Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

4 February 2026

10:00 GMT 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 04.02.2026.pdf

Meeting of the Board of Directors held in Public
Wednesday 4 February 2026 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
PRESENTATION **The Future of Podiatric Surgery in EPUT** **Jason Nandlal, Clinical Director for Podiatric Surgery and** **Richard Sharp, Operational Lead Podiatric Surgery Essex and Bedfordshire**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 3 December 2025	HLD	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	HLD	Attached	Noting
5	Chairs Report (including Governance Update)	HLD	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	Freedom to Speak-Up Policy	DG	Attached	Approval
Questions taken from the General Public				
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework	DG	Attached	Noting
9	**STRATEGIC INITIATIVES**			
9.1	Green Plan	TS	Attached	Approval

10	**REGULATION AND COMPLIANCE**			
10.1	Emergency Preparedness, Resilience & Response (EPRR)	AG	Attached	Noting
10.2	Quarterly Report on Safe Working Hours for Resident Doctors	KS	Attached	Noting
11	**OTHER**			
11.1	Use of Corporate Seal	PS	Attached	Noting
11.2	Correspondence circulated to Board members since the last meeting.	HLD	Verbal	Noting
11.3	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.4	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12.1	Reflection on risks, issues or concerns including: • Risks for escalation to the CRR or BAF • Risks or issues to be raised with other standing committees	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 1 April 2026 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 3 June 2026 at 10.00, The Lodge Training room 1 Wednesday 5 August 2026 at 10:00, The Lodge Training room 1 Wednesday 7 October 2026 at 10:00, The Lodge Training room 1 Wednesday 2 December 2026 at 10:00, The Lodge Training room 1			

Hattie Llewelyn-Davies
Chair

1. APOLOGIES FOR ABSENCE

Standing item HLD

2. DECLARATIONS OF INTEREST

Standing item HLD

PRESENTATION: THE FUTURE OF PODIATRIC SURGERY IN EPUT

Information Item

Jason Nandlal, Clinical Director for Podiatric Surgery and
Richard Sharp, Operational Lead Podiatric Surgery Essex and Bedfordshire

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 3 DECEMBER 2025

Decision Item HLD

REFERENCES

Only PDFs are attached

BoD Minutes Part 1 03.12.2025.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 03 December 2025
Held in person at Anglia Ruskin University

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Paul Scott	PS	Chief Executive Officer
Doug Field	DF	Associate Non-Executive Director
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
Denver Greenhalgh	DG	Executive Director of Corporate Governance
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive 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
Dr Feena Sebastian	FS	Deputy Medical Director (For Dr Kallur Suresh)
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Richard Spencer	RS	Non-Executive Director
Sarah Teather	ST	Non-Executive Director
Zephan Trent	ZT	Executive Director of Digital, Transformation and Strategy

IN ATTENDANCE:

Scott Huckle	SH	Service Development and Assurance Lead, Specialist Care Unit
Chris Jennings	CJ	Assistant Trust Secretary
Angela Laverick	AL	EA to Chief Executive, Chair and NEDs (minutes)
Martine Munby	MM	Director of Communications
Bernie Rochford	BR	Principal Freedom To Speak Up Guardian
Kim Russell	KR	Head of Communications
Clare Sumner	CS	Trust Secretary Administrator

There were 4 member of the Public / Staff Members present.

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

The meeting commenced at 10am.

126/25 APOLOGIES FOR ABSENCE
Dr Kallur Suresh, Interim Executive Chief Medical Officer

127/25 DECLARATIONS OF INTEREST
There were no declarations of interest.

128/25 PRESENTATION: UPDATE ON QUALITY IMPROVEMENT PROJECT – LIGATURE REDUCTION, LONGVIEW WARD

SH delivered a presentation providing an update on the Ligature Risk Reduction Quality Improvement Project at Longview Ward. SH had previously presented to the Board of Directors to provide details of the project which commenced following patient and staff feedback. SH highlighted the following:

- The comparative data from the six-month pre-project baseline data and six-month post-implementation data showed there had been no significant reduction in the number of ligature incidents, but demonstrated that the management of these incidents had improved.
- A ligature scale had been introduced to help staff describe a ligature incident on the Datix incident reporting system, to help with the accurate reporting of data and inform MDT decision making. There had been a slight decline in staff recording this scale, but it was now increasing.
- All new preceptees now have ligature management training; this has yet to be rolled out to healthcare assistants (HCAs) but is informally provided as part of the culture of the ward
- The approach was person-centred, with meetings held with patients on an individual basis to discuss the approach being taken. The approach to ligature was tailored to the individual, in line with their clinical formulation.
- Informal evidence gathered following the implementation of the project suggested staff were experiencing less stress and burnout. There was now an opportunity to review metrics such as sickness, retention levels etc. and compare these to before the implementation of the project.
- The next steps of the project were to continue to manage ligature in a patient focussed way and remind staff of the changes that had been introduced, including use of the ligature scale in reporting incidents

<u>Questions and Answers</u>

- DL asked why HCAs do not complete the ligature management training referred to in the presentation, including the ligature scale, which may help in the consistency of recording incidents. SH advised the majority of incidents are reported by the qualified staff on Datix but that HCAs were aware of care plans and the management of ligatures. SH agreed the training should be extended to HCAs and he hoped to have this in place within the next six months.
- AM commented on the benefit of comparing the de-escalation of patient observation levels with patients having an individual ligature plan. SH agreed it would be good to triangulate the data and agreed to take this forward.
- AS highlighted the previous presentation to Board which had been undertaken following a learning event with people with lived experience describing their journey and heard that many people used ligature as a way of managing their distress. AS appreciated the co-productive approach as opposed to a reactive response, and felt it could help change practice.
- AG commented that the process had been developed for children and young people, but felt a similar approach could be undertaken for adult care. AG asked if there had been any feedback from young people on the new approach. SH advised feedback had been positive in relation to the transparency of the approach and person-centred approach.
- ST commented the project was a good example of methodically following data, accepting the data and learning from the results. ST felt there was a tension between the personalised approach and the requirements on the Trust to see a reduction in incidents. ST asked if there was anything the Board could do to encourage staff to follow the evidence and provide a personalised best interest approach. SH felt there were other areas in which the approach could be implemented, such as seclusions, which could be managed in a similar way to ligature incidents and reporting.

- LL asked how the example of excellent practice could be shared. AS advised the Trust needed to have conversations at a national level about the approach and could have the process peer reviewed.
- RJ commented there could be more work undertaken in terms of measuring young people's experience and may be something which could be explored through research. MJ commented that national tools for physical health did not always align with mental health and it would be helpful to demonstrate good practice on what was needed for mental health services. SH agreed and advised he was working on identifying data to measure and demonstrate improvement.
- EL asked whether there was a need to share the learning with families and carers. SH advised meetings are held with the young people and their families around the person-centred approach to ligature management.
- EL asked what the next step was for the project. SH advised the next step was look at patients across the Trust with a high ligature profile to see if it is appropriate to utilise a similar methodology elsewhere.

HLD thanked SH for the presentation and felt it demonstrated a good level of learning from the project. HLD advised that any further feedback would be provided through the Quality Committee and onto Board as appropriate.

129/25 MINUTES OF THE PREVIOUS MEETING HELD ON 1 October 2025

The Board of Directors reviewed the minutes of the meeting held on 1 October 2025 and agreed these as an accurate record, noting the record of questions from members of the public and the responses provided.

130/25 ACTION LOG AND MATTERS ARISING

The Board of Directors reviewed the action log from the meeting held on 1 October 2025 and noted one action was open requiring an update.

The action related to a meeting being held between AG and LL to discuss the appropriateness of developing a simulation around flow and capacity. AG advised the meeting had been held on 28 November, where it was agreed a simulation would be useful, but there was need to focus on winter planning at the current time. It was agreed that this would be revisited in the new year. The Board of Directors agreed to close the action as the meeting had taken place.

131/25 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.

The Board of Directors:

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

132/25 CEO REPORT

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

- Industrial action had taken place in November, with the potential for more in the winter period. PS thanked those involved in the planning to ensure any impact on patient care was mitigated.
- PS thanked Dr Milind Karale, who had stepped down from the Board as Executive Medical Director. PS highlighted his devotion to the role and the positive legacy. PS welcomed Dr Kallur Suresh to the Board as the Interim Executive Medical Director, with a recruitment process for a substantive replacement now underway.

- The cases of flu had continued to rise steeply and earlier in the season than normal. PS encouraged staff and the public to take the opportunity of flu vaccination where possible to protect themselves and others.

The Board of Directors:

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

133/25 QUALITY AND PERFORMANCE SCORECARD

PS presented the report, in conjunction with a summary provided in the CEO report, with Executive Directors providing updates for their areas.

Operations (AG)

- The care units had been engaged in winter preparations with system partners to ensure flow across the system. The Trust had welcomed a flow expert to review the winter plan and the sustainability of the overall flow plan. The review had identified some areas for improvement, such as collective ownership of flow across the organisation. AG suggested holding a Board session to review the content of the report and would take this forward.
- The Trust had moved to locality flow models and a recent test and learn programme had led to the leadership of home treatment and urgent crisis teams for North East Essex moving to combine with the existing community services care unit for this area. If the move proves to be successful, it will be rolled out across the Trust.
- The Time To Care programme was coming to the end of the transformational stage and was moving into business as usual.
- There had been reductions in adult and older people's length of stay. This was the third month where there had been a sustained improvement in performance, including for inappropriate out of area placements. AG acknowledged that the situation was fragile, but added that there was a focus on maintaining the position and delivering medium term commitments.
- NHS Talking Therapies had seen access rates reduce slightly. Future focus would be on recovery rates.

Nursing (AS)

- Work was being undertaken to ensure Allied Health Professionals were embedded within care unit leadership.
- The national Culture of Care Programme was being taken forward, including looking at standards associated with avoiding harm which has a number of quality improvement areas being taken forward by the Trust.
- The Director of Patient Experience was reviewing the development of a Peer Academy across the system to continue the development of peer support roles. Further information would be provided as this developed.
- Cardio Metabolic compliance had improved, with a number of inpatient units reporting full compliance. Community areas were just under 60% and focused work was being undertaken to improve the position.

People and Culture (AM)

- The engagement score for the 2025 Staff Survey was reported at 51.2% amd was expected to increase further following a data quality review. The engagement score for last year was 41% and AM thanked staff and leaders for their engagement in the survey this year.
- There were partnership arrangements in place with Harlow and Chelmsford Colleges and a commitment made to T-level placements.

- The Trust was slightly outside of performance for use of Temporary Staff in October, but November data showed an improvement and was back within the target range.
- There was a positive staff turnover rate, but staff sickness had been increasing month-on-month. The People Committee was focused on understanding the increase and ensuring it was understood throughout the winter period.

Finance (TS)

- The Month 7 I&E deficit was at £5.1m, with excess inquiry costs and the loss of deficit support funding impacting the current position. The Trust continued to liaise with regional colleagues and seek dispensation for these matters. If dispensation is not received, the I&E and cash position would be affected by c£4m for the Inquiry and £10.2m for the deficit support. This would affect the Trust's forecast outturn position. The cash impact would need to be reflected in the Board Assurance Framework and Strategic Risk 7 would therefore be reviewed.
- The Capital position remained behind plan, but most major capital projects were under way. National support had been sought to defer slippage associated with the Electronic Patient Record and lease credit. This had not been received to date and therefore work was underway to internally broker it and to try to ensure the funding is not lost this financial year.

Questions and Discussions

- RS noted that Talking Therapies was on target for wait times and queried if there could be an exploration as to the impact of outperforming those targets. AG advised the commissioning of the service meant that these were provided differently in different localities, which created a complex system. AG agreed there was an opportunity to look at different thresholds, both prior to accessing the service and secondary services. FS advised work was being undertaken with Mid & South Essex ICB to implement a model where GPs can refer directly to Talking Therapies, which would allow a specialist mental health practitioner to focus on the step-down process.
- MJ noted the cardio metabolic compliance and noted the overlap where data is collected at different touchpoints, where individuals access different services which collect similar data. MJ asked how the Trust could challenge in this area to gain access to this information and avoid overlap. AG advised there was a good opportunity with the development of neighbourhood models of care for neighbourhood teams to access and utilise this data.
- LL suggested having a future Board Seminar on understanding the shared care record and the progress with the implementation of the data strategy. ZT advised there would be a six-monthly report presented to the Finance & Performance Committee and agreed the data strategy would be a good subject for a future Board Seminar.

HLD summarised the discussion, noting the two items for the Board Seminar programme. HLD noted the importance of the neighbourhood models of care going forward and the financial challenges highlighted in the report. HLD congratulated AM on the positive achievement of the engagement score for the staff survey.

The Board of Directors:

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

Action:

1. **Undertake Board Seminar session for Capacity / Winter Planning and Data Strategy as part of the Board Development programme. (AG / ZT)**

134/25 COMMITTEE CHAIRS' REPORT

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

Audit Committee (EL)

- There was good progress reported for the Internal Audit programme, with positive assurance that the auditors would be able to form an opinion of the Trust position at the end of the year.
- EL thanked Dr Milind Karale for his active contribution to the Committee and thanked him for the time and expertise in shaping a report which allowed the Committee to receive substantial assurance for Clinical Audit.

Finance and Performance Committee (DL)

- The Committee had undertaken a good deep dive of length of stay, which had been insightful and informative.
- The Committee had received and discussed the Strategic Impact Report.

People Committee (RJ)

- The Committee had received and noted the first draft of the People and Education Strategy.

Quality Committee (MJ)

- The Committee had discussed the use of remote monitoring technology in different areas. MJ highlighted the use of the term "Oxevision" to describe this technology, which was a specific brand and did not incorporate all aspects of the conversation. MJ highlighted the importance of moving away from using the term "Oxevision" and instead using the term "remote monitoring". LL agreed, noting the technology where people are able to monitor their health at home (through Hospital at Home) was a form of remote technology not covered by the term "Oxevision".

The Board of Directors:

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

135/25 CQC Assurance Report

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

- The Trust remained fully registered with the CQC.
- The CQC had published their report in November following their inspection of Learning Disability services in July. The report had received a rating of Requires Improvement and actions identified had been incorporated into the overarching CQC Improvement Plan.
- The CQC Improvement Plan as at 31 October had thirteen regulatory actions, with 56 associated sub-actions. Of these, 39 actions had been completed and signed off through the assurance process.
- The internal assurance process for the Trust had continued with the current internal rating of "Good" compliance.

<u>Questions and Discussion:</u>

- DG advised the Requires Improvement rating for Learning Disability services had resulted from one element for improvement which had capped the report at a score of 62%, resulting in a Requires Improvement rating. The overall score for the service was higher, but the one element had led to the score being capped.
- ST asked if there was a way to identify themes where areas have received a lower rating to see if the Trust was learning. AS advised work was underway to utilise AI to review eight different data sources to triangulate areas and see if there has been improvement in those areas. This process would be used to understand patient safety profiles and if the Trust was considering the right areas and learning.
- RS welcomed the inspection and learning, but noted that the service was inspected as a seven-bedded unit that had one patient at the time of the inspection. RS asked if there was any scope to work with the CQC to try to make the inspection process more efficient. DG advised there was an opportunity to provide this feedback at a national level.
- DL noted there were some areas identified in the report where these had been identified previously. DL asked how the Trust can ensure consistency of practice and ensure learning is embedded. DG advised there was a drive in the Trust for self-regulation for individual members of staff to have ownership and accountability for their individual compliance as well as collective responsibility.

HLD summarised the discussion, noting the Trust continued to learn and there was further work to be undertaken around developing individual learning and accountability.

The Board of Directors:

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

BR joined the meeting at this point.

136/25 Freedom to Speak Up Service

BR presented a report providing an update on Freedom to Speak Up activity from 01 April to 30 September 2025. BR highlighted the following:

- There had been an increase in the number of people using the service and a recent national comparison suggested the Trust was at the higher end of people speaking up.
- The percentage of individuals speaking up anonymously was currently at 48% which may be due to the availability of the online form allowing people to easily raise concerns anonymously.
- The service was currently a reactive service, with little capacity for proactive work to be undertaken to improve the service. BR advised her focus was to review and clear the backlog of cases to allow for more proactive work to be undertaken.
- There were plans in place to simplify the route to speaking up, but the focus was currently on ensuring the current process continued to be taken forward whilst reviewing and clearing the backlog of the complex cases.

<u>Questions and Discussions</u>

- ST noted the increase use of the service anonymously and whether this suggested and lack of maturity in the relationships between staff and managers. ST asked how the Board should approach this area. BR agreed the rate of anonymous concerns was high, but felt this was likely due to the ease of using the online form, rather than fear of retribution from managers. BR advised it was important to review the flow of the system to ensure the service is being used appropriately to raise concerns.

- AG commented on previous marketing campaigns for the service, where there had been a suggestion it was a first point of escalation. AG felt it was important to encourage individuals to have conversations with their teams first and would be a proactive step in signalling the right way to raise a concern. BR agreed and that there was a need to simplify the process and move it in the right direction for raising concerns in the right way. AM advised the cultural review would be key and would feed into the leadership development programme. AM agreed to link BR into the review to triangulate data.
- LL agreed with the discussions and actions, noting the themes in the report were around HR, culture etc. rather than clinical practice / patient safety for which the service was established.
- RS added the need to consider data inputs in relation to any adjustments to the Datix reporting, such as being able to identify any protected characteristics of any alleged perpetrator, rather than only see this for the individual reporting the issue.

HLD summarised the discussion, noting the importance of clearing the backlog of cases and utilising the cultural review to understand how the organisation can utilise the service appropriately.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted in principle, the next steps set out in the priority section as reviewed by the People Committee.**

137/25 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

Member of the Public
Given staff are raising concerns about their own circumstances (HR, culture etc.) rather than patient safety issues, was there a way for staff to have their say rather than just through the staff survey? For example, conversations with managers, unions etc.

BR advised it was clear that Freedom to Speak Up was not a union or advocate for anyone, but was an impartial service. The scope of the service had broadened nationally to extend to anything impacting an individual's ability to do their job. There was a plan in place to develop a bespoke Datix module which would allow data to be measured on where individuals had raised issues before accessing the service, which would help understand the flow of raising concerns through the organisation.

BR left the meeting.

138/25 BOARD ASSURANCE FRAMEWORK

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

- The Board discussions had related to the BAF, such as capital / use of resources in terms of financial outturn, cash, digital quality metrics and reporting, cultural review and freedom to speak up.

<u>Questions and Discussion</u>

- MJ noted that for Strategic Risk 6: Cyber Attack, there have been audits completed providing positive assurances. MJ asked how often the risk was revisited once audits have been completed, in order to identify any potential gaps. ZT advised the red action regarding the Cyber Assurance Framework had now been completed and had been a focus for the previous six months since NHS England announced the move from the Data Protection Security Toolkit (DPST).

The focus had provided the opportunity to consider the risks more broadly and there was constant review of risks to ensure the potential threats and controls are equal. There were also national alerts of general and specific cyber risks which ensure the risks are constantly being reviewed in line with these alerts.

The Board of Directors:

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

139/25 Q1 2025/26 Learning From Deaths – Quarterly Overview of Learning and Data Reporting

AS presented the report which provided the Board of Directors with the final draft report for Q1 which includes data relating to deaths recorded on Datix for the period 01 April – 30 June 2025, a summary of progress of reviews of deaths occurring in previous periods, and examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board of Directors.

Questions and Discussions

- MJ advised the Quality Committee was prioritising triangulating the themes from the report with CQC findings and the PSIRF to understand the key occurrences over recent reviews and where there are any gaps in assurance, particularly around record keeping.

The Board of Directors:

1. **Noted and approved the information presented.**
2. **Noted the assurance provided by the content of this report of robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing care and ensuring that patients are receiving safe, high quality services.**
3. **Did not request any further information or action.**

140/25 Strategic Impact Report M6 2025/26

ZT presented a report which provided the Board of Directors with an update on the implementation of the Trust's Strategic Plan at Month 6 of 2025/26, half way through the five-year planning period. ZT highlighted the following:

- The operational planning process for the next financial year was under way, with national guidance now received. Work was under way to develop a fully integrated plan which covered the planning guidance and drove key areas of focus for the Trust's strategic priorities for the coming year.
- The Trust had completed a mid-point strategic review, which included involvement from the Board and considered the overall vision of the Trust to become the leading mental health and community provider. The review concluded that the vision remained valid and the four strategic objectives were still appropriate for achieving the vision.
- The review highlighted three areas of focus to achieve the objectives, becoming a trauma informed organisation, taking on accountable care delivery and adoption of AI.

The Board of Directors:

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

142/25 Annual Review of Governance Documents

DG presented a report which provides the revised Standing Orders for the Board of Directors, Standing Orders for the Council of Governors, the Scheme of Reservation

and Delegation, Standing Financial Instructions and Detailed Scheme of Delegation for approval by the Board of Directors. DG advised that the documents had been reviewed through internal governance processes via the Audit Committee and Council of Governors (for the Standing Orders for the Council of Governors). The amendments highlighted in the report linked with Strategic Risk 8: Use of Resources.

The Board of Directors:

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

143/25 Quarterly Report on the Safe Working Hours of Resident Doctors

FS 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. FS highlighted there had been an increase in the number of exception reports and fines than in the previous year. FS advised the reason for the increase was understood and action taken to address.

The Board of Directors:

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

144/25 Provider Capability Assessment 2025/26

PS presented a report which provided the EPUT Provider Capability Self-Assessment submitted to NHS England. The Board of Directors had provided delegated authority to ensure the submission of the assessment could be made within the required timescale, but there was a requirement for the final submission to be shared at a public Board of Directors meeting.

The Board of Directors:

1. **Noted the report and the assurance provided.**

146/25 USE OF THE CORPORATE SEAL

PS presented the report which provided information on the use of the Corporate Seal since the last Board meeting.

The Board of Directors:

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

147/25 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

- Letter from the Secretary of State 19 November 2025

148/25 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.

It had been agreed that Strategic Risk 7 is reviewed and refreshed in line with potential risks identified by TS under item 133/25.

149/25 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

RS noted the discussion around Freedom to Speak-Up and how to capture data as there was currently a binary picture in terms of protected characteristics, as there is only data on the alleged victim rather than the alleged perpetrator.

151/25 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.

152/25 ANY OTHER BUSINESS

There was no other business.

153/25 QUESTION THE DIRECTORS SESSION

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

154/25 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday04 February 2026.

The meeting closed at 12.35pm.

Signed: Date: 2025

Hattie Llewelyn-Davies, Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 153/25)

Governor / Member of the Public	Query	Response
Member of the Public (RL)	RL attended the previous Board of Directors meeting and had raised concerns regarding continuing discrimination and abuse of individuals. RL asked the Board if it was satisfied with the response provided to the allegation that the Trust had failed to investigate and act on reports of discrimination. RL felt the concerns that had been raised had not been clearly represented in the minutes and wanted it to be made clear that they believed there were serious failures in the organisation not acting on reports of abuse and discrimination to members of staff at different levels. RJ could only speak from their own experience, but felt it was not likely to be affecting others. RL said they had been barred from making further complaints.	HLD advised that following the previous meeting she had reviewed all the case papers relating to the original complaint and had felt that it had been responded to adequately. HLD said she would like to meet with RL, along with AS, to discuss and understand the wider learning from their experience.

4. ACTION LOG AND MATTERS ARISING

Standing item HLD

REFERENCES

Only PDFs are attached

Action Log Part 1 04.02.2026.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 3 December 2025

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG	Ann Sheridan	AS	Zephan Trent	ZT

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
113/25 October	Future Board Seminar session to include a presentation on the enactment and use of the Mental Health Act across the Trust.	AS	March 2026	This has been added to the Board planner to take place at the next Board Seminar session in March 2026.	Future Action	
133/25 December	Undertake Board Seminar session for Capacity / Winter Planning and Data Strategy as part of the Board Development programme	AG / ZT	May 2026	This has been added to the Board Seminar schedule to take place in May 2026 for Flow and Capacity / Data Strategy.	Future Action	

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item HLD

REFERENCES

Only PDFs are attached

Chair's Report 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

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 Lampard Inquiry

The next Lampard Inquiry public hearings will take place from Monday 2 to Monday 16 February. They will hear evidence from bereaved family members, related to the circumstances of those who died under the care of mental health trusts in Essex, including EPUT. Understandably, colleagues patients and families may be impacted by the hearings, with lots of support available for colleagues through our Here for You Team and the EPUT Inquiry Project Team. Support for patients, families and carers can be arranged by contacting PALS on 0800 085 7935 or on the Lampard Inquiry website. Colleagues are actively encouraged to engage with the Inquiry openly - by being open and transparent, we can support Baroness Lampard and her team to provide the answers that patients, families and carers are seeking.

2.2 NED Appointed to the House of Lords

Congratulations to EPUT NED Sarah Teather on her appointment to the House of Lords. Prior to joining the Trust Sarah was a Liberal Democrat MP and government minister, who throughout her time in Parliament gained a reputation as a formidable campaigner on social justice issues. As a Liberal Democrat member of the House of Lords, Sarah hopes to create space for people excluded from decision making to get their voices heard. On behalf of the Board, congratulations to Sarah on this exceptional achievement.

2.3 Changes to the Board of Directors

I would like to formally welcome Dr Kallur Suresh to the EPUT Board of Directors. Following the departure of Dr Milind Karale who had been in post since the inception of EPUT, Dr Suresh was appointed Interim Chief Medical Officer, and following a robust recruitment process, substantive Executive Chief Medical Officer. Congratulations and welcome Kallur.

I would also like to formally note that Doug Field has taken the decision to step down from his role as Associate NED from the end of January. Since joining the Trust, Doug has embraced the role of Associate NED and has been a welcome and effective member of the Trust Board. On behalf of the Board, I would like to wish Doug the very best in his future endeavours.

2.4 Recovery Café for Patients at Brockfield Hospital

The Recovery Café at Brockfield House is a weekly patient led space designed to offer warmth, connection and peer to peer support for patients throughout their mental health and addiction treatment journeys. The idea was created by Trust peer workers, an expanding team of people who use their personal experience to support patients and ensure their voice remains at the heart of care. The café offers a space to talk openly with people who understand recovery, an opportunity for peer workers to share their lived experiences and guest speakers to join and talk about their own journeys. The Recovery Café has kindly been supported by Tesco, whose Community Champion has donated coffee, tea and biscuits to help create a welcoming and comforting environment for all who attend.

2.5 Breaking Down Barriers to Employment

EPUT is one of three providers delivering the free Connect to Work programme across Greater Essex to help people with complex barriers to employment return to work. We are working alongside the Shaw Trust and Essex Cares Limited (ECL) to deliver personalised support to people who are not currently working, or finding it difficult to work. It is aimed at people who have a long term health condition, have a disability, and are part of the programme's priority groups. EPUT has been part of the programme, which is funding by the Department of Work and Pensions, since

August 2025 and is supporting 190 people with long term mental or physical health conditions. Being in good quality employment can have so many positive impacts on a person's health and we are working with clients to build their confidence and find good quality and fulfilling employments where they can use their skills and talents and build important social connections to reduce feelings of isolation.

2.6 Queen's Nurses

Three members of the EPUT nursing staff - Alexandra Bartlett, Emefa Dokosi and Jennie Keane - have been awarded the prestigious title of Queen's Nurse for their commitment to patient care. The Queen's Institute of Community Nursing awards the title of Queen's Nurse to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. On behalf of the Board of Directors, congratulations to Alexandra, Emefa and Jennie.

2.7 How We Are Making The Trust More Energy Efficient

January saw Energy Saving Week (17-23 January), a national campaign that encourages us to consider the changes we can make to reduce the amount of energy we use in work and at home. At EPUT our Green Plan sets out how we will operate in a sustainable manner that benefits both the Trust and the community we serve and sets out clear targets for measuring success towards achieving a Net Zero Carbon future.

We can all play a part in helping to reduce the Trust's carbon footprint and saving energy by doing some simple things:

- Reducing energy consumption by switching off any electrical equipment when we leave Trust premises, including computer screens, lights, heaters etc.
- Limiting car travel wherever possible by walking, cycling or using public transport and car sharing.
- Not leaving your vehicle running when it is idle. Anti-vehicle idling clean air signs are being installed the Severalls site in Colchester to support the reduction of air pollution from vehicles at Trust sites.

As part of our Green Plan we are installing solar panels at our sites at Clough Road in Colchester and Rochford Hospital as a renewable source of energy. Old lighting in being replaced with energy efficient LED lighting at four of or sites at:

- Clough Road
- Pride House
- Brentwood Resource Centre
- Chelmsford and Essex Centre

There is a lot of work going on at the Trust as part of our Green Plan but we know there is more to do to reduce our energy consumption, and we all need to work together to achieve this. Our Trust Green Champions help to promote and get involved in initiatives across the Trust to drive positive changes to protect and enhance the environment.

3.0 Legal and Policy Update

3.1 Reforms To Mental Health Act Set To Pass Into Law

Please find below a link to the report published on 18 December 2025. Long-awaited updates to the legislation governing the assessment, treatment, and rights of individuals with mental health disorders are set to become law as the revised Mental Health Act receives Royal Assent.

These reforms follow many years of work by successive governments to update the Mental Health Act 2007, ensuring it better reflects modern understanding of mental illness and addresses concerns around detention and racial inequalities.

A range of changes—including removing the ability to detain individuals with learning disabilities or autistic people without a co-occurring mental health condition for more than 28 days, and introducing a requirement for care and treatment plans when an individual is detained—will be implemented over a period of up to ten years. **For Information: Mental Health Act 2025**

3.2 Changes To Medicines Policy: What You Need to Know

Please find below a link to the report published on 15 December 2025. Recent domestic and international developments in medicines policy are anticipated to increase NHS expenditure on medicines, while enhancing access to innovative treatments and strengthening the UK's position as a global leader in life sciences.

For Information: Changes to medicines policy: what you need to know | NHS Confederation

3.3 Employment Rights Act 2025

The Employment Rights Act 2025 completed its path through Parliament on the 16 December 2025 and received Royal Assent two days later. The Act provides measures for Trade Unions and industrial action, fire and re-hire and employment rights measures. There are a range of other provisions which come into effect on the 17 February 2026. The link below provides access to the legislation.

For Information: Employment Rights Act 2025

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item PS

REFERENCES

Only PDFs are attached

CEO Report 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

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 for sharing with the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to 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 strategic developments and key operational matters and initiatives.

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

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

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

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

Supporting Reports and/or Appendices
CEO Report

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

CHIEF EXECUTIVE OFFICER REPORT

1. CEO UPDATES

1.1 New Year and Looking Forward

As always, the winter period can be challenging with higher demand for our services which has been seen in recent weeks. I visited a number of services during the festive period including sites at Thurrock, Derwent Centre and Colchester where I saw the hard work and dedication of our staff first hand. Our Trust priorities remain the same for 2026, with more patient and carer involvement in both individual care and wider service development; delivering Nova – our ground breaking new Electronic Patient Record system - and delivering our Community First programme. During visits to services, I have heard first hand from staff and patients the impact that the Time To Care programme has had on improved care. Time To Care as a programme of change to a new way of running our inpatient wards is now business as usual, but we know that for many of our patients an inpatient stay is just part of their story, and they will need care and support following discharge. Our focus in 2026 will be transforming our community mental health services through our Community First programme. This programme will change the way in which we provide care in people's homes and in the community. Community First will help to standardise processes and approaches, better align the community teams with our inpatient mental health wards and reflect the move to support and care for more people in their homes and in the community. We are now talking to patients, their families and carers, and our staff to gather their views, with a series of workshops taking place in January to bring in partner organisations and colleagues.

1.2 Appointment of new Executive Chief Medical Officer

Following his appointment as interim Chief Medical Officer, and after a thorough recruitment process, Dr Kallur Suresh has been appointed as the Trust's permanent Executive Chief Medical officer. I am sure you will all join me in congratulating Kallur on his appointment. Myself and others involved in the interview process were impressed by Kallur's passionate commitment to improving patient care across the Trust and for his vision for clinical leadership. I look forward to working with Kallur to take forward our plans with patients, their families and carers at the heart of all we do as we build on the development of our mental health and community health services.

1.3 Hospital At Home

Delivering seamless community care closer to home is one of the Trust's core priorities, and the Hospital at Home service in West Essex is a clear example of how EPUT is expanding care in the community, integrating physical and mental health services, and working in partners with acute hospitals, GPs and local services. More than 1,750 patients received hospital equivalent care at home in 2025 thanks to our West Essex Hospital at Home service. The service supports people whose conditions can be safely managed at home instead of in hospital and is a shining example of our focus on delivering community care differently to meet our patients where they are, using a combination of home visits, phone calls and digital remote monitoring technology to safely and effectively monitor patients in the comfort of their homes, intervening if their health deteriorates. The team also look after people who have been discharged from hospital, and on average patients can safely leave hospital two days earlier than planned to continue their care under Hospital at Home. With around half of people aged 65 and over admitted to hospital in West Essex living with frailty, the service is helping prevent avoidable admissions. Digital innovation continues to underpin this work and feedback from patients, carers and GPs being overwhelmingly positive. This holistic approach reflects EPUT's wider focus on personalised, inclusive care that looks beyond diagnosis and reflects our vision and strategic objectives by delivering seamless personalised community care, supported by digital innovation.

1.4 Parliamentary Round Table

I was pleased to have the opportunity to speak at a parliamentary round table event on delivering the next phase of mental health reform on 25 November. This event hosted by Cat Eccles MP, Member for Stourbridge, focussed on the move from crisis management to improvement and how the Mental Health Bill can be used to help make lasting improvements in patient outcomes and service sustainability. Discussions focussed on the importance of recognising the needs of

neurodivergent people when planning and delivering mental health services, as well as suicide prevention.

1.5 EPUT Role as Regional Lead for Op COURAGE Recognised

EPUT is the regional lead across the east of England for Op COURAGE, the NHS's England wide service which supports the needs of armed forces veterans, people in active service and their families. We recently took part in two events to help further understanding of the issues veterans and those in active service can face:

- We supported the Papyrus Prevention of Yong Suicide charity to help colleagues from organisations across Essex to learn essential skills to support people in distress who are having thoughts about suicide at an event held at the Ministry of Defence's Personnel Recovery Centre at Colchester Garrison.
- Colleagues from EPUT and our Op COURAGE partners Norfolk and Suffolk NHS Foundation Trust were invited to Westminster to an event hosted by the Rt Hon Mark Francois MP, Member for Rayleigh and Wickford and Shadow Armed Forces Minister. The event showcased The Forcer Protocol, a lifesaving preventative measure for UK veterans and serving personnel, including reservists, which enables police forces to access key information on people reported missing, such as health conditions, triggers and possible locations.

1.6 Lampard Inquiry

EPUT is one of the core participants in the Lampard Inquiry into mental health deaths in Essex between 2000 and 2023. The Inquiry has held four sets of public hearings in 2025, with further hearings scheduled in 2026 – beginning in February. Board members, together with leaders from the Trust, are attending every hearing to hear the moving accounts of family members, along with evidence from expert witnesses so that we can react in real time to emerging themes and issues. Dedicated support is in place for anyone affected by the Inquiry, including current and former patients, families, loved ones and carers and EPUT staff, who are actively encouraged to engage with the Inquiry to support Baroness Lampard and her team to provide the answers that patients, families and carers are seeking.

1.7 HSJ Digital Award Nomination

EPUT has been shortlisted for a national HSJ Digital Award, recognising the work taking place across the Trust to build digital confidence and skills that support safer, better patient care. Working in partnership with Mid and South Essex NHS Foundation Trust (MSEFT), we have been shortlisted in the Digital Literacy, Education and Upskilling Award category for The Nova Academy - a learning programme designed to support staff at all levels to develop the digital skills needed in today's NHS.

Since its introduction in 2024, more than 90 colleagues across both Trusts have completed the Nova Academy, which is made up of a mix of courses, workshops, and resources. Participants finish with long lasting skills in digital innovation, clinical safety and governance, leadership, change management, and data quality. As more colleagues develop their capabilities through the Academy, we are strengthening our ability to deliver our new unified EPR effectively.

The HSJ Digital Awards shine a light on teams and organisations driving meaningful change through technology, improving patient outcomes, streamlining processes and enhancing the overall quality of care. This year marks a milestone for the HSJ Digital Awards, with a record-breaking 468 entries submitted, of which 201 projects have been shortlisted - each demonstrating remarkable ingenuity, passion and transformative impact in digital health.

The winners will be revealed at the HSJ Digital Awards ceremony on 19 June, a night dedicated to celebrating the brightest minds and most impactful projects in digital health.

2. EXECUTIVE UPDATES

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

Mental health inpatient flow has been challenged during this period as a result of numerous factors including industrial action. Community and inpatient teams across physical and mental health have continued to focus on the delivery of our winter plan and working closely with system partners to ensure patients are supported in the most appropriate place.

Progress against the recommendations resulting from the recent internal flow review is reported through to the Executive Team, with several actions now complete. The flow recovery plan has been reviewed and refreshed following the learning from a recent regional peer discharge review.

As part of a winter test and learn process, our West Essex Care Unit is delivering a Community Assessment and Treatment Unit at Poplar Ward, St Margarets. The unit provides an alternative referral option for urgent medical care for adults and aims to deliver improved short- and medium-term outcomes for patients and better system demand and capacity management. The service has provided care for nearly 200 patients in the first seven weeks, with a five-day mean length of stay.

All inpatient wards within the scope of Time to Care have achieved substantial completion of the new therapeutic target operating model and the reporting focus will turn to benefits realisation.

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

Following an extensive procurement process, Grant Thornton have been appointed as the Trust's External Auditors. Their appointment includes Independent Review of the Trust's Charity Accounts. The process included Audit Committee recommendation to the Council of Governors for approval and Finance & Performance Committee acting on delegated authority from the Board.

The Trust continues to develop its plans for the next three to five years. This includes patient activity, performance expectations, people numbers and revenue and capital projections. The national deadline for submission is 12 February following consideration and challenge by Board members.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Patient Safety & Quality Priorities

The Trust is undertaking a major programme of work with Carradale Futures (a UK-based health-tech company specialising in the development of digital solutions to standardise and optimise healthcare delivery) to strengthen the development of our Quality Priorities and the Patient Safety Incident Response Plan (PSIRP). Using AI-enabled analysis of data from incidents, complaints, CQC findings and Prevention of Future Deaths reports, this work aims to align Quality Priorities, PSIRP and Safety Improvement Plans to deliver focused, evidence-driven improvements. The planned engagement event being held on 18 February 2026 will present this work to support development of the next Quality Priorities and PSIRP.

Health Inequalities

Work to reduce health inequalities continues to progress, particularly through PCREF implementation, race equity initiatives, and targeted programmes. Peer workers will form the first cohort of Race Equity Champions to support cultural awareness and anti-racism work. The COMPASS programme is advancing, focusing on improving access and outcomes for young men from racialised communities. Collaboration with VCFSE partners is also increasing through Community First, with Basildon identified as the initial site for the Essex Peer Academy to test a community-led, health-creation model. Learning from this pilot will inform wider rollout and help shape partnership-based approaches to reducing inequalities and improving population outcomes.

Fundamentals of Care

The Trust continues to play a leading role in the International Learning Collaborative (ILC), strengthening our national and international profile in Fundamental Care. The Trust involvement supports evidence-based improvements in patient safety and quality and is feeding into the development of the Trust's nursing strategy. The Trust Named Nurse person-centred care model has been selected for presentation at the ILC International Conference in June 2026. EPUT is recognised as a key UK partner in this agenda and has extended ILC membership benefits to ARU, UoE, MSEFT and internal teams, demonstrating strong system leadership and collaborative improvement.

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

Resident Doctor Industrial Action - December 2025
Resident Doctors staged a five-day strike from 17-22 December 2025, marking their 14th walkout since March 2023. The strike stemmed from a breakdown in negotiations between the BMA and Government. Resident doctors have received an average 28.9% pay uplift over the past three years, with the Government stating it cannot increase pay further for 2025. A Government offer on 8 December - which included expanded training places, backdated exam fee reimbursement, and emergency legislation to prioritise UK graduates - was rejected by the BMA on 15 December and the strike went ahead.

The Trust managed the resident doctors' industrial action effectively, supported by robust pre-existing plans, clear patient communication, strong system-wide coordination, and uninterrupted delivery of critical services.

Resident Doctors 10 Point Plan – Update
The 10-point plan aims to improve the working lives of the 75,000 resident doctors across the NHS by addressing persistent issues and ensuring consistent standards across all trusts. Trusts are required to act on all points within a set time frame, ensuring sustained improvement and long-term commitment embedded in the NHS Oversight Framework. The Trust has appointed a Senior Lead - Dr Kallur Suresh - and a Peer Lead was appointed on 2 December – Dr Eriki. The second national survey was jointly completed, and the Trust scored 91% compliance rate against the set criteria. The national team noted a positive shift in the dial and confirmation that improvement plans are in place for swift improvement.

Workforce Dashboard
A programme has commenced to design, develop and deliver a workforce dashboard asset in Power BI, aimed at modernising the Trust's capability to monitor workforce performance and support evidence-based decision-making and planning. The programme is being led by the Trust Digital team, with support from TrustMarque in the design and build of the dashboard. The solution will integrate key workforce data sources, including ESR, HealthRoster, Training Tracker and relevant local databases, to provide a more comprehensive and timely view of workforce metrics. The workforce dashboard is scheduled for launch in April 2026.

Mandatory Training Compliance
Overall mandatory training compliance for substantive staff is at 89% with a target of 90%. Closer attention on the details of compliance continues, highlighting areas of risk by professional group and subject to support stronger compliance rates.

Partnership Working
EPUT is looking to expand its education partnership arrangements by working with primary care to provide training and shadowing opportunities to GPs and other staffing groups. Initial conversations have taken place, with further planning expected to commence in quarter 1 of 2026/27.

National Staff Survey
The Trust achieved a 52% response rate in this year's Staff Survey, a 10% increase on 2024 that gives us a stronger and more representative view of staff experience. Most People Promise scores have improved, overall morale and engagement continue to rise, and advocacy for EPUT as a place to work and receive care has strengthened.

We have identified that flexibility, the experience of our bank workforce and early signs of declining motivation and stress-related indicators require further focus. Local results are already informing improvement activity with Care and Corporate Units, supported by upcoming focus groups and the launch of a Staff Survey Toolkit in March.

These insights will shape a Trust-wide action plan, with findings scheduled for discussion at Executive Team, People Committee and Board level. Further analysis will follow once national

benchmarking and final bank staff data are available, and we are also exploring how AI can support deeper insight and more efficient improvement planning.

Culture and Leadership Development
In September 2025, EPUT commissioned BRAP and the Kings Fund to undertake a review into our organisational culture and develop a pilot leadership programme, recognising the need to address long-standing cultural misalignment and build the foundations for sustainable change.

Early findings highlight several themes, including a sense of organisational paralysis driven by heightened scrutiny, a strong pull to action that risks fragmentation, and pressures on middle managers that limit the capacity for relational and visionary leadership. Insights from this diagnostic phase will be used to co-design and pilot targeted interventions that will inform a leadership programme running from May to July, supporting leaders to navigate complexity, balance accountability with trust and create the conditions for learning and psychological safety.

The learning generated through these pilots will shape an annual cycle of leadership development aimed at embedding learning more intentionally across the Trust and supporting longer-term cultural change.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS

REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

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

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

Purpose of the Report		
This report provides the Board of Directors with: • 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 reported at 99.1%, remaining out of target (an increase from 98.7% in November) - Target <93%
- PICU Occupancy reported at 92.3%, remaining out of target (a decrease from 93.2% in November) – Target <88%
- Specialist Occupancy reported at 82.2%, however, remains within target (an increase from 77.3% in November) - Target >95%
- Older Adult Occupancy reported at 96.8%, remaining out of target (a decrease from 96.9% in November) – Target <86%

There is ongoing focus to reduce the out of area placements and this work will have an impact on the bed occupancy.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (Including the Assessment Unit) reported at 48.8 days (a decrease from 52.7 days in November) - Target <60 (Oversight Framework)
- 85 discharges in December - 25 long stays (60+ days).
- In December there was 85 discharges and 25 of those were long stays:
    - **60+ days –** 9 discharges
    - **100+ days –** 8 discharges
    - **200+ days –** 8 discharges

Older Adult Average Length of Stay on Discharge

- Older Adult ALoS reported at 126.9 days (an increase from 118.6 days in November) - Target <90 (Oversight Framework)
- 47 discharges in December - 32 long stay (60+ days).
- In December there was 47 discharges and 32 of those were long stays:
    - **60+ days –** 7 discharges
    - **100+ days –** 18 discharges
    - **200+ days –** 7 discharges

Older Adult Average Length of Stay on Current Inpatients

- Older Adult current inpatients ALoS reported at 102.5 days (a decrease from 109.1 days in November) - target of <90 (Oversight Framework).

PICU average length of stay

- PICU ALoS reported at 55.0 days (a decrease from 64.4 days in November) – Target <50
- Eleven discharges from PICU in December;
    - o Hadleigh – 6 discharges
    - o Christopher Unit – 5 discharges

Rates of Patients Clinically Ready for Discharge:

Patients with a delayed transfer of care have all been reporting within target limits for the last 4 months, following a peak in August where Adults were outside of target with 5.5%. Most delays are due to awaiting care packages.

Inappropriate Out of Area Placements:

- December reported an increase in the number of placements to 60.
  - Adult increased by 7
  - Older Adult increased by 1
  - PICU increased by 6
- 21 repatriations in December
  - Adult – 24
  - PICU - 4
- 60 remain OOA in November
  - Adult – 46
  - Older Adult - 1
  - PICU - 13

The number of OOA remaining at month end has increased from November (46 up to 60). Adult decreased by 3 and PICU decreased by 1.

The number of OOA remaining at month end has increased from November, (46 to 60). Increased by Adults 7, Older Adult by 1 and PICU by six. Industrial action that lasted 5 days (17/12/25 to 22/12/25) and demand pressures (1,708 OBDS in December) will have had an impact on performance.

Cardio Metabolic:

Overall compliance saw a decline in performance with 63.8% reported in December:

- Six inpatient wards fully compliant in December (439 Ipswich Road, Tower, Roding, Topaz, Meadowview and Byron Court).

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

Community SMI patients under 1-year have seen a decrease in performance in December with a reported 57.1%. Annual health checks for SMI patients on the risk register for the Mid and South Essex Care Unit due to demand v capacity impacting further progress. SystmOne access is being given to teams so they can identify the Health Check gaps to be undertaken. A tracking report used by teams was reinstated in August and has been working to improve performance. The work has identified the need for greater clarity of processes, better data quality and the importance of sharing learning from teams that are performing well.

NHS Talking Therapies:

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

The moving to recovery indicator continues to report above the 50% target, with 54.3% in December.

No Harm / Low Harm Incident Rates:

In December there was a slight increase in reported incident rates with 85% of incidents are reported as no or low harm. The highest categories were self-harm, pressure ulcers and physical assault.

This year has reported particularly low levels of No/Low Harm incident rates, especially for the period of February to July 2025.

Workforce:

Sickness has been increasing month on month since May and is now reported in at 5.8%. The trust continues to operate 1% above KPI and 1% above comparable benchmarking. This is in line with past seasonal trends where the sickness recorded is higher in the summer months.

Anxiety/stress/depression/other psychiatric illnesses were the most reported reason for sickness. Although sickness absence reasons indicate that rising sickness rates are associated with absence due to cold, cough and flu. The flu vaccination update is being promoted throughout the Trust, although EPUT has one of the lowest flu vaccination uptake in the NHS.

A comprehensive review is underway to identify services and areas where sickness absence exceeds 5%. This analysis will inform targeted interventions aimed at improving staff wellbeing and reducing absence rates. To strengthen HR support, across the care units where there is high absence HR surgeries will be implemented at the beginning of 2026.

Temporary Staffing:
Agency WTE worked in M9 continued to fall and remains significantly under Trust targets and generally aligns well when benchmarked with other Trusts. All units reported a reduction in agency use except for Medical and estates and facilities. Agency Spend in month was £6.2m, reflecting a continuation of the downward spend.

Bank WTE worked increased in month and was operating 31 WTE above planned target, increased used was aligned primarily to inpatient areas within MH Inpatient wards and specialist services aligned to increase need for observations. Overall the Trust bank spend represents 12% of total pay spend, this month (2% increase) the majority of the increase will be aligned to high pay rates during public bank holidays during M9, EPUT benchmarks high in comparison to other Trusts, oversight meetings continue to ensure focus on bank reduction with plans being worked up to further support temporary staffing reductions in 26/27

Ward Fill Rates:
December reported 27 wards having less than 90% fill rates against the target of <13, this remains the same as reported in November. The current year has shown a negative increase and hasn't achieved target. This is in comparison to 2024, where the target was achieved 7 out of 12 months.

Income & Expenditure
YTD deficit is £6.9m, £5.8m adverse to plan (£5.1m of which is deficit support funding withheld). Position includes £3.4m of new income: Revenue Support £2.7m, Industrial Action £0.7m.

Temporary staffing
In month temporary staffing spend is £4.3m, an increase of £0.1m, this includes bank holiday costs.

Efficiency
In month delivery £2.3m, £0.7m behind plan impacted by Out Of Area costs but continued over-performance on temporary staffing. YTD delivery £21.2m (64% of plan), £1.3m behind YTD plan.

Capital
Capital spend YTD £11.9m, £7.9m variance to plan. Internal mitigations being sought for lack of national flexibility to move EPR monies across years.

Cash
Cash balance is £31.5m, above plan by £18.4m due to receipt of deficit support funding and lower 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	FTE	Full Time Equivalent
AWoL	Absent without Leave	IAPT	Improving Access to Psychological Therapies
CCG	Clinical Commissioning Group	MHSDS	Mental Health Services Data Set
CHS	Community Health Services	NHSE	NHS England
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OOA	Out of Area
FRT	First Response Team	OT	Outturn

Supporting Reports/ Appendices /or further reading

EPUT Quality & Performance Board Report **HERE.**
Appendix 1: Financial Performance Month 9 – December 2025

Executive Lead

Paul Scott
Chief Executive Officer

NHS
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Financial Performance

Month 9 - December 2025

EPUT

NHS
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NHS Foundation Trust

Trust Summary Financials – Month 9

Commentary & RAG:

Income & Expenditure
YTD deficit is £6.9m, £5.8m adverse to plan (£5.1m of which is deficit support funding withheld).

Position includes £3.4m of new income: Revenue Support £2.7m, Industrial Action £0.7m.

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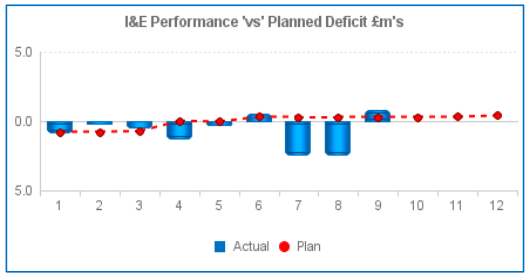
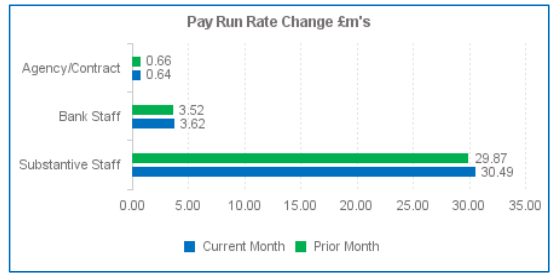
Capital spend YTD £11.9m, £7.9m variance to plan. Internal mitigations being sought for lack of national flexibility to move EPR monies across years.

Cash
Cash balance is £31.5m, above plan by £18.4m due to receipt of deficit support funding and lower capital spend.

Income & Expenditure Position

Income & Expenditure Position	Annual Budget £m	Monthly Actual £m	Monthly Variance £m	YTD Actual £m	YTD Variance £m	RAG Rating	Prior Month £m	Current Month £m	Run Rate Mvmt £m
Income	656.0	56.1	1.9	479.1	(15.2)		51.9	56.1	4.2
Pay	(400.4)	(34.7)	(1.5)	(305.1)	(4.4)		(34.0)	(34.7)	(0.7)
Non Pay	(239.2)	(20.0)	(0.1)	(175.2)	6.2		(19.9)	(20.0)	(0.1)
Net Finance Costs	(10.6)	(0.6)	0.1	(5.8)	1.0		(0.5)	(0.6)	(0.2)
Other Gains / (Losses)	0.5	0.0	0.0	0.0	(0.1)		0.0	0.0	0.0
Operating (Deficit) / Surplus	**6.2**	**0.7**	**0.4**	**(7.0)**	**(12.4)**		**(2.5)**	**0.7**	**3.2**
Technical Adjustments	(6.2)	0.0	(0.0)	0.2	6.5		0.0	0.0	(0.0)
Adjusted Financial Performance	**(0.0)**	**0.7**	**0.4**	**(6.9)**	**(5.8)**		**(2.5)**	**0.7**	**3.2**

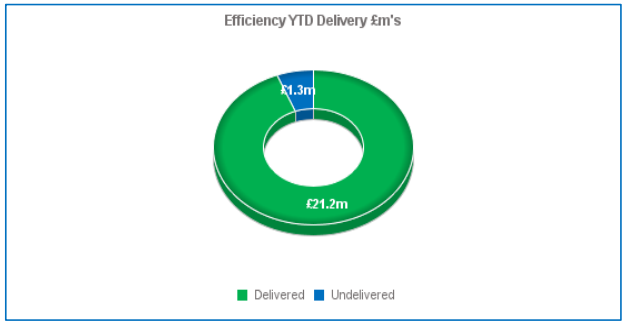


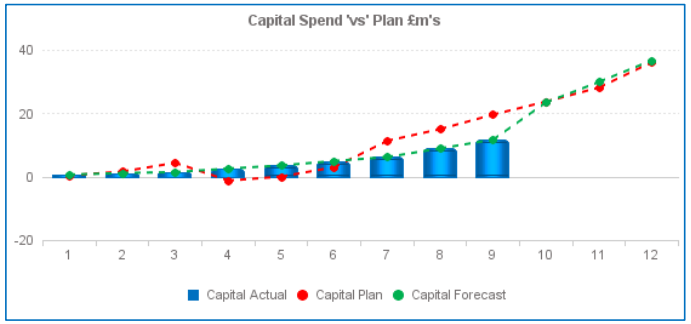


Capital & Efficiency Position

Efficiency	Annual Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Actual £m	YTD Variance £m	RAG Rating
Recurrent	31.3	1.7	(1.2)	16.1	(6.4)	
Non-Recurrent	0.0	0.6	0.6	5.1	5.1	
Total	**31.3**	**2.3**	**(0.7)**	**21.2**	**(1.3)**	

Capital	Annual Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Actual £m	YTD Variance £m	RAG Rating
EPUT Capital	36.0	2.8	1.8	11.6	7.9	
Non System Commitments	0.1	0.0	0.0	0.1	0.0	
Total CDEL	**36.1**	**2.8**	**1.8**	**11.7**	**7.9**	

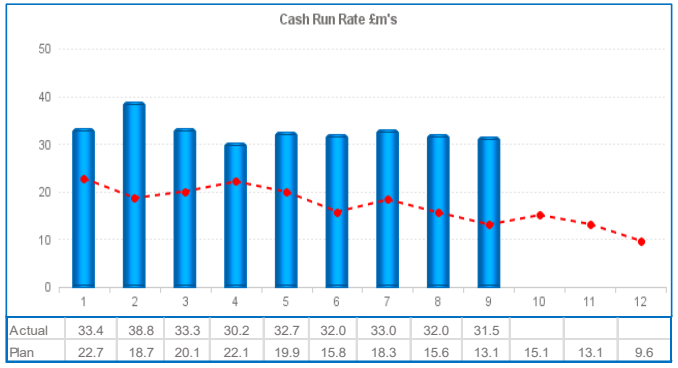




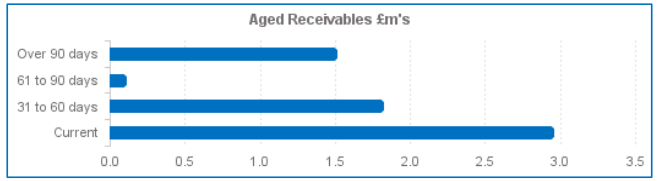
Statement of Financial Position

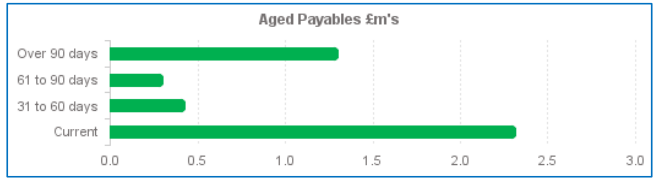
Statement of Financial Position	YTD Actual £m's	In Year Mvmt £m's
Non Current Assets	277.6	(3.7)
Current Assets	61.7	9.4
Current Liabilities	(80.8)	(6.3)
Non-Current Liabilities	(74.8)	6.0
Net Assets Employed	**183.7**	**5.3**

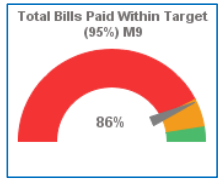
Cash Position	YTD Actual £m's	YTD Variance £m's
Opening Cash	28.1	3.1
Cash Inflow / (Outflow)	3.4	15.3
Closing Cash	**31.5**	**18.4**

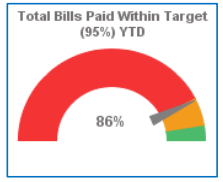


Actual	33.4	38.8	33.3	30.2	32.7	32.0	33.0	32.0	31.5			
Plan	22.7	18.7	20.1	22.1	19.9	15.8	18.3	15.6	13.1	15.1	13.1	9.6









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Summary Financials Month 9 Commentary - Including Key Risks

Income and Expenditure

YTD deficit £6.9m, £5.8m adverse to plan. The M9 results continue to exclude the loss of Deficit Support Funding (DSF) from M7 onwards £5.1m. This is partially offset by revenue support income of £2.7m and £0.7m of Industrial action (IA). Underlying overspends remain including Out of Area placements.

Efficiency

YTD efficiency delivery £21.2m (64% of annual plan), £1.3m off plan. Results continue to be driven by temporary staff over-performance offset by shortfalls relating to Out Of Area placements.

Capital & Cash

Year-to-date capital spend £11.7m, £7.9m below plan mainly driven by delays in key strategic estates schemes and EPR. Continued action to accelerate capital spend, FOT remains £36.6m whilst further mitigations are sought.

Cash balances total £31.5m, £18.4m better than plan including deficit support funding (£15.8m) and lower than planned capital spend. Excluding DSF recovery the Trust forecasts closing cash balances of £5.8m, £3.8m worse than plan. The Trust will review cash applications following outcomes of DSF discussions and, in conjunction with the final 26/27 plan submissions

Key Risks

- Excess Lampard Inquiry costs.
- Patient demand and Out of Area placements requirements.
- Delivery of temporary staffing trajectories.
- Full recovery of planned income.

Other Matters

- **External Audit Appointment:** The Trust has undertaken a market exercise for the provision of external audit services. An evaluation process of three tenders was undertaken on the 09 Jan including supplier presentations. A recommendation was made by the Audit Committee to the Council of Governors to appoint a new auditor. The Council of Governors met on the 15 Jan to consider and agree the appointment with effect from the audit year 25/26, including Charity Accounts.

- **CQC Well Led Inspection:** The Trust has been notified of a CGC Well Led inspection for March 26. Data requests have been received. These include details of financial performance, Committee agenda's, financial audits, financial plans and efficiency reviews.

- **2026/27 Planning:** The Trust has received feedback from its initial plan submission and is preparing for the second submission due for 12 February. A separate paper including a request to convene a delegated Committee meeting to approve the final plan is subject to a separate agenda.

- **Out Of Area Unification:** The Trust has received a final draft report from PA Consulting. The report outlines a number a scenarios and models LOS trajectory reductions against capacity to reduce Out Of Area placements including financial forecasts. The Inpatient team have selected a scenario for operational adoption. This is being tested against flow interventions and a recommendation will then be made to Executive team and commissioners.

- **NHSP Dispute:** The Trust has arranged further meetings with NHSPropCo and the ECFO has written to NHSPs CFO.

7.2 COMMITTEE CHAIRS REPORT

Information Item Chairs

REFERENCES

Only PDFs are attached

Committee Chairs Report 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

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

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

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

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

Summary of Key Points

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

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

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

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

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

1. Finance & Performance Committee (Diane Leacock)
2. People 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

February 2026

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
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1. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 22 January 2026

Assurance

Performance Report

- Assurance on the Trust's performance during December 2025 included the following areas:
  - Crisis call response times
  - Mental health inpatient capacity and mental health readmissions within 28 days for adults
  - Adult, older adult and PICU average length of stay on discharge
  - Inappropriate out of area placements
  - OPEL status
  - Cardio metabolic
  - Virtual ward occupancy
  - Urgent Community Response Team two-hour performance
  - Rates of delayed transfer of care
  - Routine mental health referrals seen within 28 days

Financial Report

- The Committee received an update on the Trust's Month 9 financial results. It considered in detail the YTD and FOT positions and the link to the BAF risks. After consideration it was agreed that SR7 Capital and SR8 Use of Resources should remain unchanged in terms of risk score, noting that SR7 had been adapted now to Capital and Cash in line with previous discussions.

Estates & Facilities Update

- The Committee received the quarterly report providing assurance on key estates and facilities matters. The increasing scale of the Trust's backlog maintenance requirements and hard to fill roles were highlighted for management, mitigation and adding to the Corporate Risk Register.

Information

Board Assurance Framework Report

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

Operational Capacity

- Significant volumes of requests for documentation and information received from the Lampard Inquiry, CQC and Commissioners, in addition to Winter Pressures, are stretching capacity within all corporate and operational areas.

Green Plan 2026/29

- The Committee received a report providing an update on progress made on the current Green Plan, and the direction of travel on national and local sustainability priorities from 2026/27.
- The Committee approved the report for presentation to the Board of Directors. This will be provided in a separate agenda item.

Action

No Actions for the Board.

Alert

No Alerts for the Board.

2. PEOPLE COMMITTEE

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

Committee meeting held: 18 December 2025

Assurance

Assurance Reports

- The following assurance reports were received by the Committee:
  - Board Assurance Framework – Workforce and People & Culture Risk Register
  - Consultant Job Planning
  - Education Strategy
  - Independent Review Action Plan
  - Management & Leadership Development
  - NHSE Self-Assessment for Placement Providers 2025
  - Resident Doctor 10-Point Plan
  - Sexual Safety Plan Progress
  - Workforce KPIs / Mandatory Training Compliance
  - Workforce Planning Submission 2026/27

Mandatory Training Compliance

- The Executive Medical Director provided assurance that improving Consultant training compliance is a priority, and progress updates will be provided to the Committee.

Information

Staff Survey 2025

- The Staff Survey 2025 is now complete, and the results are being analysed.

All Stars

- The All Stars employee recognition programme has been rolled out across the Trust, receiving 10,000 visits during its first week.

Operational Plans

- New Operational Plans are currently being developed, involving collaboration with transformational, operational, financial and clinical colleagues.
- The objective is to achieve financial savings whilst maintaining quality and safety of care.

Student Story

- A final year mental health nursing mature student attended to give their perspective on student nursing placements at the Trust.
- Overall their experience had been positive, and they had felt very supported during challenging personal events.

Action

No Actions for the Board.

Alert

Resourcing Plan (Recruitment Strategy 2025-30)

- The Committee received and approved the Recruitment Strategy 2025-30.

3. QUALITY COMMITTEE

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

Committee meetings held: 11 December 2025 & 15 January 2026

Assurance

Assurance Reports:

- The Committee received the following Assurance Reports:
  - Board Assurance Framework (Aligned Risks)
  - Care Plans Update
  - Complaints Concerning Abuse & Discrimination: Themes, Learning & Assurance
  - CQC & PFD Assurance Report
  - Clinical Audit & NICE Quarterly Report
  - Emergency Preparedness Resilience & Response Report
  - Executive Emergent Issues
  - Falls Reduction Report
  - Health, Safety & VAPR Report / HSSC Assurance Report
  - Learning from Incidents / Development of a Patient Safety Culture
  - Learning Disability Improvement Standards Report
  - Management of the Deteriorating Patient
  - Quality of Care Performance Dashboard
  - Quality Senate Report
  - Reducing Restrictive Practice Report
  - Research & Innovation Strategy Report
  - Sexual Safety Report
  - Time to Care Highlight Report
  - Working with Neurodivergence Report

Information

Winter Planning

- The Committee received an update on plans for the winter period, noting the Trust was working closely with system partners and maximising the resource available, staff sickness levels were being monitored, and the flu vaccination programme was underway.

Resident Doctor Industrial Action

- The Committee received details on plans in place to mitigate Resident Doctor industrial action.

Voice Technology

- A steering group has been established to oversee a pilot programme trialling voice technology.
- The outcomes of the trial are expected by the end of the current financial year.

Management of Controlled Drugs

- Updates on actions carried out so far and future plans in place to manage controlled drugs across the Trust were provided to the Committee by the Director of Pharmacy and Executive Medical Director for assurance.
- The Committee will receive further updates and assurance as work progresses.

Ardleigh Ward

- Members of the Ardleigh Ward team attended to share their experience and discuss the impact of recent improvements made on the Ward.

Action

No Actions for the Board.

Alert

Learning From Deaths Quarterly Overview of Learning & Data Report

- The Committee approved the Quarter 2 2025/26 Report for presentation to a future Board meeting.

7.3 CQC ASSURANCE REPORT

Information Item AS

REFERENCES

Only PDFs are attached

CQC Assurance Report 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality Committee 15 January 2026, Quality of Care 22 January 2026					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the contents of the report.
2. Note the assurance on progress against the improvement plan.

Summary of Key Issues

- EPUT continues to be fully registered with the Care Quality Commission.
- The CQC have published their final inspection report for Learning Disability Inpatient services (Byron Court) reporting an overall score of requires improvement. The Operational Director is taking forward actions in response.
- The CQC completed unannounced visits to 439 Ipswich Road (Nov 2025), Avocet Ward and Cumberlege Intermediate Care Centre (CICC) (Dec 2025) and Ardleigh Ward (January 2026). Data requests issued have been completed and CQC queries responded to.
- Implementation of version 02 of the CQC improvement plan 2025 which includes actions from both the Forensic inspection and MH Adult Acute and PICU inpatient inspection.
- CQC Action plan (v02) overview as of the 31 December 2025:
  - Thirteen regulatory and improvement actions made up of 56 sub-actions in progress to address the improvements required.
  - Of the 56 sub-actions
    - 2 (3%) are in recovery (CCTV, Activity Cancellation KPI reporting)
    - 5 (9%) are off track, no recovery plan
    - 20 (36%) are on track
    - 28 (50%) reported as complete and pending evidence
  - 1 (2%) have been closed through the evidence assurance process
- There were fifteen CQC enquiries raised during this reporting period.

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

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

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

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

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

Supporting Reports/ Appendices /or further reading

- CQC Assurance Report
- Appendix 1 – CQC Action Plan Update December 2025

Lead

Ann Sheridan
Executive Chief Nurse

CQC Assurance Report – February 2026

1. Purpose of the report

This report provides the Board of Directors with:

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

2. CQC Registration Requirements

2.1. Registration

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

3. CQC Inspections and Improvement Plans

3.1. CQC Unannounced MH Adult Inpatients (Ardleigh Ward) (January 2026)

The CQC completed unannounced visit to Ardleigh Ward. Data request has been completed and CQC queries responded to. The Trust awaits the draft report.

3.2. CQC Unannounced Community Health Inpatients (Avocet and CICC) (December 2025)

The CQC completed unannounced visits to Avocet Ward and CICC. Data request has been completed, and the Trust awaits the draft report.

3.3. Long Stay Rehab (439 Ipswich Road) (November 2024)

The CQC completed unannounced visits to 439 Ipswich Road. Data request has been completed and CQC queries responded to. The Trust awaits the draft report.

3.4. CQC Unannounced inspection Learning Disability (LD) Inpatients (Byron Court) 16.07.25

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

Improvement actions arising from this inspection will be added to the Trust overarching CQC improvement plan. (Attached Appendix 2)

3.5. CQC Improvement Plan

Progress continues against the CQC Action plan (02) developed to bring together actions identified following CQC inspections reports received in 2025 (Forensic Services and Adult Acute & PICU Services) and open PFD action plans.

As of 31 December 2025:

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

- Of the 56 sub-actions

    - 2 (3%) are in recovery (CCTV, Activity Cancellation KPI reporting)
    - 5 (9%) are off track, no recovery plan
    - 20 (36%) are on track
    - 28 (50%) reported as complete and pending evidence

- 1 (2%) have been closed through the evidence assurance process

Implementation of the plan continues via the local operational CQC Care Unit meetings with oversight reporting to the Quality of Care Group.

The Care Unit CQC meeting hold action owners to account for delivery. The meeting is chaired by the Executive Chief Nurse

3.6. CQC Enquiries

During the reporting period (November/December), the CQC raised fifteen (15) enquiries as outlined below.

Received	Service	Enquiry related to
11/11/2025	Ardleigh Ward	Inappropriate behaviour
12/11/2025	Specialist Mental Health Team The Gables	Patient Relationship
13/11/2025	Willow Ward	Discharge / Follow Up
17/11/2025	Willow Ward	Discharge / Follow Up
19/11/2025	Wood Lea Clinic	Inappropriate behaviour
21/11/2025	Willow Ward	Mental Health Act Detention
25/11/2025	Recovery and Wellbeing Southend Taylor Centre	Unhappy with Treatment
03/12/2025	Galleywood Ward The Linden Centre	Communication - Communication breakdown with relatives
03/12/2025	Kelvedon Ward Basildon Mental Health Unit (MHU)	Clinical Practice - Admission Process
03/12/2025	Wood Lea Clinic	Assault / Abuse - Staff to patient physical
09/12/2025	Peter Bruff Ward The Kings Wood Centre	Security - Patients belongings
11/12/2025	Stort Ward Derwent Centre	Clinical Practice - Drugs on Ward
17/12/2025	Christopher Unit (PICU) The Linden Centre	Systems & Procedures - MHA Detention
22/12/2025	Cherrydown Ward Basildon Mental Health Unit (MHU)	Staff Attitude - Inappropriate Language

30/12/2025	Ruby Ward The Crystal Centre	Clinical Practice - Poor Care on Ward

3.7. CQC Notifications

During the reporting period, the Trust made twenty-seven (27) notifications to the CQC including:

- Absent without official leave (AWOL) (5)
- Death of a person using the service (8)
- Serious injury to a person using the service (5)
- Abuse (6)
- Death of a detained Mental Health patient (3)

4. Independent Assurance against CQC Quality Statements

4.1. Internal Assurance (Annual Assurance Visit Programme)

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

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

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

4.2. Internal Assurance (Quality Statements Assurance Framework)

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

4.3. Quality Assurance Visits

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

5. Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report.

2. Note the assurance on progress against the improvement plan.

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Ann Sheridan
Executive Chief Nurse

Appendix 1

CQC Action Plan Update Report

31 December 2025

Introduction

Level of Assurance: Level 1

NHS Essex Partnership University NHS Foundation Trust

The purpose of this report is to provide an update on key CQC compliance requirements including implementation and assurance status against those actions within the CQC/PFD action plan 02.

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

Version 02 of the action plan includes:

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

Key Messages

CQC Activity

The CQC have published their final inspection report for LD Inpatient services (Byron Court) reporting an overall score of requires improvement. The Operational Director is taking forward actions in response.

CQC Action Plan v02 (2025)

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

For note,

- 2 (3%) are in recovery (CCTV, Activity Cancellation KPI reporting)
- 5 (9%) are off track, and await a recovery plan

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

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

Next Steps

Set recovery plans for actions off track
Focus on delivery of actions due in February 2026
Progress collation of evidence for actions reported as completed by action owners.

CQC Action Progress Update

NHS Essex Partnership University NHS Foundation Trust

Summary of implementation status

Overview as of the 31 December 2025:

- 13 Regulatory and Improvement Actions made up of 56 sub-actions have been developed to address the improvements required.

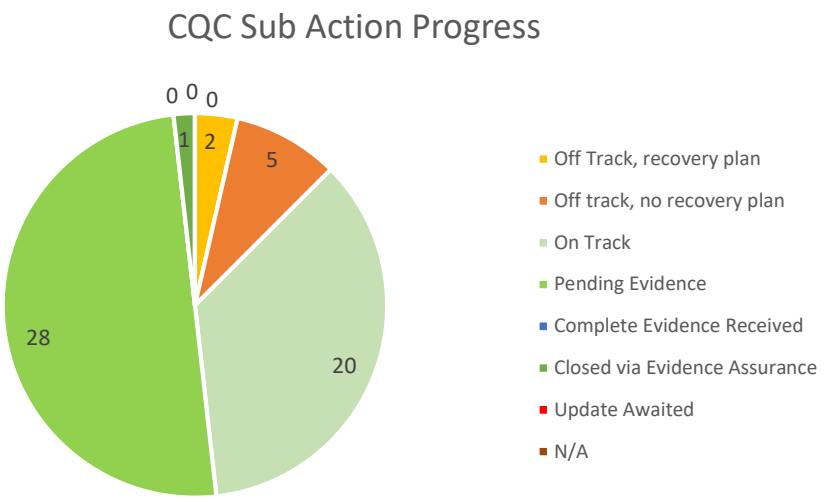
- Of the 56 sub-actions
  - 2 (3%) are in recovery (CCTV, Activity Cancellation KPI reporting)
  - 5 (9%) are off track, no recovery plan
  - 20 (36%) are on track
  - 28 (50%) reported as complete and pending evidence
  - 1 (2%) have been closed through the evidence assurance process

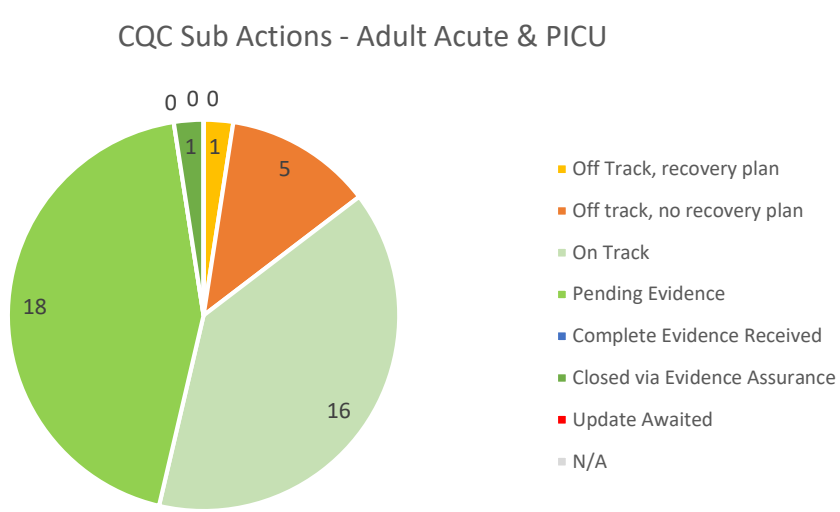
Summary of key activities completed in the reporting period

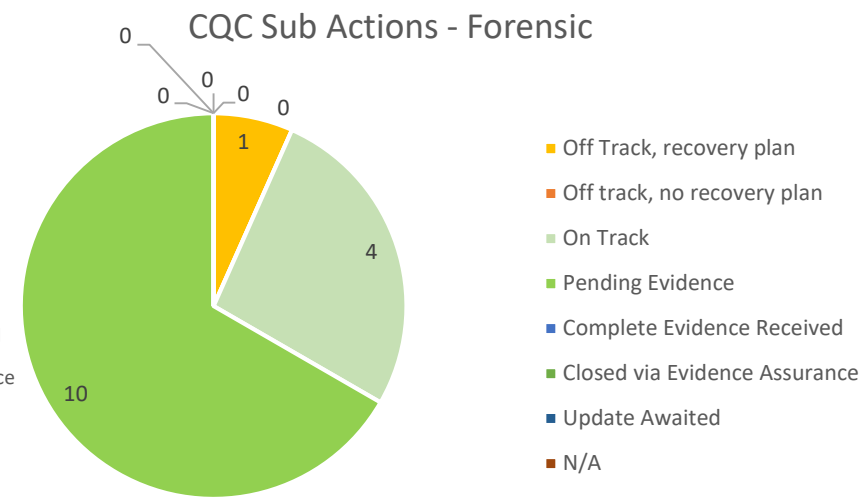
Actions completed (pending evidence) in the period:

- M15.3 Informal rights action closed via the Evidence Assurance.

- All Inpatient areas confirmed that site improvement meetings are taking place to support maintenance concerns. This meeting supports the closure of IA5.1/2/3.







CQC Action Recovery Plan

Action Recovery Plan				
CQC Concern	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
RA2 Rapid Tranquilisation and PRN Breach in safe care and treatment: Continued evidence of systems and processes not always being used safely, to prescribe, administer and record medicines.	RA2.6 Implementation of PRN audit programme	PRN audit is in progress. Data has been collected, and it is in the process of being written up. From there it will go to Medicines Management Group.	New audit data collection is complete and audit programme going forward to be confirmed. Audit analysis is in progress with discussion at the Senior Management Team meeting to be held and then forward to Medicines Management Group.	Katy Stafford
IA2.4 (April 2025) Nine patients said that activities were cancelled all the time due to staffing	Develop and present a quarterly activity KPI report through Care Unit governance, including narrative and mitigations for any cancelled activities.	Work in progress to develop report, all vacancies recruited to, activity Programmes available on all wards and Therapy Corridor is soon to be open.	To continue development of report and present KPI through Care Unit governance.	Vijay Chuttoo

CQC Action – Awaiting 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	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.	Workshop, supported by Transformation Team to be held on 5 January 2026 and a timeline of end of March for transition to be confirmed. CCTV working group established	Tendai Ruwona
(April 2025) **Governance (embedding learning - supervision and appraisal)** Identified a breach in governance due to the oversight of previous issues raised. CQC found there were still concerns as identified at the previous inspection, relating to staff supervision and appraisal rates. We found there continued to be issues relating to safe prescribing, administration and recording of medicines which resulted in a breach in safe care and treatment.	**RA4.1** To review Trust target compliance rate for staff 1-1 support to ensure this is in line with other Trusts. Timescale Nov – 25		Trust wide review to confirm target.	Katy Stafford
	RA4.2 Care Unit meeting to include discussions on forward planning rather than current position and feedback from AF meetings Timescale Oct—25	Meetings have been taking place.	Seeking assurance from AF and Care Unit meeting minutes that this is complete and sustainable.	Katy Stafford

CQC Action – Awaiting Recovery Plan

Action				
CQC Concern	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
Medicines Management Breach in safe care and treatment: Continued evidence of systems and processes not always being used safely, to prescribe, administer and record medicines.	**RA3.2** Medical Staff to include discussion on patient medication preference in the doctor's clinical review and ensure recorded on the patient notes Timescale Oct—25	Actions are part of the clinical procedure.	Discussion with medical leadership to agree monitoring mechanism going forward.	Katy Stafford
	RA3.4 Doctors to record within their physical health assessment the impact of prescribed medicines on the patient's physical health, regular side effects and outline the required routine monitoring. Timescale Oct—25	Actions are part of the clinical procedure.	Discussion with medical leadership to agree monitoring mechanism going forward.	Katy Stafford

7.4 FREEDOM TO SPEAK-UP POLICY

Decision Item DG

REFERENCES

Only PDFs are attached

Freedom to Speak-Up Policy 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

Report Title:	**Freedom to Speak-Up / Whistleblowing Policy**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Executive Director of Governance					
Report Author(s):	Janice Scott, Freedom to Speak-Up Guardian					
Report discussed previously at:	Joint Partnership Committee Executive Operational Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report 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. FTSU provides insight into strategic risks.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	~~Yes~~/No	

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

Purpose of the Report		
This report provides the Board of Directors with: • A review of the Freedom to Speak Up Policy/whistleblowing policy in line with the governance process. • Assurance that the policy is reflective of current practice and reviewed in line with the NHS England guidance.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the content of the report
2. Approve the Freedom to Speak-Up / Whistleblowing Policy

Summary of Key Issues

The EPUT Freedom to Speak-Up / Whistleblowing Policy has been reviewed in line with the routine review process. The policy has been reviewed by the Freedom to Speak Up Guardians using the NHS England Freedom to Speak-Up National Policy (June 2022).

The attached policy includes the following amendments:

- The addition of policy at a glance document
- Updated names and contact details for internal escalation mechanisms
- Updated links to documents and services
- Removed duplicated information for greater clarity

The policy has been reviewed in consultation with the Joint Policy Group and has been approved by the Joint Partnership Committee. It is a recommendation of the National Guardians' Office for the Freedom to Speak-Up / Whistleblowing Policy to be approved by the Board of Directors and is therefore attached for final approval.

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	FTSU	Freedom to Speak Up
PIDA	Public Interest Disclosure Act	LGBTQ+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and others

Supporting Reports/ Appendices /or further reading

Freedom to Speak-Up / Whistleblowing Policy and Appendix
Policy Approval Slide

Lead

Denver Greenhalgh
Executive Director of Governance

Essex Partnership University NHS Foundation Trust

Document title:	**FREEDOM TO SPEAK UP / WHISTLEBLOWING POLICY**		
Document reference number:	CP53	**Version number:**	sV 4.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Author:	Principal Freedom to Speak Up Guardian / Senior HR Advisor		
Approval group/ committee(s):	Joint Partnership Committee		08 January 2026
Professionally approved by: (Director)	Denver Greenhalgh, Executive Director for Governance		
Executive Director:	Denver Greenhalgh, Executive Director for Governance		
Ratification group(s):	Board of Directors		11 February 2026
CQC Quality Statement	Well led – Freedom to Speak Up		
Key word(s) to search for document on Intranet / TAGs:	Freedom to Speak Up FTSU F2SU Raising Concerns Speaking Up Whistleblowing	**Distribution method:**	☐Intranet ☒SOPHIA

Initial issue date:	03 April 2017	**Last Review date:**	11 February 2026	**Next Review date:**	01 November 2028	**Expiry Date:**	01 February 2029

What we do together matters

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Related Trust documents (to be read in conjunction with)
• Fraud and Bribery Policy (CP11) • Civility, Respect and Grievance Resolution Policy (HR2) • Employee Wellbeing, Sickness & Ill-Health Policy/Procedure (HR26) • Disciplinary (Conduct) Policy and Procedure (HR27A) • Capability Policy and Procedure (HR27B) • Maintaining High Professional Standards (HR32)

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
1.0	Gill Brice Associate Director of Planning	Harmonising NEP and SEPT's previous wording in relation to definition, duties, monitoring and compliance, and references to other sources and policies and procedure.	01 April 2017
2.0	Associate Director of Planning	Reviewed and updated in line with current best practice	24 January 2019
2.1	Associate Director of Planning	3 month extension Jan 22 F&P	01 January 2022
3.0	Principal Freedom to Speak Up Guardian Senior HR Adviser	Reviewed and updated in line with current best practice.	01 May 2022
4.0	Principal Freedom to Speak Up Guardian Senior HR Advisor	Reviewed in accordance with request from NHSE to update local policy to reflect national template by the end of January 2024. Old suite of Appendices rescinded	05 July 2023
4.1	Principal Freedom to Speak Up Guardian Senior HR Advisor	4.1 – Exec changed	01 November 2023
sV 1.0	Policy Team	Transferred to New Template – Not uploaded	
sV 2.0	Principal Freedom to Speak Up Guardian Freedom to Speak up Guardian Senior HR Advisor	Reviewed in accordance with request from NHSE to update local policy to reflect national template by the end of January 2024.	02 June 2025
sV 3.0	Policy Team	Extended to February 2026	January 2026
sV 4.0	Freedom to Speak Up team	Three year review Reviewed in accordance with NHSE guidance, to reflect changes in responsibilities and include reporting process CP53 – duplicated details from National Policy taken out to provide greater clarity and avoid confusion	11 February 2026

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
		Updated Director and HR details and links	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Policy at a Glance

Saved as a separate document; click here to open

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1 Principles

1.1 The Freedom to Speak Up policy sets out the rights and responsibilities of staff when raising issues of concern about what is happening at work and aims to make it clear that:

- Individual members of staff in the organisation have a legal right and a duty to raise with their managers or the Trust Board any matters of concern they may have about safety, clinical practice, malpractice or wrongdoing which may affect patients, the public, other staff or the organisation itself.

- The Board of Directors is committed to running the organisation in the best way possible. This policy is in place to reassure staff that it is safe and acceptable to speak up and to enable staff to raise any concerns they may have at an early stage and in the right way. Rather than wait for proof we would prefer staff to raise the matter when it is still a concern.

- The Executive Director responsible for the Freedom to Speak Up agenda in the Trust is the Executive Director of Governance.

- The Trust has in place Freedom to Speak up Guardians who are an independent and impartial source of advice to staff. They can facilitate access to anyone in the organisation, including the Chief Executive, or where necessary, refer staff to external agencies.

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

1.3 The accompanying process to be followed when raising a concern and further information on raising concerns can also be found here.

1.4 Colleagues Speaking Up and raising concerns should not expect to receive any detriment for doing so (see Appendix 1). In the unfortunate event this should happen, it must be reported to their line manager, senior manager, or Freedom to Speak Up Guardian.

1.5 Where needed, colleagues raising a concern which is being managed by a formal process will be provided with the opportunity to be accompanied by an accredited representative of a Trade Union or Trust work colleague at each stage of the process.

1.6 Any clauses within employment contracts that conflict with the protections provided by the Public Interest Disclosure Act (PIDA) are void.

1.7 Such settlement agreements (previously called compromise agreements) and commonly referred to as ‘gagging clauses’. The Government now requires an inclusion in settlement agreements to make it clear that staff can make a disclosure in the public

interest in accordance with PIDA, regardless of any confidentiality clause. This means that settlement agreements cannot be used by employers to stop employees from whistleblowing.

2 Duties

2.1 The Freedom to Speak Up policy applies to all staff who work for the Trust in full–time or part-time roles in a substantive or temporary capacity. It also applies to bank workers, students, trainees, people who are self-employed, employed through an agency, contractors or those working as a volunteer.

2.2 Former employees may also raise concerns in line with this policy and procedure. Concerns should be raised ideally within three months of the last day of employment.

2.3 It is an expectation that all colleagues will raise any concerns about safety, clinical practice, malpractice or wrongdoing which may affect patients, the public, other staff or the organisation itself. Every manager has a duty to ensure that colleagues can express their concerns through all levels of management of the organisation. Managers must ensure that any colleague's concerns are dealt with thoroughly and fairly and that the staff member raising the concern does not receive any detrimental treatment because of raising their concern.

2.4 Individual members of staff in the Trust have an obligation to safeguard all confidential information to which they have access, particularly information about individual service users or clients, which under all circumstances is strictly confidential, in line with the General Data Protection Regulation, 2016 (GDPR).

2.5 Workers registered with a professional regulatory body such as Nursing and Midwifery Council (NMC), General Medical Council (GMC) and Health and Care Professionals Council (HCPC) must adhere to their respective codes of conduct. Professional codes of conduct usually place a duty on the practitioner to raise concerns where they see instances of poor practice or wrongdoing, acting in the best interests of services users and protecting service users from danger. The NHS Constitution stresses the importance of honesty and openness. It pledges that the NHS will "encourage and support all staff in raising concerns at the earliest reasonable opportunity". The professional Duty of Candour makes a clear requirement to be open with patients and families when mistakes occur. Freedom to Speak Up encourages an environment where colleagues feel it is safe to raise concerns with confidence, be thanked for doing so, they will be listened to and the concerns acted upon across the organisation.

3 Monitoring and audit

3.1 The Board of Directors has delegated responsibility to the People Committee for the monitoring and review of the Freedom to Speak Up policy (CP53) which will be reviewed annually.

3.2 The Freedom to Speak Up team will record and report on formal concerns raised to the Freedom to Speak Up Service.

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4 Approval and implementation

4.1 All policies, procedures and guidelines will be approved by the Executive Operational Committee, which is the specialist group with the authority to approve local FTSU documents. These will then be forwarded to the Policy team for compliance check with CP1, and to the Board of Directors for approval.

4.2 It is the author's responsibility to inform the Trust services of the approved documents when they are uploaded to the Trust's Intranet.

5 Preliminary equality analysis

5.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals (see Appendix 3).

6 References

Speak up for a healthy NHS – How to implement and review whistleblowing arrangements in your organisation). DH 2nd July 2010 in conjunction with the Social Partnership Forum and Whistleblowing Helpline.
Professional or ethical rules guidelines and codes of conduct on freedom of speech, such as, for example, the NMC Code of Professional Conduct, and the GMC Guidance on Contractual Arrangements in Health Care.
NHS Employers – The Speaking Up Charter. October 2012
The Public Interest Disclosure Act (PIDA) 1998
Enterprise and Regulatory Reform Act 2013
Raising Concerns at Work, published by Whistleblowing Helpline, March 2014
NHS Constitution
Professional Duty of Candour
Fit and Proper Person's Test, 2014,
Freedom to Speak up Review, 2015
Freedom to Speak up (whistleblowing) policy for the NHS April 2016
NHS England: National Freedom to Speak up policy

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Appendix 1: Freedom to Speak Up Policy (National Policy)

Saved as a separate document for ease of printing; click here

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Appendix 2: Responding to Unfavourable Treatment as a Result of Speaking Up

Speaking up is a gift – an opportunity for us to engage with colleagues. A chance to hear different ideas and suggestions, enhance worker experience, prevent patient harm, and learn and improve when things don't go to plan or could be better.

One of the biggest barriers to speaking up is a fear of reprisals. Over 600 healthcare colleagues who spoke up across the NHS in 2020/21, believed they experienced some form of disadvantageous and/or demeaning treatment as a result.

The impact for individuals can be devastating and long-lasting. Our health and wellbeing suffers, and these experiences often lead to sickness absence and resignation. We cannot work at our best when our environment feels psychologically unsafe and this impacts on communication, effective teamwork, and safe patient care. It is important that we hear as soon as possible if someone believes they, or others, are in that position so we can work to resolve the situation.

Freedom to Speak Up (FTSU) Guardians have come together to develop this best practice guide to help us respond consistently when colleagues tell us about these experiences, and it has been localised for relevance to EPUT staff.

We call on the support of all healthcare workers to make it as safe as possible for us all to speak up by living our organisational values, treating each other with civility and respect, and creating a just and learning culture where listening and learning happens every day.

Guiding principles:

- We can expect to be thanked and treated with dignity and respect when we speak up
- We expect all colleagues to create a **psychologically safe** environment where speaking up is business as usual
- We won't tolerate mistreatment or poor behaviour towards colleagues who speak up
- We appreciate speaking up can affect people in different ways and will do all we can to support everyone involved fairly and with compassion
- Our focus will be on learning and improving
- We encourage colleagues to report any concerns about disadvantageous and/or demeaning treatment
- We will refer all concerns about disadvantageous and/or demeaning treatment to the executive lead for Freedom to Speak Up
- We will follow our Freedom to Speak Up process to ensure any such concerns are fully explored and any necessary steps taken.
- We will keep colleagues informed and updated throughout the process.

What we mean by disadvantageous/demeaning treatment:

- This guide refers to treatment as a result of the act of speaking up, rather than the specifics of the matter raised by speaking up. It can be a deliberate act or a failure to act/omission. Sometimes these actions can be subtle and not always easy to recognise. Whilst behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

Such treatment may include, but is not limited to:

- Experiencing poor behaviours not in line with our organisational values e.g. being ostracised, gas lighting, gossiping, and incivility
- Given unfavourable shifts; repeated denial of overtime/bank shifts; being denied shifts in a certain area/department without good reason; changes to shifts at short notice with no apparent reason
- Repeatedly denied annual leave; failure on a regular basis to approve in reasonable time, or leave cancelled without good reason
- Micro-managing, or excessive scrutiny
- Sudden and unexplained changes to work responsibilities, or not being given adequate support
- Being moved from a team or inexplicable management of change
- Being denied access to development opportunities; training or study leave without good reason
- Being overlooked for promotion

Responsibilities:

We appreciate that speaking up can, at times, feel challenging, particularly when we are involved in the issues that are being raised. However, we rely on each other to do the right thing, and we all share a responsibility to speak up when we see something that doesn't feel right. By working together and supporting everyone affected by speaking up, we can prevent colleagues experiencing poor treatment.

As individuals we share a responsibility to:

- Create a psychologically safe environment where speaking up is business as usual
- Treat our colleagues well when they speak up
- Speak up and be an ally when we witness disadvantageous and/or demeaning treatment
- Listen up and learn from speaking up

As an organisation we have a responsibility to:

- Protect workers who speak up from disadvantageous/demeaning treatment
- Ensure the working environment is a safe one
- Respond to concerns of disadvantageous/demeaning treatment by examining the facts, reviewing outcomes, providing feedback, and reflecting and learning

Recording:

- Reports of disadvantageous/demeaning treatment will be recorded by the Freedom to Speak Up Guardian on the central Speak Up database
- Information will be kept strictly confidential, only shared on a need-to-know basis
- Freedom to Speak Up Guardians are required to report speak up activity on a quarterly basis to the National Guardian's Office. The number of people sharing concerns relating to perceived disadvantageous/demeaning treatment as a result of speaking up is included in this data

What to do:

I/my colleague spoke up and now I believe I am/my colleague is experiencing disadvantageous or demeaning treatment as a result:

Process after a colleague reports detriment after speaking up to a manager or the Freedom to Speak Up (F2SU) Guardian:

- Clarify matters of confidentiality, what information will be shared and with whom
- FTSU Guardian will record on the central FTSU database
- Consider if any immediate action is required to protect the worker from disadvantageous or demeaning treatment (particularly important in the case of perceived bullying and/or harassment)
- Consider any potential patient safety issues and immediate action required
- Receive assurance that line management arrangements are in place to support anyone who might be affected
- Responsible executive to co-ordinate discussion involving FTSU Guardian and appropriate colleagues, for example, operational colleagues, HR, patient safety, safeguarding, Staff Side

In line with Speak Up process:

- Clarify matters of confidentiality
- Agree how and what to be explored (terms of reference), and timescales for completion
- Identify independent lead for any review/investigation
- Agree arrangements for monitoring and feedback
- Share and record key actions, outcomes, learning and recommendations
- Share wider learning across the organisation

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Appendix 3: Equality Impact Assessment [2024]

Please Note: An EIA must be attached to papers submitted to Board, the Executive Team or any other committee within EPUT. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.

How to complete this EIA

The lead assessor must be a member of the team leading the implementation of the service, function or project. If this is not the case, the final assessment should be approved by the lead before submission, examples of what warrants an EIA include:

- Introducing a new way of working into the Trust, or developing new services.
- Implementing new technology or processes.
- Creating a new policy or process that will affect staff in EPUT, or patients in their care.
- Implementing significant changes to an existing service, function or process within EPUT.

1) **Review evidence:** What evidence do you have that this may affect those from minority or marginalised communities? Have you looked at similar projects to identify best practice or discussed this in your team?

2) **Consultation:** Have you discussed this with stakeholders in the Trust or sought evidence?
   - Involving staff or patients who would be impacted in the decision-making process
   - Guidance from national organisations *(CQC / NHS Employers)*
   - The Equality and Inclusion Hub *(on the staff intranet)*
   - Input from Staff Equality Networks
   - Reviewing this against good practice in other NHS Trusts

3) **Provide rationale:** Explain clearly why this project will not affect marginalised or minority groups in the section below. Discuss this with your team and ensure that you are involving as many diverse viewpoints as possible in the conversation. List your reasons clearly in the boxes overleaf.

   The Equality and Inclusion Committee can review this and develop actions to support with implementation. You should also make a note on if this might benefit one group over others (for example, if an initiative improves the experience of those with disabilities or long-term conditions). This information can be used to suggest future improvements.

Submission: Please send a copy to epunft.equality@nhs.net for approval by the Equality and Inclusion Committee. These will be reviewed and approved as part of the next committee meeting. Actions may be suggested if concerns are raised by the initial screening. Please ensure that clear actions for these concerns is part of the final EIA document.

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Date (DD/MM/YYYY)	24/09/ 2025	
Directorate / locality / department	Freedom to Speak Up Service	
Name of new policy / service / function	CP53 Freedom to Speak Up / Raising Concerns and Whistleblowing Policy	
Is this a new policy / service / function or a change / review to an existing one?	Review to existing policy.	
Name of person(s) completing this EIA and their role(s) within the Trust *(Inc. the lead assessor completing this assessment)*	Name: Bernadette Rochford	Role: Principal Freedom to Speak Up Guardian
	Name: Janice Scott	Role: Freedom to Speak Up Guardian
	Name:	Role:
Name of relevant director of services	Denver Greenhalgh Executive Director for Governance	
Contact email address of lead assessor	bernadette.rochford1@nhs.net	

Actions as a result of this EIA:

Actions developed if requested by the Equality and Inclusion Committee following completion of screening questions and project details:

	E&IC suggested action (To be completed by the EIC in response to a concern raised by the screening questions overleaf)	**How / when was this completed?** (please provide a short summary of how this was addressed and when)
1		
2		
3		

This section to be completed by the Chair, following approval by the EPUT Equality and Inclusion Committee			
Equality Impact Assessment Authorised by:			
Name:	Gary Brisco	**Role:**	Equality Advisor
Date:			

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Screening Questions: *To be Completed by lead assessor:*

Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	No	• FTSU Guardians attend Staff Network (EMREN) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardians when staff raise issues • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Sex (Based on Biological / Anatomical Sex; Male, Female or Intersex)	No	• FTSU Guardians attend Staff Network (Gender Equality) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Age	No	• Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Sexual Orientation Including Heterosexual, Lesbian, Gay, Bisexual or any other orientation.	No	• FTSU Guardians attend Staff Network (LGBTQ+) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.

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Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
People who are/were Married or are/were in a Civil Partnership	No	• Taken into consideration as a protected characteristic by FTSU Guardians when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
People who are Pregnant or are on Maternity / Paternity Leave	No	• Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Transgender people, including those undergoing gender reassignment or those who do not identify as the gender they were assigned at birth	No	• FTSU Guardian attends Staff Network (LGBTQ+) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardian. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Religion or Belief Including an absence of belief or philosophical beliefs such as Veganism	No	• FTSU Guardian attends Staff Network (Faith and Spirituality) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardians when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.

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Does this work affect this group more / less favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	No	• FTSU Guardian attends Staff Network (Disability and Mental Health) and has discussed this with members. • Taken into consideration as a protected characteristic by FTSU Guardians when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.	No	• Taken into consideration as a protected characteristic by FTSU Guardian when staff raise issues. • Policy modelled on best practice from other NHS organisations by FTSU Guardians. • Ongoing monitoring and feedback received will determine any further consultation needed for all categories. • No direct negative impact identified. Additional consideration and recognition that staff from this group could have a heightened risk of suffering detriment.

EPUT

Essex Partnership University
NHS Foundation Trust

FREEDOM TO SPEAK UP POLICY [RAISING CONCERNS / WHISTLEBLOWING]

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CP53 Version 3, approved February 2026

CONTENTS

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This policy is for all our workers and we want to hear your concerns. At Essex Partnership University NHS Foundation Trust, we ask that all our workers including students and volunteers complete the online training on speaking up, listening up and following up.

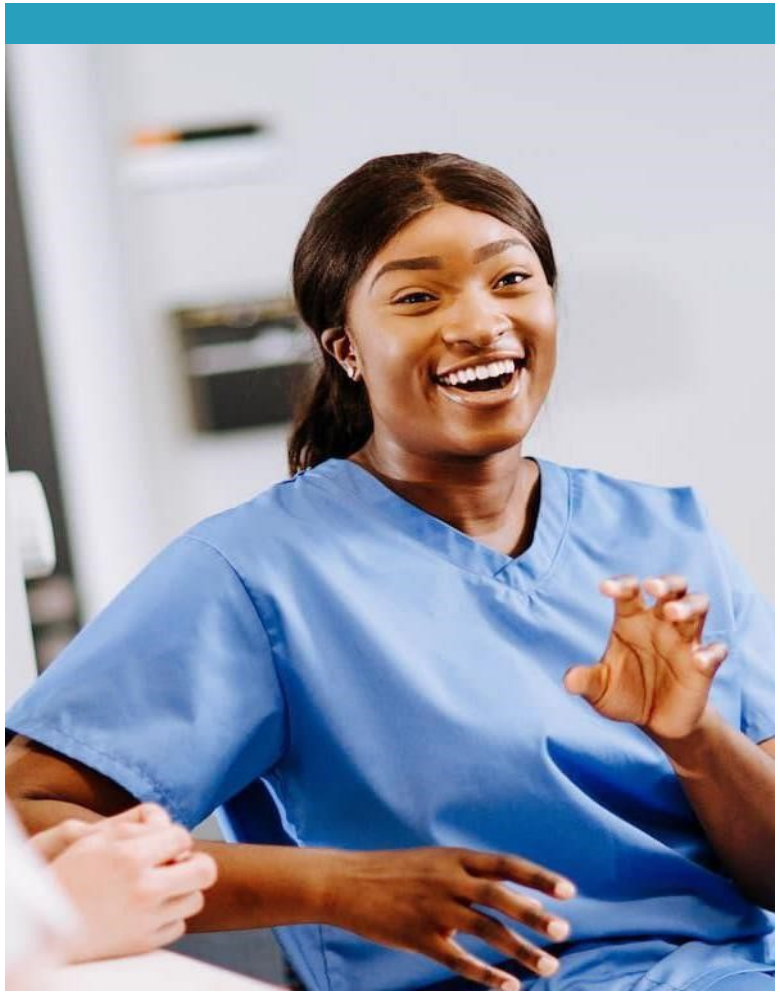
SPEAK UP – WE WILL LISTEN

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all of our workers. The NHS People Promise commits to ensuring that 'we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to and understand the hopes and fears that lie behind the words'.

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos.



THIS POLICY

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England, are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

WHAT CAN I SPEAK UP ABOUT?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviour of others is affecting your wellbeing, or that of your colleagues or patients. Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes and relevant EPUT policies:

- Civility, Respect and Grievance Resolution Policy (HR2)
- Managing Temporary Worker Conduct and Complaints Policy (HR59)
- Employee Wellbeing, Sickness & Ill-Health Policy (HR26)
- Disciplinary (Conduct) Policy (HR27a)
- Maintaining High Professional Standards (HR32)
- Capability Policy (HR27b)
- Fraud and Bribery Policy (CP11)

As an organisation, we will listen and work with you to identity the most appropriate way of responding to the issue you raise.

WE WANT YOU TO FEEL SAFE TO SPEAK UP

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about. We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

WHO CAN SPEAK UP?

Anyone who works at EPUT.

This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers and former workers.

WHO CAN I SPEAK UP TO?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters. However, you have other options in terms of who you can speak up to, depending on what feels most appropriate:

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about
- The patient safety or clinical governance team for when concerns relate to patient safety or wider quality issues.
- Local counter fraud team (where concerns relate to fraud) Andrew Ede, Anti-crime and Investigations Manager – TIAA. Email andrew.ede1@nhs.net / andrew.ede@tiaa.co.uk or call 07814 285 177 or you can report fraud online at https://cfa.nhs.uk/reportfraud or by calling 0800 028 40 60; Or NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their Freephone line 0800 028 4060.

Our HR business partners for each directorate are listed below together with the email link for employee relations:

Amy Rackham – Medical and Corporate Services HR Business Partner: amy.rackham@nhs.net

Helen Shonowo – Mid and South Essex HR Business Partner: helen.shonowo@nhs.net

Matt Cope – West Essex and North Essex HR Business Partner: matthew.cope2@nhs.net

Rachel Laverty – Specialist Services and Psychology HR Business Partner: rachel.laverty@nhs.net

Stacey Oliver – Mental Health Urgent Care and Inpatient Services: Stacey.oliver1@nhs.net

WHO CAN I SPEAK UP TO? Continued

Operational HR including Employee relations: epunft.operationalHR@nhs.net

Our Executive Chief People Officer is Andrew McMenemy: andrew.mcmenemy@nhs.net

Freedom to Speak Up Guardian Service

You can contact our Freedom to Speak Up Guardian service by email f2su.eput@nhs.net or phone 07581 014992 or 07814 226709

Our Freedom to Speak Up Guardians Bernadette Rochford and Janice Scott can support you to speak up if you feel unable to do so by other routes. The Guardians will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the Guardian role here

- Our Senior Executive Lead responsible for Freedom to Speak Up is Denver Greenhalgh: Denver.greenhalgh@nhs.net. Denver provides senior support for our Speaking Up Guardians and is responsible for reviewing the effectiveness of our FTSU arrangements.

- Our non-executive director responsible for Freedom to Speak Up is Ruth Jackson: ruth.jackson25@nhs.net

The Non-Executive Director role is specific to organisations with boards and provides more independent support for the guardian; provides a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.

You can also incident report/Datix your concerns. Concerns raised through an incident report or Datix are managed outside of the Freedom to Speak Up Guardian service.

WHO CAN I SPEAK UP TO? Continued

Speaking up externally

If you do not want to speak up to someone at EPUT, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
- GP surgeries • Dental practices • Optometrists • Pharmacies
- How NHS trusts and foundation trusts are being run *(incl. community and mental health trusts)*
- NHS procurement and patient choice • the national tariff

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix A contains information about making a 'protected disclosure'.

HOW SHOULD I SPEAK UP?

You can speak up to any of the people or organisations listed previously in person, by phone or in writing (including email).

Confidentiality:

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly**: you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially**: you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously**: you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

As a trust, we would prefer that you raise your concerns anonymously, than not at all.

ADVICE AND SUPPORT

You can find out about the local support available to you at health and wellbeing support via the intranet.

Your local staff networks can be a valuable source of support including:

- Here for You and Employee Assistance Programme
- Staff side/Trade Union

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up support scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

WHAT WILL WE DO?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in **Appendix B**.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside EPUT or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

WHAT WILL WE DO? CONTINUED

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the full outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardians.

APPENDIX A:

Making a protected disclosure

A protected disclosure is defined in the Public Interest Disclosure Act 1998.

This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up.

The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom.

To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.

APPENDIX B:

What will happen when I speak up?

We will:

Thank you for speaking up

Help you identify the options for resolution

Signpost you to health and wellbeing support

Confirm what information you have provided consent to share

Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

Referral to HR process

Referral to patient safety process

Other type of appropriate investigation / mediation etc.

Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified.

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive director lead for FTSU

Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body such as the CQC or NHS England

CP53 – Freedom to Speak-Up / Whistleblowing Policy

NHS
Essex Partnership University
NHS Foundation Trust

Policy Code	Policy Name	Author	Director	Executive Director
CP53	Freedom to Speak Up (Whistleblowing) Policy	Bernadette Rochford Principal Freedom to Speak Up Guardian	Denver Greenhalgh Executive Director of Corporate Governance	Denver Greenhalgh Executive Director of Corporate Governance

Documents included in Review	Reason for Approval	Details of Changes	Risk Summary
CP53 Freedom to Speak Up Policy (Raising Concerns / Whistleblowing) CP53 – Policy at a Glance CP53 – Freedom to Speak Up (National) Policy	Reviewed in line with NHS guidance Update Director details and links	CP53 duplicated details from Appendix 1 national policy taken out to provide greater clarity and avoid confusion. CP53 updated Director and HR details and links	Risk to the Trust if a suitable, current Freedom to Speak Up Policy is not in place

Consultation Groups	Sub-Committee / Expert Committee Approval	References Reviewed	Any other points for note
JPC	Joint Partnership Committee 08 January 2026	Yes	Submitted to 04 February 26 Board

Policy Oversight Group Checks							
Reflective of Best Practice (see references reviewed)	✓	Consultation Undertaken (see consultation groups)	✓	Consistent with other Trust Documents	✓	In correct template	✓

QUESTIONS TAKEN FROM THE GENERAL PUBLIC

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Information Item DG

REFERENCES

Only PDFs are attached

BAF Report 04.02.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Denver Greenhalgh, Executive Director of Governance					
Report discussed previously at:	Executive Board Assurance Framework Meeting Board of Directors Standing Committees					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

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

Summary of Key Issues

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

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

The Board is asked to note:

- Board Assurance Framework dashboard providing an oversight of the reporting period.
- There have been no changes in risk score
- SR7 has been extended to be inclusive of cash position and capital, considering the increased risk to cash balances in line Finance & Performance Committee discussions.
- 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. The Finance & Performance Committee noted the increasing backlog maintenance risk for the Trusts aging estate and hard to recruit Estate & Facility roles. These risks will be escalating to the Corporate Risk Register.

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 of Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

January 2026

NHS
Essex Partnership University
NHS Foundation Trust

Risk Dashboard

Jan-26

EPUT

Strategic Risk Register at a Glance

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

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register > 12 months
0	0	11	10

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

% Risks with Controls	% Risks with Assurances	Actions Overdue	
100%	100%	10	

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR3	All	Finance & Resources 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 oversight continues, with scheduled meetings to confirm progress and forward plans; no high or significant risks are currently identified. PAM reporting evidences strong and sustained improvements, with 197 items rated as 'good' and the remaining 15 actions linked to BCP updates. Actions are tracked monthly, and the improvements are now embedded within business-as-usual processes. Overall, the programme is progressing well and provides a high level of assurance. Therefore, the action will be reviewed to potentially closed as results are seen as business as usual. Review of actions and assess further to improve status covering all related operational risks.
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.	Progress continues on the procurement workstream for Appropriate OoAPs placements, including length of stay and out-of-area activity. The Trust has received a report from external consultancy which has provided a range of scenarios, interventions, length of stay trajectories and potential out of area reduction impact. This has been shared with operational colleagues and internal testing (two workshops) have been completed. The report has been shared with the ICB and resource transfer levels are forming part of the 2026/27 contract discussions. Extension requested for March 2026. Action RAG rated 'red' in recognition of the extended timeline. Time to Care Steering Group has agreed move of focus from implementation to a period of embedding the model and benefits realisation. The scope of the data set for the Community First Programme is complete, with Performance Team capacity to populate the data will be available at the end of January. Initial findings will be presented to the Community First Group in February '26. Extension requested to February '26 to enable this work phase to be completed.
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16	16 16 16	Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	A significant increase in the volume of Rule 9 requests was seen from November onwards, with ≥ 60% (89 Rule 9s) of all Rule 9s being received between August and December 2025, with November and December representing 34% of all Rule 9s received to date. This, combined with the Christmas period and the already open Rule 9s created significant pressure on EPUT's Inquiry Team's ability to respond. With a further 16 received in January, with significantly shorter timeframes, the pressure on the Team and ability to respond has increased. New Project Director started in post 12 January 2026, with this being a key focus to align with the now outlined in the newly released inquiry timeline and thematic reviews outline to June 2027. This is ongoing, with the ability focus on this impacted by the significant increase in demand on the team to respond to Rule 9s (61% of all Rule 9s received during August to December 2025). The focus is on key learning and developments mid-to-late February. Note the revision of the action timeline to March 2026.

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.	Complete baseline DSPT submission signed of by SIRO and submitted. New Action pre-submission audit planned for Feb '26.
SR7	All	Capital & Cash	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	Estates Safety Funding of £6m has now been fully approved. Final submission of the Programme of Works is planned by October for the UEC funding. The majority of the works are now in the process of being tendered. The Trust continues to work up business cases for future investments in preparation for the announcement of new Estates and Digital national funding for 2026/27. The Trust has approach Frontline Digitisation to support moving the forecast EPR capital underspend funding into 2026/27 to support CDEL Trust capacity, this is driven by slippage in the EPR programme timeline. The Trust is also working through the profile of a number of property disposals as agreed in the Estates Strategy to support the CDEL and capital availability in the year of EPR go-live. YTD Capital spend is £11.7m, £7.9m behind plan mainly driven by delays in key strategic estates schemes and EPR. Actions to accelerate capital spend remain in place with MH Urgent care centres and critical infrastructure now in construction phase.
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 efficiency performance including key risks and mitigation actions. At month 9 the YTD deficit is £6.9m, £5.8m behind plan. £5.1m relates to deifcit support funding with £2.7m of YTD unplanned Inquiry costs incurred. The Trust has been instructed to record a forecast deficit of £10.2m. This will be updated in M10 and will incorporate outcomes of deficit support funding discussions. YTD efficiency delivery is £21.2m (64% of annual plan), £1.3m off plan. Results continue to be driven by temporary staff over-performance offset by shortfalls relating to Out Of Area placements due to patient demand, in particular during month 9 a high level of PICU placements were required.
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	NOVA is influencing the requirements for the Target Operating model for Digital. NOVA future state validation (FSV) needs to conclude to inform the remaining gaps for phase 2. Therefore, timeline for the action has been extended to June 2026 to align with the programme. The NOVA programme is progressing, but new risks - linked to system integration and programme complexity - are likely to delay the EPR “go-live” date. Oracle Health has confirmed no additional costs, though extra resourcing will be needed and is being reviewed with Finance. The Board is advised that a new EPR risk will be escalated to the CRR next reporting cycle.
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.	People and Education Strategy and approved TOR have been socialised within consultation groups and aiming to be in plan by March 2026. *Staff Experience and Inclusion Group to commence in Dec 25. (PT) *Education Group due to commence Dec 25. (GB) *Staff Resourcing and planning Workforce Planning due to commence Dec 25. (KG) Consultation meetings with stakeholders both internal and external to develop a clear recruitment plan to support sustainability going forward and be aligned to the People Strategy. This includes aims to have full recruitment for HCA and band 5 nursing as an early area of focus. It also looks at developing a recruitment plan that supports career development and is aligned to our learning and education priorities. Consultations underway via Workshops and sharing of additional draft with a view to launch at the end of the year. Plan will be presented to People committee next week and fed to Board following.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
SR11	All	Staff Retention	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12	12 12 12	The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	Following a presentation to the HR SMT in December '25, work is now underway to strengthen processes for new starters and leavers, including (i) redesigning the new starter survey, (ii) leaver questionnaire and exit interview approach, (iii) working with the Recruitment Team to review their existing surveys and remove duplication, (iv) developing a script and guidance to support managers, (v) updating the Manager's Handbook, (vi) creating a dedicated intranet page to host the new resources, and (vii) reviewing the Recruitment and Retention Policy to identify any required amendments once the updated processes are ready for implementation. The data from exit interviews is to be aligned to findings from the National Staff Survey and Pulse surveys, integrated performance data and presented to the Executive Team and People Committee in April '26 (RAG rated amber to note extended timeline for the final part of this action). A revised induction process has been proposed that will improve staff experience of corporate induction, aligned to other NHS Trusts. Further work is required for local induction processes that follow corporate induction to ensure that new starter experience is enhanced, and turnover is further reduced in the first 12-months of employment. A report on induction and new starters will be provided alongside the work undertaken with leavers and exit interviews to the Executive Team and People Committee in April '26.
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.	Delivery commenced with BRAP and King's Fund for a 12-month pilot which will include a culture review starting in September 2025. Leadership programme to be established and developed alongside future leadership development with ARU utilising the apprenticeship levy. Nomination process for leadership development programme commenced in Jan 2026. BRAP & Kingsfund Phases are being progressed in a trajectory programme in three month intervals. Action timescales require extension to reflect phases within the 12 month pilot. 302 colleagues have now been trained across Specialist Services (Brockfield House), inpatient settings (Basildon) and a number of the leadership team. An impact analysis commenced in December 2025 and an assurance paper presented to People Committee in December 2025.Training is now being rolled out. Cascade training is not available due to capacity but is on track.
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.	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 IA to test the sustainability in progress. Note further extension to enable IA to conclude their testing.

Corporate Risk Register at a Glance

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

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

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

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

ID	SO	Title	Lead	Impact	CRS	Risk Movement (Last 3 months)	Context	Key Progress
CRR11	All	Suicide Prevention	MK	Safety	4x3=15	12 12 12	Implementation of suicide prevention strategy	The Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25 and outlining priorities for year 2 which are set out in the Trust Quality of Care Plan (QoC). The Quality of Care Group has received the Q2 report which highlighted: increase in suicide deaths in the quarter (note no suicides occurred within EPUT premises and all are current suspected suicides until COD is confirmed). A full project plan is in development for the move from risk stratification to Safety Planning. STORM training compliance has increased to 77% for all urgent care clinicians. Reduction in self harm incidents has continued this quarter. Monitoring has continued looking at correlation between staffing and reduced levels of self-harm and ligature activity.

Strategic Risk Register

January 2026

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previous reported completed actions 1- 7 have been removed from the report. **Note 2:** Completed actions (1–7) have been removed from the report, and a review of remaining action is underway to ensure ongoing alignment with operational risks
C5 x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs ERIC and PAM Groups Established	Premises Assurance Model in place with assessment (97 items rated as 'good')	
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 (PAM assessment notes 15 actions linked to BCP updates)		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
8	Deliver action plan from Premises Assurance Model (PAM) self-assessment	Sep-26	MM	Control	ERIC and PAM oversight continues, with scheduled meetings to confirm progress and forward plans; no high or significant risks are currently identified. PAM reporting evidences strong and sustained improvements, with 197 items rated as 'good' and the remaining 15 actions linked to BCP updates. Actions are tracked monthly, and the improvements are now embedded within business-as-usual processes. Overall, the programme is progressing well and provides a high level of assurance. Therefore, the action will be reviewed to potentially closed as results are seen as business as usual. Review of actions and assess further to improve status covering all related operational risks.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C5 x L3 =15*	*C5 x L3 = 15*	**Note 1:** Previous reported completed actions 1-6, 9-12 have been removed from the report. **Note 2:** Actions 8, is reported as complete and will be removed from future reports

Executive Responsible Office: Executive Chief Operating Officer
Board Committee: Finance and Performance Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff integrated flow team including Discharge Co-ordination Teams, Clinical Patient Flow Leads, Clinical Director for Flow & Capacity, Associate Director for Flow, Bed Management Team	Flow & Capacity Staffing Established under TTC	Performance Reporting Accountability Framework Meetings Demand Flow and Capacity Steering Group	
Care Unit Leadership	Establishment Integrated Director posts		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy Integrated Flow Team Staffing Therapeutic Acute Inpatient Operating Model Introduction of the SMART tool Enhance Sit-rep Process - Locality Based Introduction of the Prioritisation Matrix	Integrated Flow and Care Unit Leadership CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Final Report to Board (2024) Demand Flow & Capacity Steering Group	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23 Development of ED Divergent in NEE and NW due to be operational in '26	Demand Flow and Capacity Steering Group ICB System UEC Task & Finish Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitRep/ Performance Reporting	Updated OPEL framework x3 Locality Based Sit Reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status Flow report within Power BI SMART Tool Foundry Tool in development	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2025/26	Developed including out of area elimination plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Community First Transformation Programme			
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
7	Model Out of Area bed capacity/demand to inform terms of unification project with ICBs including appropriate level of resource transfer.	Extended Mar '26	SC/JW	Control	Progress continues on the procurement workstream for Appropriate OoAPs placements, including length of stay and out-of-area activity. The Trust has received a report from external consultancy which has provided a range of scenarios, interventions, length of stay trajectories and potential out of area reduction impact. This has been shared with operational colleagues and internal testing (two workshops) have been completed. The report has been shared with the ICB and resource transfer levels are forming part of the 2026/27 contract discussions. Extension requested for March 2026. Action RAG rated 'red' in recognition of the extended timeline.
8	Implementation of new operating model	Complete	LW	Control	Time to Care Steering Group has agreed move of focus from implementation to a period of embedding the model and benefits realisation.
13	Demand and Capacity Length of Stay Programme	Extended March '26	AG	Control	Steering groups established, this will feed into the Adult Acute Mental Health Programme and incorporates the Winter Plan (agreed at Board on 3 September) and the Flow Recovery Plan (FRP) hosted by EPUT but with a System wide approach/leadership. MADE events created within EPUT and Essex OOA Providers Findings and recommendations from EPUT Flow Review received. 90 day action plan developed with oversight from the Executive Team and the timeline for full delivery of plan is March 2026. Green RAG rating applied as denotes this action has changed and become a new action in light of the review.
14	Community First Transformation Programme with four key work streams (Community demand and capacity work stream initiated)	Extended Feb '26	VI		The scope of the data set is complete, with Performance Team capacity to populate the data will be available at the end of January. Initial findings will be presented to the Community First Group in February '26. Extension requested to February '26 to enable this work phase to be completed.

SR5 - Statutory Public Inquiry (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note 1:** Previous reported complete actions 1-7, 9 & 10 have been removed from the Board report. **Note 2:** The continued significant number of new Rule 9 requests from the Inquiry in the period is challenging our capacity, with a S21 notice issued in respect of one Rule 9 response.

Executive Responsible Office: Executive Director of Governance Board Committee: Board of Directors	**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 3 Associate Directors Browne Jacobson Essex Chambers	Trust Board of Directors	S21 Notice issued in respect of one Rule 9 request from the Lampard Inquiry (negative assurance)
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial allocation £8.6m to end of 2026	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry completed for 2024/25. (Note additional cost pressure of £6.6m to end of 2026 as consequence of accounting treatment).
Inquiry Response Governance	Inquiry Project Team leadership through Project Director Multi-Disciplinary Working Group Schedule of work agreed with Legal Advisors / Counsel	Trust Board of Directors	S21 Notice issued in respect of one Rule 9 request from the Lampard Inquiry (negative assurance)
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Project Team Here for You Provision Executive & Leadership team	Trust Board of Directors	Internal audit.
Support for families	Report from HPT to Project Working Group	Trust Board of Directors	Internal audit.
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Trust Board of Directors	
Management Development Programme (Inquiry Module)	*Note first session 25 April 2025*		

Actions (to modify risks)		By When	By Who	Gap	Update
8	Rule 9 progress	End of October 26	CBD	Assurance	A significant increase in the volume of Rule 9 requests was seen from November onwards, with ≥ 60% (89 Rule 9s) of all Rule 9s being received between August and December 2025, with November and December representing 34% of all Rule 9s received to date. This, combined with the Christmas period and the already open Rule 9s created significant pressure on EPUT's Inquiry Team's ability to respond. With a further 16 received in January, with significantly shorter timeframes, the pressure on the Team and ability to respond has increased.
11	Review and refocus of Project Inquiry resource to align with the skill set required to respond to the latest Rule 9's.	Revision of Date March 2026	DG	Control	New Project Director started in post 12 January 2026, with this being a key focus to align with the now outlined in the newly released inquiry timeline and thematic reviews outline to June 2027. This is ongoing, with the ability focus on this impacted by the significant increase in demand on the team to respond to Rule 9s (61% of all Rule 9s received during August to December 2025). The focus is on key learning and developments mid-to-late February. Note the revision of the action timeline to March 2026.

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C3 x L5 = 15*	*C4 x L3 = 12*	**Note 1:** Previous reported completed actions 1 - 9 have been removed from the report. **Note 2:** Action 10 new action due this reporting month.

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)
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)	Completed	AW	Assurance / Control	DSPT / CAF approved as assurance framework for cyber security and will now form part of routine reporting into F&P. Action closed.
10	Cyber assurance Framework preparation for baseline submission for DSPT will identify any remaining gaps in control for 26/27 full submission.	Completed	AW	Assurance /Control	Complete baseline DSPT submission signed of by SIRO and submitted
11	Deliver against DSPT CAF assurance plan to reach 'standards met'.	30-Jun-26	AW	Assurance	New Action pre-submission audit planned for Feb '26.

SR7- Capital and Cash (At a Glance)

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

Likelihood based on: Capital : capital requirements (incl backlog maintainence) compared to capital resource avalaibility. Cash : levels of 5 working days

Consequence based on: Capital : Impact of critical infrastructure failure. Cash : Impact of sufficient cash resources to support operating activites

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note 1:** Previously report completed actions 2 - 4 have been removed from the report.
C5 x L4 = 20	*C5 x L4 = 20*	*C5 x L3 = 15*	

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

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital funding allocation 2025/26	Capital Project Group forecasting	Capital Planning Group reporting to ET and onto Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources secured	Capital Planning Group reporting to ET and onto Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB; Chairing System Investment Group	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2025/26 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	FBC Agreed, contract signed.
Cash Application through NHSE	Cash forecasting with cash tolerance of 5 working days	Executive Team, Finance and Performance	NHSE review cash forecasting ever two weeks.

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing for financial year	JD	Control	Estates Safety Funding of £6m has now been fully approved. Final submission of the Programme of Works is planned by October for the UEC funding. The majority of the works are now in the process of being tendered. The Trust continues to work up business cases for future investments in preparation for the announcement of new Estates and Digital national funding for 2026/27. The Trust has approach Frontline Digitisation to support moving the forecast EPR capital underspend funding into 2026/27 to support CDEL Trust capacity, this is driven by slippage in the EPR programme timeline. The Trust is also working through the profile of a number of property disposals as agreed in the Estates Strategy to support the CDEL and capital availability in the year of EPR go-live.

Actions (to modify risks)		By When	By Who	Gap	Update
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	YTD Capital spend is £11.7m, £7.9m behind plan mainly driven by delays in key strategic estates schemes and EPR. Actions to accelerate capital spend remain in place with MH Urgent care centres and critical infrastructure now in construction phase.
6	New Action: Discussions with NHSE to decouple Deficit Support Funding.	March '26	TS / NHSE	Mitigation	Further updates awaited as at 16 Jan 2026.
7	Address underlying financial deficit and financial sustainability	Ongoing	Exec Team	Mitigation	Subject to final plan submission.

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

Executive Responsible Office: Executive Chief Finance Officer
Board Committee: Finance and Performance Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment IA Core Financial Assurance (2024/25) **Substantial Assurance Opinion** IA Payroll including Salary Overpayments (2024/25) - **Reasonable Assurance opinion**	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).IA E-rostering - Limited Assurance opinion. IA Consultant Job Plans - Limited Assurance opinion.
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	Oversight Framework and ratings
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2026/27	Multidisplinary team stood up	Finance and Workforce Committees	NHSE Oversight
Forecast Outturn and risk/ opportunities assessments 25/26	Forecast outturn reports including risks and mitigations	Accountability Framework reporting and F&P	NHSE Oversight
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.	NHSE Oversight - Triple lock

	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 efficiency performance including key risks and mitigation actions.

Actions (to modify risks)		By When	By Who	Gap	Update
6	Deliver Financial plan for 24/25	Mar '26	TS	Control	At month 9 the YTD deficit is £6.9m, £5.8m behind plan. £5.1m relates to deifcit support funding with £2.7m of YTD unplanned Inquiry costs incurred. The Trust has been instructed to record a forecast deficit of £10.2m. This will be updated in M10 and will incorporate outcomes of deficit support funding discussions. YTD efficiency delivery is £21.2m (64% of annual plan), £1.3m off plan. Results continue to be driven by temporary staff over-performance offset by shortfalls relating to Out Of Area placements due to patient demand, in particular during month 9 a high level of PICU placements were required.

SR9 - Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*	**Note 1:** Previously reported complete action 1-10 have been removed from the report. **Note 2:** Action 12 progress has highlighted potential slippage with NOVA programme.

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Board Committee: Finance and Performance Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Resources			
IT/Digital team Resource and skill set is appropriate and sustainable	Education and training in specific technology Target operating model - modernise digital services	Digital strategy resource management (RAID Log)	
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.	CCIO/CNIO oversight		
Strategies & Policies			
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures	Information governance controls processes	Information Governance Steering Sub-Committee reporting and assurance	Data Security and Protection toolkit assessment (Standards Met)
Data quality is of a standard that assures national standards.	Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT “standards met” can be achieved		Internal Audit	DSPT submission and Cyber assurance framework
Investment			
Capital allocation to digital and data initiatives secured	Approved Digital capital plan		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes	Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation			
The space and governance exists to support innovation	CIO discover opportunities from national forums and partners (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 June '26	AW	Control	NOVA is influencing the requirements for the Target Operating model for Digital. NOVA future state validation (FSV) needs to conclude to inform the remaining gaps for phase 2. Therefore, timeline for the action has been extended to June 2026 to align with the programme.
12	Implementation of new UEPR	Apr-27	ZT	Control	The NOVA programme is progressing, but new risks - linked to system integration and programme complexity - are likely to delay the EPR “go-live” date. Oracle Health has confirmed no additional costs, though extra resourcing will be needed and is being reviewed with Finance. The Board is advised that a new EPR risk will be escalated to the CRR next reporting cycle.

SR10 - Workforce Sustainability (At a Glance)

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L3 = 12*	**Note 1:** Previously reported completed actions 1 - 5 have been removed from the report. **Note 2:** Action 7 over timescale request to extend to March 26. **Note 3:** Action 8 due in this reporting month.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Delivery the People and Education Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee. Reviewing and refining strategy with presentation of revised draft at Executive Committee and People Committee in October 2025. Implimentation plan on track
7	Revised governance arrangements in People & Culture directorate with 3 distinct but aligned groups covering Staff Experience, Recruitment & Retention and Education that will all feed into a People & Culture Group. This will then escalate matters of decision to the Executive Committee and matters of assurance to the People Committee.	Ext. Dec 26	Executive Director of People and Culture	Assurance	People and Education Strategy and approved TOR have been socialised within consultation groups and aiming to be in plan by March 2026. *Staff Experience and Inclusion Group to commence in Dec 25. (PT) *Education Group due to commence Dec 25. (GB) *Staff Resourcing and planning Workforce Planning due to commence Dec 25. (KG) Note RAG rated red as an agreed further extension to this action to Dec 2026.

Actions (to modify risks)		By When	By Who	Gap	Update
8	Delivery the Trust Recruitment Plan.	Dec-25	Associate Director of People - Resourcing	Assurance	Consultation meetings with stakeholders both internal and external to develop a clear recruitment plan to support sustainability going forward and be aligned to the People Strategy. This includes aims to have full recruitment for HCA and band 5 nursing as an early area of focus. It also looks at developing a recruitment plan that supports career development and is aligned to our learning and education priorities. Consultations underway via Workshops and sharing of additional draft with a view to launch at the end of the year. Plan will be presented to People committee next week and fed to Board following.

SR11 - Staff Retention (At a Glance)

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*	**Note 1:** Previously reported completed actions 1 - 5 have been removed from the report.

Executive Responsible Office: Executive 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 Education Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	Quarterly updates through People Committee. Reviewing and refining strategy with presentation of revised draft at Executive Committee and People Committee in October 2025.
7	To develop a mechanism to review exit information and identify clear trends. This information will be triangulated with pulse and annual staff survey information to better understand interventions to reduce staff turnover.	Extended April '26	Director of OD & Culture	Assurance	Following a presentation to the HR SMT in December '25, work is now underway to strengthen processes for new starters and leavers, including (i) redesigning the new starter survey, (ii) leaver questionnaire and exit interview approach, (iii) working with the Recruitment Team to review their existing surveys and remove duplication, (iv) developing a script and guidance to support managers, (v) updating the Manager's Handbook, (vi) creating a dedicated intranet page to host the new resources, and (vii) reviewing the Recruitment and Retention Policy to identify any required amendments once the updated processes are ready for implementation. The data from exit interviews is to be aligned to findings from the National Staff Survey and Pulse surveys, integrated performance data and presented to the Executive Team and People Committee in April '26 (RAG rated amber to note extended timeline for the final part of this action).
8	Delivery of People Promise objectives with an emphasis on new starter experience.	Extended Jan '26	Director of OD & Culture	Assurance	A revised induction process has been proposed that will improve staff experience of corporate induction, aligned to other NHS Trusts. Further work is required for local induction processes that follow corporate induction to ensure that new starter experience is enhanced, and turnover is further reduced in the first 12-months of employment. A report on induction and new starters will be provided alongside the work undertaken with leavers and exit interviews to the Executive Team and People Committee in April '26.(RAG rated amber to note extended timeline for the final part of this action).

SR12: Organisational Development (At a Glance)

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**: Action 7 complete and will be removed from future reports. **Note 3**: New action 9 regarding Sexual Safety & Unprofessional Behaviour training to L300 group.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
7	Revised structure in OD & Culture to meet aims and objectives	Complete	Director of OD & Culture	Control	Action complete new structure in place.
8	Culture Review and Leadership Development Programme.	March 26	Director of OD & Culture	Assurance	Delivery commenced with BRAP and King's Fund for a 12-month pilot which will include a culture review starting in September 2025. Leadership programme to be established and developed alongside future leadership development with ARU utilising the apprenticeship levy. Nomination process for leadership development programme commenced in Jan 2026. BRAP & Kingsfund Phases are being progressed in a trajectory programme in three month intervals. Action timescales require extension to reflect phases within the 12 month pilot.
9	New Action: OD team to train the wider leadership group (L300) with sexual safety and unprofessional behaviours training and conclude cascade training so that a wider roll-out across the Trust can be implemented.	Feb-26	Director of OD & Culture	Assurance	302 colleagues have now been trained across Specialist Services (Brockfield House), inpatient settings (Basildon) and a number of the leadership team. An impact analysis commenced in December 2025 and an assurance paper presented to People Committee in December 2025.Training is now being rolled out. Cascade training is not available due to capacity but is on track.

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 C5 x L4 = 20	*Current Risk Score* C5 x L3 =15	*Target Score* C5 x L2 = 10	**Note 1:** Previously reported completed actions 1-3, 5 and 7 - 8 have been removed from the report. **Note 2:** Following completion of actions a re-assessment is planned to review the score and to assess whether further controls / mitigations are required.

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			
Patient Incident Response Plan			IA Falls Management (2024/25) Reasonable Assurance opinion IA Recording and Monitoring of Therapeutic Observations (2024/25) Reasonable Assurance opinion IA Care Plans and Risk Assessments (2024/25) Reasonable Assurance opinion

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

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Review the Quality forums from Care Unit to Board and reporting.	Extended February 26	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 IA to test the sustainability in progress. Note further extension to enable IA to conclude their testing.
7	Undertake a review of the Quality Control Audits (Tendable) one year post implementation	Complete	RP	Assurance	The care units receive monthly audit reports with additional in reach support from the Quality Governance Lead to assist them with taking forward actions, that are then fed into the local monthly Quality & Safety meetings. These interventions are addressing root cause of non compliance which were identified as lack of capacity, expertise, and a focus on holding care units to account.

Corporate Risk Register

January 2026

EPUT

CRR11 - Suicide Prevention

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

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

Executive Responsible Office: Executive Medical Director
Director Lead: Dr Nuruz Zaman Deputy Medical Director
Leads: Alan Hewitt, Deputy Director of Quality and Safety
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Electronic observations recording tool	In trial phase		
Ward level oversight	Tendable Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos	STORM training (achieved year one target of 60% of registered staff)		
Self Harm Clinical Guideline Ligature Environmental Risk assessment and Management Policy		Suicide Prevention Group (Co-chaired with a Lived Experience Ambassador) Ligature Risk Reduction Group	
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		

	Actions (to modify risks)	By When	By Who	Gap	Update
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	The Quality Committee received the annual report detailing year 1 actions in line with the Suicide Prevention Plan 2024-25 and outlining priorities for year 2 which are set out in the Trust Quality of Care Plan (QoC). The Quality of Care Group has received the Q2 report which highlighted: increase in suicide deaths in the quarter (note no suicides occurred within EPUT premises and all are current suspected suicides until COD is confirmed). A full project plan is in development for the move from risk stratification to Safety Planning.

Risk Movement

January 2026

EPUT

Risk Movement and Milestones

Strategic Risk Movement – two-year period (Jan 24 – Jan 26)

Risk ID	Initial Score	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
SR1	20	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	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15
SR5	20	20	20	20	15	15	15	15	15	15	15	8	**8**	8	16	16	16	16	16	16	16	16	16	16	16	16
SR6	12	15	15	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15
SR7	20	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20	20	20	20	20	20	20	20	20	20	20	20
SR8	15	20	20	20	20	20	20	20	20	20	20	20	**20**	20	20	20	20	20	20	20	20	20	20	20	20	20
SR9	20	New	20	15	15	15	15	15	15	15	15	15	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15
SR10	16										New	16	**12**	12	12	12	12	12	12	12	12	12	12	12	12	12
SR11	16										New	16	**12**	12	12	12	12	12	12	12	12	12	12	12	12	12
SR12	16										New	16	**16**	16	16	16	16	16	16	16	16	16	16	16	16	16
SR13	20											New	**15**	15	15	15	15	15	15	15	15	15	15	15	15	15

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two-year period (Jan 24 – Jan 26)

Risk ID	Initial Score	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
CRR11	16	12	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
CRR45	12	16	16	12	12	12	12	12	12	12	12	12	12	16	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**				
CRR77	16	16	16	16	16	16	16	16	16	16	16	8														
CRR81	12	16	16	12	12	12	12	12	12	12	12	12														
CRR92	20	12	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**	**12**	**12**	**12**	**12**	**12**						
CRR93	15	15	15	15	15	15	15	15	15	15	15	10														
CRR94	16	20	20	20	20	20	20	20	20	20	20	10														
CRR98	20	20	12	12	12	12	12	12	12	12	12	12	**12**	12	**12**	**12**	**12**	**12**	**12**							

9. STRATEGIC INITIATIVES

9.1 GREEN PLAN

Decision Item TS

REFERENCES

Only PDFs are attached

Green Plan Report 04.06.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

Report Title:	**Green Plan 2026-29**					
Executive/ Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer/Deputy CEO					
Report Author(s):	Martin Mizen, Senior Director of Estates and Facilities					
Report discussed previously at:	Executive Operational Committee and Finance & Performance Committee on the 22 January 2026.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Statutory Public Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data		✓
	SR10 Workforce Sustainability		✓
	SR11 Staff Retention		✓
	SR12 Organisational Development		✓
	SR13 Quality Governance		✓
Does this report mitigate the Strategic risk(s)?			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	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		
The report provides progress made on the current Green Plan and agree the direction of travel on national and local sustainability priorities within the Green Plan 2026-29.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Approve the Green Plan 2026-29.

Summary of Key Issues
Significant investment and improvements have been made over the last 5 years. Further significant ambitious and challenging targets going forwards. The need to link building plans (including disposal pipeline) to the Green Plan. Gaining traction, engagement and momentum across the Trust i.e. linking to key initiatives where possible. Ensuring prioritisation across the timeline with oversight through the Finance & Performance Committee.

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**	

Supporting Reports/ Appendices /or further reading
Green Plan 2026-2029

Lead
Trevor Smith **Executive Chief Finance Officer & Deputy CEO**

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Green Plan 2026 to 2029

EPUT

FOREWORD

Paul Scott
Chief Executive

Trevor Smith
Executive Chief Finance and Resources Officer/ Deputy Chief Executive

Martin Mizen
Senior Director, Estates and Facilities

Essex Partnership University NHS Foundation Trust (EPUT) is on a sustainability journey to reduce the impact of our operations on the environment and the communities we serve. Our new green plan is designed to reduce operating costs wherever possible and not divert funding from front-line services. We remain committed to meeting the sustainability challenges and achieve Net Zero in accordance with our statutory obligations by learning, listening and innovating so that we deliver the highest quality and safest care possible sustainably. The Trust has made significant capital investments over the last 5 years to reduce its carbon emission including circa £7 million on air source heat pumps EV charging and LED Lighting.

As we look to the future, the role of our estate is critical in supporting our vision of being the leading health and wellbeing service in the provision of mental health and community care. Our Green Plan therefore serves as a road map supporting our commitment to delivering high quality, accessible and sustainable health care services and in so doing address the wider determinants of health, including but not limited to air quality. The Trust will continue to invest in sustainability, including but not limited to the generation of its own electricity, expansion of electric vehicles charging and LED lighting across its estates.

Our estate strategy a comprehensive forward-thinking plan that sets out how we will develop our estate over the next 10 years, ensuring that it is fit for purpose and aligns with our strategic goals. As we navigate the complexities of modern healthcare, our estate must not only respond to current needs but also anticipate future challenges, including climate change mitigation and adaptation. Our latest green plan supports this and the Trust's strategic objective of "helping our communities to thrive".

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

Our green plan embraces our enabling strategies including digital, quality of care, social impact and working in partnership with people and communities. We have also embraced the principles of sustainability, recognising our responsibility to incorporate sustainable development aiming to reduce energy consumption, minimise waste and enhance the overall environmental performance of our estate.

Achievements 2025/26 and Green Plan Priority Areas 2025 to 2040

Funding:

Charge point accelerator scheme

£74K for the installation of electric chargers is going through the procurement process for The Lodge, Heath Close and Pride House

Solar Panels

£833k funding for solar panels has been awarded for Clough Road and Rochford with installation by 31st March 2026

Building Management Systems (BMS)

£123K of funding was awarded 2024/25 for upgrading on the BMS for Rochford, King's Wood and Thurrock

Projected costs savings

- LED Lighting Thurrock £186K
- Solar clough Road £25K
- Solar Rochford £75K
- BMS upgrades £20K
- Reduction in backlog maintenance costs (lighting) £68K

Carbon emissions reduction

The following reoccurring emissions reduction have and or will be achieved:

- LED Lighting at Thurrock will save 150,000 kg of CO2 emissions
- Solar panel installation at Clough Road will save 20,000 kg of CO2 emissions (2026 onwards)
- Solar panel installation at Rochford will save 61,000 kg of CO2 emissions (2026 onwards)
- BMS upgrades will save 20,000 kg of CO2 emissions

Waste:

- 925 unused assets re-used via 3rd part placement, of which 518 assets went to support registered charities
- 694 unused assets recycled with zero waste going to landfill
- 326 assets in storage for recycling, reuse or repurposing within the Trust
- 39 assets reused within the Trust
- Trust avoided 81,314 kg of CO2e emissions attributable to waste produced and prevented cir 46,998 kg of waste going to landfill

BRONZE Award Best Reuse Initiative of the Year - Excellence in Waste Management for the NHS in England 2025

Priorities	Green Plan 2025 to 2040

1 Electric Vehicle Charging Infrastructure

- Trust will only be able to lease or purchase electric vehicles from 2027
- Salary sacrifice vehicles can only be electric from 2027
- Capital costs/Funding
- Priority locations ie priority 1 sites first
- Income generation potential

2 Renewable Energy Generation

- Identify potential opportunities i.e. photovoltaic, private wire to reduce costs and carbon
- Capital costs/Funding availability
- Potential savings to be made

3 Heat Decarbonisation

- Capital Cost/Funding availability
- Heat Decarbonisation Plan Completed
- Age of heating system
- Backlog maintenance prioritisation
- 80% reduction in carbon emissions required between 2028 and 2032

4 Climate Change Mitigation and Adaptation

- Capital Cost/Funding availability
- Risk profile of property portfolio and service provided
- Backlog maintenance prioritisation for climate change mitigation and adaptation

CONTENTS.

1. INTRODUCTION

Introduction

Our new green plan contributes to the Trusts, vision, values and the achievement of the strategic objectives as outlined in our operational Plan.

Our Green Plan is designed to ensure a sustained contribution to progress against each of the Trust's four strategic objectives in a way that embodies our three values of **caring**, **learning** and **empowerment**, and will carry us further towards our vision of **being the leading health and wellbeing service in the provision of mental health and community care**.

Strategic Objectives:-

We have four strategic objectives to achieve our vision:

We will deliver safe, high quality integrated care services

- By developing an energy efficient low carbon estate
- By contributing to the improvement in air quality across Essex

We will work with our partners to make our services better

- We will empower our teams to make sustainable choices
- We will work with our systems partners to mitigate and adapt to a changing climate

We will enable each other to be the best we can be

- We will work together to reduce waste
- We will together to reduce energy and water consumption

We will help our communities to thrive.

- By reducing the impact of our services on our communities
- By reducing the impact of our services on the environment

Green Plan - Action Plan

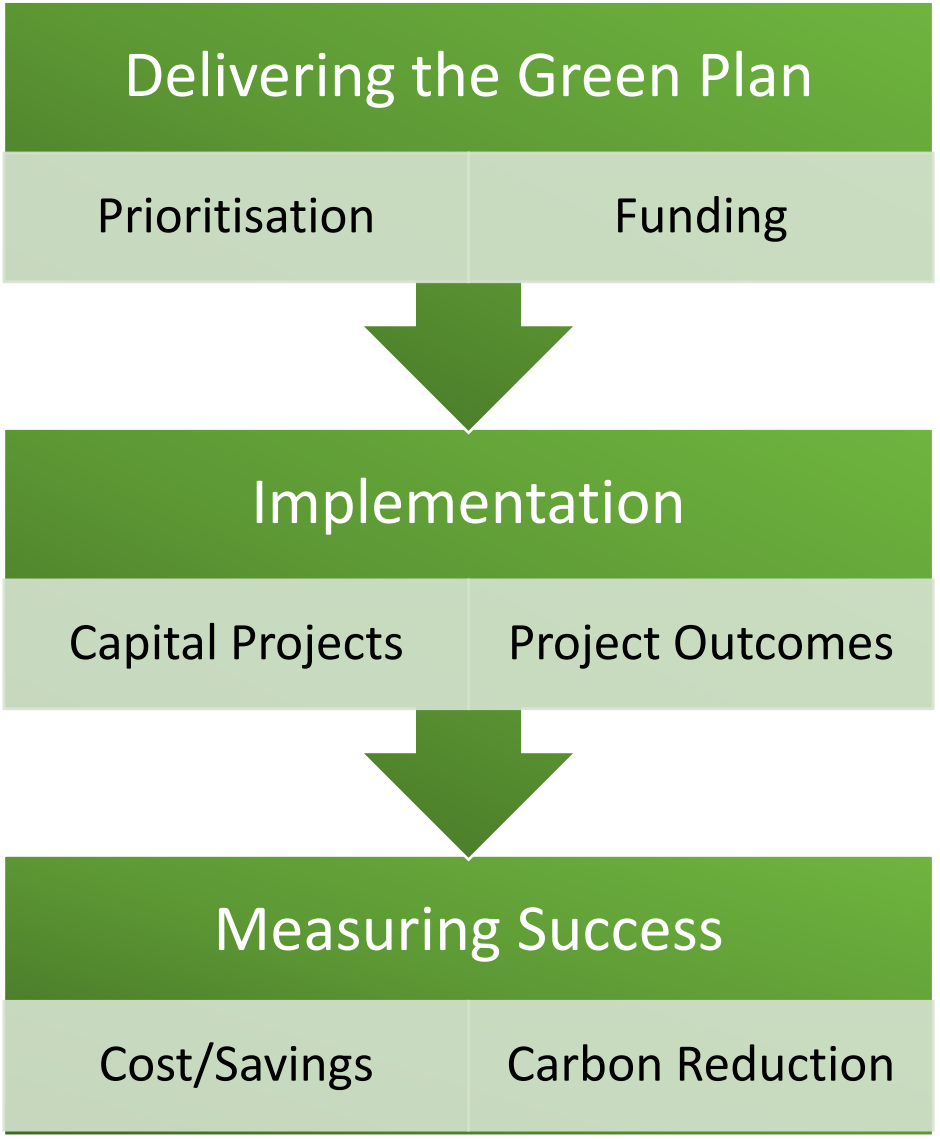
Introduction

Our green plan sets the direction of travel for our estate development as we continue on our Net Zero Emissions journey over the next 10 years to ensure that the Trust is sustainable and able to meet the challenges that climate change will undoubtable present over the next 10 years. Our green plan enables our vision, values and strategic objectives, and will support the deliver of a safe and compliant estate which is fully utilised and agile, and meets our quality aspirations as well as being environmental compassionate. The green plan is linked to our Trust enabling strategies and estate infrastructure planning within the wider system context in Hertfordshire and West Essex, Mid and South Essex, Suffolk and North East Essex, and Bedfordshire, Luton and Milton Keynes.

Our green plan has been developed through facilitated workshops and stakeholder engagement as well as supporting evidence from meeting our statutory obligations (Display Energy Certificates), independent guidance from leading industry partners to identify current Net Zero and climate change risks, issues and opportunities. The green plan in part takes it direction from the key estate strategy objectives to inform the development of estate options to support our vision to be the sustainable leading health and wellbeing service in the provision of mental health and community care.

Using a model of transformational change to deliverer the Green Plan to achieve net-zero emission and strategic resilience. Appendix 1 maps the inputs to the green plan and the resulting outcomes and impact, providing a governance and risk management framework for success. Appendix 2 details milestones and key performance indicators to support achievement and monitoring of the implementation of the green plan in line with statutory obligations.

Our green plan is a living document and is underpinned by the estate decarbonisation, travel and transport and waste reduction strategies which together are designed to evolve as we grow and adapt to new sustainability and climate change challenges.



2. WHERE ARE WE NOW?

Our Service Delivery Locations

EPUT provides community health, mental health, learning disability and social care services to over 3.2 million people across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk. Our services are delivered by more than 5,500 staff working across more than 150 sites. At any one time, we care for more than 100,000 people, in the context of operating sustainably this creates significant challenges for the Trust.

We are a key partner in four Integrated Care Systems (ICSs) - Hertfordshire and West Essex, Mid and South Essex, Suffolk and North East Essex, and Bedfordshire, Luton and Milton Keynes (providing some specialist services).

One of the key strands of operations for all of the Trusts partners is sustainability and preparing for the impact of climate change to ensure we continue to support our communities, our staff and business partners.

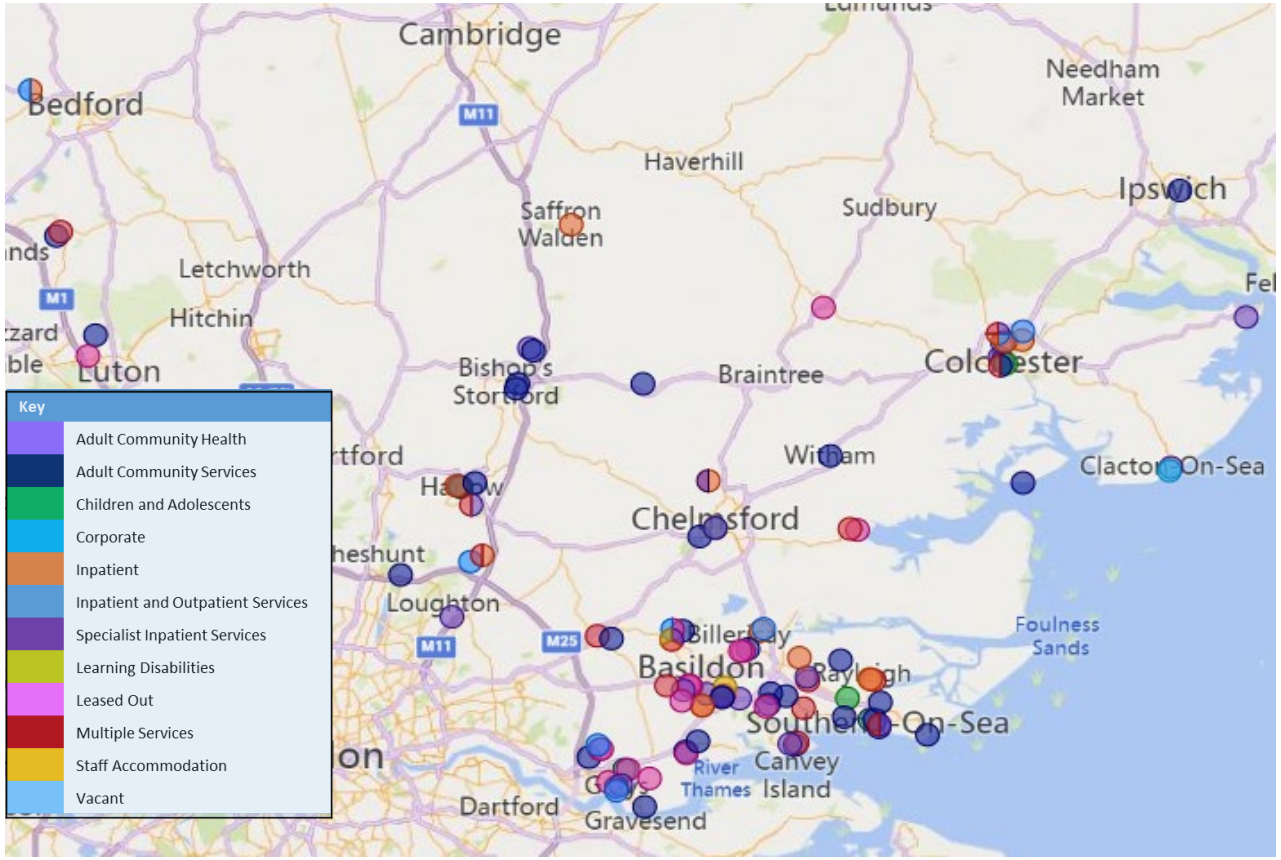
We work in partnership with Essex County Council, Thurrock Borough Council, Southend City Council and local district and borough councils. We also work closely with other providers of NHS services including GP practices, primary care networks, acute trusts, mental health and community trusts, voluntary, community and social enterprise organisation and independent sector providers.

Our place-based and trust wide services are delivered through the following care units:

- Mid and South Essex Community Services
- North East Essex Community Services
- West Essex Community Services
- Specialist Services
- Urgent Care and Inpatient Services
- Psychological Services

The distribution of our services across the East of England

The map illustrates the locations for EPUT properties delivering services within the six care units. The majority of properties are clustered around the bulk of the population in South Essex.



Overview of Our Estate

EPUT services are provided from circa 150 properties across Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk, with a total size of 127,000sqm. A vast majority of the estate is older than 40 years and circa 34% of properties has poor energy performance which does not support the Trust's net zero ambitions.

Age

Buildings older than 40 years is the measure used in ERIC as an indicator of the end of the life cycle, i.e. fitness for purpose relating to both condition (physical condition and statutory compliance) and functional suitability. 57% of EPUT's estate is over 40 years old.

PFI Properties

The majority of the PFI properties are to be handed back to the Trust cir 2033. The buildings will be handed back to the Trust in their original specification and in accordance with contractual obligations. Consequently any infrastructure will be as originally specified and will require the Trust to consider its options for decarbonisation of these facilities and the associated capital investment required.

Energy Performance (EPC) Rating

EPCs indicate the energy efficiency of a property and include estimated energy costs as well as a summary of the property's energy performance. Properties that have an EPC of E or below are classed as 'substandard' by regulations. 23% of EPUT's properties have an EPC rating of E or below.

Climate Change mitigation/adaptation

The Trust faces Significant challenges in preparing for the challenges climate change will present, this is due to the number and age profile of the Trusts Estate, notwithstanding the investment requirements. The Trust has robust Business Continuity plans in place, which includes dealing with extremes in weather, to ensure patient and staff safety and service delivery is maintained.

152 Properties	**57%** of estate is over 40 years old
127,000 Sqm Total size of estate	**2.6%** of properties are PFI's
34% of properties have an EPC rating of E or below	**5,607** tCO2e from energy consumption
1.9% of properties have heat pumps	**1.3%** of properties with Photovoltaics'
4.6% of properties have Electric vehicle charging facilities	**Zero** Domestic waste to landfill
51,583 cu.m of waste water to foul	The Trust as invested over £3 million in air source het pumps, LED lighting and EV charging since 2019

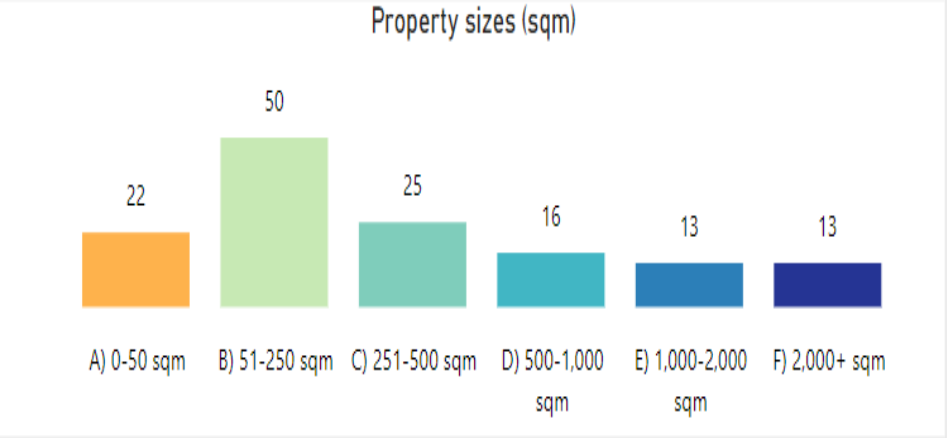
Key Messages

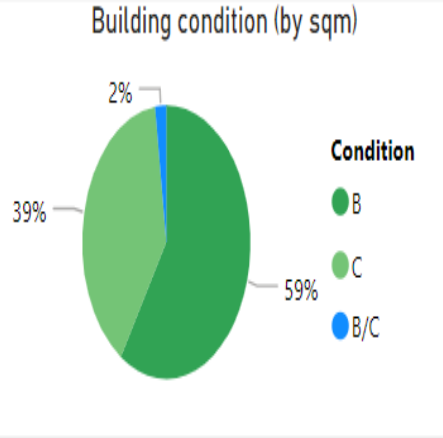
- Just over half of the estate is over 40 years old
- Predominately old estate with poor energy performance 23% E and below
- Electricity consumption 7,325 Mwh
- Gas consumption 16,682 Mwh
- Small electric vehicle charging network 14 chargers, 31 charge point

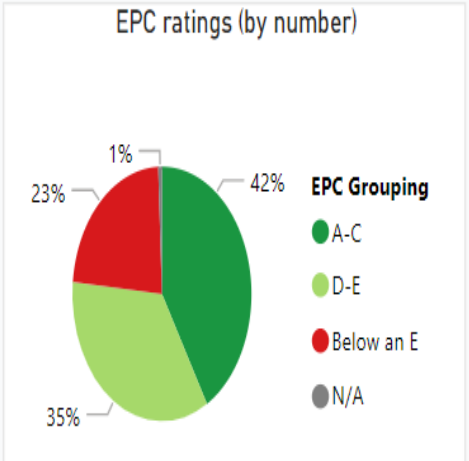
Overview of Our Estate Data

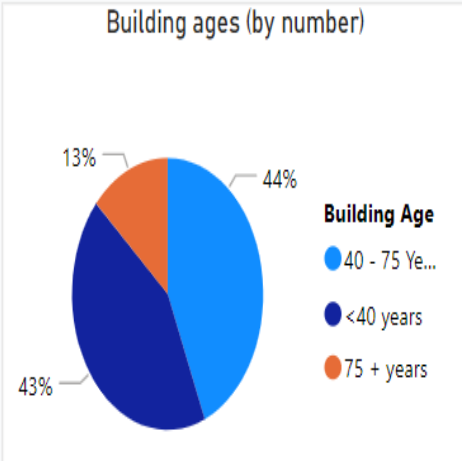
Key Messages

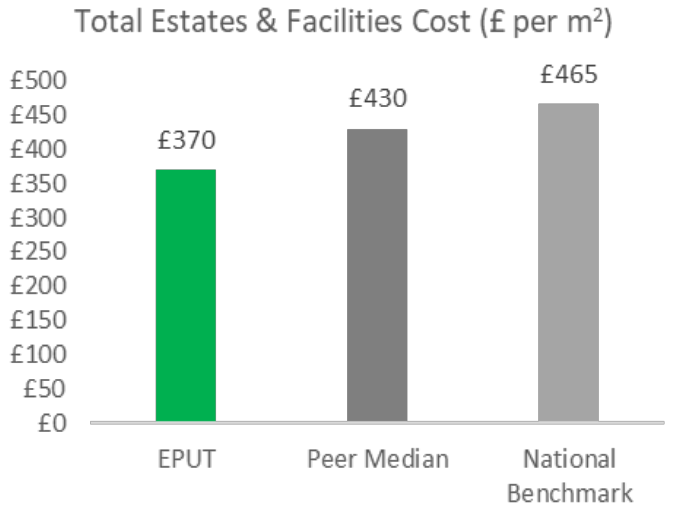
- We deliver many services from a large number of properties. A vast amount of these properties are under 250sqm, indicating small scale delivery across a large geography and number of sites.
- Our energy costs per m2 ~ 44-46% below our peer median and national benchmark.
- 23% of our properties and EPC rating at E or below, this is impacted by the thermal efficiency, age and condition of the buildings, resulting in higher energy costs.

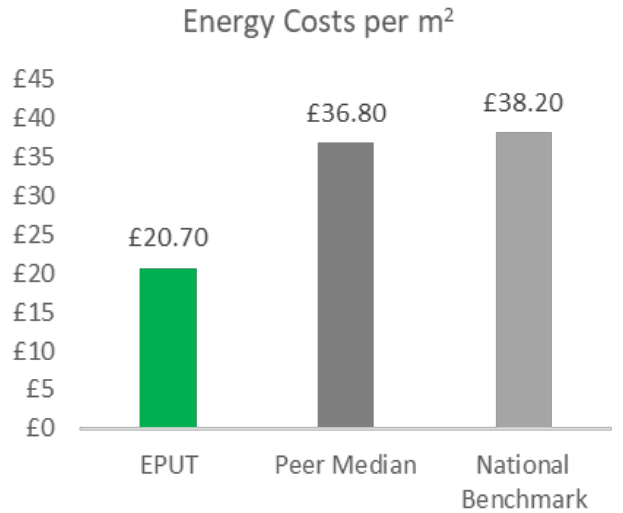










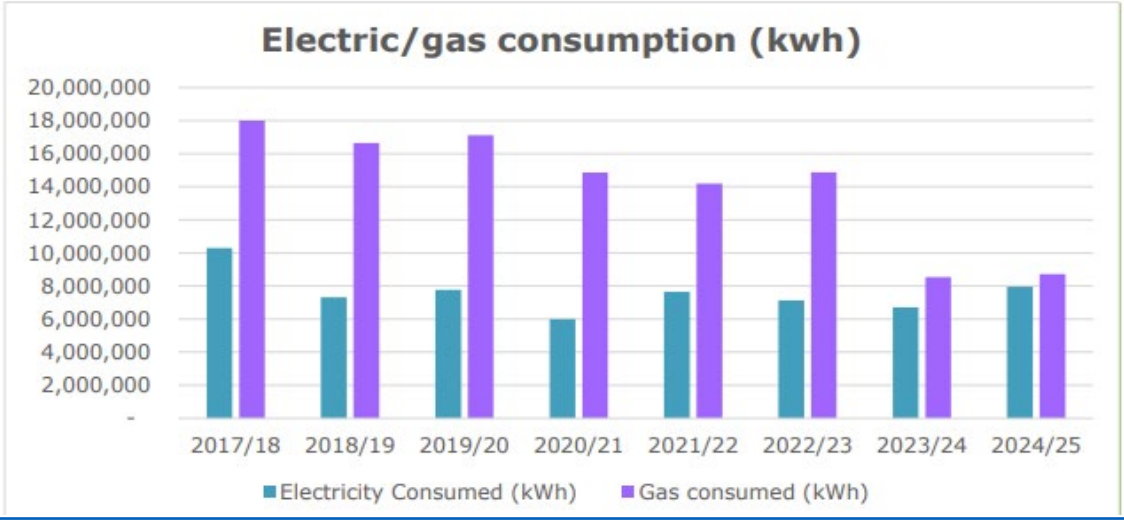


Overview of Our Estate Data

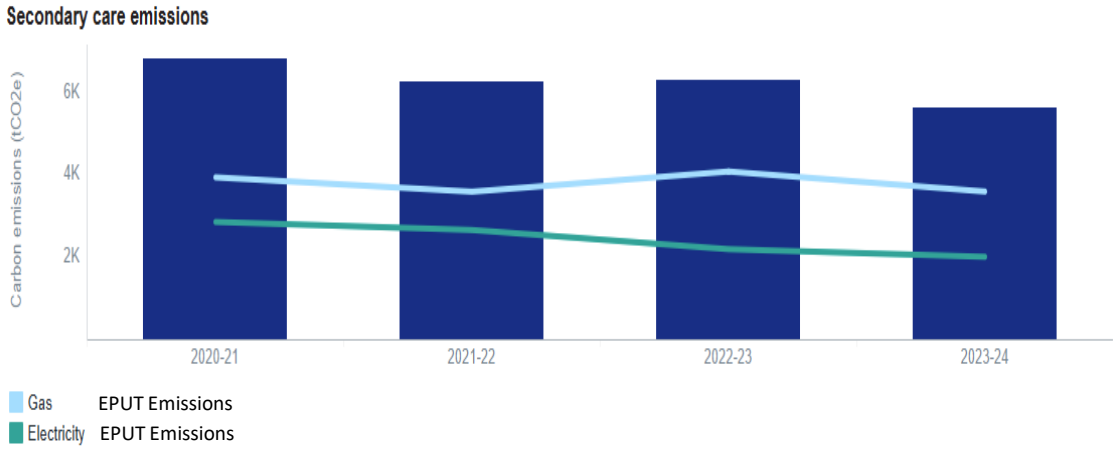
Key Messages

- Since 2017/19 energy consumption has consistently reduced year on year. Whilst there was a small increase in energy usage in 2024/25, this could be attributed to leased properties returning to the Trust and electric vehicle charging, changes to building utilisation and increased provision of new services to the community.
- Water consumption has also decreased since 2018/19, however 2024/25 showed a slight increases in consumption, this has been attributed to leased properties returning to the Trust, increase in services provided to the community and improved metering accuracy and data collection.
- Carbon emissions continue to fall and are significantly lower for the Trust compared to regional performance.

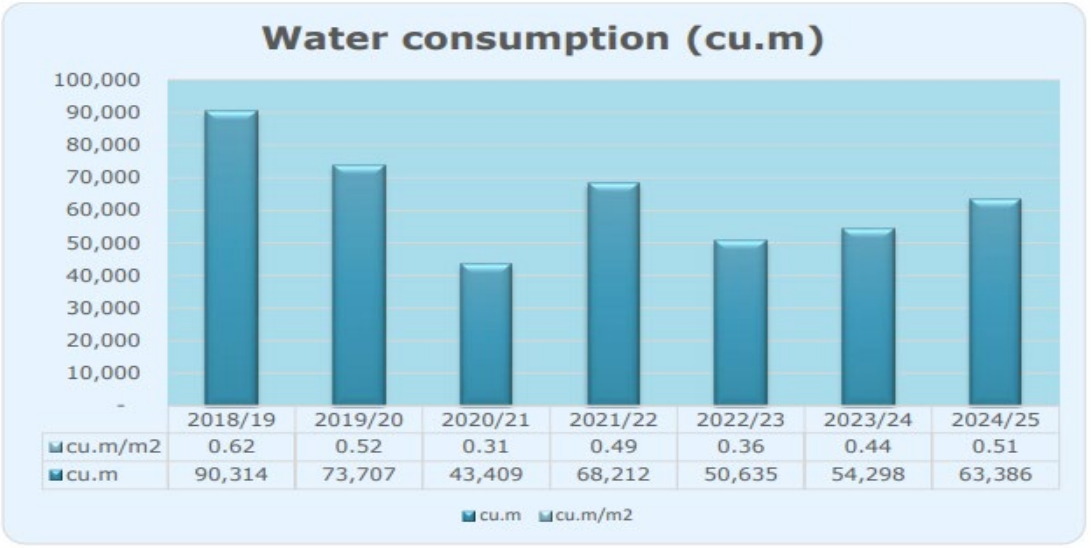
NB: The Trust annual report provides significantly more details: Annual-Report-2024-25-FINAL-V2.pdf



Regional & Trust Carbon Emissions (tCo2e)



Data from the 2023/24 annual Estates return (ERIC)



	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
cu.m/m2	0.62	0.52	0.31	0.49	0.36	0.44	0.51
cu.m	90,314	73,707	43,409	68,212	50,635	54,298	63,386

NHS
Essex Partnership University
NHS Foundation Trust

Capital Investment 2020/21 - 2025/26

Description	Forecast/ Actual (£)	Charge point accelerator scheme (£)	Solar Panels (£)	Building Management Systems (BMS) (£)	LED Lighting Upgrade (£)	Air Source Heat Pumps (£)
2025/26						
Solar PV – Linden Centre	422		422			
Brockfield House external lighting upgrade	26				26	
Lighting replacement programme (LED)	149				149	
Panels - Solar Projects - Rochford Com Hospital	618		618			
Panels Solar Projects - Clough Road, Colchester	215		215			
EV Chargepoint Accelerator Scheme	74	74				
Total 2025/26	**1,504**	**74**	**1,255**	**0**	**175**	
2024/25						
LED lighting upgrade – Edward House	71				71	
Derwent LED Lighting	63				63	
Emergency lighting upgrade at Landermere	26				26	
New Dedicated Power Supply For Ev Charging At Clough Road	39	39				
Building Management Systems upgrade	122			122		
LED Lighting Thurrock Community Hospital	407				407	
Total 2024/25	**728**	**39**	**0**	**122**	**567**	
2023/24						
BMS - Building Mgt System upgrades	35			35		
Edward House LED Lighting	7				7	
Total 2023/24	**42**	**0**	**0**	**35**	**7**	
2022/23						
C - EV Charging Units	122	122				
Boiler / Energy Replacement - Thurrock Hospital	350					350
Total 2022/23	**472**	**122**	**0**	**0**	**0**	**350**
2021/22						
C BM BMS Upgrade All Sites	415			415		
C BM Kingswood Carpark Lighting	4				4	
C - Electrical Vehicle Charging Points	254	254				
C - Basildon MHU External Lighting Upgrade	8				8	
Total 2021/22	**682**	**254**	**0**	**415**	**13**	
2020/21						
	3,428	**489**	**1,255**	**573**	**761**	**350**

3. WHERE DO WE WANT TO BE?

Strategic Context - Overview

The development of our green plan cannot be viewed in isolation. This section considers the most pertinent national, regional, and Trust-wide priorities with which our green plan must align to support delivery of our vision and estate strategy objectives, specifically in the context of the green plan to deliver a sustainable estate, fit for purpose.

National Policies and Strategies	For emissions controlled by the Trust: • Delivering a 'Net Zero National Health Service by 2040 • Interim target of 80% between 2028-2032 For emissions not controlled but influenced by the Trust: • Delivering a 'Net Zero National Health Service by 2045 • Interim target of 80% between 2036 - 2039

Regional Strategies	• Alignment of Trust Green Plan with the Integrated Care Systems sustainability strategies (green plans):
	  • Hertfordshire and West Essex
	  • Suffolk and North East Essex Estate Infrastructure Strategy
	  • Mid and South Essex Estate Infrastructure Strategy
	  • Bedfordshire, Luton and Milton Keynes Infrastructure Strategy

EPUT Strategies and Plans	• Estates Strategy
	• Green Plan
	  • Decarbonisation Strategy
	  • Travel & Transport Strategy
	  • Waste Strategy
	• Digital Strategy
	• Social Impact Strategy

Strategic Context – National - Governance

Task force on climate-related disclosures (TFCD

The Trust is required to follow the ***'task force on climate-related financial disclosure'*** on a comply or explain basis. The Trusts governance process including the management of risk, including but not limited to scope 1, 2 and 3 carbon emissions, climate change adaptation and mitigation, as demonstrated by the Trust's assessment of climate change risk is consistent with the Health and Climate Adaptation Report 2023, with key strategic and operational risks identified as:

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

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

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

Surface water (extreme weather – flash floods)
High Risk – 36 locations
Medium Risk 7 locations

Rivers and sea (sea level rises, extreme weather) o
High Risk – 2 locations;
Medium Risk 1 location

Reservoirs (Collapse, overflowing/ extreme weather) o
Unqualified Risk – 3 locations

Ground water (water table rises/prolonged extreme weather) o
Unlikely (we have no properties at risk).

The Trust's assessment of climate change risk is consistent with the Health and Climate Adaptation Report 2023, with key strategic and operational risks identified and included in the annual report and accounts: Annual-Report-2024-25-FINAL-V2.pdf

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

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

Strategic Context - National

Delivering a 'Net Zero' National Health Service

The NHS aims to deliver the world's first net zero health service, responsive to health emergencies brought about by climate change. Two clear targets have now been developed:

- For emissions we control directly, net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032; and
- For the emissions we can influence, net zero by 2045, with an ambition to reach an 80% reduction by 2036 and 2039.

The plan included estates as one of the areas where direct intervention can be taken to reduce emissions.

Upgrading Buildings
LED lighting, HVAC systems, hot water, insulation

Optimising Usage
Real time monitoring, Building Management Systems

Onsite Energy Generation
Heat pumps, renewable resources

National Electricity Decarbonisation
Converting to 100% renewable energy

Reducing Travel & Transport Emissions
Trust vehicles, Staff, Patient, Visitors & Contactors

Reducing Waste
Clinical, Domestic, Confidential – Asset Recycling

Reducing water consumption & Wastewater to Foul

Reduce Dependency on Natural Gas

Decarbonisation
Converting to 100% renewable energy - Hydrogen

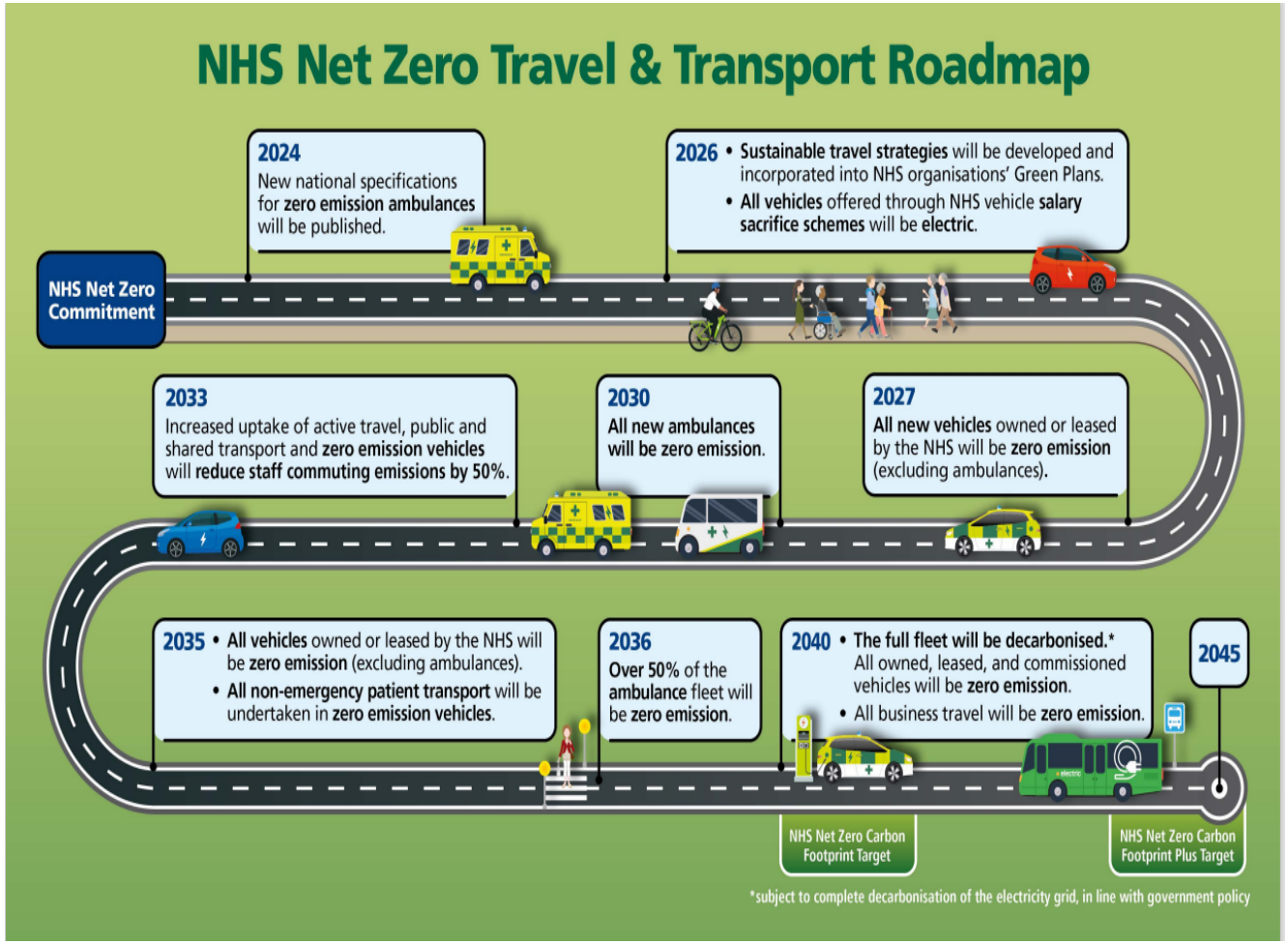
Strategic Context - National

Delivering a 'Net Zero' National Health Service

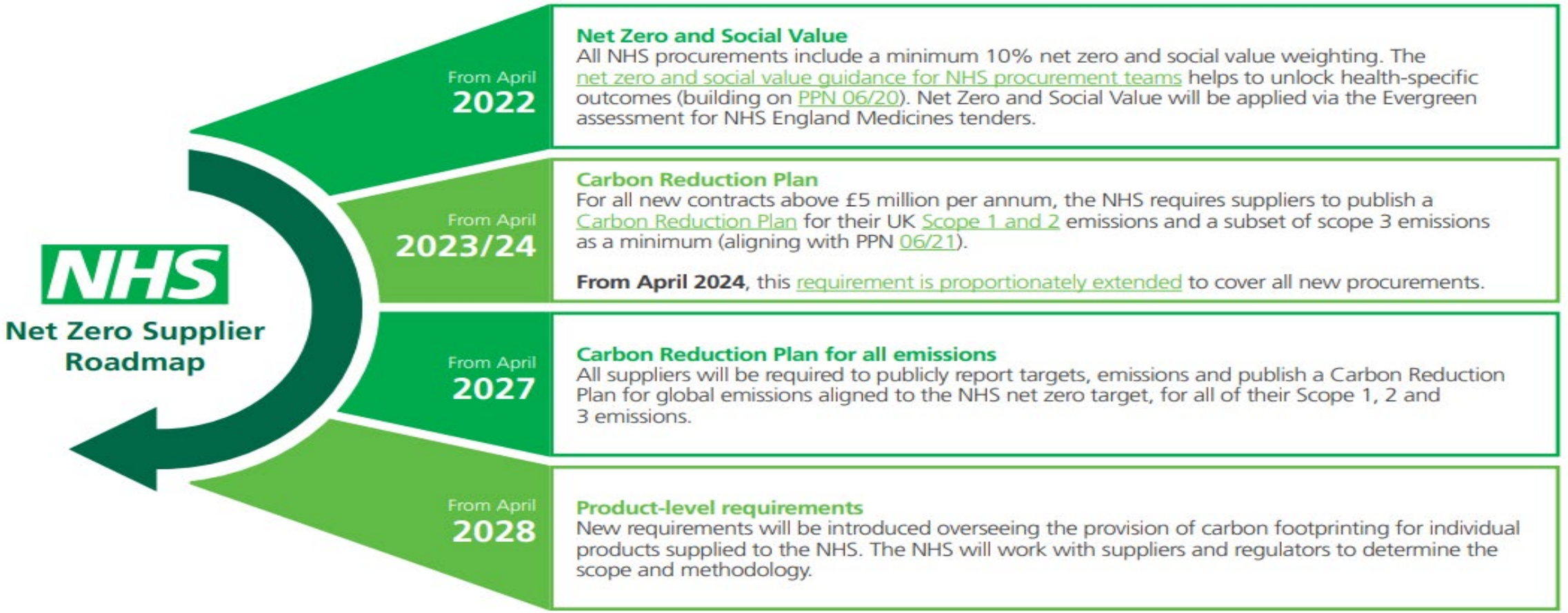
NHS Net Zero Travel & Transport Strategy

The NHS aims to deliver the world's first net zero health service, responsive to health emergencies brought about by climate change. Two clear targets have now been developed:

- 2026 All vehicles offered through NHS vehicles offered through salary sacrifice scheme will be electric.
- 2027 all vehicles owned or leased by the NHS will be zero emissions.
- 2035 all non-emergency patient transport will be undertaken by zero emissions vehicles.



NHS Net Zero Supplier Roadmap



4. HOW DO WE GET THERE?

Introduction

The Trusts green plan underpins the estates strategy and the Trusts strategic vision, aims and objectives. To ensure we have an estate that is sustainable, of good quality, fit-for-purpose and aligns with our strategic vision.

Green Spaces & Biodiversity Action Plan

The green spaces and biodiversity action plan will focus on key aspects of the Trust green space to enhance biodiversity, including but not limited to creating natural habitats, tree planting and creating meadows were possible.

Waste Reduction Strategy

Focusing on each waste stream:

- Clinical
- Domestic
- Confidential
- Food
- Weee
- Surpluses Assets

The strategy will define key actions to reduce waste, including ensuring zero waste to landfill.

Decarbonisation Strategy

The decarbonisation strategy will define the priorities for the removal of gas fired heating systems from the Trust estate.

The Strategy is underpinned by an individual property decarbonisation plan, which defines the actions to remove emissions from a specific sites.

Climate Change Adaptation Strategy

Preparing for the challenges climate change will bring (extreme weather events, water scarcity) in the coming years is a fundamental aspect of the Trust being able to meet the needs of its community, without disruption to service.

The 4th Health Effects of Climate Change Report, published by UKHSA in 2023, consolidates the latest evidence to inform policy and actions to safeguard health in a changing climate.

Green Plan

The Trusts Green Plan defines its national, regional and organisational responsibilities to reduce carbon emissions, reduce waste and mitigate against climate change risks.

Appendices 1 of the green plan identifies the key actions that need to be undertaken to deliver a sustainability estate

Estates Strategy

One of the key aspects of the estates strategy is to create a sustainable estate, fir for purpose whilst reducing carbon emission and waste from Trust activities.

The Trust green plan is fundamental to delivering this element of the states strategy and supporting the vision, aim and objects of the Trust.

Priority Investment for Sustainability

Priority	Considerations
1	Electric Vehicle Charging Infrastructure

- Trust will only be able to lease or purchase electric vehicles from 2027
- Salary sacrifice vehicles can only be electric from 2027
- Capital costs/Funding
- Priority locations ie priority 1 sites first
- Income generation potential

2 Renewable Energy Generation

- Identify potential opportunities i.e. photovoltaic, private wire to reduce costs and carbon
- Capital costs/Funding availability
- Potential savings to be made

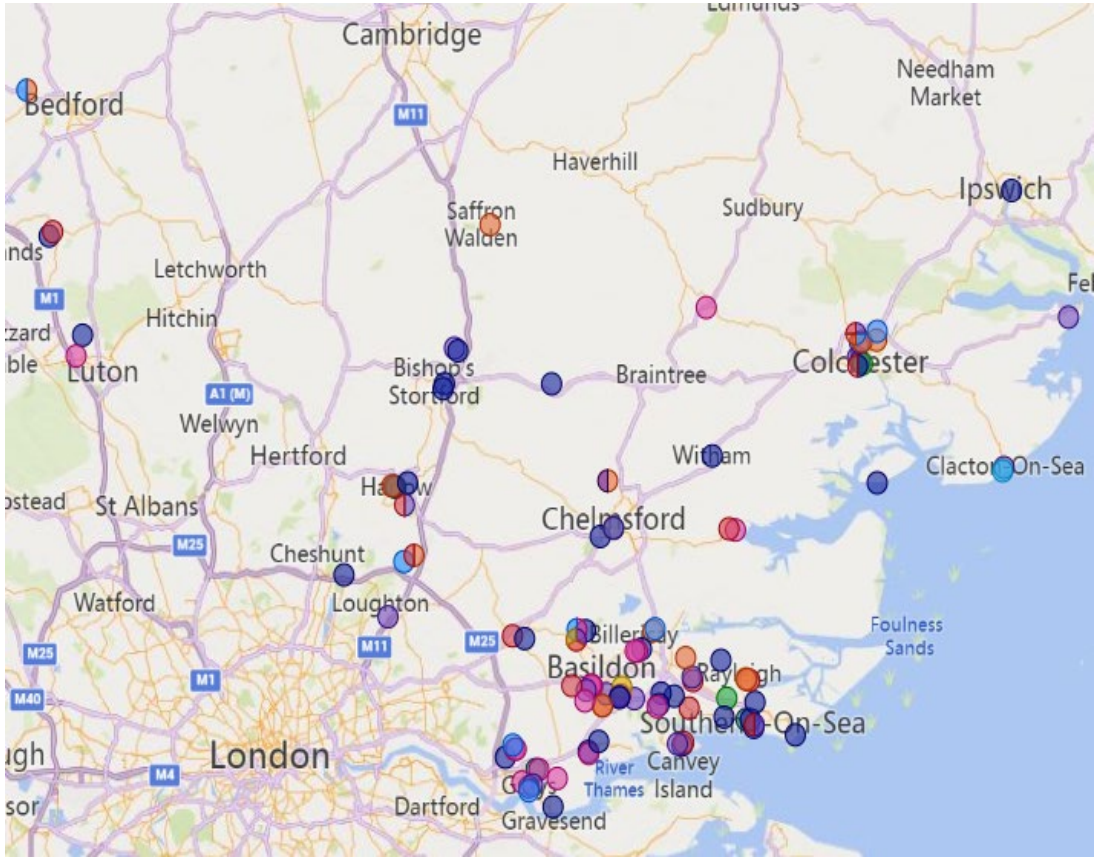
3 Heat Decarbonisation

- Capital Cost/Funding availability
- Heat Decarbonisation Plan Completed
- Age of heating system
- Backlog maintenance prioritisation
- 80% reduction in carbon emissions required between 2028 and 2032

4 Climate Change Mitigation and Adaptation

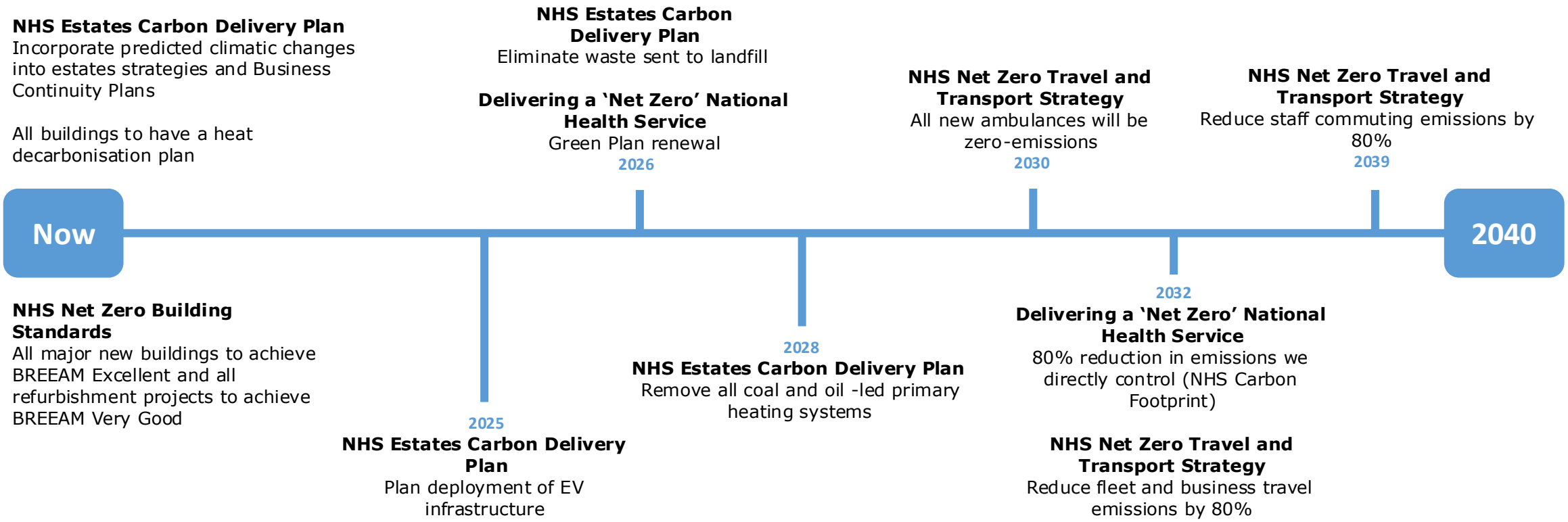
- Capital Cost/Funding availability
- Risk profile of property portfolio and service provided
- Backlog maintenance prioritisation for climate change mitigation and adaptation

The Trust has a significant number of properties geographically dispersed across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk. There is a need to priorities these facilities to reduce carbon emissions, facilitate the use of electric vehicles, prepare for climate change and take advantage of opportunities to reduce utility costs.



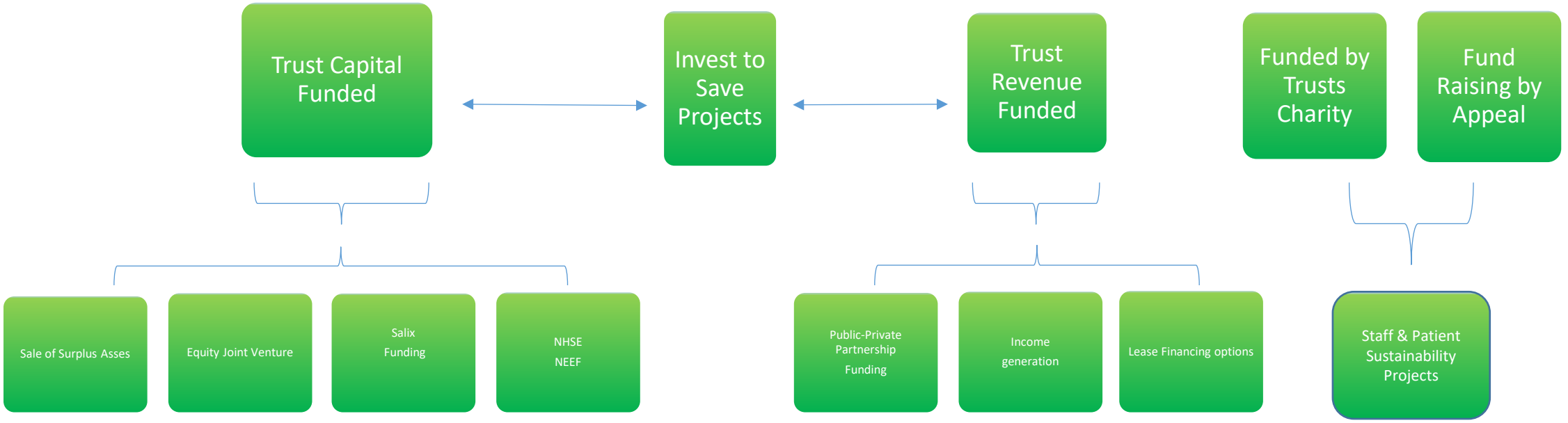
How to we get there ?

This timeline below collates all the net zero benchmarks outlined in all the current NHS guidance. Creating a roadmap of targets for the Trust to work towards. We must ensure we are considering these goals to avoid barriers in the future. Ensuring buildings have sufficient infrastructure to accommodate an electric fleet and considering climate risks and transport connections when reviewing and or redeveloping existing sites and considering new sites.



5. FUNDING, DELIVERY AND MEASURING SUCCESS

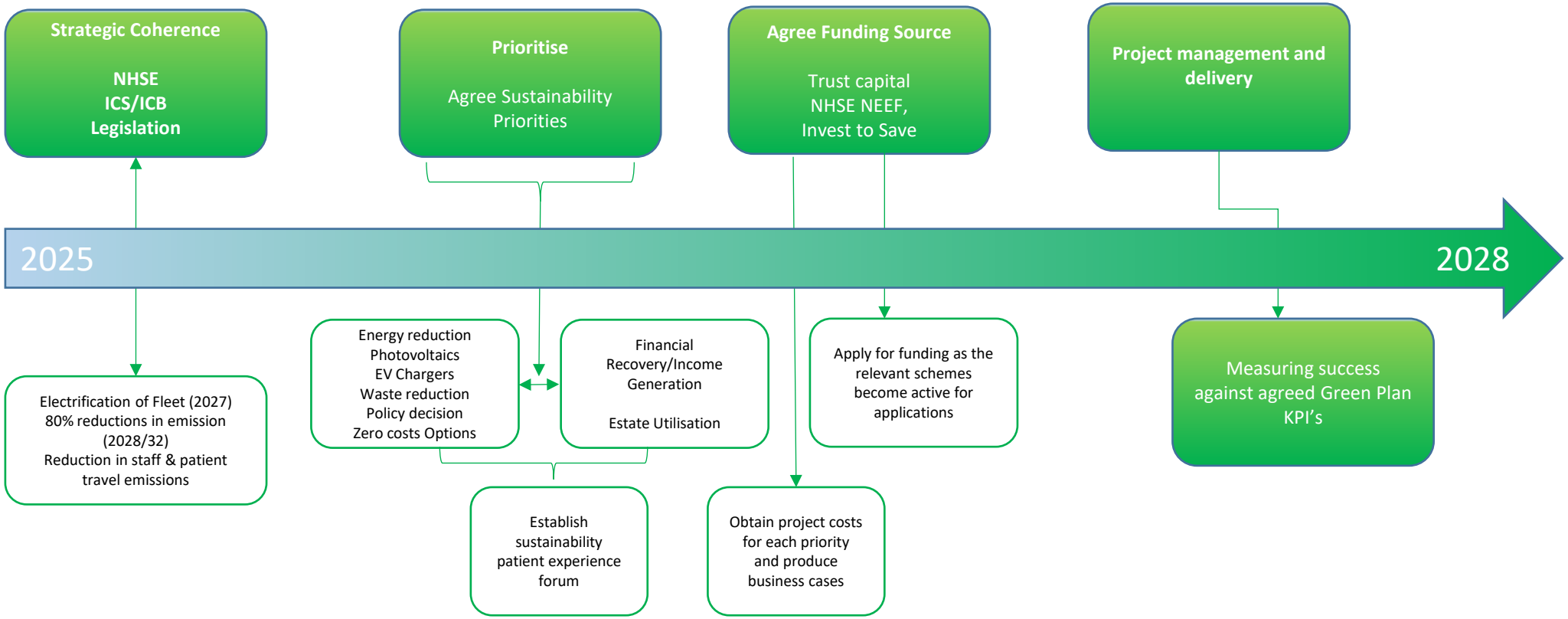
Sustainability Funding Options



The diagram above sets out potential funding options, focusing on sustainability. The development and viability of funding will need to be tested through business cases and financial review dependent on the ability to obtain appropriate CDEL cover. The development of revenue streams, for example Electric Vehicle Charging and or revenue off-setting through invest to save for example photovoltaics. Many public organisation like the education sector encourage donations through a will legacy or bequests.

Delivering the Green Plan 2025 to 2028 – Key Steps

The Trust Green Plan supports the delivery of the estate strategy and its vision. Next steps will involve the development of implementation plans that further establish key actions to deliver a sustainable estate as outlined in the estates strategy. Appendices 1, 2 and 3 set out how the Green Plan will be implemented and monitored including key performance indicators to measure success.



Measuring Success

The Trusts estates strategy defines a broad range or measures, one of which is to reduce carbon emission from building energy, water & waste, anaesthetic gases, metered dose inhalers, business and patient travel by 80% to 28KtCo2e, with a target date between 2028 to 2032.

The Trusts green plan is designed to support the achieve of this objective, appendices 1 providing a detailed action plan and associated activities to ensure the Trusts activities its objective of creating a sustainable estate.

The Trust has defined the performance measures and key performance indicators for its green plan as follows. These will be reported in the Trust's Annual Report and through Finance & Performance Committee Updates:

Trust Strategy	• Create a Sustainable Estate
Estates Strategy	• Reduce Carbon Emission by 80% to 28 Kt CO2e by 2028 to 2032
Green Plan	• Objectives and Key Performance Indicators

Delivery Assurance:

Twice yearly delivery reviews with finance and planning committee

APPENDIX 1 –

Transformational change towards delivering the Green Plan to achieve net-zero emission and strategic resilience

EPUT

Transformational change towards delivering the Green Plan to achieve net-zero emission and strategic resilience

Impacts

Reduce GHG emissions, reduced waste, improved air quality	Strengthened climate resilience, of services, people, assets & supply chain.	Transformations of energy, asset-use, social, environmental and governance to deliver Green Plan	Supporting our communities to thrive - Improved health outcomes, social and economic impact	Investment strategies delivered a sustainable estate, that exceeds expectation of staff, patients and stake holders.	Use of disruptive climate technologies and innovative solutions.

Outcomes

Energy: increased renewable energy (sola). Resilience and flexibility via grid and off gird systems – phase-out use of gas	**Land Resources & Assets:** Improved sustainability, use and management to land, resources and assets	**People:** Empowered, Carbon literate teams, focused on waste minimisation, making sustainable choices	**Finance:** Costs reductions: utilities, waste, purchasing (disposables/single use items)	**Policies:** Improved climate-responsive governance, with policies adopted and implemented.	**Innovation:** Piloting of technologies and innovative solutions to reduce emissions, reduce costs, improve air quality

Outputs

New investments made in: renewable energy, decarbonisation of estate, clean travel & transport, waste reduction, clean technology, bio-diversity and climate resilience (mitigation/adaptation).	Accelerate sustainability actions by stakeholders (teams, patients) local communities and infrastructure support enables (local authority/councils)	Demonstrate systems wide coordination in development activities.	Sustainability responsive organisational policies developed, implemented and supported.	Learning, accountability, feedback loops, and innovation fostered.

Activities

Implementation of Trust's Estates Strategy Estates and sustainability investment plan Implement Green Plan Develop project pipelines (LED. PV, BMS, Decarbonisation, EV charging)	Strategically aligned investment • Capital (NHSE, NEEF,) • Revenue • Invest to save (Trust Capital/Revenue)	Technical assistance, capacity building, policy development, stakeholder engagement, professional development and learning	Project initiation, governance, monitoring evaluation and learning.

Inputs

Trust wide, participatory approach	Scheme/project investment: Trust's capital – Backlog focused on sustainability	Technical Expertise: LED Lighting, EV Charger Surveys Decarbonisation plans & associated project bid documents)	System transformation: • Operational • Clinical • Digital	External Funding NEEF NHSE	Dedicate financial resources for driving innovation, policy support and technical assistances.

Implementation Element | System Design Element | Financial Element | Policy Element | Enhancing Element

APPENDIX 2 –

Green Plan Milestones and Key Performance Indicators

EPUT

Green Plan Milestones and Key Performance Indicators

Green Plan Milestones 2025 to 2045

Milestones

KPIs

For carbon emission we controlled by the Trust: 80% reduction between 2028 /2032

- Reduction in energy consumed (%)
- Reduction in energy costs (%)
- Buildings with a DEC/EPC rating above a D rating (%)
- Reduction in waste produced (%)
- Vehicles fleet electric/hybrid (%)
- Sites with EV charger Facilities (%)
- Buildings with Solar PV (%)
- Renewable energy generated as a percentage of energy consumed (%)
- Building using alternative heating sources (%)
- Buildings with LED lighting
- Salary sacrifice leased vehicles are EV's (%)

For carbon emissions we don't control, but influence: 80% reduction

- Suppliers committed to Net Zero (%)
- Suppliers with a carbon reduction plan (%)
- Suppliers using EV's (%)
- Suppliers with clean air, anti-idle policies (%)
- Increase in the use of low, zero carbon modes of travel and transport (%)

For carbon emissions controlled by the Trust: Net Zero by 2040

- Net Zero Carbon Emissions
- All buildings with an EPV/DEC rating of D or above
- All Trusted operated vehicles electric
- All vehicle based at a Trust site to have access to EV charging facilities
- All buildings to have LED lighting fitted
- Solar PV to be installed on all building on which it is economically viable
- All salary sacrifice vehicles electric
- Trust accredit at carbon literate

For carbon emissions not controlled but influenced by the Trust: Net Zero b 2045

- Net Zero Emissions
- All of suppliers using EV's
- Supply chain accredit as carbon literate

Net Zero Mental Health

APPENDIX 3 –

Glossary

EPUT

Glossary

Term	Definition
BMS	Building Management System
CDEL	Capital Departmental Expenditure Limit
CFC	Chlorofluorocarbon
CH4	Methane
CO2	Carbon Dioxide
CO2e	Carbon Dioxide Equivalent
DEC	Display Energy Certificates
EPC	Energy Performance Certificate
EV	Electric Vehicle
HCF	hydrofluorocarbons
HVAC	Heating, Ventilation and Airconditioning
ICB	Integrated Care Board
ICS	Integrated Care System
IT	Information Technology
LED	Light Emitting Diode
N2O	Nitrous Oxide (laughing gas)
NEEF	NHS Energy Efficiency Fund
PDC	Public Dividend Capital
PFC	Perfluorinated compounds
PFI	Private Finance Initiative
PSDS	Public Sector Decarbonisation Scheme
Scope 1, 2 & 3	Emissions from sources that an organisation produces in connection with its business
SDAT	Sustainable Development Assessment Tool
SF6	Sulphur Hexafluoride
sqm	Square Meters (m^2)
UKHSA	UK Health Security Agency
ULEV	Ultra Low Emissions Vehicle
WEEE	Waste Electrical and Electronic Equipment
WIP	Work In Progress
ZEV	Zero Emissions Vehicle

10. REGULATION AND COMPLIANCE

10.1 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR)

Information Item AG

REFERENCES

Only PDFs are attached

EPRR Report 04.02.2026 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2026

Report Title:	**Emergency Preparedness, Resilience & Response (EPRR)**					
Executive/ Non-Executive Lead:	Alex Green, Executive Chief Operating Officer & Deputy CEO (EPRR AEO)					
Report Author(s):	Amanda Webb, Emergency Planning and Compliance Manager					
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)?	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 presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2025-26 completion of which is a requirement for all NHS organisations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Note the final Emergency Preparedness, Resilience and Response national core standards 2025-26 assurance level for EPUT

Summary of Key Issues

The NHSEI Emergency Preparedness, Resilience and Response (EPRR) Framework 2022 places a responsibility on the Trust to have effective emergency preparedness, resilience and response arrangements in place to ensure that it can respond so far as is reasonably practicable, in the event of an emergency.

NHS England Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

A self-assessment of compliance with the national EPRR core standards is required to be submitted on an annual basis providing assurance that the Trust is meeting all standards and supply relevant evidence on request.

Last year, the Trust scored 'substantially compliant' with 94.8% which was a slight decline from the 96.5% reported in 2023-24. The 2025-26 self-assessment was submitted on the 27th October 2025 with a self-assessment score of 98% with 1 indicator being identified as 'Substantially compliant'. However, the Check & Challenge meeting with the ICB on the 6th November, saw this lifted to 100%, indicating fully compliant.

Identified areas of good practice by the ICB:

The following areas of good practice were identified:

- Use of the EPRR core standards self-assessment document throughout the year to track EPRR compliance and ongoing improvements made against the standards.
- EPUT Major Incident Plan comprehensive including clear action cards.
- Process for assessing and tracking newly identified risks, including maintaining a watching brief.
- Overall Governance process for EPRR and Risk Management.

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	✓

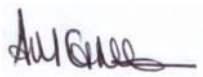
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
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			
NHSEI	NHS England and NHS Improvement	EPRR	Emergency Preparedness Resilience and Response

Supporting Reports/ Appendices /or further reading
2025-26 MSE ICB EPRR Core EPUT Standards Report v1.0 Final

Lead



Alex Green
Executive Chief Operating Officer & Deputy CEO

Mid and South Essex Integrated Care System

2025-2026
Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance Report

Essex Partnership University NHS Trust (EPUT)

Final v1.0

Mid and South Essex Integrated Care System

Table of Contents

Document Control

Version	Date	Distribution
Draft report	30/12/2025	Amanda Webb Comfort Sithole Alex Green Nicola Jones
Response received	20/01/2026	Jim Cook Hannah Calvert
Revised draft report issued	n/a	n/a
Proposed final report issued	n/a	n/a
Final report issued	20/01/2026	<u>ICB</u> Jim Cook Hannah Calvert Sam Goldberg <u>EPUT</u> Amanda Webb Comfort Sithole Alex Green Nicola Jones

1. Executive Summary

1.1 Background

As part of the NHS Emergency Preparedness Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to business continuity, critical and major incidents while maintaining services to patients.

The NHS Core Standards for EPRR sets out the minimum requirements expected of providers of NHS Funded services in respect of EPRR. These core standards are the basis of the EPRR annual assurance process. For more information, please refer to NHS EPRR Annual Assurance Guidance.[1]

Mid and South Essex Integrated Care Board (MSE ICB) are responsible for monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable core standards and lead the local assurance process.

This report documents the outcome of the 2025-2026 EPRR annual assurance process for EPUT.

1.2 Outcome

Organisation EPRR Assurance Rating	
Fully	It was agreed that EPUT has achieved full compliance having reached 100% against the 2025-26 Core Standards for EPRR.
Substantial	
Partial	
Non-complaint	

[1] https://www.england.nhs.uk/long-read/emergency-preparedness-resilience-and-response-annual-assurance-guidance/

2. Assurance Review Process

The assurance process was conducted as follows:

Assurance Element	Date	Attendance / Distribution
Self-Assessment and Evidence	Received 23/10/2025	N/A
Confirm and Challenge Session	06/11/2025	MSE ICB Hannah Calvert Jim Cook Sam Goldberg EPUT Amanda Webb Comfort Sithole Alex Green Nicola Jones
Assurance Report	20/01/2026	MSE ICB Hannah Calvert Jim Cook Sam Goldberg EPUT Amanda Webb Comfort Sithole Alex Green Nicola Jones HWE ICB Grainne Stephenson Jo Burlingham SNEE ICB Christopher Chapman Amanda Lyne

3. Overall level of compliance

Core Standards

The overall EPRR assurance rating is based on the percentage of core standards each organisation assess itself as being ‘fully compliant’ with. The table below details EPUT’s compliance against the relevant standards and agreed actions where not ‘fully compliant’ or further action was agreed to maintain compliance.

Core Standards	Total applicable	Fully compliant	Partially compliant	Non-compliant	Agreed actions
Domain 1: Governance	6	6	0	0	
Domain 2: Duty to risk assess	2	2	0	0	
Domain 3: Duty to maintain plans	11	11	0	0	
Domain 4: Command and Control	2	2	0	0	
Domain 5: Training and exercising	4	4	0	0	
Domain 6: Response	5	5	0	0	
Domain 7: Warning and informing	4	4	0	0	
Domain 8: Cooperation	4	4	0	0	
Domain 9: Business Continuity	10	10	0	0	
Domain 10: CBRN	10	10	0	0	
TOTAL	58	58	0	0	
Overall compliance (%)	100%				

Deep Dive

There was no Deep Dive for this year.

4. Assurance Review Outcomes

EPUT have demonstrated robust EPRR and business continuity arrangements which is reflected in their compliance score.

Agreed Actions

- None

Identified areas of good practice

The following areas of good practice were identified:

- Use of the EPRR core standards self-assessment document throughout the year to track EPRR compliance and ongoing improvements made against the standards.
- EPUT Major Incident Plan comprehensive including clear action cards.
- Process for assessing and tracking newly identified risks, including maintaining a watching brief.
- Overall Governance process for EPRR and Risk Management.

5. Next Steps: Action Plan and Governance

This report should be signed off by the Accountable Emergency Officer and formally reported to the organisations Board or Executive.

Where actions have been agreed, arrangements should be made with the MSE ICB EPRR Team to monitor improvement plans and assist progress, no less than quarterly.

Key priority for the next 12 months should be undertaking the agreed actions and working towards an overall rating of full compliance.

6. Conclusion

EPUT has achieved full compliance with the EPRR Core Standards, marking a significant improvement and demonstrating a strong commitment to resilience and preparedness. This accomplishment reflects the dedication and professionalism of the EPUT EPRR Team and includes several examples of notable practice that set a high benchmark.

On behalf of the NHS Mid and South Essex ICB, I would like to extend my sincere thanks for the team's hard work and dedication in maintaining high standards of EPRR, ensuring the safety and resilience of services for our patients, communities, and the wider public.

Jim Cook, Associate Director for EPRR

10.2 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Information Item KS

REFERENCES

Only PDFs are attached

Quarterly Report on Safe Working Hours for Resident Doctors 04.02.2026 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4th February 2026

Report Title:	**Quarterly Report on Safe Working Hours for Resident Doctors**					
Executive/ Non-Executive Lead:	Dr Kallur Suresh, Executive Chief Medical Officer					
Report Author(s):	Dr P Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	
	SR12 Organisational Development	
	SR13 Quality Governance	
Does this report mitigate the Strategic risk(s)?		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at the Resident Doctors Forum. Any unresolved issues is further escalated to the Executive Chief Medical Officer. Medical Workforce ensures that the Resident doctors working hours are in line with the terms and conditions of the Resident Doctors Contract 2016.	
Are you requesting approval of financial / other resources within the paper?	No	

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

Purpose of the Report		
The purpose of this report is to provide assurance to the Board of Directors that doctors in training and safety rostered and that they working hours are compliant with the terms and conditions of their contract.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.

Summary of Key Issues

1. The National recruitment of trainees is an ongoing issue, however the intake of trainees in the Trust has improved, leaving less gaps on the rota.

2. Gaps in the rota are managed by existing doctors within the Trust and no agency locums were used.

3. 12 Exception reports were raised in this quarter:
   a) One trainee received payment of £44.72 and Trust was fined £74.53 as it was a breach of contractual working hours.
   b) One trainee will receive a payment of £99.19 (payment in progress) for working extra hours. Time off in lieu was not applicable as the trainee was starting their maternity leave from the next day.
   c) Time off in lieu was given for the other 10 exception reports raised by the trainees.

4. The Trust was fined a total of £74.53 in this quarter for the exception report raised on 1 October 2025.

5. Resident Doctors took part in the Industrial Action from 14-19 November 2025 and from 17-22 December 2025. A total of 838.5 hours were covered by internal locums and 10 Consultants stepped down to cover Resident Doctors. A total of £100,834 was spent on shadow rota to cover gaps to ensure patient safety.

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

7. The Board to note that the number of exception reports in this quarter remains the same as the previous quarter.

8. Trust has appointed Dr Eriki Osagbai (Senior Trainee) as the Peer Representative for Resident Doctors, as per the requirement of the NHS 10-point plan.

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

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

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

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

Supporting Reports/ Appendices /or further reading
Quarterly Report on the Safe Working of Resident Doctors

Lead

Dr Kallur Suresh
Executive Chief Medical Officer

QUARTERLY REPORT ON SAFE WORKING OF RESIDENT DOCTORS

1 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the Board of Directors that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 EXECUTIVE SUMMARY

This is the thirty fourth quarterly report submitted to the Board on Safe Working of Resident Doctors for the period 1 October to the 31 December 2025. The Trust has established robust processes to monitor safe working of resident doctors and report any exceptions to their terms and conditions.

Exception Reports:

1. 1 October 2025: GP trainee worked an extra 1 hour following an on-call shift. Trainee was paid £44.72, and Trust was fined £74.53
2. 3 October 2025: Core Trainee (CT1) worked an extra 30 minutes on the ward. Trainee was given time off in lieu.
3. 11 October 2025: Core trainee (CT1) worked an extra 45 minutes post on-call as the on-call doctor arrived late. Trainee was given time off in lieu.
4. 4 November 2025: Foundation Year 2 trainee worked an extra 1 hour on the ward. Trainee was given time off in lieu.
5. 11 November 2025: Specialty trainee (ST6) worked extra hours to complete medical scrutiny forms sent by Mental Health Act office at a short notice. Trainee was given time off in lieu.
6. 13 November 2025: Core trainee (CT1) worked an extra 30 minutes on the ward. Trainee was given time off in lieu.
7. 3 December 2025: Core trainee (CT3) worked extra 2 and a half hours on the ward. Trainee was given time off in lieu.
8. 8 December 2025: Foundation Year 2 trainee worked extra 1 hour on the ward. Trainee was given time off in lieu.
9. 11 December 2025: Foundation Year 2 trainee worked extra 1 and a half hour on the ward. Trainee was given time off in lieu.
10. 12 December 2025: Foundation Year 2 trainee worked extra 4 and a half hours on the ward. Trainee was given time off in lieu. Clinical tutor had a meeting with the trainee and informed on the process of handing over emergency work to the on-call doctor and escalating to senior Trainees and Consultants when necessary.
11. 16 December 2025: Core Trainee (CT3) worked extra 1-hour 40minutes post on-call. Trainee was starting her maternity leave from the next day. Hence time off in lieu was not applicable and trainee will receive payment of £99.19
12. 16 December 2025: Specialty trainee (ST5) had to step down from 5pm until 9pm as the tier 1 on-call doctor was not available. Trainee preferred to take time off in lieu although trainee was eligible for a payment as per the stepping down policy.

Previous quarters

July 2025 – September 2025: 12 Exception Reports
April 2025 – June 2025: 10 Exception Reports.

The number of exception reports has held steady in the last three quarters.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 3 December 2025.

Doctors in Training Data (Average across reporting period)

Total number of posts EPUT Training Scheme inclusive of foundation and GP	**169**
Total number of psychiatry training posts	**112**
Total number of doctors in psychiatry training on 2016 Terms and Conditions	**96**
Total number of foundation posts	**39**
Total number of GP posts	**18**
Total number of vacancies across all grades	**16**
Total vacancies covered LAS/Agency	**12**
Total gaps	**4**

Figures include psychiatry trainees who work less than full-time, and two trainees may be occupying one post

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick	131	131	0	1576	1576
Total	131	131	0	1576	1576
Total Cost	**£95,286**				

<u>Resident Doctor Industrial Action</u>

Resident doctors took part in two episodes of industrial action held from 14 November 2025 until 19 November 2025 and from the 17 December 2025 to the 22 December 2025. The Trust ensured that patient safety was not compromised, and a shadow rota was set up to cover both day and night shift across all five areas of the Trust.

In total 838.5 hours were covered by internal locums and 10 consultants stepped down to cover Resident Doctors over the strike period, so a total of £100,834 was spent on the shadow rota.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, so they can express an interest in covering extra shifts when they leave EPUT.
3. Gaps in the rota are filled with internal locums.

Fines:
Trust was fined £74.53 for the exception report raised on 1 October 2025.

Issues Arising:

1. No major issues were raised by Resident Doctors.
2. On-call monitoring will take place once again in March 2026 as the response rate was poor for the previous monitoring that was held.
3. The Trust has appointed Dr Eriki Osagbai as the Peer Representative for Resident Doctors, as per the requirement of the NHS 10-point plan.

3 Action Required

The Board of Directors is asked to:

1 Note the contents of the report.

Report prepared by

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

On behalf of

Dr Kallur Suresh
Executive Medical Director

11. OTHER

11.1 USE OF CORPORATE SEAL

Information Item | PS | 12.03

REFERENCES

Only PDFs are attached

Use of Corporate Seal 04.02.2026 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	4 February 2025

Report Title:	**Use of Corporate Seal**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, Executive Assistant					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**	**X**	**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with a summary of when the Corporate Seal has been used.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
The EPUT Corporate Seal has been used on the following occasions: - 26.01.26 Deed of Variation relating to S108 Agreement relating to land known as Former Severalls Hospital and Cuckoo Farm, Colchester, Essex

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
None

Lead
 **Paul Scott** **Chief Executive Officer**

11.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item HLD 12.05

Letter from the Secretary of State

11.3 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item | ALL | 12.06

Verbal

11.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item | ALL | 12.08

Verbal

12. ANY OTHER BUSINESS

Information Item | ALL | 12.15

12.1 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING

- Risks for escalation to the CRR or BAF
- Risks or issues to be raised with other standing committees

13. QUESTION THE DIRECTORS SESSION

12.25

14. DATE AND TIME OF NEXT MEETING

12.30

Wednesday 1 April 2026 at 10:00, The Lodge Training room 1