by the Compliance team, supported with audit and action planning information supplied by the IPC team. These visits have assisted in further escalation of certain environmental concerns previously raised and have also highlighted some of the good clinical practices seen.

The approved IPC programme of work will continue into years 2 and 3, reporting bi-annually to the Quality Committee. There will not be a specific IPC quality priority set for 25/26

SUMMARY

Key Infection Prevention and Control Achievements to Drive Positive Impact and Care Improvement in the Organisation:

- Provision of expert advice and leadership on the management of nosocomial outbreaks of infection within the organisation
- Quarterly review and submission of the National Board Assurance Framework
- Maintained levels of support in relation to all related IPC issues/queries
- Supportive site visits for clinical and non-clinical staff and provided bespoke responses to team IPC needs
- Carried out yearly IPC audits as per the annual Audit Programme to assist teams in identifying and actioning areas of good practice and improvement in accordance with evidence based best practice and National Technical Memorandum Standards
- Collaboration with the Facilities and Estates team in refurbishment and change of use projects, providing advice to align with the National Health Technical Memorandums to ensure healthcare standards were met when changes of use or refurbishment projects were in the planning stages
- Attendance at and provision of expert IPC advice at the Trust Water and Ventilation Safety Committees
- Collaboration between IPC, Facilities and Estates and clinical teams in the safe management of water quality issues linked to positive legionella results
- Collaboration with ICB specialists in urinary catheter care to support reduction in gram negative infections as well as work towards evidence based best practices across the system
- Active member of the Harm Free Care Group focusing on the physical health of patients within our care
- Provision of shadowing opportunities for staff and students
- Ongoing collaboration with Facilities and Estates colleagues to review clinical hand wash sink provision within the organisation, in order to meet current Health Technical Memorandum Standards
- Hand hygiene week kick started a focus on the appropriate use of gloves, not only to improve hand hygiene, but also to support a more sustainable approach to IPC, in collaboration with the Trust Sustainability Lead
- Hosted an IPC Conference for Trust staff in November 2024 which was well attended with staff who demonstrated real engagement with IPC
- Continued a monthly IPC Link Champion Forum as an education and Q&A platform
- Continued the Community Collaborative Band 6 Network Forum for IPC nurses across the geography of Mid and South Essex
- Supported the Staff Influenza Vaccination Campaign which was led by EPUT Vaccination teams

- Lead provider of the MSE Community IPC Collaborative Work stream working to unify aspects of IPC standards and policy across Essex
- Delivery of the Trust Induction Programme for staff
- Provision of ad-hoc training sessions in the workplace for staff
- Creation of a monthly IPC Newsletter providing updates, education and lessons learned whilst out in the clinical areas
- Provided expert IPC advice to EPUT teams working with migrant populations across the geography of the Trust
- Review of IPC guidelines
- Provision of fit testing for FPF3 masks for relevant staff on behalf of the organisation as part of wider role
- Collaborative working with Trust Performance team to establish IPC Dashboard
- Peer review visits with colleagues from Norfolk and Suffolk Foundation Trust
- Commenced work on staff scoping exercise in relation to oral health
- Secured the support of a Lived Experience Ambassador for IPC
- Collaborative working with the Trust Audit team reviewing/ streamlining the Tendable audit programme to ensure IPC representation remains within audit tools
- Facilitated initial governance discussions with key stakeholders in relation to potential new services being commenced at Saffron Walden outpatients
- Embed a "getting it right first time" approach in IPC by applying the right precautions immediately, consistency of practices, learning and improvements built into all incidents with compliance with training.

Appendix 1

Priority 1: Improved patient environment	• Support of Estates led water and ventilation safety meetings • Undertake yearly IPC environmental audits across the organisation, providing expert advice on and supporting improvements to be led by operational colleagues • Attendance at capital projects meetings to provide feedback on environmental auditing and compliance with Health Technical Memorandum • Collaboration with Trust Facilities team to ensure high standards of cleanliness where Trust services are delivered • Collaborative approach to IPC walk rounds with Estates, Facilities and Operational colleagues
Priority 2: Systems to manage & monitor the prevention and control of infection	• Development of IPC dashboard which will give clinical leaders and Corporate colleagues oversight at a glance and the ability to work through IPC challenges with the IPC team and other key stake holders, themes can be easily identified and be acted upon at local and trust level to support evidence based best practice. • Roll out of community and out patient audit tools • Investigation into robust alert organism surveillance system to provide timely relevant information as part of collaborative work with system partners including ICB
Priority 3: Systems to ensure the appropriate risk assessment & management of infection	• Oral Health-Utilising work produced by colleagues in Salisbury with their permission a base line of our current position in relation to oral health and the provision of mouth care will be established from staff and then followed up in a similar way with our patients. Information gathered will inform a QI project to support improvement in oral health provision for our patients. Poor oral health has been proven to negatively impact patients not only in relation to long term health conditions but also their response to infection • Support Pharmacy in relation to antimicrobial stewardship ensuring reports are provided and fed into IPC steering group • Provide expert IPC advise in system wide urinary catheter and gram negative infection reduction working groups • Provide expert advice in the management of individual cases and outbreaks of infection
Priority 4: Review of practices in community settings	• Following a recent period of increased incidence of infection across South Essex a full review of practices within community care teams in EPUT using the national hierarchy of control • Close collaboration with clinical teams and our ICB and UKHSA colleagues • Utilisation of the hierarchy of controls to identify evidence based changes to practice • Standardisation of practice across the trust within community services • Trial of alternative hand sanitiser that is alcohol free which if successful may impact hand hygiene across all services within the organisation • Local, regional, national sharing of the experiences had during the PII for the learning of others across the healthcare system
Priority 5: Ready and competent workforce	• Provision of IPC training as part of trust induction, national mandatory E-learning, and ad hoc sessions • Review of Trust position in relation to staff training and competence in Aseptic non touch technique in collaboration with education colleagues • Co- ordinate and deliver activities in relation to global hand hygiene day- focus on appropriate glove use using the addition of sustainability as another angle of approach • Review and update IPC guidelines to align with national changes • Ensure all relevant are provided with face fit testing for FFP3 masks for use with certain infectious illnesses and as part of long term NHS preparedness for future pandemic • Advise Occupational Health service provider on the collection and maintenance of staff immunisation records • Investigation of more sustainable ways of managing IPC risks in ways which do not increase risk to patients and staff

Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Tel: 0300 123 0808

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11:30

9. STRATEGIC INITIATIVES

9.1 PARTICIPATIVE CULTURE INQUIRY & SENIOR LEADERSHIP DEVELOPMENT PROGRAMME

Discussion Item | AM | 11.34

REFERENCES

Only PDFs are attached

Participative Culture Inquiry & Senior Leadership DP Oct 2025.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

Report Title:	**Participative Culture Inquiry & Senior Leadership Development Programme**					
Executive/ Non-Executive Lead:	Andrew McMenemy – Executive Chief People Officer					
Report Author(s):	Paul Taylor – Director of Organisational Development and Culture					
Report discussed previously at:	People Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	• Without a structured, values-led approach, existing cultural fractures are likely to persist or deepen. • Misalignment between stated values and lived experience will continue to erode trust, engagement, and cohesion across the organisation. • Persistent cultural issues can lead to disengagement, burnout, and higher turnover among staff. • Difficulty attracting and retaining high-calibre talent, particularly in leadership and specialist roles, may compromise service quality.	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	
	Area	Who / When

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

Purpose of the Report		
This report sets out the context, approach and delivery of the participative cultural inquiry and senior leadership development programme. The report also highlights areas that address some of the recommendations made from the independent well-led development review in 2024.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Note the cultural participative inquiry and leadership development programme, including methodology, expected benefits and key performance indicators.
- Discuss the required sponsorship and active participation from the Board to achieve maximum organisational impact.

Summary of Key Issues

Cultural misalignment remains a persistent and systemic challenge across the NHS, including within EPUT. Despite the application of numerous methodologies and frameworks over recent years, interventions have too often delivered short-term initiatives rather than the enduring change required. This has resulted in a recurring cycle of investment without achieving the deep, structural transformation to which EPUT aspires.

Sustainable cultural change cannot be imposed externally and must be owned, driven, and embedded from within the organisation. In recognition of this, EPUT has commissioned an innovative cultural inquiry and leadership development programme in collaboration with *BRAP* and *The King's Fund* - two nationally respected organisations with a proven track record in NHS leadership, equity, and organisational development. This partnership will provide the expertise, challenge, and facilitation necessary to enable EPUT to confront entrenched issues and to co-create a culture that reflects our values and supports our long-term strategic objectives.

The approach, timetable of activity and expected benefits are set out in the report including proposed key performance indicators aligned to the milestone delivery of parts 1 and 2.

In terms of the recommendations made from the independent well-led development review in 2024, the cultural review and leadership development programme provide progress against two of the recommendations to Board.

The main recommendations from the well-led review in relation to culture and leadership capability were:

The trust needs to continue to focus on culture across the organisation with a focus on the areas which are perceived outliers and consider how best to undertake a culture review.

There appears to be a gap with the training and development of care unit leaders, which was recognised by the CEO. The care unit leaders also expressed frustration at that fact that they are left alone to lead the units, with very little support and resource. This needs to be addressed to improve their effectiveness, impact, psychological safety, empower leaders and enable collective leadership across the organisation.

It is expected that the initiatives addressed in this report to Board will directly address some of the findings and recommendations provided in the independent review. However, it is also recognised that this work alone is a starting point and further and continued consideration to both areas will be necessary.

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

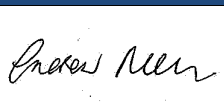
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Participative Culture Inquiry and Senior Leadership Development Programme Report (included details of the specification)

Lead



Andrew McMenemy
Executive Chief People Officer

PARTICIPATIVE CULTURE INQUIRY & SENIOR LEADERSHIP DEVELOPMENT PROGRAMME

1 INTRODUCTION

Cultural misalignment remains a persistent and systemic challenge across the NHS, including within EPUT. Despite the application of numerous methodologies and frameworks over recent years, interventions have too often delivered short-term initiatives rather than the enduring change required. This has resulted in a recurring cycle of investment without achieving the deep, structural transformation to which EPUT aspires.

The critical insight is clear: sustainable cultural change cannot be imposed externally. It must be owned, driven, and embedded from within the organisation. In recognition of this, EPUT has commissioned an innovative cultural inquiry and leadership development programme in collaboration with *BRAP* and *The King's Fund* - two nationally respected organisations with a proven track record in NHS leadership, equity, and organisational development. This partnership will provide the expertise, challenge, and facilitation necessary to enable EPUT to confront entrenched issues and to co-create a culture that reflects our values and supports our long-term strategic objectives.

2 APPROACH

This initiative is not conceived as a top-down directive or a time-limited programme. Rather, it is a values-led inquiry into the organisational culture, underpinned by *Myron's Maxims* - a set of guiding principles that emphasise ownership, authenticity, and systemic learning:

- People own what they help create.
- Real change happens in real work.
- Those who do the work, do the change.
- Connect the system to more of itself.
- Start anywhere, follow everywhere.
- The process you use to get to the future is the future you get.

These principles will inform both the design and delivery of the work, ensuring that change is co-created, embedded in day-to-day practice, and sustained over time.

A Steering Group will be convened, comprising a representative cross-section of colleagues from diverse roles and levels across EPUT. Members will be selected for their ability to actively lead and champion the cultural inquiry across three pilot sites (to be confirmed). Trust partners, *BRAP* and *The King's Fund*, will provide expert facilitation, constructive challenge, and targeted support throughout the process. Crucially, their role is not to deliver change on the Trust's behalf, but to enable and equip EPUT to lead it ourselves.

This collaborative, participatory approach - and EPUT's commitment to investing in it - represents the first tangible step towards the cultural transformation the Trust seeks. The process itself is both the catalyst for, and the embodiment of, the change the Trust aims to achieve. EPUT is at a time of great change across the NHS, with national changes in leadership and scrutiny locally through the Lampard Inquiry. The NHS has recently seen a cultural shift that indicates performance led focus alongside greater levels of financial scrutiny. The rationalisation of central bodies and the strategic move towards community care may provide some opportunities for EPUT, it is therefore important that leaders are in an optimum position based on skills and understanding to enhance themselves and the services they lead. As such, any successful delivery of this culture inquiry must recognise that:

- There is no single, uniform culture within EPUT. The Trust operates across many different sites, each with its own unique dynamics, challenges, and ways of working. Any approach must work with the grain of this diversity rather than assume a one-size-fits-all solution.

- The NHS is inherently hierarchical. The supplier must navigate this structure sensitively, ensuring that the inquiry engages staff across all levels in a way that is inclusive and meaningful.

- National challenges impact EPUT. Broader NHS-wide pressures, policy changes, and workforce issues shape the cultural landscape. The inquiry must use an approach that is mindful of these wider influences when interpreting findings and designing interventions.

- Culture is not a 'problem' to be solved. There is no single report, solution, or action plan that will 'fix' culture. Instead, the inquiry should build a realistic, evolving understanding of cultural dynamics, supporting ongoing learning and adaptation rather than delivering a static, finalised conclusion.

- The intervention must not be something 'done to' people. Staff engagement must be central to the process, ensuring that employees feel part of the solution rather than subjects of an external assessment. Any approach should foster a participatory, co-designed method that empowers staff and embeds ownership of cultural development within the trust.

3 PROGRAMME TIMETABLE

The following table provides an indicative set of activities and timeframes that *BRAP* and the *King's Fund* will be undertaking from September 2025 to August 2026:

Activity type	Activity detail	Indicative timescale
Project initiation, desk-based review of policies, data, past interventions, etc	• Project plan / Communications and monitoring protocols established	Sep 2025
	• identification of at least 5-10 key stakeholders for early engagement	Sep-Oct 2025
Orientation	• Meetings with key stakeholders, site visits to different parts of the trust. Feedback to wider project team	Sep-Nov 2025
Working with internal comms to communicate of the project across the whole organisation	• Ongoing communication of the project across the organisation • Advert to recruit participants for Inquiry	Oct 2025
Recruitment and induction of steering group	• Induction of steering group members • Tools and resources for steering group members to conduct their role	Oct 2025
Design of engagement process, including discussion with project steering group	• One meeting with project steering group. • Reflection and development time	Oct 2025
	• Research materials, engagement strategy, test sites identified	
Trial engagement with staff	Provider researchers spend two days on site conducting interviews/surveys. Findings from interviews/ surveys/ focus groups	Nov 2025
Recruitment and support for cohort 1	• Finalised research materials • List of staff willing to take part in research • engagement • Raw findings • Demographic analysis of participants • Minimum of 250 staff members engaged	Dec 2025
Recruitment and support for cohort 2		Nov – Jan 2026
Recruitment and support for cohort 3		Jan – Mar 2026

Activity type	Activity detail	Indicative timescale
Regular steering group meetings	• Regular (fortnightly, moving to monthly) meetings	Oct – Apr 2026
Initial data processing and coding of themes.	• Reflection time by provider to produce short report outlining key themes	Feb 2026
Staff workshops to generate intervention ideas	• Two staff workshops with project steering group members and, if possible, executive team to devise responses to findings • Change management approach identified and refined	Jan 2026
Report writing	• Short paper outlining findings to date	Jan 2026
Develop learning opportunities based on findings and prepare pilot designs.	• Provider meetings to devise learning programmes for staff and leaders	Jan-Feb 2026
Implement pilot interventions at selected site	• Pilot development sessions	Mar-Jun 2026
Gather feedback and evaluate impact	• Ongoing evaluation of pilot, looking at process and outcome impact	Jun-July 2026
Final de-brief and short report to account for the journey in Year 1 and recommendations for future years.	• Debrief session with executive team	Aug 2026

4 EXPECTED BENEFITS & KEY PERFORMANCE INDICATORS

Part 1 of the Participative Culture Inquiry aims to deliver the following benefits:

- Build the capacity of staff to actively participate in diagnosing workplace culture.
- Involve staff directly in identifying issues and co-creating solutions.
- Provide the Trust with a clearer, more nuanced understanding of staff experiences within the organisation.
- Strengthen staff commitment to sustaining the changes needed to improve organisational effectiveness.

Part 2 will be designed to equip senior staff to lead more effectively. This will include:

- Supporting leaders to develop the skills necessary to hold themselves accountable to the expectations of their roles.
- Cultivating leaders who can self-regulate, demonstrate compassion, and build high-performing, purposeful teams.
- Encouraging leaders to commit to cross-sector collaboration across the ICS through strong multi-disciplinary relationships.
- Embedding the use of improvement methodologies into everyday leadership practice.
- Fostering a learning culture in which leaders share their expertise and continue to learn from the programme and each other.
- Developing leaders who serve as role models by living the organisation’s values, upholding expected behaviours, and setting renewed standards.
- Enabling leaders to identify and support high-potential talent across the organisation.

- Supporting managers to demonstrate enhanced levels of resilience both individually and within their teams in order that provides wider support across the organisation.

Key Performance Indicators (KPI)

The following KPIs have been proposed with the *King's Fund/BRAP*:

- Total number of staff engaged with King's Fund/BRAP (Trust-wide target of 10%).
- Staff satisfaction scores from culture review (target of 90% of staff engaged who experienced improved engagement/understanding of diagnostic issues).
- Staff from BME backgrounds engaged in the pilot cohort of leadership development (target 20%).
- Staff with other protected characteristics engaged in pilot cohort of leadership development (target 10%).
- Staff in pilot cohort of leadership development who have undertaken a Quality Improvement initiative (95%).
- Staff engaged in an action learning set as part of the leadership development programme (90%).

5 CONCLUSION

This cultural inquiry and senior leadership programme represent a pivotal moment for EPUT. It is not another initiative to be delivered to the organisation, but a deliberate, values-driven process that places ownership of change firmly in the hands of EPUT's people. By engaging openly with the realities of the current culture and by working in partnership with *BRAP* and *The King's Fund*, EPUT is creating the conditions for meaningful, systemic transformation.

The success of this endeavour will depend on the collective commitment at every level and to participate fully, to challenge constructively, and to model the behaviours the Trust wishes to see. If EPUT embraces this opportunity with honesty and resolve, it can move beyond cycles of short-term intervention and embed a culture that is aligned, inclusive, and capable of sustaining the highest standards of care and performance.

10. REGULATION AND COMPLIANCE

10.1 A FRAMEWORK OF QUALITY ASSURANCE AND IMPROVEMENT FOR RESPONSIBLE OFFICERS AND REVALIDATION ? ANNUAL BOARD REPORT

Decision Item MK 11.39

REFERENCES

Only PDFs are attached

A Framework of Quality Assurance and Improvement for Responsible Officers and Revalidation ? Annual Board Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 October 2025

Report Title:	**A Framework of Quality Assurance and Improvement for Responsible Officers and Revalidation – Annual Board Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr.Gladvine Mundempilly – Director for Medical Appraisal and revalidation					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None identified	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

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

Purpose of the Report		
This report provides the Board of Directors information on the implementation of revalidation within the Trust for 2024/25 appraisal year to provide an annual statement of compliance provided to the higher level Responsible Officer at NHS England.	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report and approve the compliance statement.
2 The Designated Body (EPUT) through its Chair or Chief Executive to submit the compliance statement to the Higher Responsible Officer at NHS England.
3 Request any further information or action.

Summary of Key Issues

The Board of Directors of Essex Partnership University NHS Foundation Trust as a designated body has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act.

The report is expected to follow the format specified by NHS England and includes comprehensive details on quality assurance, clinical governance, the Trust's performance on revalidation, action plans to enhance the revalidation process, audits on concerns regarding doctors' practice, and audits on appraisal inputs and outputs.

As of 31st March 2025, there were 206 doctors with a prescribed connection to EPUT. Of these, 189 (92%) completed their annual appraisal, within the timeframe during the period from 1 April 2024 to 31 March 2025. Of the remaining 17 appraisals, 15 were delayed with approval and 2 were unapproved.

Of the 15 approved delays; 7 doctors were new starters not due for appraisal within the 2024-25 year, 3 delays were due to long-term sickness, and 5 doctors had other valid reasons for the delay. Both of the unapproved delayed appraisals have now been completed.

Out of the 17 appraisals, 14 doctors have since completed their appraisals, meaning that all connected doctors, except for the 2 still currently on long-term sickness and 1 new starter appraisal due shortly, have now been appraised.

Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 95%.

Steps are being taken to increase the recruitment and retention of medical appraisers to ensure that appraisals are conducted to the expected standards. The Trust is continuing to progress the procurement process for an appraisal system with a view to migrating to the new system in 2025-26.

The Board will are required to continue supporting the annual appraisal and revalidation processes to maintain and enhance current practices, ensuring compliance with the Responsible Officer Regulations Act.

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

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

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

Communication and consultation with stakeholders required	N/A
Service impact/health improvement gains	✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	No new financial implications
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	N/A
Equality Impact Assessment (EIA) Completed	**NO**

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Annex A: Illustrative Designated Body Annual Report and Statement of Compliance

Lead

Dr Milind Karale
Executive Medical Director and Responsible Officer

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board of:
Essex Partnership University NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	None

Comments:	EPUT has an appropriately trained medical practitioner, Dr Milind Karale, who was appointed as Responsible Officer in 2012
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	The Board to continue its support for annual appraisal and revalidation processes.
Comments:	The Designated Body currently provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.
Action for next year:	The Board to continue its support for annual appraisal and revalidation processes.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue to carry out process and amend the prescribed connection list as appropriate.
Comments:	There is an established process to ensure the accuracy of the list of doctors with prescribed connections to the Trust. In addition to the information gathered prior to and at the time of a job offer to a doctor, the Workforce Department provides a monthly report of new starters and leavers to the Appraisal and Revalidation Manager. Triangulation of this information is carried out with Human Resources – Medical Staffing Department and the clinician concerned. This is cross-checked with our Prescribed Connection list with the GMC and is amended as appropriate.

Action for next year:	Continue to carry out process and amend the prescribed connection list as appropriate.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Continue to monitor and review the policies in place to support medical revalidation.
Comments:	All new national guidance and amendments to existing documentation is read, shared appropriately and implemented where possible. EPUT's Medical Appraisal and Development policy was reviewed, updated and ratified in January 2025.
Action for next year	Continue to monitor and review the policies in place to ensure that these support medical revalidation.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Organise a peer review of our appraisal and revalidation processes.
Comments:	We undertook a Designated Body Peer Review exercise with Cambridgeshire and Peterborough NHS Foundation Trust in July 2024. We looked at and discussed each other's Appraisal and Revalidation processes and procedures as a way to inform best practice and further improve. The feedback from this was positive. We also had an independent quality assurance process of our appraisal policies and procedures which was completed by an external provider and concluded in February 2023. The external provider completed a comprehensive report on our appraisal and revalidation policies and processes and the findings were presented to Board at the time. An action plan on the feedback was drawn up accordingly. We continue to carry out internal quality assurance processes and annual audits. The processes have been regularly reviewed by the RO and the Director of Medical Appraisals and Revalidation along with Human Resources. The information relating to appraisal and revalidation is shared with the CQC as part of their inspections of the organisation as and when required.

Action for next year:	To continue to carry out the action plan resulting from the feedback that we received from the independent quality assurance process and to continue the internal quality assurance processes and annual audits.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continue to ensure that all doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance.
Comments:	All doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance. The Medical Education department has regular internal CPD activities and all the doctors are encouraged to attend. The doctors are also assisted with their external CPD requirements both in terms of study leave and financial support. The Revalidation Office provides regular support for the doctors on appraisal and revalidation, including timely reminders of appraisals, appraisal training and support in developing appraisal portfolios. Where the doctor does not have a prescribed connection to the Organisation, such as agency locums, they are provided with the necessary supporting information to pass on to their Designated Body and include at their appraisal.
Action for next year	Continue to ensure that all doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the

appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.
Comments:	All doctors with a prescribed connection to EPUT are required to have a whole practice annual appraisal, which includes any necessary information on complaints and/or significant events that they have been named in for each appraisal year so that lessons learnt and reflections can be drawn upon. The Trust has a process in place to assist the doctor to collate this information held internally. The doctor is required to declare all their medical work, both with EPUT and any external, within the appraisal document. Where the appraiser is not the line manager of the doctor, the latter provides a medical managers report covering specific issues if any, to be discussed during the appraisal. Where EPUT is not the doctor's sole employer within their appraisal year, the doctor is required to provide a fitness to practice statement from all places where they were employed in a medical capacity. The Trust has adopted the new Appraisal 2022 model whilst still allowing our doctors to choose the standard appraisal template if they wish to. The majority of the doctors are now using the 2022 model.
Action for next year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.
Comments:	Where a doctor does not have a whole practice annual appraisal, the reasons are explored and a plan put in place for its completion. These are further analysed to improve the process and ensure that the doctor is supported to complete these in a timely manner. The Responsible Officer and the Director of Medical Appraisal and Revalidation review the report on delayed appraisals on a monthly basis.
Action for next year:	Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete an audit on missed or incomplete appraisals.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Continue to review national policy and update the Medical Appraisal policy and procedure accordingly.
Comments:	EPUT has a Medical Appraisal policy in place, which is in line with national policy. This was updated and ratified in January 2025.
Action for next year:	Continue to review national policy and update the Medical Appraisal policy and procedure when it is up for renewal.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	N
Action from last year:	Organise new and appraiser refresher training.
Comments:	The recruitment and retention of the appraisers has been challenging under the current work pressures of the doctors. As of 31st March 2025 we have 206 doctors on our prescribed connection list and 33 medical appraisers for the

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 6-7 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 40 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers. Further new and refresher training for appraisers has taken place in June 2024.
Action for next year:	New and appraiser refresher training has taken place in June 2024. We will look at further training opportunities for 2024-25 year. Look at options to encourage recruitment and retention of medical appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.
Comments:	There is on-going support for the medical appraisers by way of regular updates. The Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is also made available to the appraisers periodically. Each appraisee is expected to complete an anonymised feedback of their experience, which is summated annually and provided to individual appraisers for their reflection. The individual appraisers include their appraiser role within their own annual appraisal for discussion and reflection.

	The appraiser network meetings have been reintroduced for 2024-25 and two such meetings have already taken place. We will continue this for 2025-26.
Action for next year:	Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal. Continue the appraiser network meetings.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue to complete annual audits and submit to the Board.
Comments:	Annual audits of our appraisal system are completed and shared with the Executive Team and discussed at the Quality Committee. This is submitted with the Board Report. Please see attached Appendix A and Appendix B for 2024/25 findings. As per section 1A (v), we have also had an independent quality assurance process of our appraisal policies and procedures completed by an external provider in 2023 and the findings were submitted to Board.
Action for next year:	Continue to complete annual audits and submit to Board.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays
Comments:	The GMC Connect is reviewed regularly and recommendations are made in a timely manner.

Action for next year:	To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue to ensure that revalidation recommendations are communicated promptly.
Comments:	Revalidation recommendations are communicated to the doctor at the point of the recommendation being made, if not sooner. Where the recommendation of deferral or non-engagement is made, the reasons are discussed with the doctor in advance and a plan is put in place to ensure a subsequent positive recommendation.
Action for next year:	Continue to ensure that revalidation recommendations are communicated promptly.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Continue to create an environment which delivers effective clinical governance for doctors.
Comments:	The organisation has effective clinical governance processes for doctors in place which includes regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team. The doctors are also encouraged to contribute to the clinical governance process by undertaking investigations and reviewing the incidents.
Action for next year:	Continue to provide an environment which delivers effective clinical governance for doctors.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y

Action from last year:	Continue to monitor the conduct and performance of all doctors working in our organisation.
Comments:	Monitoring the performance of all doctors working within the Trust is carried out regularly in a variety of ways. Some examples include monitoring adherence to Trust policies and procedures, recording data on complaints, significant events and service provision, compliance with mandatory training and revalidation requirements and feedback from trainees. In addition the Clinical Directors have a monthly meeting with the doctors under their line management to discuss any concerns relating to working practices or performance.
Action for next year:	Continue to monitor the conduct and performance of all doctors working in our organisation.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Continue to provide all relevant information to include at their appraisal.
Comments:	Corporate data such as information on complaints, significant events, audits and attendance at internal weekly teaching sessions are provided to the doctor to include in their annual appraisal. In the appraisal, the doctors include their updated job plan, mandatory training record, probity declaration and issues relating to any suspensions/investigations that they are subjected to. This is triangulated with Trust and GMC Connect data.
Action for next year:	Continue to provide all relevant information to include at their appraisal.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	Continue with established process and update the policy and procedure as and when required.

Comments:	The organisation has a process in place for responding to concerns and has a Maintaining High Professional Standards – Conduct and Capability policy for Medical and Dental staff, which is in line with national guidance and was last updated in 2024. The Trust has an adequate number of trained Case Managers and Case Investigators. Refresher training is provided periodically.
Action for next year:	Continue with established process and update the policy and procedure as and when required.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Continue to complete annual audit and submit to Board.
Comments:	Annual audit of responding to concerns about a doctor in our organisation is completed and submitted to Board with the Board Report. Please see Appendix C
Action for next year:	Continue to complete annual audit and submit to Board.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Continue to transfer information and concerns in a timely manner between Responsible Officers when necessary.
Comments:	Medical Practice Information Transfer forms are used to transfer information and concerns between Responsible Officers where necessary. This is a nationally approved form. The doctors are required to declare to the organisation, all the places where they are employed in a medical capacity and to provide a fitness to practice statement from them to include in their annual appraisal.
Action for next year:	Continue to transfer information and concerns in a timely manner between Responsible Officers when necessary.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	Continue to ensure the appropriate policies and procedures in place are followed and updated to ensure that those involved in investigations are adequately trained.
Comments:	The organisation has a Maintaining High Professional Standards policy and procedure which has been ratified and which is in line with national guidance. Those involved in investigations are appropriately trained for the role. There is also an appeal and remediation policy and procedure, which are followed when required.
Action for next year:	Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are adequately trained.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.
Comments:	The organisation has systems in place to capture development requirements in relation to governance from the wider system. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. This is in the form of regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. Our policies and procedures are updated as and when necessary in light of information from the wider system.
Action for next year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	To review the systems in place for assessing professional standards for clinical staff other than medical and nursing.
Comments:	Systems are in place to review professional standard arrangements for medical staff. This is done through appraisals and there are systems in place to provide doctors with copies of their complaints, patient safety incidents and report from the line manager. The Trust has a system for appraising nursing staff.
Action for next year:	Continue to review the systems in place for assessing professional standards for clinical staff other than medical and nursing.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	Continue with new starter processes
Comments:	EPUT has systems in place to ensure that we are compliant with the Responsible Officer Regulations Act with regards to recruitment and employment checks. Medical HR carries out the necessary pre-employment checks prior to any doctor joining the Trust. Once the doctor is in the post the Appraisal and Revalidation Team carries out further assurance checks, which include the name of the last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form. The Medical staffing department follows an agreed process for recruiting agency locums ensuring that they meet the expected standards for their role.
Action for next year:	Continue with new starter processes

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y

Action from last year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.
Comments:	As mentioned previously, we have regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. This has created a learning culture within EPUT whereby excellence in clinical care can flourish and be continually enhanced.
Action for next year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	Develop and continue to enhance our People and Culture Strategy
Comments:	Our people strategy will support EPUT to be recognised as an attractive place to work, and that our leaders are best placed to make EPUT the best mental health and community provider. At the core of our strategy is our ambition to ensure that staff not only have a great experience but feel happy and valued at work. We will also tackle equality, diversity, and inclusion issues within our Trust to collectively improve civility and respect and ensure that staff from underrepresented backgrounds have equal opportunities. The strategy will have 3 key pillars: 1) workforce planning at strategic and operational levels, 2) leadership development at all levels of the organisation and, 3) culture with a specific focus on wellbeing, lived experiences, equality, diversity, and inclusion. We want EPUT to be an employer of choice, and we recognise that to achieve this we need to continuously identify opportunities to transform our workforce, support our people to grow, and take steps to ensure that our staff feel happy and valued at work, and connected and supported in a positive work environment. We will tackle equality, diversity, and inclusion issues within our Trust to collectively improve civility and respect and ensure that staff from underrepresented backgrounds have equal opportunities. We will plan for the future by ensuring that our staff have the tools required to be successful in their current and future

	roles and strive to offer attractive, flexible and accessible health and care role opportunities to local people within our communities. We will utilise and upskill our corporate support services, and volunteers, to add value to our patient facing services in an intelligent and meaningful way.
Action for next year:	Develop and continue to enhance our People and Culture Strategy

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	Continue to enhance these processes within the Organisation at all levels.
Comments:	Behaviour framework in place -Where people do not behave in line with our values and behaviours we will challenge this and will ensure that where performance and behaviour are not consistent with our vision for a high performing organisation, this is addressed. Leaders are role models for personal and professional development. They equally encourage all of those in their teams to develop the values, skills and knowledge to be their best for patients and their families. Reflective learning is part of the appraisal and 1-1 process so that shared learning and action becomes 'how we do things around here'. Feedback is regularly provided and time for critical reflection promotes individual and organisational learning. Leaders consistently demonstrate compassion with their staff and take a genuine interest in their lives and well-being. They actively role model what high standards of care look and feel like, both in clinical or non-clinical roles. Leaders care for themselves and others so they are psychologically able to manage the challenges of leadership - they create a just culture of fairness, openness and learning.
Action for next year:	Continue to enhance these processes within the Organisation at all levels.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y

Action from last year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.
Comments:	We have mechanisms that support feedback about the organisation' professional standards processes. Feedback can be provided in a number of ways in both a formal and informal manner. Such processes include freedom to speak up, complaints and grievance procedures.
Action for next year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	
Action from last year:	Formally record and review any parity issues due to protected characteristics or country of primary qualification
Comments:	The organisation has not collected the data in terms of their country of primary care qualification or protected characteristics while addressing concerns about doctors' practice. The line managers are often aware of protected characteristics and take these into account. This is however not formally recorded. However, protected characteristics are recorded on ESR. Country of primary qualification is to be included and is currently being discussed with ESR regarding recording capability. All documents pertinent to individuals' qualifications are on personnel files.
Action for next year:	Continue liaising with ESR regarding recording Country of primary qualification on the system to enable formally recording and reviewing any parity issues due to protected characteristics or country of primary qualification.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Continue to calibrate and network with others and engage with peer review programmes when requested.

Comments:	The Appraisal and Revalidation Team regularly attend the NHS England networking events and read any updates. The Responsible Officer also meets with the GMC ELA on a routine basis. As mentioned previously, we have had an independent review of our appraisal and revalidation processes in 2023 and a peer review with CPFT in July 2024.
Action for next year:	Continue to calibrate and network with others and engage with peer review programmes when requested.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	206
Total number of appraisals completed	189
Total number of appraisals approved missed	15
Total number of unapproved missed	2
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	44
Total number of late recommendations	1 – due to admin error, submitted 1 day late
Total number of positive recommendations	39
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	5
Total number of trained case investigators	Approx 25
Total number of trained case managers	Approx 25
Total number of concerns received by the Responsible Officer[2]	2
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	16 weeks
Median duration of concerns processes closed (working days)[3]	23 weeks
Total number of doctors excluded/suspended during the period	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	2
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	46
Total number of new employment checks completed before commencement of employment	46
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	TBC

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Our action plan for the 2024-25 appraisal year consisted of: • Look at ways to recruit and retain our medical appraisers • New and refresher appraiser training • Update our Medical Appraisal Policy and Procedure • Re-introduce an appraiser network • Undertake a peer review • Procurement process of an appraisal system We have made good progress with this action plan over the course of the year. The procurement process of an appraisal system is still ongoing at the time of writing. The approvals process has taken longer than anticipated to get through but is in progress. Recruiting and retaining our medical appraisals remains an issue and we will need to continue to address this over the course of 2025-26.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions still outstanding
Finalising the procurement process for our appraisal system and looking at ways to recruit and retain our medical appraisers.
Current issues
The main current issue is to recruit and retain our medical appraisers. As of 31st March 2025 we have 206 doctors on our prescribed connection list and 33 medical appraisers for the Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 6-7 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 40 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Look at ways to recruit and retain our medical appraisers • New and refresher appraiser training • Continue to develop the appraiser network • Procurement process of an appraisal system
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
As of 31st March 2025, there were 206 doctors with a prescribed connection to EPUT. Of these, 189 (92%) completed their annual appraisal, within the timeframe during the period from 1 April 2024 to 31 March 2025. Of the remaining 17 appraisals, 15 were delayed with approval and 2 were unapproved. Of the 15 approved delays; 7 doctors were new starters not due for appraisal within the 2024-25 year, 3 delays were due to long-term sickness, and 5 doctors had other valid reasons for the delay. Both of the unapproved delayed appraisals have now been completed.

Of the 17 appraisals, 14 doctors have since completed their appraisals, meaning that all connected doctors, except for the 2 still currently on long-term sickness and 1 new starter appraisal due shortly, have now been appraised.

Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 95%.

There are a couple of questions on the form where the Trust has answered “no” with action being taken to address these areas. Steps are being taken to increase the recruitment and retention of the medical appraisers to ensure that appraisal processes are carried out at the expected standards.

We are continuing to progress the procurement process for an appraisal system with a view to migrating to the new system in 2025-26.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

Section 4 – Statement of Compliance

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Essex Partnership University NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Nicola Foley
Email address:	Nicola.foley2@nhs.net

Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

	Totals
Number of doctors on GMC Connect as of 31 March 2025	206
Number of Completed appraisals for 2024-25	189
Number of doctors who were not due for an appraisal by 31 March 2025 (new starters after April 2024)	7
Number of doctors who were LTS/Maternity Leave for the majority of the appraisal year	3
Number of Approved Incomplete/Missed Appraisals for 2024-25	5 (all have now been completed)
Number of Unapproved Incomplete/Missed Appraisals for 2024-25	2 (1 has now been completed)

Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		189
	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs - Is there sufficient supporting information from all the doctor's roles and places of work? (To include CPD, QIA & evidence from external roles)	38	37
Review of complaints: Have all complaints been included?	38	38[1]
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	38	38[1]
Has a patient and colleague feedback exercise been sufficiently completed by year 3 of the revalidation cycle?	38	22
Appraisal Outputs		
Appraisal Summary	38	37
Appraiser Statements	38	38
Personal Development Plan (PDP)	38	36

[1] Based on evidence submitted within appraisal portfolio.

Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[5]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2024 – Mar 2025) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	3	3	3	9
Capability concerns (as the primary category) in the last 12 months	0	0	2	2
Conduct concerns (as the primary category) in the last 12 months	3	3	1	7
Health concerns (as the primary category) in the last 12 months	0	0	0	0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2025 who have undergone formal remediation between 1 April 2024 and 31 March 2025. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				8
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				1

[5] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	9
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2024 and 31 March 2025: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	1 – 3 months
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	4
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1

Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	2
Number of NCAS assessments performed	0

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

11:42

11. OTHER

11.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item HLD 11:45

Verbal

11.2 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item ALL 11:46

Verbal

11.3 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL 11:50

Verbal

11.4 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

Information Item | ALL | 11:55

Verbal

12. ANY OTHER BUSINESS

Information Item ALL 11:56

12.1 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING

12:01

- Risks for escalation to the CRR or BAF
- Risks or issues to be raised with other standing committees

13. QUESTION THE DIRECTORS SESSION

12:02

14. DATE AND TIME OF NEXT MEETING

12:15

Wednesday 3 December 2025 at 10:00, The Lodge Training room 1