



Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING PART 1

BOARD OF DIRECTORS MEETING PART 1



1 April 2026



10:00 GMT+1 Europe/London



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

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REFERENCES

Only PDFs are attached

 #0 Part 1 BoD Agenda 1 April 2026 FINAL.pdf

**Meeting of the Board of Directors held in Public
Wednesday 1 April 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
Introduction to Dr Eriki as the recently appointed peer support representative for Resident Doctors to share their experience. (Action from the Board Seminar)				
PRESENTATION Time to Care and Partnership Working Elizabeth Wells, Director of Mental Health Urgent Care & Inpatient Services Trust Wide				
3	MINUTES OF THE PREVIOUS MEETING HELD ON: 4 February 2026	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	National Staff Survey – Benchmarking, Results, Analysis & Next Steps	AM	Attached	Noting
Questions taken from the General Public				
8	ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL			
8.1	Board Assurance Framework	PS	Attached	Approval
8.2	End of Life Annual Report	AS	Attached	Approval

8.3	Learning from Deaths – Mortality Report Q2	AS	Attached	Noting
8.4	Public Sector Equality Duty (PSED)	AM	Attached	Approval
8.5	Equality Delivery System (EDS)	AM	Attached	Approval
8.6	Pay Gap Report 2025	AM	Attached	Approval
Questions taken from the General Public				
9	STRATEGIC INITIATIVES			
9.1	Time to Care Closure Report	AG	Attached	Noting
10	REGULATION AND COMPLIANCE			
10.1	EPUT Constitution	Attached	DG	Approval
Questions taken from the General Public				
11	OTHER			
11.1	Correspondence circulated to Board members since the last meeting.	HLD	Verbal	Noting
11.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
12	ANY OTHER BUSINESS			
12.1	Reflection on risks, issues or concerns including: <ul style="list-style-type: none"> Risks for escalation to the CRR or BAF Risks or issues to be raised with other standing committees 	ALL	Verbal	Noting
13	QUESTION THE DIRECTORS SESSION A session for members of the public to ask questions of the Board of Directors			
14	DATE AND TIME OF NEXT MEETING Wednesday 3 June 2026 at 10.00, The Lodge Training room 1			
15	DATE AND TIME OF FUTURE MEETINGS 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

INTRODUCTION TO DR ERIKI AS THE RECENTLY APPOINTED PEER
SUPPORT REPRESENTATIVE FOR RESIDENT DOCTORS TO SHARE THEIR
EXPERIENCE. (ACTION FROM THE BOARD SEMINAR)

● Information Item

Elizabeth Wells, Director of Mental Health Urgent Care & Inpatient Services Trust Wide


3. MINUTES OF THE PREVIOUS MEETING HELD ON: 4 FEBRUARY 2026

● Decision Item

👤 HLD

REFERENCES

Only PDFs are attached

 Board of Director Part 1 Minutes 04.02.2026 FINAL.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 4 February 2026
Held in person at Trust Headquarters

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Paul Scott	PS	Chief Executive Officer
Alex Green	AG	Executive Chief Operating Officer / Deputy CEO
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
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Richard Spencer	RS	Non-Executive Director
Dr Kallur Suresh	KS	Interim Executive Chief Medical Officer
Sarah Teather	ST	Non-Executive Director
Zephan Trent	ZT	Executive Director of Digital, Transformation and Strategy

IN ATTENDANCE:

Angela Laverick	AL	EA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Clare Sumner	CS	Trust Secretary Administrator
Jason Nandlal	JN	Clinical Director for Podiatric Surgery
Richard Sharp	RS	Operational Lead Podiatric Surgery Essex and Bedfordshire
Victoria Green		Care Quality Commission (observing via MS Teams)

There were 7 members 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.

001/26 APOLOGIES FOR ABSENCE

Apologies were received from Denver Greenhalgh, Executive Director of Corporate Governance and Ruth Jackson, Non-Executive Director.

002/26 DECLARATIONS OF INTEREST

There were no declarations of interest. ST advised she had recently been appointed as a peer in the House of Lords for the Liberal Democrat Party. This did not affect any items for discussion on the agenda and would be declared via the public register.

003/26 PRESENTATION: THE FUTURE OF PODIATRIC SURGERY IN EPUT

JN and RS joined the meeting to give a presentation on the future of Podiatric Surgery in EPUT. Key Points included:

- The service was awarded the EPUT Innovation and Research Award in 2025.

- The service was originally established in 1994 and is now the largest service of its kind nationally.
- The service had provided a strong contribution to avoiding major lower limb amputation, which included working with Acute partners to identify patients for early support.
- There was a need to educate individuals regarding the correlation between lifestyle choices and conditions which could lead to lower limb amputation.
- The service had received high satisfaction rates (85-90%).
- There were significant opportunities for system-wide integrated pathways. The outcomes from the current service, in terms of working with acute partners, educating etc. had led to outcomes demonstrating rapid healing times and reduced reoccurrence. However, further funding would be required to continue the service in this way and continue the positive outcomes.

Questions and Discussion

- AM asked, from a patient experience perspective, what the timescales were for the service. JN advised the aim was to see patients from referral in eight weeks and surgery within 12-16 weeks. The service works to the 18-week wait target.
- AS asked whether more could be done to increase day-care provision to help patient experience and what more could be done to embed acute community working. JN advised the solution was funding as the working with acute vascular services was originally undertaken as a proof-of-concept and is now being undertaken outside of the service specification. There had been excellent support from the clinical teams so far, who have the passion to deliver the service, and funding is now needed to continue to deliver the positive outcomes.
- ST commented that education around early access was key and asked what could be done to develop in this area. JN agreed that education is fundamental, especially for those with diabetes and in the acute sector. The continued work with acute partners would help drive the education piece forward.
- DL queried if the majority of patients are diabetic and what is done to ensure non-diabetic patients are not missed in terms of early access. JN advised of the work with acute partners for vascular conditions and the establishment of the diabetic service to increase early access for higher risk individuals. The service was initially established to undertake elective surgery and there are lots of individuals receiving surgery who are non-diabetic. RS advised there was a patient pathway for patients with diabetes and a pathway for general foot concerns, which lead into the service.
- LL suggested developing a business plan for funding and that members of the Board could review and provide advice prior to submission.
- ZT noted the importance of the service in reducing waiting times and providing a better experience from patients and queried the barriers experienced to date. RS advised there were different barriers in different areas, but generally it was having a system view of funding streams. TS advised there were commissioning groups, system forums etc. that colleagues can raise and promote these issues where the service fits into the medium-term plan. ZT agreed to liaise after the meeting to link the service with acute partners.

HLD thanked JN and RS for the presentation.

Action:

- 1. Liaise with JN and RS to provide support for liaising with acute partners for the Podiatric Surgery service. (ZT)**

The Board of Directors reviewed the minutes of the meeting held on 03 December 2025 and agreed these as an accurate record.

005/26 ACTION LOG AND MATTERS ARISING

The action log was reviewed, noting two actions were open that were not yet due for completion.

006/26 CHAIR'S 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. Key points included:

- The changes to the timeline for the Lampard Inquiry.
- A formal welcome to KS as the Interim Executive Medical Director and a thank you to Dr Milind Karale.
- The recognition of staff achievements, including winners of the Queen's Award.
- The stepping-down of Doug Field as Associate Non-Executive Director, thanking him for his time in office.

Questions and Discussions

- RS noted upcoming changes to the Mental Health Act and how the Trust would ensure compliance with any new requirements. KS advised senior clinicians were attending a webinar on the changes, which are in the early stages of implementation nationally. The new requirements will lead to significant changes and implementation would be phased with training available. The Code of Practice would be published in the next few months. AS advised it would also be important to ensure the patient voice was included in any changes, training was established for the workforce and patient pathways were reviewed to consider changes to criteria.

The Board of Directors:

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

007/26 CEO REPORT

PS presented a report providing a summary of key activities and information to be shared. Key points included:

- PS had undertaken service visits over the Christmas period. The visits had been positive, with compassionate care observed and positive patient feedback.
- The Trust had two key priorities for 2026, the Nova Electronic Patient Record and the Community First programmes.
- There are integration initiatives taking place across West Essex, including Home First and community assessment pilots.
- There was national recognition of the Nova Programme provided through HSJ award shortlisting.

Questions and Discussions

- AS highlighted the work around the Peer Academy, which provided an opportunity to expand the work around peer support.
- AS highlighted the use of the Fundamentals of Care, which will be used to support the Quality of Care Strategy.
- AG highlighted the pilot underway in West Essex, working with primary care and acute providers to deliver a community assessment and treatment unit. The pilot commenced over the winter period and has seen over 200 patients, with a mean length of stay of five days. It offered an alternative option to an acute hospital bed.

- AM highlighted the work with the King's Fund and BRAP on a cultural review of the organisation.

The Board of Directors:

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

008/26 QUALITY AND PERFORMANCE SCORECARD

PS presented the report, in conjunction with a summary provided in the CEO report. Executive Directors provided key points:

Operations (AG)

- All areas where EPUT provides Talking Therapies are reporting a reduction in access rates but are meeting the waiting for treatment times. There is a move towards a recovery indicator which is reporting positively and above target.
- Inpatient Adult Acute Mental Health capacity remains challenged, with high occupancy rates and a recognition of the drive to improve length of stay and out of area placements. There had been positive progress on length of stay for adults, but older adults remain challenged due to complex system delays. This has caused out of area placements to spike in November. There was strong clinical oversight of these placements through the new Clinical Director and the Discharge Team.
- The Time to Care programme is now moving to benefits realisation following completion of the implementation phase.
- There was a refreshed flow recovery plan with a system focus. This is now linked to the Community First programme through the Board Assurance Framework.

Medical (KS)

- The new Clinical Director for Flow and Capacity now chairs a daily bed management meetings and provides clinical oversight of decision making. KS had attended sit-rep meetings and had met with inpatient consultants to review capacity issues. There was also a move to asking community consultants to be actively involved in decision making around admission and discharge.

Nursing (AS)

- There was decline in the Cardio Metabolic Rate in December for inpatient services, with six wards fully compliant. A deep dive was undertaken which highlighted the importance of the work of resident doctors in this area. There was a decrease in compliance for community services, though there were high levels of compliance in other areas. A meeting was held to understand the differences and the need to improve clarity of processes and data quality.

People and Culture (AM)

- The sickness absence rate for the Trust was at 5.8% and was an area of focus for the People Committee.
- The use of agency staff maintained a positive trajectory. The use of bank staff was slightly over target, and the Trust had established its benchmark for the year.
- There was a good, continued improvement around the vacancy rate and staff turnover.
- Mandatory Training was above the target compliance rate and direct communication had been made with staff with continued compliance issues with Mandatory Training, which had seen an improvement in the compliance rate. These areas remain a key focus for the People Committee.

Finance (TS)

- A summary of the financial results to date were included within the Quality and Performance Dashboard.
- There had been recognition and contribution to inquiry costs and the potential to release deficit support funding (DSF).. This had been discussed by the Finance and Performance Committee with an agreement that the Trust would continue to operate with enhanced controls in place in order to deliver the forecast outturn. The risk has been considered in the Board Assurance Framework (SR8 – Use of Resources) and the recommendation was that the risk score is not changed at this point.
- In terms of capital investment the Trust was looking to accelerate expenditure over the last quarter of the financial year to deliver the forecast outturn.

Questions & Discussions

- ST asked whether the decline in access for Talking Therapies was temporary or a trend. AG advised the reduction was likely due to seasonal trends but would continue to be monitored.
- ST noted good progress in some areas for length of stay and added that it was positive to note the focus on admission and discharge. ST asked what had been learned from what had gone well. AG advised that the shift to localities and driving greater ownership of flow in community services had led to positive progress. There had been differences in system structures, but this had been progressed through the Essex-wide Strategy Implementation Group. A workshop was held with local authorities to focus on the gaps in the commissioned pathway for supported accommodation and there were actions agreed with system accountability. TS advised the Finance and Performance Committee had completed a deep dive of flow and engaged with external support. The outcome of this work would be shared at a future Board Seminar.
- EL asked how robust and realistic the case for commissioning more beds was through demand planning at a system level to reduce out of area placements to zero. AG advised the key was the out of area unification work with ICB colleagues, which would enable the Trust to make different decisions about capacity that is commissioned. There was a need to focus on individuals waiting on inpatient wards who do not require acute care, so the answer is not necessarily to have more acute beds. The local authority is conscious of the gaps in provision and is working to address it. PS advised the Trust had indicated to the ICB its desire to move to be commissioned based on outcome, which would allow services to be delivered in a different way and improve patient experience. TS advised the unification of resources was the right thing to do for patient and their families as well as being a more effective use of resources.
- Following discussion, AG agreed to invite local authority colleagues to the Board Seminar session to share information on flow and capacity challenges from a system perspective.
- ST commented on the current sickness absence rate and the low flu vaccination uptake, asking whether there was a process in place to learn from what went well to prepare for a more successful campaign this year. AM advised a review had been undertaken and a plan was in place for this year's campaign. The key learning incorporated into the plan was to begin the campaign early and have closer involvement with clinical staff, including having peer vaccination across local areas. AS advised, there had been an improvement in the uptake from the previous year but wanted to drive this improvement further.
- MJ advised this was considered by the Quality Committee, focusing on the impact of uptake, rather than just compliance rates. The Committee also looked

at other areas such as the impact of mandatory training compliance on the quality of services. AM advised there was a continued upward trend in mandatory training compliance and was pleased to note improvements in certain professions where compliance levels had been lower.

- PS queried how easy it was for people to undertake mandatory training and the effectiveness of that training. AS advised it was important to change the culture around mandatory training, so staff see the importance and the impact it can have. KS advised there had been changes to training requirements based on national guidance and work was underway to ensure time was available for doctors to complete training and the potential for group training sessions to take place.

The Board of Directors:

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

Action:

- 1. Invite local authority colleagues to the Board Seminar session in March 2026 to provide details of flow and capacity from a system perspective. (AG)**

009/26 COMMITTEE CHAIRS' REPORT

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

Finance and Performance Committee (DL)

- The SR8 risk in the Board Assurance Framework had been reviewed and updated to include “cash due to the potential inability to recover deficit support funding.
- The Committee had received an update from Estates and Facilities, noting the resourcing challenges for the teams and the challenges with an aging estate. Mitigating factors had been implemented, including utilising external support to help with prioritisation. TS advised there was a backlog maintenance of c.£114m which, combined with an aging and disparate estate, was placing operational pressures on colleagues and compliance
- The Committee had received a comprehensive Green Plan which was due to be presented today.

People Committee (DL – on behalf of Dr Ruth Jackson)

- The Committee had discussed mandatory training compliance and noted the previous update provided regarding improving mandatory training compliance within the medical workforce.
- The Committee had reviewed workforce planning and focused on reducing temporary staffing spend, which was progression well.
- The Committee had received a staff story from a student nurse, who had challenging issues during their rotation and had felt supported and appreciated. AG and AS advised they had recently met with third year students, who had reported consistent experience and were seeking roles at the Trust.

Quality Committee (MJ)

- The Committee was reviewing the way it discussed quality improvement, including considering evidence-based information from academia to further improve.
- The Committee had focused on neurodiversity and heard patient stories of the work being undertaken to improve the experience for neurodivergent patients.

KS advised the successful appointment of a specialist clinical support for neurodiversity.

The Board of Directors:

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

010/26 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. Key points included:

- The Trust remained fully registered with the CQC.
- The CQC had undertaken unannounced inspections and had published the final report for the inspection of Learning Disability Inpatient Services (Byron Court) which had received an overall rating of “Requires Improvement”. The operational director is taking forward the actions following the inspection.
- The Trust had undertaken a quality review of Ardleigh Ward, and improvement actions identified were underway..

Questions and Discussion:

- ST asked whether there were any areas for improvement highlighted from CQC inspections that the Trust was not expecting. AS advised the Trust was aware of the areas identified, including governance oversight at a local level. There were challenges previously reported, such as length of stay, service demand etc. and it was important to ensure patients had supportive effective admission and discharge.
- EL noted that the inspection reports provided feedback at a point in time and asked how the Trust could ensure there was improvements over time. AS advised, this could be monitored through quality data and triangulating this with patient and staff feedback. The feedback from patient and staff stories, such as the student story highlighted previously, provides good intelligence to how services are operating.

The Board of Directors:

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

011/26 FREEDOM TO SPEAK UP POLICY

PS presented the report which provided 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. PS advised the key changes were the removal of duplicated information and the updating of links and contact details. The policy had been through robust governance process prior to presentation to the Board for approval.

The Board of Directors:

- 1. Noted the content of the report.**
- 2. Approved the Freedom to Speak Up / Whistleblowing Policy**

012/26 QUESTIONS TAKEN FROM THE GENERAL PUBLIC

There were questions taken from Members of the Public in attendance at the meeting, and these have been summarised in the appendix attached to these minutes.

013/26 BOARD ASSURANCE FRAMEWORK

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

- The discussions at today's meeting had covered many of the strategic risks included in the Board Assurance Framework.
- The Cyber Risk had been reviewed, and the score had remained the same. There were actions and standards in place, but it was recognised there would always be a risk given the nature of the threat.

Questions and Discussion

- EL noted references to the Community First programme as a key lever in many of the risks, including demand and capacity. EL asked what proportion of the programme relied on system partners and what was in the control of the Trust. AS advised, there were areas that can be taken forward internally, including reviewing the pathway between community and inpatient services, including assertive outreach. The programme would need support from primary care and the local authority. AG advised it was difficult to give a specific percentage of partner organisations in the programme, but there were a number of areas such as refreshing the Section 75 operational model and step-down beds requiring primary care input.

The Board of Directors:

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

014/26 GREEN PLAN

TS presented a report which provided progress made on the current Green Plan and the direction of travel on national and local sustainability priorities within the Green Plan 2026-29. Key points included:

- The Green Plan acknowledged and promoted the investments and improvements that had been made to date, as well as setting out the ambitions and plans for the future.
- The Plan had been discussed at the Finance and Performance Committee and comments made included ensuring the estates programme and procurement are linked to the plan.
- The Plan was a live document which would be reported to the Finance and Performance Committee on a quarterly basis, with an annual report including tracking progress against the plan.
- The Finance and Performance Committee had considered the plan and agreed to recommend it to the Board of Directors for approval.

Questions and Discussion:

- AM highlighted the quarterly pulse survey included options for adding questions and suggested including a question around the Green Plan / sustainability.

The Board of Directors:

1. **Approved the Green Plan 2026-29**

015/26 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

AG presented the report which presented the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment for 2025-26, completion of which is a requirement for all NHS organisations. Key points included:

- Assurance was provided that robust governance had been followed, including discussion at the Quality Committee and a confirm and challenge session with ICB colleagues.
- The Trust had achieved full compliance across all core standards with areas of good practice identified.

The Board of Directors:

- 1. Noted the final Emergency Preparedness, Resilience and Response national core standards 2025-26 assurance level for EPUT.**

016/26 QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

KS presented a report which provided assurance to the Board of Directors that doctors in training are safely rostered and their working hours are compliant with the terms and conditions of their contract. Key Points included:

- There remained a challenge with national recruitment, but the Trust has been able to fill posts.
- Details were provided of reported breaches and fines received since the last quarter, which was similar to previously reported quarters.
- Industrial action had taken place and action was taken to ensure there was minimal disruption to services. There was a mandate for further industrial action to take place in the next six months.

Questions and Discussion:

- RS asked if there were any risks of staff underreporting issues. KS advised staff are encouraged to submit reports and there was a Guardian of Safe Working to monitor and meet with individuals as needed.
- DL noted the recent appointment of a peer support representative for Resident Doctors and asked whether they could attend a future Board meeting to share their experiences. KS agreed, noting the individual had started in the role in December. Once they have had more time to settle into the role, they would be invited to a Board meeting.

The Board of Directors:

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

017/26 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.**

018/26 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

None

019/26 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.

020/26 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

HLD reflected on equalities as a result of decisions and discussions, noting:

- The discussions around Peer Support Workers and the current structure to promote career progression.
- The discussions around neurodiversity and the progress made within the Trust.
- The presentation on Podiatric Surgery, highlighting health inequalities and education contributing to ill health.
- The Community First programme supporting fair access to services.

021/26 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.

022/26 ANY OTHER BUSINESS

There was no other business.

023/26 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.

024/26 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 1 April 2026.

The meeting closed at 12:32.

Signed:

Date:

Hattie Llewelyn-Davies, Chair

DRAFT

Appendix 1: Governors / Public / Members Query Tracker (Item 012/26 and 024/26)


Governor / Member of the Public	Query	Response
Stuart Scrivener, Public Governor, Essex Mid & South (pre-submitted questions)	In relation to SR11. Given that staff retention and development are identified as priorities, can the Board be assured that feedback from staff surveys and questionnaires is being captured, acted upon, and that resulting actions and outcomes are effectively communicated to staff?	<p>AM advised that results from the annual Staff Survey, quarterly pulse surveys and local engagement questionnaires are collated centrally by the Staff Engagement Team. Themes are analysed at Trust, care unit and team level to ensure both strategic and local insights are identified. These priorities are incorporated into local action plans, which are monitored through existing governance routes, including care unit accountability framework meetings and the newly formed Staff Experience and Inclusion Group.</p> <p>Outcomes and planned actions are communicated through multiple channels, including team briefings, intranet updates, leadership forums, and targeted communications within Care Units. Progress is reviewed by the Executive Team and reported to the People Committee and Board.</p>
	In relation to page 138 of the PDF - Item 6 - Review of Quality Forums from Care Units. Continuous improvement in quality is clearly important. Given that this item remains rated red and has been extended, are the Board / NEDs satisfied with the progress being made and the current focus of care unit quality reviews?	<p>AS / MJ advised we have now clearer structures leading to better quality of discussions and strengthened reporting through care unit quality and safety meetings, AFs, Quality of Care and the Quality and Safety Committee, all supported by better triangulated data.</p> <p>Over the next six months we want to translate this further into more measurable improvements at a care unit level. This will be supported by piloting an early warning sign on a small number of mental health wards and teams which will have a mixture of outcomes from Experience, Quality and Safety. However, we will continue to apply scrutiny and support.</p> <p>There is also a question around what is being analysed and the need to move towards deeper critical questions to see what is actually happening within services and what needs to be changed. The development of local indicators would provide this information and help drive local change.</p>

Governor / Member of the Public	Query	Response
Member of the Public (Service User – Brockfield House)	<p>The individual described their positive experience on Dune Ward at Brockfield House and commended the effort from staff to improve and maintain quality of life for patients.</p> <p>The individual proposed an anonymous study on the effects on patients and staff of smoking cessation, noting the potential effect of nicotine withdrawal on patients.</p>	<p>AG thanked the individual for the positive feedback and the proposal to undertake an anonymous study. AG felt this would demonstrate the relationship between physical and mental health and would be happy to meet with the individual outside the meeting, with clinicians, to see how this could be progressed.</p> <p>Action:</p> <ol style="list-style-type: none"> Undertake meeting with member of the public attending Board and clinicians to take forward suggestion of completing a study on the effects of smoking cessation on patients and staff. (AG)
Member of the Public (Peer Support Worker)	<p>The individual described their experience as a Peer Support Worker, noting the positive impact on patients with recovery and admission back into society.</p> <p>The individual highlighted an issue with the structure of peer support workers, noting there appeared to be no roles between the peer support worker and the Director of Patient Experience. This meant there was no potential for career progression and good people may move elsewhere in order to progress their career. There were also issues with BAME representation in lead roles and certain staffing benefits not being available for individuals under Band 5 which created a disparity.</p>	<p>AM provided details of the RISE programme regarding career progression for BAME staff, which included some good case studies which could be shared. AM agreed to meet with the individual outside of the meeting to discuss career progression and identify where there are gaps that could be improved.</p> <p>Action:</p> <ol style="list-style-type: none"> Undertake a meeting with the Peer Support Worker attending Board to review gaps in processes for career progression. (AM)
Member of the Public	<p>The individual described their own experiences of neurodiversity services through their children. The individual's children had been diagnosed with autism and ADHD and were on the waiting list for services. They had been on the waiting list for some time, and when the individual contacted to service to ask their position on the list, they were told that they were on the list and no further information could be provided.</p>	<p>AG thanked the individual for raising the issue and confirmed the service should be able to advise the position on the waiting list. There was a national challenge around waiting times for ADHD services, but she would follow up with the service regarding providing support while waiting. AG agreed to meet with the individual outside the meeting to gain further information to allow follow-up with the service.</p> <p>Action:</p>

Governor / Member of the Public	Query	Response
		<p>1. Arrange for the relevant service to contact the member of the public regarding support whilst on waiting list for Autism / ADHD service. (AG)</p>
Member of the Public	<p>The Member of the Public had attended previous Board meetings and raised issues with their experience of abuse. They had continued to experience discrimination and abuse from the Trust and had spent some time reviewing emails they had sent raising these concerns, which had caused them to relive the trauma.</p> <p>From their review, the emails had been passed onto managers and members of the Board, but there was no evidence that the issues had been investigated or a response provided to them.</p> <p>The Member of the Public had reviewed the Equality, Diversity and Inclusion Policy and noted this was not in date and did not provide details of what staff should do if they receive a report of abuse from a patient.</p> <p>The individual acknowledged they had met with AS and HLD but felt there had been no accountability for past abuse and it was not clear where the responsibility lay within the organisation for these issues.</p> <p>The individual also advised they had previously submitted questions to the Board of Directors but had not received a written response.</p>	<p>HLD thanked the individual for attending and raising the concerns and agreed to review the EDI policy - available online - to ensure the correct version is accessible.</p> <p>AM noted the point regarding what action should be taken by staff who have received reports of abuse from patients and agreed to review the current process and check if it is represented in a policy. AM also agreed to consider the action to be taken to ensure leadership accountability and would report back to a future Board meeting.</p> <p>HLD agreed to review questions that had been raised to the Board in the past and to ensure there was a process in place for responses to be provided.</p> <p>Action:</p> <ol style="list-style-type: none"> 1. Review Equality, Diversity and Inclusion Policy on the intranet to ensure the correct version is accessible. (AS) 2. Review comments made by member of the public in regards to instruction to staff if a patient reports experiencing abuse and whether this needs to be explicit in policy. (AM) 3. Review questions submitted to the Board of Directors to ensure a process is in place for providing written responses.. (HLD)


4. ACTION LOG AND MATTERS ARISING

Standing item

 HLD

REFERENCES

Only PDFs are attached

 Action Log Part 1 01.04.2026.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting held on the 4 February 2026

Lead	Initials	Lead	Initials	Lead	Initials	Requires immediate attention /overdue for action	
Zephan Trent	ZT	Alex Green	AG	Ann Sheridan	AS	Action in progress within agreed timescale	
Trevor Smith	TS	Andrew McMenemy	AM	Hattie Llewelyn-Davies	HLD	Action Completed	
						Future Actions/ Not due	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
004/26 February	Liaise with JN and RS to provide support for liaising with acute partners for the Podiatric Surgery service	ZT	April 2026	ZT liaised with JN / RS and connected them with individuals at Mid & South Essex Foundation Trust who are now working with them to take this forward.	Closed	
008/26 February	Invite local authority colleagues to the Board Seminar session in March 2026 to provide details of flow and capacity from a system perspective.	AG	April 2026	Peter Devlin, Essex County Council attended the Board Seminar session in March 2026 and shared the system / local authority perspective on flow and capacity.	Closed	
012/26 024/26 February	Undertake meeting with member of the public attending Board and clinicians to take forward suggestion of completing a study on the effects of smoking cessation on patients and staff.	AG	April 2026	This has been taken forward with the Research and Development Team. .	Closed	
	Undertake a meeting with the Peer Support Worker attending Board to review gaps in processes for career progression.	AM	April 2026	A meeting has been arranged.	Closed	
	Arrange for the relevant service to contact the member of the public regarding support whilst on waiting list for Autism / ADHD service.	AG	April 2026	The service has made contact with the individual and is taking forward their concerns.	Closed	
	Review Equality, Diversity and Inclusion Policy on the website to ensure the correct version is accessible.	AS	April 2026	The website has been reviewed and it was identified that an FOI contained a link to an older version of the Equality, Diversity and Inclusion	Closed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				<p>Policy, which would appear in a search for the policy. It is a legal requirement for the Trust to disclose FOI's on its website and therefore it is not possible to remove the link. However, the website has been reviewed to ensure the latest version of the policy is available on the Equality, Diversity & Inclusion section of the website:</p> <p>Equality, diversity and inclusion - Essex Partnership University NHS Foundation Trust</p>		
	Review comments made by member of the public in regards to instruction to staff if a patient reports experiencing abuse and whether this needs to be explicit in policy.	AM	May 2026	This is being taken forward by the Executive Chief People Officer, Corporate Nursing and the Violence and Aggression Prevention (VAPR) Team.	Future Action	
	Review questions submitted to the Board of Directors to ensure a process is in place for providing written responses.	HLD	April 2026	<p>There is a process in place for responding to questions raised to the Board of Directors, in relation to the board business of the day. Where the individual submits a question and subsequently attends the meeting to ask the question, a response is provided on the day and written into the minutes for that meeting.</p> <p>Where the person submits a question, but does not attend the meeting, the question is read-out and answered at the meeting and a response written into the minutes for that meeting. A written response is also provided to the individual after the meeting via email.</p> <p>Where the question / query is related to an individual's care this is passed onto the relevant services to liaise directly.</p>	Closed	

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 Development Plan to take place in May 2026 as part of regulatory changes.	Closed	
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	The Digital and Data Strategy has been added to the Board Development Plan for January 2027. Flow and Capacity was discussed at the Board Seminar in March 2026.	Closed	


5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

● Information Item

👤 HLD

REFERENCES

Only PDFs are attached

 Chair's Report 01.04.2026 FINAL.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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

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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:	<p style="text-align: right;">Capital £ Revenue £ Non Recurrent £</p>
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

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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 Quality and Excellence Awards**

The annual EPUT Quality and Excellence Awards were held recently to celebrate the achievements of our teams, services, partners and volunteers. Over 200 nominations were received, which highlighted individuals and teams who go above and beyond to provide the best care, support others and drive improvements across the Trust. Congratulations to all that were nominated and of course, to the well deserving winners

2.2 Lampard Inquiry

The Lampard Inquiry have published their investigative approach to sexual safety as part of meeting the Inquiry's Terms of Reference. The purpose is to investigate the rights of patients within mental health settings to be prevented from sexual harm or unwanted sexualised behaviour and to feel safe within care environments. They will examine sexual safety within mental health inpatient settings and will focus on systems, culture, decision making, accountability and the multi-agency responses to sexual safety concerns on inpatient wards or hospital premises; while an inpatient is on authorised or unauthorised leave, and those responsible for the patient knew or ought to have known of potential behaviour or associated risk. More information can be found on the Lampard Inquiry [Website](#).

As the work of the Lampard Inquiry progresses the Trust Board remains committed to doing all we can to support the Inquiry and encourage past and present staff members to engage with the Inquiry to enable the Inquiry Team to fulfil its terms of reference and provide answers that families are seeking. Dedicated support is in place for anyone affected by the Inquiry, including current and former patients, families, loved ones and carers and EPUT staff.

2.3 West Essex Health and Care Partnership

In February Nicole Rich, Director of Community Physical and Mental Health Services in west Essex, joined system partners from west Essex in a panel discussion at the NHS Confederation's Care Closer to Home conference. Nicole spoke alongside colleagues from Princess Alexandra Hospital NHS Trust, a local patient representative and primary care and system leads on the work of the West Essex Health and Care Partnership, which brings together a wide range of health and care services across a number of sectors to support people who can be safely cared for at home or in the community. The partnership and its approach and services have evolved over more than a decade and now include a community coordination centre, integrated urgent treatment centre, hospital at home services and a community assessment and treatment unit, all of which can help patients stay at home or in the community whilst receiving a range of care and interventions. It is a great example of what we can achieve together and we are grateful to our patient and system partners for their continued support.

2.4 Helping Young People Step Into Healthcare Careers

At EPUT we have been running the Step Forward Programme, designed to help young people develop workplace skills for a career in healthcare, successfully since August 2025. During this time, 35 young people have taken part in the flexible four week programme, designed to help people aged 18 – 30 living in the Southend and Basildon areas to develop the skills and expertise needed to work in healthcare roles, with 10 young people from the programme having gone on to secure employment or paid placements in health and social care.

2.5 Lived Experience in Education Digital Library

We recognise and value the input of those with lived experience to help us provide the best quality of care to our patients that we can. A Lived Experience in Education Digital Library is available for staff and students to be able to access bite sized resources that help raise awareness around a number of different topics, with many resources available produced or coproduced with Lived Experience Ambassadors.

2.6 Support for Anyone Experiencing Domestic or Sexual Abuse

The Trust is a signatory on the NHS Sexual Safety Charter as part of our ongoing commitment to supporting our staff to be safe at work. The Sexual Safety Charter outlines ten pledges we make to our staff, including a commitment to ensure clear reporting and support mechanisms are in place for colleagues who experience sexual assault, harassment or abuse in the workplace. To coincide with NO MORE Week (02 – 08 March), Trust wide communications included information on the staff support pathway, which offers guidance on what to do to keep themselves and others safe. A dedicated sexual safety phone line is available for staff to report any incidents confidentially at any time, day or night seven days a week. All reports will be escalated to senior level, investigated promptly and necessary actions taken. Safety is our priority and inappropriate behaviour will not be tolerated across our organisation.

2.7 We Are A Disability Confident Leader

EPUT continues to be recognised as a Disability Confident Leader, following a review by our Disability and Mental Health Network. This reflects our ongoing commitment to inclusion and to supporting colleagues with disabilities through inclusive policies and reasonable adjustments. As a Disability Confident Leader, we also share best practice with other organisations and use workforce data to help drive improvement. Thank you to our Network Chairs and to everyone supporting inclusive workplaces across EPUT.

3.0 Legal and Policy Update

3.1 Children and Young People's Mental Health

Please see the link below for a copy of the report. The Education and Health and Social care Committees have jointly launched an inquiry into the mental health of children and young people. This inquiry will examine mental health support and services provided in education and community settings, available to children and young people up to the age of 25. The Committees wish to understand how this provision is integrated with specialist Child and Adolescent Mental Health Services (CAMHS) acute and other statutory NHS Services. **For Information:** [Children and Young People's Mental Health - Committees - UK Parliament](#)

3.2 SEND Reform: Putting Children and Young People First Government Consultation

Please see the link below for a copy of the report. A Department for Education consultation seeks views on proposed changes to improve outcomes for children and young people with special educational needs and disabilities (SEND). It states it will: strengthen the law to ensure evidence-based support for children and young people is provided early in mainstream settings; integrate support across health, care, and family services, ensuring children's needs are identified and addressed as soon as they emerge; and increase upfront investment so support is readily available for classes and communities of children. Comments by 23.59 on 18 May 2026. **For Information:** [SEND reform: putting children and young people first - GOV.UK](#)

3.3 Transforming Access to Children And Young People's Mental Health Support

Please see the link below for a copy of the report published on 17 February 2026 advising that evidence and insight on the importance of early intervention for children and young people with mental health issues. And key points, the NHS 10 Year Health Plan **For Information:** [Transforming access to children and young people's mental health support | NHS Confederation](#)


6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

● Information Item

👤 PS

REFERENCES

Only PDFs are attached

 CEO Report 01.04.2026 FINAL.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	Yes / No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	Yes /No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			
Purpose of the Report				
This report provides an update on news and developments.	Approval			
	Discussion			
	Information		✓	

Recommendations/Action Required
<p>The Board of Directors is asked to:</p> <ol style="list-style-type: none"> 1. Receive and note the content of the report.

Summary of Key Points

The report attached provides information on behalf of the CEO and Executive Team in respect of 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:	<p style="text-align: right;">Capital £ Revenue £ Non Recurrent £</p>

Governance implications

Impact on patient safety/quality				
Impact on equality and diversity				
Equality Impact Assessment (EIA) Completed	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 20%; text-align: center;">YES/NO</td> <td style="width: 30%; text-align: center;">If YES, EIA Score</td> </tr> </table>		YES/NO	If YES, EIA Score
	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 Support for Colleagues During Ongoing World Events**

Many of us will have seen coverage in the media and on social media about the ongoing conflict in the Middle East. As a Trust we are proud of the diversity of our workforce, with 90 nationalities represented across the Trust and it is important that everyone is respected, feels valued and knows they can report any issues of concern. Acknowledging that events like these can bring a range of emotions, details of support mechanisms in place for our staff have been shared widely across the Trust.

1.2 CQC Well Led Inspection

A planned 'Well Led' Inspection of EPUT was recently carried out by the Care Quality Commission, focussed on ensuring that we have an inclusive and positive culture of continuous learning and improvement that meets the needs of people who use services and wider communities. In addition they looked at the role of leadership across the Trust, especially the way which leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person centred and sustainable to reduce inequalities. The CQC plays a vital role in ensuring services provide safe, effective and high quality care for those in need and their feedback is really important in helping to drive improvements to our Trust and more widely across the health and care system. I welcome the CQC's visit, which provided an opportunity to share our story of transformation and improvement – I am proud of the work that has been achieved, although recognise there is still more to do, and look forward to receiving the outcome of this inspection in due course.

1.3 Changes to Integrated Care Board

From 01 April, there will be a move from the three current Integrated Care Boards in Essex, to one Integrated Care Board to cover the whole of the County of Essex. This is a welcome change for us as a healthcare provider and will help us to work more cohesively with our partners across the whole county. At the same time, we are carefully reviewing the opportunities presented by the government's plans for NHS Trusts to be more widely involved in commissioning and organising services in neighbourhoods and local areas. We are doing this with partners, including local GPs, and will involve our patients and staff in any significant developments as they occur. We also await the outcome of the government's decision on the format of new unitary councils for Essex as part of the local government reorganisation programme, and we will be ready to work with these councils as they emerge from the process.

1.4 Two New Mental Health Urgent Care Departments in Essex

We have recently started construction work for two new mental health urgent care departments on existing EPUT sites (Derwent Centre, Harlow and Kings Wood Centre, Colchester). Both departments will be adjacent to our existing mental health inpatient assessment wards and very close to the relevant hospital's A&E department. The two Departments represent a capital investment of around £5.3million in local mental health services and will enable us to provide high quality, compassionate care for people experiencing a mental health crisis in a calm and appropriate environment.

Our existing urgent care department in Basildon has already seen over 4,500 attendances since it opened in March 2023. We will build on the knowledge gained at Basildon, in particular working with our system partners, voluntary sector colleagues and people with direct lived experience of the service to develop crisis support plans and avoid admissions to inpatient beds wherever possible. We expect both units to be completed and operational by the summer of this year.

1.5 Changes to the Mental Health Act

The Mental Health Bill received Royal Assent at the end of 2025, paving the way for a number of changes to the Mental Health Act and its use in health, care and justice services. The Bill was designed to modernise the Act – which dates back to 1983 – to help ensure it is fit for purpose in a modern day setting.

We welcome the key changes and believe the Bill will make the Act more just, and will give patients more autonomy and will bring a wider range of benefits to patients and their loved ones, in particular:

- Developing onward support for people with a learning disability / autistic people so that they are only detained for as long as necessary, and not for longer than other patients with similar mental health needs.
- Introducing the nominated person role to enable patients to choose someone actively involved in their life who they believe will act in their best interests (rather than it automatically being a close relative).
- Introducing an opt out system for accessing independent advocacy to provide more room for support and help people challenge detention where appropriate.
- Removing police stations and prisons as places of safety to help ensure people are treated humanely and in appropriate places / environments.

1.6 Community First – Transforming our Community Mental Health Services

I have previously mentioned Community First – our transformation programme for our community mental health services which will change the way in which we provide care in people's homes and in the community. The programme responds to a number of current issues, including:

- Significant increases in demand, waiting times and capacity issues.
- The often complex nature of existing community mental health services which are provided by multiple organisations and can be confusing for patients to understand.

Community First will help to standardise processes and approaches, better align community teams with our inpatient mental health wards and reflect the national and local strategic shifts in health and care delivery which are set out in the NHS's Ten Year plan – in partnership moving more care from hospital settings to local communities.

A series of initial engagement workshops were held in 2025 with our staff and key stakeholders including local authorities, primary care colleagues, voluntary sector organisations and integrated care boards which have helped us to identify the key priorities for the programme.

1.7 People With Lived Experience Help Patients Stay Engaged in Care

A new pilot project in north east Essex is demonstrating how EPUT is turning its vision for the future of mental health care into action – meeting people where they are and bringing more personalised support closer to home. Launched in Colchester and Tendring, the one year pilot supports people with severe and complex mental health needs to stay connected with services and get the right help at the right time and introduces peer workers (people with lived experience of mental health challenges) into NHS community mental health assertive outreach teams. These teams focus on reaching people who often find it difficult to engage with traditional services, offering support in places where they feel safe and building consistent, trusting relationships. By embedding peer workers directly into these teams EPUT is strengthening its commitment to personalised inclusive care that improves mental health for everyone.

Peer workers use their own lived experience to help people feel understood rather than managed, building trust, reducing barriers and offering hope – supporting recovery beyond systems and helping to prevent mental health crises. This trauma informed, person centred approach reflects EPUT's wider focus on understanding people's needs beyond diagnosis and designing services in partnership with those who use them.

This pilot is delivered in partnership with local charity SUMMIT, whose work advocates for residents in the Tendring area living with mental health illness or long term health conditions. This collaboration reflects EPUT's broader ambition to lead joined up healthcare by working differently with partners across Essex.

1.8 Fairer Deal for Nurses

NHS England, the Royal College of Nursing (RCN) and NHS Staff Council have agreed a package of measures to ensure a fairer deal for nurses, with a particular focus on Band 5 nursing roles. Every Band 5 nurse role will undergo a proper review to ensure fairness and consistency across the NHS and that duties match the correct banding. Band 5 nurses will also benefit from investment in early career development through the new preceptorship programme. These changes are part of a wider commitment to strengthening job evaluation, role clarity and career progression frameworks for all nurses at the Trust.

1.9 EPUT Digital Skills Programme Shortlisted for National HSJ Award

Recognising the Trust's work to build digital confidence and skills that support safer, better patient care, EPUT has been shortlisted for the HSJ Digital Awards. In partnership with Mid and South Essex NHS Foundation Trust (MSEFT), EPUT has been shortlisted with The Nova Academy – a learning programme helping staff develop the digital skills needed in today's NHS. More than 90 colleagues across both Trusts have completed the Nova Academy since its launch in 2024, taking part in courses, workshops and digital learning resources designed to strengthen our readiness for the new unified EPR.

This year there were a record 468 entries with 21 shortlisted for their impact, innovation and commitment to digital health. Winners will be announced at the HSJ Digital Awards Ceremony on 19 June.

2. EXECUTIVE UPDATES

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

Despite continued operational pressure, our inpatient mental health adult average length of stay continues to decrease, staying well below the oversight framework target.

A second system wide discharge workshop has been held, focused on gaps in the supported accommodation pathway. Progress against identified actions will be monitored through the Strategy Implementation Group.

The Mid and South Community Collaborative is taking forward work to consolidate community pathways to reduce variation and improve patient and staff experience.

We were invited back to meet with colleagues from the Local Medical Committee to talk about opportunities to work closely together to deliver neighbourhood health. The SRO for the National Neighbourhood Health Implementation visited West Essex, enabling the opportunity to showcase current practice together with future plans. The North East Essex programme continues to make strong progress.

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

The Trust has expressed interest in a number of sites and buildings currently residing with NHS Property Services, in line with national guidance and following Finance & Performance Committee consideration. This is one of a number of initiatives the Trust is undertaking as it progresses its Estate Strategy. The Committee also agreed a new lease for a facility that will enhance its training capabilities and over time increase clinical space availability.

In terms of performance, the recent confirmation of the Trust's full receipt of deficit support funding means that the National Oversight Rating of 4 is expected to improve going forwards. The Trust has also recently submitted its Plan for FY2627-FY2829 in line with national guidelines. It forecasts to breakeven this year and has plans to going forwards.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Quality Priorities Stakeholder Event

In February, we held a multi-agency stakeholder event at Anglia Ruskin University (ARU), bringing together colleagues from the ICB, NHSE, partner providers, peer workers, frontline staff, and managers to review our key opportunities to improve care. The group examined core safety intelligence including Prevention of Future Deaths (PFD) reports, Patient Safety Reviews, and associated action plans, and concluded that while progress is evident, improvements remain inconsistent and are often driven by low to medium-level transactional actions. Five system-wide priorities emerged: ensuring policies and SOPs are fit for practice; strengthening engagement with families and carers; improving record-keeping to support safe care; enhancing communication within and between teams; and improving physical healthcare for people with mental health needs. These priorities align with the Fundamentals of Care Framework, and we are therefore proposing a focused three-year programme to embed the Fundamentals of Care through five core Safety Improvement Plans (SIPs), each supported from Year 1 by embedded Lived Experience Leads, with the aim of delivering consistent, reliable, coordinated, and person-centred care.

Nurses Conference

We will be hosting a Trust-wide Nursing Conference on 11 May 2026 titled *Reclaiming Our Professional Pride & Reconnecting with Our Patients*, designed to refocus our nursing workforce on the core values, standards, and person-centred principles that underpin excellent care. All registered and unregistered nursing staff will be invited to attend one of two identical sessions at Anglia Ruskin University, Chelmsford, as part of a wider programme of cultural renewal and professional reflection. Alongside the conference, staff will be asked to complete a short values-based questionnaire and will be offered a series of open Teams sessions, in and out of hours, to share their experiences, challenges, and ideas in a safe and supportive environment. These collective activities aim to strengthen professional identity, improve the consistency of patient experience, and ensure nursing priorities are shaped directly by staff voice.

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

Workforce Planning

The Trust has submitted its Workforce plan which covers a 3 year. The workforce plan sets out the forecasted changes to EPUTs workforce over the next three years. The plan is largely driven by the Trusts financial position and supports a strategy of transformation.

Establishment trajectory aligns with the Trusts financial plan, following triangulation of both plans. Expected areas of efficiency, in particular in non-clinical roles, along with the continued reduction in temporary staffing, play key roles in achieving this.

Pay Award

On 12th February 2026 the announced the 2026/27 pay award for staff under the remit of the NHS Pay Review Body (NHS PRB) agenda for change pay scales. No pay awards have been notified yet for doctors and dentists or Very Senior Managers (VSMS) for 26/27.

This offer includes:

- Staff on Agenda for Change NHS terms and conditions will receive a 3.3 per cent consolidated uplift from 1st April 2026.

- As part of the 2026/27 Agenda for Change pay package, the Department of Health and Social Care will begin fast-paced discussions with trade unions and employers through the NHS Staff Council to agree funded improvements to the pay structure. This builds on earlier work on potential multi-year arrangements and is supported by separate funding committed following the 2025/26 PRB recommendations. Once agreed, reforms will provide some staff with additional pay increases backdated to 1 April 2026. Priorities include raising pay for the lowest bands and improving pay for graduates across professions.

Mandatory Training Compliance

Overall mandatory training compliance for substantive staff is at 91% with a target of 90%. The Trust is continuing to work with colleagues to increase compliance across all professions and subjects in order to protect our staff and patients.

Annual Self-Assessment for Placement Providers

Each year NHS England request that Trusts who provide placements for students carry out their own quality evaluation against a set of standards, including achievements, challenges, compliance with funding and quality domains. It is based on the philosophy of continuous quality improvement, identification of quality improvement potential, development of action plans, implementation, and subsequent evaluation. Senior colleagues at EPUT recently met with representatives from NHS England to discuss the evaluation and confirm actions the Trust are taking forward to improve the experience for learners and staff and discuss the good work and achievements that have taken place over the last year.

Equality Diversity and Inclusion

Following the completion of the Organisational Development and Culture restructure, we are revitalising Equality, Diversity and Inclusion (EDI) at EPUT. This has enabled the development of EDI priorities informed by our risk register and the refreshed People Strategy, which commits to prioritising EDI and embedding it across all activity. We have developed a new equality network model in collaboration with network leads and staff through co-design and by incorporating related questions into an upcoming pulse survey. The proposals recommend five networks with participative executive sponsorship, defined deliverables, protected time, funded work programmes and dedicated administrative support. Senior leaders are establishing clear equality objectives to guide and influence staff networks and to sharpen the focus on equality within their portfolios.

Finally, as part of our International Women's Day programme, we will be delivering a '*Women in Leadership*' event on Friday 8 May, open to all staff, where senior women leaders will share their journeys, insights, and advice for emerging talent.

7. QUALITY AND OPERATIONAL PERFORMANCE


7.1 QUALITY & PERFORMANCE SCORECARD

● Information Item

👤 PS

REFERENCES

Only PDFs are attached

 Quality and Performance Scorecard 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 2026	
Report Title:		Quality & Performance Scorecard				
Executive/ Non-Executive Lead:		Paul Scott, Chief Executive Officer				
Report Author(s):		Janette Leonard, Director of ITT				
Report discussed previously at:		Finance and Performance Committee Clinical Governance & Quality Committee				
Level of Assurance:		Level 1		Level 2	✓	Level 3

Risk Assessment of Report				
Summary of risks highlighted in this report				
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure			
	SR4 Demand/ Capacity		✓	
	SR5 Statutory Public Inquiry			
	SR6 Cyber Attack			
	SR7 Capital		✓	
	SR8 Use of Resources		✓	
	SR9 Digital and Data		✓	
	SR10 Workforce Sustainability		✓	
	SR11 Staff Retention		✓	
	SR12 Organisational Development			
	SR13 Quality Governance			
	Does this report mitigate the Strategic risk(s)?		No	
	Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>		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: <ul style="list-style-type: none"> 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. 	Approval	
	Discussion	
	Information	✓

- 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.

Recommendations/Action Required

The Board of Directors is asked to:

- 1 Note the contents of the report
- 2 Request any further information or action

Summary of Key Issues

Operations

Mental Health Inpatient Capacity:

- Adult Occupancy reported at 96.9%, remaining outside of target - Target <93%
- PICU Occupancy reported at 97.3%, remaining outside of target - Target <88%
- Specialist Occupancy reported at 80.8%, remaining outside of target - Target >95%
- Older Adult Occupancy reported at 93.0%, remaining outside of target – Target <86%

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

Adult wards have seen a small reduction in occupancy levels whilst seeing an increase on January’s admission, this is evidence of the work to manage the ALoS with increased admissions not driving up the occupancy. We saw seven OOA PICU patients repatriated back to EPUT beds in February which contributes to the high PICU occupancy.

Average Length of Stay:

Adult Average Length of Stay on Discharge

- Adult ALoS (Including the Assessment Unit) reported at 36.2 days - Target <60 (Oversight Framework)
- 82 discharges in February – 21 long stays (60+ days)
- Long stay discharge breakdown:
 - **60+ days** – 12 discharges
 - **100+ days** – 6 discharges
 - **200+ days** – 3 discharges

In the most recently published National Oversight Framework league tables (202526 Q3), EPUT is ranked 9th out of 47 for **Percentage of inpatients aged 18-65 with over 60-day length of stay**. (To note, 2025/26 Q2 EPUT ranked 14th out of 47)

Older Adult Average Length of Stay on Discharge

- Older Adult ALoS reported at 122.1 days - Target <90 (Oversight Framework)
- 27 discharges in February – 19 long stays (60+ days)
- Long stay discharge breakdown:
 - **60+ days** – 6 discharges
 - **100+ days** – 7 discharges
 - **200+ days** – 6 discharges

PICU average length of stay

- PICU ALoS reported at 49.9 days – Target <50
- 13 discharges in February – 5 long stays (60+ days)
 - **60+ days** – 3 discharges
 - **100+ days** – 2 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. Most delays are due to awaiting care packages.

Inappropriate Out of Area Placements:

- February reported an increase in the number of placements to 70.
 - Adult increased by 11
 - PICU reduced by 3
- 33 repatriations in February
 - Adult – 26
 - PICU - 9
- 70 remain OOA in February
 - Adult – 60
 - Older Adult - 1
 - PICU - 9

February also saw an increase in the number of admissions to Adult wards which is responsible for the increase seen remaining at month end (Adults by 11). The planning commitment is to reduce this to 0 by March 2028. The trajectory to 0 assumes a position of 46 at the end of April 2026.

Quality**Cardio Metabolic:**

Overall compliance reported at 69.7% in February and remains below target of >90%:

- Eleven inpatient wards reported fully compliant in February (439 Ipswich Road, Ardleigh, Tower, Kitwood, Ruby, Topaz, Cherrydown, Gloucester, Hadleigh, Poplar (CAMHS) and Byron Court)

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

Community SMI patients under 1-year have seen an increase in performance in February with a reported 60.6%. Although below target, this is an increase of 5% on January's dataset. Multiple elements have been identified to improve performance, and regular meetings are taking place with the operational productivity team to understand what actions need to be taken.

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. SystemOne access is being given to teams so they can identify the Health Check gaps to be undertaken. A tracking report used by teams was reinstated in August and expected to support improvements

NHS Talking Therapies:

NEE and CPR are reporting reduced access rates whilst SOS is showing an increase, both the 6wk and 18wk wait to treatment are reporting 100%.

The moving to recovery indicator continues to report above the 50% target, with 55.0% reported in February.

No Harm / Low Harm Incident Rates:

February No Harm/Low Harm rates continue to report below target. This month saw a slight increase in reported incident rates. This comes after May 2025 reported the lowest rates for over five years.

This year has reported particularly low levels of No/Low Harm incident rates, especially for the period of February to July 2025. Staffing pressures are impacting on the time available for staff to sign off all incidents. Whilst this will improve on refresh next month, it is not expected that this will improve to meet target.

Ongoing promotion of reporting on Datix and around the levels of harm as outlined by NHSE's Learn from Patient Safety Events that staff allocate to an incident. Timely sign off of incidents continues to be a priority and the Care Units are working hard to achieve this.

Virtual Ward Occupancy:

MSE reported below target with 74%. West has seen a reduction in performance to 56% reported in February. We are awaiting the outcome of the extensive review of the Virtual Hospital process across East North Herts and West Essex. This will be shared back at F&P once received.

Workforce**Staff Sickness:**

Sickness has continued to be high in 2025 and into 2026 with current rate at 5.9% against a target of 5%. The trust continues to operate 1% above KPI and 1% above comparable benchmarking. This rate is having an impact on staff continuity to deliver our services and impacting on the use of temporary staff.

A comprehensive review is underway to identify services and areas where sickness absence exceeds 5%. This will be led by the Operational HR team alongside local managers with proposals presented to the Executive Committee and People Committee at the end of April 2026.

Vacancy Rate & Turnover:

The vacancy rate continues to improve with the current rate at 8.8%. This has seen a considerable improvement over the last 18 months alongside continued and targeted focus on recruitment to support our strategy of having a sustainable workforce supporting patient safety and quality.

The Trust has seen successful levels of recruitment for qualified nursing, AHPs and HCAs as well as a reduction in vacancies for consultant roles. However there continues to be areas, particularly within specialist services where there is further work to reduce vacancy rates for clinical staff.

In terms of turnover this has also seen a continued trend of improvement with a slight increase in January 2026 to 8.9% against a target of 10%. This continues to be positive and supports the work on staff recognition, engagement as well as recruitment.

Temporary Staffing:

The performance against temporary staffing continues to be maintained with a small increase in the use of bank staff while agency staff has continued at the same level. Therefore, bank use is above plan by 47wte while at the same time agency has an improved position which is 36wte better than plan. Therefore overall, the Trust has a variance of 11wte against plan as at month 10.

The plans for 26/27 are more challenging with areas of focus that will support the planned reductions in temporary staff use. This includes implementation of safer staffing recommendations, continued reduction in corporate use of temporary staff and enhanced oversight of patient observations that have an impact on the use on temporary staff.

Ward Fill Rates:

February reported 26 wards having less than 90% fill rates against the target of <13, this remains outside of target. The current year has shown an increase of wards not achieving target. 2024-25 had an average of 15 wards not achieving target and up to month 11 in 2025-26, the average is 27 wards.

Finance**Income & Expenditure:**

YTD deficit is £0.6m, £0.2m adverse to plan. The improvement is predominantly driven by securing Deficit Support Funding (DSF). The Trust is forecasting a breakeven position against plan.

Temporary Staffing:

Temporary staffing expenditure for the month is £4.1m, a £0.2m reduction from last month with bank and agency within planned trajectories.

Efficiency:

In month delivery £2.5m, £0.4m behind plan. There is continued good performance on temporary staffing offset by under-performance against Out of Area targets. YTD delivery £25.9m (83% of annual plan).

Capital:

Capital spend has increased to YTD £19.4m. Including planned lease disposal reduces YTD spend to £12.2m with forecast outturn remaining unchanged.

Cash:

Cash balance is £28.6m, £15.4m better than plan due to lower capital spend and receipt of capital allocations. Balances will improve with the confirmed receipt of deficit support funding.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

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

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

Acronyms/Terms Used in the Report

ALOS	Average Length of Stay	OOA	Out of Area
CPA	Care Programme Approach		

Supporting Reports/ Appendices /or further reading

EPUT Quality & Performance Board Report [HERE.](#)
 Financial Dashboard

Lead



Paul Scott
Chief Executive Officer



Essex Partnership University
NHS Foundation Trust

Financial Performance

Month 11 - February 2026

EPUT

Trust Summary Financials - Month 11

Commentary & RAG:

Income & Expenditure

YTD deficit is £0.6m, £0.2m adverse to plan. The improvement is predominantly driven by securing Deficit Support Funding (DSF). The Trust is forecasting a breakeven position against plan.

Temporary staffing

Temporary staffing expenditure for the month is £4.1m, a £0.2m reduction from last month with bank and agency within planned trajectories.

Efficiency

In month delivery £2.5m, £0.4m behind plan. There is continued good performance on temporary staffing offset by rising levels of under-performance against Out Of Area targets. YTD delivery £25.9m (83% of annual plan).

Capital

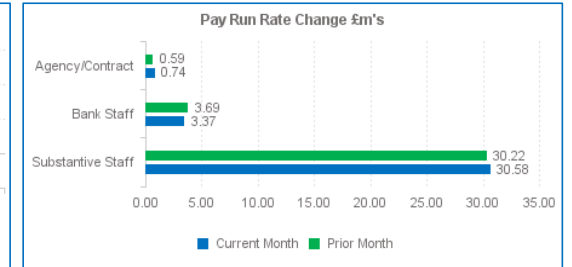
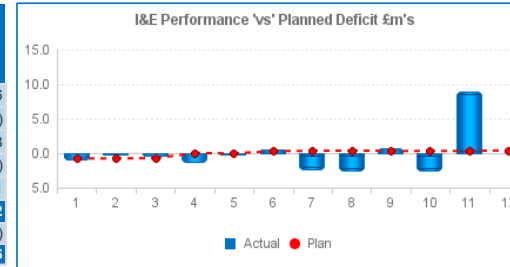
Capital spend has increased to YTD £19.4m. Including lease disposal reduces spend to £12.2m. Forecast outturn remains unchanged.

Cash

Cash balance is £28.6m, £15.4m better than plan due to lower capital spend and receipt of capital allocations. Balances will improve with the receipt of deficit support funding.

Income & Expenditure Position

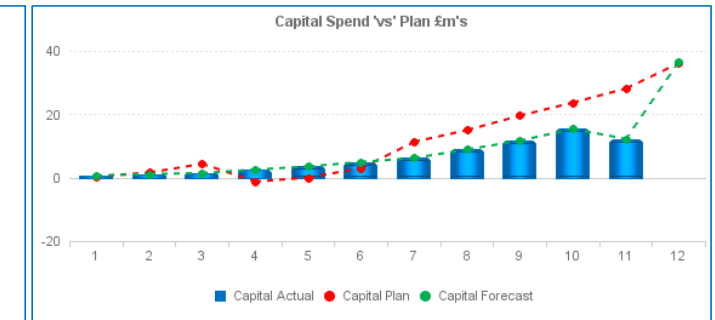
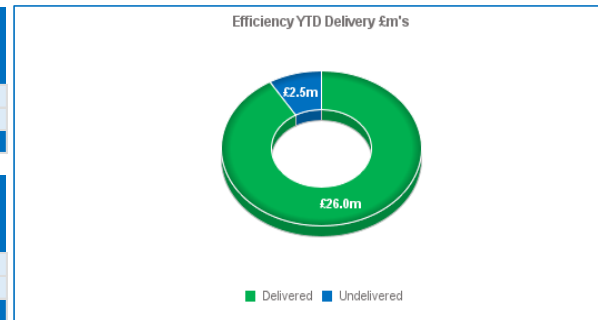
Income & Expenditure Position	Annual Budget	Monthly Actual	Monthly Variance	YTD Actual	YTD Variance	RAG Rating	Prior Month	Current Month	Run Rate Mvmt
	£m	£m	£m	£m	£m		£m	£m	£m
Income	656.3	71.3	18.0	604.0	2.4		53.6	71.3	17.6
Pay	(400.4)	(34.7)	(1.5)	(374.3)	(7.1)		(34.5)	(34.7)	(0.2)
Non Pay	(239.6)	(20.3)	(1.3)	(216.7)	3.6		(21.1)	(20.3)	0.8
Net Finance Costs	(10.6)	(0.7)	0.0	(7.1)	1.2		(0.6)	(0.7)	(0.1)
Other Gains / (Losses)	0.5	0.1	0.1	0.1	0.0		0.0	0.1	0.1
Operating (Deficit) / Surplus	6.2	15.6	15.3	5.9	0.0		(2.7)	15.6	18.2
Technical Adjustments	(6.2)	(6.7)	(6.7)	(6.5)	(0.2)		0.0	(6.7)	(6.7)
Adjusted Financial Performance	(0.0)	8.9	8.6	(0.6)	(0.2)	■	(2.6)	8.9	11.6



Capital & Efficiency Position

Efficiency	Annual Plan	Monthly Actual	Monthly Variance	YTD Actual	YTD Variance	RAG Rating
	£m	£m	£m	£m	£m	
Recurrent	31.3	1.9	(1.0)	19.7	(8.7)	
Non-Recurrent	0.0	0.6	0.6	6.3	6.3	
Total	31.3	2.5	(0.4)	26.0	(2.5)	■

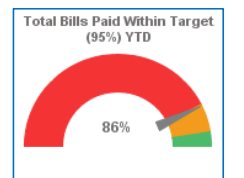
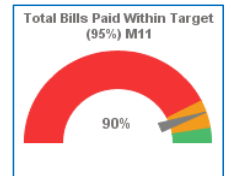
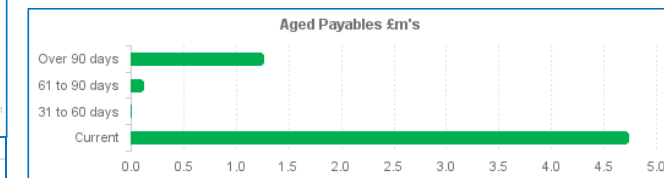
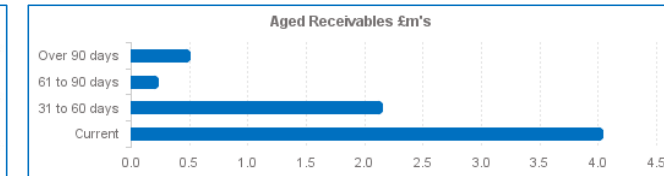
Capital	Annual Plan	Monthly Actual	Monthly Variance	YTD Actual	YTD Variance	RAG Rating
	£m	£m	£m	£m	£m	
EPUT Capital	42.7	4.1	0.3	19.6	15.1	
Non System Commitments	(6.6)	(7.3)	7.4	(7.4)	0.8	
Total CDEL	36.1	(3.2)	7.7	12.2	15.9	■



Statement of Financial Position

Statement of Financial Position	YTD Actual	In Year Mvmt
	£m's	£m's
Non Current Assets	281.2	(0.1)
Current Assets	70.0	17.7
Current Liabilities	(82.9)	(8.4)
Non-Current Liabilities	(65.4)	15.4
Net Assets Employed	203.0	24.6

Cash Position	YTD Actual	YTD Variance
	£m's	£m's
Opening Cash	28.1	3.1
Cash Inflow / (Outflow)	0.5	12.4
Closing Cash	28.6	15.4



Summary Commentary - including Key Risks

Income and Expenditure

YTD deficit is £0.6m, £0.2m adverse to plan. The improvement is predominantly driven through successful outcome securing £10.2m of DSF funding for the 2nd half of the financial year. As a result of securing DSF the Trust is forecast to breakeven.

Efficiency

YTD £25.9m (83% of annual plan) vs £28.4m planned, £2.5m behind plan. Results continue to be driven by temporary staff over-performance, delivery of local efficiencies including lockdown underspends offset by shortfalls relating to delivery of Out Of Area placements impacted by patient demand.

Capital & Cash

Capital spend is £4.1m in-month and £19.5m YTD, reduced by £7.4m in planned lease-disposal credits, primarily the £6.7m Basildon Mental Health Unit, bringing the Trust to a net capital position of £12.2m, with the full-year forecast of £36.5m.

To deliver the full-year capital forecast, a number of key transactions are scheduled for Month 12, including new leases for two properties, £9.6m of spend on external programmes (including NOVA EPR), and a further £2.7m planned on the local capital programme.

Cash balances total £28.6m (£31.5m M10), £15.4m better than plan including lower than planned capital spend and additional Public Dividend Capital receipts.

Cash balances are now forecast to significantly improve with receipt of DSF funding expected to be actioned in M12. Cash balances are therefore significantly better than previously forecasted and there is no longer a requirement for revenue loan applications.

Key Risks

Risks in delivery of breakeven position have significantly decreased with DSF secured. Residual risks include :

- Increase in resource requirements relating to Lampard Inquiry.
- Patient demand and Out of Area placements requirements.
- Full recovery of other planned income.

Other Matters

- ❑ **External Audit Appointment:** The new auditors have commenced work and are working closely with management. A number of dedicated sessions to orientate auditors on key items of Accounts preparation have been undertaken and arranged.
- ❑ **2026/27 Planning:** Following agreement of breakeven plan for FY2627 the Trust made a plan realignment submission on 18 March.
- ❑ **Out Of Area Unification:** The Trust awaits ICB analysis of FY2526 outturns and agreement to appropriate resource transfer.


7.2 COMMITTEE CHAIRS REPORT

Information Item

Chairs

REFERENCES

Only PDFs are attached

 Committee Chairs Report (Part 1) 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 April 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
<p>The Board of Directors is asked to note the report and assurance provided.</p> <p>The Board of Directors is asked to approve the Terms of Reference 2026/27 for the following Committees, which are attached as Appendices:</p> <ul style="list-style-type: none"> • Audit Committee • Finance & Performance Committee • People Committee <p>The Quality Committee Terms of Reference are impacted by the development of the Schedule of Business for the Quality of Care Group, and will be presented at a future meeting.</p>

Summary of Key Points

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

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

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

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

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

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

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

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

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

Acronyms/Terms Used in the Report

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Supporting Reports and/or Appendices

- Committee Chairs Report
- Audit Committee Annual Report and Terms of Reference
- Finance and Performance Committee Annual Report and Terms of Reference
- People Committee Annual Report and Terms of Reference
- Quality Committee Annual Report

Executive/ Non-Executive Lead / Committee Lead:

Chairs of Board of Director Standing Committees



Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors

1 April 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

1. AUDIT COMMITTEE

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

Committee meeting held: 6 March 2026

Assurance

Internal Audit Progress

- Six audits have been finalised since last report. One audit issued in draft form and the four remaining audits schedule in FY2526 plan are in progress. Progress against the plan, including assurance ratings show improvement compared to FY2425.
- Four overdue recommendations, relating to:
 - Patient Safety Incidents Process (remediation date agreed)
 - Compliance with Policies and Procedures – Site Visits (remediation date agreed)
 - Apprenticeship Levy - x 2 (actions complete awaiting policy approval)

Procurement Breaches (previously waivers)

- The Committee received a report providing an update on procurement breaches between October 2025 and January 2026. There was an expected increase relating to capital allocation notifications. Management have implemented a number of measures to plan procurements as early as possible. Enhanced reporting to demonstrate Value For Money discussed.

Risk Management Assurance Framework Key Controls Report

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

Information

Consultant Job Planning

- An update on Consultant Job Planning was provided by the Executive Chief Medical Director.
- The majority of FY2526 Job Planning was complete, and planning for FY2627 was underway. The Committee recommended a bi-annual assurance report be added to the People Committee Work Plan.

Counter Fraud Progress Report and Counter Fraud Work Plan 2026/27

- The Committee received a report on counter fraud activity and a provisional assessment (Green rating) against functional standard return.
- The Committee approved the Counter Fraud Work Plan FY26/27.

External Audit

- There have been handover delays from the exiting auditor, despite this the Trust's new auditors (Grant Thornton) have commenced interim work. Ahead of Accounts closure meetings to discuss more complex accounting matters had been arranged between auditors and management.

Year End Timetable FY2526

- The Committee received the Year End Accounts and Annual Report timetable and deadlines. Committee noted deadlines are challenging.

Draft Internal Audit Plan FY2627

- The Committee discussed and approved the Draft Internal Audit Plan FY2627, subject to assurance being built into the Terms of Reference and a half-year update in November 2026.

Audit Committee Annual Review

- The Committee received and discussed the Committee Effectiveness Review with improved ratings.
- Terms of Reference and a Work Plan for FY2627 were approved by the Committee.

AUDIT COMMITTEE *(Cont.)*

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

Committee meeting held: 6 March 2026

Action

Audit Committee Terms of Reference 2026/27

- The Board of Directors is asked to approve the Audit Committee Terms of Reference FY2627, which are attached as an Appendix.

Alert

No Alerts for the Board.

2. FINANCE & PERFORMANCE COMMITTEE

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

Committee meeting held: 19 March 2026

Assurance

Performance Report

- Assurance on the Trust's performance during February covered a range of performance metrics in the IPR.

Financial Report

- The Committee received a report providing Month 11 FY2526 financial results. It was noted the revenue position was broadly on plan and forecasting break even. Capital was also forecast to achieve it's resource limit, subject to potential NHS Property Service resolutions.
- Since the last reporting period the Trust has been successful in receiving confirmation it will be eligible to receive deficit support funding. This change will also improve NOF rating in Q4 results.
- It was noted underlying financial challenges remain and need to be addressed.

Information

AI Solutions

- The Executive Director of Strategy & Transformation will be organising:
 - A Deep Dive on the use of AI including corporate redesign opportunities.
 - A Board Seminar on an AI solutions pilot which the Trust is considering lead arrangements on behalf of the East of England.

Board Assurance Framework Risk Deep Dive – MSECC Waiting Times

- The Committee received a Deep Dive into waiting times performance for the Mid & South Essex Community Collaborative, including:
 - Current performance and progress within adult services.
 - Strategic actions underway and shorter term mitigating actions.
 - Details of projected improvements to waiting times.

Finance & Performance Committee Annual Review

- The Committee received and discussed the Committee Effectiveness Review FY2526. Members discussed the positive contribution and value of the Committee noting some areas of further focus including how to balance attention for Community and Mental Health services going forward.
- Terms of Reference and Work Plan for FY2627 were considered and approved by the Committee.

Action

Finance & Performance Committee Terms of Reference 2026/27

- The Board of Directors is asked to approve the Finance & Performance Committee Terms of Reference FY2627, which are attached as an Appendix.

Alert

No Alerts for the Board.

3. PEOPLE COMMITTEE

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

Assurance

Assurance Reports

- The following assurance reports were received by the Committee:
 - Annual Workforce Plan Progress Report
 - Board Assurance Framework – Workforce
 - Equality Delivery System Report 2025/26
 - Gender, Ethnicity & Disability Pay Gap Report March 2025
 - Guardian of Safe Working Report
 - Lived Experience and Volunteers Update & Recommendations
 - National Staff Survey 2025 and Quarterly Pulse Survey Q4 Results
 - Operational Human Resources Report
 - People & Culture Risk Register
 - Public Sector Equality Duty Report 2024/25
 - Workforce Key Performance Indicators

Action

People Committee Terms of Reference 2026/27

- The Board of Directors is asked to approve the People Committee Terms of Reference 2026/27, which are attached as an Appendix.

Committee meeting held: 26 February 2026

Information

HCA Academy

- Members of the HCA Academy team attended the meeting to provide a presentation on the work of the Academy.

Medical Workforce Mandatory Training

- The Executive Chief Medical Officer provided an update on work undertaken to address mandatory training requirements in the medical workforce, noting that significant progress had been made and actions to drive further improvements are underway.

Draft People Strategy

- The Committee received and discussed the draft People Strategy

People Committee Annual Review

- The Committee received and discussed the Committee Effectiveness Review 2025/26.
- Terms of Reference and a Work Plan for 2026/27 were approved by the Committee.

Alert

Equality, Diversity & Inclusion (EDI) Annual Reports

- The following EDI Annual reports were approved by the Committee for presentation to the Board of Directors. These will be provided in separate Agenda items:
 - Equality Delivery System Report 2025/26.
 - Gender, Ethnicity & Disability Pay Gap Report March 2025.
 - Public Sector Equality Duty Report 2024/25.

Draft People Strategy

- The Committee approved the Draft People Strategy for presentation to the Board of Directors. This will be provided in a separate Agenda item.

4. QUALITY COMMITTEE

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

Assurance

Assurance Reports

- The Committee received the following assurance reports:
 - Board Assurance Framework (Aligned Risks)
 - Contactless Patient Monitoring
 - Corporate Health, Safety & VAPR
 - CQC & PFD Assurance Report
 - Development of a Patient Safety Culture
 - Digital Clinical Safety Framework Progress
 - Emergency Preparedness Resilience & Response
 - Executive Emergent Issues
 - Falls Reduction
 - Infection Prevention & Control
 - Management of the Deteriorating Patient
 - Mental Health Act
 - Patient Experience & PSIRF
 - Patient & Service User Experience
 - Patient Safety Strategy
 - PCREF Plan (including Reducing Health Inequalities)
 - Quality of Care Performance Dashboard
 - Safeguarding
 - Suicide Prevention
 - Time to Care

Action

No Actions for the Board.

Committee meetings held: 12 February 2026 & 12 March 2026

Information

Staff Supervision & Support

- The Committee received a verbal update on improvements to staff supervision and support, noting that improvements are already visible.
- A further update will be provided at a future meeting.

Contactless Patient Monitoring

- The Committee agreed that the term 'contactless patient monitoring' would be used in place of brand names or the previously agreed phrase 'remote monitoring technology'.
- The Executive Medical Director shared information he had received from other Trusts about their consent processes.
- An Ethics Committee meeting has been convened to consider ethical and legal implications.
- A meeting has been arranged in April 2026 to review the Standard Operating Procedure.
- A Deep Dive will be presented to the Committee in June 2026.

Quality Improvement Project Update

- The Committee received an update on changes to shift patterns within Community Physical Health Teams to strengthen quality oversight and improve quality, safety and staff wellbeing.

People Committee Annual Review

- The Committee received and discussed the Committee Effectiveness Review 2025/26.
- Terms of Reference and Work Plan for 2026/27 are impacted by the development of the Schedule of Business for the Quality of Care Group, and will be presented at a future meeting.

Alert

End of Life Annual Report 2024/25

- The Committee approved the End of Life Annual Report 2024-25.

Audit Committee Annual Report 2025/26

1. Background

The purpose of this report is to review the work undertaken by the Audit Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2025 – 31 March 2026.

The Committee oversees all aspects of internal control (including internal audit and external audit activity) and provides assurance to the Board of Directors in meeting its terms of reference.

2. Committee Membership

Elena Lokteva, Non-Executive Director chaired the Committee throughout the year.

Included within the current membership are one other Non-Executive Director, an Associate Non-Executive Director. The Executive Chief Finance Officer regularly attends to support the business of the meeting.

The Committee has several subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Committee Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting, they are made available to Board members for information via the Board portal.

Table 1: Attendance at meetings held 2025/26

	Meetings Attended	Total No. Meetings
Elena Lokteva (Chair)	6	6
Doug Field (from August 2025)	2	2
Dr Mateen Jiwani	5	5
Loy Lobo (from March 2026)	1	1
Jenny Raine (until May 2025)	1	1
Trevor Smith (in attendance)	5	6

The stepping-down of Jenny Raine and Doug Field as Associate Non-Executive Director had an impact on the membership of the Committee during the year.

3. Meetings

Meetings were held in May, June, July, November, January and March.

The six meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Committee terms of reference was reviewed by the Chair, Executive Chief Finance Officer, Director of Finance and Executive Director of Governance. The following amendments were agreed by the Audit Committee at its meeting on 6 March 2026.

- Section 5 amended to include as part of receiving assurance relating to the Board Assurance Framework and Corporate Risk Register includes a focus on controls and assurances from other parties. This strengthens the requirement included in the Audit Committee Handbook and potentially addresses an area raised in the Effectiveness Review.
- Membership updated to clarify that the membership is three Non-Executive Directors and could include an Associate Non-Executive Director if the NED's in office are depleted. This addresses the issue of fluctuating membership when Associate NEDs have stepped down in year.

The revised Terms of Reference are attached at Appendix 1.

5. Arrangements

The Committee provides internal assurance by reviewing the systems of control, Including:

- Governance, Risk Management and Internal Control (excluding those managed by the Quality Committee)
- Internal Audit
- External Audit
- Anti-Crime (Fraud)
- Governance Manual
- Other Assurance Functions (such as reviews by the Department of Health Arm's Length Bodies)
- Annual Accounts Review
- Value for Money (VFM)

The Audit Committee receives reports and assurances from directors and managers on the overall arrangements for governance control, including, but not limited to the annual anti-crime report, financial statements, the annual report, the annual internal audit plan and reports (including an update on management actions), external audit plan and reports and any other required reports.

The minutes of the Committee are made available to the Board of Directors. The Committee reports to the Board via a Committee Chairs Report providing assurance on the items discussed and provides alerts, actions or approvals for the Boards attention.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. The minutes and action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule. It is amended as necessary throughout the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with the scheduled of business.

The Committee received reports on the following within the year. Each item has been mapped to a CQC Quality Statement where applicable:

- Annual Reports and Accounts, including scrutiny of the content and overseeing challenges from the External Auditors. (Well-Led)
- Annual Review of Audit Service, including the review of the External Audit contract and the tender process to appoint new External Auditors. (Well-Led)
- Annual Review of Governance Manual. (Well-Led)
- Anti-Crime Progress report, including details of progress against the counter fraud work plan and current investigations. (Safe / Well-Led)
- Claims Annual Scorecard. (Safe / Well-Led)
- Clinical Audit – Assurance on Process and Delivery. (Effective / Well-Led)
- Conflict of Interest (Well-Led)
- Counter Fraud Services Annual Report. (Safe / Well-Led)
- Directors Expenses. (Well-Led)
- External Audit Plan, including monitoring progress and identifying any risks. (Well-Led)
- Internal Audit progress reports, including the outcomes of the audits, progress with ongoing audits and the implementation of recommendations following audits. It also included contemporary updates and technical releases. (Well-Led)
- Losses and Special Payments. (Well-Led)
- Risk Focus for operational risks with a consequence score of over 5. (Safe / Well-Led)
- Risk Management Assurance Framework Annual Report. (Safe / Well-Led)
- Salary Overpayments. (Well-Led)
- Waiver of Standing Orders / Procurement Breaches. (Well-Led)

The business of the Committee provides assurance across all four of the Trust strategic objectives. A wide range of report – including clinical audit, risk management, counter fraud and claims analysis – collectively strengthens the oversight of safety, quality and regulatory compliance. This ensures that risks are identified early, learning is embedded and the organisation continues to deliver safe, high quality integrated care.

In support of strong and effective governance, the Committee reviews the Annual Reports and Accounts, audit plans and programmes and the annual review of the Governance Manual. These activities ensure transparency, accountability and high-quality external scrutiny. Other items, such as procurement breaches, losses and special payments and

salary overpayments reinforces sound financial stewardship and adherence to organisational standards.

The Committee also strengthened the Trust’s approach to safety and risk management, through scrutiny of items such as the Anti-Crime progress report, Counter Fraud services, the Claims Annual Scorecard and the risk focus on operational risks scoring a consequence of over 5. Alongside the Risk Management Assurance Framework, these items ensure that risks are well-understood, mitigated and escalated appropriately, support the delivery of safe and reliable services.

Finally, assurance on Clinical Audit processes and delivery provides confidence that care remains evidence-based and aligned with best practice. Oversight of Conflict of Interest arrangements ensures openness and integrity in decision-making, supporting a culture of transparency and ethical leadership across the organisation.

6. Duties of the Audit Committee

Committee members undertake a self-assessment of the effectiveness of the Committee. The Trust Secretary’s Office facilitates this on an annual basis. The results enable the Committee to develop a plan for improvement. The Committee identified the following for 2025/26 based on the outcome of the previous effectiveness review:

Priority	Progress
To strengthen the reporting of the Board Assurance Framework and associated controls assurance to the Committee.	<p>The assurance providers refer back to the Strategic Risks, where relevant, to provide a clearer link between the business of the Committee and the Board Assurance Framework.</p> <p>There were overall positive scores in the Effectiveness review for assurances being provided to the Committee.</p> <p>The Committee also completed a focused review of operational risk scores with a consequence of over 5 at its meeting in November 2025.</p>
To continue to work (where appropriate) with other Committees of the Board through the sharing of Internal Audit reports for information.	<p>The Internal Audit reports are regularly uploaded to the Board Portal and are accessible to other Committee members.</p> <p>The Internal Audits have been shared with other Committees where there was Limited / No Assurance.</p>
Continue to build relationships within the Committee and seek to put in place guidance for when executives are required to attend.	<p>There were positive scores for the leadership and relationships within the Committee (in terms of appropriate challenge etc.).</p> <p>Executive Directors attended the Committee during the year where</p>

Priority	Progress
	appropriate and the statement in the Effectiveness Review relating to Executive Directors attending the meeting received a maximum score of 5.0.
To embed the reporting of clinical audit – assurance on process and delivery.	The Committee receives a regular report on the process and delivery of Clinical Audit. The report has been amended to ensure it contains the right level of information to allow the Committee to discharge its duties.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2025/26 is summarised above in section 2 of the report.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from other Committees of the Board of Directors. There were no risks identified which could constitute a “significant issue” for disclosure within the annual governance statement.

For the year 2025/26 the Committee has met its terms of reference in the discharge of its duties based on the papers discussed throughout the year.

8. Priorities for 2026/27

The schedule of business for the Committee has been developed with the Chair and members of the Committee. The schedule was reviewed by the Committee and the following key amendments agreed:

- Clarification that the Annual Report of Auditors as a Part 2 item.
- The addition of “Review of service specification for market testing and procurement updates for Internal Audit and Counter Fraud services” as a Part 2 for July and November.
- The addition of reflections on External Inspections where relevant to the Committee, such as CQC inspections and the CQC Well-Led Review.
- The addition of the Committee receiving the effectiveness reviews for all the Standing Committees in May to provide oversight of the process and outcome.
- The removal of the Clinical Audit Assurance on Process & Delivery as this is covered within the remit of the Quality Committee.

The Committee discussed the outcome of the effectiveness review and agreed the following priority actions for 2026/27

- Continue to seek benchmarking data to support the Committee in understanding comparatives for presented data.
- Consider succession planning for the Committee membership via the Council of Governors and Chair of the Trust.

The outcome of the CQC Well-Led Review will be reviewed by the Committee and any further priority areas identified if required.

Report prepared by:
Chris Jennings
Assistant Trust Secretary

On behalf of:
Elena Lokteva
Chair of the Audit Committee.

DRAFT AUDIT COMMITTEE TERMS OF REFERENCE 2026/27

CHAired BY:	TOR AUTHORISED BY:	Elena Lokteva, Non-Executive Director	Board of Directors
SECRETARIAT:	FREQUENCY:	Board Standing Committee Secretary	Meetings shall be held not less than four times a year
AUTHORITY:	<p>The Audit Committee (hereafter Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. The Committee is authorised by the Board of Directors to investigate any activity within the Trust. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board of Directors to instruct the in-house legal advisors and other professional advisors with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.</p>		
PURPOSE- The duties of the Committee shall include the following:	<p>Governance, Risk Management and Internal Control:</p> <ol style="list-style-type: none"> 1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. 2 In particular, the Committee will review the adequacy of: <ul style="list-style-type: none"> • All risk and control related disclosure statements (in particular the Annual Governance Statement and Care Quality Commission essential standards of quality and care), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • Arrangements by which staff of the Trust may raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority • Proposals for tendering for both Internal or External Audit services and the Anti Crime Specialist services or for purchase of non-audit services from contractors who provide audit services. 3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Counter Fraud Services and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness 4 The Committee will create an Annual Working Plan against which its performance is to be evaluated on an annual basis 5 To receive assurance that the Board Assurance Framework, Corporate Risk Register and the Directorate Risk Registers are properly utilised by the standing committees of the Board of Directors and by the Executive Directors to identify and adequately manage risk and identify mitigating actions including a focus on controls and assurances from other parties. <p>Internal Audit:</p> <ol style="list-style-type: none"> 6 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and all other internal audit codes, and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: <ul style="list-style-type: none"> • Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal 		

- Review and approval of the Internal Audit strategy, operational plan and more detailed program of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimize audit resources
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annually reviewing of the effectiveness of internal audit.

External Audit:

- 7 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:
- consideration of the appointment of the External Auditor leading to an annual recommendation by the Audit Committee to the Council of Governors regarding the appointment/re-appointment of the External Auditor. This report will include reference to the performance of the external auditor including details such as the quality and value of the work and the timeliness of reporting and fees
 - discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan
 - discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact of the audit fee
 - review all External Audit reports before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
 - ensuring that there is a current policy on the engagement of the external auditor to supply non-audit services which has been approved by the Council of Governors
 - ensuring that there is a process in place so as to be able to report to the Council of Governors on any matters of significance
 - ensuring that there is a process in place which delegates responsibility to the Audit Committee to review and monitor the independence and objectivity of the external auditor.
- 8 The Audit Committee has a responsibility to ensure that the Trust's appointed External Auditors are not compromised in terms of maintaining their integrity, objectivity and independence (as per section 1.8 of the Code of Audit Practice produced by the National Audit Office) or prohibited from undertaking such work. The Chair of the Audit Committee is required to be consulted with, and approve the use of the Trust External Auditors for any non-audit work prior to their appointment. This does not delegate the approval of expenditure to the Chair of the Committee.

Anti Crime (Fraud):

- 9 The Committee will:
- Review the effectiveness and delivery of the annual Anti Crime Specialist work plan, and approve the Annual Plan
 - Approve the Functional Standards submission
 - Monitor the implementation of Anti Crime reports
 - Consider the annual report of the Local Anti Crime Specialist

Governance Manual:

- 10 The Committee will:
- Review annually the Governance Manual (consisting of the Standing Orders, Standing Financial Instructions and the Scheme of Delegations)
 - Review changes to the aforementioned documents
 - Examine the circumstances associated with each occasion when SOs are waived and comment as necessary.

Other Assurance Functions:

- 11 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation
- 12 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
- 13 Where necessary, the Committee can review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee

Annual Accounts Review:

- 14 To review the annual statutory accounts for exchequer funds (which subject to an annual materiality test, are not consolidated), before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:
 - The meaning and significance of the figures, notes and significant changes
 - Areas where judgement has been exercised
 - Adherence to accounting policies and practices
 - Explanation of estimates or provisions having material effect
 - The schedule of losses and special payments
 - Any unadjusted statements
 - Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved
- 15 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy
- 16 To receive reports on the review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Value for Money (VFM):

- 17 The Committee will consider the appropriateness of value for money assessments.
- 18 The Committee will also consider other topics as defined by the Board of Directors or Council of Governors arising from any sources that are considered by the Committee to be significant to the Trust.

Management:

- 19 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control, including but not limited to:
 - Annual Counter Fraud Report
 - Annual Report
 - Financial Statements
 - Annual Internal Audit Plan and reports
 - External Audit Plan and reports
 - Other reports as required
- 20 They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.

ATTENDANCE:

MEMBERSHIP:

Three (3) Non-Executive Directors one of whom must have relevant and recent financial experience and one being a member of the Quality Committee. **Could include** Associate Non-Executive Director.

IN ATTENDANCE:

Executive Chief Finance Officer / Director of Finance
 Head of Financial Accounts
 Executive Director of Governance

		<p>Internal Audit Representative External Audit Representative Anti Crime Specialist Chief Executive (to present the Annual Governance Statement) Other Directors and Officers as requested by the members (Limited assurance reports)</p>
QUORUM:	<p>Two (2) Members It is expected that members will attend a minimum of 75% of meetings per year.</p>	
	<p>INPUTS: The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.</p> <p>They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.</p>	<p>OUTPUTS: Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval.</p> <p>The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered.</p> <p>The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.</p>
Document Control:	Approved by Board: <i>(to be approved April 2026)</i>	<p>Date of Last Review: March 2025 Next Review: March 2027</p>

Finance and Performance Committee Annual Report 2025/26

1. Background

The purpose of this report is to review the work undertaken by the Finance and Performance Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2025 – 31 March 2026.

The Committee oversees all aspects of finance and performance and provides assurance to the Board of Directors on meeting national standards and quality objectives, informing the Audit Committee of any significant issues.

2. Committee Membership

Diane Leacock, Non-Executive Director chaired the Committee throughout the year. Included in the membership are three further Non-Executive Directors and five Executive Directors.

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may also be requested to attend where required.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting, they are made available to Board members for information.

Table 1: Attendance at meetings held 2025/26

	Meetings Attended	Total No. Meetings
Diane Leacock (Chair)	13	13
Alex Green	9	13
Denver Greenhalgh	9	13
Dr Ruth Jackson	1	1
Loy Lobo	7	13
Andrew McMenemy	13	13
Trevor Smith	13	13
Richard Spencer	10	13
Zephan Trent	7	13

3. Meetings

Meetings were held bi-monthly, with extra-ordinary meetings held in October, December and twice in February. The extra-ordinary meetings were held to consider key contractual items and planning submissions where delegated authority had been given by the Board of Directors.

The thirteen meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Committee reviewed its terms of reference had been reviewed and attached as Appendix 1. The Committee reviewed and approved the following amendments for onward presentation to the Board of Directors:

- The “in attendance” has been updated to include clinical and operational representatives to address feedback from the effectiveness review. The Director of Estates has also been added, to reflect the significant estates work taking place over the next year through the strategy and Green Plan.

5. Arrangements

The Committee has responsibility for the oversight and monitoring of the Trust’s financial, operational and organisational performance in accordance with the relevant legislation, national guidance and best practice.

The Committee is responsible for ensuring the appropriate investment of funds, and to oversee the amalgamation and disaggregation of funds arising from potential mergers, acquisitions or organisational reconfigurations.

The minutes of the Committee are made available to the Board of Directors. The Committee reports to the Board via a Chairs Key Issues report, which highlights for the Board’s attention whether an issue is for approval, alert, action or assurance.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. Together, the minutes and the action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule and is amended as necessary through the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with its schedule of business.

The Committee received reports on the following within the year. Each item has been mapped to a CQC Quality Statement where applicable:

- Annual Data Security and Protection Toolkit (DSPT) Submission (Safe / Well-Led)
- Board Assurance Framework (Well-Led)
- Contracting & Commissioning Report (Responsive / Well-Led)
- Cyber Security and Information Governance (Safe / Well-Led)
- Electronic Patient Record Update and Shared Care Record (Safe / Effective)
- Estates and Facilities Report (Safe / Well-Led)
- Estates Strategy (Safe / Well-Led)
- Financial Planning (Well-Led)
- Finance Report, including income, expenditure, capital, cash, risk and mitigations. (Well-Led)
- Financial Updates, including performance, planning and mid-year review (Well-Led)

- Flow and Capacity Report (Safe / Responsive)
- Green Plan (Well-Led)
- Lampard Inquiry Financial Update (Well-Led)
- National Oversight Framework update (Effective / Well-Led)
- Operational Planning, including progress updates and details (Effective / Well-Led)
- Out of Area Patient Update (Safe / Responsive)
- Payroll Contract Update (Well-Led)
- Performance Report, providing key performance indicators and indicating key updates (Effective / Well-Led)
- Provider Licence Self-Certification (Well-Led)
- Strategic Impact Report (Well-Led)
- System Partnership and Performance Update (Responsive / Well-Led)
- Time To Care Highlights Report (Effective)

The Committee also received a verbal update from the Executive Directors on emergent and topical issues, including:

- Details of the progress with the Annual Report and Accounts, including the complexities.
- Regular updates of the financial position and capital initiatives applied for.
- The financial and performance related changes taking place nationally and locally and the impact it has on the Trust and system working.
- Details of any performance related issues for higher priority discussion outside the regular report.
- Details of ongoing projects such as the Unified Electronic Patient Record and unification of out of area placements.
- The highlighting of a large number of Lampard Inquiry Rule 9 requests impacting on leadership time and capacity.
- Details of the significant activity that had taken place following the government announcement regarding changes to NHS England and the impact on the System Medium Term Plan.
- Details of workforce related items, such as the MARS programme, reduction of temporary staffing usage and staff vacancies.

There were also deep dives undertaken of risks identified in the Board Assurance Framework, including:

- Digital and Data Strategy
- Length of Stay
- MSECC Waiting Times
- Pharmacy

The Committee supports the strategic objectives through such items cyber security reports, EPR updates, estates reports, flow and capacity monitoring and financial assurance ensuring that care is delivered safely, reliably and in environments that support high quality services.

The Board Assurance Framework, operational planning, financial planning, performance report and improvement initiatives, such as Time To Care give staff clarity, stability and the

right tools to do their jobs well. These items support a positive culture, informed decision-making and ensuring there is a well-resourced workforce.

Reports on commissioning, contracting, flow, system partnership, national oversight and out-of-area placements strengthen collaboration with partners across the system. They ensure services are aligned, pathways are smooth and joint priorities are acted on to improve overall care quality.

Items such as the Green Plan, estates strategy, strategic impact and facilities reporting help to improve the wider environment, support community wellbeing and ensure services contribute positively to local health outcomes. They show how resources, estates and long-term plans are shaped with community benefit in mind.

6. Duties of the Finance and Performance Committee

Committee members undertake a self-assessment of the effectiveness of the Committee. The Trust Secretary's Office facilitates this on an annual basis. The results enable the Committee to develop a plan for improvement. The Committee identified the following for 2025/26 based on the outcome of the previous effectiveness review:

Maintain an open dialogue around any areas of overlap between Committees, to ensure any areas of overlap are considered by the relevant Committee.	✓	There were positive scores regarding the overlap with other Committees.
Ensure connections are made between Internal Audits which receive limited or moderate assurance and the BAF controls within the remit of the Committee.	N/A	There have been no Internal Audit reports receiving limited or moderate assurance in year within the remit of the Committee.
Ensure subsequent Internal Audits undertaken, for any areas receiving limited or moderate assurance, are reported back to the Committee for assurance / triangulation.	N/A	There have been no Internal Audit reports receiving limited or moderate assurance in year within the remit of the Committee.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2025/26 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from other Committees of the Board of Directors. There were no 'significant risks' identified for disclosure in the annual governance statement.

For the year 2025/26 the Committee has met its terms of reference in the discharge of its duties based on the papers discussed throughout the year.

8. Priorities for 2026/27

The schedule of business for the Committee has been developed with the Chair and members of the Committee. The schedule was reviewed by the Committee and the following key amendments agreed:

- Removal of the Time To Care Benefits Report as the programme has concluded and should be business as usual.
- Addition of an ad hoc item for the national submission in September 2026.
- Amendment of Annual Plan and Budget Setting with the Operating Plan to form a single item entitled "Operating Plan & Budget"
- Moving of the Data Protection & Security Toolkit Annual Assessment to Part 2 of the Committee
- Some minor amendments to titles of papers.

The Committee discussed the outcome of the effectiveness review and agreed the following priority actions for 2026/27:

- Continue to ensure conciseness of papers and presentations, to support focused Committee discussions.
- Greater use of table-summaries as part of reports to help support the understanding and focus of the data presented to the Committee. This should also include benchmarking data where possible.
- Ensure the Committee reflects at the end of each meeting on what has gone well and any potential areas for improvement.
- Pilot the introduction of a RAG rating of actions for each meeting, to ensure realistic timescales are agreed to avoid continued action slippages.
- Consider Committee overarching objectives going forwards.

Report prepared by:
Chris Jennings
Assistant Trust Secretary

On behalf of:
Diane Leacock
Chair of the Finance and Performance Committee

FINANCE & PERFORMANCE COMMITTEE
DRAFT TERMS OF REFERENCE 2026/27

CHAired BY:	Diane Leacock, Non-Executive Director	TOR AUTHORISED BY:	Board of Directors
SECRETARIAT:	Board Standing Committee Secretary	FREQUENCY:	Meetings shall be held not less than six times a year and in exceptional circumstances, as determined by the Chair or three members of the Committee
AUTHORITY:	The Finance and Performance Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance and best practice. The Committee is responsible for ensuring the appropriate investment of funds, and to oversee the amalgamation and disaggregation of funds arising from potential mergers, acquisitions or organisational reconfigurations.		
PURPOSE- The duties of the Committee shall include the following:	<p>Performance</p> <ol style="list-style-type: none"> 1 To consider in detail as necessary reports prepared on a monthly basis by the Executive Operational Committee detailing the performance against identified local and national targets/ indicators that contribute to the delivery of quality services and ensuring that the Trust meets its contractual requirements. To monitor agreed plans to mitigate underperformance, where necessary reporting these to the Board. 2 To scrutinise the risks (hotspots) to organisational performance, seeking assurance that the risks are clearly articulated and mitigating action has or is being taken by Executive Directors. To monitor progress made with implementing actions to address identified risk. 3 To ensure the Trust's compliance with the terms of its Licence, and its Constitution. To oversee self assessment of compliance with annual corporate governance statements. 4 To scrutinise financial performance, seeking assurance that variation and risk are clearly articulated and mitigating action has or is being taken by Executive Directors. To monitor progress made with implementing actions to address identified variation or risk. 5 To receive assurance in relation to the use of resources and efficiencies (including people, estates & facilities, digital, capital / revenue and assets). 6 To develop and monitor the implementation of the corporate and Care Unit objectives including Transformation (including Transformation & Efficiency Group reporting) in the Annual and Medium Term Plans. Provide oversight to key major projects and programmes as instructed by the Board of Directors. 7 To provide oversight of the relevant Trust Strategies including Digital and Estates. 8 To ensure appropriate links with the Audit Committee, PEC Committee and Quality Committee. 9 To receive assurance on management of the Trust's strategic capital programme approved by the Board of Directors. 10 To receive BAF risk action plans appropriate to the scope and role of the committee. 11 To consider reports on the performance of any Joint Committees where they are transacting business on behalf of the Trust. 12 To ensure the Trust's compliance with the Data Security and Protection Toolkit and that cyber security risks are being clearly articulated and mitigating action has or is being taken by Executive Directors. 		

ATTENDANCE:	<p>Investment:</p> <p>13 To establish and monitor compliance with a written Investment Policy (which is periodically reviewed by independent professional advisors) to establish the overall methodology, processes and controls which govern selection of Trust investments.</p> <p>14 To monitor investments where total revenue resulting from the investment or capital value is within the delegated limits outlined in the Trust's Investment Policy for the Committee.</p> <p>15 To consider contracts, investments or marketing initiatives/opportunities:</p> <ul style="list-style-type: none"> • Where a change to the Trust's corporate structure is required (for example establishment of a subsidiary vehicle) • To approve development of ITT that are reportable transactions to NHS England • To review all potential new transactions in the light of potential risks • To review investment properties and vacant properties plans. <p>16 Ensure that the underlying liquidity of the Trust is maintained where surpluses are used to finance investments.</p> <p>17 The committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and setting the terms of reference for any external investment consultants.</p> <p>18 To approve external funding within limits delegated by the Board of Directors.</p>	
	<p>MEMBERSHIP:</p> <p>Three (3) Non-Executive Directors, one of whom to be the Chair, and includes Associate Non-Executive Director.</p> <p>Executive Chief Finance Officer</p> <p>Executive Chief Operations Officer</p> <p>Executive Director of Strategy, Transformation and Digital</p> <p>Executive Chief People Officer</p> <p>Executive Director of Governance</p>	<p>IN ATTENDANCE:</p> <p>NED (Chair of Audit Committee) as required</p> <p>Executive Medical Director and/or Executive Nurse</p> <p>Director of Finance</p> <p>Other Directors / Officers as required</p> <p>Clinical Representative - Deputy Medical Director</p> <p>Operational Director / Deputy Director</p> <p>Director of Estates</p>
QUORUM:	<p>Two (2) Non-Executive Directors and two (2) Executive Directors.</p> <p>It is expected that members will attend a minimum of 75% of meetings per year.</p>	
	<p>INPUTS:</p> <p>The Committee shall request and review reports and positive assurances from directors and managers on performance (contractual, operational and financial)</p> <p>They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.</p>	<p>OUTPUTS:</p> <p>Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval.</p> <p>The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered.</p> <p>The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.</p>
Document Control:	<p>Approved by Board: 1 April 2026</p> <p>Date of Last Review: March 2025</p> <p>Next Review: April 2027</p>	

People Committee Annual Report 2025/26

1. Background

The purpose of this report is to review the work undertaken by the People Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2025 – 31 March 2026.

The Committee oversees all aspects relating to workforce, culture, leadership, education training and development across the Trust.

2. Committee Membership

Dr Ruth Jackson, Non-Executive Director chaired the Committee throughout the year.

Included within the current membership are two other Non-Executive Directors, the Executive Chief Operating Officer, Executive Director of Governance, Executive Chief People Officer, Executive Nurse and Executive Chief Finance Officer.

The Committee has several subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Committee Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting, they are made available to Board members for information via the Board portal.

Table 1: Attendance at meetings held 2025/26

	Meetings Attended	Total No. Meetings
Dr Ruth Jackson (Chair)	6	6
Alexandra Green	3	6
Denver Greenhalgh	4	6
Diane Leacock	6	6
Andrew McMenemy	6	6
Ann Sheridan	0	6
Trevor Smith	4	5
Dr Kallur Suresh	1	1
Sarah Teather	4	5

3. Meetings

Meetings were held bi-monthly, with meetings held in April, June, August, October, December and February.

The six meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Committee reviewed its terms of reference in February 2026. The revised draft Terms of Reference are attached to this report (Appendix 1) with the following amendments agreed by the Committee:

- The membership of the Committee has been updated to include the Executive Chief Medical Officer.
- The “in attendance” has been added for members to ensure a suitable deputy attends the meeting if they are not able to attend. This will help to address the finding in the effectiveness review regarding potential issues with the number of attendees at the meeting.

5. Arrangements

The Committee provides internal assurance regarding the Trust’s processes in relation to people, equality and culture. Providing assurance that adequate workforce resourcing processes and controls are in place throughout the Trust to identify, prioritise and manage workforce risk, ensure effective and efficient use of resource and protect the health and wellbeing of employees. The Trust also ensures the Trust is working within the legal requirements of a foundation trust and with reference to guiding principles as set-out in the NHS People Plan.

The Committee receives reports from management forums regarding workforce planning, workforce performance, staff experience, equality, diversity and inclusion, training and education. The Committee also received a regular update from the Executive Chief People Officer of any emergent and topical issues and an update from the Trust’s Freedom to Speak UP Guardian.

The minutes of the Committee are made available to the Board of Directors. The Committee reports to the Board via a Committee Chairs Report providing assurance on the items discussed and provides alerts, actions or approvals for the Board’s attention.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. The minutes and action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule. It is amended as necessary throughout the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with the scheduled of business.

The Committee received reports on the following within the year. Each item has been mapped to a CQC Quality Statement where applicable:

- Annual Report on Employee Relations Activity (Well-Led)
- Annual Workforce Plan for 2025/26 (Safe / Well-Led)
- Apprenticeships (Effective / Well-Led)
- Board Assurance Framework for Workforce risks and People & Culture Risk Register. (Safe / Well-Led)
- Continued Professional Development Planning (Effective / Well-Led)
- Education Strategy Assurance Report and subsequent revised People & Education Strategy. (Effective / Well-Led)
- Equality & Inclusion Reports and Annual Report (Caring / Well-Led)
- Freedom to Speak-Up Report and Annual Report (Safe / Well-Led)
- Guardian of Safe Working Annual Report (Safe)
- HCA Academy (Well-Led)
- Independent Review Action Plan, providing the Committee with a view on the action taken following an independent review of sexual safety allegations at a Trust service. (Safe / Well-Led)
- Job Evaluation (Well-Led)
- Lived Experience and Volunteers Workforce Update (Caring / Responsive)
- Management & Leadership Development Update (Effective / Well-Led)
- National Quarterly Pulse Survey Results (Responsive / Well-Led)
- NHS England Self-Assessment for Placement Providers (Effective / Well-Led)
- Operational Human Resources Assurance Report (Safe / Well-Led)
- People Promise Report (Caring / Well-Led)
- People Strategy Implementation Plan (Well-Led)
- Recruitment Strategy 2025 – 2030 (Safe / Well-Led)
- Resident Doctor Ten-Point Plan (Safe / Effective)
- Sexual Safety Plan Assurance Report (Safe / Well-Led)
- Social Impact Strategy (Caring / Well-Led)
- Staff / Student Story (Responsive / Well-Led)
- Staff Survey Results for 2024/25 and action being taken to address findings and preparations being made for 2025/26. (Responsive / Well-Led)
- Strategic Impact Report, providing updates on the strategic implementation plan within the remit of the Committee. (Well-Led)
- Time to Care Update (Effective / Well-Led)
- Workforce Disability Equality Standards (WDES) / Workforce Race Equality Standards (WRES) (Caring / Well-Led)
- Workforce Key Performance Indicators, including progress against the workforce plan, mandatory training compliance, supervision compliance, appraisal compliance, sickness rate and vacancy rate. (Safe / Well-Led)

The business of the Committee supports the Trust strategy by ensuring there are sufficient qualified, skilled in place to deliver safe, high quality integrated care. The overview of KPI's relating staffing numbers (vacancies, sickness etc.) and monitoring of recruitment plans, contributes to ensuring there are sufficient staff in place and action taken to address any shortfalls.

The Committee ensures there are mechanisms in place to raise any safety concerns (Freedom to Speak-Up) and any additional feedback through national surveys or employee relations. The Committee also receives updates on any operational human resourcing areas to provide assurance of action taken where staff have fallen short of the expected standard.

The Committee also considers equality, diversity and inclusion within the workforce to ensure equity of experience and to enable staff to perform at their best.

The Committee regularly monitors key performance indicators relating to supervision and appraisal. This combined with oversight of education, professional development and mandatory training means the Committee is supporting the objective for enabling each other to be the best we can be, as well as ensuring staff have the right skills and experiences to deliver safe care.

The Committee also received a verbal update from the Executive Chief People Officer on emergent and topical issues, including:

- Temporary Staffing and the progress towards a reduction.
- Updates on the development of the Operational Plan, including reviews of other areas as rostering, observation policies, safer staffing / MHOST to support the workforce plan.
- The operational review of the People and Culture directorate.
- Details of the Mutually Agreed Resignation Scheme (MARS)
- Details of the development of the People Strategy, including working with system partners to consider alignment.
- The impact of Lampard Rule 9 requests on the People & Culture directorate.
- Details of the staff survey and the work being undertaken to promote engagement and the subsequent positive response rate.
- Issues relating to mandatory training, supervision and appraisal compliance.

6. Duties of the People Committee

Committee members undertake a self-assessment of the effectiveness of the Committee. The Trust Secretary's Office facilitates this on an annual basis. The results enable the Committee to develop a plan for improvement. The Committee identified the following for 2025/26 based on the outcome of the previous effectiveness review:

Priority	Progress
Further develop reports presented to the Committee to ensure these are concise and data refined for the Quality Dashboard, to support meaningful discussion at the Committee.	<p>There has been significant progress made in ensuring reports are concise and data refined for the Quality Dashboard which has been noted in Committee Chair Report updates to the Board of Directors.</p> <p>This is further supported by the statement in the effectiveness review that Committee papers received allowed members to perform their role effectively received a score of 4.6</p>

Priority	Progress
	out of 5 and positive comments on the improved quality of papers.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2025/26 is summarised above in section 2 of the report.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from other Committees of the Board of Directors. There were risks identified relating to mandatory training compliance (including safeguarding training) which were referred to the Quality Committee. This will be reviewed to determine if it constitutes a “significant issue” for disclosure within the annual governance statement.

For the year 2025/26 the Committee has met its terms of reference in the discharge of its duties based on the papers discussed throughout the year.

8. Priorities for 2026/27

The Trust Secretary’s Office developed the Committee schedule of business for 2026/27, based on the required Board schedule of business and the Committee Terms of Reference with direction from the Chief People Officer. The Committee Schedule has been adjusted to allow reports to the Board of Directors to be presented in October, which would allow a focused Board meeting around workforce, including a staff story as the presentation. The Committee schedule was discussed with the Executive Chief People Officers Senior Team Meeting. The Work Plan was discussed and agreed by the Committee for presentation to the Board of Directors.

The outcome of the Effectiveness Review did not identify any specific priority areas for 2026/27, except in relation to membership which has been reflected in the Terms of Reference. The Committee agreed to utilise the People Strategy Implementation Plan to set the focus areas for the Committee over the next financial year.

Report prepared by:
Chris Jennings
Assistant Trust Secretary

On behalf of:
Dr Ruth Jackson
Chair of the People Committee

PEOPLE COMMITTEE
DRAFT TERMS OF REFERENCE 2026/27

CHAired BY:	Ruth Jackson, Non-Executive Director	TOR AUTHORISED BY:	Board of Directors
SECRETARIAT:	Board Standing Committee Secretary	FREQUENCY:	Bi-monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee.
AUTHORITY:	<p>The People Committee (hereafter the Committee) is constituted as a standing committee of the Board of Directors. The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by this committee. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Constitution and SFI's as appropriate. The Committee has responsibility for the oversight and monitoring of the Trust's people, equality and culture. In particular, that adequate workforce resourcing governance processes and controls are in place throughout the Trust to: a) identify, prioritise and manage risk arising from our status as an employer; b) ensure effective and efficient use of resources through evidence based people and leadership development and c) protect the health and wellbeing of employees. To ensure the organisation is working within the legal requirements of a foundation trust, and with reference to guiding principles as set out in the NHS People Plan.</p>		
PURPOSE- The duties of the Committee shall include the following:	<p>Workforce Strategy</p> <ol style="list-style-type: none"> 1 To recommend to the Board for approval and oversee delivery of the Trust's strategy and associated implementation plan relating to people and culture. 2 To approve the Trust's strategic workforce plan as part of the overall operational planning process, taking into account local, regional and national policies and /or directions and receive assurance on its implementation. <p>Workforce Performance</p> <ol style="list-style-type: none"> 3 To receive assurance and relevant reports detailing compliance with key national and local workforce indicators including progress against local workforce metrics. <p>Staff Experience</p> <ol style="list-style-type: none"> 4 To maintain oversight of the Trust's systems and process by which staff are able to raise concerns and ensure that these are fit for purpose and the outcomes are monitored. 5 Receive the annual staff survey results and ensure appropriate actions are taken to address any issues. <p>Equality, Diversity and Inclusion</p> <ol style="list-style-type: none"> 6 Receive assurance that the Trust is meeting its statutory and regulatory obligations in relation to equality, diversity and inclusion and delivers improvements as required. 7 Receive annual reports on the Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality Delivery Standards and the NHS EDI Improvement Plan 8 Oversee the Trust's programme of work on EDI for both staff and patients <p>Learning & Education</p> <ol style="list-style-type: none"> 9 Receive assurance on the quality and effectiveness of leadership and management development in the Trust 10 Receive assurance on the approach to talent management and succession planning (for roles other than very senior managers) 11 Receive assurance on the implementation of appraisals and mandatory training 12 Receive assurance on the development of career pathways for all roles, linked to learning opportunities and apprenticeships 13 Receive assurance on the provision of high quality professional under and post graduate education <p>Resourcing</p> <ol style="list-style-type: none"> 14 To receive reports on sustainability of staffing within the remit of our recruitment strategy. <p>Governance and Risk Management</p> <ol style="list-style-type: none"> 15 Review those entries on the Trust's Board Assurance Framework (BAF) and corporate risk registers which are to be overseen by the Committee and identify any new or emerging risk areas which may need to be added to the BAF. 16 Receive and review the findings of relevant Internal and External Audit reports covering workforce, education and training and staff engagement and to assure itself that recommendations are appropriately responded to and implemented in a timely and effective way. 		

ATTENDANCE:	MEMBERSHIP: Three (3) Non-Executive Directors, one of whom to be the Chair, and includes Associate Non-Executive Director Chief People Officer Executive Chief Finance Officer Executive Chief Operating Officer Executive Chief Nurse Executive Chief Medical Officer Executive Director of Governance	IN ATTENDANCE: NED (Chair of Audit Committee) as required Other Directors / Officers as required Staff Side Representative Suitable deputy if Committee Member is unable to attend
QUORUM:	Two (2) Non-Executive Directors and two (2) Executive Directors. It is expected that members will attend a minimum of 75% of meetings per year.	
	INPUTS: The Committee shall request and review reports and positive assurances from directors and managers. They may also request specific reports from individual functions within the organisation as they may be appropriate to overall arrangements.	OUTPUTS: Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval. The Committee will report in writing to the Board of Directors after each meeting advising it has met and the decisions it has made. If requested to do so it will provide further information to the Board including the terms of any advice it has received and considered. The Committee shall report to the Board of Directors an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors.
Document Control:	Approved by Board: To be approved April 2026 Date of Last Review: April 2025 Next Review: April 2027	

Quality Committee Annual Report 2025/26

1. Background

The purpose of this report is to review the work undertaken by the Quality Committee (a standing Committee of the Board of Directors) for the period covering 1 April 2025 – 31 March 2026.

The Committee oversees all aspects of quality performance and provides assurance to the Board of Directors on meeting national standards and quality objectives, informing the Audit Committee of any significant issues.

2. Committee Membership

Dr Mateen Jiwani, Non-Executive Director chaired the Committee throughout the year.

Included within the current membership another Non-Executive Director, Executive Chief Operating Officer, Executive Director of Governance, Executive Nurse and Executive Medical Director.

The Committee has a number of subject matter leads who attend to provide additional probity as required. Other members of the Executive Team may attend on an ad hoc basis.

Administration relating to the Committee business was undertaken by the Board Committee Secretary. In line with the Terms of Reference, the agenda and accompanying papers were circulated to members during the week prior to each meeting.

The Chair provides a highlight report of key issues on Committee business at the following Board of Directors meeting. Once the Committee minutes have been signed as a true record of the meeting they are made available to Board members for information.

Table 1: Attendance at meetings held 2025/26

	Meetings Attended	Total No. Meetings
Dr Mateen Jiwani (Chair)	11	11
Alexandra Green	9	11
Denver Greenhalgh	7	11
Dr Ruth Jackson	10	11
Dr Milind Karale (until November 2025)	4	7
Ann Sheridan	11	11
Dr Kallur Suresh (from November 2025)	5	5

3. Meetings

Meetings were held monthly, with the exception of August 2025.

The eleven meetings held met the obligations regarding membership, attendance and quoracy.

4. Terms of Reference

The Terms of Reference for the Committee will be reviewed as part of the review of the Committee schedule of business.

5. Arrangements

The Committee provides internal assurance by reviewing the establishment and maintenance and effective systems of clinical governance, clinical risk management, quality assurance and clinical effectiveness in all areas, excluding those managed by the Audit Committee.

The Quality Committee receives reports from the management forums for patient experience, patient safety, clinical effectiveness and the Health & Safety Committee. It received a chairs escalation report throughout the year.

The minutes of the Quality Committee are made available to the Board of Directors. The Committee also reports to the Board via a Committee Chairs Report which provides assurance on the items discussed and provides any alerts, actions or approvals for the Boards attention.

The Committee maintains an annual reporting schedule of business. Actions arising from meetings are recorded on a rolling action tracker. The minutes and action tracker are used to plan, record and monitor the work of the Committee.

The reporting schedule of business is updated annually in line with revisions to the Board reporting schedule, and is amended as necessary through the year to take account of changes to the reporting structures and any projects, which may be required to report to the Committee. Throughout the year, the Committee has received a range of information in accordance with the scheduled of business.

The Committee received reports on the following within the year. Each item has been mapped to a CQC Quality Statement where applicable:

- Board Assurance Framework (Well-Led)
- Clinical Audit and NICE Report (Effective / Well-Led)
- Complaints and Compliments Annual Report (Caring / Responsive)
- CQC Assurance Report and findings from recent inspections. (Safe / Well-Led)
- Development of a Patient Safety Culture (Safe / Well-Led)
- Digital Clinical Safety Framework (Safe / Well-Led)
- Emergency Preparedness, Resilience and Response (EPRR) Annual Report (Safe / Well-Led)
- End of Life Annual Report (Caring / Effective)
- Environmental Ligature Risk Management Annual Report (Safe)
- Falls Prevention and Management Report (Safe / Effective)
- Health & Safety and Violence & Aggression Prevention (VAPR) Annual Report (Safe)
- Infection Prevention & Control updates and Annual Report. (Safe)
- Learning Disability Improvement Standard (Caring / Responsive)
- Learning From Deaths (Safe / Effective)
- Learning Lessons Update (Safe / Effective)
- Management of the Deteriorating Patient (Safe / Effective)

- Mental Health Act (MHA) Performance / Activity Report and Annual Report (Safe / Responsive)
- Neurodiversity, providing progress on delivery of the work plan. (Caring / Responsive)
- Patient / Family Story (Caring / Responsive)
- Patient and Carer Race Equality Framework briefing paper and plan. (Caring / Responsive)
- Patient and Service User Experience Report (Caring / Responsive)
- Patient Experience and Volunteers Annual Report (Caring / Responsive)
- Patient-led Assessment of the Care Environment (PLACE) (Safe / Caring)
- Patient Safety Incident Response Framework (PSIRF) (Safe)
- Patient Safety Strategy (Safe / Well-Led)
- Pharmacy and Medicines Optimisation Strategy progress update (Safe / Effective)
- Physical Health Annual Report (Effective)
- Prevention of Future Deaths (PFD) report (Safe)
- Quality Account, including draft versions for review and the final version for approval. (Responsive / Well-Led)
- Quality Control Audits, relating to the development of the audits. (Effective / Well-Led)
- Quality of Care Performance Dashboard (Well-Led)
- Quality Senate Report (Well-Led)
- Reducing Health Inequalities Report (Caring / Responsive)
- Reducing Restrictive Practice (Safe / Caring)
- Research and Innovation Strategy Update (Effective / Well-Led)
- Safeguarding updates and Annual Report. (Safe / Caring)
- Safer Staffing for Inpatient Nursing (Safe)
- Safety Improvement Plans update report. (Safe / Well-Led)
- Senior Information Risk Owner Annual Report (Safe / Well-Led)
- Sexual Safety (Safe / Caring)
- Strategic Impact Report, providing details of strategic objectives within the remit of the Committee. (Well-Led)
- Suicide Prevention (Safe / Effective)
- Time To Care (Effective / Well-Led)
- Transforming Community Mental Health Teams (Responsive / Well-Led)
- Update on the Trust approach to neurodiversity (Caring / Responsive)

The Committee also received a verbal update from the Executive Nurse and Executive Medical Director on emergent and topical issues, including:

- Details of joint working undertaken with partner organisations, including a review of the patient liaison service, supporting caseload management.
- Details of any incidents or national issues which may impact the quality of care provided and the action taken to address, including a national shortage of Best Interest Assessors, issues raised regarding care provided at a partner organisation where the Trust places patients and industrial action.
- Details of quality reviews undertaken and action taken where issues were identified.

- Details of service developments or changes to processes to address quality issues, such as the development of the Urgent Treatment Centre and changes to shift patterns for community health inpatient services.
- Details of evidence provided to the Lampard Inquiry and proposed additional assurances to be provided to the Committee as a result.
- Details of CQC inspections and any regulatory action taken as a result, including the action taken by the Trust to resolve.
- Details of any upcoming inquests, including a large volume planned for the end of year and the impact this would have on teams.
- Details of a thematic review undertaken for safeguarding issues raised by the Lampard Inquiry.

There were also matters arising throughout the year for any risks arising from Committee discussions:

- Care Plans update
- Contactless Patient Monitoring, including changes to the use of Oxevision and a deep dive of practice.
- Emerging risks relating to medication clinical practice.
- Improvements made at Ardleigh Ward following a quality review.
- Management of Controlled Drugs (Deep Dive)
- Quality Improvement Project Report
- Staff Supervision and Support
- The Trust's approach to support neurodiversity.
- Update on the use of voice technology
- Winter Pressures and Plan
- Workforce Disability Equality Standards (WDES) / Workforce Race Equality Standards (WRES) triangulation between Quality and People Committees.

The Committees programme of work provided broad and robust assurance across all four of the Trust's strategic objectives. A wide range of reports – including clinical audit, risk management patient safety and quality performance data – collectively strengthened oversight of safety, quality and regulatory compliance. This provided assurance that risks were identified early, learning embedded and the organisation continued to deliver safe, high-quality integrated care.

The Committee provided strong oversight of governance, quality systems and regulatory assurance through reviewing the Board Assurance Framework, Quality Account and Quality of Care Performance Dashboard. Regular scrutiny of other items, such as Clinical Audit and a range of annual reports reinforces the robustness of the Trust's governance arrangements and supports continuous improvement in the quality and safety of care.

The Committee had significant focus on patient safety and risk management. The Committee reviews a wide-range of safety reports, including PSIRF, Safety Improvement Plans, Learning Lessons, Learning From Deaths, Suicide Prevention, Safeguarding and Prevention of Future Deaths. Assurance was also provided through thematic reviews and deep dives completed in year. These activities ensured that risks were well understood, mitigated and acted upon, support the deliver of safe and reliable services.

The Committee also maintains oversight of key areas of patient experience and equity. This included complaints and compliments, patient and service user experience, PLACE and Patient / Family stories. Additional reports on the Learning Disability Improvement Standard, Neurodiversity, Reducing Restrictive Practice, Reducing Health Inequalities, End of Life Care and Transformation ensure the Trust continued to improve the experience and outcomes of people who use the services.

6. Duties of the Quality Committee

Committee members undertake a self-assessment of the effectiveness of the Committee. The Trust Secretary's Office facilitates this on an annual basis. The results enable the Committee to develop a plan for improvement. The Committee identified the following for 2025/26 based on the outcome of the previous effectiveness review:

Improve oversight of quality issues arising from subcontracted services	✓	<p>There were no issues flagged for oversight of quality issues around subcontracted services. There was an issue identified in year regarding a partner organisation where services were placed and details were provided of the action taken.</p> <p>It was agreed an annual review would be undertaken to ensure there are no issues that have been missed.</p>
Receive all internal audit reports pertaining to clinical governance, irrespective of the auditor's opinion.	✓	<p>There was one Internal Audit Report in year pertaining to clinical governance, which related to Oxevision, and this was discussed by the Committee under this item.</p> <p>There are potentially some further reports which will be presented to the Committee as the Internal Auditors finalise its programme of work.</p>
Develop and streamline papers to ensure these are short and concise, to allow for meaningful discussions to be held by the Committee	Partial	<p>There was positive feedback in relation to the quality of the content of the papers, with the acknowledgement that further development is needed in terms of quality and conciseness in presenting the reports.</p>

Ensure members of the Committee or their deputies attend all meetings and relevant subject matter experts join the Committee for specific items if required.	✓	<p>There was good attendance during the year, except in July where Non-Executive Directors who were not regular members of the Committee attended to ensure quoracy. This has subsequently been resolved with new membership agreed and the issue did not re-occur.</p> <p>There was a discussion with the Chair and Executive Members regarding deputies attending, ensuring they do not come to present a report but stay for the meeting and contribute to discussions. Where subject matter experts attend to present a report, it should be clear whether they are attending for that specific item or attending for the whole meeting to support further agenda items.</p> <p>This may be a priority for 2026/27 to review and clarify membership / attendance at the Committee.</p>
Oversee the provision of digital support for the development of the new quality dashboard.	✓	This was included and overseen as a monthly report during the year.

The Committee administrator monitors attendance at the Committee and compliance for reporting arrangements. Where an Executive member is unable to attend a meeting, a deputy is required wherever possible. The attendance during 2025/26 is summarised above.

7. Control

During the past year, the Committee has considered issues escalated by reporting forums and from other Committees of the Board of Directors. There were some risks identified which were reverted to the People Committee for consideration, relating to mandatory training. There were no “significant issues” identified for disclosure in the annual governance statement.

For the year 2025/26 the Committee has met its terms of reference in the discharge of its duties based on the papers discussed throughout the year.

8. Priorities for 2026/27

The Committee discussed the outcome of the effectiveness review and agreed the following priority actions for 2026/27:

- Continue the development of reports and presentations to the Committee to ensure reports focus on quality and support the Committee from discussion areas outside of its remit.
- Committee members to identify individuals to present reports at sub-committee level prior to presenting papers at the Quality Committee. Constructive feedback to be provided to presenters following the Committee to support development.

- Introduce RAG rating of Committee action timescales, to ensure realistic timescales are agreed for reporting back to the Committee, to avoid continued slippage of action timescales.
- Embed the quality improvement agenda into the Committee as part of the prioritisation of quality improvement activities, including receiving assurance on the methodology across the quality of care delivery in the organisation.

The schedule of business for the Committee is being developed and requires the development of the Quality of Care Group schedule of business. This will be presented to a subsequent Quality Committee meeting for agreement.

Report prepared by:
Chris Jennings
Assistant Trust Secretary

On behalf of:
Dr Mateen Jiwani
Chair of the Quality Committee

7.3 CQC ASSURANCE REPORT

● Information Item

 AS

REFERENCES

Only PDFs are attached

 CQC Assurance Report 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 April 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 of Care 10 March 2026, Quality Committee 12 March 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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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 has initiated a Well Led inspection for EPUT. The CQC information/data request has been received and being processed.
- The Well Led inspection planned for week of 23 March 2026.
- Following the CQC unannounced visit to 439 Ipswich Road in November 2025, the Trust received a Section 29 warning notice, with improvement required by 30 April 2026. The draft report following the assessment has been received for factual accuracy.
- Following the CQC unannounced visits to Avocet Ward and CICC in December 2025 a Data request has been completed and the draft report received for factual accuracy.
- The CQC completed an unannounced visit to Ardleigh Ward in January 2026. A CQC letter of Intent was received on 05 February 2026 to which the Trust responded. The CQC confirmed no enforcement action was to be taken. The report is awaited.
- The CQC Improvement Plan (v02) continues to be implemented. There are currently 13 CQC concerns being taken forward and as of the 28 February 2026, 56 sub-actions have been identified for the CQC actions.
 - 2 are in recovery (Implementation of PRN audit programme, Activity Cancellation KPI reporting)
 - 1 is past timescale awaiting recover confirmation (Discussion and documentation of patient medication preference in the clinical review)
 - 19 are on track.
 - 33 reported as complete and pending evidence.
 - 1 (2%) have been closed through the evidence assurance process
- There were six CQC enquiries raised during this reporting period.
- The overall compliance against CQC quality statements remains 'Good,' based on information available from internal compliance programme.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓


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

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	✓
Service impact/health improvement gains	✓

Financial implications:		Capital £	
		Revenue £	
		Non-Recurrent £	
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed		YES/NO	

Acronyms/Terms Used in the Report			
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
<ul style="list-style-type: none"> • CQC Assurance Report • Appendix 1 – CQC Action Plan Update February 2026 • Appendix 2 – 439 Ipswich Road Section 29A Warning Notice

Lead
 <p>Ann Sheridan Executive Chief Nurse</p>

CQC Assurance Report**1. Purpose of the report**

This report provides the Board of Directors with:

- An update on CQC related activities that were undertaken within the Trust in the reporting period.
- 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. Registration changes were made to reflect the removal of Dr Milind Karale and adding of Dr Kallur Suresh as the new Chief Executive Medical Officer.

3. CQC Inspections and Improvement Plans**3.1. Well Led Inspections**

The CQC has initiated a Well Led inspection for EPUT. The CQC information/data request has been received and being progressed within timescales set.

The Well Led inspection interviews and focus groups planned for week of 23 March 2026.

3.2. CQC Unannounced inspection**3.2.1. LD Inpatients (Byron Court) (July 2025)**

The final report from the unannounced CQC visit at Bryon Court (LD Inpatients) published with a maintained a rating of 'requires improvement.' An action plan to address the regulatory breaches was developed and is being implemented.

3.2.2. Long Stay Rehab (439 Ipswich Road) (November 2025)

Following the CQC unannounced visit to 439 Ipswich Road in November 2025, the Trust has received a Section 29 warning notice, with improvements required by 30 April 2026. The Trust has received the draft report for factual accuracy checks.

3.2.3 Ardleigh Ward (January 2026)

The CQC completed an unannounced visit to Ardleigh Ward in January 2026. A letter of intent was issued on 05 February 2026 to which the Trust responded, with the CQC confirming no further action to be taken. The Trust awaits the report.

3.2.3. 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 draft report received for factual accuracy.

3.3. Clifton Lodge PIR

The CQC Care Home Provider Information Request for Clifton Lodge was completed and submitted following approval.

3.4. CQC Improvement Plan

Progress continues against the v02 CQC Improvement Plan via the operational CQC Care Unit Operational meetings, the Joint Care Unit meeting and the Quality of Care Group.

As of 28 February 2026, thirteen (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)
- 1 (2%) are off track, recovery plan to be confirmed
- 19 (34%) are on track
- 33 (59%) reported as complete and pending evidence
- 1 (2%) have been closed through the evidence assurance process

3.5. CQC Enquiries

During the reporting period (January / February 2026), the CQC raised six (6) enquiries as outlined below. Concerns and enquiries raised by the CQC are managed via the PALS process and where requested, via a director or Executive.

Received	Service	Enquiry related to
07/01/2026	Chelmer Ward	Staff Attitude / Unhelpful
07/01/2026	Edward House	Environment / Heating and Ventilation
23/01/2026	Peter Bruff Ward	Systems & Procedures / Visiting Hours
29/01/2026	Cedar Ward	Clinical Practice / Drugs - Administration
10/02/2026	Dune Ward	Communication / Communication breakdown with patient
20/02/2026	Health Based Place of Safety (HBPoS) Rochford Hospital	Systems & Procedures / No Beds

3.6. CQC Notifications

All providers are required to notify the CQC of key events and during the reporting period, the Trust made twenty-one (21) notifications to the CQC including:

- Absent without official leave (AWOL) (5)
- Death of a person using the service (9)

- Serious injury to a person using the service (3)
- Abuse (2)
- Death of a detained Mental Health patient (2)

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 February 2026, the Trust is reporting 'Good' compliance across all the domains assessed. 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 updated 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. Four visits were completed and multi-stakeholder reports providing areas of good practice and areas for improvement are highlighted back to the relevant service and Care Unit leadership and followed through the risk and compliance reports provided to the accountability framework governance.

5. Recommendation

The Board of Directors is asked to:

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

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of
Ann Sheridan
Executive Nurse

Appendix 1

CQC Action Plan Update Report

February 2026

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)

STRATEGIC OBJECTIVES

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

VALUES

- We **CARE**
- We **LEARN**
- We **EMPOWER**

Key Messages

CQC Activity

Unannounced CQC visit to 439 Ipswich Road in November 2025, the Trust received a Section 29 warning notice, with improvement actions underway and to be achieved by 30 April 2026. Factual accuracy of the report has been completed, with final report awaited.

Unannounced CQC visit to Ardleigh Ward in January 2026. A letter of intent was received on 05 February 2026 to which the Trust responded, with no further action taken by the CQC. The Trust awaits the draft inspection report.

Unannounced CQC visits to Avocet Ward and CICC in December 2025, draft report received for factual accuracy.

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)
- 1 (2%) are off track, with recovery plan to be confirmed

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

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

CQC Action Progress Update

Summary of implementation status

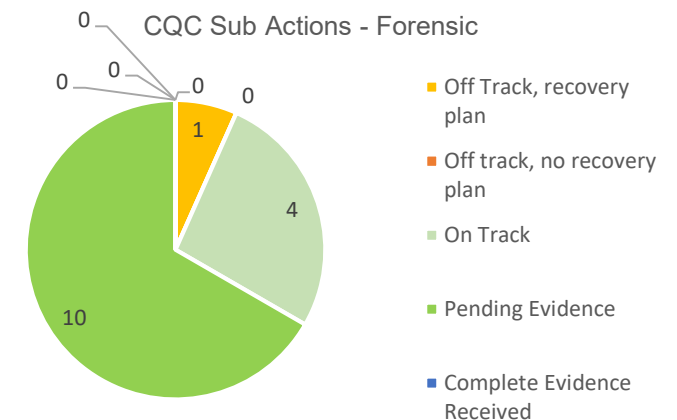
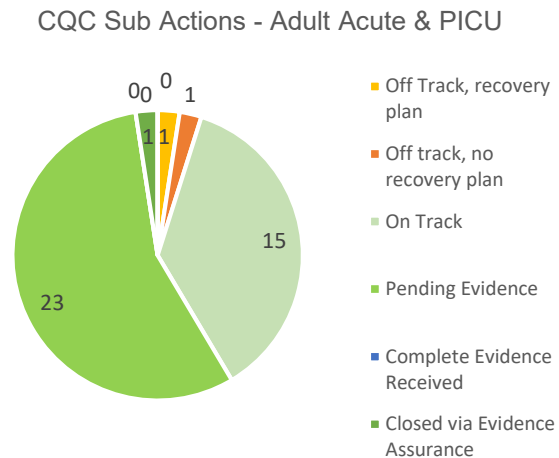
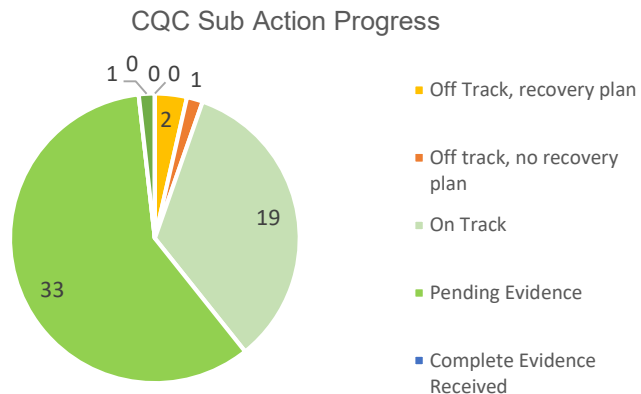
Overview as of the 28 February 2026:

- 13 Regulatory and Improvement Actions made up of 56 sub-actions.
- Of the 56 sub-actions
 - 2 (3%) are in recovery (CCTV, Activity Cancellation KPI reporting)
 - 1 (2%) is off track, recovery plan to be confirmed
 - 19 (36%) are on track
 - 33 (59%) reported as complete, 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:

- RA3.4 Medicines Management – Recording of the impact of prescribed medicines on the patient’s physical health, regular side effects and outline the required routine monitoring being included within physical health assessment.
- RA4.3 Governance (embedding learning – supervisions and appraisal) – Enhanced accountability monitoring of supervision and appraisal compliance. at care unit Accountability framework Care Unit meeting.
- RA4.6 Enhanced monitoring of Medication themes and reported monthly and included on Q&S agenda for shared learning
- RA2.6 Rapid Tranquilisation and PRN - Implementation of PRN audit programme
- RA4.1 Governance (embedding learning - appraisal and supervision) - To review Trust target compliance rate for staff 1-1 support
- RA4.2 Governance (embedding learning - supervision and appraisal) - Care Unit meeting to include discussions on forward planning
- IA5.3 Maintenance - Monitor outstanding
- maintenance repairs via local governance meetings



CQC Action Recovery Plan

Action Recovery Plan				
CQC Concern	Sub-Action past timescale	Current Position	Recovery Plan	Lead
<p>M6: (July 2023)</p> <p>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</p>	<p>M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning</p>	<p>The CCTV software procurement decision has been escalated to Director of Estates for a decision.</p> <p>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.</p>	<p>Workshop, supported by Transformation Team 5 January 2026 and a timeline of end of March for transition to be confirmed.</p> <p>Update Jan 26 – ET approved paper - Task & Finish group in place to review CCTV project</p>	<p>Tendai Ruwona</p>
<p>IA2.4 (April 2025)</p> <p>Nine patients said that activities were cancelled all the time due to staffing</p>	<p>Develop and present a quarterly activity KPI report through Care Unit governance, including narrative and mitigations for any cancelled activities.</p>	<p>Work in progress to develop report, all vacancies recruited to, activity Programmes available on all wards and Therapy Corridor is soon to be open.</p>	<p>To continue development of report and present KPI through Care Unit governance.</p>	<p>Vijay Chuttoo</p>
<p>Medicines Management</p> <p>Breach in safe care and treatment: Continued evidence of systems and processes not always being used safely, to prescribe, administer and record medicines.</p>	<p>RA3.2</p> <p>Medical Staff to include discussion on patient medication preference in the doctor's clinical review and ensure recorded on the patient notes</p> <p>Timescale Oct—25</p>	<p>Actions are part of the clinical procedure.</p>	<p>Discussion with medical leadership to agree monitoring mechanism going forward.</p>	<p>Katy Stafford</p>

For the attention of the Chief Executive
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

05 February 2026

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: Essex Partnership University NHS Foundation Trust

Regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Our reference: ENF2-000000003840

Account number: R1L

Dear Paul,

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by Essex Partnership University NHS Foundation Trust for the regulated activities above requires significant improvement:

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the locations identified below:

439 Ipswich Road
Colchester
Essex
CO4 0HF

The reasons for the Commission’s view that the quality of health care you provide requires significant improvement are as follows:

Regulation 13, Safeguarding

Regulation 13 (1)

Service users must be protected from abuse and improper treatment

1. Staff failed to report safeguarding incidents appropriately. On 22 March 2022 patient A was exposed to inappropriate staff conduct. On 15 May 2023 staff reported concerns that staff member A was developing a close relationship with patient B. On 29 August 2023 concerns were raised that staff member A was spending time in patient C’s bedroom. On 15 September and 01 October 2025 patient D and patient E reported money missing. Patients were advised to lock bedroom doors, but no further action was taken. Failure to report safeguarding incidents exposes people to risk of abuse and improper treatment.
2. From April 2020 to May 2025 there were 12 incidents reported about inappropriate behaviour and sexual safety concerns involving staff member A. Staff failed to identify appropriate actions to prevent ongoing harm. On 28 April 2020 a concern was raised about sexually inappropriate behaviour. A disciplinary decision-making tool was completed but immediate actions were not identified. On 5 May 2022 staff member B reported that staff member A had inappropriate material on her phone while at work. Photographic evidence was provided. It was decided that there was not enough evidence to support the allegation. There were 3 previous concerns regarding behaviour of staff member A. In August 2023 a new concern about an inappropriate relationship of staff member A was raised. This was discussed in supervision, but no further action was taken. There continued to be concerns raised after this date, which are still being investigated. Failure to identify and implement actions from investigations puts patients at risk of abuse and improper treatment.

Regulation 17, Good governance

Regulation 17 (2)(a)

Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

1. Managers did not have adequate oversight of staff. Supervision compliance was an average of 46% from May to October 2025. On 18 August 2022 an investigation identified supervision as an action to address concerns about staff not wanting to report incidents to staff member B. There is no evidence this discussion took place in supervision. Staff did not receive regular supervision or appraisals. Supervision was not effective in managing concerns and staff conduct issues. Appraisal compliance was 40% from May to October 2025.
2. There was lack of management oversight. There were gaps in clinical audits. For example, ward manager audits were not completed for 4 out of the last 12 months.

17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

3. Managers did not have adequate systems in place to monitor the assessment of risk. Systems did not give staff tools to put mitigation in place and to keep patients safe. Staff told us patients were placed inappropriately at 439 Ipswich Road, due to bed shortages on other wards. We raised this concern during our inspection and risk assessments for patient F and patient G were reviewed in their absence. Failure to have systems in place to ensure assessment of risk puts patients at risk of avoidable harm.
4. Managers did not have robust oversight of incidents. They had missed opportunities to improve the quality and safety of the services provided to patients as outlined in point 1 and 2. This meant people were exposed to ongoing harm. Staff were not assured that managers would appropriately manage risk. Staff did not follow processes when reporting incidents, due to lack of confidence that leaders would take action to mitigate risk to patients.
5. Concerns relating to the health and safety of the environment were not effectively actioned, putting patients at risk of avoidable harm:
 - a) There was a large hole in the garden fence, providing an opportunity for patients to abscond. On 28 May 2025 a patient raised this as a concern and had disclosed “a wish to die” but no urgent action was taken. Following our inspection, we raised concerns that patients detained under

the Mental Health Act 1983 could abscond and no urgent action was taken to mitigate this risk.

- f) Fire risks were not appropriately identified or managed. An emergency fire exit was covered with a black bin bag, due to patients reporting the light was shining into their room. In the laundry room, items such as a pillow were stored directly behind the washing machine and tumble dryer.
- f) Ligature risks were not appropriately identified or mitigated. There was a shed in the garden and the door did not shut. There were hose pipes and other items in the shed that were a risk to patients. When we raised this as an immediate safety concern, the shed was temporarily screwed shut to mitigate risk. As of 16 January 2026 the shed door had not been fixed with a permanent solution. There were broken appliances in the garden that had not been disposed of and were a risk to patients. Some broken appliances had long electrical cables, which were a ligature risk. Managers had to be prompted to make the environment safe during inspection.
- f) Due to some patients not being assessed on admission their risk of self-harm and suicide was unknown and unable to be mitigated. There were no ligature cutters in the Coach House.
- f) Cleaning liquids were not safely stored. We found cleaning liquid in a paper cup in a kitchen cupboard in the Coach House.
- f) Managers did not enforce safety processes. Not all staff were wearing personal alarms. There were no alarms around the building in the event of an emergency.

Why you need to make significant improvements in safeguarding (regulation 13):

- Patients were not safeguarded from abuse and improper treatment. Appropriate safeguarding authorities were not always notified of safeguarding incidents. Full investigations did not always take place so there were missed opportunities to protect people. Where investigations did take place, appropriate actions were not always identified. Where actions were identified, they were not always completed to safeguard patients from ongoing risk of harm. Investigations after incidents did not protect patients from abuse and safeguarding authorities were not always notified of safeguarding incidents. Repeated safeguarding incidents took place with one staff member, and appropriate measures were not taken to address their behaviour and safeguard patients.

Why you need to make significant improvements in good governance (regulation 17):

- Systems and processes were not operating effectively to assess, monitor and improve the quality and safety of the service. Risk assessments were not always completed, and risks were not always known. Staff were not assured that managers would take action when incidents and concerns were reported. The environment was not safe and patients were at risk of avoidable harm. A lack of oversight and governance meant CQC identified risks for the staff to address. You have failed to ensure there were adequate governance processes in place to identify these issues and take remedial action, which put patients at risk of avoidable harm.

You are required to make the significant improvements identified above regarding the quality of healthcare by Thursday 30 April 2026.

Please note: If you fail to comply with the above requirement and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale(s) we will decide what further action to take against you. Possible action includes:

requiring Monitor, now known as NHS England and NHS Improvement, to make an order under Section 65D (2) of the National Health Service Act 2006 (appointment of trust special administrator).

We will notify the public that you have been served this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the notice has been served wrongly. This could be because you think the notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making

representations and make sure that you include the reference number ENF2-000000003785

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

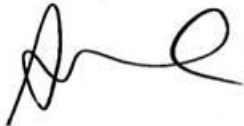
Telephone: 03000 616161

Email: HSCA_Representations@ccq.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number ENF2-000000003785 as it may cause delay if you are not able to give it to us.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Anna Warrington', written in a cursive style.

Anna Warrington
Operations Manager

7.4 NATIONAL STAFF SURVEY ? BENCHMARKING, RESULTS, ANALYSIS &


NEXT STEPS

Discussion Item

 AM

REFERENCES

Only PDFs are attached

 National Staff Survey 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 2026	
Report Title:		National Staff Survey – Benchmarking, Results, Analysis & Next Steps				
Executive/ Non-Executive Lead / Committee Lead:		Andrew McMenemy – Executive Chief People Officer				
Report Author(s):		Paul Taylor – Director for Organisational Development & Culture Jo Debenham – AD for Organisational Development & Culture				
Report discussed previously at:		Board of Directors, People Committee				
Level of Assurance:		Level 1	✓	Level 2		Level 3

Risk assessment of report		
Summary of risks highlighted in this report	<ul style="list-style-type: none"> • The Trust-wide response rate has risen by 10% this year, signalling improved engagement. However, further progress is required next year to secure a more representative view of staff experience across all groups. • Despite positive movement in several areas, overall staff experience remains below the levels reported in the previous two years, indicating that sustained focus and targeted action are still needed. • Morale, We are a team and We are always learning score positively above benchmarking average. • EPUT performs favourably when compared to our local benchmarking peers as well as other trusts facing similar levels of scrutiny. • Declines in key indicators such as motivation suggest emerging risks to staff retention and highlight the importance of reinforcing our people and culture priorities. • Bank staff remain an essential component of our workforce, and the notably poorer experience reported by nursing bank colleagues represents a significant area requiring attention. • While there has been progress in reducing unwanted behaviours between staff, these issues persist from patients and their families. 	
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data	
	SR10 Workforce Sustainability	✓
	SR11 Staff Retention	✓
	SR12 Organisational Development	✓
SR13 Quality Governance		
Does this report mitigate the Strategic risk(s)?	Yes	

Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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	Andrew McMenemy	
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides a summary, analysis and set of Trust-wide priorities based on the NHS Staff Survey results.	Approval	
	Discussion	✓
	Information	✓

Recommendations/Action Required
<p>The Board of Directors is asked to:</p> <ol style="list-style-type: none"> Discuss and note the results, analysis and next steps following the National Staff Survey (2025) benchmarked results.

Summary of key issues
<p>This report presents the findings and benchmarking analysis from the 2025 Staff Survey.</p> <p>The Trust achieved a 52% response rate this year, representing a 10% increase on 2024 and providing a stronger and more representative insight into staff experience as well as a general indication of improved engagement levels from staff.</p> <p>Key findings include:</p> <ul style="list-style-type: none"> • Most People Promise scores have improved, except for flexible working. • EPUT performs favourably when benchmarked against local trusts and those trusts facing similar levels of scrutiny. • Staff motivation and stress-related indicators show a slight decline. • Advocacy has strengthened, with more staff recommending EPUT as a place to work and for care. • Overall morale and engagement scores are improving. • Morale among bank staff continues to lag substantive colleagues. • Despite progress, further work is required to return to the stronger performance seen in 2023 and 2024, although the current trajectory is overall positive. <p>The Organisational Development & Culture programme of work to mitigate risk and provide assurance includes some key elements as follows:</p> <ul style="list-style-type: none"> • Work at a local level through SMT presentations and improvement planning at care unit level. • Care Unit level focus groups are scheduled to review findings, interpret them in context, and co-design improvement plans as part of the quarterly governance cycle aligned to Trust-wide priorities in leadership, recognition, inclusion, and career development. • Oversight of staff experience improvements in the People & Culture strategy and associated plans.

- A Staff Survey Toolkit and improvement guide to support teams in progressing their actions. The staff engagement team will monitor delivery throughout the year in alignment with preparations for the 2026 survey.
- Further analysis once national bank survey, benchmarking and free-text comments are received to drill down into more detailed analysis which will inform care unit and corporate level work.
- Collaboration with Information colleagues to explore how AI can enhance the interpretation of local results, support the design of improvement plans, and identify opportunities for cost efficiencies.
- A sustained focus throughout the year on measures to increase response rates in both pulse and main surveys using regular focus groups, action planning and references to engagement surveys throughout the year.
- Re-development of corporate induction that supports new starters to understand the context and values of the organisation in a more coherent way.
- A strong focus on a staff co-design model and relationships this year through a newly launched staff cafes and a proposal for improved staff equality networks (including funding allocations, reformed leadership and participative and active executive sponsors).
- A culture review and co-designed leadership programme for EPUT with the King’s Fund and BRAP. Focus groups are already underway to co-design both a permanent senior leadership programme and quarterly senior leadership development programme of focussed employee experience related subjects.
- Improvement plan for Entry/Exit processes for EPUT staff.
- Investment in improved staff spaces across the trust as a result of 24/25 charitable funds allocation.
- The follow through of our promise to invest in local charities with offers of wellbeing support for our staff in return [Charity Contribution](#)
- The development of a heat map which identifies EPUT’s worst performing areas in staff survey combined with CQC improvement notices or local intelligence to prioritise interventions.

Next Steps

- Local level results have already been shared with Care and Corporate Unit leads, who are engaging with the staff engagement team for support in identifying priorities and shaping improvement activity.
- The scheduling of Care Unit led focus groups (‘Big Conversations’) to review findings, interpret them in context, and co-design improvement plans as part of the quarterly governance cycle aligned to Trust-wide priorities in leadership, recognition, inclusion, and career development.
- The launch of quarterly staff recognition events supported by senior leaders across the Trust.
- The co-ordination of local plans into concise Trust-level actions contained within the People Strategy Plan.
- The staff engagement team will monitor delivery of local staff experience improvements throughout the year in alignment with preparations for the 2026 survey.
- The OD and Culture team are collaborating with Information colleagues to explore how AI can enhance the interpretation of local results, support the design of improvement plans, and identify opportunities for cost efficiencies.
- The mapping of wellbeing support for staff to give a clear strong improved access route to the services available.

Relationship to Trust Strategic Objectives

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


Which of the Trust Values are Being Delivered

1: We care	X
2: We learn	X
3: We empower	X

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			
AI	Artificial Intelligence		

Supporting Reports and/or Appendices
National Staff Survey Results Report 2025

Executive/ Non-Executive Lead / Committee Lead:

<p>Andrew McMenemy Executive Chief People Officer</p>



Essex Partnership University
NHS Foundation Trust

NHS National Staff Survey 2025

Results & Analysis



EPUT

This report summarises the findings from the core [NHS Staff Survey 2025*](#) carried out by Picker, on behalf of [Essex Partnership University NHS Foundation Trust](#). Picker was commissioned by [19 Mental Health and Mental Health Community Trusts](#) organisations to run their survey – this report presents our results in comparison to those organisations used by Picker only.

A total of **124** questions were asked in the 2025 survey, of these, **110** can be compared to 2024 and **101** can be positively scored. Results include every question where our organisation received at least 10 responses (the minimum required).

7113 Invited to complete the survey	7049 Eligible at the end of survey	52% Completed the survey (3641)	56% Average response rate for similar organisations	42% Your previous response rate
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Advocacy Questions

<p>62% q25c. Would recommend organisation as place to work</p> <p>60% q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation</p> <p>76% q25a. Care of patients/service users is organisation's top priority</p>	<p>Comparison to 2024**</p> <ul style="list-style-type: none"> ■ Significantly better ■ Significantly worse ■ No significant difference 	<p>Comparison with average**</p> <ul style="list-style-type: none"> ■ Significantly better ■ Significantly worse ■ No significant difference
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*Bank worker survey results are presented via separate reports for those organisations who took part

**Chart shows the number of questions that are better, worse, or show no significant difference

Below highlights the five most improved scores vs. the five most declined scores.

Most improved scores	Org 2025	Org 2024
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46%	40%
q8a. Teams within the organisation work well together to achieve objectives	54%	50%
q9b. Immediate manager gives clear feedback on my work	77%	74%
q9i. Immediate manager helps me with problems I face	76%	73%
q23b. Appraisal helped me improve how I do my job	34%	30%

Most declined scores	Org 2025	Org 2024
q5b. Have a choice in deciding how to do my work	59%	64%
q24a. Organisation offers me challenging work	68%	72%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	72%	76%
q5a. Have realistic time pressures	30%	33%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	88%	91%

Tables are based on absolute % differences, not statistical significance

Below shows the difference in EPUT's scores over a 3-year period. Most scores have shown positive increases when compared to the previous year except for 'We work flexibly'.

People Promise Scores 3 year Overview

People Promise Element/Theme	Benchmarking Average	2025	2024	2023
We are compassionate and inclusive	7.61	7.56 + 0.10	7.46 - 0.10	7.56 + 0.07
We are recognised and rewarded	6.37	6.35 + 0.04	6.31 - 0.06	6.37 + 0.15
We each have a voice that counts	6.89	6.87 + 0.01	6.86 - 0.13	6.99 + 0.09
We are safe and healthy	6.34	6.35 + 0.05	6.30 - 0.16	6.46 + 0.23
We are always learning	5.83	6.06 + 0.09	5.97 + 0.01	5.96 + 0.26
We work flexibly	6.84	6.77 - 0.01	6.78 - 0.07	6.85 + 0.08
We are a team'	7.17	7.22 + 0.11	7.11 - 0.10	7.21 + 0.12
Staff Engagement	7.02	7.01 + 0.04	6.97 - 0.20	7.17 + 0.17
Morale	6.12	6.17 + 0.04	6.13 - 0.16	6.29 + 0.17

Below shows the difference in EPUT's scores over a 3-year period.

Most 2025 scores have shown positive increases when compared to the previous year except Motivation & Stressors which have shown small declines.

Engagement & Morale Scores

3 year Overview

People Promise Element/Theme	Benchmarking Average	2025	2024	2023
Staff Engagement Overall Score	7.02	7.01 + 0.04	6.97 - 0.20	7.17 + 0.14
Motivation Sub Score	7.06	7.11 - 0.01	7.12 - 0.19	7.31 + 0.08
Involvement Sub Score	7.03	7.12 + 0.04	7.08 - 0.22	7.30 + 0.22
Advocacy Sub Score	6.87	6.80 + 0.09	6.71 - 0.19	6.90 + 0.12
Morale Overall Score	6.12	6.17 + 0.04	6.13 - 0.16	6.29 + 0.17
Thinking about leaving Sub Score	6.15	6.17 + 0.07	6.10 - 0.17	6.27 + 0.06
Work Pressure Sub Score	5.61	5.65 + 0.08	5.57 - 0.24	5.81 + 0.34
Stressors Sub Score	6.66	6.69 - 0.02	6.71 - 0.08	6.79 + 0.10

Below shows how EPUT compares against other Trusts within the Mid & South Essex ICS. EPUT performed significantly better in all People Promise elements/themes.

Benchmarking

Mid & South Essex ICS


Response Rate –
39%

People Promise Element/Theme	Mid & South Essex NHS FT (Acute & Acute Community) CQC RATING: Inadequate	EPUT 2025
We are compassionate and inclusive	6.71	7.56
We are recognised and rewarded	5.27	6.37
We each have a voice that counts	5.93	6.99
We are safe and healthy	5.51	6.46
We are always learning	4.99	5.96
We work flexibly	5.69	6.85
We are a team'	6.31	7.21
Staff Engagement	5.92	7.17
Morale	5.06	6.29

Below shows how EPUT compares against 3 other local trusts within our benchmarking group, EPUT placed 1st in one element, 2nd place in seven elements and 3rd place in one element. **Ranking based solely on the three Trust's listed below.*

Benchmarking

Other local MH & LD, and MH, LD, & Community

People Promise Element/Theme	Hertfordshire NHS FT Response Rate: 59% CQC RATING: Outstanding	North East London NHS FT Response Rate: 48% CQC RATING: Good	East London NHS FT Response Rate: 51% CQC RATING: Outstanding	RANKING EPUT 2025 Response Rate: 52% <i>*Ranking based on the three Trust's within table.</i>
We are compassionate and inclusive	7.72	7.62	7.53	7.56 3rd
We are recognised and rewarded	6.50	6.26	6.25	6.37 2nd
We each have a voice that counts	7.04	6.93	6.96	6.99 2nd
We are safe and healthy	6.44	6.31	6.19	6.46 1st 
We are always learning	6.29	5.76	5.66	5.96 2nd
We work flexibly	6.96	6.70	6.44	6.85 2nd
We are a team'	7.24	7.14	7.15	7.21 2nd
Staff Engagement	7.24	7.04	7.10	7.17 2nd
Morale	6.31	6.05	6.01	6.29 2nd

Below shows how EPUT compares against other trusts facing the same levels of scrutiny as EPUT. EPUT placed 1st in all elements. *Ranking based solely on the Trust's listed below.

Benchmarking

Other Trusts facing similar levels of scrutiny

People Promise Element/Theme	Norfolk & Suffolk NHS FT Response Rate: 68% CQC RATING: Requires improvement	Tees, Esk & Wear Valleys NHS FT Response Rate: 52% CQC RATING: Requires improvement	RANKING EPUT 2025 Response Rate: 52% <i>*Ranking based on the three Trust's within table</i>
We are compassionate and inclusive	7.16	7.55	7.56 1st
We are recognised and rewarded	6.01	6.37	6.37 Joint 1st
We each have a voice that counts	6.23	6.85	6.99 1st
We are safe and healthy	5.94	6.38	6.46 1st
We are always learning	5.21	5.84	5.96 1st
We work flexibly	6.51	6.61	6.85 1st
We are a team'	6.84	7.02	7.21 1st
Staff Engagement	6.37	6.87	7.17 1st
Morale	5.67	6.11	6.29 1st

Q 25c – 61.7% of staff would recommend EPUT as a place to work.

Compared to 61% in 2024.

Green Score > +3% better than EPUT overall

Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	60%
Medical & Dental	68.5%
Registered Nurses & Midwives	60.8%
Additional Clinical Services	69.1%
Admin & Clerical	57.1%
Allied Health Professionals	66.3%
Estates & Ancillary	40%

Q25d – 59.75% would be happy with the standard of care provided if a friend or relative needed treatment.

Compared to 57% in 2024.

Green Score > +3% better than EPUT overall

Red Score > -3% worse than EPUT overall

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	47.8%
Medical & Dental	65.7%
Registered Nurses & Midwives	63.8%
Additional Clinical Services	69.7%
Admin & Clerical	52.8%
Allied Health Professionals	58.1%
Estates & Ancillary	41.1%

Q17a – 90.87% did not experience unwanted behaviour of a sexual nature from patients, services users, their families or members of the public.

Compared to 92% in 2024.

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	93.3% - 1.1% since 2024
Medical & Dental	91.7% + 1.3 since 2024
Registered Nurses & Midwives	88.9% + 0.03 since 2024
Additional Clinical Services	84.8% -2.1% since 2024
Admin & Clerical	97.8% - 0.6 since 2024
Allied Health Professionals	88.8% - 0.5 since 2024
Estates & Ancillary	90.6% + 0.8 since 2024

Q 17.b – 96.98% did not experience unwanted behaviour of a sexual nature from other colleagues. Compared to 96.5% in 2024.

Occupation Group	% of respondents selecting 'agree' or 'strongly agree'
Add Prof / Scientific & Technical	98.6% + 0.6% since 2024
Medical & Dental	100% + 1.5% since 2024
Registered Nurses & Midwives	96.4% + 0.8% since 2024
Additional Clinical Services	95.1% + 0.4% since 2024
Admin & Clerical	98.7% + 0.9% since 2024
Allied Health Professionals	96.4% - 0.5% since 2024
Estates & Ancillary	94.5% + 4.0 since 2024

Operational Care Units

Staff Survey People Promise Comparator												
People Promise Element	Comparator (Organisation Overall)	Community Collaborative MSE	EPUT Operations	Inpatient Services	Medical	Mid & South	North Essex	Psychological Services	Quality & Safety	Specialist	West Essex	
We are compassionate and inclusive score	7.6	7.9	7.3	7.2	7.2	7.7	7.5	7.8	7.2	7.7	7.7	
We are recognised and rewarded score	6.4	6.6	6.1	6.0	6.1	6.5	6.3	6.9	6.3	6.4	6.3	
We each have a voice that counts score	6.9	7.3	6.6	6.7	6.5	6.9	6.7	6.8	6.7	7.2	6.9	
We are safe and healthy score	6.4	6.5	6.3	5.9	6.4	6.5	6.3	6.4	6.0	6.4	6.2	
We are always learning score	6.1	6.4	5.4	6.2	5.5	6.1	5.9	6.3	5.7	6.2	6.1	
We work flexibly score	6.8	7.1	6.1	6.2	6.2	7.0	6.8	7.2	7.5	6.8	6.5	
We are a team score	7.2	7.5	7.2	7.0	6.7	7.4	7.1	7.5	7.0	7.5	7.2	
Staff Engagement score	7.0	7.4	6.6	7.0	6.8	7.1	6.9	6.9	6.5	7.4	7.1	
Morale score	6.2	6.5	5.8	5.9	6.2	6.3	6.0	6.3	5.5	6.4	6.1	
Key:												
10.0												
>0.4 ppt above												
<0.4 ppt below												
In between												

Corporate Areas

Staff Survey People Promise Comparator										
People Promise Element	Comparator (Organisation Overall)	Chief Executive	Contracting, Bus Dev & Procurement	Corporate Governance	Digital, Strategy & Transformation	Estates & Facilities	Finance & Resources	Lampard Inquiry	People & Culture	
We are compassionate and inclusive score	7.6	8.7	8.3	7.1	7.6	6.7	8.0	7.5	7.4	
We are recognised and rewarded score	6.4	8.1	7.2	6.2	6.5	5.3	7.1	6.4	6.3	
We each have a voice that counts score	6.9	8.3	7.7	6.3	6.8	6.2	7.2	6.3	6.7	
We are safe and healthy score	6.4	7.7	7.2	6.6	6.8	6.2	7.0	6.3	6.7	
We are always learning score	6.1	7.8	6.4	5.4	5.4	5.0	6.5	5.8	5.5	
We work flexibly score	6.8	8.4	8.0	6.8	7.2	5.9	7.4	7.1	7.2	
We are a team score	7.2	8.8	7.1	6.8	7.1	6.0	7.6	7.4	7.1	
Staff Engagement score	7.0	8.4	8.0	6.2	6.6	6.2	7.2	6.3	6.6	
Morale score	6.2	7.6	6.8	5.7	6.2	5.8	6.6	5.7	6.1	
Key:										
10.0										
>0.4 ppt above										
<0.4 ppt below										
In between										

Bank National Staff Survey 2025

Bank Staff Results

19.72% of Bank staff completed the survey

227 responses were received from an eligible sample of 1151 bank staff.

This is an increase of almost 3% from the previous year's response rate of 17%.

Below is a snapshot of initial scores. Focus will be given to Nursing Registered Bank where results show some negative areas when compared to the rest of EPUT Bank Staff. Morale is considerably low in this staff group.

Staff Survey People Promise Comparator								
People Promise Element	Comparator (Organisation Overall)	Add Prof Scientific and Technical	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered
We are compassionate and inclusive score	7.5	*	7.5	7.9	*	8.0	*	7.1
We are recognised and rewarded score	6.4	*	6.4	7.3	*	7.1	*	5.9
We each have a voice that counts score	6.9	*	6.9	7.5	*	*	*	6.9
We are safe and healthy score	6.9	*	6.8	7.6	*	8.0	*	6.8
We are always learning score	6.5	*	6.6	6.9	*	6.2	*	5.8
We work flexibly score	6.7	*	6.6	8.0	*	7.6	*	6.3
We are a team score	7.0	*	7.1	7.5	*	7.8	*	6.5
Staff Engagement score	7.5	*	7.6	7.3	*	7.6	*	7.3
Morale score	6.3	*	6.4	6.4	*	7.2	*	5.7
Key:								
10.0								
>0.4 ppt above								
<0.4 ppt below								
In between								

*confidentiality threshold of 10 responses not met.

National Quarterly Pulse Survey (NQPS)

Latest Update

Q4 Jan 2026

The most recent NQPS was open from 2nd January – 2nd February.
396 responses were received in this quarter. All scores saw a decline in this quarter.

- Results have been shared with care group/corporate areas and published for all staff to view, low scores discussed and incorporated into wider survey action planning.
- Results shared with relevant stakeholders.

National Quarterly Pulse Survey



A 5-minute check-in for staff to share their views



Scan the QR code to participate
or visit the intranet for more information
Open until 2 February

What the results are telling us



Stability with signs of gradual improvement

Most measures have remained broadly stable, compared to last year. Further improvements are required to reach 2023 scores.



Stronger engagement with the survey itself

10% increase in response rate suggests greater trust and willingness to share views.



Positive movement across People Promise areas

Scores for 'team', 'compassion & inclusivity', and 'learning' are all improving, but 'working flexibly' has declined.



Staff engagement is improving

Engagement score improved, especially recommendation as a place to work.



Better engagement from Bank Staff

Improved response rate to the Bank Staff Survey.



Sexual Safety

Less staff experiencing unwanted sexual behaviour.

Actions & Next Steps

- Results have been shared with Care Unit/Corporate Leads
- Results have been presented at Executive Team, People Committee and will be signed off by Trust Board – April 2026
- Care Units and Team Level results to be accompanied by high impact actions agreed monitored and supported by the staff experience team.
- Staff Survey Improvement Guide for directorates rolled out and promoted – February/March 2026.
- Care Unit led ‘Big conversations’ model rolled out with 2 sessions per group before 2026 survey launch supported with All Staff Experience Monthly Cafes
- Cycle of progress for teams and care units tracked by the staff engagement team with a view to progress reporting which aligns to launch of 2026 staff survey – quarterly 2026/2027
- Regular drum beat of Staff Survey focus at SMTs - quarterly.
- Team level reports and work has commenced alongside specific analysis’ to support Trust priorities such as Sexual Safety.
- Bank Staff Survey Results to be analysed and actioned.
- Free text comments report awaited from Picker


8.1 BOARD ASSURANCE FRAMEWORK

● Decision Item

👤 PS

REFERENCES

Only PDFs are attached

 BAF 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1			1 April 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	<input type="checkbox"/>	Level 2	<input checked="" type="checkbox"/>	Level 3	<input type="checkbox"/>

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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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	<input type="checkbox"/>
	Discussion	<input type="checkbox"/>
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: <ol style="list-style-type: none"> 1. Note the contents of the report. 2. Note the new corporate risks

3. 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.
- There have been no risks agreed for closure.
- Three new risks have been escalated by the Executive Team to the Corporate Risk Register
- Nova Programme. Risk assessment undertaken following emerging risks noted in delivery of Nova programme (included in reporting)

The following have been escalated and being finalised with timelines and will feature in the next reporting cycle.

- Neuro Developmental Services, ADHD, MSE NE and West Essex. Risk assessment has identified that demand for Neurodevelopmental (ND) services (ADHD MSE NE and West) is exceeding commissioned capacity, service has seen rapidly rising referrals leading to backlogs and extended waits. Current risk score 4x4=16.
- Service Demand exceeding capacity for Neuro Developmental services (Autism South and NE) Risk assessment has identified that demand for Neurodevelopmental (ND) services (Autism South and NE) is exceeding commissioned capacity, service has seen rapidly rising referrals leading to backlogs and extended waits. Current risk score 4x4=16.
- Emergent risk noted through the Finance & Performance Committee is the increasing backlog maintenance risk for the Trusts aging estate and hard to recruit Estate & Facility roles.
- 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. For note:
- SR12 Organisational Development – Audit of Employee Relations received reasonable assurance (Feb 2026).
- SR13 Quality Governance - Following completion of all actions a re-assessment is planned to review the score and to assess whether further controls / mitigations are required. Internal Audit reviewed CG structure process - received reasonable assurance Feb 26
- Corporate Risk register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

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

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

Acronyms/Terms Used in the Report

SR	Strategic Risk	CR	Corporate Risk
BCP	Business Continuity Plan		

Supporting Reports/ Appendices /or further reading

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

Lead



Paul Scott
Chief Executive Officer



Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

March 2026





Essex Partnership University
NHS Foundation Trust

Risk Dashboard

Mar-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

		Consequence				
		1	2	3	4	5
Likelihood	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%	5

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		Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	<p>ERIC and PAM oversight continues, with scheduled meetings to confirm progress and forward plans; no high or significant risks are currently identified. 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. Propose to move (PAM) to a control from 2026. Responsibilities relating to PAM are being allocated. Task and finish groups have been established, with completion expected by April 2026. ERIC submission: Scheduled for July 2026, supported by established task and finish groups.</p> <p>Expressions of interest have been submitted for NHS Property Services properties and lease agreed for enhanced training facilities.</p>
SR4	All	Demand and Capacity	AG	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=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.	<p>The PA consulting work regarding demand modelling is complete and has been shared with ICBs. Scenarios have been considered by the operational planning group. Out of Area trajectories for the planning submission are reflective of discussions informed by this work. Following ICB consolidation Essex ICB is now calculating the aggregate level of resource, including budgets transferred from other ICBs. This will inform the resource transfer and is being discussed as part of 26/27 contract discussions with a target to sign contracts by 31 March 2026. Both parties continue with firm unification intentions. The action has been rated as red due to being further extended until March 2026.</p> <p>New action identified for the Trust to hold the system to account for delivery of works, with a second workshop arranged to confirm timelines and governance for oversight.</p>
SR5	All	Statutory Public Enquiry	NL	Compliance, Reputation	4x4=16		Statutory Public Inquiry into Mental Health services in Essex (Lampard Inquiry)	<p>The Trust has recovered the backlog position in line with plan agreed with the Inquiry. The Trust is on track to deliver the open 17 Rule 9's and the 23 case summaries. However risk remains if the 45 Rule 9's and 7 thematic reviews are issued to the Trust in March as planned and with the 3 thematic rule 9's under discussion with the Lampard Inquiry team. The potential for further significant request to be made of the Trust for completion in very short period of time does need to be recognised and planned for by the Trust. Additional resource has been added to the Project Team.</p> <p>A number of staff have now received individual Rule 9s from the Lampard Inquiry. The requests are issued under a Restriction Order and therefore EPUT is not permitted to know the detail of these requests. Staff are able to say they have received one and agree capacity to comply. Staff are reminded of the legal provision provided for and that this is separate to the team representing EPUT as corporate body.</p>

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		The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	The audit has commenced, with recommendations expected in April 2026. The action plan remains on track for delivery by June 26.
SR7	All	Capital	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=20		Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	The Trust continues to horizon-scan for regional and national opportunities to secure capital investment and is actively pursuing additional external funding within the five-year plan from 2026/27 onwards, including £33m currently progressing through approval by (NHSE). The capital plan net SDT remains £12.5m below Month 10 spend, reflecting the impact of disposals, with £24m still to be utilised by Month 12 but fully committed to leases. The remaining programme includes £9.36m for external-funded schemes such as NOVA and urgent care centres, and £2.7m for local schemes, with estates, IT and procurement teams working to optimise delivery this year. NHSE has confirmed decoupling from Partnership Support Funding, enabling deficit support funding to flow. A plan realignment process covering the next three financial years is underway, with submission expected next week, which will complete this action.
SR8	All	Use of Resources	TS	Safety, Experience, Compliance, Service Delivery, Reputation	5x4=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 has been briefed on efficiency delivery, associated risks, and mitigating actions. As at Month 11, the Trust has delivered £25.9m in efficiencies, £2.5m behind plan year-to-date, improving to an expected £2.2m gap at year end against the full-year target of £31.3m. For 2025/26 financial planning, the Trust is reporting a £0.6m deficit at Month 11, £0.2m off plan, with the position strengthened by securing DSF in full alongside additional surge and inquiry funding. Despite this, the financial environment remains challenging, particularly given inquiry pressures and the establishment of the new audit team. A three-year revenue plan realignment is underway, aiming for a breakeven position in Year 1 supported by a stretching efficiency programme.
SR9	All	Digital and Data Strategy	ZT	Safety, Experience, Compliance, Service Delivery, Reputation	5x3=15		The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation	NOVA system integration and overall programme complexity has been assessed as a risk and a dedicated corporate risk register entry has been made for NOVA. Action timescale for the implementation of Phase 2 of the Digital Target Operating Model extended until June 2026.
SR10	All	Workforce Sustainability	AM	Staff Morale Skills Gap Workforce Sustainability	4x3=12		The risk of not being able to recruit and retain staff. Resulting in associated skills deficit, reliance on temporary staffing, impact on staff morale and quality of care provided to our service users.	The People Strategy Implementation Plan for 2025/26 continues to progress, with bi-monthly updates provided through the People Committee. The strategy is being refined, with a revised draft presented to the Executive Committee and People Committee in October 2025 and the final draft submitted to the People Committee in February 2026. A detailed implementation plan is in place, outlining objectives across the life of the strategy, with Board ratification expected in April or May 2026 subject to agenda availability. Enhanced People & Culture governance arrangements have now been established, with clear terms of reference and reporting lines agreed. A new action ensure adherence to the Workforce Plan for 2026/27 as part of the operational planning process, covering both substantive and temporary workforce requirements. This will include strengthened recruitment controls particularly for non-clinical roles, alongside actions to support safer staffing, reduce reliance on temporary and corporate agency workers, and lower medical vacancies from the current consultant vacancy level of 22 WTE.

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		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.	<p>A quarterly retention report has been completed and will be presented to the Executive Team and People Committee on 30 April 2026. Exit interviews continue to be manager-led, with refreshed prompt questions, scripts and guidance now in place, and updates to the Managers' Handbook to follow. The Staff Experience intranet pages are being redesigned so that all retention resources, tools and quarterly reports are available in a single, dedicated space. The Recruitment and Retention Policy (HR57) is scheduled for review in December 2026, with the Head of Resourcing briefed to include strengthened retention elements.</p> <p>Proposals to enhance the induction experience—drawing on learning from other NHS trusts—will be considered at an upcoming Executive Team meeting, with trials underway through March 2026. These developments are incorporated within the retention report (Action 7), and further work is planned to improve local induction processes following corporate induction to ensure a consistently positive new-starter experience. Alongside this, engagement with staff networks is supporting the co-creation of a strengthened Trust-wide engagement model, ensuring representative staff voices that champion improvement, support local teams and enhance staff experience.</p>
SR12	All	Organisational Development	AM	Staff Morale Skills Gap Workforce Sustainability	4x4=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.	<p>Delivery has commenced with BRAP and The King's Fund commissioned to undertake a Trust-wide culture review, delivered in three phases: orientation (September–November 2025), discovery (December–January), and deep-dive research across three sites—Brockfield House, North Essex inpatient services, and West Essex community services—along with the Senior Leadership Group (February–April). A Board seminar is proposed for May 2026 to present findings and outline next steps, including the pilot leadership programme. To date, 525 colleagues have been trained across Specialist Services, inpatient settings in Basildon, and within the leadership team. Twenty cascade trainers have been identified, and staff survey benchmarking is being used to determine the next areas for rollout. Action completed.</p> <p>New actions 10–14: Capturing the phases of strategy delivery.</p>
SR13	All	Quality Governance	AS	Safety Effectiveness Experience Regulator	5x3=15		Government Led Inquiry; Trust and Confidence in our services; Adverse regulatory inspection outcomes.	<p>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.</p> <p>Action Complete</p>



Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
2	1	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			CRR 2598	
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		Implementation of suicide prevention strategy	The Quality of Care Group has received the Q3 report which highlighted: increase in suicide deaths in community pathways, risks re Neurodiversity assessment waiting times, non fixed ligature prevalence on inpatient wards and winter demand pressures impactinf flow. Year 2 priorities have continued to be taken forward including; A full project plan is in development for the move from risk stratification to Safety Planning. STORM training compliance has increased to 78% for all urgent care clinicians. Increase in ligature incidents this quarter. Quality improvements projects have continued to be taken forward. Seeing reduction in out of area placements.
CRR 2598	All	Nova Programme	ZT	Safety, Quality, Service Delivery, Reputation	4x4=16		Potential for implementation delays, system integration issues, technical challenges	New Risk System list socialised and being reviewed through programme governance. Design and build underway Recruitment process for Nova Director of Operations

Strategic Risk Register

March 2026

SR3- Finance and Resources Infrastructure

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 C5 x L3 = 15	Current Risk Score C5 x L3 =15	Target Score C5 x L2 = 10	Note 1: 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 Note 2: Consideration to close Action 8, moving PAM to a control from 2025.		
Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance & Performance Committee		Controls Assurance			
Key Controls		Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
EPUT Strategy		EPUT Strategy (approved Jan '23) Estates Strategy (Board approved)	Finance and Performance Committee Report (update 2 x year)		
Operational Target Operating Model		Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework		
Estates and Facilities, Contracting and Business Development, Finance Teams		Established Support services	PMO support in place reporting to Executive Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)	
Range of corporate, finance policies		Policy Register and procedures in place	Accountability Framework		
PMO, Capital Programme, E-expenses system,		Capital Steering Group	Capital Planning Group		
Audit Programme and ISO			Audit Committee		
Premises Assurance		Operational meetings for PFIs ERIC and PAM Groups Established	Premises Assurance Model in place with assessment		
6-Facet Survey		Review of core premises undertaken through the Estates Strategy	6- Facet Survey completed	6-Facet Survey	
Business Continuity Plans		Business continuity plan in place - updated to reflect changes relating to asbestos, fire, water, and electrical safety.			
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. 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. Propose to move (PAM) to a control from 2026, Responsibilities relating to PAM are being allocated. Task and finish groups have been established, with completion expected by April 2026. ERIC submission: Scheduled for July 2026, supported by established task and finish groups.
9	Expression of interest for NHS Property Services Properties	Mar-26	MM	Control	Expression of interest submitted with data packs to be received and considered for formal business cases
10	Enhanced Training Facilities	Mar-26	MM	Control	Lease agreed at F&P under delegated authority from the Board. Enabling enhanced facilities for the Trust and system partners. It will also improve clinical space availability through phase 2 and 3 developments.

SR4- Demand and Capacity

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 <i>C5 x L4 = 20</i>	Current Risk Score <i>C5 x L3 = 15</i>	Target Score <i>C5 x L3 = 15</i>	<p>Note 1: Previous reported completed actions 1-6, 8-12 have been removed from the report. Note 2 : See new action 13a recognising system partner accountabilities for delivery Note 3: Undertaking analysis of Trend over time for length of stay occupancy, OOA placements and proportion of mental health act detainees - this will inform the current risk score and enable assessment of further actions to mitigate the risk and arrive at a new target score.</p>		
Executive Responsible Office: Executive Chief Operating Officer Board Committee: Finance and Performance Committee		Controls Assurance			
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)		
Operational staff integrated flow team including Discharge Co-ordination Teams, Clinical Patient Flow Leads, Clinical Director for Flow & Capacity, Associate Director for Flow, Bed Management Team	Flow & Capacity Staffing Established (Fully Established)				
Care Unit Leadership	Fully Established	Accountability Framework Meetings provide oversight to operational progress (to provide an assessment outside of AF)			
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				

Key Controls		Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Target Operational Model			Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability		
Community First Transformation Programme 4 key work streams					
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 March 26	SC/JW	Control	The PA consulting work regarding demand modelling is complete and has been shared with ICBs. Scenarios have been considered by the operational planning group. Out of Area trajectories for the planning submission are reflective of discussions informed by this work. Following ICB consolidation Essex ICB is now calculating the aggregate level of resource, including budgets transferred from other ICBs. This will inform the resource transfer and is being discussed as part of 26/27 contract discussions with a target to sign contracts by 31 March 2026. Both parties continue with firm unification intentions. Red RAG rated because of further extension(next touch point end of March 2026)
13	Demand and Capacity Length of Stay Programme Internal(EPUT)	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.
13a	Demand and Capacity Length of Stay Programme (System) EPUT to hold the system to account for delivery	Ongoing		Control	New action: Trust to hold the system to account for delivery of works 2nd workshop to confirm timelines & governance for oversight Action plan contains 7 themes with 25 agreed actions for system partners
14	Community demand and capacity work stream initiated	Complete	AS	Road Map	Community First Programme initiated - moving to delivery phase.
15	Deliver Community First Programme	Sept '26	AS	Control	Demand and capacity modelling for community mental health services is showing increasing demand relative to available workforce capacity. The workstream is using national guidance in reviewing caseloads, professional staffing capacity to align to demand, which will support service redesign, with the aim of ensuring safe and timely access to community mental health care. The first part of this work involves the offer for assertive outreach patients and a proposal for patients with complex emotional needs will be presented to the Executive Team in 2 weeks time and both of these components will support the wider Community First model. The Community First programme update will be presented the Executive Team on 27th April 2026.

SR5 - Statutory Public Inquiry

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 <i>C5 x L4 = 20</i>	Current Risk Score <i>C4 x L4 = 16</i>	Target Score <i>C4 x L2 = 8</i>	Note 1: Previous reported complete actions 1-7, 9 & 10 have been removed from the Board report. Note 2: The continued significant number of Rule 9 requests from the Inquiry in the period challenging our capacity. Note 3: S21 notice issued in respect of one Rule 9 response was complied with.
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Executive Responsible Office: Executive Director Major Projects Board Committee: Audit Committee	Controls Assurance
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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	Internal audit.
Management Development Programme (Inquiry Module)	<i>Note first session 25 April 2025</i>		

Actions (to modify risks)	By When	By Who	Gap	Update	
8	Rule 9 progress	Extended June '27 (Lampard Inquiry extended to this timeline)	CBD	Assurance	<p>The scale and pace of Rule 9 requests has significantly increased (2025: Q1 - 26; Q2 - 2; Q3 - 25; Q4 - 66) (2026: Jan/ Feb and March to date - 68, plus 49 case summary reviews). In response to the rising demand in Q3 2025, additional resources were mobilised, we did underestimate the rise in Q4 and a backlog was created necessitating discussions for extensions with the Inquiry. The Inquiry being concerned of EPUTs ability to deliver against the significant requests it had sent, held discussions with the Trust. Following discussions the Inquiry issued revised timelines based on their priorities and advised of the forward plan of requests to come (these being 50 further documentary / information rule 9s, 10 substantive thematic Rule 9's and between 20 - 65 cases summaries to be issued to the Trust in March with 3-4 week turnaround timelines). We have increased the resource further with additional staff from internal transformation team, corporate clinical teams, support from PWC coming on board by 01 April 2026 and increased our legal support from Browne Jacobson, and utilising barristers to support the thematic reviews.</p> <p>In terms of progress: We have to date (19 March 2026) met the revised timelines set out in correspondence on the 5 March 2026. From Jan - YTD we have submitted 93 Rule 9 responses. And, 26 phase one case summaries by their original stated timelines. There are a further 8 Rule 9's due submission in March 2026 and 12 due in April 2026 (with 3 being discussed with the Lampard Inquiry Legal Team).</p> <p>Situation Report on the Inquiry list: Up to the 19 March 2026 we have received 5/50 Rule 9's and 3/10 Thematic Reviews and 23 phase 2 Case summary reviews. All with timelines for submission between now and the 21 April for delivery.</p> <p>In summary, we have recovered the backlog position in line with plan agreed with the Inquiry. We are on track to deliver the open 17 Rule 9's and the 23 case summaries. However risk remains if the 45 Rule 9's and 7 thematic reviews are issued to the Trust in March as planned and with the 3 thematic rule 9's under discussion with the Lampard Inquiry team. The potential for further significant request to be made of the Trust for completion in very short period of time does need to be recognised and planned for by the Trust.</p>
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 '26	DG	Control	<p>We have increased the resource:</p> <ul style="list-style-type: none"> - Increased legal support from Browne Jacobson - Increased PMO support from our internal Transformation Team (Note: this will have an impact on clinical transformation programmes) - Adding four clinicians and corporate services - Bringing in external support from external consultancy firm <p>Additional resource financial impact will be updated at year end.</p>
12	Ensure all staff receiving individual Rule 9 requests from the Inquiry are reminded of the legal support available to them. And, facilitate time (supported with backfill) for the individuals to comply with the request.	June '27	CBD	Control	<p>A number of staff have now received individual Rule 9s from the Lampard Inquiry. The requests are issued under a Restriction Order and therefore EPUT is not permitted to know the detail of these requests. Staff are able to say they have received one and agree capacity to comply. Staff are reminded of the legal provision provided for and that this is separate to the team representing EPUT as corporate body.</p>

SR6- Cyber Security

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 C5 x L4 = 20		Current Risk Score C3 x L5 = 15		Target Score C4 x L3 = 12		Note 1: Previous reported completed actions 1 - 10 have been removed from the report.						
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 England 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 England 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 England Data Security Centre, Penetration Testing,			
CareCert notifications from NHS England Cyber Alerts				Monitored and acted upon within 24 hours of their announcement		Reported to IGSSC			NHS England			
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		
11		Deliver against DSPT CAF assurance plan to reach standards met.		30-Jun-26		AW		Assurance		The audit has commenced, with recommendations expected in April 2026. The action plan remains on track for delivery.		

SR7- Capital

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 maintenance) compared to capital resource availability. Cash : levels of 5 working days

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

Initial Risk Score C5 x L4 = 20	Current Risk Score C5 x L4 = 20	Target Score C5 x L3 = 15	Note 1: Previously report completed actions 2 - 4 have been removed from the report. Note 2: Actions 6 and 7 are now complete and will be removed from future reports.		
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	Continue to seek additional external funding within the plan submitted, which covers the five-year period from 2026/27 onwards. This includes £33 million in external funding to be processed by NHSE for approval.
5	Delivery Capital Plan 2025/26	Apr-26	JD	Control	Capital plan net SDT is £12.5 million less than spent at Month 10, with the variance impacted by the number of disposals. £24 million remains until Month 12 but is allocated to leases. The remainder includes £9.36 million within the external funding scheme covering NOVA and urgent care centres and £2.7 million for local schemes. Work continues with estates, IT, and procurement teams to maximise spend for this financial year.

Actions (to modify risks)		By When	By Who	Gap	Update
6	Discussions with NHSE to decouple Deficit Support Funding.	March '26	TS / NHSE	Mitigation	NHSE has confirmed that we are now decoupled from Partnership Support Funding, meaning deficit support funding will be issued. This completes Action 6 once the realignment plan has been submitted.
7	Address underlying financial deficit and financial sustainability	Ongoing	Exec Team	Mitigation	A plan realignment submission has been completed, planned return to underlying financial balance over next two financial years.

SR8 - Use of Resources

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 <i>C5 x L4 = 20</i>	Current Risk Score <i>C5 x L4 = 20</i>	Target Score <i>C5 x L3 = 15</i>	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 Note 3: Previous Internal Audit opinions have been replaced with reasonable assurance for 2026, demonstrating progress from earlier limited assurance ratings.	
Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: Finance and Performance Committee		Controls Assurance		
Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)	
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment IA Core Financial Assurance (2024/25) Substantial Assurance Opinion IA Payroll including Salary Overpayments (2024/25) - Reasonable Assurance opinion	Use of Resources NHSE Assessment Financial Assurance received substantial assurance (Feb 2026)	
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 - Reasonable Assurance (Nov 25) opinion. IA Consultant Job Plans - Reasonable Assurance (Feb 26) opinion.	
Estates & Digital Team (Response to new resource bids)	Team in place			
Deliver efficiency savings and targets 25/26		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	Multi disciplinary 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 Opinion F&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	As at M11, Trust successfully delivered efficiencies of £25.9m. YTD behind plan by £2.5m, reducing to £2.2m at year end against full year plan of £31.3m.
6	Deliver Financial plan for 25/26	Mar '26	TS	Control	At M11, £0.6m deficit which is £0.2m off plan. Successfully secured DSF in full for year which has improved position. However, position remains challenging in terms of extensive inquiry resourcing and associated costs. Plan realignment submission made for 3 year revenue plan with breakeven position Yr1 and Yr2 with challenging high level efficiency programmes.

SR9 - Digital and Data Strategy

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 C5 x L3 = 15	Current Risk Score C5 x L3 = 15	Target Score C5 x L2 = 10	Note 1: Previously reported complete action 1-10 have been removed from the report.	
Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Board Committee: Finance and Performance Committee			Controls Assurance	
Key Controls		Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Resources				
IT/Digital team Resource and skill set is appropriate and sustainable		Education and training in specific technology Target operating model - modernise digital services	Digital strategy resource management (RAID Log)	
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.		CCIO/CNIO oversight		
Strategies & Policies				
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures		Information governance controls processes	Information Governance Steering Sub-Committee reporting and assurance	Data Security and Protection toolkit assessment (Standards Met)
Data quality is of a standard that assures national standards.		Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT "standards met" can be achieved			Internal Audit	DSPT submission and Cyber assurance framework
Investment				
Capital allocation to digital and data initiatives secured		Approved Digital capital plan		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes		Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation				
The space and governance exists to support innovation		CIO discover opportunities from national forums and partners (incl. Academic)	Innovation strategy governance - Strategy Steering Group	
Academic partnerships promote innovation		CIO engagement with academic partners on digital innovation opportunities		

Actions (to modify risks)		By When	By Who	Gap	Update
11	Digital Target operating model implementation - phase 2	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 continues to make good progress. Through ongoing programme review and assurance activity, a new potential risk relating to system integration and overall programme complexity has been identified and entered onto the Trust Corporate Risk Register.

SR10: Workforce Sustainability

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

Likelihood based on: Staff turnover, temporary staff usage and EPUT ability to provide career pathways

Consequence based on: Staff morale (staff survey results), skills gaps and identified quality of care risks associated with workforce sustainability.

Initial Risk Score C4 x L4 = 16	Current Risk Score C4 x L3 = 12	Target Score C4 x L3 = 12	Note 1: Previously reported completed actions 1 - 5 have been removed from the report. Note 2: Action 7 & 8 are now complete and will be removed from future reporting Note 3: Consider reducing score due to vacancy rate has reduced from 12 to 9 Note 4: New Action 9 capturing the Workforce planning for 26/27
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Executive Responsible Office: Executive Director People and Culture

Director Lead: Paul Taylor

Board Committee: People Equality and Culture

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
People 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).	
Recruitment Plan	People and Culture Group	Executive Team	Essex ICB People Board & NHSE oversight
People and Culture Governance	People and Culture Group	Executive Team	People Committee
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 Strategy Implementation Plan 2025/26	March '26	Executive Director of People and Culture	Assurance	There are currently bi-monthly updates through People Committee. Reviewing and refining strategy with presentation of revised draft at Executive Committee and People Committee in October 2025 with final draft provided to People Committee in February 2026. Strategy implementation plan has also been developed with objectives described over the course of the strategy. It is expected that strategy will be ratified at Board in either April or May 2026 depending on agenda availability.

Actions (to modify risks)	By When	By Who	Gap	Update
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 25	Executive Director of People and Culture	Assurance	The new People & Culture governance arrangements are in place with clear terms of reference for all the groups created and reporting lines agreed and shared with Executive Committee and People Committee.
8 Delivery the Trust Recruitment Plan.	Dec-25	Associate Director of People - Resourcing	Assurance	Recruitment Strategy approved at People committee 18/12/2025 with measures and updates provided monthly to the new People & Culture Group as part of the new governance arrangements.
9 New Action: Adherence to the Workforce Plan for 26/27 as part of the overall Operational Planning process.	Mar-27	Executive Chief People Officer	Assurance	These actions are associated to the substantive workforce and the temporary workforce plans. In terms of the substantive staffing plan this will required enhanced controls around recruitment with an emphasis on the non-clinical workforce. In terms of the temporary workforce and achieving the plan this will be based on recruitment alongside safer staffing, oversight of observations, reduction in corporate temporary staff and a reduction in medical vacancies from the position of consultant vacancies at 22wte.

SR11: Staff Retention

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

Likelihood based on: Staff turnover, temporary staff usage and EPUT ability to provide career pathways

Consequence based on: Staff morale (staff survey results), skills gaps and identified quality of care risks associated with workforce sustainability.

Initial Risk Score C4 x L4 = 16	Current Risk Score C4 x L3 = 12	Target Score C4 x L3 = 12	<p>Note 1: Previously reported completed actions 1 - 5 have been removed from the report.</p> <p>Note 2: Both actions 7 & 8 have been extended for final part of actions</p> <p>Note 3: New action 11 capturing the new 'workforce ambassador' model</p>		
<p>Executive Responsible Office: Chief People Officer Director Lead: Director of OD and Culture Board Committee: People Equality and Culture</p>		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 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	A quarterly retention report has been completed and will be presented at the Executive Team and People Committee on 30 April 2026. Exit interviews are led by managers and the prompt questions have been refreshed alongside a script and guidance. The managers handbook will be updated to reflect these changes in due course. The Staff Experience Intranet is under review and all resources and tools will be clearly available on a dedicated page alongside the quarterly reports. The recruitment and retention policy HR57 is next due for review in December 2026 by the head of resourcing who has been informed that retention elements will need review.
8	Delivery of People Promise objectives with an emphasis on new starter experience.	Extended April '26	Director of OD & Culture	Assurance	Proposals for strengthened and improved induction experience will be presented to an upcoming Executive Team with trials in place through march 2026. This will work will be included in the above retention report (See action 7). These proposals are based on research from other NHS Trusts. Further work is required for local induction processes that follow corporate induction to ensure that new starter experience is enhanced.

Actions (to modify risks)		By When	By Who	Gap	Update
11	Develop a revised staff engagement champions model to a 'workforce ambassador' model that connects the senior leadership of the organisation with the operational care units and corporate teams.	Oct-26	AD of OD & Culture	Assurance	Alongside the staff networks, engagement and co-creation of a new model of engagement with staff is being developed, ensuring representation and a voice across the Trust that can champion, help improve staff experience and act as an relational link between the care units, corporate teams and leadership.

SR12: Organisational Development

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

Likelihood based on: limitations of workforce plans that support recruitment and development leading to workforce sustainability

Consequence based on: Staff Survey (culture indicators) and identified quality of care risks associated with workforce sustainability.

Initial Risk Score C4 x L4= 16	Current Risk Score C4 x L4= 16	Target Score C4 x L3 = 12	Note 1: Previously reported completed actions 1-7 have been removed from the report. Note 2: New actions 10-14: Capturing phases of delivery of strategy Note 3: Action 9 Complete and will be removed from future reports Note 4: Employee relations IA findings added to the controls assurance
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Executive Responsible Office: Executive Director People and Culture Director Lead: Director of OD and Culture Board Committee: People Committee	Controls Assurance
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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 People Committee by Director of OD & Culture.	
People Strategy	Oversight by Learning & Education Group	Oversight by People committee and approved by Board of Directors January 2024	
Key performance indicators.	Workforce Efficiency Group	Oversight by People Committee and Board within the Integrated Performance Report	Audit of Employee Relations received reasonable assurance (Feb 2026)
OD Practitioners Partnership			

Actions (to modify risks)		By When	By Who	Gap	Update
8	Initiate and deliver Trust-wide Culture review.	Extended May-26	Director of OD & Culture	Assurance	Delivery has commenced with BRAP and King's Fund commissioned to undertake a Trust-wide culture review, set out in three phases - orientation (September to November 2025), discovery (December to January) and three research site deep dives across North Essex inpatient services, West Essex Community services and the Senior Leadership Group (February to April). Board seminar proposed for May 2026 to outline the culture review findings and next steps with the pilot leadership programme.
9	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	Nicky Reeves	Assurance	525 colleagues have now been trained across Specialist Services (Brockfield House), inpatient settings (Basildon) and a number of the leadership team. We have currently identified twenty cascade trainers, and work is underway to use staff survey benchmarking to determine the next areas in which the programme will be implemented. Action completed.
10	New Action: Deliver the Senior Leadership Development Programme pilot with the King's Fund/brap	Aug-26	Director of OD & Culture	Assurance	Following the culture review, a pilot senior leadership programme will be initiated for 30 colleagues from the three research sites. Action leads to Action 13

Actions (to modify risks)		By When	By Who	Gap	Update
11	New Action: To develop 3 year development plans that highlights talent mapping and support succession plans for each Care Unit as well as corporate teams.	Mar-27	Director of OD & Culture	Assurance	The OD & Culture team will work closely with care unit and corporate management teams to develop 3 year succession plans for development. This will start in Q4 (25/26) with nominations for the King's Fund/brap programme with engagement continuing with care units/corporate teams in Q1/2 (26/27) to develop 3-year talent and succession plans.
12	New Action: The introduction of revised EDI plan with review of objectives for Executive Directors and reviewed focus on EDI staff networks.	Dec-26	Director of OD & Culture	Assurance	The Executive have been provided with new areas for EDI objectives in February 2026 that includes implementation of reciprocal mentoring and revised focus on EDI responsibilities. The role of staff networks are also being reviewed with clearer focus and measurable outcomes as part of a wider review of the Trust strategy on Equality Diversity and Inclusion.
13	New Action: Deliver the Senior Leadership Development Programme with the King's Fund/brap for a further 60 colleagues, based on the culture review findings and pilot leadership programme.	Oct-26	Director of OD & Culture	Assurance	Service specification currently being co-developed with the King's Fund/brap with support from an internal steering group. Nomination forms and a talent mapping process will be undertaken to establish the first cohort starting in Autumn 2026.
14	New Action: To develop a mid manager and aspirant leadership programme.	Mar-27	Director of OD & Culture	Assurance	It is expected that a new aspirant and middle manager development programme, funded by a proportion of the apprenticeship levy will be implemented by March 2027 and delivered alongside partners at Anglia Risking University.

SR13 - Quality Governance

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 <i>C5 x L4 = 20</i>	Current Risk Score <i>C5 x L3 = 15</i>	Target Score <i>C5 x L2 = 10</i>	<p>Note 1: Previously reported completed actions 1-8 have been removed from the report.</p> <p>Note 2: Following completion of all actions a re-assessment is planned to review the score and to assess whether further controls / mitigations are required.</p> <p>Note 3: Seeking to include any clinical audits that have reported outcomes</p>
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Executive Responsible Office: Executive Chief Nurse Board Committee: Quality Committee	Controls Assurance
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Key Controls	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) identified high level diagnostic safeguarding practice with the aim of integrating coherent governance & training system across partnership working
Patient Safety Incident Management Team	Team Established		IA PSIRF - received Reasonable assurance received May 25
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. IA reviewed CG structure process - received Reasonable assurance Feb 26
Learning Collaborative Partnership	Forum attendance and effectiveness review. Quarterly Learning events		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	Reviewing dashboards from IPR - key quality measures to focus on metrics to support patient outcomes		
Clinical staff mandatory and essential training	Training tracker and reports	Training reports to PECC	CQC inspection reports 2024 - 2025 for Clifton Lodge, Brockfield House and Adult MH Inpatients and PICU provided positive assurance.
ESLMS			

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Patient Incident Response Plan			IA Falls Management (2024/25) Reasonable Assurance opinion IA Recording and Monitoring of Therapeutic Observations (2024/25) Reasonable Assurance opinion IA Care Plans and Risk Assessments (2024/25) Reasonable Assurance opinion
Quality Governance Policy, Guidelines and SOPs	Register Monitoring		IA Compliance with policies - Site Visits (2024/25) Reasonable Assurance opinion. IA Board Assurance and Risk Management – Substantial Assurance opinion. Audit of Clinical Governance Arrangements received reasonable assurance (Feb 2026) Audit of safety plans - received reasonable assurance (Feb 2026)
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.	Complete Feb 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. Action complete.

Corporate Risk Register

March 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 C4x L4 = 16	Current Risk Score C4 x L3 = 12	Target Score C4 x L2= 8	Note 1: Previous reported completed actions 1 - 5 have removed from the report for CRR11.		
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	Tenable 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 of Care Group has received the Q3 report which highlighted: increase in suicide deaths in community pathways, risks re Neurodiversity assessment waiting times, non fixed ligature prevalence on inpatient wards and winter demand pressures impactinf flow. Year 2 priorities have continued to be taken forward including; A full project plan is in development for the move from risk stratification to Safety Planning. STORM training compliance has increased to 78% for all urgent care clinicians. Increase in ligature incidents this quarter. Quality improvements projects have continued to be taken forward. Seeing reduction in out of area placements.	

CRR 2598 - Nova Programme

If the Nova programme is not delivered successfully then this may result in implementation delays, system integration issues with existing and third party systems, technical challenges and difficulties in managing change, leading to operational disruptions, inefficiencies, reduced stakeholder confidence and increased staff resistance. The organisation will remain on the current systems and will not realise the expected clinical and productivity benefits.

Additional reputational damage due to negative stakeholder perception, financial loss from increased costs and resource inefficiencies. Additionally, failure to transition effectively from legacy systems could compromise the delivery of safe, efficient, and responsive patient care, potentially affecting clinical outcomes and compliance with regulatory requirements at the trust and through its work with partners.

Likelihood based on: the likelihood of the Nova programme to achieve its agreed milestones and outcomes according to programme RAG status: 5 = Red programme status and programme go-live dates not recoverable; 4 = Red programme status with recovery plans to achieve go-live dates, 3 = amber programme status, 2 = Green programme status; 1 = Green programme status with go-live decision approved.

Consequence based on: Quality, effectiveness and safety of clinical/patient outcomes, compliance to the business case, contractual commitments, financial sustainability and benefits realisation.

Initial Risk Score C4 x L4 = 16	Current Risk Score C4 x L4 = 16	Target Score C4 x L2 = 8	Note 1: Initial assessment of a new Corporate Risk for the Nova programme	
Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Director Lead Board Committee: ET Week 1 & 3 and Joint Steering Board (JSB)			Controls Assurance	
Key Controls	Level 1	Level 2	Level 3	
Governance and Assurance	Established governance framework with supplier representation embedded in core meetings Reporting and assurance process embedded Nova Implementation Group Design Authorities CODA and TDRA	Exec oversight through ET week 3 Regular SRO, CEO and Senior Oracle Health meetings Nova Joint Programme Board and Nova Joint Steering Board	Quarterly assurance reviews with NHSE and ICB on all Nova risks DHA assurance partner oversight Strategic Delivery Partner engagement	
Financial Controls	Defined accounting treatments embedded into programme processes Ongoing revalidation of the Business Case Regular financial monitoring Finance oversight Finance risk and assurance reviews Nova Implementation Group	Nova Joint Programme Board and Nova Joint Steering Board	Independent specialist/audit advice sought when required DHA assurance partner oversight	

Key Controls	Level 1	Level 2	Level 3
First-of-Type	<p>Established Mental Health, Community Care and Community & Mental Health PAS workstreams</p> <p>Unification Governance and dependencies with Acute work streams.</p> <p>Design Authorities CODA and TDRA</p> <p>Weekly Nova Change Control Group</p> <p>Weekly Nova Configuration Change Group</p> <p>Nova Implementation Group</p>	Nova Joint Programme Board and Nova Joint Steering Board	<p>DHA assurance partner oversight</p> <p>Strategic Delivery Partner engagement</p>
Clinical Digital Safety	<p>Clinical Safety Officers (CSOs) engaged in workstream development</p> <p>Ongoing training for additional CSOs to help ensure the system remains safe</p> <p>Regular review of robust Hazard Log</p> <p>Nova Clinical Safety Officer Working Group</p> <p>Design Authority CODA</p> <p>CCIO/CNIO oversight of workflow assurance</p> <p>Nova Implementation Group</p>	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Change and Engagement	<p>Change and Engagement Pillar governance</p> <p>Communication Strategy and plan in place</p> <p>System partners and GP engagement</p> <p>Regular communications across the Trusts including regular slot on All Team Briefing and Senior Leader meetings</p> <p>Design Authority CODA</p> <p>Nova Implementation Group</p>	Nova Joint Programme Board and Nova Joint Steering Board	DHA assurance partner oversight
Resourcing	<p>Clear forward planning for operational staffing identifying required roles, skills and backfill</p> <p>Nova Implementation Group</p>	<p>Weekly Exec forums for escalations and concerns including resourcing</p> <p>Nova Joint Programme Board and Nova Joint Steering Board</p>	<p>Regional Team oversight</p> <p>DHA assurance partner oversight</p> <p>Strategic Delivery Partner support</p>

Key Controls		Level 1		Level 2		Level 3	
Nova Strategy and Planning		Pillar strategies approved with delivery objectives in plan Domain plan assurance into Nova Implementation Group Nova Implementation Group		Nova Joint Programme Board and Nova Joint Steering Board		DHA assurance partner oversight	
Actions (to modify risks)		By When	By Who	Gap	Update		
1	The scope of the systems to be replaced or integrated requires sign off between the trusts and Oracle health and approval through Nova governance	01/05/2026	CIO	Control	System List socialised and being reviewed through programme governance, including CCIO/CNIO/CIO		
2	Complete design and build for localisation which incorporates workflows and tests scripts being fully approved	27/07/2026	PD	Control	Design and build underway		
3	Strengthen EPUT operational leadership by appointing a Nova Director of Operations who will further support programme delivery	12/06/2026	PD	Control	Recruitment process in progress with advertisement published		
4	Additional staff resources to be released to support programme delivery	27/07/2026	CEO	Control	Weekly executive escalation meetings established and reviewing additional staffing resource requests		
5	Baseline and regularly monitor the programme plan to ensure key milestone dates are achieved, and that any changes are formally agreed with full understanding of associated impacts prior to approval	30/11/2026	PD	Control	Fortnightly reviews with the programme team of the baselined programme plan are in place		

Risk Movement

March 2026

EPUT

Risk Movement and Milestones

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

Risk ID	Initial Score	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	Feb 26	Mar 26	
SR1	20	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	15
SR4	20	20	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
SR5	20	20	15	15	15	15	15	15	15	8	8	8	16	16	16	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	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	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	20
SR9	20	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
SR10	16								New	16	12	12	12	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	12	12	12
SR12	16								New	16	16	16	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	15	15	15

Risk Movement and Milestones

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

Risk ID	Initial Score	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	Feb 26	Mar 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	12
CRR45	12	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	8																	
CRR81	12	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									
CRR93	15	15	15	15	15	15	15	15	15	10																	
CRR94	16	20	20	20	20	20	20	20	20	10																	
CRR98	20	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12										
CRR2598	16																								New	16	

8.2 END OF LIFE ANNUAL REPORT 2024-25

● Decision Item

AS

REFERENCES

Only PDFs are attached

 End of Life Annual Report 2024-25 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 2026	
Report Title:		End of Life Annual Report 2024-25				
Executive Lead:		Ann Sheridan, Executive Nurse				
Report Author(s):		Tracy Reed, Clinical Lead End of Life Care				
Report discussed previously at:		End of Life Sub-Committee, Quality of Care Group and Quality Committee				
Level of Assurance:		Level 1	✓	Level 2		Level 3

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	✓	
	SR4 Demand/ Capacity		
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		
	SR13 Quality Governance	✓	
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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 an update on ongoing actions and the quality of care linked to the Trust's 2024 - 25 End of Life Care priorities. It outlines progress against local and national guidance, supports monitoring of the End of Life Care work plan and framework, and offers assurance on the delivery of End of Life Care services.	Approval	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Note the contents of the report
- Approve the report
- Request any further information or action

Summary of Key Issues

The report provides an overview of work undertaken by services supporting people at End of Life and in the last days of life. End of Life Care received an ‘Outstanding’ rating from the Care Quality Commission (CQC) in 2019, and services continue to strive for and uphold this standard. Internal compliance visits took place in 2025 and, during preparation of this report, the CQC also visited several community wards. Findings have not yet been received and are therefore not included.

Throughout late 2024 and into 2025, services continued to adapt and redesign care pathways to deliver the best possible outcomes for people at End of Life, regardless of diagnosis, service, or care setting, with a focus on care closer to home. Community health services continue to see an increase in individuals identified as End of Life and dying at home, as more people present later in their illness. The use of Frailty, End of Life and Dementia (FrEDA) templates has also contributed to increased recognition of deaths associated with dementia and frailty.

In September 2024, a new national process was introduced whereby all deaths are reviewed by a Medical Examiner. This supports both the Coroner and the production of death certificates, replacing the previous requirement for a patient to have been seen by a doctor within 28 days of death. This significant change has required updated staff competencies, team support, and revised guidance. The process has strengthened system-wide learning from deaths and partnership working. Staff have adapted well, although there has been an increase in late presentations of people who are actively dying and who may not have been seen by services previously, including primary care.

The report includes findings from both Trust-wide and national audits related to End of Life Care outcomes. This year, EPUT contributed to the National Audit of Care at the End of Life (NACEL) for community adult services, including a new component assessing mental health services. NACEL 2024 findings have been incorporated into the report; NACEL 2025 results are expected later in 2026. Community audit results for 2025 are also included.

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			
CHS	Community Health Services	EoLC	End of Life Care
HPAL	Digital electronic platform for palliative care information	PPC	Preferred Priorities for Care
ICB	Integrated Care Board	ESNEFT	East Suffolk and North Essex NHS Foundation Trust
ICS	Integrated Care Services	PCN	Primary Care Network
LPA	Lasting Power of Attorney for health and welfare	EPaCCs	Electronic Palliative Care Co-ordination system
MEO	Medical Examiner's Office	TEP	Treatment Escalation Plan
MDT	Multi-disciplinary Team	NHSI	NHS Improvement National collaborative
GSF	Gold Standards Framework	PPD	Preferred Place of Death
GP	General Practitioner	NACEL	National audit care at end of life
PEACE	Proactive Enhanced Advance Care Plan	VOED	Verification of expected death
EPUT	Essex Partnership University NHS Foundation Trust	CQC	Care Quality Commission
STaRS	Specialist Treatment and Recovery Service	Datix	Electronic risk management incident reporting system
NCEPOD	National Confidential Enquiry into Patient Outcome and Death Audit	DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment	NICE	National Institute for Health and Care Excellence

Lead
 <p>Ann Sheridan Executive Nurse</p>



Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

*END OF LIFE ANNUAL REPORT
2024-25*

EPNHS

**ESSEX PARTNERSHIP
UNIVERSITY
NHS FOUNDATION
TRUST**

**END OF LIFE
ANNUAL REPORT**

Nov 2024 – Nov 2025

Report prepared by:

Tracy Reed and Alison Drew
Clinical Leads, End of Life Care

Dr Fiona McDowall
Old Age Psychiatrist

Prepared: December 2025



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PURPOSE

The purpose of this report is to ensure that the services across Essex Partnership University NHS Foundation Trust – (EPUT) are measurable against local and national guidance. This report will provide an update for quality of care and the ongoing actions linked to the agreed

priorities for end of life care across EPUT. The end of life care subcommittee monitor quality through the Trust end of life care work plan and framework and this report supports the progress reporting as assurance to the Quality of Care Group and Board.

INTRODUCTION

There were 568,613 deaths registered in England and Wales in 2024, this was a decrease of 2.2% from the previous year. With Dementia and Alzheimer’s disease continuing to be the top leading cause of death these were registered as 68,273 of deaths (12.1% of all deaths which is an increase from 11.6% in previous year).

End of life care seeks to enhance quality of life in the face of death by addressing physical, psychological, social and spiritual needs of patients with life limiting diseases and their families. High quality end of life care is an indicator of how we care for sick and vulnerable people across health and social care services. Good end of life care encompasses recognising life limiting illness as well as the dying phase, high quality coordinated care, carer support and advice. It must be delivered with an individualised personalised, dignified and respectful approach to the person and their families/loved ones.

Whatever the cause or condition, people with advanced life threatening illnesses and their families should expect an individualised service to meet their end of life care needs. All

those identified as within the last year of life or actively dying should have the opportunity to discuss, plan and identify their preferences for their care and their preferred place of death. Therefore all services within the organisation need to recognise end of life care as it encompasses all long term conditions and requires care delivery to patients as a core element.

Introduced in September 2024, the new statutory medical examiner review process of all deaths supports the coroner’s services and the process of releasing a death certificate. It means that all care leading up to death is scrutinized by a medical examiner who then supports discussions with the family/loved ones and the process of the production of the accurately documented cause of death on the death certificate. People are no longer required to be seen twenty-eight days prior to death by a doctor.

There are a number of national documents which support recommendations for high quality end of life care. These include the Ambitions for Palliative and End of Life Care (2021-2026), NICE

guidance for end of life care (2019) that built on the Strategy for End of Life Care (2008). They identify six ambitions and the actions required to achieve each one;

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff prepared to care
- Each community is prepared to help

Community health service teams in South East and West Essex play a key role in ensuring people at the end of their lives have options regarding care and place of death. Mental health teams also provide care and support people at end of life and the Trust recognises an integrated approach is essential to provide the very best care for people and their families/carers, during the last days of life and

beyond.

This report provides a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life. In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission (CQC). The services continue to strive to maintain and support 'outstanding' care to all those recognised as end of life.

During 2024 into 2025 we have continued to see service adaptations to ensure the best outcomes for people at end of life irrespective of diagnosis, the service delivering care or care setting. The community health services continue to see an increase in the number of people dying at home as more people are requesting for their care closer to home and local service adaptations have been implemented to support this.

END OF LIFE SUB-COMMITTEE

The End of Life Sub-Committee continues to report into the Quality Committee with Leadership overview from the Director of nursing, and Chief Nursing and AHP information officer. For the Quality Governance structure end of life sits with the Quality of Care and has recruited two lived experience ambassadors. The sub-committee meets monthly with representation from:

- Clinical Lead, End of Life Care
- Specialty Doctor (consultant psychiatrist)
- Director of Nursing and Clinical Governance
- End of Life Care, Frailty and Urgent Care (GP)
- Integrated Services Manager, West Essex Community Health Services
- Head of Inpatient Services, West Essex Community Health Services
- Operational Service Manager, Mental Health Older Adult In-patients
- Associate Director, Dementia and Frailty, West Essex Mental Health Services
- Deputy Director of Integrated Services & Out of Hospital Care, South East Essex Community Health Services
- Integrated Services Manager, South East Essex Community Health Services
- Lead Nurse Palliative Care Team, South East Essex Community Health Services
- Operational Service Manager, Dementia & Older People's

Community Mental Health (Mid & South Essex)

- Representative from Experience and Volunteers
- Head of Complaints
- Consultant Clinical Psychologist
- Senior Performance and Information Manager
- Lived experience ambassadors.

The sub-committee is responsible for overseeing and monitoring the implementation of the End of Life Care Framework and work plan by making recommendations to the Trust in relation to the planning and provision of end of life and last days of life care. The data from community services is captured on an end of life care dashboard which is

measured against national averages. Monitoring trends and performance. End of life care is a standing agenda item at locality Quality group meetings and the Clinical Governance and Quality sub-committee to ensure updates and lessons learned are shared at a local level across the organisation and this year has seen growth of sharing lessons learned within the integrated care boards and more widely with system partners. These are also shared and reviewed with the Learning from Death oversight group.

Papers for the End of Life Sub-Committee can be downloaded in PDF format from the meetings section of the Trust Intranet.

CLINICAL LEADS FOR END OF LIFE CARE AND SPECIALTY DOCTOR

The Trust appointed in January 2019 a clinical lead and specialty doctor. In 2024 the clinical lead recruited a job share to support the reduction in hours following retire and return. This is now a job share role with two clinical leads working to cover a whole time equivalent. The post-holders are responsible for leading Trust wide initiatives to promote and improve standards of care at end of life and during the last days of life. They work

closely with staff in the community, mental health and learning disability services and are responsible for developing education and support learning and development to ensure staff have the confidence and competence throughout each of the six ambitions. They are responsible for supporting policy and procedural guidelines related to end of life care to support best practice.

COMPETENCIES

The EPUT competency framework for end of life care to support the enhancement of knowledge, development of skills and promotion of positive attitudes and behaviors in care delivery is in place. It is awaiting

an update to incorporate national guidelines that are due to be published in 2026. The objective of the framework is to ensure staff develop professionally through reflection, supervision, informal and

formal training. The aim is to ensure staff confidently provide the highest quality of care by early identification and response to patients who are recognised as end of life in all settings. The use of digital training and blended approaches to supporting learning and competency training has become a necessity to meet the needs of teams across EPUT. As caseloads continue to grow adapting a blended approach to training is essential as it supports the capacity issues within the teams and the number of staff attending. Bespoke training for certain elements of care to support new staff and new teams has been created to ensure staff are confident in end of life care delivery. Staff also have the opportunities to attend external

training to support their roles as identified during their supervision and appraisals. A quarterly training report shared with the end of life care Sub-Committee, shows numbers of staff trained and type of training. In the first three quarters of 2025 526 staff from across EPUT have attended training with the clinical leads for end of life care. The last report will not be available until the end of the financial year. Each team within community services maintains a record of their staff competencies for certain procedures for more specialist roles. These are measured during the compliance visits for end of life care and formulate part of the final report as an assurance statement to support CQC.

POLICIES AND PROCEDURAL GUIDELINES

All procedural guidance and policies are currently being reviewed which has been ongoing during 2025. There is support to develop standard operating procedures for staff to have easier access to guidance and the use of the SOPHIA platform to support fast and effective staff access to all SOPs and guidelines.

Procedural Guideline for the care of the Deceased Patient

The guideline was revised and updated in 2025, it sets the standard for sensitive and compassionate communication with family members or significant others. Providing guidance on cultural and spiritual elements of care throughout end of life services. Sensitive care and support after death can be one of the

most difficult and challenging aspects for clinical staff but, equally, the most rewarding. The aim of the guideline is to ensure that there is timely confirmation and notification of death by medical staff and there is correct preparation of the deceased person's body for viewing by family members / significant others and dignified removal to the appropriate mortuary.

Advance Decisions and Advance Statements

This guideline was introduced to provide clarity to staff in relation to the process for advance decision making and advance statements and choice for adults within the care of EPUT. It supports safeguarding, mental capacity issues and person centered choices though the provision of guidance on the process and legislative requirements. This

guideline was also updated in 2025 it includes updates related to changes in national guidance including the introduction of The Universal Principles of Advance Care Planning 2022.

Verification of Expected Death (VOED)

The existing guideline is under review in 2026 to support the changes to the Medical Examiners process and the governance process to support are in place. The training and competency for staff has already been updated to support the changes that were introduced in September 2024. It is accompanied by a competency framework and a register of competent staff is maintained within each locality and service.

Subcutaneous Drug Administration in Community Health Services by Patients, Carers, Relatives

This was developed to support areas without 24 hour domiciliary services and rural localities. The operational guidance provides the legal and management information to support patient/carer/relative to administer subcutaneous medication in the community in a timely way to manage symptoms. The guideline is robust in ensuring safe and effective practice and provides clear information and practical steps to ensure robust risk assessment whilst ensuring a person-centered approach to patients, carers, relatives who wish to take on this element of care. This was updated in 2025 in line with local integrated care boards - ICB guidance. A new care plan and information to the end of life

template has been added to support audit across all systems and a training session twice yearly introduced for community staff.

Standard Operational Procedure - For Senior Clinician Competencies and Assessment of Do Not Attempt Cardiopulmonary Resuscitation

The introduction of this appendix to the do not attempt cardiopulmonary resuscitation guidelines (DNACPR) in 2022 provides a standard operating procedure for senior clinical staff competencies to support education, training and competencies to support senior clinical staff discussing and implementing DNACPR documents. This has been updated in 2025 in line with ICB guidance across systems.

The standard operating procedure, training programme and competency framework has been developed in partnership with hospices across Essex and the clinical lead for end of life care supports all elements of education, training and the competency framework. This has resulted in us now having fifty-eight senior clinical staff who have successfully completed their competencies and supporting this element of care across our community services in West and South East Essex.

At the deteriorating patient meeting it was discussed that the next update for cardio-pulmonary resuscitation guideline the DNACPR element should be taken out and rewritten as a separate guideline. This is currently being written and will become a stand-alone guidance in 2026.

End of Life Care Guidelines

The guideline was updated in 2025 to reflect the changes and updates from National Guidance. This includes the cultural and spiritual support of those receiving end of life care and supporting personalisation of care.

It sets out the guidance from recognition of death through to last days of life. Within dementia and Learning disability services this was adapted into a poster as a visual aid to support process and ensure staff were familiar with guidance.

Operational Guideline for Deactivation of Implantable Cardioverter Defibrillator

The need for development of this document as an independent guideline was highlighted during the Covid 19 pandemic and with the increase of patients being treated

with an implantable cardioverter defibrillator device.

In 2021 education and training was developed in collaboration with the heart failure teams to support best practice and provide guidance for deactivation of the defibrillating element of a pacemaker. This is usually necessary when someone is recognised as end of life and are unable to return to hospital to have the procedure for deactivation carried out. This training is ongoing within community teams. The increase in deaths at home has seen this element of care is used more frequently. Training has also included system partners in the ICB to ensure best practice across services including us supporting our hospice partnerships. It has supported advance care planning information for patients at insertion of a pacemaker to support discussion and understanding during their disease progression.

END OF LIFE CARE CHAMPIONS

End of Life Care Champions have been identified in all areas across the Trust to share learning and continuously develop the approaches to care at end of life. The aim of the champion is to share best practice and ensure, staff, patients and their loved ones have a positive experience of end of life, delivered to the very highest standard. There are currently seventy two champions across the Trust. Forums are held four times a year where reflective learning and shared practice are encouraged. The forum has also been able to provide a platform to share lived experience with guest speakers from bereaved families to support learning. The forums provides the opportunity to

update champions on the latest national and local guidance and for them to share experiences within their clinical settings. Champions have the opportunity to complete end of life care training to support this role. The forums relevant to the whole trust are recorded and available to all staff on the end of life care intranet page for wider sharing.

The Clinical Leads for End of Life Care supports this role within the teams and works with each individual to support partnership working with their local specialist palliative care teams ensuring that, irrespective of a patient's environment they receive fair access to palliative and end of life

care services, this is irrespective of the clinical setting. The clinical leads for end of life care are also supporting the role of the practice development team to support this role and enhance patient experiences within our mental

health settings in terms of physical care in last days of life. This has seen some positive outcomes for patient care. As identified in the patient story/lived experience section of this report.

END OF LIFE CARE FRAMEWORK

The Trust End of Life Care Framework sets out clear guidance in accordance with the ambitions for palliative and end of life care (2021-2026) and the National End of Life Care Strategy (2008). These, together with NICE guidelines are the quality standards to support end of life care practices. The Framework was reviewed in accordance with the guidance issued in 2024 and the Trust End of Life Care Framework third edition 2025 includes the new guidance.

support people to live well and die well with effective management of all their life limiting needs. By recognising early identification and effective person-centered approaches to individualised care and patient choice. The actions within the framework are to support the Trust in meeting the requirements as laid out nationally. The ambitions align with the Trusts’ vision, values and strategic objectives to continuously improve quality of care, patient safety, experience and outcomes and are outlined below:

The principle aim of our teams is to

1. Each person is seen as an individual	
Key Achievements	<p>The systems capturing incidents, compliments and complaints have continued to be strengthened during 2025. The clinical leads are copied into any Datix or complaints in any EPUT’s service related to end of life care or expected deaths so they can support lessons learned and wider sharing for learning across the trust. There were six complaints in 2024-25 and to date in 2025/26 there have been two complaints. These complaints are shared for learning and teams are encouraged to meet with bereaved to support a resolution and shared for learning. The focus on quality improvement and wider organisational lessons learned have seen a wider sharing of learning and outcomes across all teams and the wider integrated care systems – (ICS).</p> <p>The use of Datix to record compliments to the teams has enhanced sharing of compliments that are sent to individual teams by a variety of other sources enabling a collation of evaluation of care. Those that are related to end of life care that show positive outcomes and possible learning are shared more widely for lessons learned and to demonstrate to staff what good quality care looks like. This element of care is also very positive for the teams to receive to build confidence and learning.</p>

	<p>The IWANTGREATCARE has been revised and the survey is now being used within our inpatient, nursing homes and specialist services. Feedback is given directly to the teams. The end of life care feedback is reported within the compliments and complaints report.</p> <p>The Electronic Palliative Care coordination systems have seen continued growth within both areas and the shared data to coordinate patients recognised as end of life has proved invaluable in increasing the numbers of people dying in their preferred place of death. The data indicates we are achieving between 75-95% for preferred place of death monthly, there has been a drop in previous years due to some issues with access via the ICB's for continuing health care funding for fast track needs. This is on the risk register and partnership working is continuing to support care in place of patient's choice. We remain above the national average of 70%. The care coordination system allows monitoring of outcome of why death in a place of choice was not achieved and is used as lessons learned across the ICB's. The palliative systems have been showcased within the East of England and nationally as part of end of life best practice and we are supporting other ICB areas with system partners to support their implementation plans. The use of the Frailty template FrEDA has also supported early recognition.</p> <p>The formation of case note review of expected deaths via a medical examiner's office – (MEO) across all our localities means a doctor from the MEO office speaks to relatives prior to issuing a death certificate. This gives bereaved families the opportunity to share concerns and systems to learn together from bereaved experiences. There has been some positive praise for the care received via this process.</p>
<p>Areas to be progressed</p>	<p>Continue to strengthen processes to gain feedback within all EPUT services. Ensure IWANTGREATCARE continue to be utilised widely for end of life care elements and encourage teams to ensure they mark compliments as relating to end of life care.</p> <p>Work with system partners to share locality learning and integration of services as a collaborative approach and continue to seek system partner's feedback. Integrating services as part of coproduction and seamless care, this is being completed within each ICB as part of end of life care steering groups and mortality review. The development of partnership integration to include all services has provided a wider opportunity for learning across the systems.</p> <p>Continue to work with local MEO's to support best practice for death certification and bereavement support, including any concerns or issues raised. Escalate to lessons learned within EPUT.</p> <p>Ensure that all praise and compliments are cascaded to teams involved as these are very positive support to staff morale.</p>

<p>2. Each person gets fair access to care</p>	
<p>Key Achievements</p>	<p>The Clinical leads and Specialty Doctor for end of life care continue to have strong links with partner organisations, these have continued</p>

2. Each person gets fair access to care	
	<p>to grow with a more joined up collaboration. The growth of integrated coproduction of services within Integrated Care Systems (ICS) have seen joint working continuing to develop services and provide fair access for all. These include local acute services, hospices, ambulance and voluntary services in all locations across EPUT. The collaboration has seen joined up policy and procedural guidance which EPUT have supported. This has also seen redesign of some ICS services with system partners introducing elements of EPUT approaches as best practice.</p> <p>The development and roll out of guidance for STaRS teams has continued to support integration of services and understanding of end of life care with positive outcomes for care and fair access to hospice services for those under STaRS services. These integration of services and partnership working has resulted in some very positive outcomes for care of patients and support for their loved ones. This has been developed as a quality of care improvement and within the ICB seen as best practice. It supports voluntary sector organisations, health and social care to integrate wrapping around need to enhance the end of life care experiences.</p> <p>The dashboard, capturing quality and performance indicators measured against national data it has seen further developments and growth especially in recognition of dementia and frailty through the FReDA template. Receiving recognition both Nationally and through the East of England, the templates developed to support the processes won an HSJ award in November 2023. These over the past year have been rolled out more widely and are now being used in all areas of the trust using SystemOne.</p> <p>The development of shared care records which includes an Electronic Palliative Care Co-ordination (EPaCCs) System has seen a growth in integrated approaches and sharing of patient choice. EPUT are leading across the ICS systems and used as best practice examples within the East of England as this supports performance data and dashboards.</p>
Areas to be progressed	To continue to support future growth of shared care records supporting EPaCCs and recognition of death across EPUT and the wider systems within local communities. To stop duplication and people having to retell their story to all those involved in care delivery by supporting continued growth in advance care planning at recognition of end of life care.

3. Maximising comfort and wellbeing	
Key Achievements	<p>The development of an updated formulary and Medicine Management Guidance in partnership and approved across the HWE and MSE ICS in 2024 continues to support common symptoms at end of life. It provides confidence to clinical staff as acts as a guidance and aid to support best practices. This includes knowledge of community pharmacists whom stock the end of life care medications out of hours.</p> <p>The development of HPAL – a digital electronic platform for palliative care information for all patients and clinical staff to support information</p>

3. Maximising comfort and wellbeing	
	<p>about treatment and services in MSE. This has provided a valuable resource for staff to support practice and provide local service information across the locality.</p> <p>The do not attempt cardiopulmonary resuscitation – DNACPR competency training for senior clinical staff. The clinical leads continues to support this training for senior clinical staff. Since 2022 we have a total fifty-eight senior clinician’s with competencies who are able to support this element of care. Resulting in partnership training and timely conversations to support best practice. This has supported the advance care planning process and timely conversations.</p> <p>To provide training and sharing of all end of life learning opportunities across all areas in EPUT to maximise care for those recognised as end of life care. The use of all elements of bespoke training to support teams and the wider development of the use of digital training and collaborative learning across ICS. EPUT have been instrumental at supporting this widening the opportunities for learning for all.</p>
Areas to be progressed	<p>Continue to cascade end of life care competencies to all grades of staff in community services to ensure maximum skills. Ensuring staff have skills to support clinical practice within the community. Align these to the new national guidance that is due in 2026 and ensure the competency framework supports this.</p> <p>Continue to work with practice development team to upskill them to enhance training support within mental health services with physical health and end of life care. Building their relationships with the wider partnership organisations who also support end of life care.</p> <p>Continue working in partnership with external stakeholders as part of co-production. This includes access to external training and development shared with all staff across EPUT.</p>

4. Care is co-ordinated	
Key Achievements	<p>The Clinical Leads and Specialty Doctor for end of life care continue to have strong links with systems partners and attend the ICB meetings both locally and within the East of England. This has seen a rise in identification of end of life care across systems. The dashboard recognises diagnosis for referrals and there continues to be a significant rise in referrals especially within frailty and dementia from primary care and now transitioning from secondary care who are recognising end of life care.</p> <p>Monthly multi-disciplinary meetings with primary, secondary care and hospices continues to be well established in all areas. To ensure an integrated approach and co-ordination of care. These include an integrated approach from any team or organisation relevant to specific patient’s needs. (Specialist teams in EPUT, mental health, paramedics, GP, social care and voluntary services).</p> <p>The guidance developed to support people with multiple organ failure and long term conditions who are on the caseload of the STaRS</p>

4. Care is co-ordinated	
	<p>Teams has seen stronger links to fairer access to care especially from hospices. This supports early recognition of end of life care needs and coordinate personalisation to supporting their choice and needs and those of their loved ones in a more joined up approach.</p> <p>The EPACCs continues to grow with caseloads increasing there is more recognition of frailty and dementia prognosis for end of life which is now higher than cancer and other long term conditions. This support allows sharing of patient choice wider across the ICB footprints and ensuring services are personalised and wrapped around the person and their loved ones.</p>
Areas to be progressed	To continue with enhanced teams to work in partnership across systems to create best approaches, co-production and ensure advance care planning, individualised care plans and shared data happen with a timely robust approach. To ensure patients and their loved ones have a voice and their preferences are known and considered at all times.

5. All staff prepared to care	
Key Achievements	<p>End of Life Care Champions are supporting staff at a local level to support best practices, lessons learned and provide updates on end of life care at a local level of their teams.</p> <p>The Clinical leads are supporting sharing training and development of standard approaches to delivery of training and care. Working with the ICB's to develop a training program to meet learning needs across localities.</p> <p>EPUT continue to have in-house training and support to teams. A quarterly training report shows training delivered by clinical lead with the number of staff and service that have attended. Bespoke training for teams related to patient care is also delivered to support staff understanding and care delivery.</p>
Areas to be progressed	<p>Continue to support the roll out of end of life care competencies for all grades of staff. Monitor national landscape as new updates are due in 2026.</p> <p>Continue to expand the number of End of Life Care Champions across all areas of the organisation. Ensure champions are engaging in updates and scope the areas they are working in line with support for the new physical health practitioners.</p> <p>Continue to partnership work to support accessibility to end of life care training as an integrated approach to include specialist services delivered by the hospices.</p>

6. Each community is prepared to help	
Key Achievements	Community staff are involved in supporting work within the Primary Care Networks – PCN to ensure local communities are supported and seamless care and approaches to care are supported. They are involved in working with all elements of the community including care

6. Each community is prepared to help	
	<p>homes and other settings.</p> <p>There is ongoing work with EPUT learning disability services to support equitable care for all. This has included using national care planning approaches, Victoria and Stuart with early recognition of end of life. The Oliver McGowan mandatory training also supports best practice.</p> <p>The Trust participates in Dying Matters events on an annual basis. The use of Death Cafés held for staff in EPUT with the Chaplaincy and Psychological services provided staff time to share their own experiences. It was attended by over sixty members of staff some sharing their experiences both personally and professionally, prompting positive discussions. Three events were held in 2025 and the feedback from staff has seen some positive learning. Including staff becoming an end of life champion for their teams.</p> <p>The Clinical Leads and Specialty Doctor for end of life are active members of all the ICB alliances across Essex, supporting NHS England nationally and within the east of England. This has supported partnership collaboration and service redesign within Essex end of life care services. It also supports EPUT to have national and local updates and share more widely best practices.</p>
Areas to be progressed	<p>To continue to provide information relating to end of life care to be posted on the Trust intranet and through Wednesday weekly to include opportunities for staff to develop and learn to enhance the quality of the patient experiences.</p> <p>The Clinical leads and Specialty Doctor to continue to work with the Chaplaincy service holding Death Café's increasing to four times a year to support staff.</p>

CLINICAL AUDIT

National Audit of Care at End of Life (NACEL)

The Trust continues to participate in NACEL. The focus is on the quality and outcomes of care experienced by those in their last admission in acute and community hospitals throughout England and Wales. The audit monitors progress against priorities set out in One Chance to Get It Right and NICE Quality Standard 144, which address last days of life, within the context of NICE Quality Standard 12 (in the last year of life).

There are several components consisting of an organisational level audit for the period 1st January 2025 - 31st December 2025 and a case note review of all deaths within the same period.

The case note review considers patients who meet the following criteria:

- I. Recognition that the patient may die – it has been recognised by the hospital staff that the patient may die imminently (i.e. within hours or days). Life sustaining treatments may still be offered in parallel to end of life care.
- II. The patient was not expected to die – imminent death was not recognised or expected by the hospital staff. However, the patient may have had a life limiting condition or, for example, be frail, so that whilst death wasn't recognised as being imminent, hospital staff were 'not surprised' the patient had died.

- III. Deaths that are classed as 'sudden deaths' are excluded from the Case Note Review.

EPUT to date have submitted 9 community and 3 mental health inpatient records within the criteria for review, this may increase as the closing date is 31st December 2025. The audit is still ongoing this year and the results will not be available until 2026.

The 2025 NACEL held a separate audit for mental health in-patients as well as the current audit. EPUT participated in both the physical and mental health audits this year. The Specialty Doctor and Clinical lead for end of life have been part of a team who supported the development of the audit with NACEL for use nationally.

The results of the NACEL 2024 community inpatient audit have only just been published and approved. The findings showed positive outcomes from our services. There were 12 expected death. The NACEL 4 found evidence that staff provide a holistic approach with evidence of compassion, personalised and evidence based care. There was confirmation of effective communication with patients and their families throughout the findings. Despite the low sample size, EPUT services achieved very good results in the NACEL 4 findings. Overall EPUT Community inpatient wards provided above the national average for End of Life services, scoring 100% in many of the case note review

End of Life Care in EPUT – Community Health, Mental Health and Nursing Homes Audit Findings

An audit of thirty two records from expected patient deaths were reviewed as a case note review, using an end of life care audit tool in line with the questions of the NACEL audit. The aim was to establish that the services within EPUT delivering end of life care are supporting the requirements in line with best practice and national averages. This included the community services in SEE and West Essex and the two nursing homes in SEE.

Findings

Within the findings overall EPUT services are providing above the national averages which are between 70-76% for end of life care services. The majority scored 100% for symptom management and coordination of care delivery. The end of life care templates within EPUT electronic databases are supporting record keeping and the trends are evident on the end of life care dashboard which is reviewed monthly. The template has made it easy to find relevant information

within the data required to complete the audit and it shares information across services as part of the EPaCCs system. The 4 other patient records were reviewed but did not meet the criteria for inclusion for the following reasons West Essex Team had not seen 1 patient until the day they died as not previously been referred or known to the caseload. In South East Essex there were 3 patient referred to palliative care services to add to the register but they were still in hospital waiting discharge so not seen when they died so not known by the team. The Findings were similar to the previous EPUT community audit in 2024 in that evidence based care was being delivered compassionately with evidence of personalisation and symptom management. Overall EPUT services are providing care above the national averages for End of Life services. Again, this year saw late recognition and referrals being received late in the patient eolc journey. It was pleasing to see that more care is delivered in those at eolc at their usual place of residence and the community services are providing care closer to home.

Audit of Do Not Attempt Cardiopulmonary Resuscitation Documents

An audit of DNACPR for those at end of life was completed in 2025. The purpose of the audit was to ensure the correct processes were in place to ensure a person centered approach to all decision making and support the recommendations from the Care Quality Commissioning review in 2021 of DNACPR implementations.

The audit reviewed thirty two documents across inpatient, community health services and care

homes, it included reviewing the following elements:

- Number of patients with a DNACPR when identified as end of life
- Number patients with a DNACPR at time of death
- Number of discussions held with patient and relatives/carers
- Number of discussions with a senior member of staff/MDT.

Findings

The Clinical and Medical Leads for End of Life Care undertook the audit, based on the DNACPR tool developed in line with national standards within the National Audit Care at end of life – (NACEL) audit and best practice guidance that was published in the Care Quality Commission (CQC) Report 2021 - Protect, Connect, Respect – decisions about living and dying Well. The findings indicate there is an overall scoring of 100% in many cases of the review suggesting an inclusive understanding of record keeping and conversations being documented in the patient records. There were some documents that were implemented in the last weeks of life but none of the expected deaths died without a DNACPR in place. There was evidence those who required a Best Interest Decision had a Mental Capacity Assessment and approaches to the decision documented with inclusion of a multi-professional approach but not all patients require mental capacity assessments.

There was evidence documented in 100% of the records to support fair access to care and supportive conversations with evidence of an MDT approach to implement the DNACPR forms. The end of life care templates within all our electronic data bases have supported a more unified and accessible process of recording and finding the end of life care information. With copies of documents scanned into data bases.

The results, which are very positive highlight support from the senior clinical staff, who have completed training and competencies to support DNACPR discussions and completion of the document. The conversations and recognition of end of life care are happening in a timely approach to support inclusion of those important to the patient and their loved ones. Irrespective of the care setting these discussions are supporting the implementation of the DNACPR document in a robust and timely way.

Audit of Do Not Attempt Cardiopulmonary Resuscitation Documents in Mental Health Units

An audit of DNACPR documents within all mental health units in EPUT was carried out in 2025. This was to review the quality of the completed documents and process to establish a

decision. This was undertaken to support future learning and ensure our practice is robust. The findings of this audit are still being reviewed and a report will follow in 2026.

All the national recommendations are mentioned within the EPUT End of Life Care work plan. EPUT's End of Life audit (24015) and DNACPR audit (24016) findings from 2025 covers most of the national actions. Project leads have compared the NACEL 2024 audit (23001) findings with these recommendations when they were published in 2025 this process will be repeated when the findings from the 2025 NACEL are published in 2026. The end of life care subcommittee continue to monitor the audit process as a standard agenda item to continue to measure quality and safety in line with national recommendations.

PATIENT STORY / LIVED EXPERIENCE

A 72 year old gentleman who was an inpatient on one of the mental health wards was recognised by staff on the ward as triggering prognostic indications for end of life care. These are indicators to support the physical changes that are seen for life limiting illness and recognition that someone is in the last year of life. Staff on the ward had received end of life care training and were supported by the end of life care and practice development teams. The gentleman had a diagnosis of dementia and had been admitted four months previously as he had become increasingly agitated and aggressive at the care home he was living in. The care home staff were no longer able to manage his symptoms. His dementia needs had been stabilised and he was much more settled on the ward but his physical health was declining rapidly.

He was transferred to the acute trust for treatment with intravenous antibiotics for a chest infection and subsequently transferred back to the mental health ward. The staff could notice the decline and he had started to lose weight, was reluctant to eat and drink, his pressure areas were becoming red and he was unable to mobilise unaided. The decline in his physical health became very rapid. The clinical lead for end of life care was asked to support an MDT meeting to look at best approaches to his care, and planning for potential needs in his future care.

The MDT provided a forum to meet with community staff who knew him previously and discuss with his family their perspective of what was happening to him. It became clear the

family and those who were caring for him previously were very aware that the care that had been in place previously at a residential care home was no longer suitable to meet his needs.

End of life care is about a personalised approach to needs and recognising what is important to the person. When they don't have capacity, it is important that we establish as much information as possible to support prioritising needs for the future ensuring that decisions are considered in his best interest. A PEACE treatment escalation plan was written identifying his priorities. This was established by looking at his current needs and discussing with those who knew him previously what was important to him. Looking at his life and aspirations. He had some indicator of pain as had been a runner and had arthritis in his knees. When he was in pain he was more agitated. His family didn't want him to keep being moved to the acute hospital if he had more chest infections and they were very clear their priority and what he would have wanted was to be made comfortable. They recognised that he was dying and also felt that although they didn't want him moved around, his care needs would be better suited to a specialist dementia nursing home. His wife and son who had lasting power of attorney for health and welfare and finances were clear they wanted to look for a care home nearer to where they lived. The ward was not within the ICB area they lived which meant to access funding to support care we needed to liaise with another hospice and ICB. This was supported by the ward team.

While he was on the ward the local hospice to the ward were able to review him and work with the ward to support managing his symptoms. He was assessed for fast track funding from his ICB and his care needs and PEACE plan were considered. His family looked for a care home and while this was being established the staff on the ward had top up training and support to build their confidence to care for him and some of the unpredictable needs he was presenting with including a reduced ability to swallow and communicate his pain. He developed another chest infection but the plan stated for him to be cared for on the ward which was done with the support of the physical health hospital avoidance team to

support those elements of care and ensure best practice.

Fast track funding was approved and he was moved to a nursing home nearer his family. His wife contacted the ward a month later to say he had died peacefully in the care home and the setting had been right for him. She stated they were very grateful staff had supported him and the family to recognise what was happening and have those difficult conversations which completely supported this outcome for them all. They were most grateful of all for recognising him as an individual and what was important to him and his family.

NHSI AND EOE END OF LIFE CARE COLLABORATIVE

The Clinical Leads and Medical Lead for End of Life Care are members of the NHSI PEOLC collaborative which supports sharing best practice across a variety of settings across England, Scotland and Wales. The work undertaken by the Trust in accordance with the Ambitions for End of Life Care has been presented both nationally and at the East of England. The end of life care dashboards have been recognised locally within the ICS localities and there is ongoing work across ICB's for other providers to align to this model. The integration of the mental health and physical health services is starting to show that our dashboard has more representation of dementia and frailty than any other long term condition or diagnosis. Nationally it has been recognised as best practice for the growth of identification of

dementia and frailty through the FReDA template as best practice and this has won an HSJ award. The benefits of these approaches is becoming apparent in our admission avoidance and advance care planning processes with frailty and dementia teams across the trust.

The medical lead is also established as a member of mental health for the East of England strategic palliative and EOL meetings.

This collaborative has also opened training and learning opportunities for members of our teams and the end of life champions have been able to benefit from joint learning and a wider scope of sharing others lessons learned regionally and nationally as reflection and positive quality outcomes

DEVELOPMENTS IN MENTAL HEALTH

The Gold Standard Framework process is now well established on Tower ward in Clacton who have achieved re-accreditation. There is strong integration with the specialist teams and patients receive person centered approaches to their end of life care. Feedback from carers and relatives has been positive. The clinical lead continues to support patients whom are identified as end of life by supporting staff on mental health wards and supports confidence to care.

The Gold Standard Framework is being completed by Rawreth Court Nursing Home staff. The staff have also participated in the Namaste training to support best practice and approaches for dementia patients.

The clinical lead was able to work with a hospice to deliver this training not just to Rawreth Court staff but also

some of the Dementia ward staff and practice development nurses. Namaste care is a specialist approach designed for individuals with advanced dementia, focusing on enhancing quality of life through personal connections and sensory experiences. This method emphasizes the importance of engaging the spirits of the individual even when their memory fades.

A clinical guidance for patients under the care of Specialist Treatment and Recovery Service – (STaRS) is established to support end of life care patients and ensure local services, including the local acute trust, work together to support patients, their families and those teams caring for them. These have been developed jointly with acute trusts, community services, local voluntary organisations, primary care, social care and Hospices.

DEVELOPMENTS WITHIN NURSING HOMES

The two nursing homes Clifton Lodge and Rawreth Court continue to have strong links with the specialist palliative care team and primary care within the South East Essex area. They are on the same electronic data bases so can share records and information across the community services. The two homes are managed by two different managers. Patients are identified using the prognostic indicators and are added to the electronic EPaCCs Register.

They use the Gold Standards Framework prognostic indicators to identify patients at end of life and manage their symptoms accordingly. This incorporates all elements of advance care planning and patient choice is recorded inclusive of their loved ones. The data sharing has further strengthened joint working and coordinated care between Primary Care, the integrated teams and the care home staff. The homes have received a number of

compliments and high praise from bereaved relatives for the approaches of personalised care. Compliments stated that their loved ones were treated with compassion and dignity and felt extremely supported by all

members of the teams. Rawreth Court Nursing Home this year have undertaken the Gold Standards Training and this will be ongoing during the next year for their accreditation.

CONTINUED SUPPORT WORKING WITHIN PARTNERSHIPS

The Clinical Leads and Specialty Doctor have continued to support the development and implementation of a wide range of initiatives including enhanced skills and guidance around early recognition of end of life, advance care planning and symptom management. These include:

- Working with the integrated care systems in each of the localities across EPUT. This supports a number of initiatives supporting integrated partnership working. Including competencies and training for end of life care, Electronic palliative care co-ordination and end of life dashboard – EPaCCs, procedural guidance documents and aligning services to system partners including hospices. Learning from current services across the end of life care services in each of area.
- Care home project in West Essex to ensure all residence with long term conditions have advance care plan choices documented whether in a residential or nursing home and are added to EPaCCs in a more timely way. Working with the ICB to develop an App for care home staff to log this on EPaCCs.
- Person centred approaches to care: complete roll out of PEACE

Treatment Escalation Plans and new DNACPR documents which include capacity as there is some variation in our localities (PEACE documents across Essex and ReSPECT document used in some other areas, staff training to ensure safe practice) to record discussions and choices including PPC /PPD /DNACPR /Requesting treatment.

- Training continues to be delivered in a bespoke way and relating to a variety of aspects of end of life care with blended approaches to delivery including, virtually and face 2 face to ensure end of life competencies for staff are met. Arranging bespoke training like Namaste from other system partners in collaboration.
- Training recorded for specific teams and podcasts to support training and provide accessibility to all staff. There is a large amount of digital podcasts and information platforms across ICB's to support staff which EPUT are involved in supporting.
- Collaborative redesign of services, working with system partners as locality growth continues of end of life care; as in previous years especially those with frailty and dementia. The EPaCC's service for

end of life is showing growth as earlier identification is becoming more apparent. The numbers of people on caseloads have doubled in some areas for end of life care. It is important that together we work to support best practices and person centred accessible care for all irrespective of care setting.

- Expert support/advice provided on a daily basis to clinical teams and staff members working outside of their usual area of expertise. The complexities of care of people being cared for in their own home has seen growth in the number of patients with complex needs.

ABBREVIATIONS

CHS	Community Health Services
CQC	Care Quality Commission
Datix	Electronic risk management incident reporting system
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
EoLC	End of Life Care
EPaCCs	Electronic Palliative Care Co-ordination system
EPUT	Essex Partnership University NHS Foundation Trust
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
GP	General Practitioner
GSF	Gold Standards Framework
HPAL	Digital electronic platform for palliative care information
ICB	Integrated Care Boards
ICS	Integrated Care Services
LPA	Lasting Power of Attorney for health and welfare
MEO	Medical Examiner's Office
MDT	Multi-disciplinary Team
NACEL	National Audit of Care at End of Life
NHSI	NHS Improvement National collaborative
NICE	National Institute for Health and Care Excellence

END OF LIFE ANNUAL REPORT 2024-25

PCN	Primary Care Network
PEACE	Proactive Enhanced Advance Care Plan
PEOLC	Palliative and End of Life Care
PPC	Preferred Priorities for Care
PPD	Preferred Place of Death
STaRS	Specialist Treatment and Recovery Service
TEP	Treatment Escalation Plan
VOED	Verification of expected death

**Essex Partnership University NHS
Foundation Trust**

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

Tel: 0300 123 0808



@EPUTNHS


8.3 LEARNING FROM DEATHS ? MORTALITY REPORT Q2

● Information Item

 AS

REFERENCES

Only PDFs are attached

 Learning From Deaths Report 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			01 April 2026	
Report Title:		Learning from Deaths Q2 2025/26				
Executive/ Non-Executive Lead:		Ann Sheridan, Executive Nurse				
Report Author(s):		Michelle Bourner, Senior Project Lead - Mortality				
Report discussed previously at:		Learning from Deaths Oversight Group, Learning Oversight Sub-Committee, Quality of Care Group and Quality Committee				
Level of Assurance:		Level 1		Level 2	✓	Level 3

Risk Assessment of Report			
Summary of risks highlighted in this report	On-going risk relating to the resourcing capacity within the learning from deaths workstream being addressed Data processes currently in place continue to be reviewed to further strengthen the Trust's ability to undertake mortality surveillance		
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure		
	SR4 Demand / Capacity		
	SR5 Statutory Public Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data		✓
	SR10 Workforce Sustainability		
	SR11 Staff Retention		
	SR12 Organisational Development		✓
SR13 Quality Governance		✓	
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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		
To present the final draft <i>Q2 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data</i> report, which includes the following: <ul style="list-style-type: none"> Data relating to deaths recorded on Datix for Q2 2025/26 (1 July – 30 September 2025) Summary of progress of reviews of deaths occurring in previous periods Examples of key learning and actions arising from the review of deaths under various methodologies since the last report to the Board. 	Approval	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: <ul style="list-style-type: none"> Note the information presented Note the assurance provided by the content of this report that there are robust processes in the Trust in line with national guidance to review deaths appropriately, forming part of the Trust’s processes for continually reviewing care and ensuring that patients are receiving safe, high quality services Request any further information or action

Summary of Key Points
The report presents the data which the Trust is nationally mandated to report to Public Board meetings on a quarterly basis, i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. The Q2 2025/26 data was extracted and analysed as at 6 November 2025. Any updates after this date will be included in future reports. There are no issues of significant concern to note from the Q2 data, which is broadly in line with that of previous quarters.
The report also provides an overview of key learning resulting from the reviews undertaken under the Trust’s Learning from Deaths arrangements and actions being taken as a result. This learning is presented in detail on a monthly basis to the Trust’s Learning from Deaths Oversight Group and/or Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust’s Safety Improvement Plans.

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


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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	✓
Service impact/health improvement gains	✓

Financial implications:			Capital £ Revenue £ Non Recurrent £	N/A
Governance implications				
Impact on patient safety/quality				✓
Impact on equality and diversity				
Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score		

Acronyms/Terms Used in the Report			
LFD	Learning from deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework		

Supporting Reports / Appendices / for further reading
Q2 2025/26 Learning from Deaths – Quarterly Overview of Learning and Data Report

Lead:
 <p>Ann Sheridan Executive Nurse</p>



QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths



QUARTER 2 - 2025/26



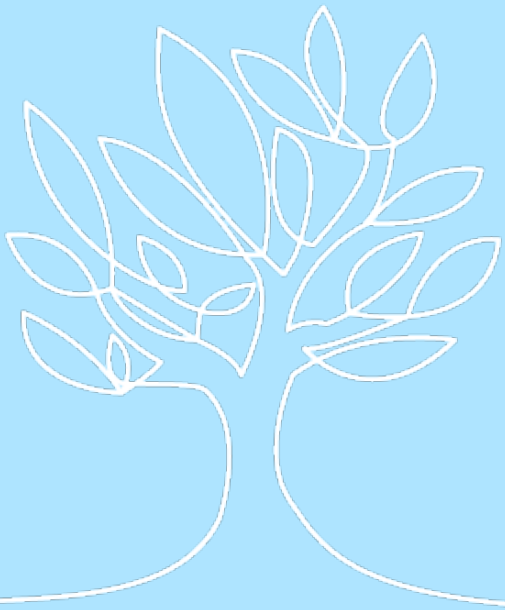
Learning from deaths



CONTENT OF REPORT

- Data relating to deaths recorded on Datix for Q2 2025/26 (1st July – 30th September 2025);
- A summary of progress of reviews of deaths occurring in previous periods;
- Examples of key learning and actions arising from the Stage 1 reviews of deaths since the last report to the Board;
- Conclusions and actions required.

Summary of Quarter 2 2025/26 mortality data (as at 06/11/25) (Page 1)



Total number of deaths reported:

There were a total of 151 reports of deaths made on Datix, relating to 148 deaths for Q2 2025/26 (these include those not falling within the scope for mandatory reporting see Appendix 1).

To date, a total of 20 have been deemed in scope for mandated reporting under the Learning from Deaths policy:

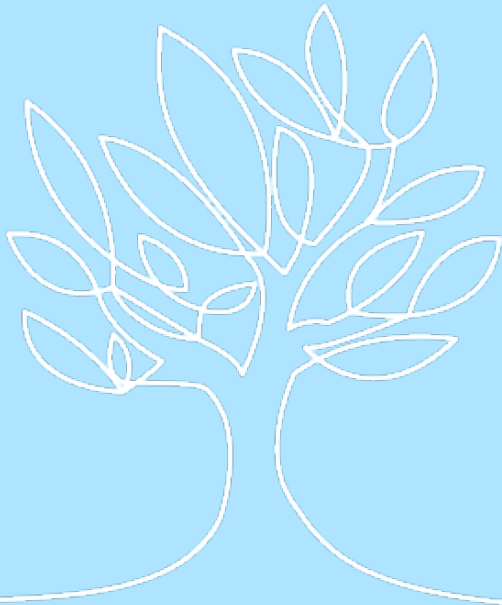
- 11 were inpatient deaths (see below),
- 2 were Learning Disability / Autism client deaths (see below),
- 6 were Essex Drug and Alcohol Partnership (EDAP) client deaths
- 1 was a death requiring review under the Patient Safety Incident Response Framework (PSIRF)

Statistical Process Control is utilised to monitor the number of deaths reported on Datix and the number of deaths in scope to identify any areas of concern for action. This indicates that the figures for Q2 are within usual parameters.

Inpatient / Nursing Homes deaths: In Q2, of the 11 inpatient deaths, 2 were EPUT community health services inpatient deaths, 2 were EPUT mental health services inpatient deaths and 7 were EPUT nursing home deaths. All these deaths have been confirmed as due to natural causes, with 10 deaths categorised as expected natural causes deaths and 1 death unexpected natural causes.

LeDeR reporting validation: The 2 reported Learning Disability service deaths have been confirmed as referred to the national LeDeR programme, which supports learning from the lives and deaths of people with a learning disability and autistic people. This quarter, the number of Learning Disability deaths reported onto Datix has been lower than would usually be expected. To provide assurance, information has been extracted from clinical systems and validated to confirm that all deaths that occurred have been recorded on Datix.

Summary of Quarter 2 2025/26 mortality data (as at 06/11/25) (Page 2)



Stage 1 (Datix) reviews:

To date, a total of 115 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the Q2 deaths.

Stage 2 (clinical case note) reviews:

Two deaths occurring in Q1 2025/26 have been referred for Stage 2 review since the last report to the Board. The number of deaths progressing to Stage 2 review remains low, as care units typically commission an immediate Decision Monitoring Tool (DMT) or a SWARM review. These tools support timely decision-making regarding whether a PSIRP review is required. A completed DMT provides early identification of learning and actions. Where a comprehensive DMT has been completed, undertaking a Stage 2 review in addition is often considered unnecessary duplication. To date, eleven DMTs have been commissioned for deaths occurring in Q2.

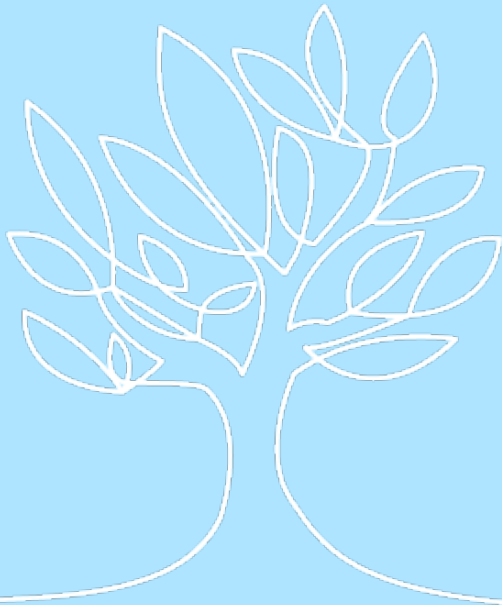
Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews:

1 PSII was commissioned in Q2. This review is still under way, in its final stages. It has been shared with West Essex director for approval. 6 PSIIIs were approved in Q2.

Problems in care assessment:

Where deaths are deemed via Stage 1 or Stage 2 methodologies to be potentially more likely than not due to problems in care, they are referred for review under PSIRP. A local approach to making this determination for deaths reviewed under PSIRF arrangements is being finalised as there is no national methodology in place for this; and will be implemented in Q1 2026/2027.

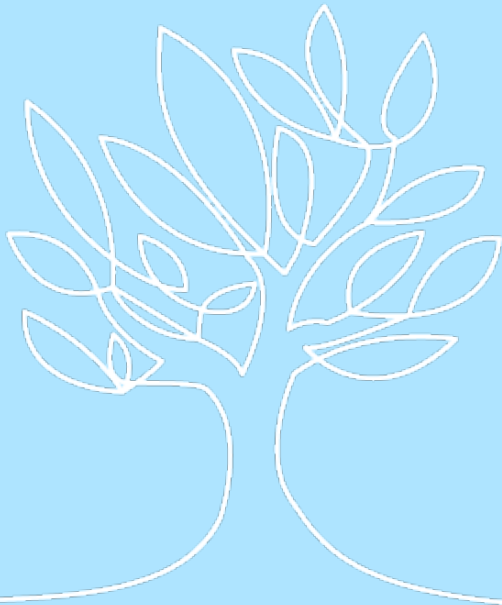
High level summary of progress with reviews of deaths occurring in previous periods



Since the last report to the Board, the following progress has been made with reviews of deaths occurring in previous periods (as at 06/11/25):

- 68 additional Stage 1 (local Care Unit) reviews have been completed
- 86 additional death reviews have been considered through Care Unit governance processes and agreed for closure at Stage 1 (local Care Unit) review
- Information has been collated for first time this quarter on deaths closed following completion of the Trust's Decision Monitoring Tool (DMT) – this review is more detailed than a Stage 1 review but does not constitute a full Stage 2 Case Note Review or PSIRF review. This information indicates that 20 2025/26 deaths, 43 2024/25 deaths and 21 2023/24 deaths were closed with a DMT review having been completed.
- These figures do not reflect the full extent of DMT closures as the functionality to code these separately has only recently been added to Datix. Previously, deaths with a completed DMT review would have been included in the Stage 1 data.
- 17 Patient Safety Incident Response Framework reviews have been approved. 6 of these were PSIIIs, 2 commissioned Q1 2024/25, 2 commissioned Q3 2024/25, 1 commissioned Q4 2024/25 and 1 commissioned Q1 2025/26.
- As of 17/12/25 for 2023/24-2024/25 there are 2 outstanding Stage 1 reviews, a reduction from 37 in Q1 data.

High level summary data 2022/23 – 2025/26



SUMMARY OF MORTALITY DATA (UPDATED AS AT 06/11/2025 FOR DEATHS REPORTED TO END OCTOBER 2025)	2025/26 YTD (Q1 & Q2)	2024/25	2023/24	2022/23
TOTAL DEATHS REPORTED ON DATIX / DEATHS IN SCOPE				
Total death reports on Datix	315	687	732	*_
Relating to x deaths (duplicates removed)	309	659	699	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	55	162	258	249
Total inpatient deaths **	10	23	24	23
Total nursing homes deaths	11	19	23	19
Total Learning Disability deaths (referred to LeDeR (national learning disability review programme))	12	26	29	17
LEVEL OF REVIEW				
Total deaths closed at Stage 1 review to date	138	444	506	322
Total deaths closed at DMT to date (included from Q2 2025/26 report onwards)	20	43	21	-
Total deaths referred to date for Stage 2 review (either individual clinical case note review or thematic review)	-	3	11	70
Total deaths referred to date for Stage 3 review (Patient Safety Incident Response Framework (PSRIF) review)	13	47	80	80
ASSESSMENT OF LIKELIHOOD OF PROBLEMS IN CARE				
Assessed as more likely than not due to PIC ***	0	0	0	0
Assessed as not more likely than not due to PIC	172	512	565	389
Assessment of likelihood of death being due to PIC underway (i.e. review still being undertaken)	122	122	96	80
Not applicable (EDAP and LeDeR reviews utilising different methodology)	21	53	71	51

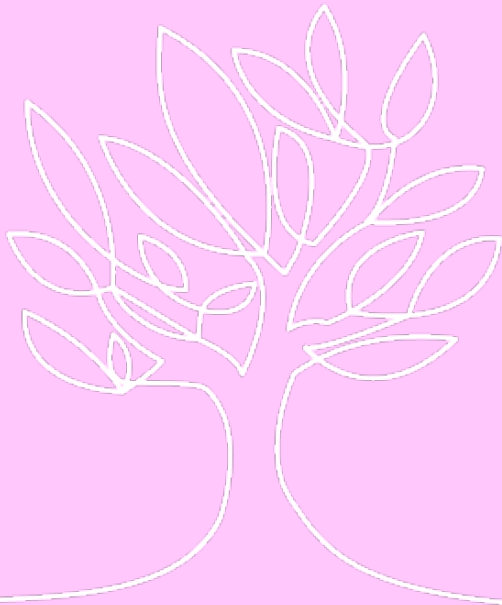
* Data collated using number of deaths only for 2022/23

** Total number of deaths occurring whilst patient in-patient with EPUT, excludes deaths occurring within 30 days of discharge

*** Research undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination for deaths reviewed under PSIRF given that the PSIRF methodology has not been designed for this purpose - local approach under finalisation. All closed PSIRF deaths have been currently coded as determination underway.

Key learning themes emerging from Stage 1 reviews

September 2025 – November 2025



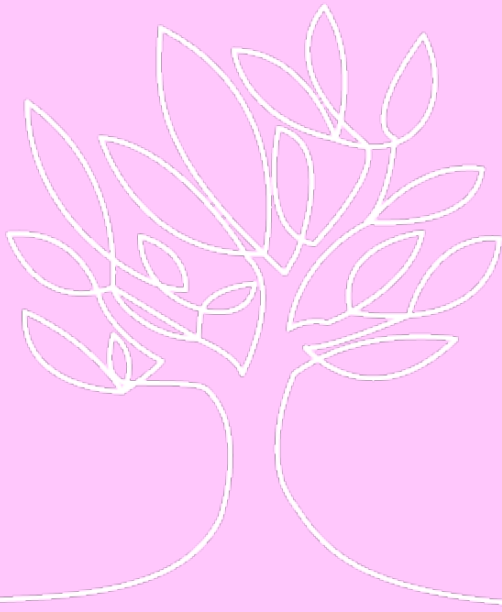
- **Theme 1:** Recognition that the majority of the deaths reviewed are from **physical health causes** (e.g. long term conditions, terminal illness, physical health crisis, deaths in Acute Trust hospitals) (cited in the learning in 13 reviews). The Trust has a specific workstream in place to strengthen physical health monitoring and how the Trust can support / contribute to the physical health care of patients.
- **Theme 2:** For a number of deaths reported on the Trust's information system, it was identified that the patient was **not under the care of the Trust** at the date of death (cited in the learning of 6 reviews). This is a result of some deaths coming to the attention of the Trust from HM Coroner's Office.
- **Theme 3:** Recognition that many of the deaths of patients are **expected deaths of patients often receiving end of life care** (cited in the learning in 11 reviews). Again, the Trust has a specific workstream in place designed to monitor the quality of end of life care provided by the Trust and to ensure this is strengthened, including quality audits reported via the Trust's governance structures.

Other learning issues emerging from Stage 1 reviews during this period included no cause of death information being available, waiting times and record keeping.

There were also a number of good practice examples cited in reviews including good communication with / referrals to partner health providers, active support to patient and family, demonstrable professional curiosity and active engagement attempts.

Key learning issues emerging from Stage 3 reviews

July - September 2025

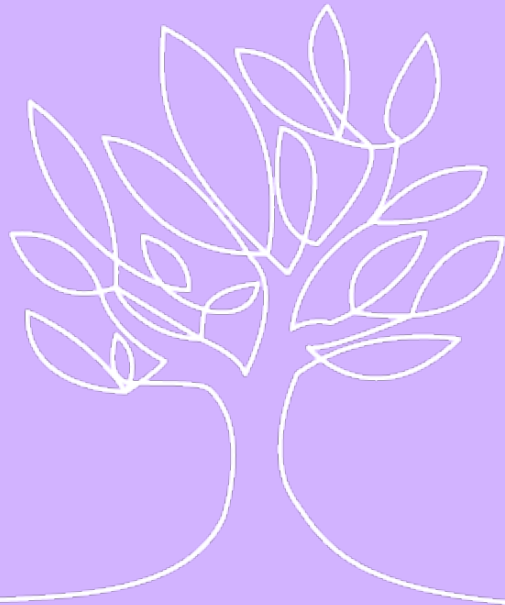


- The need to assess needs and risks effectively and accurately and timely record keeping.
- Carer engagement
- Promoting professional curiosity and deeper engagement.
- Working with different teams
- Communication and collaboration
- Clinical care and patient monitoring
- Patient Centred care pathways
- Training and workforce development

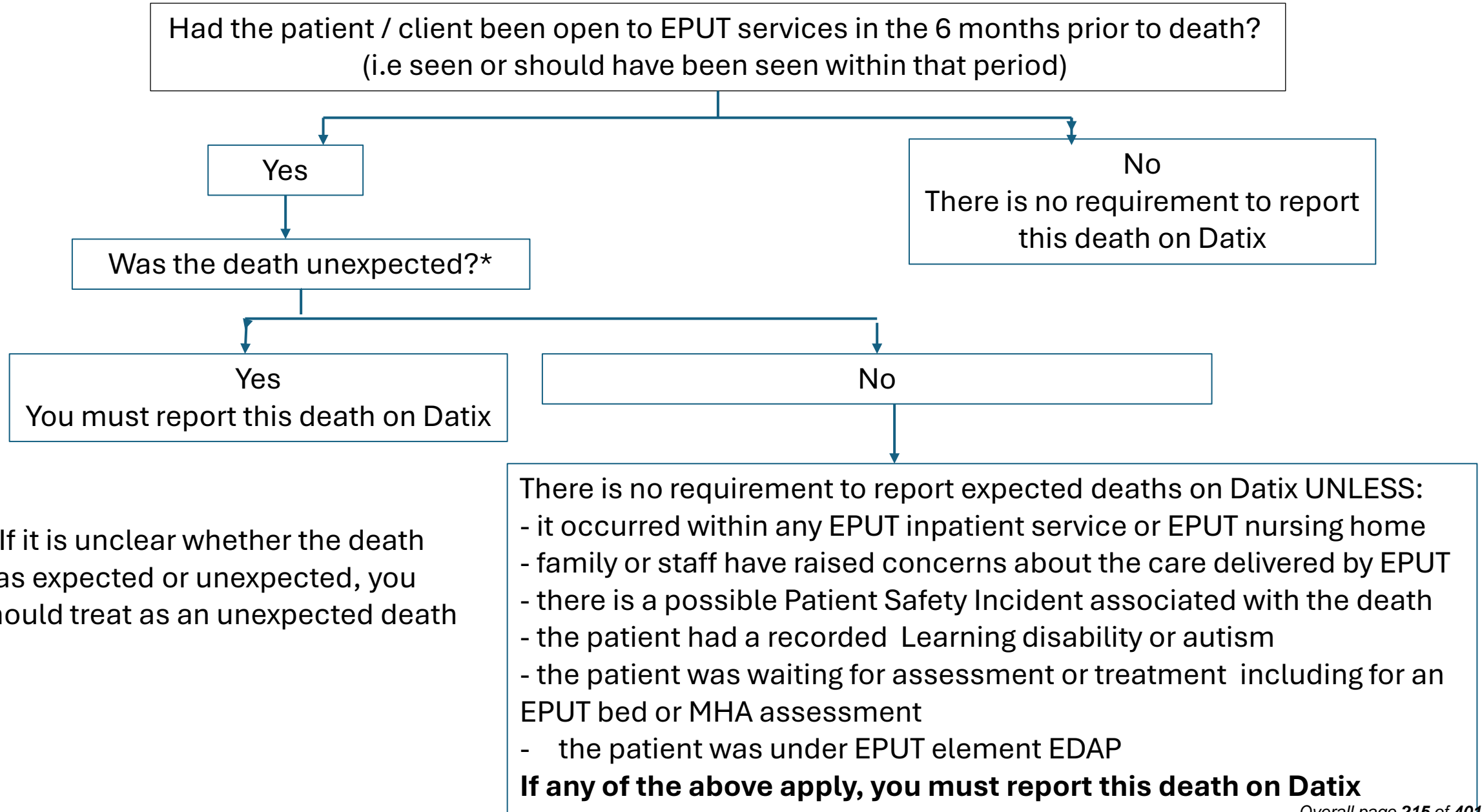
ACTIONS REQUIRED

The Board is asked to:

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



Appendix 1: DO I NEED TO REPORT THIS DEATH ON DATIX?



* If it is unclear whether the death was expected or unexpected, you should treat as an unexpected death

8.4 PUBLIC SECTOR EQUALITY DUTY (PSED)

● Decision Item

👤 AM

REFERENCES

Only PDFs are attached

 PSED Report 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 2026	
Report Title:		Public Sector Equality Duty (PSED) 2024-2025				
Executive/ Non-Executive Lead:		Andrew McMenemy - Executive Chief People Officer				
Report Author(s):		Paul Taylor - Director of Organisational Development and Culture				
Report discussed previously at:		People Committee 26 February 2026				
Level of Assurance:		Level 1	✓	Level 2		Level 3

Risk Assessment of Report

Summary of risks highlighted in this report	<p>If the Trust does not produce accurate, timely, and credible Public Sector Equality reporting, it will fail to meet statutory requirements under the Public Sector Equality Duty.</p> <p>More importantly than publication, it will undermine staff confidence in the organisation's commitment to fairness, pay equality, and the elimination of discrimination.</p> <p>This poses a significant risk to staff experience, retention, and organisational development, as employees who feel undervalued or treated unfairly are less likely to stay or to engage positively.</p> <p>Poor reporting also prevents the Trust from realising the full benefits of a diverse workforce, including improved decision-making, innovation, and cultural strength.</p>		
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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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	Statutory Reporting		
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	Andrew McMenemy	
	Finance		
	Estates		
	Other		

Purpose of the Report

This report is one of three statutory submissions consolidating our Public Sector Equality Duty, Equality Delivery System and Pay Gap reporting.

Relating to the time period of 2024-25, it demonstrates how EPUT gives due regard to eliminating discrimination and advancing equality of opportunity by publishing annual workforce data, narrative analysis and the actions we are taking to address identified inequalities.

The report meets our legal publishing obligations and provides clear, accessible evidence of progress and priorities. Content is presented in plain language and supported by data and recommended next steps to inform governance, decision making and public transparency.

Approval	✓
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Discussion	✓
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Information	✓
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Recommendations/Action Required

The Board of Directors is asked to:

- **Note** the contents of this report including the Trust’s performance for 2024-25 in supporting equal opportunities for staff, patients and communities with protected characteristics, the insights and the areas of focus which continue into our current work plans.
- **Approve** for publication on our external facing website.

Summary of key issues

The 2024-25 Public Sector Equality Duty report demonstrates how EPUT has given due regard to eliminating discrimination and advancing equality of opportunity. It presents comprehensive workforce data, key observations and a focused set of recommended actions to close gaps in representation, experience and outcomes. This report and the following themes relate to April 2024 to March 2025:

Key findings (grouped by theme)

Theme 1: Workforce representativeness and demographics

The workforce broadly reflects the local population, with rising ethnic diversity and increased disability disclosure. Variation persists across staff groups, grades and professions. Progress is evident in some ethnic minority representation and reduced reports of bullying and harassment, but disparities remain in career progression and appointment likelihood. Disability disclosure has increased, yet perceptions of progression, workplace adjustments and engagement for disabled staff have declined. Declaration rates for LGBTQ+ and other groups require improvement.

Theme 2: Staff experience, culture and behaviours

The staff survey results from 2024 shows small declines across most People Promise themes despite improved participation from protected groups. Behaviour, dignity and sexual safety remain priority areas. Survey response rates fell in 2024, and feedback emphasises the need for visible action and clearer communication.

Theme 3: Leadership, governance and accountability

The Trust has established clear EDI objectives with formal oversight and assurance from the Executive Team and People Committee; however, these objectives are not yet consistently integrated into executive appraisal processes, creating a clear opportunity to strengthen accountability and leadership across 2026/27. Embedding EDI into appraisal criteria, performance conversations and development plans will

ensure senior leaders are measured on inclusive behaviours and outcomes, reinforce organisational priorities, and accelerate progress on equality, diversity and inclusion throughout the Trust.

Theme 4: Patients, families and carers

Over the next 12 months the Trust will strengthen its population health approach by developing a co-produced population health plan shaped with patients, carers, communities and system partners. This needs to align to Core20PLUS5 priorities, PCREF delivery and place-based learning. The key priorities will need to include strengthening the quality and consistency of Equality and Health Inequality Impact Assessments, deepening engagement with communities, voluntary, community and social enterprise partners. Further work will be required to embed co-design and co-production across strategic and operational decision-making and continue to develop and support the peer workforce. Currently, population health data is not informing priority areas like workforce planning and operational activity/demand in a coherent way.

Priority actions for Equality and Inclusion

Actions set out in this report were based on 2024-2025 data and extend into our newly developed Equality Delivery System Action Plan and Pay Gap Action Plan. The six priority areas are:

- **Demographics and employee declaration:** Maintain Board-level oversight through monthly Executive Committee updates and regular People Committee reporting. Publish user-friendly summaries and infographics to support decision making and Equality Impact Assessments. Drive data confidence and disclosure with monthly executive oversight of completeness and trends.
- **Recruitment and career progression:** Strengthen inclusive recruitment and promotion practices, maintain global ethnic majority representation on interview panels, introduce reciprocal mentoring, and embed equality scrutiny in conduct triage panels. Work with recruitment teams to increase declaration rates and close progression gaps.
- **Leadership and behaviours:** Refresh the behaviours framework (including developing a leadership behaviour framework) with staff, strengthen visible leadership ownership through partnership with Kings Fund and BRAP to develop a Trust-wide leadership programme. Continue targeted training on unprofessional behaviours, sexual safety and anti-racist practice, informed by survey and other data intelligence. Deliver quarterly leadership sessions to the Senior Leadership Group (SLG) and executive team on trauma-informed approaches to leadership and inclusion, enhancing relationally informed and purposeful practice.
- **Governance and assurance:** Regular reporting into the Staff Experience and Inclusion Group, People Committee, Executive Committee and Board. Improve triangulation of workforce, staff survey and employee relations data to evidence impact.
- **Staff engagement and feedback:** Increase staff survey participation through targeted engagement with care units and strengthen feedback loops such as 'You Said We Did' and executive briefings. Review and strengthen staff network representation and establish a co-designed calendar of recognition events.
- **Patients, families and carers:** Enhance EQUIA quality checks, use population health intelligence to surface risks, and ensure lived experience is central to transformation and planning. Improve data quality and analytical capability to triangulate equality, patient experience and safety data and target action through Core20PLUS5 and place-based partnerships.

These actions will create a fairer, more supportive Trust where all colleagues can develop and progress.

Next steps and governance

The report and in particular the actions will be discussed with staff networks and the newly formed Staff Experience and Inclusion Group. It will be published on external and internal channels alongside other statutory reports. Ongoing oversight will be provided through quarterly EDI progress reports to the Executive Team, the Staff Experience & Inclusion Group and periodic assurance to People Committee and Trust Board.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

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

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

Acronyms/Terms Used in the Report

WRES	Workforce Race Equality Standard	PSED	Public Sector Equality Duty
WDES	Workforce Disability Equality Standard	EDI	Equality Diversity and Inclusion
EDS 2	Equality Delivery System 2	HR /ER	Human Resources / Employee Relations
ESR	Electronic Staff Record		
BME	Black, Asian and Minority Ethnicity		

Supporting Reports/ Appendices /or further reading

Public Sector Equality Duty Report (2024/25)
Appendix 1: Essex Census Data & EPUT workforce data

Lead



**Andrew McMenemy,
Executive Chief People Officer**



Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

***PUBLIC SECTOR EQUALITY DUTY
ANNUAL REPORT
April 2024-March 2025***

PART ONE – WORKFORCE

Introduction

Implementation of the Public Sector Equality Duty (PSED) is a legal requirement for all listed public authorities. Organisations are required to follow the implementation of PSED in accordance with PSED guidance documents.

The report provides staff and leaders with tools to improve, review and develop their approach in identifying and addressing disparities which affect people from 9 protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage or civil partnership). The PSED has two parts – the General Duty and the Specific Duty. The General duty is as follows;

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act 2010.
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

The specific duties are the practical requirements that make the duty more transparent, namely:

- Publishing equality information and updating it every year
- Setting objectives every four years

This report shares two parts of information. Part 1 gives data about our workforce, which has been collected from employee records, recruitment, and employee relations data. Part 2 focuses on patients, families and carers.

Each year we are required to publish this information on our public website. The reporting period for this data is **1 April 2024 to 31 March 2025**.

Continued Improvements

Over the last 12 months the Trust has seen sufficient progress on a number of EDI work streams, which is combined across the People Promise themes and the 9 protected characteristics. These include:

- › Board engagement – EDI objectives embedded into Executive appraisals.
- › Trust Behavioural framework – co-created across the Trust by all levels, embedded within appraisals, team away days, ward managers training, leadership development programme and management development programme
- › Wellbeing conversations & awareness workshops created for middle managers in a management development programme.
- › Menopause friendly accreditation via Henpicked delivering Menopause awareness sessions for managers and staff.
- › Revised and refreshed Reasonable adjustments passport, guidance and policy for staff with disabilities

- › Implementation of the NHS sexual safety charter and commenced implementation of sexual safety awareness with improved experience evidenced in our most recent staff survey results

Equality, Diversity and Inclusion

EDI Monitoring

We are committed to challenging discrimination, both within our workforce and within the care we provide. We're proud of the diversity of our staff and want EPUT to be a great place to work and for all staff to feel they belong and are equally valued.

This Equality Diversity and Inclusion (EDI) Strategy is aligned with the Trust's strategic vision, values and objectives. It is about everyone actively reducing inequalities, respecting one another, and building an open and equitable culture within our organisation that celebrates diversity. This strategy enables us to fulfil the Trust's purpose, "We care for people every day. What we do together, matters"

Demographic of Essex

The National Census takes place every 10 years. It gives us a picture of all the people and households in England and Wales. The benchmarking information in this report is taken from the National Census Information for 2021.

The overall analysis demonstrates that **the Trust's demographic profile when compared with the community profile shows us that our workforce is representative of the community it serves.** Where there are variations these are highlighted.

- The population of Essex (Excluding Southend or Thurrock), 1.5m in 2021, has seen an **increase of 109,713** over the last 10 years (since Census 2011) – an average annual growth rate of 0.76%
- The areas with the highest number of residents are Colchester (155.5k), Basildon (154.0k), and Chelmsford (151.0k)
- Over the last 10 years, the population of Essex has grown at a faster rate than England (0.64% growth per year). Essex's growth rate is similar to London (0.74% growth per year), though this may be in part due to the impact of the pandemic on where people were living on Census Day
- The largest ethnic group in Essex is "White British", which accounts for 85.1% of Essex residents. Taken together, all other ethnic groups account for 14.9% of the Essex population.

Staff Diversity Networks

The staff networks work with the Trust to improve staff experience and develop and deliver the Trust's priorities by creating an inclusive environment. The Networks provide a psychologically secure environment for staff to share lived experiences, feel empowered, be heard and drive change. Membership is open to all EPUT staff who identify with one or more of the networks or allies who express a shared interest in driving Equality, Diversity and Inclusion.

EPUT currently have the following 5 diversity networks:

- Spiritual and Faith
- Disability and Mental Health
- LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, +)

- Gender Equality
- EMREN (Ethnic Minority Race Equality)

To drive the agenda forward each network has a Chair and an Executive Sponsor.

In 2024 the Trust introduced the following additional support structures providing resources and building awareness to specific focusses

- Menopause Café
- Neuro-Inclusive Café

The networks meet regularly, enabling them to grow, develop staff-related activities, explore opportunities for cross-network collaboration, and establish the priorities and objectives that support their members and colleagues within the Trust. They are valued representative bodies of the Trust and are members of a number of committees.

Next Steps:

We continue our journey to reduce inequalities and over the coming year EPUT will take the following actions:

- Launch of a Staff Carer's Lounge
- Increase and build the membership of each the networks, refreshing the networks and the purpose.
- Celebration of key events, holding awareness sessions for all staff.
- Develop intersectional approaches to working with all networks.
- Continue to develop and build resources to support EPUT staff and to build a culture of inclusivity.
- Prepare proposals to coach our leaders in cultural awareness
- Continue our programme of sexual safety at work
- Align the executive team appraisals and EDI objectives to staff network priorities.









Staff Survey

The NHS staff survey areas are aligned to the NHS People Promise [NHS England » The Promise](#). These questions set out in the words of NHS staff the things that would most improve their working experience.

In 2024, the Trust achieved a response rate of 41%, with 2,785 questionnaires returned; this was a decrease from 2023 although despite an overall lower response, we saw an increase in respondents across all minority groups. Moreover, we have also seen an increase of respondents with a long-lasting health condition or disability.

The People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together.

The table below shows the result from the national staff survey. A higher score is better:

People Promise Year	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team	 Staff Engagement	 Morale
2023	7.55	6.37	6.98	6.45	5.96	6.84	7.20	7.17	6.28
2024	7.46	6.31	6.86	6.30	5.97	6.78	7.11	6.97	6.13

As a result of the declines, **we are working to see increases in the 2025 response rate and the overall scores** through the following:-

Improvements for 2025

The Trust understand the importance of hearing everyone’s voice and experiences. Our key focus is to continue to engage with colleagues to obtain a more accurate and comprehensive understanding of our employee’s needs and experiences. In doing so we will make our actions meaningful and tangible.

Our response rate in 2024 was our lowest: 41% (2785 respondents)

Next steps 2025:

To improve momentum and experiences of our people from protected characteristics, we are planning the next steps of disseminating our results, which includes:

- Timeline and commitment to share results with key stakeholders and the Trust
- Collaborative working with the communication team to enhance our ‘You Said, We Did’ campaign to create a little and often approach to consistency show progress made.
- Investment in additional reports to support divisional analysis of the results.
- To ensure that the analysis of core data is meaningful and identify areas for improvement the following analysis will be undertaken,
- Divisional overview by Staff Experience Team.
- Trust and divisional breakdown by core actions, disseminated to relevant managers.
- Professional behaviours workshops
- Sexual safety workshops
- Protected characteristics by core EDI and staff experience questions

We will continue to undertake walk-a round’s and engage with colleagues, running focus groups to support the identification and implementation of short-term actions ahead of receiving the results to ensure we are being seen to take action and progress over the entire year.

Workforce Culture

The Trust recognises that delivering equitable, inclusive care depends on the **knowledge, skills and behaviours of its workforce**. Creating a culture that values equality, diversity and lived experience is essential to meeting the Public Sector Equality Duty in practice.

Learning from patient and carer experience, including feedback relating to discrimination, communication and cultural competence, informs workforce development activity. This includes training, reflective practice and leadership development, ensuring that staff are supported to deliver care that is respectful, compassionate and responsive to individual need.

The involvement of people with lived experience in workforce development activity (i.e. **induction, Buddy scheme, Oliver MacGowan**), including training and service improvement, recruitment (i.e. interview panels and recruitment policy change), strengthens understanding and supports cultural change. This approach reinforces the Trust's commitment to shared power, mutual learning and continuous improvement.

Workforce equality and experience data are monitored through established governance processes and contribute to the Trust's overall assurance framework. This ensures that issues relating to culture, inclusion and equality are addressed alongside clinical quality and safety.

Our Workforce Breakdown

Workforce Data

As a public body, we are required to publish equality information about our workforce across all of the protected characteristics.

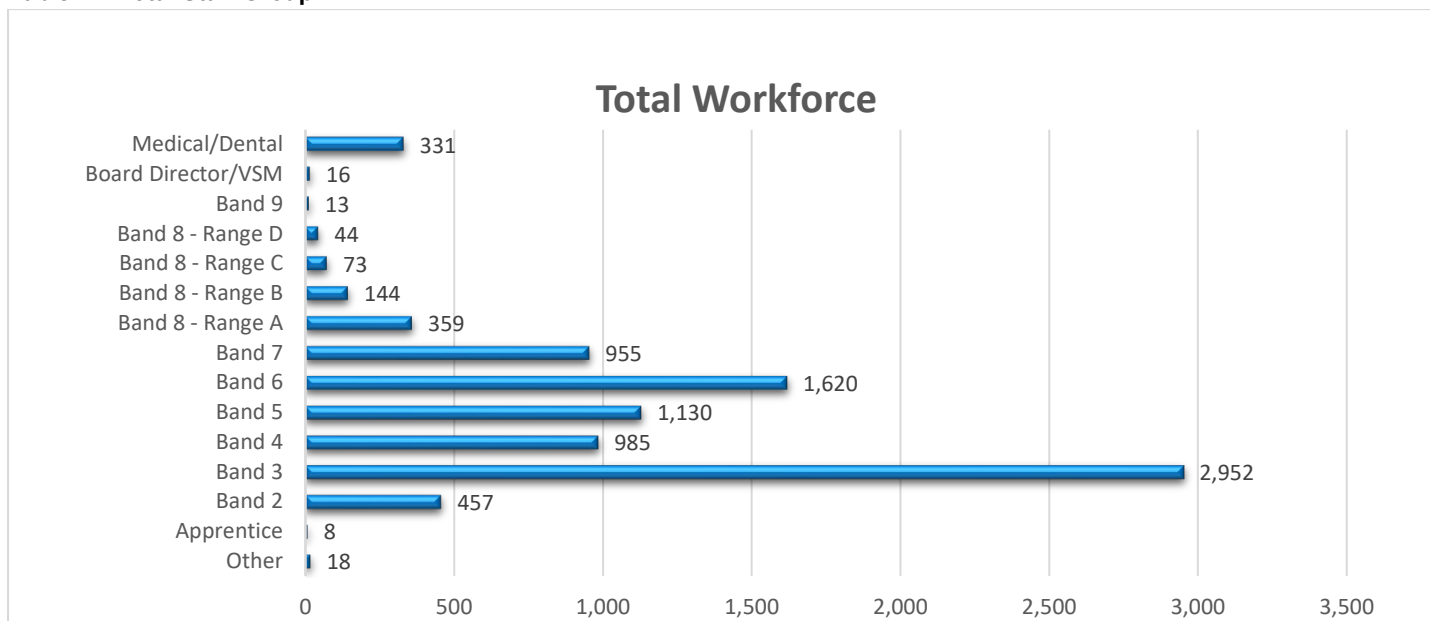
The workforce data contained within this report has been obtained from various sources:

- Electronic Staff Record (ESR)
- TRAC (recruitment records)
- Employee Relations
- NHS Staff Survey
- WRES (Workforce Race Equality Standard)
- WDES (Workforce Disability Equality Standard)

Full breakdowns are attached at Appendix 1 to this report. It is important to note that within ESR, there may be gaps in data relating to certain protected characteristics where colleagues have been given the option not to disclose information in relation to those protected characteristics. This is a common dynamic across most NHS organisations.

For the 2024/2025 reporting period, the total headcount for EPUT was 9105, a decrease of 136 staff from the last reporting period. This figure includes all permanent, fixed-term, bank workers, and leavers during this period. The table below provides a split across staffing groups and grades. From the previous reporting period we can see a decrease in variance within Band 2, 3 and Apprentice level.

Table 1 – Total Staff Group



Staff Profile by Ethnicity

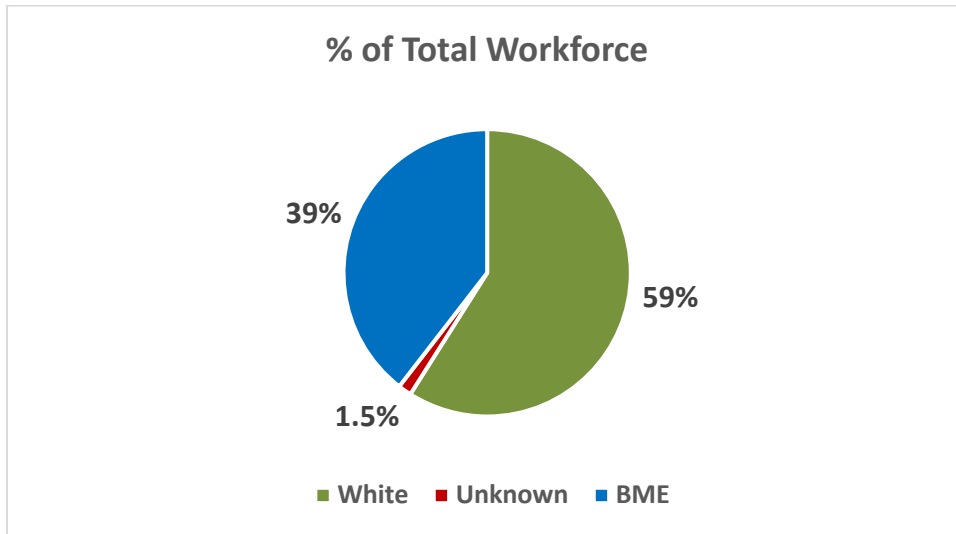
Our records show **39%** of our workforce including Bank workers is from a BME background, which is an increase of 2% compared to the previous year’s PSED report. This indicates that our workforce demographic aligns to our local population, which has a BME representation of 14.9% (Census 2021). This is positive and shows that EPUT employs a diverse workforce for the community it serves. ,

The Trust composition of ethnicities are as follows:

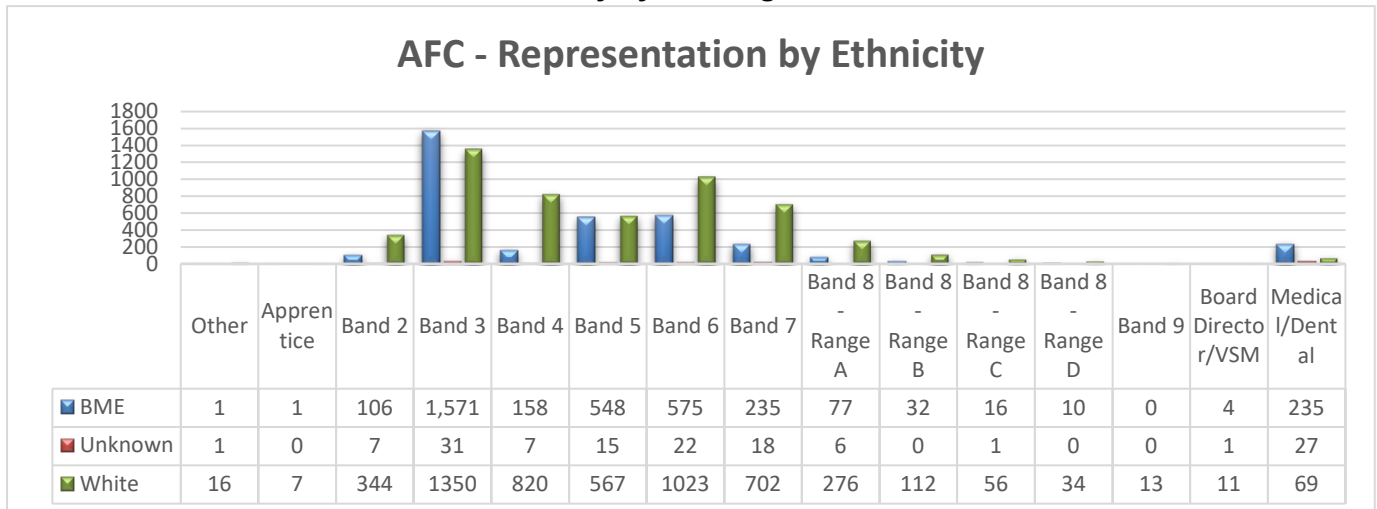
Table 2 – Ethnicity Breakdown

Code	Ethnic Origin	EPUT Workforce - 2024	Code	Ethnic Origin	EPUT Workforce - 2024
A	White - British	4811	K	Asian or Asian British - Bangladeshi	71
B	White - Irish	72	L	Asian or Asian British – Any other Asian background	182
C	White-Any other White background	517	M	Black or Black British – Caribbean	99
D	Mixed – White & Black Caribbean	46	N	Black or Black British – African	2043
E	Mixed – White & Black African	57	P	Black or Black British – Any other Black background	369
F	Mixed – White & Asian	40	R	Chinese	21
G	Mixed – Any other mixed background	61	S	Any other ethnic group	136
H	Asian or Asian British-Indian	366	U	Unknown / Not Stated	23
J	Asian or Asian British - Pakistani	78	Z	Unknown / Not Stated	113

The pie chart below is a breakdown of ethnicity by percentage:



The table below is a breakdown of ethnicity by banding. :



Slight changes were identified in comparison with the previous reporting period;

- Medical & Dental (71%), an increase of 3%.
- Apprentice (13%) an increase of 5%.
- Band 3 (53%), an increase of 3%.
- Band 6 (35%), an increase of 5%.
- Band 7 (25%), an increase of 3%.
- Band 8c (22%), an increase of 7%.

Whilst overall BME representation across the Trust is increasing, this is not proportional in all bandings, particularly in roles Band 5 which remained the same at 48% and we saw drops in representation for higher bandings 8d and above.

There is still further work needed to obtain representation across all bandings which is representative of our overall workforce but there are some year on year improvements are being seen.

Workforce Race Equality Standard (WRES) Metrics 2024/2025

The WRES looks at the experience of our BAME staff compared to their white counterparts. We have seen improvements in two out of the nine WRES indicators in 2025 report, eight of which remain close to national averages. A full breakdown of results is available in the WRES Report

Notable areas of encouraging performance includes:

- An increase of 2.9% BME staff representation from the previous year's report
- The BME clinical workforce (non-medical) has also seen significant growth in bands 3, 6, 7 and 8a
- 1.5% decrease in the percentage of BME Staff reporting experiences of harassment, bullying or abuse from patients / service users, relatives, or the public in last 12 months

Whilst we have worked hard to improve the experiences of BME staff, the WRES 2025 report highlights areas for development, including:

- 3.06% fall in the percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion.
- Whilst the Trust have seen some improvements, there remained a disparity in the negative experience of BME staff in all indicators in comparison to their White counterparts
- Likelihood of appointment, with White staff appointed at rates of 1.44 for every 1 appointment compared to applicants from a BME background. This highlights that White staff were more likely to be appointed during this period

We will continue to work in collaboration with our Leadership, our Ethnic Race Equality Network and Organisational Development & Culture Team to drive improvement in creating an inclusive and supportive environment for our BME staff.

Steps we are taking to eliminate discrimination and improve experience:

- We have continued to roll out our new values-based recruitment procedures, encouraging hiring manager to utilise the de-bias toolkit, ensuring interviews for roles 8a and above include a diverse panel members.
- We have made updates to our disciplinary policy, special leave policy, flexible working policy and grievance policy, to be more compassionate and supportive to colleagues
- The disciplinary process has been revised and a preliminary assessment form and independent triage panel have been introduced. This process supports consistency and fairness in the incident review, emphasising learning, and informal resolution and is already showing impact on the % of BME staff being referred to the formal disciplinary process
- We will refresh our approach to Reciprocal Mentoring
- Following the trust signing up our Anti-Racism pledge, we will continue to promote and rollout a zero-tolerance approach to racism in our trust, promoting the behaviour framework.
- Unacceptable behaviour and sexual safety workshops will continue to be rolled out – with focussed interventions in areas reporting negative experiences in the staff survey. .
- A 'leaders course' for unprofessional behaviour and sexual safety training will be rolled out.
- We have a very active BME staff network (EMREN), who have celebrated key events throughout the year, including South Asian Heritage Month and black history month.

The full report can be accessed at <https://eput.nhs.uk/wp-content/uploads/2025/10/WRES-2025.pdf>

Staff Profile by LTC/Disability

EPUT have **712 (8%)** staff who declared themselves as having a disability or long term health condition (LTC)

during this reporting period. With a **1% increase** from the previous year' report, it is encouraging to see staff with a LTC or disability declaring a declaring their condition. This reflects that EPUT is a disability confident leader and promotes an inclusive environment where everyone feels they belong.

The Trust will continue to encourage all colleagues to declare their status and reassure colleagues the benefits of doing so. This will help the Trust in providing a psychologically safe environment for its staff, as well as, improving the quality of data for this protected group. To further support achieving this we are:

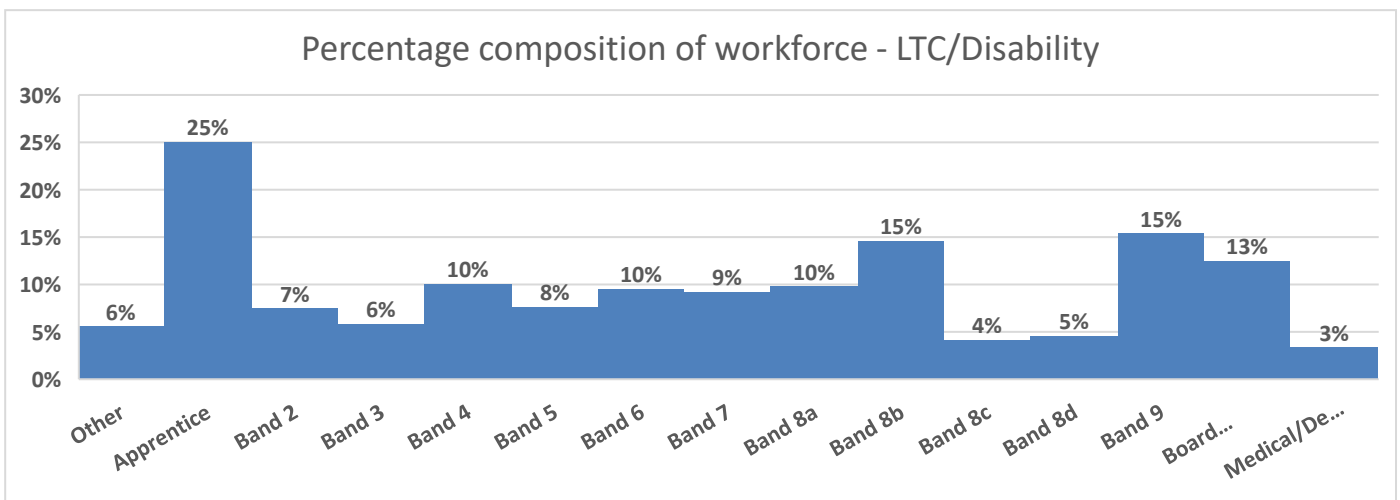
- Encouraging staff to share their personal experience relating to their disability/LTC;
- Encouraging wellbeing discussions and updates at appraisal and 1:1 support
- Promoting the use of the ESR self-service function in which staff have the opportunity to update information relating to their protected characteristics.
- Encouraging different forms of staff support, including the new neuroinclusive café and staff carer's lounge
- Working to progress the excellent work of the disability staff network

Observations

AFC Bands 3-7 have the highest number of staff who have disclosed a disability or LTC. The highest percentages of staff who declared a disability or LTC lie within the apprentice group (25%) which is an increase of 12% from the previous reporting period. In addition, the percentages of colleagues sharing their disability is higher within senior roles Board/VSM (13%), which is contrary to the pattern seen across the local system.

Whilst EPUT is a disability confident leader and continually encouraging staff to disclose a LTC or disability we saw 10% of staff chose the following:

- Not to declare – 8%
- Prefer not the answer – 0.4%
- Unspecified – 2%



There are low numbers of Medics who declared themselves as having a disability or LTC. This can be explained by a high number of trainee doctors rotating through different Trusts, meaning that demographic data needs to be re-shared each time.

There were 1104 medical and non-medical new starters in EPUT during 2024/2025, which was lower than 2023/2024 by 1,093. All new starters are given the opportunity to share their information relating to a disability, LTC and required workplace adjustments. For this period, 8% of new starters stated that they have a disability or LTC, an increase of 1% since the previous report.

A further breakdown of new starters indicates the following declarations:

- Physical impairment – 0.5%
- Sensory impairment – 0.5%
- Mental health condition – 0.9%
- Learning disability/difficulty – 1.35%
- Long-standing illness – 2%
- Other- 2.5%

This demonstrates that the Trust is in alignment with the NHSE EDI Improvement plan and the WDES by continuing to improve the experiences of our workforce who have a disability or LTC. Further information about the Improvement Plan is detailed at the end of this report.

WDES – Workforce Disability Equality Standard Indicators 2024/25

EPUT has seen improvement in three out of the ten WDES Metrics, with the remaining seven being close to national averages. **Notable positives were seen across the following indicators:**

- Increased representation of staff with a disability; 8.84% of staff are recorded as declaring a disability, an increase of 1.28% from the previous year
- Likelihood to appoint performance remained strong at 0.91, with disabled applicants slightly more likely to be appointed than non-disabled counterparts
- 1.56% of disabled staff who completed the NHS Staff Survey reported feeling satisfied with the extent to which the organisation values their work. This is 0.3% greater improvement than non-disabled counterparts.

Whilst there are some improvements in experience, the WDES 2025 report highlights areas for development, including:

- There was a significant decline in staff with disabilities reporting belief that EPUT offers equal opportunities for career progression or promotion, with a similar decline for nondisabled staff.
- 5.9% fall in percentage of disabled staff saying that the organisation has made adequate adjustment(s) to enable them to carry out their work.
- Falls in engagement amongst disabled staff. The 2024 survey saw a 0.27 score decrease in the Staff Engagement People Promise Theme, 0.07 greater than non-disabled counterparts

We are working hard to ensure the experience and treatment of disabled staff is fair and equitable. As part of this work the Trust has taken the following measures:

- Disability and Mental Health Network meetings are attended by senior leads to ensure feedback is heard and acted upon.
- Staff Network Sessions are held virtually, with access to subtitles / transcribing tools to ensure they are as accessible as possible for attendees.
- Staff can raise concerns anonymously through our Freedom to Speak Up Guardians, as well as

raise issues about their accessibility via our Employee Relations and Staff Experience functions. The Equality Advisor can also provide managers or employees with guidance and support in these areas.

- We have worked closely with our Transformation Team to ensure the Disability and Mental Health Network has clear goals for the year and is able to measure their own progress via SMART KPI's.

The full report can be accessed via <https://eput.nhs.uk/wp-content/uploads/2025/10/WDES-2025.pdf>

Health and Wellbeing

A comprehensive occupational health (OH) service is available to staff via PAM Wellness Solutions' core services which include mental health, physical health and rehabilitation services.

PAM Wellness provide 24/7/365 confidential helplines, including employee assistance programmes (EAP), offering enhanced psychological services and specialist therapies, as well as pre and post-incident trauma services. Other services within the OH Services include:

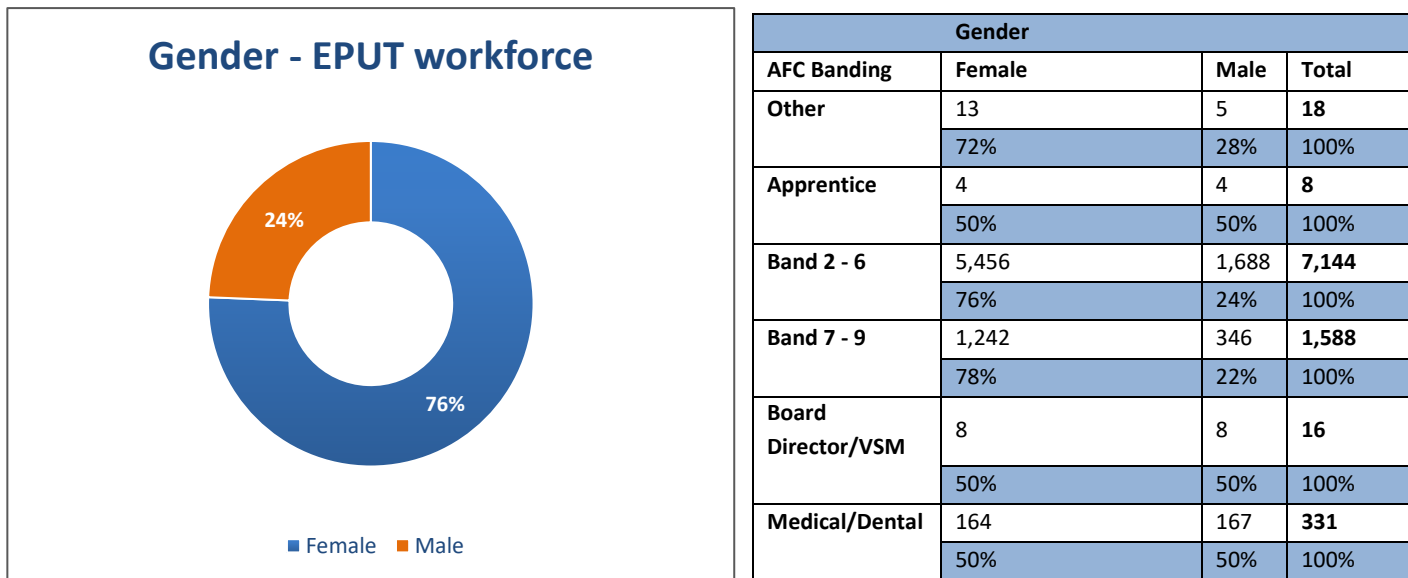
- Health assessments
- Fitness to work/practice
- Permanent/temporary injury applications
- Detailed recommendations for work related rehabilitation (for example, phased return to work, re-deployment, adjustments to duties/post)
- Ill health retirement, providing advice in line with national guidelines
- Immediate response and follow-up service for staff with sharps injuries
- Pre-employment health assessments (including for international recruitment)
- Fast track physiotherapy referral
- Workplace assessments for neurodiverse colleagues supporting reasonable adjustments within the workplace.

The wellbeing of our colleagues is our priority; there are several aspects in place to help, manage and support individuals, such as:

- Staff Experience Team, which offer support guidance, resources and wellbeing promotion.
- Newly developed and refreshed Reasonable adjustments passport.
- Menopause awareness training for managers and colleagues
- Menopause café for staff
- Neuro-inclusive café for staff
- Staff Carer's Lounge
- Here for you - provides therapeutic support where difficulties are linked to the workplace. This could be stress, distress and/or trauma, which is impacting on a person's ability to be at work or carry out their duties. Continued support via the various EDI network meetings.
- Promoting wellbeing local and national wellbeing initiatives/programmes relating to mental and physical wellbeing.
- Utilising the Occupational Health service for advice/support on the health of staff in the workplace.
- Promoting the services of the Trust's EAP, which provides a range of counselling services, self-help programmes, as well as, a fast-track physiotherapy service.
- Health and wellbeing resources, information's and guidance for all colleagues which is available via EPUT Intranet.

Staff Profile by Gender

Our workforce is predominantly female 76% and has remained relatively consistent over the last several years with minor declines and increases. These figures are similar to the wider NHS, which is predominantly female.



The largest proportion of staff lie within AFC Bands 2-6, with a female workforce of **76%**. In comparison to last year, the reported percentage of female staff holding a senior management role 50% which has increased by 6% since 2023/2024. We can see from 2023 Board Director/VSM level has increased by 6% for females and males have decrease by 6%, meaning gender within Board Director /VSM roles are equal.

This year we are pleased to see the increase in percentage of females entering Board Director/VSM level having encouraged female colleagues to progress into senior roles ensuring they are proportionally represented in talent management and leadership development programmes, as well as, identifying dedicated and bespoke development programmes.

Working Patterns

Pay Gap

The Trust adheres to the Government Equalities Office’s Pay Gap (GPG) reporting requirements and has an action plan, in which it sets out its remedial objectives to address any gender pay inequality.

In June 2023, NHS England launched the EDI Improvement Plan which sets out targeted actions to address the prejudice and discrimination, the Pay Gap report contains data and analysis relating to the gender, race and disability pay gap. This information is contained in a separate dedicated report which can be found here: *insert link after reports are approved*

Flexible working

Over the last 3 years we have seen a significant increase in flexible working requests. Reviewing the working patterns, female colleagues are significantly more likely to work part time than their male counterparts in many cases due to caring responsibilities. Moreover, female colleagues are more likely to become and provide more hours of unpaid care than men. The staff survey responses in 2024 indicated:

- 37% from 2746 responses said ‘yes’ to ‘Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.’
- 40% of 2754 responses answered ‘Yes’ to ‘Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for?’

The implementation of the flexible working policy can often influence individuals in feeling supported and fulfilled in undertaking their role. Flexible working increases diversity and equality of opportunities for those with disabilities, caring responsibilities and provides further support during pregnancy or older colleagues who no longer wish to work full time and is a priority retention strategy for EPUT.

Table of flexible working request:

Category	2022/2023	2023/2024	2024/2025
Flexible Working	249	301	280

Flexible working requests for our female workforce is significantly higher (237) than for our male (43) workforce.

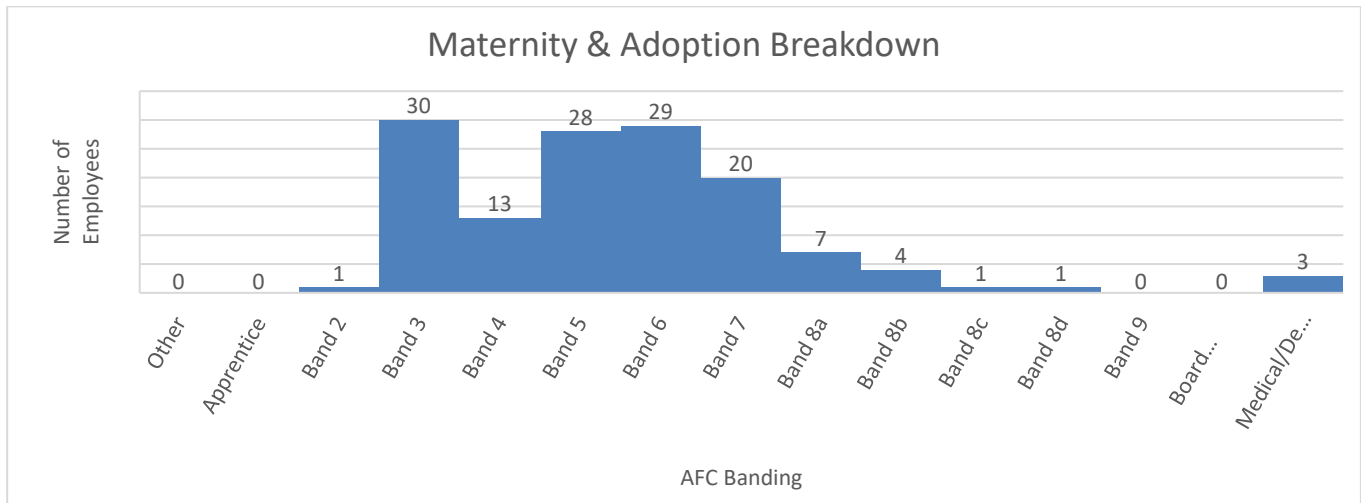
The Trust currently has a Gender Staff Equality network, which holds regular awareness sessions, sessions include flexible working and paternity leave, men’s health (MOT), international women’s day and many other events. In addition, a Carer’s Lounge is now in place, giving carers the opportunity to share experiences, raise awareness and share advice ensuring that our culture recognises the significance of caring in our workforce.

There is more to be done to encourage positive attitudes to flexible working whilst recognising the need for continuity of patient care and we will continue to build on the positive examples of success.

Pregnancy & Maternity

Workforce data shows 8757 members of staff are in active assignments, of these active assignment the data show us **137 (2%) of staff have taken maternity or adoption leave which is a slight increase** from the previous year report.

The bar chart below shows a further breakdown from the data reported within this period, showing that the highest number of those who have taken maternity or adoption are paid AFC band 3, 5 and 6.



Menopause

Our workforce breakdown of gender indicates that a significant proportion of our staff are likely to be exposed to the menopause and therefore it is vital that we are providing a supportive working environment.

EPUT strive to ensure all staff genders have the understanding, resources and guidance available to make sure the working environment is inclusive and everyone feels they belong, EPUT have introduced the following:

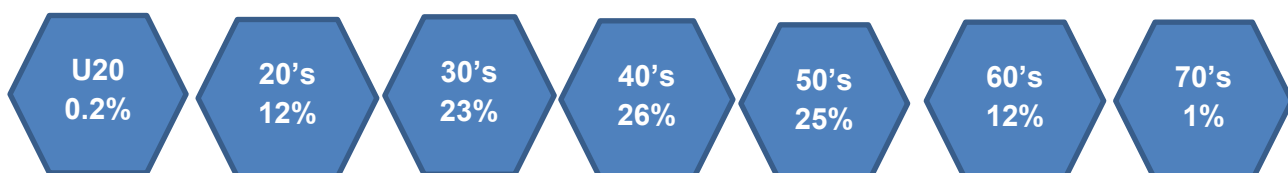
- The Menopause Café – offering colleague’s educational sessions relating to nutrition, work life balance, exercise, bone health and hosting events with guest speakers.
- Wellbeing hub – resources and information accessed via EPUT intranet
- Menopause guidance and information on the staff internet website.
- Menopause advocates – Delivering awareness sessions for colleagues and Line managers.

Managers also are able to record menopause related absence for their staff via the health roster system. This enables the Trust record reasons behind absence and gain a better understanding of the impact of the menopause on its staff and put in place appropriate support.

Age Profiles

There has been a slight decrease in employed staff in their 20’s, a slight increase by 1% for staff in their 40’s, and a slight decrease by 1% for staff in their 50’s. All other age groups have remained the same. The age demographic of our local area has a significantly higher population in the aged 50+ category meaning that our age demographic is slightly younger.

Workforce breakdown by Age:



With 38% of our total workforce over the age of 50, we work to offer support and sustainable career pathways to help attract and retain the younger pipeline workforce to ensure that our service users continue to receive high-quality care. This is then supported by working closely to retain our older workforce into working arrangements that not only encourage them to stay – retaining and valuing their input but also enhancing flexible working opportunities and work life balance

The Trust is actively engaging with young people in local communities by:

- Hosting recruitment drives
- Working closely with the Anchor programme locally to bring employment into areas of high deprivation
- Working with local schools, colleges and universities, encouraging young adults to consider a career within the NHS.
- Promoting the benefits of the NHS apprenticeship schemes available at the Trust.
- Health Care Assistant Academy

Flexible Retirement

Within the reporting period EPUT saw 111 staff leavers due to retirement which is less than the previous year. Recognising the contribution of our people and maximising retention of the knowledge, skills and experience of our older workforce , we strive to offer a range of flexible retirement options to support the health and wellbeing of staff. Options include:

- Step Down;
- Retire and Return;
- Partial Retirement;
- Part time reduced hours
- Early Retirement Reduced Buy Out

Sexual Orientation

Under the Public Sector Equality Duty of the Equality Act (2010) Sexual Orientation is a defined protected characteristic therefore EPUT must pay due regard. This is around ensuring colleagues benefit equally from all HR policies and functions, whilst ensuring they receive equal opportunities and recognition of sexual orientation and Equal Marriage status.

- The majority of staff declared their sexual orientation as heterosexual (84%) 7643 which is a 1% increase from the previous years report.
- 2% of the workforce (142) declared their sexual orientation as lesbian, gay, bisexual, transgender, queer/questioning and any other gender identified (LGBTQ+), which is a slight increase of 1% from the previous year's report.
- 10% (956) of staff choosing to not declare their sexual orientation.
- 2% of staff (178) declared their sexual orientation as Bisexual
- 2% of staff choose Unspecified for their sexual orientation

The Trust is conscious that the percentage of staff who shared their sexual orientation as LGBTQ+ is extremely low; this could be a result of anticipated discrimination, bullying and harassment, hate crimes and fear of being undermined.

EPUT updated the Equality, Inclusion and Human Rights policy and procedure with additional guidance for managers to support transgender staff members and patients, this was developed in collaboration with the LGBTQ+ Network in EPUT as well as contribution from the East of England Rainbow Network.

EPUT recognises there is more that can be done to support its LGBTQ+ colleagues in terms of offering reassurance, physiological safe spaces, further LGBTQ+ training and resources. The Trust provides resources and guidance for colleagues on the EDI hub, embedded the LGBTQ+ diversity network and develop a Transgender guidelines.

Marriage & Civil Partnership

The marital status with the highest percentage reported was married 50% of the workforce, with single following thereafter at 36%. In the previous reporting year we saw an increase of 4% for those selecting unspecified; this could be due to the fact that staff no longer had the option to select 'unknown', the figure has remained the same for this reporting year. The data from this reporting period show a slight decrease in the following statuses: divorced and Married with a slight increase in the following areas; legally separated, widowed, and civil partnership.

Marital Status of Staff in Post:

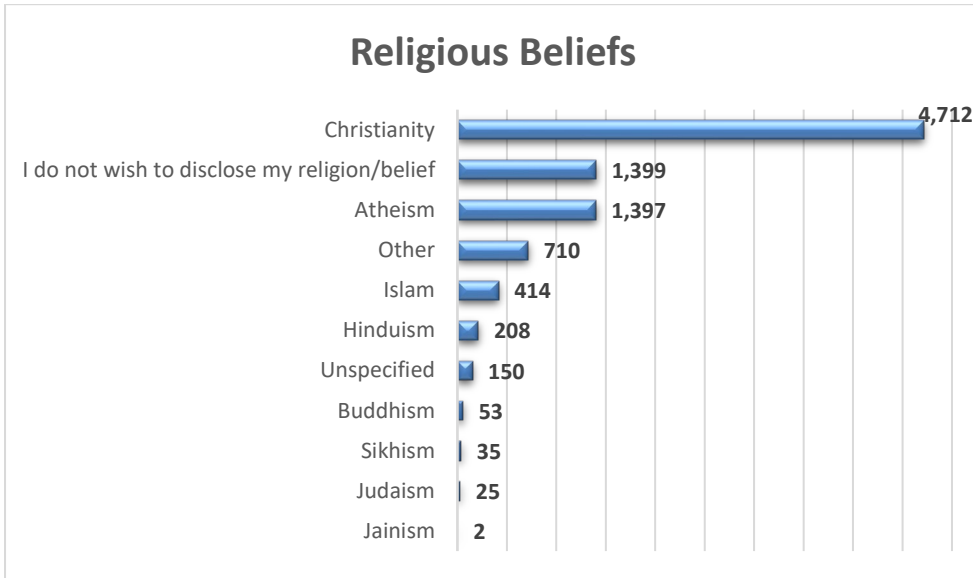
	Total	Percentage
Divorced	598	7%
Legally Separated	145	2%
Married	4586	50%
Single	3254	36%
Widowed	115	1%
Civil Partnership	127	2%
Unspecified	280	3%

The Trust ensures all colleagues have equal opportunities and recognition, regardless of marital status, by keeping HR policies up to date which align with employment law. The Trust also encourages colleagues to update their status on ESR.

Staff Profile Religious Belief

Similarly to previous years, the predominant shared religious belief is **Christianity (51%)** and **Atheism (15%)**. **15%** of staff chose not to disclose their religious belief; this also reflects the current Census as more people across the UK selected the option, 'No Religion' as their belief.

Chart below shows a breakdown EPUT's religious Belief:



EPUT pays due regard to religious beliefs by promoting the Faith and Spirituality Diversity Network, and celebrating religious festivals and events. The Trust encourages staff to update their religious status on ESR to support the Trust in providing equal opportunities for all faiths and non-faiths. The Interfaith and Spirituality Diversity Network works in collaboration with the Trust chaplaincy services, offering emotional, spiritual and religious guidance to all colleagues. Newly embedded prayer rooms have been provided, to enable staff the space for prayer and reflection.

New Starters & Leaver Profile

The Trust has taken action to promote a more diverse workforce by embedding a fairer recruitment process, with large recruitment campaigns advertising posts in multiple job platforms to ensure a larger talent pool of candidates including a focus on our local people and communities and areas of high unemployment.

In 2024/2025 there were **1714** new starters, 5437 were shortlisted of which 32% were appointed. The majority of new starters were employed in Band 3 posts.

Below gives an overview of our equality breakdown for new starters:



The demographic composition of new starters within the Trust:

Ethnicity: The total percentage of all new starters from ethnic minority backgrounds during this reporting period was 53%. This has remained the same from the previous reporting period.

Age: The highest percentage of new starters are those aged in their 20’s (24%), 30’s (24%) and 40’s (26%)

Gender: The workforce is predominately female which reflects in the new starters data - 72% new starters were female and 28% were male. In comparison from last year’s report, we saw a 1% increase of female new starters.

Disability: Overall **8%** of new starters stated that they have a disability, an increase of **1%** since the previous year report. There has been a slight increase year on year in the percentage of new starters disclosing a disability or LTC.

Sexual Orientation: The highest representation for sexual orientation was heterosexual (86%), followed by 8% of new starters declining to provide a response. 5% of our new starters disclosed as LGBTQ+ which was an 1% increase from the previous year.

Religious Belief: The highest representation of religious belief within new starters was Christianity (55%), followed by Atheism 18%, which reflects the figures of the overall Trusts demographics. However, there were a large number of new starters who chose not to disclose this information (10%).

Marital Status: The highest declared marital status was single (44%) and married (44%) which has equalised since the previous year reporting. 5% of new starters disclosed being divorced.

To align with the NHS EDI High Impact Action Plan, as well as the WRES/WDES action plans, EPUT continues to strive:

- To improve the recruitment process by developing and embedding the De-Bias toolkit for hiring managers to ensure the process is fair for all.
- Inclusion Ambassadors on interview panels for 8a and above roles is mandatory to increase a fairer recruitment process.
- To promote and build awareness of the Disability Confident Scheme.
- To promote our status as a Disability Confident Leader on all job advertisements and re-accredit in 2026
- Advertise roles within a wide range of recruitment platforms and outlets

Leavers

In 2024/2025 1700 employees left the Trust with an overall turnover rate of 2%, a 2% increase from the previous reporting period. The highest proportion of leaver’s falls within AFC bands 3.

Of the 1700 leavers, 58% of were planned (end of fixed term contracts, retirements and employee transfers) and 42% were unplanned exits (death in service, dismissal and voluntary resignation). 38% of unplanned leavers were recorded as ‘other’ or ‘unknown’.

Percentage breakdown Leavers:



The demographic composition of leavers for the Trust:

Ethnicity: 39% of leavers were from ethnic minority groups, which is a decrease of 3% in comparison to the previous year's report.

Disability: 8% of all leavers identified themselves as having a disability, an increase of 2% in comparison to the previous year.

Gender; 75% of leavers were female and 25% were male, which is proportionate to the overall workforce. We can see a slight decrease in female leavers (1%) and an decrease of male leavers (1%) from the previous reporting period.

Religion; The highest percentage of leavers declared themselves as Christian (53%), which is proportionate to the overall workforce.

Sexual Orientation: 3% of leavers were LGBTQ+, a decrease of 2% compared to last year.

Age: The average percentage of leavers remains equal across the 30-60 year age groups, however leavers which fall within the age group of 70 remains at 2% the same as the previous year's report.

We have not seen a substantial increase in leavers within the Trust and will continue with our combination of the Trust's initiatives to improve staff retention & on-boarding process, improved access to career development opportunities, fewer dismissals and the refresh and development of the exit questionnaire processes.

Promotions

The data collected from ESR on primary job assignments shows 423 promotions which was a decrease from the previous reporting period by 18%, This could be as a result of no promotional vacancies or appropriate candidates for the role as well as the financially challenged position of the trust and financial recovery programmes.

The demographic composition of staff who have been promoted within the Trust:

Ethnicity: 34% of staff who were promoted were from a BME background. This is a **4% increase** in comparison to last year's report. The highest promotional band for BAME staff was Band 6 (51%) and medical staffing (75%)

Disability: 7% of the staff that were promoted declared that they had a disability, which is a **1% decrease** in comparison to last year's report. EPUT have seen a decrease of 1% for 2 consecutive years.

Gender Breakdown: 77% of the promotions were female, while **23%** were male (an increase of **1%** in comparison to last year's data).

Religious Belief: The highest number of promotions came from those who declared themselves as Christian, which is representative of the underlying workforce.

Sexual Orientation: The highest proportion of staff who were promoted declared themselves as heterosexual (**86%**), which aligns to the overall workforce of the Trust. The percentage of LGBTQ+ staff who received a promotion was **5%** which was a (1%) increase in comparison to last year.,

Age: The data shows EPUT’s staff promotions falls within the younger and older adults, however appearing more frequently within the workforce aged group 26 – 45.

There is currently no marital status breakdown for promotions.

The Trust recognises the importance supporting staff throughout their career within EPUT and encourages career progression and development by providing the following initiatives::

- Management Development Programme
- Ward Manager Programme
- Leadership Development Programme
- RISE Programme
- Career Lounge for BME colleagues.

Employee Relations

Employee relations is the ways in which we manage our relationships at work and the management of workplace issues such as complaints or grievances and matters of behaviour and conduct.

Data in this category includes the following:

- The number of staff undergoing a disciplinary hearing
- The number of staff submitting formal grievances
- The number of staff who have been the subject of investigation and capability procedures the number of allegations made in relation to bullying and harassment (Dignity at Work)
- The number of staff whose level of sickness absence prompted formal action as detailed in the Trust’s Management of Sickness & Ill Health Procedure.

The data includes all staff (permanent and bank workers) across all pay bands.

Type / Category (reporting only)	Number of cases - 2023/24	Number of cases - 2024/25
Capability	22	28
Conduct	96	129
Temporary Worker Conduct	149	113
Flexible Working	301	280
Grievance	84	47
Temporary Worker Complaint	18	14
Sickness	10	10
TOTAL	680	621

The table above shows an increase in capability, conduct and temporary worker cases, with the exception of cases relating to sickness absence which has remained the same. We can see a decrease across other areas particularly in cases relating to flexible working and temporary worker conduct.

The demographic composition of staff who were involved in ER cases within the Trust:

Ethnicity: In comparison to the previous year's report we have seen an increase in formal cases overall, including **an increase in cases involving our BME staff**. Within this reporting period:

- 81 BME staff were subjected to ER procedures for conduct
- 103 BME staff were subjected to Temporary worker conduct
- 69 BME staff subjected to flexible working

Most staff who are involved in ER cases are white British (48%), with just under half of cases (46%) being attributed to workers from a BME background which in comparison is higher than the % within our workforce overall (39%). 69 flexible working applications were submitted from BME employees, with a further 211 from non-ethnic employees.

Disability: 11% of ER cases involved staff who identified as having a disability or long term health condition, an increase of 1% since the previous reporting period. In comparison, 80% of cases involved staff who declared that they did not have a disability an increase of 2% from the previous year.

Gender: The gender breakdown of staff involved in ER cases is 27% for men and 73% for women. This figure is particularly high for male staff as nearly a quarter of the workforce are men.

Religious: Christianity (56%) is the highest declared religion followed by "I do not wish to disclose my religion or belief" (14%) and Atheism (14%).

Sexual Orientation: 10% of staff who have been involved in ER cases have chosen not to disclose their sexual orientation, which is a decrease of 1% in comparison to the previous year.

Age: The majority of staff who were involved in ER cases were aged group 30 – 50, this is aligned with the Trust's overall workforce as this is the largest age group within the Trust. The main areas for ER procedures falls within conduct, flexible working and Temporary worker conduct.

Equality Delivery System

The Equality Delivery System (EDS) designed by NHS England to support the NHS in making improvements on equality, diversity, wellbeing and inclusion for the benefit of patients and staff.

- Domain One: Commissioned or provided services led by the Patient Experience Team and graded by patient, carers and volunteers.
- Domain Two: Workforce Health and Wellbeing led by the Staff Experience Team and graded by staff

volunteers.

- Domain Three: Inclusive Leadership led by the Staff Experience Team and graded by an independent evaluator, peer reviewer and trade union representatives

EPUT has seen an improvement in both Domain 1 and Domain 3 whilst Domain 2 remains consistent. It is encouraging to have improvements as it shows a positive perception of our services from both an internal perspective within our workforce and an external perspective from our patients and independent adjudicators. Under the EDS rating EPUT was rated as 'achieving'.

To achieve and monitor progress we will:

- Align action plans for each domain with the WDES, WRES, and EDI Improvement Plan
- Track and monitor actions via the EDI committee, Staff Experience Team and patient feedback.
- Complete annual stakeholder engagement to rate our performance

PART TWO – PATIENT FAMILY AND CARERS

Organisational Commitment and Governance

EPUT is committed to meeting its responsibilities under the Public Sector Equality Duty by embedding equality, inclusion and participation within its quality, safety and population health priorities. The Trust recognises that patient, family and carer experience is a fundamental component of care quality and that addressing inequalities in access, experience and outcomes is essential to delivering safe, effective and compassionate services.

The Trust's approach is aligned to the principles set out in its **Quality Account** and **Annual Report**, which emphasise learning from experience, continuous improvement, and reducing unwarranted variation in care. Equality and health inequalities are not treated as standalone areas of work but are integrated within the Trust's wider quality governance framework. This ensures that consideration of the Public Sector Equality Duty is embedded in decision-making, service planning, transformation activity and assurance processes.

Assurance in relation to the patient and carer component of the Public Sector Equality Duty is provided through the **Quality Committee** which receives regular reports on patient experience, health inequalities, equality performance and progress against key national frameworks like the **Patient and Carer Race Equality Framework** and **CORE20PLUS5**. Executive leadership is provided by the Chief Nursing Officer, who holds responsibility for patient experience, participation and quality governance. The Quality Committee provides formal assurance to the Trust Board through established reporting routes, including integrated quality and performance reporting and the annual Quality Account. This ensures that the Board maintains oversight of how the Trust is meeting its statutory responsibilities and addressing inequality in practice.

Strategic leadership and coordination of patient experience, health equity, population health, co-production and participation is provided by the Director of Patient Experience and Participation through the **Patient Experience and Participation portfolio**. This portfolio provides assurance that lived experience insight informs policy development, service transformation and quality improvement, and that equality considerations are consistently applied across the organisation through things like the quality and safety meetings and

accountability framework. This governance structure ensures that the Trust can demonstrate due regard to the three elements of the Public Sector Equality Duty in a systematic and accountable way.

Eliminating unlawful discrimination

The Trust recognises that unlawful discrimination may be experienced by patients, families and carers through barriers to accessing services, ineffective or inappropriate communication, failure to make reasonable adjustments, or care pathways that do not adequately reflect cultural, racial or socio-economic needs. Such experiences can undermine trust, reduce engagement with services and negatively impact health outcomes. Eliminating discrimination is therefore a core component of the Trust's quality and safety agenda.

To mitigate this risk, **Equality and Health Inequality Impact Assessments (EQUIAs)** are routinely applied to new policies, service developments and transformation programmes. The use of EQUIAs ensures that potential disproportionate impacts on people with protected characteristics and underserved groups are identified at an early stage and that mitigating actions are built into service design. This process is embedded within governance arrangements and supported through the quality and safety directorate, working in partnership with clinical services, transformation teams and the Trust's data and intelligence functions.

EQUIAs are informed by a combination of population health data, patient and carer feedback, lived experience insight and local intelligence. This strengthens their effectiveness and ensures that they reflect the realities experienced by the communities the Trust serves. The quality and consistency of EQUIAs are subject to review through governance processes, providing assurance that they are applied meaningfully and not solely as a compliance exercise.

Learning from complaints, the **Patient Advice and Liaison Service (PALS)**, patient surveys (I Want Great Care) and other experience feedback mechanisms is routinely analysed to identify themes that may indicate discrimination, exclusion or inequity. This learning is triangulated with clinical quality and safety data and reviewed through the Trust's quality governance arrangements. Where themes or risks are identified, actions are taken at both service and organisational level to address root causes and reduce the likelihood of recurrence.

Progress and areas of risk relating to discrimination are reported through the **Quality Committee**, with escalation to the **Trust Board** where appropriate. This provides assurance that the Trust maintains oversight of equality risks and that action is taken to improve practice where required.

Advancing equality of opportunity

Advancing equality of opportunity is central to the Trust's population health approach and its commitment to improving outcomes for patients, families and carers. The Trust recognises that different people and communities have different starting points and levels of need, and that equitable outcomes require services to respond flexibly and proportionately.

The Trust applies the **Core20PLUS5 framework** as a key mechanism for identifying and addressing health inequalities. This framework supports a focus on people living in the most deprived communities, alongside other population groups at risk of experiencing poor access, experience and outcomes. Core20PLUS5 is used alongside local population health intelligence and learning from patient experience to inform service priorities and resource allocation.

Equality of opportunity is further advanced through place-based working and partnership with voluntary, community and social enterprise organisations, carers' networks and wider system partners. These

partnerships support improved access to services, earlier intervention and more joined-up support, particularly for people who may face barriers in engaging with traditional NHS provision.

This approach is consistent with the Trust's Quality Account commitments to partnership working and community engagement.

Reasonable adjustments are a key element of advancing equality of opportunity. The Trust works to ensure that patients and carers are supported to identify their individual needs and that services respond appropriately. This includes adjustments to communication methods, appointment arrangements, environments and care planning processes. Feedback from patients and carers is used to inform continuous improvement in how reasonable adjustments are identified, recorded and delivered.

Progress in advancing equality of opportunity is monitored through established quality and performance reporting arrangements and is considered by the **Quality Committee** as part of its oversight of patient experience, health inequalities and quality improvement. This ensures that the Trust Board receives assurance that action is being taken to reduce inequalities in access, experience and outcomes.

Fostering good relations

The Trust recognises that fostering good relations between people from different backgrounds is essential to building trust, improving patient and carer experience, and supporting effective engagement with services. Positive relationships between patients, families, carers, communities and staff underpin the delivery of safe, compassionate and inclusive care.

EPUT has invested in the development of a **strong co-design and co-production infrastructure**, ensuring that patients, families and carers are actively involved in shaping service design (i.e. **Time to Care**), delivery (i.e. Inpatient Peer Workforce) and evaluation (i.e. **Patient Led Assessments of Care Environments**). This approach reflects the Trust's commitment, as set out in its Quality Account, and strategy, to learning from experience and embedding improvement through meaningful engagement. From a patient and carer perspective, this ensures that involvement is not tokenistic but leads to visible change and shared ownership of decisions.

Lived experience roles, including **peer workers**, **lived experience ambassadors** and **volunteers**, play a central role in fostering good relations between services and communities. These roles support people to feel understood, represented and supported by individuals who have personal experience of using mental health services. They also contribute directly to service improvement by bringing insight that cannot be gained through data alone. The Trust recognises the peer workforce as a key asset in reducing stigma, strengthening engagement and improving cultural understanding within services (i.e. **Recovery Café** at Brockfield, **Community Clothes Cycle** across inpatient services).

The Trust's implementation of the **Patient and Carer Race Equality Framework (PCREF)** further strengthens its approach to fostering good relations and addressing racial inequalities. PCREF provides a structured mechanism for identifying disparities in access, experience and outcomes for racialised communities and for ensuring that these communities have meaningful influence over service design and improvement. This includes strengthening governance arrangements, improving the collection and use of ethnicity data, and supporting culturally responsive models of care.

Progress in relation to PCREF is monitored through established governance structures and reported through quality assurance routes. The Reducing Health Inequalities Group meets monthly, is co-chaired by a person with lived experience, and reports into the Quality of Care Group. The co-chair of the RHI group is the Trusts coproduction lead for the PCREF and has personal lived experience of racial stigmatisation and mental health issues.

The Quality Committee receives updates on progress and provides assurance to the Trust Board that actions are being taken to reduce racial inequalities and improve relationships with communities who have historically experienced disadvantage or exclusion. Furthermore, the PCREF is being used to drive improvements across the Trust (i.e. spiritual care assessments pilot in forensics through the chaplaincy service).

Through this work, the Trust aims to build greater trust, transparency and collaboration with the communities it serves, supporting improved engagement, better experiences of care and more equitable outcomes. Working towards becoming a truly anti-racist organisation.

Co-design, co-production and due regard

Co-design and co-production are fundamental to how the Trust demonstrates due regard under the Public Sector Equality Duty. The Trust is committed to ensuring that patients, families and carers are involved throughout the service lifecycle, from understanding need and designing services, through to implementation, evaluation and improvement. The trust now has **circa 400 Lived Experience Ambassadors** involved in dozens of activities to improve its services by sharing their lived experience perspective and feedback. Further, the Trust routinely captures lessons learned from PALS, complaints, and patient and carer feedback to drive continuous improvement in identifying and addressing discrimination.

This approach supports all three elements of the duty. It helps to identify and address discrimination by bringing to light issues that may not be visible through quantitative data alone. It advances equality of opportunity by ensuring that services are designed in ways that respond to the needs of different communities and groups. It fosters good relations by building trust, mutual understanding and shared ownership of change (i.e. Perinatal services work with disadvantaged communities).

Leadership and coordination of co-production activity are provided through the Patient Experience and Participation portfolio, which ensures that involvement is embedded within strategic planning, service transformation and quality improvement. This includes providing guidance, support and assurance to services to ensure that engagement is meaningful, inclusive and proportionate to the level of change being undertaken.

The effectiveness of co-design and co-production is monitored through quality governance arrangements and contributes to the Trust's overall assurance in relation to equality and participation. Reporting through the Quality Committee enables the Trust Board to maintain oversight of how lived experience insight is influencing decision-making and improving care.

Population health approach and reducing inequalities

The Trust's approach to the Public Sector Equality Duty is closely aligned with its population health ambitions. EPUT recognises that many of the inequalities experienced by patients, families and carers are driven by **wider social, economic and environmental factors** and that addressing these requires a coordinated, system-wide approach.

Population health principles are applied across service planning and transformation activity, enabling the Trust to identify where inequalities are most pronounced and where targeted action is required. This includes the **use of population health data**, learning from patient experience and insight from community partners to inform priorities and resource allocation (i.e. the **Community First programme**).

The Trust's focus on **Core20PLUS5** provides a consistent framework for addressing inequalities, ensuring that action is directed towards communities and groups experiencing the greatest disadvantage. This approach supports the Trust's wider quality objectives by reducing unwarranted variation and improving outcomes for people who are most at risk of poor health and poor experience.

Partnership working with voluntary, community and social enterprise organisations, local authorities, Integrated Care System partners and community groups is central to this approach. These partnerships enable the Trust to reach communities that may be less likely to engage with statutory services and to develop more holistic, preventative and community-based responses to need (i.e. COMPASS with **Start Change**, Resilience Workshops with **Heads2Minds**, Learning Arena with **Sports for Confidence**).

Assurance in relation to the Trust's population health approach is provided through reporting, with oversight from the Quality Committee and escalation to the Trust Board as required. This ensures that equality, health inequalities and population health remain visible and prioritised at the highest level of organisational governance.

Equality, Data and Intelligence

The Trust recognises that robust data and intelligence are essential to understanding inequality and demonstrating compliance with the Public Sector Equality Duty. Accurate, timely and meaningful information supports the identification of variation in access, experience and outcomes, and enables the Trust to target action where it is most needed.

Equality data is considered alongside patient experience, quality and safety information within the Trust's Quality of Care reporting framework. This includes analysis of protected characteristics like, ethnicity, age, gender, and disability and other relevant factors that may influence experience and outcomes. This approach reflects the Trust's Quality Account commitment to using intelligence to drive improvement and reduce unwarranted variation.

Learning from data is strengthened through triangulation with qualitative insight from patients, families and carers. Feedback gathered through complaints, **PALS**, **surveys**, **co-production activity** and **lived experience forums** is used to add depth and context to quantitative information. This ensures that assurance is based not only on performance indicators, but on an understanding of how care is experienced in practice.

Reports relating to equality and health inequalities are reviewed through the Quality Committee, which provides challenge and assurance on progress and areas of risk. The Quality Committee escalates key issues to the Trust Board through established reporting mechanisms, ensuring that equality remains a visible and accountable part of organisational governance.

Use of Equality and Health Inequality Impact Assessments

Equality and Health Inequality Impact Assessments are a core mechanism through which the Trust demonstrates due regard under the Public Sector Equality Duty. Their routine use ensures that equality considerations are embedded in service design, policy development and transformation activity.

EQUIAs are informed by population health data, patient and carer feedback, and lived experience insight. They are used to identify where proposed changes may disadvantage particular groups and to ensure that mitigating actions are built into plans from the outset. This approach supports safer, more inclusive service development and strengthens organisational accountability.

The quality and application of EQUIAs are monitored through governance processes, with assurance provided through the Quality Committee. This ensures that EQUIAs are used as meaningful tools for improving equity, rather than solely as compliance documentation.

Peer workforce and lived experience leadership

The Trust recognises the peer workforce as a key component of its approach to equality, inclusion and addressing inequity. **Peer workers, lived experience ambassadors and volunteers** bring unique insight and understanding that supports more person-centred, culturally responsive and compassionate care.

The peer workforce contributes to all three elements of the Public Sector Equality Duty. It supports the identification of discrimination through lived experience insight, advances equality of opportunity by improving access and engagement, and fosters good relations by strengthening trust between services and communities.

The development and support of lived experience roles are overseen through the **Patient Experience and Participation portfolio**, ensuring that these roles are embedded within governance, supported appropriately and aligned with the Trust's quality objectives. Progress and impact are monitored through quality assurance arrangements and reported through the Quality Committee and the People Committee.

Conclusion and Future Plan

Patient, Family and Carer Perspective

Over the next 12 months, the Trust will further strengthen its population health approach through the development of a co-produced population health plan. This plan will be shaped in partnership with patients, carers, communities and system partners and will align Core20PLUS5 priorities, PCREF delivery and place-based learning.

Key priorities will include:

- Strengthening the quality and consistency of Equality and Health Inequality Impact Assessments
- Deepening engagement with communities and voluntary, community and social enterprise partners
- Further embedding co-design and co-production across strategic and operational decision-making
- Continuing to develop and support the peer workforce
- Improving the use of data and intelligence to understand and address inequalities

Progress against these priorities will be monitored through the Quality Committee and reported to the Trust Board through integrated quality and performance reporting and the annual Quality Account. This will provide ongoing assurance that the Trust is meeting its responsibilities under the Public Sector Equality Duty.

Essex Partnership University NHS Foundation Trust demonstrates compliance with the Public Sector Equality Duty through a structured, embedded and accountable approach to equality, inclusion and participation. The Trust has established robust governance arrangements, with assurance provided through the Quality Committee, executive leadership from the Chief Nursing Officer and oversight by the Trust Board.

Equality considerations are embedded within quality governance, service planning, transformation activity and population health work. The systematic use of Equality and Health Inequality Impact Assessments, implementation of Core20PLUS5 and PCREF, investment in co-design and co-production, and development of the peer workforce provide clear evidence of due regard.

From a patient, family and carer perspective, this approach supports care that is fair, inclusive and responsive. It ensures that lived experience informs decision-making, that inequalities are identified and addressed, and that relationships between services and communities continue to strengthen. This provides the Trust with assurance that it is meeting both the legal requirements and the underlying intent of the Public Sector Equality Duty.

Workforce Perspective

Whilst we acknowledge the improvements in declarations rates for many protected characteristics within 2024/2025, the Trust are aware that extensive efforts are required to reach its objectives and to fully embed EDI across the organisation.

We are committed to challenging discrimination, both within our workforce and the care we provide. Our new People and Education Strategy and Trust Behavioural Framework is aligned with the Trust's values and objectives, on the basis that everyone takes an active role to reduce inequalities, respects one another and builds an open and equitable culture within our organisation. We believe that EDI is everyone's responsibility, not the function of a single team.

Improvements will be made, through a number of approaches led by the Trust's Executive Board and The People and Culture Team. Our approaches to improve EDI will be aligned with NHSE EDI Improvement Plan and our own priorities and will incorporate the WRES, WDES, staff survey in order to create a diverse and inclusive culture at work and ensure there is fair representation at all levels of the Trust.

Next steps and Actions

- Recruitment - Improving proportional representation of ethnicity, gender, disability and sexual orientation in all band and roles by:
 - Implementing the De-bias Recruitment Toolkit
 - Encouraging the use of NHS values-based questions
 - Embedding Inclusion Ambassadors to drive actions to mitigate potential bias within recruitment
 - Delivering targeted workshops and career development lounges for minority staff, such as the Trust's leadership and management programs, as well as, the RISE program.
- Training - promoting EDI, Unprofessional behaviours and sexual safety workshops across the Trust.
- Reasonable Adjustments and Flexible working – refreshed reasonable adjustments passport and awareness for staff across EPUT.
- ER Cases – Reducing the number ER cases adding triage panels for formal and informal cases to be review under the just culture of learning and reflective outcomes.
-
- Behavioural Framework - utilising the Framework to improve patient and employee experience in order to reassure patients and staff that the Trust takes a zero tolerance approach to violence and abuse.

END

2024/2025

PSED – Appendices

- **Essex Census**
- **EPUT Workforce data**

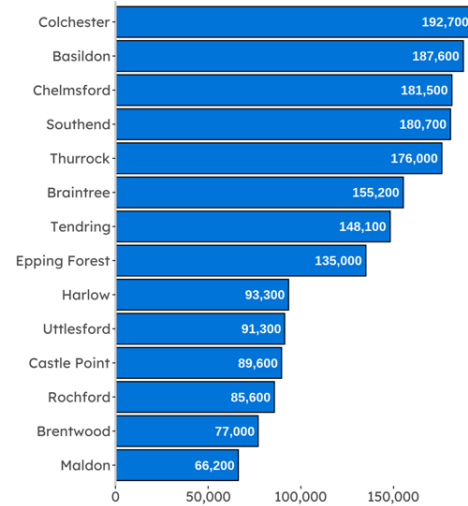
WE CARE.
WE LEARN.
WE EMPOWER.

Essex Census

Population counts

- The total population of Essex on Census day 2021 was 1,503,300, not including Southend or Thurrock
- The most populous districts in the county are Colchester, Basildon, and Chelmsford
- The least populous are Maldon, Brentwood, and Rochford

Population counts, 2021 census



Note: district figures will not sum to Essex total due to rounding

This is the first in a series of outputs, presenting analysis of data collected through Census 2021. It examines the data published on 28th June 2022 for Essex and Essex districts.

This census data released to date is limited in scope. It includes: household & population counts by district; age & sex breakdowns for local populations; and calculations of population density.

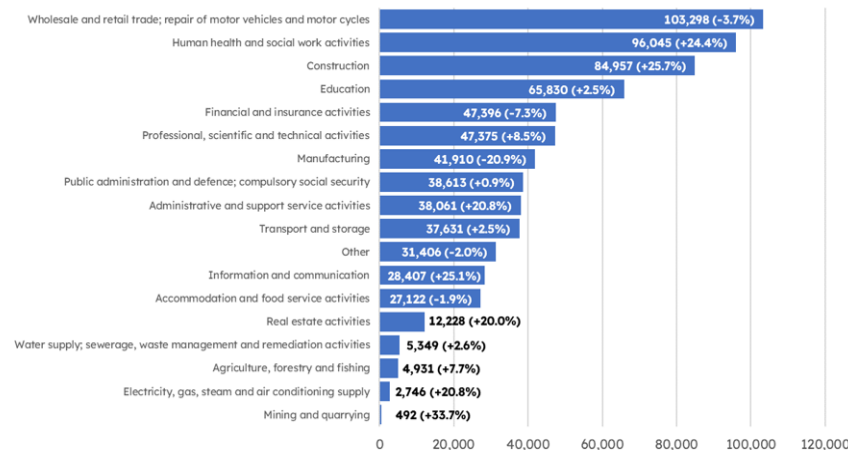
No data on population/household characteristics (e.g. ethnicity, disability, education, household tenure, economic activity) has yet been released. The next major release of census data is expected in Autumn/Winter 2022. We expect that this release will include data on population/household characteristics.

Industry

- The largest industries in Essex (excluding Southend and Thurrock) are 'Wholesale and retail trade', 'Human health and social work', and 'Construction'. Together these three industries account for 40% of all employments across Essex
- Most industries have seen an increase in employees since 2011. The largest increase has been in the construction, information and communication, and health and social care industries which have all grown by around 25% since 2011. There has also been a large increase in mining and quarrying (up by 33%) but this industry makes up less than 500 jobs across Essex
- The largest decreases in employments are in the manufacturing, finance and insurance, and wholesale / retail industries. Part of these decreases are likely due to covid

Number of employees (inc. self employed) by industry - Essex

Census 2021. Change since 2011 shown in brackets



This is the fourth in a series of outputs, presenting analysis of data collected through Census 2021. It examines the data published on 29th November 2022 for Greater Essex (Essex, Southend, and Thurrock) and Essex districts.

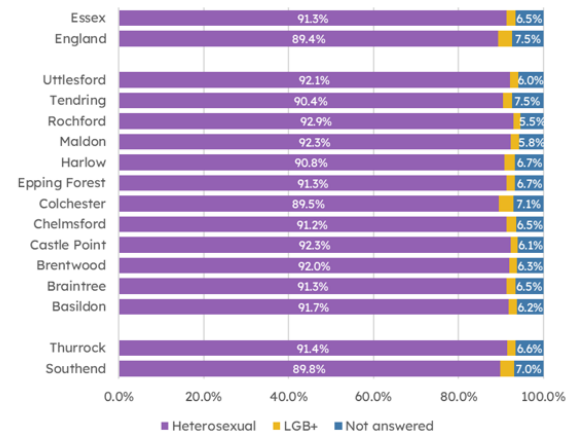
Throughout this report, 'Essex' refers to Essex County, and 'Greater Essex' refers to Essex, Southend, and Thurrock.

This census data release covers industry and occupations worked across Greater Essex, economic activity status.

Sexual orientation

- 99k Greater Essex residents (6.6%) did not answer this question. This is lower than the 7.5% non-response in England. The areas with the highest non-responses are Tendring (7.5%) and Colchester (7.1%)
- 2.5% of Greater Essex residents identify as Lesbian, Gay, Bisexual, or Other Sexualities (LGB+), compared to 3.4% in England
- Aside from Colchester, every area in Greater Essex has a lower proportion of the population identifying at LGB+ compared to England

Sexual orientation
Census 2021



This is the fifth in a series of outputs, presenting analysis of data collected through Census 2021. It examines the data published on 6th January 2023 for Greater Essex and Essex districts.

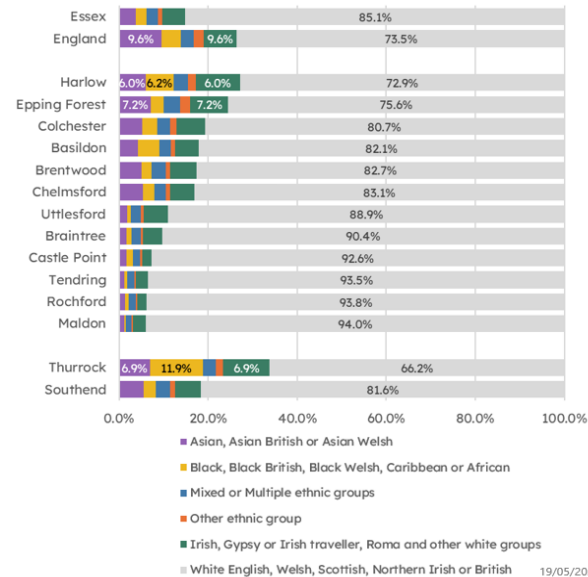
Throughout this report, 'Essex' refers to Essex County, and 'Greater Essex' refers to Essex, Southend, and Thurrock.

This census data release covers sexual orientations and gender identity. All data released is univariate – we are unable to look at combinations (e.g. gender identity by age) using this data.

Ethnic Group

- The largest ethnic group in Essex is "White English, Welsh, Scottish, Northern Irish, or British" (hereafter "White British"), which accounts for 85.1% of Essex residents. This is a higher proportion compared to England as a whole 73.5%.
- Taken together, all other ethnic groups account for 14.9% of the Essex population. The appendices at the end of these slides contain more detailed tables and maps showing the size and distribution of these populations.
- Ethnic diversity has increased in Essex since the 2011 census. In 2011 ethnic groups other than White British accounted for 9.2% of residents, compared to the 14.9% recorded in 2021.
- The scale of this increase is similar to that seen nationally. Between the two census exercises all other ethnic groups increased by 5.7 percentage points across Essex, compared to 6.5 percentage points across England.

Ethnic group
Census 2021



This is the third in a series of reports, presenting analysis of data collected through Census 2021. It examines the data published on 29th November 2022 for Greater Essex (Essex, Southend, and Thurrock) and Essex districts.

Throughout this report, 'Essex' refers to Essex County, and 'Greater Essex' refers to Essex, Southend, and Thurrock.

This data relates to ethnicity

1. Staff in Post

1.1 Ethnic Profile of Staff in Post

1.2 Disability of Staff in Post

	Ethnic Code								
	A	B	C	D	E	F	G	H	J
Total Headcount	4,811	72	517	46	57	40	61	366	78
% of Total Workforce	53%	1%	6%	1%	1%	0.4%	1%	4%	1%

AFC Band	Disability						Staff in Post %
	No	Not Declared	Prefer Not To Answer	Unspecified	Yes	Total	
Other	13	4	0	0	1	18	6%
Apprentice	6	0	0	0	2	8	25%
Band 2	340	74	1	8	34	457	7%
Band 3	2,586	162	8	24	172	2,952	6%
Band 4	750	105	6	25	99	985	10%
Band 5	975	57	1	11	86	1,130	8%
Band 6	1,309	120	5	32	154	1,620	10%
Band 7	730	106	10	21	88	955	9%
Band 8a	282	31	1	10	35	359	10%
Band 8b	106	14	1	2	21	144	15%
Band 8c	57	9	0	4	3	73	4%
Band 8d	34	6	0	2	2	44	5%
Band 9	8	3	0	0	2	13	15%
Board Director/VSM	14	0	0	0	2	16	13%
Medical/Dental	286	24	0	10	11	331	3%
Total	7,496	715	33	149	712	9,105	8%

1.3 Gender Breakdown of Staff in Post

AFC Banding		Gender		Total
		Female	Male	
Other	Headcount	13	5	18
	Percentage	72%	28%	100%
Apprentice	Headcount	4	4	8
	Percentage	50%	50%	100%
Band 2 - 6	Headcount	5,456	1,688	7,144
	Percentage	76%	24%	100%
Band 7 - 9	Headcount	1,242	346	1,588
	Percentage	78%	22%	100%
Board Director/VSM	Headcount	8	8	16
	Percentage	50%	50%	100%
Medical/Dental	Headcount	164	167	331
	Percentage	50%	50%	100%
Total	Headcount	6,887	2,218	9,105
Total Percentage	Percentage	76%	24%	100%

1.4 Religion

Religious Belief

AFC Band	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified	Total
Other	3	4	10	0	0	0	0	1	0	0	0	18
Apprentice	1	3	3	0	0	1	0	0	0	0	0	8
Band 2	113	51	210	6	4	17	0	1	44	1	10	457
Band 3	354	314	1801	15	46	175	1	5	200	14	27	2,952
Band 4	174	212	442	2	11	22	0	4	91	0	27	985
Band 5	132	178	669	3	17	43	0	0	73	4	11	1,130
Band 6	247	288	798	9	41	44	0	6	153	7	27	1,620
Band 7	187	184	413	5	23	20	0	3	101	2	17	955
Band 8a	61	88	148	2	6	15	0	1	22	3	13	359
Band 8b	25	28	67	2	4	3	1	1	11	1	1	144
Band 8c	15	15	30	0	3	2	0	0	3	1	4	73
Band 8d	10	3	20	0	1	1	0	1	4	1	3	44
Band 9	2	3	8	0	0	0	0	0	0	0	0	13
Board Director/VSM	2	3	7	0	1	1	0	0	2	0	0	16
Medical/Dental	73	23	86	9	51	70	0	2	6	1	10	331
Total	1,399	1,397	4,712	53	208	414	2	25	710	35	150	9,105
%	15%	15%	52%	1%	2%	5%	0.02%	0.3%	8%	0.4%	2%	100%
2011 Census Information	*	518,330	1,142,603	6,381	19,709	78,340	*	9,009	8,297	9,924	134,243	1,926,836
% 2011 Census information	*	27%	59%	0%	1%	4%	*	1%	0%	1%	7%	100%

1.5 Sexual Orientation

AFC Band	Sexual Orientation							
	Bisexual	Gay or Lesbian	Heterosexual	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	Total
Other	0	0	15	3	0	0	0	18
Apprentice	0	0	8	0	0	0	0	8
Band 2	7	1	347	90	0	0	12	457
Band 3	51	37	2558	270	10	3	23	2,952
Band 4	32	13	816	90	3	3	28	985
Band 5	18	13	979	105	2	1	12	1,130
Band 6	32	34	1360	158	6	2	28	1,620
Band 7	20	17	775	121	3	2	17	955
Band 8a	6	13	293	33	2	0	12	359
Band 8b	5	3	123	12	0	0	1	144
Band 8c	2	2	57	9	0	0	3	73
Band 8d	0	4	31	6	0	0	3	44
Band 9	0	0	12	1	0	0	0	13

Board Director/VSM	0	0	15	1	0	0	0	16
Medical/Dental	5	5	254	57	0	0	10	331
Total	178	142	7643	956	26	11	149	9,105
%	2%	2%	84%	10%	0.3%	0.1%	2%	
LGB %								4%
2023-2024 %	2%	1%	83%	12%	0.2%	0.1%	2%	100%

1.6 Age

AFC Band	Age Band							Total
	20 under	20's	30's	40's	50's	60's	70 and above	
Other	0	0	1	3	11	2	1	18
Apprentice	0	3	3	2	0	0	0	8
Band 2	5	39	58	93	130	104	28	457
Band 3	13	401	656	815	693	337	37	2,952
Band 4	1	176	196	204	252	145	11	985
Band 5	0	204	264	283	264	105	10	1,130
Band 6	0	213	399	395	409	171	33	1,620
Band 7	0	43	225	299	272	110	6	955
Band 8a	0	11	99	112	96	39	2	359
Band 8b	0	2	32	61	41	7	1	144
Band 8c	0	0	6	23	31	13	0	73
Band 8d	0	0	3	15	23	2	1	44
Band 9	0	0	0	5	6	2	0	13
Board Director/VSM	0	0	1	1	9	4	1	16
Medical/Dental	0	32	118	93	59	23	6	331
Total	19	1,124	2,061	2,404	2,296	1,064	137	9,105
	0.2%	12%	23%	26%	25%	12%	1%	100%

1.7 Marital

AFC Band	Marital Status							Total
	Divorced	Legally Separated	Married	Single	Widowed	Civil Partnership	Unspecified	
Other	0	0	16	1	1	0	0	18
Apprentice	0	0	1	6	0	1	0	8
Band 2	30	3	219	167	13	8	17	457
Band 3	170	56	1414	1137	36	51	88	2,952
Band 4	91	10	437	393	13	18	23	985
Band 5	68	19	547	440	9	13	34	1,130
Band 6	108	25	786	610	26	16	49	1,620
Band 7	76	22	520	281	11	9	36	955
Band 8a	27	6	216	89	2	8	11	359
Band 8b	8	1	94	32	3	1	5	144
Band 8c	7	1	47	13	1	0	4	73
Band 8d	3	0	31	5	0	1	4	44
Band 9	2	0	11	0	0	0	0	13
Board Director/VSM	0	2	13	1	0	0	0	16
Medical/Dental	8	0	234	79	0	1	9	331
Grand Total	598	145	4,586	3,254	115	127	280	9,105
	7%	2%	50%	36%	1%	2%	3%	100%

1.8 Assignment Status

AFC Band	Assignment Status								Total
	Acting Up	Active Assignment	Career Break	Internal Secondment	Maternity & Adoption	Out on External Secondment - Paid	Suspend No Pay	Suspend With Pay	

Other	0	18	0	0	0	0	0	0	0	18
Apprentice	0	8	0	0	0	0	0	0	0	8
Band 2	0	454	1	0	1	1	0	0	0	457
Band 3	0	2907	1	8	30	4	0	2	0	2,952
Band 4	5	946	1	19	13	0	0	1	0	985
Band 5	5	1080	1	13	28	2	0	1	0	1,130
Band 6	11	1539	1	37	29	2	0	1	0	1,620
Band 7	15	879	1	35	20	5	0	0	0	955
Band 8a	6	334	0	12	7	0	0	0	0	359
Band 8b	1	135	0	2	4	2	0	0	0	144
Band 8c	1	63	1	6	1	1	0	0	0	73
Band 8d	1	40	0	2	1	0	0	0	0	44
Band 9	2	11	0	0	0	0	0	0	0	13
Board Director/VSM	0	16	0	0	0	0	0	0	0	16
Medical/Dental	0	327	1	0	3	0	0	0	0	331
Total	47	8,757	8	134	137	17	0	5	0	9,105
	1%	96%	0.1%	1%	2%	0.2%	0%	0.1%	0%	100%

2. New Starters

2.1 Ethnicity breakdown for new starters

AFC Band	Ethnic Code																		TOTAL	No. BME	% BME	
	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	U	Z				
Other	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0%
Apprentice	14	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	16	1	6%
Band 2	65	0	9	0	3	0	0	8	0	2	4	1	19	8	0	3	1	0	123	48	39%	
Band 3	327	1	31	4	14	2	2	18	11	15	16	17	537	101	0	8	15	13	1,132	745	66%	
Band 4	139	1	21	2	3	2	4	26	5	2	3	2	46	3	0	4	3	0	266	102	38%	
Band 5	82	1	5	1	1	0	2	15	0	1	4	3	38	5	1	1	0	1	161	72	45%	
Band 6	121	1	20	1	2	2	4	15	3	3	4	2	37	4	0	1	0	7	227	78	34%	
Band 7	65	3	4	0	1	1	0	6	1	1	2	3	14	2	0	3	0	2	108	34	31%	
Band 8a	20	1	6	1	0	0	0	4	0	1	3	0	2	0	0	1	0	2	41	12	29%	
Band 8b	9	1	0	0	0	0	0	0	0	0	0	0	3	1	1	0	1	0	16	5	31%	
Band 8c	9	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	11	2	18%	
Band 8d	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3	1	33%	
Band 9	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0%	
Board\Director\VSM	3	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	5	1	20%	
Medical\Dental	7	0	10	0	1	1	0	19	9	2	3	1	13	4	2	7	7	0	86	62	72%	

TOTAL	865	10	106	9	25	8	12	113	29	27	39	31	710	128	4	28	27	26	2,197	1,163	53%
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2.2 Disability breakdown for new starters

Disabled	AFC Banding						TOTAL	%
	Other	Apprentice	Band 2-6	Band 7-9	Board\Director\VSM	Medical\Dental		
No	1	13	1,735	155	5	81	1,990	91%
Not Declared	0	0	31	3	0	0	34	2%
Prefer Not To Answer	0	0	5	2	0	0	7	0.3%
Unspecified	0	0	15	4	0	3	22	1%
Yes	0	3	123	16	0	2	144	7%
Total Headcount of starters	1	16	1,909	180	5	86	2,197	100%
% of new Starters who declared disability as Yes	0%	19%	6%	9%	0%	2%	7%	

2.3 Gender Breakdown for new starters

AFC Banding	Data	Gender		
		Female	Male	TOTAL
Other	Headcount	0	1	1
	Percentage	0%	100%	100%
Apprentice	Headcount	12	4	16
	Percentage	75%	25%	100%
Band 2-6	Headcount	1366	543	1909
	Percentage	72%	28%	100%
Band 7-9	Headcount	131	49	180
	Percentage	73%	27%	100%
Board\Director\VSM	Headcount	5	0	5
	Percentage	100%	0%	100%
Medical\Dental	Headcount	44	42	86
	Percentage	51%	49%	100%
Total Headcount of starters		1,558	639	2,197
Total % of starters		71%	29%	100%
Staff in Post %		76%	24%	100%

2.4 Religious Belief of new starters

AFC Band	Religious Belief											Grand Total
	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified	
Other	0	0	1	0	0	0	0	0	0	0	0	1
Apprentice	3	8	4	0	0	0	0	0	1	0	0	16
Band 2	17	21	65	1	3	5	0	0	11	0	0	123
Band 3	98	111	755	4	15	81	0	0	60	7	1	1,132

Band 4	31	76	119	1	9	11	0	0	19	0	0	266
Band 5	23	27	87	2	5	5	0	0	9	3	0	161
Band 6	27	55	105	3	9	6	0	1	20	1	0	227
Band 7	18	29	48	0	3	3	0	0	7	0	0	108
Band 8a	5	8	19	2	2	3	0	0	1	1	0	41
Band 8b	1	5	8	1	0	1	0	0	0	0	0	16
Band 8c	1	4	4	0	1	0	0	0	1	0	0	11
Band 8d	0	0	1	0	0	0	0	1	0	1	0	3
Band 9	0	0	1	0	0	0	0	0	0	0	0	1
Board\Director\VSM	0	1	3	0	0	0	0	0	1	0	0	5
Medical\Dental	9	12	27	1	11	19	0	0	1	1	5	86
TOTAL	233	357	1,247	15	58	134	0	2	131	14	6	2,197
%	11%	16%	57%	0.7%	3%	6%	0%	0.1%	6%	1%	0.3%	100%
Staff in Post %	17%	15%	51%	0.6%	2%	4%	0.03%	0.3%	8%	0.4%	2%	100%

2.5 Sexual Orientation of new starters

Sexual Orientation								
AFC Band	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	TOTAL
Other	0	0	1	0	0	0	0	1
Apprentice	2	1	11	2	0	0	0	16
Band 2	3	0	109	11	0	0	0	123
Band 3	24	14	971	116	3	2	2	1,132
Band 4	10	2	232	20	2	0	0	266
Band 5	5	1	138	16	0	1	0	161
Band 6	7	6	196	17	0	1	0	227
Band 7	3	0	91	14	0	0	0	108
Band 8a	2	1	36	2	0	0	0	41
Band 8b	0	1	14	1	0	0	0	16
Band 8c	0	0	9	2	0	0	0	11
Band 8d	0	1	2	0	0	0	0	3
Band 9	0	0	1	0	0	0	0	1
Board\Director\VSM	0	0	5	0	0	0	0	5
Medical\Dental	1	3	65	11	0	1	5	86
TOTAL	57	30	1,881	212	5	5	7	2,197
%	3%	1%	86%	10%	0.2%	0.2%	0.3%	100%
LGB %	4%							
Staff in Post LGB %	3%							

2.6 Age profile of new starters

Afc Band	Age Band							TOTAL
	20 under	20's	30's	40's	50's	60's	70 and above	

2.7 Marital Status of new starters

AFC Band	Marital Status							TOTAL
	Divorced	Legally Separated	Married	Single	Widowed	Civil Partnership	Unspecified	
Other	0	0	1	0	0	0	0	1

Band 5	35	0	2	0	1	1	1	0	1	0	0	0	1	1	0	0	0	0	43	6	14%
Band 6	72	1	5	0	0	0	2	9	2	1	2	0	55	8	1	1	0	0	159	81	51%
Band 7	53	3	3	0	0	0	0	3	0	0	5	0	16	1	0	0	0	0	84	25	30%
Band 8a	24	0	2	0	0	0	0	0	1	0	0	0	2	0	0	0	0	1	30	3	10%
Band 8b	3	0	1	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	6	2	33%
Band 8c	2	0	0	1	0	0	1	0	0	0	1	0	2	0	0	0	0	0	7	5	71%
Band 8d	4	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	5	1	20%
Band 9	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0%
Board Director/VSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Medical/Dental	1	0	1	0	0	0	0	2	3	0	0	1	2	0	1	0	0	1	12	9	75%
TOTAL	254	4	18	1	1	1	4	17	7	2	10	2	85	11	2	2	0	2	423	145	34%

3.2 Disability of promotions

AFC Band	Disabled						TOTAL	Promotions %	Staff in Post %
	No	Not Declared	Unspecified	Yes	Prefer Not To Answer				
Other	0	0	0	0	0	0	0%	6%	
Apprentice	1	0	0	0	0	1	0%	25%	
Band 2	0	0	0	0	0	0	0%	7%	
Band 3	16	0	0	0	0	16	0%	6%	
Band 4	54	1	0	4	0	59	7%	10%	
Band 5	39	2	0	2	0	43	5%	8%	
Band 6	138	5	1	13	2	159	8%	10%	
Band 7	74	2	1	5	2	84	6%	9%	
Band 8a	27	0	0	3	0	30	10%	10%	
Band 8b	5	1	0	0	0	6	0%	15%	
Band 8c	6	1	0	0	0	7	0%	4%	
Band 8d	4	1	0	0	0	5	0%	5%	
Band 9	1	0	0	0	0	1	0%	15%	
Board Director/VSM	0	0	0	0	0	0	0%	13%	
Medical/Dental	9	2	0	1	0	12	8%	3%	
Total	374	15	2	28	4	423	7%	8%	

3.3 Gender Breakdown Promotions

AFC Band	Gender			
	Data	Female	Male	TOTAL
Other		0	0	0
		0%	0%	0%

3.4 Religious Belief of promotions

AFC Band	Religious Belief										
	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified

Apprentice	Headcount	1	0	1
	Percentage	100%	0%	100%
Band 2	Headcount	0	0	0
	Percentage	0%	0%	0%
Band 3	Headcount	9	7	16
	Percentage	56%	44%	100%
Band 4	Headcount	46	13	59
	Percentage	78%	22%	100%
Band 5	Headcount	36	7	43
	Percentage	84%	16%	100%
Band 6	Headcount	122	37	159
	Percentage	77%	23%	100%
Band 7	Headcount	65	19	84
	Percentage	77%	23%	100%
Band 8a	Headcount	24	6	30
	Percentage	80%	20%	100%
Band 8b	Headcount	5	1	6
	Percentage	83%	17%	100%
Band 8c	Headcount	5	2	7
	Percentage	71%	29%	100%
Band 8d	Headcount	5	0	5
	Percentage	100%	0%	100%
Band 9	Headcount	0	1	1
	Percentage	0%	100%	100%
Board/Director/VSM	Headcount	0	0	0
	Percentage	0%	0%	0%
Medical/Dental	Headcount	7	5	12
	Percentage	58%	42%	100%
Total		325	98	423
Total gender breakdown split for promotions %		77%	23%	100%
Staff in Post %		76%	24%	100%

3.5 Sexual Orientation of promotions

AFC Band	Sexual Orientation							
	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined)	Other sexual orientation not listed	Undecided	Unspecified	TOTAL

				to provide a response)				
Other	0	0	0	0	0	0	0	0
Apprentice	0	0	1	0	0	0	0	1
Band 2	0	0	0	0	0	0	0	0
Band 3	1	0	15	0	0	0	0	16
Band 4	3	1	49	5	0	1	0	59
Band 5	1	0	39	3	0	0	0	43
Band 6	5	3	135	14	0	1	1	159
Band 7	2	2	73	4	1	1	1	84
Band 8a up to Board/ Director/ VSM	1	3	42	2	1	0	0	49
Medical/Dental	0	1	9	2	0	0	0	12
TOTAL	13	10	363	30	2	3	2	423
Promotions %	3%	2%	86%	7%	0.5%	0.7%	0.5%	100%
LGB Promotions %	5%							
LGB Staff in workforce %	4%							

3.6 Age Range of promotions

AFC Band	Age Band												TOTAL	
	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71 +		
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Apprentice	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Band 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Band 3	0	1	2	4	2	1	2	2	1	1	0	0	0	16
Band 4	1	12	9	7	8	5	5	6	5	0	1	0	0	59
Band 5	0	8	10	4	6	2	1	7	5	0	0	0	0	43
Band 6	0	15	40	17	25	21	19	10	8	4	0	0	0	159
Band 7	0	5	10	15	13	10	12	10	8	1	0	0	0	84
Band 8a	0	0	4	14	2	5	3	1	0	1	0	0	0	30
Band 8b	0	1	0	0	0	2	2	1	0	0	0	0	0	6
Band 8c	0	0	0	0	1	2	3	1	0	0	0	0	0	7
Band 8d	0	0	0	0	0	3	0	1	1	0	0	0	0	5
Band 9	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Board Director/VSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical/Dental	0	0	0	4	2	3	1	2	0	0	0	0	0	12

No	0	0	1301	116	4	43	1464
Not Declared	0	0	62	16	0	3	81
Prefer Not To Answer	0	0	5	0	0	0	5
Unspecified	0	0	15	0	0	2	17
Yes	0	0	111	18	0	4	133
TOTAL	0	0	1494	150	4	52	1700
Leavers % of staff stating that they have a Disability	0%	0%	7%	12%	0%	8%	8%
Staff in post % stating they have a disability	6%	25%	8%	10%	13%	3%	8%

4.4 Religious Belief

AFC Band	Religious Belief											TOTAL
	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified	
Other	0	0	0	0	0	0	0	0	0	0	0	0
Apprentice	0	0	0	0	0	0	0	0	0	0	0	0
Band 2	30	39	99	2	6	14	0	1	13	1	3	208
Band 3	97	66	410	4	5	49	0	0	40	4	4	679
Band 4	30	31	66	0	2	6	0	0	9	0	2	146
Band 5	25	33	174	2	7	12	0	0	19	1	1	274
Band 6	26	41	87	2	2	9	0	2	16	0	2	187
Band 7	16	22	30	0	3	2	0	1	6	1	0	81
Band 8a	7	10	10	3	2	3	0	0	4	0	0	39
Band 8b	6	3	7	0	0	0	0	0	1	0	0	17
Band 8c	2	1	3	0	0	0	0	0	0	0	0	6
Band 8d	1	0	5	0	0	0	0	0	0	0	0	6
Band 9	0	0	0	0	0	0	0	0	1	0	0	1
Board Director/VSM	0	1	2	0	0	0	0	0	1	0	0	4
Medical/Dental	14	1	16	0	5	10	1	0	3	1	1	52
TOTAL	254	248	909	13	32	105	1	4	113	8	13	1700
Leavers %	15%	15%	53%	1%	2%	6%	0.1%	0.2%	7%	0.5%	1%	100%

4.5 Sexual Orientation of leavers

AFC Band	Sexual Orientation							
	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	TOTAL
Other	0	0	0	0	0	0	0	0
Apprentice	0	0	0	0	0	0	0	0
Band 2	1	1	177	26	1	0	2	208
Band 3	16	7	572	76	3	1	4	679
Band 4	6	0	121	16	1	1	1	146
Band 5	1	2	245	24	1	0	1	274
Band 6	2	2	165	16	0	0	2	187
Band 7	2	2	69	8	0	0	0	81
Band 8a up to Board/Director/VSM	0	2	61	10	0	0	0	73
Medical/Dental	2	0	38	12	0	0	0	52
TOTAL	30	16	1448	188	6	2	10	1700
% of Total Leavers	2%	1%	85%	11%	0.4%	0.1%	1%	100%
Leavers LGB %	3%							
Staff in post LGB %	4%							

4.6 Age Range Breakdown of leavers

Afc Band	Age Band 2							
	< 20	20's	30's	40's	50's	60's	70 and above	TOTAL
Other	0	0	0	0	0	0	0	0
Apprentice	0	0	0	0	0	0	0	0
Band 2	3	28	44	42	36	48	7	208
Band 3	2	132	118	165	144	103	15	679
Band 4	0	43	23	26	23	31	0	146
Band 5	0	36	63	55	67	42	11	274
Band 6	0	37	40	34	38	38	0	187
Band 7	0	3	24	23	15	15	1	81
Band 8a	0	1	7	10	13	7	1	39
Band 8b	0	0	0	4	3	10	0	17
Band 8c	0	0	0	1	2	3	0	6
Band 8d	0	0	1	0	2	2	1	6
Band 9	0	0	0	0	1	0	0	1

Board Director/VSM	0	0	1	0	1	1	1	4
Medical/Dental	0	3	24	15	4	5	1	52
TOTAL	5	283	345	375	349	305	38	1700
%	0.3%	17%	20%	22%	21%	18%	2%	100%

5. Employee Relations

5.1 Employee relations

Type / Category (reporting only)	2023/24	2024/25
Capability	22	28
Conduct	96	129
Temporary Worker Conduct	149	113
Flexible Working	301	280
Grievance	84	47
Temporary Worker Complaint	18	14
Sickness	10	10
TOTAL	680	621

5.2 Ethnic breakdown ER cases

Ethnicity	Capability	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaints	Sickness	TOTAL	% of all cases
A	14	43	6	192	32	5	5	297	48%
B	0	0	0	1	2	0	0	3	0.5%
C	2	2	1	16	3	0	1	25	4%
D	0	0	0	0	0	0	0	0	0%
E	1	0	1	1	0	0	2	5	1%
F	1	0	0	2	0	0	0	3	0.5%
G	0	3	0	2	0	0	0	5	1%
H	2	8	0	7	1	0	0	18	3%
J	0	3	0	2	0	0	0	5	1%
K	0	0	0	2	0	0	0	2	0.3%

L	0	5	2	7	0	0	2	16	3%
M	0	3	1	2	0	0	0	6	1%
N	7	45	89	35	6	5	0	187	30%
P	0	11	10	7	1	4	0	33	5%
R	0	0	0	0	0	0	0	0	0%
S	1	3	0	2	0	0	0	6	1%
U	0	0	0	0	0	0	0	0	0%
Z	0	3	3	2	2	0	0	10	2%
TOTAL	28	129	113	280	47	14	10	621	100%
BAME Total	12	81	103	69	8	9	4	286	46%

5.3 Disability breakdown ER cases

Declaration of Disability on ESR	Capability	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaints	Sickness	TOTAL	%
No	19	112	100	218	33	9	3	494	80%
Not Declared	1	9	3	19	4	2	1	39	6%
Unspecified	1	0	1	12	4	0	0	18	3%
Prefer Not To Answer	0	1	0	0	0	0	0	1	0.2%
Yes	7	7	9	31	6	3	6	69	11%
TOTAL	28	129	113	280	47	14	10	621	

5.4 Gender Breakdown ER Cases

Type / Category (reporting only)	Female	Male	Total
Capability	20	8	28
Conduct	75	54	129
Temporary Worker Conduct	61	52	113
Flexible Working	237	43	280
Grievance	39	8	47
Temporary Worker Complaint	11	3	14
Sickness	8	2	10
TOTAL	451	170	621

%	73%	27%	
Trust Staff in Post %	76%	24%	

5.5 Religious breakdown ER cases

AfC Band	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified	Grand Total
Capability	4	1	17	0	2	0	0	0	3	0	1	28
Conduct	10	11	89	1	7	4	0	0	6	0	1	129
Temporary Worker Conduct	8	3	96	0	0	4	0	0	1	0	1	113
Flexible Working	49	60	113	3	3	11	0	2	25	1	13	280
Grievance	10	10	19	1	0	0	0	1	3	0	3	47
Temporary Worker Complaints	6	0	6	0	0	1	0	0	1	0	0	14
Sickness	1	2	5	0	0	0	0	0	2	0	0	10
TOTAL	88	87	345	5	12	20	0	3	41	1	19	621
%	14%	14%	56%	1%	2%	3%	0%	0.5%	7%	0.2%	3%	

5.6 Age Breakdown ER cases

Row Labels	Capability	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaint	Sickness	Grand Total	%
< 20	0	0	0	0	0	0	0	0	0%
20's	2	14	10	28	3	3	0	60	10%
30's	2	27	16	60	8	3	0	116	19%
40's	2	37	53	90	14	3	5	204	33%
50's	20	40	28	68	12	3	5	176	28%
60's	2	9	6	30	9	2	0	58	9%
> 70	0	2	0	4	1	0	0	7	1%
TOTAL	28	129	113	280	47	14	10	621	


8.5 EQUALITY DELIVERY SYSTEM 2 - 2025 (EDS)

● Decision Item

👤 AM

REFERENCES

Only PDFs are attached

 EDS Report 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1			1 April 2026
Report Title:	Equality Delivery System 2 - 2025			
Executive/ Non-Executive Lead:	Andrew McMenemy - Executive Chief People Officer			
Report Author(s):	Paul Taylor - Director of Organisational Development and Culture			
Report discussed previously at:	People Committee, Executive Team			
Level of Assurance:	Level 1	✓	Level 2	Level 3

Risk Assessment of Report – mandatory section

Summary of risks highlighted in this report	<p>If the Trust does not produce accurate, timely, and credible Equality Delivery System reporting, it will fail to meet statutory requirements under the Public Sector Equality Duty.</p> <p>More importantly than publication, it will undermine staff confidence in the organisation’s commitment to fairness, pay equality, and the elimination of discrimination. This poses a significant risk to staff experience, retention, and organisational development, as employees who feel undervalued or treated unfairly are less likely to stay or to engage positively.</p> <p>Poor reporting also prevents the Trust from realising the full benefits of a diverse workforce, including improved decision-making, innovation, and cultural strength.</p>		
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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	No		
If Yes, describe the risk to EPUT’s organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report

This report forms one of three key reports that bring together a set of required statutory reporting requirements: Public Sector Equality Duty, **Equality Delivery System** and Pay Gap Reporting.

The Equality Delivery System is an agreed framework that support organisations to deliver fair and inclusive services to patients, carers and workforce by tackling inequity in experience and working to ensure everyone has equitable access.

It should be noted that this reporting period ends in March 2025 so in some cases may feel slightly out of date. It is expected that the annual report for 25/26 will be provided in October 2026 in order that the information presented is more relevant. The report aims to use plain language where possible to meet accessibility requirements.

Approval	✓
Discussion Information	✓

Recommendations/Action Required

The Board of directors is asked to:

- **Discuss and approve** the contents of this report noting the Trust’s ratings across the three themes supporting equal opportunities for staff with protected characteristics, the insights and the areas of focus.
- **Approve** the publication and submission of the report and appendices to Mid and South Essex Integrated Care Board (MSE ICB) and on our external facing website.

Summary of key issues

This report provides the Board of directors with a summary of last years’ actions on the EDS 2024, oversight of the EDS2 report for 2025 and then a list of actions which have been developed using stakeholder feedback.

Using evidence rather than aspiration, it provides assurance of where the trust sits in terms of its own self-assessment as well as a finalised position based on stakeholder feedback and external adjudication.

It provides transparency and accountability as the report is formally reviewed by our people and external colleagues and helps us to identify key areas of improvement and leadership.

The paper focusses on 3 key themes based on national equality goals namely:

- Theme 1 – Commissioned or provided services**
- Theme 2 – Workforce health and wellbeing**
- Theme 3 – Inclusive Leadership**

Theme One: Commissioned or Provided Services:

This theme focusses on patient services. Two Services were provided this year namely; Southend Primary Care Mental Health Team and Basildon and Brentwood Older People’s Community Mental Health Team. Led by EPUT’s patient experience team this involved evidence packs and ratings by our lived experience ambassadors through a dedicated session.

This year there was a reduction overall in the sub-domains rated as ‘achieving’ from 4/4 to 2/4. **‘Patients are free from harm’** and **‘patients report positive experiences’** saw a reduction in rating from **achieving to developing**.

Theme Two: Workforce Health and Wellbeing

This theme focusses on staff wellbeing, harassment, support and advocacy. This year saw ratings remain the same for **‘staff support with physical and mental health conditions’** and **‘staff are free from**

abuse harassment and bullying at work. ***'Access to independent support and advice when suffering stress and abuse'*** saw a reduction in rating from **achieving** to **developing** and **staff recommending the organisation as a place to work** saw a reduction in rating from **developing** to **under-developed**.

Theme Three: Inclusive Leadership:

This theme focusses on leadership commitment to Equality Diversity and Inclusion.

This year saw a reduction in rating from **achieving** to **developing** for ***'board and system members routinely demonstrate their understanding and commitment to equality and health inequalities'***.

'Board committee papers identify equality related risks and how they will be managed' and ***'board members ensure levers are in place to manage performance'*** both held their ratings from last year as **developing**.

As a result of this report the Trust has **maintained** its overall position as a **developing** organisation – one of four gradings available (underdeveloped/developed/achieving/excelling).

Next Steps

The EDS Action Plan has been developed based on these scores and is included in the main EDS template (**Appendix A**). These will also influence our wider EDI, Health Inequalities and Wellbeing work within the Trust in 2025-26. Objectives include the following:

Domain 1 Commissioned and Provided Services (Patient Experience)

- Create reporting templates to capture how services accommodate patients with protected characteristics or those at risk of health inequalities.
- Co-Produce improvements to access for individuals with protected characteristics.
- Expand the safety dashboard to ensure equality-related factors are systematically flagged within incident and near-miss reporting.
- Enhance Protected Characteristic Recording Within iWGC.

Domain 2 Workforce Health and Wellbeing (OD and Culture)

- Review Health and Wellbeing initiatives and opportunities in the Trust and provide evidence of uptake.
- Raise awareness of support available for staff who experience anti-social behaviour, discrimination, or sexual misconduct, highlighting what consequences there are for patient/staff perpetrators. This includes working closely with our Occupational Health and EAP Provider.
- Strengthen the current model of Staff Networks to ensure they can provide impartial support.
- Improve the 2026 NHS Staff Survey scores for staff recommending the organisation as a place to work and for treatment (Advocacy).

Domain 3: Inclusive Leadership (Trust Board and Senior Leadership)

- Strengthen Staff Networks as above and ensure commitment from Senior Sponsors.
- Work closely with the Kings Fund/BRAP Organisational Culture Inquiry and pilot Leadership Programme to align ED&I priorities with outcomes of this work as it progresses through 2026
- Data is clearly communicated to Trust Board and evidence of analysis and interventions developed at this level are promoted to staff, the Executive and People Committees regularly
- Show clear evidence as an organisation that equality and health inequalities are discussed, with clear interventions undertaken at Board / Committee level when issues are identified.

The EDS2 report will be discussed with our staff networks and the newly formed Staff Experience & Inclusion Group (SEIG). The report has been discussed with the People Committee and after approval in this meeting it will then be with our ICB and published on our external facing websites and internal intranets.

Oversight of progress will be tracked through quarterly EDI progress reports to the Executive Team, Staff Experience & Inclusion Group and at relevant intervals to the People committee for assurance.

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:	<p style="text-align: right;">Capital £ Revenue £ Non Recurrent £</p>
Governance implications	
Impact on patient safety/quality	✓
Impact on equality and diversity	✓
Equality Impact Assessment (EIA) Completed	NO If YES, EIA Score N/A

Acronyms/Terms Used in the Report

WRES	Workforce Race Equality Standard	PSED	Public Sector Equality Duty
WDES	Workforce Disability Equality Standard	EDI	Equality Diversity and Inclusion
EDS 2	Equality Delivery System 2	HR /ER	Human Resources / Employee Relations
ESR	Electronic Staff Record	NHSE	National Health Service England
BME	Black, Asian and Minority Ethnicity		

Supporting Reports/ Appendices /or further reading

Equality Delivery System Report (2025/26)

Lead



**Andrew McMenemy,
Executive Chief People Officer**

EQUALITY DELIVERY SYSTEM (2025-26)

1 EXECUTIVE SUMMARY

This report provides the Board of Directors:

- A summary of actions from the previous Equality Delivery System (2024-25)
- Oversight of the EDS Report for 2025-26
- Actions for 2026, which have been developed using stakeholder feedback.

This report summarises EPUT's implementation of inclusion and wellbeing throughout the year. Patient and staff stakeholders grade this, with feedback informing the actions proposed as part of the action plan in **Appendix A** and in line with our Public Sector Equality Duty or PSED (2010).

We as a Trust remain as a "developing" Trust based on the EDS scoring system, with a reduction from 20.21 / 33 in 2024 to 14.7 / 33 in 2025. Feedback from our stakeholders (**Appendix B**) has been developed into proposed actions for the Trust (**Appendix A**) and guides our actions alongside our wider Trust strategies. Whilst this has been drafted based on EPUT data, this will also be submitted to Mid and South Essex (MSE) Integrated Care Board (ICB).

2 BACKGROUND

The Equality Delivery System (EDS) is a tool to support the NHS in inclusion and wellbeing. Whilst this framework is referred to as "EDS2022" based on the last date of revision, this will be referred to as 'EDS' to show this report is for our current progress. The EDS is included in the NHS standard contract, and we use the report template (**Appendix A**) to share our performance. This involves summarising our progress and providing evidence where relevant, then presenting this to stakeholder volunteers for grading:

- **Domain One: Commissioned or Provided Services** Led by the Patient Experience Manager (Amy Poole) based on two services selected alongside other provider organisations within the ICB, then graded by Lived Experience Ambassadors in the Trust.
- **Domain Two: Workforce Health and Wellbeing** Evidence compiled and presented by the Equality Advisor (Gary Brisco) with assistance from the OD and Culture directorate, then graded by staff volunteers acting as Stakeholders.
- **Domain Three: Inclusive Leadership** Evidence compiled by the Equality Advisor (Gary Brisco) and the Director of OD and Culture, then graded by an independent evaluator (Arleen Brown) and Trade Union representative (Oladipo Ogedenbe).

A breakdown of grading from stakeholders and comparison to previous years is available in **Appendix B**.

3 EPUT EDS PERFORMANCE 2025

Stakeholders grade each domain's outcome as either "undeveloped (0)", "developing (1)", "achieving (2)" or "excelling (3)" based [on technical guidance and criteria provided by NHS England](#). The average score is used to calculate a final grade for each outcome and the overall EDS for the Trust. Following the submission of evidence (**Appendix A**) to the three stakeholder cohorts, each group was encouraged to provide their grading as well as any potential improvements they would like to see within the organisation:

Domain One (Commissioned or Provided Services)

- In line with EDS technical guidance, EPUT's Patient Experience Manager (Amy Poole) conducted this collaboratively with Mid and South Essex ICB, with different patient-facing services nominated each year.
- This year evidence was provided for Southend Primary Care Mental Health Team and Basildon and Brentwood Older People's Community Mental Health Team.
- This evidence was shared with our Lived Experience Ambassadors, who were invited to review the material and provide their assessments through an MS Teams form.
- Each ambassador independently rated the evidence against the relevant EDS indicators, ensuring a diverse and representative range of perspectives.
- In total, 12 Lived Experience Ambassadors participated in this process, offering valuable insight rooted in lived experience and strengthening the credibility, inclusivity, and robustness of the final outcomes.
- Scores were provided and then averaged to create a final score for each. **(Appendix B)**

Domain Two (Workforce Health and Wellbeing)

- EPUT staff members acting as stakeholders completed this, promoted across the Trust via Communications, engagement with Staff Networks promotion on EPUT's EDI pages.
- Multiple staff were provided with a summary of EPUT progress in Domain Two **(Appendix A)**, this evidence was shared alongside the criteria for an Excelling Trust to help give context and a video version was made available alongside the survey to ensure this was accessible for all staff members.
- Thirty-three participants completed the anonymous online survey (via MS Forms), which also collected demographic information and gave the opportunity to provide general feedback on workforce health, inclusion, and wellbeing. **(Appendix B)**

Domain Three (Inclusive Leadership) was graded independently by two stakeholders:

- Arleen Brown (*Equality and Diversity Lead for Princess Alexandra Hospital*) and Oladipo Ogedengbe (EPUT Staffside Chair) provided peer review as independent evaluators.
- These two stakeholders were provided with evidence, including a snapshot of EPUT Board papers, public reports (including the WRES, WDES, Pay Gap and PSED) and the information listed for Domain 3 **(Appendix A)**.
- Stakeholders provided their individual grading, feedback and suggested next steps for improvement, used in developing the recommendations in this report. **(Appendix B)**.

4 CONCLUSION

In conclusion, whilst we remain a "developing" organisation, we have seen a decline in score from 20.21 to 12.7 out of a possible 33 **(Appendix B)**. This is in part due to lower scores across Domain 1 (Commissioned and Provided Services) from Lived Experience ambassadors within the organisation, reductions in Domain 2 for both "2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source" and "2D: staff recommend the organisation as a place to work and receive treatment."

Whilst our evidence shows we are achieving in these areas as a Trust, with predicted grading showing a higher score for Domain 2 and 3, more work needs to be done to raise awareness and improve perceptions of the support available for wellbeing, equality, and inclusion.

5 NEXT STEPS

The EDS Action Plan has been developed based on these scores and is included in the main EDS template (**Appendix A**). These will also influence our wider EDI, Health Inequalities and Wellbeing work within the Trust in 2025-26. Objectives include the following:

Domain 1 Commissioned and Provided Services (Patient Experience)

- Create reporting templates to capture how services accommodate patients with protected characteristics or those at risk of health inequalities.
- Co-Produce improvements to access for individuals with protected characteristics.
- Expand the safety dashboard to ensure equality-related factors are systematically flagged within incident and near-miss reporting.
- Enhance Protected Characteristic Recording Within iWGC.

Domain 2 Workforce Health and Wellbeing (OD and Culture)

- Provide Health and Wellbeing initiatives and opportunities in the Trust and evidence uptake.
- Raise awareness of support available for staff who experience anti-social behaviour, discrimination, or sexual misconduct, highlighting what consequences there are for patients and staff.
- Develop Staffside and Staff Networks to ensure they can provide impartial support.
- Improve the 2026 NHS Staff Survey scores for staff recommending the organisation as a place to work and for treatment.

Domain 3: Inclusive Leadership (Trust Board and Senior Leadership)

- Strengthen Staff Networks and improve participation and collaboration of Senior Sponsors.
- Data is clearly communicated to Trust Board and evidence of analysis and interventions developed at this level are promoted to workforce.
- Show clear evidence as an organisation that equality and health inequalities are discussed, with clear interventions undertaken at Board / Committee level when issues are identified.
- Collaborate with other teams to present staff wellbeing data to Executive Operational Team, ensuring they can understand current EDI and Health Inequalities issues within the organisation.

6 ACTION REQUIRED

Trust Board are required to:

1. Approve the report and appendices.
2. Approve the proposed actions in response to stakeholder feedback.
3. Approve the submission of the report and appendices to Mid and South Essex Integrated Care Board (MSE ICB) for submission by February 2026

Report prepared by:

Paul Taylor
Director of Organisational Development and Culture

On behalf of:
Andrew McMenemy
Chief People Officer

Appendix A – Equality Delivery System Reporting Template

NHS Equality Delivery System (EDS)

Name of Organisation	Essex Partnership University NHS Foundation Trust (EPUT)	Organisation Board Sponsor/Lead	
		Andrew McMenemy – Chief People Officer	
Name of ICB	Mid and South Essex ICB		

EDS Lead	Amy Poole (Patient Experience Team) Domain 1 Gary Brisco (Equality Advisor) Domain 2 and 3	At what level has this been completed?	
			*List organisations
EDS engagement date(s)	Domain 1 09/12/2025 – Lived Experience Experts 09/12/2025 – Collaborative with MSE ICB Domains 2 and 3 01/12/2025 – Engaging with Staff Stakeholders and Independent Adjudicators	Individual organisation	Domain 2 and 3 EPUT and submission to MSE ICB on February 2026
		Integrated Care System-wide*	Domain 1 Graded collaboratively with Mid and South Essex ICB

Date completed	Thursday 11th December 2025	Month and year published	March 2026
Date authorised	TBC	Revision date	-

2025 EDS ACTIONS AND PROGRESS

Domain 1: Commissioned or provided services actions from EDS 2025

Equality Objectives

1A: Patients (service users) have required levels of access to the service.

- 1. Improve data quality and visibility so that evidence is made available which shows how services accommodate patients with higher risks due to a protected characteristic or at risk of health inequalities to have adequate access to the service.**
- Data quality and visibility have improved through Power BI developments.
 - Further enhancements are expected with the implementation of the new UEPR.
 - This topic has been included as an agenda item for discussion at the People Participation Group of the UEPR. The focus is on ensuring evidence demonstrates how services accommodate patients with higher risks due to a protected characteristic or those at risk of health inequalities, ensuring adequate access to the service.

Trust Strategic Objective SO1
 “We will delivery safe, high quality integrated care services.”

1B: Individual patients (service users) health needs are met.

- 1. Document routine signposting to VSCE organisations and use of social prescribing.**
 - 2. Ensure details of how personalised care is embedded into the care for those with higher risks due to a protected characteristic is clearly evidenced.**
 - 3. Increase scope of working in partnership with community groups, and VCSE organisations to support service delivery for those with protected characteristics.**
- The new inpatient operating model has been designed to ensure that routine signposting to VCSE organisations and the use of social prescribing is documented.
 - Personalised resources such as trauma buddy resources reflect how those with protected characteristics are able to tailor their care even more in practice.
 - EPUT has strengthened partnerships with community groups and VCSE organisations through co-production initiatives, including the Lived Experience Team, co-production champions, and events such as the Co-production 2025 Conference.
 - Practical collaborations, e.g., peer support on inpatient wards, involvement of lived experience ambassadors in service design and recruitment, and joint projects with VCSE partners like the SET MH PPG discussing and co-designing ways in which access can be improved for those with protected characteristics.

Trust Strategic Objective SO2
 “We will enable each other to be the best we can”

1C - Increase scope and utilisation of Patient Safety Partner role across organisation.

- 1. Actively include equality and health inequality themes in safety incidents and near misses.**
 - 2. Continue and increase scope of Patient Safety visits to include community services.**
 - 3. Agree reporting method for Patient Safety Partner interviews; ensure actions, themes, and trends from patient interviews are captured and incorporated into learning from complaints and PALS with assigned accountability.**
- This work has been incorporated into safety dashboard developments.

Trust Strategic Objective SO1
 “We will delivery safe, high quality integrated care services.”

Domain 1: Commissioned or provided services actions from EDS 2025

Equality Objectives

- Increased scope of PSPs in discussion as role currently on pause; set to move away from a Reward and Recognition role to a permanent role within the trust.
- Triangulation of PALS, Complaints and “I want great care” (iWGC) data now included in care unit quality and safety reports. This can include PSP data once the role has become embedded as permanent within EPUT and data capture of interviews has been specified.

1D - Ensure every service within EPUT is using iWGC as the recognised patient feedback service.

- 1. Improve protected characteristic listing with iWGC.**
 - 2. Improve access to collate data from patients with protected characteristics about their experience of the service with iWGC.**
 - 3. Continue campaign to ensure every service within EPUT is using iWGC as the contracted provider of PREMS.**
 - 4. Patient Experience team to work with services to engage with patients specifically with protected characteristics and other groups at risk of health inequalities about their experience of the service.**
 - 5. Document existing and future work with the VCSE to ensure all patient voices are heard; from this create data driven/evidence-based action plans to monitor progress. Governance structure to follow PCREF; EoC and Quality committee.**
- Request sent to iWGC to update ethnicity coding’s- this work is set to be achieved in January 2026 once iWGC move to their new platform.
 - iWGC cannot remove the option of “other” from ethnicity coding’s which accounts for the majority of individuals from racialized backgrounds not having their ethnicity correctly documented. Improved ethnicity coding’s to match current best national standards set to go live with new platform in January 2026.
 - Patient Experience iWGC reporting co-ordinator remains in dedicated post, to support teams with utilising iWGC.
 - Part of reporting co-ordinators 2026 objectives, in line with new platform go live date.
 - Action plans created as part of work streams including PCREF, CMH survey and UEPR are shared with Quality of care as part of the People Participation update

Trust Strategic Objective SO1
 “We will delivery safe, high quality integrated care services.”

Domain 2: Workforce health and well-being actions from EDS 2025

Equality Objectives

2A When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions:

- **Continue to monitor health, inclusion, and wellbeing of staff via appraisal process.**
- **Use sickness and absence data in the Trust to help guide wellbeing interventions, use this learning to reduce negative impacts in working environment.**
- **Promote initiatives for work-life balance in the Trust, including access to VCSE organisations.**

- NHS Weight Management Service advertised in EPUT Payslips.
- Wellbeing, health, and any current issues affecting staff members are incorporated into the staff appraisal and supervision processes to monitor and support employee health and wellbeing.
- Sickness and Absence data reported to Trust Board via Employee Relations team, with trends highlighted for action and intervention.
- Health and wellbeing training awareness sessions for line managers are integrated into the Management Development Programme and leadership development programme aiming to a raise awareness, provide support, and offering essential resources.
- VCSE offers regularly promoted via staff intranet pages, and available on request to staff.
- The EPUT staff intranet hosts numerous health and wellbeing pages featuring links and resources related to physical activity, sleep, healthy eating, hydration, smoking cessation, substance misuse, resilience, mindfulness, and the Cycle-to-Work scheme.
- Equality Advisor / Disability and Mental Health Staff Network can provide guidance and support, with updates made to our Reasonable Adjustments policy and procedure.
- The Employee Assistance Programme (EAP), provided by our Occupational Health Provider PAM (People Asset Management), offers support related to health and wellbeing matters, guidance on workplace reasonable adjustments, debt management, legal issues, bereavement, and relationship concerns. This service is free, confidential, and available 24/7.
- The Organisational Development and Culture team provides monthly newsletters to all staff, featuring topics such as health and wellbeing, financial wellness, healthy tips, and updates on health and wellbeing initiatives.
- Throughout the year, the Employee Experience Team deliver health and wellbeing sessions to staff, covering areas including menopause, financial difficulties, and support through difficult periods (such as tragic news events).

NHS EDI Improvement Plan HIA4:
Develop and implement an improvement plan to address health inequalities within the workforce.

Domain 2: Workforce health and well-being actions from EDS 2025

Equality Objectives

2B When at work, staff are free from abuse, harassment, bullying and physical violence from any source:

- 1. Develop effective interventions against bullying, discrimination, and harassment from service users against staff members, as well as improved support for those affected.**
- 2. Collaboratively develop new guidance with Ethnic Minority and Race Equality Network for staff to promote EPUT’s Anti-Racist and Zero-Tolerance approach to discrimination.**

- Staff members who experience assault or abuse within the organisation can receive support from our Violence and Aggression Prevention and Management (VAPR) Team, who can support staff experiencing threatening and violent behaviour from patients and members of the public, as well as raise issues with the police for intervention.
- EPUT is an Anti-Racist Trust and regularly confirms this through our Communications Team, discriminatory behaviour from patients will be challenged.
- EPUT has implemented the Unprofessional Behaviours and Sexual Safety Program for all staff. This program enables staff to discuss unprofessional behaviours within the workplace, reflect on their own conduct, and provides an essential tool for managing difficult and challenging behaviours. Embedding this program contributes to fostering a more positive workplace culture.
- “Discrimination is not part of my job” campaign developed in collaboration with the Ethnic Minority and Race Equality Network part of EPUT messaging in our patient facing services, offering support to staff members experiencing discriminatory behaviour and clearly informing staff that this is not tolerated.
- Active bystander training delivered in line with Unprofessional Behaviours and Sexual Safety program for staff, empowering our staff to call out, report and challenge discrimination from patients and staff.
- Those who report discrimination via DATIX are directly contacted by the Equality Advisor, offering support and guidance. They are also promised a debriefing session by their manager where this is racially motivated discrimination, bullying or harassment.

NHS EDI Improvement Plan HIA6
 Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

2C Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source:

- 1. Promote and distribute Reasonable Adjustments / Health, and Wellbeing Toolkit across EPUT.**
- 2. Continue to promote and raise awareness of Freedom to Speak up Guardians.**
- 3. Improve access to workforce support resources for those unable to access them online.**

- Collaborative working alongside the Disability and Mental Health Network to develop a Neuroinclusive Café and update our reasonable adjustments guidance and training to better support staff and inform managers.

NHS EDI Improvement Plan HIA6
 Create an environment that eliminates the conditions in which bullying, discrimination,

Domain 2: Workforce health and well-being actions from EDS 2025

Equality Objectives

- EPUT is working collaboratively with the local ICS on staff health and wellbeing initiatives. This collaboration ensures that EPUT maintains high standards, provides well-led services, and adheres to best practices.
- Freedom to Speak up Guardians regularly engage with staff and promote their services throughout the year, including Freedom to Speak Up month in October.
- Staff engaged frequently in-person by Employee Experience Managers and Staff Engagement Team visits, who can signpost to external services and confidential services offered within the Trust.
- EPUT has trained Mental Health First Aiders, who play a vital role in promoting and supporting employee wellbeing. Mental Health First Aiders acquire skills to identify the signs of someone experiencing mental health challenges and gain the confidence to initiate a supportive conversation and learn about the resources available to guide individuals to appropriate support, ensuring a positive and healthy workplace for all.

harassment and physical violence at work occur.

2D Staff recommend the organisation as a place to work and receive treatment:

- 1. PSED / General Workforce / Staff Survey data will be used gauge the experience of marginalised staff (BME, LGBTQ+) within EPUT and develop interventions for retention.**
 - 2. Implement EPUT retention strategy, with actions to improve staff turnover and experience.**
 - 3. Creation of a Recruitment and Retention Task and Finish Group to continue development of retention actions within the Trust.**
- Teams regularly engaged by Employee Experience Managers, who each cover a locality in the area and support staff development and wellbeing.
 - Retention Strategy still in development within the organisation.
 - Recruitment Task and Finish group implemented, with Inclusion Ambassadors in response to the experiences of BME staff shown in our WRES data.
 - Reward and Recognition Hub allows staff to share praise for each other on the Staff intranet.
 - Long-Term Service awards at 25 and 40 years for staff.
 - EDS, PSED, WRES and WDES data all reviewed at Board level, with actions for improvement suggested by Equality Advisor, difficulties experienced by marginalised staff and interventions all reported to Board.
 - Associate Health Practitioners engaged to collect feedback alongside Chief AHP to improve conditions for flexible working, retention, and intake. Program modified to add improvements to work-life balance and on-boarding process.
 - Health Care Assistant academy aimed at HCA staff members, introducing a buddy scheme to improve on-boarding / mentoring of new intake. Developed and delivered in collaboration with the recruitment team. Ongoing check-ins after 30, 60 and 90 days to gauge wellbeing.

NHS People Promise
 “We are Recognised and Rewarded, Staff Engagement and Morale”

Domain 2: Workforce health and well-being actions from EDS 2025

Equality Objectives

- Deep dive into work-life balance of employees conducted by Retention Lead and People Promise Manager based on Staff Survey and focus grouping staff. Flexible working promoted across the Trust to raise staff awareness and increase uptake.
- New starters surveyed after one-month, also called by Retention Lead to gauge their on-boarding and identify issues working in the Trust.
- Funding sourced by Employee Experience managers to improve Staff Areas across Trust, providing better quality spaces for staff. One of which is at Trust Head office (The Lodge).

Domain 3: Inclusive leadership actions from 2025

Equality Objectives

3A Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.

- 1. Senior Leaders to continue to demonstrate a commitment to health inequalities, wellbeing, and EDI by attendance of relevant events.**
- 2. Ensure evidence for board members actively communicating messages for inclusion, wellbeing and health are collected throughout the year.**
 - Senior Leaders to continue to demonstrate a commitment to health inequalities, wellbeing and EDI and are frequently invited to relevant events.
 - Re-commitment to the Anti-Racist charter, which was signed by the CPO, working alongside colleagues from staff-side. This has been distributed across the wards/services to ensure parity with other EDI initiatives including sexual safety. Ensure evidence for board members actively communicating messages for inclusion, wellbeing and health are collected throughout the year.
 - Board members are part of Communications regarding health inequalities, wellbeing, and EDI within the organisation, although a full archive of these has not been collated across the year as these tend to be intranet articles.

High impact action 1:
Chief executives, chairs, and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

Domain 3: Inclusive leadership actions from 2025

Equality Objectives

3B Board / Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.

- 1. Equality and Inclusion as well as Health Inequalities of Patients and Staff to be standing agenda items in all board and committee meetings, even those outside of People and Culture Directorate (such as Estates or Finance.)**
 - 2. Review Equality Impact Assessment process in EPUT to ensure this is a mandatory item in project development and approval / discussion takes place at a senior level.**
 - 3. Ensure equality and health inequalities are reflected in the organisational business plans to help shape work to address needs.**
- Equality Impact Assessment updated and now a mandatory part of project submission to Board, with improved guidance and a streamlined process for submission and approval. Equality and Quality Impact Assessments are performed on all projects led within EPUT's transformation team.
 - Equality and health inequalities are reflected in the organisational business plans to help shape work to address needs.
 - EDI and Health inequalities are not reflected in papers outside of People and Culture Directorate, but this is an ongoing development.
 - Equality and Health Inequalities KPI's are reflected in EPUT's People and Education Strategy (2025-28) and Trustwide Strategy, both published on EPUT's public website, reviewed at board level based on WRES / WDES and Staff Survey data.

High impact action 1:
Chief executives, chairs, and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

Domain 3: Inclusive leadership actions from 2025

Equality Objectives

3C Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

- 1. Review Trust staffing to ensure those at Band 7+ are reflective of the population served and Trust demographics to ensure representation.**
 - 2. Ensure Accessible Information Standard (AIS) is present in EPUT, and part of the contracts and services provided by the Trust.**
 - 3. Board EDI objectives should be dictated by existing data from PSED, Staff Survey and WRES / WDES data, with interventions at a senior level to address negative trends or lack of progress.**
- Demographic reporting shared with Trust Board via PSED, Staff Survey and WRES / WDES data.
 - Accessible Information Standard promoted throughout Trust and part of current EPUT training.
 - WRES data investigated following severe disparity rates in formal disciplinary rates, discussed as part of People Committee board alongside EMREN Chair.
 - Board EDI objectives dictated by existing data from PSED, Staff Survey and WRES / WDES data, with interventions proposed as part of these reports.
 - Leadership interventions will include graduates from our award-winning RISE programme that is sponsored by our Executive Chief People Officer and delivered by our OD team alongside external consultants including Dr. Joan Myers. Whilst the RISE programme is for colleagues from Bands 2 to 8b and has now become an ICS endeavour, the King's Fund will be supporting at least 20% BME staff into the future senior leadership programmes.

High impact action 1:
Chief executives, chairs, and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

DECEMBER 2025 EDS EVIDENCE PACK & STAKEHOLDER RATING

Outcome	Evidence: Commissioned or Provided services 2025	Rating	Owner (Dept/Lead)
<p>1A: Patients (service users) have required levels of access to the service</p>	<p>Southend Primary Care Mental Health Team simone.longley@nhs.net</p> <ul style="list-style-type: none"> • Option of a face-to-face appointment, particularly for the initial assessment, reliant on the availability of rooms at GP practices. Difficult to achieve in the larger surgeries since the introduction of the ARRS (additional roles reimbursement scheme) which has seen primary care networks employing more healthcare professionals from a range of disciplines to meet the need of their patient population. • Choice of face-to-face, video or telephone consultations. • Joint working with other services. We aim to work in a trauma informed way. We regularly carry out joint assessments and reviews with the community drug & alcohol team, HARP (the homeless action resource project and the social prescribers as well as our colleagues in other EPUT teams. • If a patient requires a home visit, this can be facilitated. • Most patients offered an assessment or review appointment by the PCMHT will be seen within two weeks of the referral date, with many offered an initial appointment within a week. • We do try to work with practice managers and primary care network leads to find a solution. We also raise the issue as a concern with ICB representatives and try to think creatively to find possible solutions. • We have ensured that we are visible and accessible to services who are supporting vulnerable patients in community services. We attend the monthly hoarding panel, have a weekly drop-in meeting with the drug & alcohol services and we attend the Complex Needs and Frailty meetings already initiated in two of our 4 PCN areas. We are in the process of establishing these in the remaining 2 PCNs. • We hold a weekly Integrated Neighbourhood MH MDT in each PCN. These are attended by the Social Prescribers and representatives from Trust Links the mental health charity and Therapy for You. We are continuing to build on this foundation by inviting cluster leads from the Recovery & Wellbeing Team and other relevant parties. We are aiming to reduce duplication and avoid referrals ‘bouncing’ around the MH teams. <p>Brentwood & Basildon Older Peoples Community Mental Health Team pauline.chittenden@nhs.net</p> <ul style="list-style-type: none"> • Referrals accepted from GPs and other health and social care professionals. • Outreach and home visits offered to reduce barriers for those with mobility or cognitive challenges. • Translation and interpretation services available to support non-English speaking service users. • Booking of transport is facilitated for service users with mobility or access issues, ensuring equitable access to appointments. 	<p>1</p>	<p>Patient Experience</p> <p>Amy Poole: Patient Experience Manager</p>

Outcome	Evidence: Commissioned or Provided Services 2025	Rating	Owner (Dept/Lead)
<p>1B: Individual patients (service users) health needs are met</p>	<p>Southend Primary Care Mental Health Team simone.longley@nhs.net</p> <ul style="list-style-type: none"> Holistic approach to healthcare and recognise that physical health and emotional wellbeing, as well as social inclusion and support are all equally as important when considering a patient’s care needs. Collaboration with colleagues and partners in health and social care as well as the wider system, in order to meet the individual unmet needs identified during our initial assessment and subsequent contact with our patients and their families/carers. Avoiding ‘signposting’ to support services and actively complete any referrals that are agreed with the patient as part of their plan of care following our assessment. As part of our local agreed protocol, we always arrange to follow up patients after two weeks to ensure that referrals have been sent and to find out if contact has been made. Honest and open about waiting lists and we endeavour to find information, resources and other support that may be available whilst waiting for treatment. <p>Brentwood & Basildon Older Peoples Community Mental Health Team: pauline.chittenden@nhs.net</p> <ul style="list-style-type: none"> Holistic assessments conducted to tailor care plans to each service user’s mental and physical health needs. Multidisciplinary team approach ensures coordinated care, including psychiatry, psychology, nursing, and social work. Regular reviews and adjustments to care plans based on service user feedback and clinical progress. Weekly MDT and monitoring meetings support collaborative decision-making and ensure timely responses to changing health needs. Integrated approach to patient care ensures seamless coordination between mental health, physical health, and social care services. 	<p>1</p>	<p>Patient Experience</p> <p>Amy Poole: Patient Experience Manager</p>

Outcome	Evidence: Commissioned or Provided Services 2025	Rating	Owner (Dept/Lead)
<p>1C: When patients (service users) use the service, they are free from harm</p>	<p>Southend Primary Care Mental Health Team simone.longley@nhs.net</p> <ul style="list-style-type: none"> • Patient safety is at the heart of all that we do. To meet the needs of each patient we ensure that we have an ‘encyclopaedic’ knowledge of community services available in our area. We ensure that we consider any risks at every contact and give patients information about what to do if they should experience a deterioration in their mental health and require a crisis response. This information is also included in all messages that we send to patients via SystemOne. As well as crisis support information, we also regularly give patients information around helplines, charities and wellbeing services that can support them with their mental and physical health challenges, and our assessments look at social inclusion and support circles recognising that loneliness and social isolation can be a major risk factor that must be considered as part of a biopsychosocial assessment. • Should we identify any issues that may require a Safeguarding investigation, we make the appropriate onward referrals to the Children or Adult Safeguarding teams. • Following initial contact, we arrange at least one follow up contact to ‘check in’ with our patients. This ensures that they have remained safe and well, gives reassurance that we have listened to them and care about their wellbeing and gives us the opportunity to check that the relevant onward referrals have been completed and have been acknowledged by the receiving team or service. <p>Brentwood & Basildon Older Peoples Community Mental Health Team: pauline.chittenden@nhs.net</p> <ul style="list-style-type: none"> • Risk assessments completed at initial contact and regularly reviewed. • Safeguarding protocols in place and actively followed. • Staff trained in de-escalation techniques and trauma-informed care. • Weekly monitoring meetings help track risk factors, incidents, and ensure proactive safeguarding measures. 	<p>2</p>	<p>Patient Experience</p> <p>Amy Poole: Patient Experience Manager</p>

Outcome	Evidence: Commissioned or Provided Services 2025	Rating	Owner (Dept/Lead)
<p>1D: Patients (service users) report positive experiences of the service</p>	<p>Southend Primary Care Mental Health Team simone.longley@nhs.net</p> <ul style="list-style-type: none"> The team uses I Want Great Care for patient feedback. We send a message out to every patient at the point of transfer back to the care of their GP. We receive around 20-30 patient feedback reports every month. Over the 5 years that the team has been working in primary care our average feedback rate has been 99.7% positive. <p>Some feedback the team has received is included below:</p> <ul style="list-style-type: none"> <i>“This is the best experience I have had in relation to mental health support.”</i> <i>Friendly and compassionate making me feel like if I needed help, they were there for me.”</i> <i>“My appointment was exemplar, she was patient centred, kind, empathetic, active and had genuine listening skills. She gave me time and space to talk, responded appropriately, clearly, and reassuringly. My concerns, questions and queries were answered clearly & concisely with a professional but human & caring approach. Solutions & next steps were discussed very clearly & with my full understanding & clarity of what I felt best for me.”</i> <i>“I spoke with a lovely lady who was very attentive at listening to my problems didn’t feel judged or rushed I gave 5 stars across the board because the service I received was of great satisfaction and I came away happy in the knowledge that I had been listened to and had a plan in to proceed forward with my mental health issues.”</i> <i>“The experience I had with this current episode of Mental Health I found to be far more comprehensive and supportive than any previous presentations I have made over the last 10-15 years. I felt listened to and validated and understood almost totally.”</i> <i>“I feel like something has been brought to light that is going to be potentially life changing. It is not the diagnosis I went in for and I’m just glad that someone was able to spot this as it has clearly been missed for the last 40 years. I’m really happy with the assessment outcome.”</i> <i>“Staff were kind, present and genuinely wanting to help me in whatever way she could. She went out of her way to speak to me probably more times than she should, and I will always be thankful of the kindness and support she has shown me.”</i> <p>Brentwood & Basildon Older Peoples Community Mental Health Team: pauline.chittenden@nhs.net</p> <ul style="list-style-type: none"> Service users report feeling listened to and respected during interactions. Feedback mechanisms in place, including feedback forms, to capture user experience. Continuous improvement driven by service user input and complaints resolution processes. Staff away days promote team cohesion, reflection, and service improvement, contributing to a more positive and responsive care environment. 	<p>2</p>	<p>Patient Experience</p> <p>Amy Poole: Patient Experience Manager</p>

Outcome	Evidence: Workforce health and Well-being 2025	Rating	Owner (Dept/Lead)
<p>2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions</p>	<ul style="list-style-type: none"> Wellbeing, health, and any current issues affecting staff members are incorporated into the staff appraisal and supervision processes to monitor and support employee health and wellbeing. Health and wellbeing training awareness sessions for line managers are integrated into the Management Development Programme and leadership development programme aiming to raise awareness, provide support, and offering essential resources. Reasonable Adjustments passport available for all staff in EPUT. Managers equipped with toolkit and resources to implement Access to Work requests or adjustments for staff with disabilities or long-term conditions, as well as supporting their wellbeing in the workplace. The Employee Assistance Programme (EAP), provided by our Occupational Health Provider PAM offers support related to health and wellbeing matters, guidance on workplace reasonable adjustments, debt management, legal issues, bereavement, and relationship concerns. This service is free, confidential, and available 24/7. Wellbeing initiatives, including live sessions facilitated by external trainers and recorded for later access, are available to all staff. These include activities such as Pilates, breath work therapy, yoga, and distance Reiki. The EPUT staff intranet hosts numerous health and wellbeing pages featuring links and resources related to physical activity, sleep, healthy eating, hydration, smoking cessation, substance misuse, resilience, mindfulness, financial wellbeing, and the Cycle-to-Work scheme. Equality, Diversity, and Inclusion (EDI) resources are accessible to support staff on the autism spectrum and those with neurodiversity, providing guidance for supporting individuals with dyslexia, ADHD, and other long-term conditions that may impact health within the workplace. We have seen a reduction in our “<i>We are Safe and Healthy</i>” score on the NHS Staff Survey, from 6.44 to 6.30 out of 10. This is also slightly lower than the national average (6.40). 	<p>1.8</p>	<p>OD and Culture</p> <p>Equality Advisor: Gary Brisco</p>

Outcome	Evidence: Workforce health and Well-being 2025	Rating	Owner (Dept/Lead)
<p>2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source</p>	<ul style="list-style-type: none"> • EPUT is an Anti-Racist Trust and regularly confirms this through our communications, discriminatory behaviour from patients will be challenged and is not condoned within the organisation. • Induction updated to include active bystander training, empowering our staff to call out, report and challenge inappropriate behaviour from patients and staff. • Equality Advisor can provide guidance and signposting to third party support organisations (such as Switchboard LGBT+, EASS and Stop Hate UK) Employee Relations or Patient Experience if staff members raise concerns of discriminatory behaviour in their teams (or if they would like help in improving the inclusion in their services). • EPUT has implemented the Unprofessional Behaviours and Sexual Safety Program for all staff. This program enables staff to discuss unprofessional behaviours within the workplace, reflect on their own conduct, and provides an essential tool for managing difficult and challenging behaviours. Embedding this program contributes to fostering a more positive workplace culture. • Sexual Misconduct can be anonymously reported via our 24hr Sexual Safety crisis line, which will be reported to the Care Unit Director and actioned. • EPUT Staff Engagement Champions in the organisation trained to challenge bullying and harassment behaviours as well as share lived experiences with our Staff Engagement Team and Employee Experience Managers. • Partnerships with Next Chapter, supporting our Safeguarding team and providing resources and seminars for patients, carers or staff members experiencing domestic abuse and stalking. • “Discrimination is not part of my job” and “No Space for Abuse” campaigns launched in the Trust, giving staff clear guidance on how to report discriminatory behaviour and clear messaging that this is not acceptable to patients and members of the public accessing our services. • Those who report discrimination via DATIX are directly contacted by the Equality Advisor, offering support and guidance. They are also promised a debriefing session by their manager where they can discuss their wellbeing and how to prevent this happening in future. • A decrease in our NHS Staff Survey scores for “In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?” (9.68% - 9.27%), but this is still above the national average (9.27%). • An increase in our NHS Staff Survey scores for “In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?” (8.23% - 9.68%), and this is still above the national average (7.63%). 	<p>1.5</p>	<p>OD and Culture</p> <p>Equality Advisor: Gary Brisco</p>

Outcome	Evidence: Commissioned or Provided services 2025	Rating	Owner (Dept/Lead)
<p>2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source</p>	<ul style="list-style-type: none"> • The Health and Wellbeing Toolkit, accessible to all staff, aligns with NHS England’s Health and Wellbeing Framework and provides guidance on physical, financial, and mental wellbeing. Topics include addiction, work-life balance, and flexible working arrangements. • Signposting to external organisations available from Equality Advisor, Employee Experience and Staff Engagement Teams when engaging with staff and resolving issues or providing support. • EPUT provides support for carers within the Trust. The Carer's Lounge offers resources, peer support, and a confidential environment for staff and patient carers. • EPUT launched the Neuroinclusive Café, establishing a safe environment for staff to network and share lived experience. Resources, support, and guidance for individuals with neurodiverse conditions available. • “Here for You” psychological support service for staff. The service is flexible and person-centred, successfully addressing the needs of staff. It provides confidential counselling and guidance. • Intranet • EPUT is working collaboratively with Mid and South Essex ICB on staff health and wellbeing initiatives. This collaboration ensures that EPUT maintains high standards, provides well-led services, and adheres to best practices. • Access-to-Work support available to individuals with depression, anxiety, stress, and/or other mental health conditions. With trained professionals able to support employees in resuming their role. 	<p>1.5</p>	<p>OD and Culture</p> <p>Equality Advisor: Gary Brisco</p>

Outcome	Evidence: Workforce health and Well-being 2025	Rating	Owner (Dept/Lead)
<p>2D: Staff recommend the organisation as a place to work and receive treatment</p>	<ul style="list-style-type: none"> • Associate Health Practitioners engaged to collect feedback alongside Chief AHP to improve conditions for flexible working, retention, and intake. Program modified to add improvements to work-life balance and on-boarding process. • Health Care Assistant academy aimed at HCA staff members, introducing a buddy scheme to improve on-boarding / mentoring of new intake. Developed and delivered in collaboration with the recruitment team. Ongoing check-ins after 30, 60 and 90 days to gauge wellbeing. • Deep dive into work-life balance of employees conducted by Retention Lead and People Promise Manager based on Staff Survey and focus grouping staff. Flexible working promoted across the Trust to raise staff awareness and increase uptake. • New starters surveyed after one-month, also called by Retention Lead to gauge their on-boarding and identify issues working in the Trust. • Funding sourced by Employee Experience managers to improve staff areas across Trust, providing better quality spaces for staff. One of which is at Trust Head office (The Lodge). • EPUT's "We are Recognised and Rewarded" score under the NHS People Promise is currently 6.31 out of 10, which is below the national average (6.35 out of 10). • We have seen a decrease in our NHS Staff Survey scores for "I would recommend the organisation as a place to work" (64.47% - 60.92%), which is below the national average (65.21%). • We have seen a decrease in our NHS Staff Survey scores for "I would recommend the organisation as a place to receive treatment" (60.20% - 57.00%) which is lower than the national average (64.84%) • Our NHS People Promise score for Morale has reduced from 6.29 to 6.13 out of 10 and is now lower than the national average (6.20 out of 10). • Our NHS People Promise score for "Negative Experiences" has reduced from 7.95 to 7.87 out of 10 and is now lower than the national average (7.98 out of 10). 	<p>0.9</p>	<p>OD and Culture</p> <p>Equality Advisor: Gary Brisco</p>

Outcome	Evidence: Inclusive Leadership 2025	Rating	Owner (Dept/Lead)
<p>3A: Board members, system leaders (Band 9 and VSM), and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities</p>	<ul style="list-style-type: none"> • Staff Networks have sponsors from the Executive Team, as well as additional support from members of the Employee Experience Team and Equality Advisor. • Senior Leaders regularly attend EPUT Staff Networks and events in Network Calendars, such as Black History Month, Pride Month and other cultural or spiritual events across the organisation. Chief People Officer and Director of People and Culture have attended where available. Chief Executive Officer currently acting as sponsor for Ethnic Minority and Race Equality Network. • Unprofessional Behaviour training with the wider leadership team, alongside colleagues with lived experience and GMC/NMC to identify where discriminatory, micro-aggressive or unprofessional behaviours need calling out. The introduction to the 'Step-Up and Check-In' model which is aligned to the Vanderbilt model has been piloted across Specialist Services and an impact analysis will be completed in December. • People Committee (PECC) comprised of VSM Directors and Non-Executive Directors for assurance and review, yearly discussions of WRES, WDES, EDS, PCREF and PSED data. • Re-commitment to the Anti-Racist charter, which was signed by the CPO, working alongside colleagues from staff-side. This has been distributed across the wards/services to ensure parity with other EDI initiatives including sexual safety. • We have commissioned a Trust-wide culture review with 'brap' and 'The Kings Fund', that commenced in September and has a focus on race, inclusion, and professional behaviours. This will lead to a series of interventions with the Senior Leadership Team to ensure that a trauma informed approach to leadership, which includes how racism and discrimination affect the lives of the workforce. • These leadership interventions will include graduates from our award-winning RISE programme that is sponsored by our Executive Chief People Officer and delivered by our OD team alongside external consultants including Dr. Joan Myers. Whilst the RISE programme is for colleagues from Bands 2 to 8b and has now become an ICS endeavour, the King's Fund will be supporting at least 20% BME staff into the future senior leadership programmes. • Furthermore, a set of quarterly leadership development forums are being established for Senior Leaders which will include issues of why inclusion is relevant and creating psychologically safe workplaces, underpinned by trauma-informed and compassionate leadership. • Our Executive Team and senior leadership group receive an EDI update each month which includes updates or decisions that need to be made. At the October submission, the EDI delivery plan was 	<p>1</p>	<p>Exec Team</p> <p>Director of OD and Culture: Paul Taylor</p>

Outcome	Evidence: Inclusive Leadership 2025	Rating	Owner (Dept/Lead)
	<p>approved and includes the delivery of reciprocal mentoring, cultural awareness training and increasing the relevance and purpose of the EMREN staff network.</p>		
<p>3B: Board & Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed</p>	<ul style="list-style-type: none"> • Our Executive Team and senior leadership group receive an EDI update each month which includes proposals for improvement or decisions that need to be made. • Equality, Diversity and Inclusion for staff and service users (as well as the measures above) discussed at each Trust Public Board and evidenced in all sets of minutes. Board members and non-executive directors are able to challenge and request additional data (for example, a deep dive into career progression and development for BME staff in Q1 2024). • Equality and Inclusion part of People Committee agenda. • Board Assurance Framework (BAF) contains section on People and Culture, addressing EDI concerns (for example bullying highlighted on the WRES) and steps being taken to mitigate these as well as controls, measures, and outcomes. Director of OD and Culture updated BAF on a regular basis. • EDI delivery plan was approved and includes the delivery of reciprocal mentoring, cultural awareness training and increasing the relevance and purpose of Staff Networks. • New governance for People and Culture has been established to ensure that there is a dedicated space for staff networks and operational and corporate leads to discuss the key EDI objectives/delivery that have been agreed with the Executive Team. This sub-group will report into the Chief People Officer group and have a direct link to the Executive Team for operational oversight and decision-making and the People Committee for assurance. • WRES, WDES, EDS2022, PCREF, Pay Gap and PSED reporting are part of overarching People and Education strategy (2024-2028) <ul style="list-style-type: none"> ○ WDES and WRES targets set, with the goal of improvement towards this each year. ○ Yearly WDES and WRES progress (completed actions, improvements) are listed to board and are used to develop approaches and priorities for the ongoing action plan. 	<p>1</p>	<p>Exec Team</p> <p>Director of OD and Culture: Paul Taylor</p>

Outcome	Evidence: Inclusive Leadership 2025	Rating	Owner (Dept/Lead)
<p>3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients</p>	<ul style="list-style-type: none"> • In October, People Committee members met with the EMREN chair and other senior HR representatives to discuss the key outlier areas of the WRES (2024) report and compared this with data from the first six months of 2025. <ul style="list-style-type: none"> ○ One indicator that was highlighted as an outlier was WRES indicator 3 which identified that BME colleagues are 3.5 times more likely to go through formal disciplinary matters vs. white counterparts. ○ However, through the implementation of the Conduct Concerns Panel (CCP) which has an equality advisor on the panel, there has been a reduction in BME colleagues going through formal disciplinary processes from 3.5 (2024) to 1.5 (first six months of 2025). ○ This highlights how reformed HR policy, training and process have positively impacted on BME staff. • Pay Gap reporting broken down by Race information in line with NHS Improvement Plan. With plans to incorporate disability and other protected characteristics in the near future. • Breakdown of Occupational Health access available, this data (appointments, access time, health surveillance, vaccinations, service usage) used to drive initiatives and identify hot-spot areas. • NHS EDI Improvement Plan High Impact Actions are aligned to the EPUT People and Education Strategy. A programme of delivery has been developed to ensure that activity is monitored and delivered on time. • Executive Director Sponsors have joined Staff Equality Networks, providing support to Network Chairs and acting as champion for the Network. 	<p>1</p>	<p>Exec Team</p> <p>Director of OD and Culture: Paul Taylor</p>

Third-party involvement in Domain 3 rating and review

Trade Union Rep(s):
Oladipo Ogedengbe (Trade Union / Staffside Rep)

Independent Evaluator(s)/Peer Reviewer(s):
Arleen Brown (EDI Manager, Princess Alexandra Hospital)

Total Rating: Commissioned and Provided Services	6 / 12
Total Rating: Workforce Health and Wellbeing	5.7 / 12
Total Rating: Inclusive Leadership	3 / 9
EDS Organisation Rating (overall rating):	14.7 / 33 Developing
Organisation name(s): Essex Partnership University NHS Foundation Trust (EPUT)	
<p>Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped.</p> <p>Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing.</p> <p>Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving.</p> <p>Those who score 33, adding all outcome scores in all domains, are rated Excelling</p>	

2026-2027 EDS ACTION PLAN

EDS Action Plan 2026 - 27

EDS Lead	Year(s) active
Gary Brisco – Equality Advisor	2019 - Present
EDS Sponsor	Authorisation date
Andrew McMenemy	March 2026

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Create standardised reporting templates within the new UEPR system to capture how services accommodate patients with protected characteristics or those at risk of health inequalities, ensuring consistent evidence collection across teams.	<ul style="list-style-type: none"> • Agree a minimum core dataset for protected characteristics and inequality risk (aligned to Equality Act and NHS standards) • Co-design templates for core data set • Ensure IT configure templates within the new UEPR system. • Establish monthly data quality monitoring to track completeness and consistency through Reducing health inequalities committee. 	Q4 2026/27
	1B: Individual patients (service users) health needs are met	Co-Produce Improvements to Access for Individuals with Protected Characteristics; Work with VCSE partners, including the SET MH PPG, to co-design targeted actions that address access barriers	<ul style="list-style-type: none"> • Identify priority protected characteristic groups using iWGC data, PALS, and complaints. • Identify and engage VCSE and community partners with lived-experience expertise from these groups. • Gather evidence on access to barriers i.e. referral thresholds, language, or faith-related barriers. • Co-design possible solutions and trial in pilot number of services. 	Q4 2026/27

		faced by people with protected characteristics.		
	1C: When patients (service users) use the service, they are free from harm	Expand the safety dashboard to ensure equality-related factors are systematically flagged within incident and near-miss reporting.	<ul style="list-style-type: none"> • Define equality related factors i.e. protected characteristic, reasonable adjustment status. • Specify dashboard flags i.e. filters, flags. • Ensure IT configure factors with dashboard and establish procedure for use. • Consider factors when examining incidents 	Q4 2026/27
	1D: Patients (service users) report positive experiences of the service	Enhance Protected Characteristic Recording Within iWGC:	<ul style="list-style-type: none"> • Establish updated ethnicity coding so reports and dashboards align with national standards. • Draft internal guidance on why demographic data matters and how to reduce "other" use. • Map reduction in "other" usage" 	Jan 2027

Domain	Outcome	Objective	Actions	Completion date
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Domain 2: Workforce health and well-being</p>	<p>2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions</p>	<p>Evidence the use of staff data in making decisions to improve the health and wellbeing of EPUT staff.</p> <p>Provide Health and Wellbeing initiatives and opportunities in the Trust and evidence uptake.</p>	<ul style="list-style-type: none"> • Employee Relations Team to review and analyse sickness and absence data to identify trends and disproportionately affected groups (for example, BME or Disabled Staff, Working Carers.) • Wellbeing Lead to promote health and wellbeing offer of EPUT Allstars platform and monitor usage of staff accessing VCSE to evidence successful implementation. • Wellbeing Lead to monitor staff use of the Champion Health Portal and App from PAM, as well as staff usage to evidence successful implementation. • Wellbeing Lead to strengthen reporting of occupational health data within the People and Culture Directorate and Care Unit Leads. • Collaborate with system partners to deliver a broader range of health and wellness sessions, specific to the needs staff report. • Increase the number of physical activity initiatives, encouraging an active and healthy workplace culture. 	<p>Q3 2026</p>

Domain	Outcome	Objective	Actions	Completion date
	<p>2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source</p>	<p>Raise awareness of support available for staff who experience anti-social behaviour, discrimination, or sexual misconduct, highlighting what consequences there are for patients and staff.</p> <p>Support staff in reporting and refusing treatment to patients who verbally or physically abuse them and improve interventions taken by the Trust in supporting their wellbeing.</p> <p>Ensure that staff are trained and supported in both challenging and reporting anti-social behaviour of any kind and understand the support available for those affected.</p>	<ul style="list-style-type: none"> • OD and Culture Function to review existing process for staff affected by anti-social behaviour through focus grouping of staff who have reported this via DATIX, this should gauge the efficacy of current interventions and support. • OD and Culture Team with Care Unit Leads to develop SOP for staff to refuse treatment and disengage when treated in an anti-social manner. This should also address how this will be challenged and managed by the MDT when this is not a feasible option. • Head of OD to roll out the unprofessional behaviours and sexual safety programme across the organisation, embedding the check-in and step up models. • Head of Staff Experience to update EPUT behavioural framework. Setting expectations for compassionate, accountable leadership. This framework will be embedded in recruitment, appraisal, and development processes to ensure consistency and accountability. 	<p>Q3 2026</p>

Domain	Outcome	Objective	Actions	Completion date
	<p>2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source</p>	<p>Develop Staffside and Staff Networks to ensure they can provide impartial support to those affected.</p> <p>Use lived experience by engaging those affected when creating and developing interventions.</p> <p>OD and Culture Team to work with the VAPR team to ensure that messaging of support to staff is clear and unambiguous.</p>	<ul style="list-style-type: none"> • Staffside Chair to review potential of pooling union representatives with partner providers to ensure impartial representatives. • OD and Culture / Board ensure that staff Networks are led by elected volunteers, are funded and provided with protected time and administrative support, improving their ability to support staff affected by anti-social behaviour or stress. • VAPR Team to monitor current data and develop interventions for anti-social behaviour of any kind with support from Culture and OD Directorate. Staff Engagement Lead should utilise lived experience from incidents in the Trust to guide and develop these interventions within our services. • Communications team to work alongside ACT for You program in Trust, promoting this wider to empower staff from all backgrounds and profession groups to access supportive psychological techniques and build upon their resilience. • OD and Culture Team to embed trauma-informed principles across our organisation, ensuring leaders and managers understand the impact of trauma on staff and patients. This approach will shape how we support colleagues, resolve conflict, and create psychologically safe environments. 	<p>Q3 2026</p>

Domain	Outcome	Objective	Actions	Completion date
	<p>2D: Staff recommend the organisation as a place to work and receive treatment</p>	<p>Improve the 2026 NHS Staff Survey scores for staff recommending the organisation as a place to work and for treatment.</p> <p>Empower staff to provide feedback in multiple forms and use this feedback to drive tangible and recognisable changes.</p>	<ul style="list-style-type: none"> • Monitor the experiences of BME, LGBTQ+ and Disabled Staff against other staff members, working with relevant VCSE and Staff Networks to review this data and develop improvements on a regular basis. • OD team to strengthen induction and onboarding processes to ensure new staff feel welcomed, supported, and connected to our values from day one. This will include early career pathway discussions, embed our culture and behaviours, and ensure a positive first impression that supports long-term retention. • OD and Culture Team to expand flexible working options to meet the diverse needs of our workforce. This includes improved rostering systems, flexible shift patterns, self-rostering, clarity on hybrid working arrangements, and opportunities for protected secondments, career breaks, and sabbaticals. • OD and Culture Team will strengthen staff voice by creating more opportunities for open dialogue, co-production, and feedback. This includes regular engagement forums, improved visibility of leaders, and acting on staff survey results to demonstrate that staff views drive real change. 	<p>Q3 2026</p>

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	<p>3A: Board members, system leaders (Band 9 and VSM), and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities</p>	<p>Board to demonstrate and evidence active participation in equality and wellbeing within the Trust.</p> <p>Strengthen Staff Networks and improve participation and collaboration of Senior Sponsors.</p> <p>Data is clearly communicated to Trust Board and evidence of analysis and interventions developed at this level are promoted to workforce.</p>	<ul style="list-style-type: none"> • Ensure Equality and Health Inequalities continue to be standing items in all Board and Committee meetings. • Trust Board to identify and allocate additional Senior sponsors for each Network, evidencing that they are working in collaboration to identify issues faced by the group they represent and championing the goals of the Network. • Senior Sponsors with support from the OD and Culture Function to produce annual impact statements that detail actions taken, issues escalated and tangible outcomes achieved. This progress should be reported monthly at the Executive Operational Committee. • OD and Culture / Board ensure that staff Networks are led by elected volunteers, are funded and provided with protected time and administrative support, improving their ability to support staff affected by anti-social behaviour or stress. • Embed WRES, WDES, PSED and EDS data into Board and People Committee development sessions, ensuring leaders understand disparities faced by marginalised communities in recruitment, bullying, and progression. • All line managers to complete mandatory training on inclusive recruitment and capability processes, with performance monitored via appraisal. • All line managers to have a specific EDI related or health inequality objective within their appraisal (beyond mandatory training, capability processes). • Board-requested deep-dives (such as BME career progression in 2025) lead to time-limited improvement plans, with progress reports shared with the Public Board and People Committee to demonstrate ongoing oversight. 	<p>Q3 2026</p>

<p>3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed</p>	<p>Show clear evidence as an organisation that equality and health Inequalities are discussed, with clear interventions undertaken at Board / Committee level when issues are identified.</p> <p>Work collaboratively with other teams to present staff wellbeing data to Executive Operational Team, ensuring they can understand current EDI and Health Inequalities issues within the organisation.</p>	<ul style="list-style-type: none"> • OD and Culture Team to ensure that Equality Impact Assessments to be widened to gauge impact of health inequalities within the organisation and will be a mandatory requirement for projects and significant changes within the Trust. EIAs should be reviewed at a senior level before approval. • Risks identified at Board must be explicitly documented, with mitigation plans. • Strategic Risks include relevant equality and health inequality risks so that they can be addressed and monitored by the Executive Team and Board. • Trust Board should communicate WRES, WDES, LGBTQ+ (based on action 2D) data and interventions with Staff Networks to the wider Trust on a regular basis to raise awareness and evidence commitment. • Trust Board to ensure that equality and health inequalities are reflected in Trust strategies and organisational business plans. 	<p>Q3 2026</p>
<p>3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients</p>	<p>Ensure representation in upper levels of the organisation in comparison with wider Trust.</p> <p>Evidence action taken to improve areas of decline or poor performance in equality and health inequality actions.</p>	<ul style="list-style-type: none"> • Board and Senior Leads continue to review implementation and impact of WRES, WDES, GPG and EDS actions, as well as internal delivery plans. With evidence of interventions taken by the organisation when there is not year-on-year improvement. • Introduce culture dashboards disaggregating workforce and patient experience data by ethnicity and disability. • Patient feedback forums to include diverse voices, with equality themes reported to the Board. • Publish annual WRES/WDES progress reports with clear accountability for delivery against agreed EDI objectives. 	<p>Q3 2026</p>

Appendix B – Grading and feedback from stakeholders.

Outcome		2022	2023	2024 EDS Grading	2025 EDS Grading
Domain 1	1A: Patients (service users) have required levels of access to the service.	D	A	Achieving (2.4)	Developing (1)
	1B: Individual patients (service users) health needs are met.	A	A	Achieving (2.4)	Developing (1)
	1C: When patients (service users) use the service, they are free from harm.	A	A	Achieving (2.4)	Achieving (2)
	1D: Patients (service users) report positive experiences of the service.	A	A	Achieving (2.4)	Achieving (2)
Domain 2	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions.	A	A	Developing (1.4)	Developing (1.8)
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.	A	A	Developing (1.3)	Developing (1.5)
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.	A	A	Achieving (2)	Developing (1.5)
	2D: Staff recommend the organisation as a place to work and receive treatment.	A	A	Developing (1.1)	Underdeveloped (0.9)
Domain 3	3A: Board members, system leaders (Band 9 and VSM), and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	D	A	Achieving (2)	Developing (1)
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.	U	A	Developing (1.5)	Developing (1)
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.	U	A	Developing (1.5)	Developing (1)
Overall Grade		D	A	Developing (20.21)	Developing (14.7)
Each Domain: Undeveloped (Score 0) Developing (Score 1) Achieving (Score 2) Excelling (Score 3)			Overall Score under 8: Undeveloped Score between 8 and 21: Developing Score between 22 and 32, Achieving . Score of 33: Excelling		

Domain One: Commissioned or Provided Services.

Data collected via anonymous online survey, all grades collected and averaged by number of participants (five anonymous lived experience stakeholders).

Average grade of Lived Experience Experts	
1A	Developing (1)
1B	Developing (1)
1C	Achieving (2)
1D	Achieving (2)

Domain One – EPUT Service User feedback (Via “I want great care”):

- *“My appointment was exemplar, she was patient centred, kind, empathetic, active and had genuine listening skills.”*
- *“This is the best experience I have had in relation to mental health support; I received Friendly and compassionate making me feel like if I needed help, they were there for me.”*
- *“The experience I had with this current episode of Mental Health I found to be far more comprehensive and supportive than any previous presentations I have made over the last 10-15 years.”*
- *“[staff member] was the light at the end of a very dark tunnel for me. She was kind, present and genuinely wanting to help me in whatever way she could.”*

Domain Two: Workforce Health and Wellbeing

Data collected via anonymous online survey, all grades collected and averaged by number of participants (33 anonymous staff volunteer stakeholders).

Average grade of EPUT Staff Stakeholders	
2A	Developing (1.8)
2B	Developing (1.5)
2C	Developing (1.5)
2D	Underdeveloped (0.9)

- 48% of participants were Black, Asian or from a Minority Ethnicity Group.
- 43% of participants were in the 30 – 40 age range, the largest cohort.
- 18% stated that they had a disability, long term condition, or neurodiversity.
- 67% of participants stated they were female, with 9% stating a non-cisgender identity.
- 85% identified as Heterosexual.
- The most common faiths listed were “No Religion” (27%), Christian (30%) and Atheism / Humanism (15%).

Domain Two – EPUT Staff Stakeholder feedback:

- *“Well done Lorraine and Gary for all your hard work. Thank you and God Bless.”*
- *“Work-life balance is supported through flexible shift patterns, but the Trust keeps making the team smaller which makes the job more stressful.”*
- *“Staff must find many of these interventions themselves, with little support or signposting from their manager.”*
- *“Staff at Wickford Lodge kept giving me funny looks when I wear Niqab.”*
- *“No support for Racist Abuse” and “We need more Black managers in EPUT, we need people who understand racism.”*
- *“LGBTIAQ+ staff never mentioned at all except Pride, more needs to be done for non-cis het staff.” and “The Trust has done nothing to support transgender or non-binary people as the government takes rights away from us, we are just ignored.”*

Domain Three: Inclusive Leadership

Data collected by liaison with Equality Advisor from two independent adjudicators:

	Arleen Brown EDI Lead for H&WE ICB	Oladipo Ogedengbe Staffside Chair / EPUT Unison Representative	Average Grade
3A	Developing (1)	Developing (1)	Developing (1)
3B	Developing (1)	Developing (1)	Developing (1)
3C	Developing (1)	Developing (1)	Developing (1)

Domain Three – Independent Adjudicator / Trade Union Representative feedback

Arleen Brown EDI Lead for H&WE ICB

- EPUT lacks evidence of sufficient activity on Health Inequalities for staff at Board Level. EPUT should evidence a strategic approach, through the EDI Delivery Plan.
- EDI should be a standard agenda item at all Board and Committee meetings.
- Equality Impact Assessment template for 2025 may improve completion with monitoring and clear sign-off procedures on completion. Ongoing EIA process should also ensure that they are able to assess health inequalities for all projects and policies.
- Board papers lack evidence of discussion or reaction to Equality Impact Assessments completed within EPUT,
- Minimal sign of Accessible Information Standard and Patient Carer and Race Equality Framework at Board Level.

Oladipo Ogedengbe, Staffside Chair / EPUT Unison Representative

- Outputs from the Brap and King’s Fund culture review are turned into mandatory leadership interventions, supervision frameworks, and decision-making tools, especially focusing on trauma-informed, anti-racist, and compassionate leadership behaviours.
- The organisation can go beyond simply having senior leaders attend Staff Network events by requiring Executive Sponsors to produce annual impact statements that detail actions taken, issues escalated, outcomes achieved, and changes made as a result of network engagement.
- Establish formal progression pathways for under-represented staff by linking RISE, Queen’s Fund programmes, and quarterly senior leadership forums to succession planning, acting-up opportunities, and senior vacancies, ensuring measurable improvements in diversity at Bands 8c+ and VSM levels.
- Formalising a process where Board-requested deep dives (e.g., BME career progression) lead to time-limited improvement plans, with progress reports shared with the Public Board and People Committee to demonstrate ongoing oversight.
- To use the new People and Culture sub-group to collaboratively develop priorities with Staff Networks, assess whether interventions (e.g. reciprocal mentoring, cultural awareness training) are effective, and escalate obstacles promptly to the Executive Team for decisions.
- Ensure that WRES, WDES, PCREF, and Pay Gap targets from the People and Education Strategy are communicated to Divisions and Services, with local ownership, dashboards, and accountability for delivery at the senior management level.
- Strengthen the Conduct Concerns Panel approach by expanding early resolution, mediation, and informal support pathways to ensure concerns are addressed fairly and consistently before escalation to formal disciplinary procedures.
- Extend Pay Gap and workforce analysis beyond race to include disability, gender identity, age, and other protected characteristics, using the data to identify intersectional inequalities and inform targeted interventions.
- Provide targeted training and ongoing support for managers on fair decision-making, unconscious bias, and inclusive people management, with disciplinary and grievance data linked to managerial performance reviews.

- Proactively analyse Occupational Health access and usage data to identify workforce health inequalities, inform early interventions, and tailor wellbeing initiatives in services or groups showing higher need.
- Move the sponsorship of Staff Equality Networks by Executive Directors beyond advocacy, requiring clear objectives, action plans, and outcome reporting to demonstrate how sponsorship directly enhances staff experience and reduces inequalities.

8.6 PAY GAP REPORT 2025

● Decision Item

👤 AM

REFERENCES

Only PDFs are attached

 Pay Gap Report 2025 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	1 April 2026
Report Title:	Pay Gap Report 2025	
Executive/ Non-Executive Lead:	Andrew McMenemy - Executive Chief People Officer	
Report Author(s):	Paul Taylor - Director of Organisational Development and Culture	
Report discussed previously at:	People Committee, Executive Team	
Level of Assurance:	Level 1	<input checked="" type="checkbox"/> Level 2
		Level 3

Risk Assessment of Report																								
Summary of risks highlighted in this report	<p>If the Trust does not produce accurate, timely, and credible pay gap reporting, it will fail to meet statutory requirements under the Public Sector Equality Duty.</p> <p>More importantly, it will undermine staff confidence in the organisation's commitment to fairness, pay equality, and the elimination of discrimination. This poses a significant risk to staff experience, retention, and organisational development, as employees who feel undervalued or treated unfairly are less likely to stay or to engage positively.</p> <p>Poor reporting also prevents the Trust from realising the full benefits of a diverse workforce, including improved decision-making, innovation, and cultural strength.</p>																							
Which of the Strategic risk(s) does this report relates to:	<table border="1" style="width: 100%;"> <tr><td>SR3 Finance and Resources Infrastructure</td><td></td></tr> <tr><td>SR4 Demand/ Capacity</td><td></td></tr> <tr><td>SR5 Statutory Public Inquiry</td><td></td></tr> <tr><td>SR6 Cyber Attack</td><td></td></tr> <tr><td>SR7 Capital</td><td></td></tr> <tr><td>SR8 Use of Resources</td><td></td></tr> <tr><td>SR9 Digital and Data</td><td></td></tr> <tr><td>SR10 Workforce Sustainability</td><td style="text-align: center;">✓</td></tr> <tr><td>SR11 Staff Retention</td><td style="text-align: center;">✓</td></tr> <tr><td>SR12 Organisational Development</td><td style="text-align: center;">✓</td></tr> <tr><td>SR13 Quality Governance</td><td></td></tr> </table>		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	
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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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	Statutory Reporting																							
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																						
	Executive Director	Andrew McMenemy																						
	Finance																							
	Estates																							
	Other																							

Purpose of the Report

This report forms one of three key reports that bring together a set of required statutory reporting requirements: Public Sector Equality Duty, Equality Delivery System and **Pay Gap Reporting**.

The Pay Gap Report is the publication of data which shows differences in pay between groups in our organisation. It sets out gaps and provides transparency with actions we are taking set out in a separate action plan to reduce gaps over time.

Approval	✓
Discussion Information	✓

Recommendations/Action Required

The Board of directors is asked to:

- **Note** the contents of this report including the Trust’s performance in supporting equal opportunities for staff with protected characteristics, the insights and the areas of focus.
- **Approve** for publication on our external facing website.

Summary of key issues

This report provides a concise, evidence-based assessment of pay differentials across gender, race, and disability within the Trust, identifying where gaps exist, how they have changed over time, and which pay elements and workforce structures drive those gaps. The paper focuses on three themes: (i) gender pay gap (ii) race pay gap and (iii) disability pay gap:

Theme 1: Gender Pay Gap: There have been modest but consistent improvements in EPUT’s gender pay position over the last eight years. The average hourly gap has narrowed from 16.9% in 2017 to 12.26% in 2025, while the median gap has fallen from 7.5% to 2.29% over the same period. These movements show that the skew caused by higher male earnings at the top of the pay distribution is reducing, and that the typical employee’s pay is becoming more equitable. When comparing EPUT’s gender pay gap nationally, EPUT is below the national average of 12.8%. EPUT is also a top performing NHS Provider in Mid & South Essex ICS (EPUT, MSEFT, NELFT, and Provide).

Theme 2: Race Pay Gap: This is the second year EPUT is publishing Ethnicity Pay Gap data. The March 2025 snapshot shows that, on average, employees from Black, Asian and minority ethnic (BME) groups have a higher mean hourly rate (£21.84) and median hourly rate (£19.09) than White colleagues (£20.43 mean; £18.13 median). The pay quartile breakdown reveals a more complex picture of progression and representation. BME colleagues are concentrated in the lower middle and upper middle quartiles, while White colleagues show large absolute representation in both the lower and top quartiles. This uneven distribution suggests that, despite favourable mean and median pay outcomes for BME staff overall, there are disparities in career progression and access to the highest paid roles.

Theme 3: Disability Pay Gap: This is EPUT’s first year reporting disability pay data, and the initial picture is broadly neutral on headline pay differences but highlights important data and disclosure issues. Employees who have declared a disability show a small mean pay gap compared with those who have not declared, with mean hourly rates of £20.40 for declared disability versus £20.84 for non-declared staff (a 2.14% difference) and similar median rates. Overall disclosure stands at 8.65% of the workforce.

Next Steps

Over the coming year we will build on recent progress by focusing on a small set of practical actions to reduce pay gaps and strengthen inclusion across the Trust. These priorities are:

- **Improve disability and long-term condition data**
 - Encourage colleagues to update records and explain why accurate data matters.

- Ensure recruitment captures disability and LTC information and that it transfers between systems.
- Create safe conditions for open conversations about support needs.
- **Embed reasonable adjustments and flexible working**
 - Clarify processes and options so managers can implement adjustments confidently and staff can thrive and progress.
- **Increase senior representation**
 - Review and evaluate leadership programmes, including management development and Women in Leadership.
 - Strengthen the Gender Staff Network and promote routine career development conversations and clear progression pathways.
- **Strengthen culture and everyday behaviours**
 - Roll out cultural awareness training starting with leaders.
 - Maintain focus on the anti-racist charter and commitments.
 - Continue the Unprofessional Behaviours programme and refresh the Behaviours Framework to support a respectful workplace.
- **Track progress and impact**
 - Monitor Staff Survey, WDES and WRES indicators.
 - Use appraisal data, training uptake and representation by pay band.
 - Measure improvements in disclosure rates and reductions in pay gaps.
 - Conduct qualitative engagement through staff focus groups and develop a culture champions scheme.

These steps will help create a fairer, more supportive Trust where all colleagues can develop and progress. The Pay Gap report and action plan will be discussed and actions tracked with our staff networks and the newly formed Staff Experience & Inclusion Group (SEIG). Oversight and assurance will be through quarterly EDI progress reports to the Executive Team and regular reporting through the People 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	NO	If YES, EIA Score	N/A

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard	PSED	Public Sector Equality Duty
WDES	Workforce Disability Equality Standard	EDI	Equality Diversity and Inclusion
EDS 2	Equality Delivery System 2	HR /ER	Human Resources / Employee Relations
ESR	Electronic Staff Record	NHSE	National Health Service England
BME	Black, Asian and Minority Ethnicity		

Supporting Reports/ Appendices /or further reading
Gender, Race & Disability Pay Gap Report

Lead

<p>Andrew McMenemy, Executive Chief People Officer</p>

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

***GENDER, ETHNICITY AND
DISABILITY PAY GAP
REPORT 31 March 2025***

REPORT

Purpose

This report presents our organisation's gender, ethnicity and Disability pay gap data. It includes an analysis of pay differences, identifies contributing factors, and outlines our commitments to addressing and closing the gap. Pay gap reporting aims to focus organisational efforts on reducing disparities, enhancing staff experience, improving retention, and fostering a workplace environment that is inclusive and rewarding for all.

The purpose of this report is to present information on the following:

Gender Pay Gap (GPG)
Ethnicity Pay Gap (EPG)
Disability Pay Gap (DPG)

The reporting information is based on a snapshot staff data as of **31 March 2025**, following national guidelines. The data is extracted from the Electronic Staff Record (ESR).

We use mean and median methods of calculation for the following reasons:

- Median pay provides a clearer picture of typical earnings, as it is not distorted by extremely high or low salaries.
- Mean pay shows how those very high or very low salaries influence overall averages.

By looking at both measures, we gain a more balanced and accurate understanding of the GPG, EPG, DPG.

We need to highlight the differences by showcasing the following aspects:

- an hourly rate (average);
- Median hourly rate (middle value);
- Mean doctors' bonus payments pay;
- Median doctors' bonus payments pay;
- Pay Quartile (from lowest to highest);
- Proportion of staff who: Clinical Excellence.

Context

Essex Partnership University NHS Foundation Trust (EPUT) was established on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust (SEPT). EPUT provides community health, mental health, and learning disability services to a large population across Bedfordshire, Essex, Suffolk, and Luton. We employ approximately 7,100 staff, excluding bank staff, volunteers, students, and contractors. The pay gap data offers valuable insights into the challenges related to inclusion and diversity within our entire workforce.

Like many NHS Trusts nationwide, EPUT has a predominantly female workforce. Our current diversity data indicates that around 76% of our employees are female, with approximately 24% male. During the period covered by this report, 53% of staff identified as White, while 39% identified as from BME backgrounds. During this reporting period 92% as no disability, while 8% identified with a disability.

One of our primary goals at EPUT is to promote fair and equitable career progression for all staff. Addressing gender, ethnicity, and disability pay gaps is a key component of this commitment. This report aims to provide full transparency regarding our current position, identify areas for improvement, and support both our statutory obligations and strategic objectives.

Many of the inequality issues highlighted in this report are not unique to EPUT; they are common across the NHS and society as a whole. By continuing to publish data on our inequalities, we aim to reinforce our commitment to understanding our own workforce, addressing challenges and to foster openness as a positive step toward meaningful change.

EPUT is committed to being an equal opportunities employer and to building equality, diversity and inclusion into everything that it does.

Gender Pay, Ethnicity Pay and Disability Pay Gap reporting requirements

Legislation mandates that organisations with 250 or more employees provide an annual report on their gender pay gap. NHS organisations are subject to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on 31 March 2017. These regulations support the Public Sector Equality Duty, requiring organisations to publish their gender pay gap data each year. This includes information on both mean and median gender pay gaps, as well as mean and median gender doctors' bonus payments gaps, the proportion of men and women receiving doctors' bonus payments, and the distribution of male and female employees across each pay quartile. Please note that only staff receiving full pay are included; therefore, figures may differ from other reports such as the PSED, WRES, or WDES.

Gender pay gap reporting illustrates the difference in average earnings between men and women within a workforce. Variations in pay gaps can be influenced by several factors, including age, length of service, and opportunities for career advancement. Recognising and addressing these factors will be key to fostering meaningful and sustainable progress.

Historical gender stereotypes and role perceptions also impact pay disparities. For example, consultants on legacy contracts receive ongoing doctors' bonus payments known as Clinical Excellence Awards.

It is important to emphasise that the gender pay gap differs from the concept of equal pay. Equal pay relates to ensuring that individuals performing the same or comparable work receive the same pay. Discriminatory pay differences based on gender are unlawful.

The Ethnicity Pay Gap (EPG) assesses the disparity in average remuneration between White staff and individuals from Black, Asian, and Minority Ethnic (BME) backgrounds. The Disability Pay Gap (DPG) measures the difference in average pay between disabled and non-disabled employees.

While reporting on EPG and DPG is not mandated by legislation, the NHS England Equality, Diversity, and Inclusion (EDI) Improvement Plan [EDI Improvement Plan](#) recommends that all Trusts analyse pay gap data based on protected characteristics and develop corresponding improvement strategies. Targets are set to implement plans for sex and race by 2024, disability by 2025, and for all other protected characteristics by 2026.

While we provide separate snapshots for the GPG, EPG, and DPG, we acknowledge that various factors—including flexible working arrangements, caring responsibilities, and socio-economic backgrounds—may intersect with different protected characteristics, resulting in compounded disadvantages.

Scope

The pay gap is defined as the difference between the mean or median hourly rate of pay colleagues receive. The mean pay gap is the difference between average hourly earnings. This is commonly known as the average and is calculated when you add up the wages of all employees and divide the figure by the number of employees (see appendix 1).

Gender doctors' bonus payments gap

Within the pay gap regulations, 'doctors' bonus payments pay' means any remuneration that is the form of money relating to profit sharing, productivity, performance, incentive or commission (see appendix 1).

EPUT's gender pay gap

The below table provides a snapshot of gender pay gap taken from 31 March 2025:

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	23.14	19.09
Female	20.3	18.66
Difference	2.84	0.44
Pay %	12.26	2.29

The below gender pay gap doctors' bonus payments table is taken as at the snapshot date of 31 March 2025.

Gender	Avg. Pay	Median Hourly Rate
Male	8,095.74	2,030.93
Female	4,172.29	2,030.93
Difference	3,923.46	0
Pay %	48.46	0

* Please see comments later in this report explaining what constitutes a doctors' bonus payments*

Pay quartiles by gender

To provide an overview of gender distribution across different levels of seniority, the proportions of male and female employees are segmented into four pay quartiles—lower, lower middle, upper middle, and upper—in lowest to highest order (ascending). The distribution of men and women within these quartiles is summarised in the table below:

Quartile	Female	Male	Female %	Male %	Description
1	1499	396	79.1	20.9	Lower - Includes all employees whose standard hourly rate places them at or below the lower quartile
2	1420	476	74.89	25.11	Lower Middle - Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	1482	415	78.12	21.88	Upper Middle - Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4	1362	534	71.84	28.16	Top - Includes all employees whose standard hourly rate places them above the upper quartile

Upon analysing the quartile distribution, although female colleagues constitute over 76% of the overall workforce, their distribution is predominantly concentrated within the first and second quartiles.

In the fourth quartile, female representation declines to 71.8%, with male representation increasing to 28.1%, compared to 20.9% in the first quartile.

This suggests that while women are well-represented throughout the organisation, their presence diminishes at more senior levels. Addressing this disparity is crucial for promoting equitable career advancement and fostering greater organisational diversity.

How we ensure equal pay

Legislation requires that men and women must receive equal pay for

- the same or broadly similar work
- work rated as equivalent under a job evaluation scheme, or work of equal value.

We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce with Agenda for Change Pay Terms and separate arrangements for Non-Executive Directors and Very Senior Managers. (see appendix 1)

What our data is telling us

The Gender Pay Gap (GPG) report examines key indicators, specifically the average and median pay differences:

- The GPG hourly pay gap for EPUT stands at 12.26%, with males earning an average of £23.14 per hour and females earning £19.09 per hour. When considering the median hourly rate, the gap narrows to 2.29%. **Compared to 2024, this represents a decrease of 0.15% in the average percentage and a 1.61% reduction in the median.** This is an improvement in our gender pay gap.

This indicates that, on average, male employees are paid approximately 2.29% more than female employees within the organisation.

- The GPG doctors' bonus payments pay gap for EPUT is 48.46%, with males receiving an average doctors' bonus payments of £8,095.74 and females receiving £4,172.29. The median doctors' bonus payments pay has remained at 0%, primarily due to the cessation of the CEA scheme for new members. **The average doctors' bonus payments pay gap has decreased by 6.85%, while the median remains unchanged compared to 2024.** This is an improvement

This suggests that there is no significant difference in doctors' bonus payments pay between males and females within the organisation.

- During the reporting period, 2.44% of male employees received a doctors' bonus payments compared to 0.37% of female employees. The Trust's workforce of consultants is composed of 62.1% males and 37.9% females, which significantly influences these figures.

Doctors' bonus payments include components of doctors' pay. This staff group has a higher proportion of male employees, which contributes to a larger doctors' bonus payments pay gap compared to other staff groups within the organisation. The components of doctors' bonus payments pay are as follows:

- Clinical Excellence Awards (LCEAs ceased from 1st April 2024)
- Discretionary Points
- Performance-Related Pay.

Over the past seventeen years, there has been substantial growth in the representation of women in medical roles, which is expected to contribute to a reduction in the gender doctors' bonus payments pay gap over time:

- **Female medical workforce:** A 17.9% increase, from 31.2% in 2008 to an estimated 49.1% in 2025. Currently, there are 163 females employed in medical roles.
- **Female medical consultants:** A 15.3% increase, from 22.7% in 2008 to an anticipated 37.9% in 2025. This represents the highest number of female consultants employed since the commencement of monitoring.

Whilst there has been a growth in the female consultant medical workforce, the legacy of the CEA scheme means that there will continue to be a gender doctors' bonus payments pay gap because there are more male consultants than female consultants. The Trusts current medical consultant gender breakdown is detailed in the table below.

Reporting Year	Female Headcount	% of Total	Male Headcount	% of Total	% Difference between Female/Male
2022/23	36	35.60%	65	64.40%	28.80%
2023/24	36	33.00%	73	67.00%	34.00%
2024/25	44	37.93%	72	62.07%	24.14%

EPUT's Race Pay Gap

This is the second year that EPUT is publicly reporting its Ethnicity Pay Gap (EPG) data. As the presentation of ethnicity pay gap information is not yet a statutory requirement, we are currently unable to benchmark our data against other organisations. The ethnicity pay gap is an emerging area of focus in this report, and we will continue collecting and analysing data to better understand the underlying factors contributing to pay disparities among different ethnic groups.

The table below provides a breakdown of staff within scope by gender and ethnicity for the reporting period from 1 April 2024 to 31 March 2025:

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	21.84	19.09	2,707
White	20.43	18.13	4,778
Not Known	24.13	22.99	99
% Diff White - BME	-6.93	-5.32	43
% Diff White - Not Known	-18.11	-26.82	98

Our snapshot for March 2025 shows an overall mean and median pay gap which is better for our BME workforce or Global Majority. In comparison to NHS England, in March 2024 the median ethnicity pay gap was reported at 1.98% in favour of white employees.

The table below is a breakdown of pay quartile by Ethnicity:

Quartile	Asian	Black	Mixed	Other	White British	White Other	Not Stated
1. Lower	114	291	39	17	1,308	113	13
2. Lower Middle	119	644	40	14	944	113	22
3. Upper Middle	142	570	47	30	962	122	24
4. Top	259	292	43	46	1,038	179	40

Looking at the above table the largest representation for each Ethnic Group by quartile is as follows:

- 43.09% of our BME workforce are in the 2nd quartile followed by 41.39% in the 3rd quartile.
- 74.99% of our White workforce are in the 1st quartile followed by 64.15% in the 4th quartile

Which consistently shows that there are disparities between White and BME colleagues in relation to career progression. The actions we are taking to reduce inequalities between ethnicities are further detailed in our 2025 WRES Report, which is published on our website and available here [\(insert once approved for publication\)](#)

The table below shows the doctors' bonus payments broken down by race as of 31st March 2025.

Ethnic Origin Grouping Summary	Employees Paid Doctors' bonus payments	Total Relevant Employees	Total Full Pay Relevant Employees
BME	53.00	3470.00	1.53%
White	24.00	5320.00	0.45%
Not Known	1.00	184.00	0.54%

The mean doctors' bonus payments pay gap was 1.5% in favour of BME colleagues. This legacy structure continues to impact equity in senior medical pay.

Changes to Clinical Excellence Awards (CEAs) over time have created disparities in doctors' bonus payments pay:

- Pre-2017 consultants receive automatic annual increases (Levels 1–9).
- 2017–March 2023 consultants must reapply every three years.
- Post-March 2023 consultants are no longer eligible.
- COVID-19 pause led to equal distribution of CEA funds for two years.

No new CEAs will be awarded going forward.

EPUT's Disability Pay Gap

This marks EPUT's first year of reporting disability pay data. It is an advisory requirement outlined in the NHS EDI improvement plan and represents a key milestone in our efforts to understand and address disparities related to pay and representation within the Trust. This initiative reinforces the Trust's commitment to workplace accessibility, promotes equitable career progression, and supports our goal of becoming a truly inclusive employer.

The table below shows the breakdown of staff in scope by disability for the period 1 April 2024 - 31st March 2025:

Disability Declarations	Mean Hourly Rate	Median Hourly Rate Grouping	Total Full Pay Relevant Employees
No	20.84	21.21	6,113
Yes	20.40	20.86	656
Prefer Not To Answer	20.50	19.98	35
Not Declared	22.28	23.08	645
Unspecified	23.89	24.65	137
% Diff No - Yes	2.14	1.65	89
% Diff No - Prefer Not To Answer	1.67	5.77	99
% Diff No - Not Declared	-6.91	-8.81	89
% Diff No - Unspecified	-14.60	-16.23	98

EPUT has 8.65% of staff who have reported a disability, compared to the overall workforce. It is important to note that at the initial stages of the employee lifecycle, candidates may choose to disclose their long-term condition (LTC) during the application process; however, this information is not always transferred into ESR. This is due to the use of separate recruitment systems, such as TRAC online application forms. This disconnection can result in underreporting at the onboarding stage, which subsequently impacts data accuracy and the Trust's ability to present an accurate picture in national workforce validation submissions.

The above table indicates that further efforts are needed to encourage our highest earners to disclose whether they have a disability.

The table below is a breakdown of pay quartile by Disability:

Quartile	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
1. Lower	1,520	163	11	17	184
2. Lower Middle	1,560	156	4	38	139
3. Upper Middle	1,579	113	9	30	166
4. Top	1,454	213	11	52	167

- 9.71% of our workforce with a recorded disability are in the 1st quartile followed by 8.80% in the 4th quartile.
- 3.64% of our workforce in the 4th quartile have not declared, this is the highest number of no declaration.

It is important to highlight that the 'Not Declared' responses are most prevalent in the highest quartile. This may indicate that more experienced colleagues are not consistently reporting this information. In order to avoid making assumptions, we must prioritise promoting accurate data entry and fostering a culture of transparency in information sharing.

The table below shows the doctors' bonus payments broken down by Disability as of 31st March 2025.

Disability Category	Employees Paid Doctors' bonus payments	Total Relevant Employees	%
No	63.00	7481.00	0.84
Yes - Unspecified		108.00	
Learning disability/difficulty	1.00	189.00	0.53
Long-standing illness (LTC)		194.00	
Mental Health Condition		104.00	
Physical Impairment		91.00	
Prefer Not to Answer		55.00	
Sensory Impairment		75.00	
Other		87.00	
Not Declared	15.00	847.00	1.77
Unspecified	1.00	1.00	100.00
		122.00	

Currently, there is no available data regarding the Clinical Excellence Awards for our LTC colleagues. This likely reflects a participant count of fewer than 10 which means that sharing such information could potentially compromise confidentiality and privacy. Therefore, we are unable to provide any specific details at this time.

EPUT comparison to the local NHS

Nationally [The gender pay gap for workers is in favour of men for the majority of occupations](#); however, occupational crowding has an effect since those occupations with the smallest gender pay gap have almost equal employment shares between men and women.

It is also important to note that men and women have different personal and job characteristics, which ultimately impact their respective pay.

Across the UK, men earned on average **12.8%** more than women in 2024, according to the Office of National Statistics 23rd October 2025, meaning that EPUT's gender pay gap is below the national average.

Below is a comparison table of how EPUT's gender pay gap sits in comparison to local neighbouring NHS organisations.

The mean gender pay gap for EPUT	Mean hourly rate 2024/25	Median hourly rate 2024/25
Hertfordshire Partnership University NHS Foundation Trust (HPFT)	5.26% lower than men's	-3.93% lower than men's
East London NHS Foundation Trust (ELFT)	7.57% lower than men's	0.85% lower than men's
EPUT	12.41% lower than men's	3.90% lower than men's
Norfolk And Suffolk NHS Foundation Trust	13.17% lower than men's	10.41% lower than men's
North East London NHS Foundation Trust (NELFT)	12.84% lower than men's	12.48% lower than men's
Mid and South Essex NHS Foundation Trust (MSEFT)	24.16% lower than men's	7.46% lower than men's
The Princess Alexandra Hospital NHS Trust	22% lower than men's	13% lower than men's
PROVIDE	17.35% lower than men's	9.51% lower than men's

Sample comparison data with neighbouring Trusts tells us:

- **EPUT is performing well in comparison with neighbouring providers**
- **EPUT is a top performing NHS Provider in Mid & South Essex ICS (EPUT, MSEFT, NELFT, and Provide).**

As part of our improvement plan, we will be working with HPFT and ELFT to share best practice and to learn what steps they have taken to reduce their gender pay gap.

A summary of our progress - 2025

On comparison to EPUT's gender pay gap for the year 2017, we have seen an improvement (reduction) of 4.64% over the eight years to 2025.

The mean gender pay gap for EPUT	2017	2018	2019	2020	2021	2022	2023	2024	2025
The mean gender pay gap for EPUT	16.90%	15.90%	15.90%	14.30%	11.90%	13%	12.93%	12.41%	12.26%
The median gender pay gap for EPUT	7.50%	7.40%	8.90%	8.10%	6.50%	6.20%	7.31%	3.90%	2.29%
The mean gender doctors' bonus payments gap for EPUT	34.40%	31.20%	25.20%	33.60%	47.00%	59.50%	56.01%	55.31%	48.46%
The median gender doctors' bonus payments* gap for EPUT	50.30%	51.70%	45.00%	30.80%	75.00%	79.60%	66.84%	0.00%	0.00%

When comparing EPUT's gender pay gap nationally, EPUT is **below the national average of 12.8%**.

Next steps and Actions

Over the coming year, we want to build on the progress already made and focus on a few practical areas that will help us continue to improve reduce our pay gaps and strengthen inclusion across the Trust. Our priorities are:

- Improving the quality of our disability and long-term condition data by:
 - Encouraging colleagues to update their information and explaining why accurate records matter.
 - Making sure the recruitment process captures this information properly and that it transfers across systems.
 - Creating the right conditions for open conversations about support needs.
- Embedding a clearer approach to reasonable adjustments and flexible working, so that staff have the best opportunity to thrive and grow at work and managers understand what is available and how to put adjustments in place with confidence.
- Continuing to improve representation in senior roles, particularly for women, Global Majority colleagues and staff with disabilities or LTCs, by:
 - Actively reviewing developing and evaluating leadership programmes such as our management development programme, national programmes and Women in Leadership opportunities
 - Strengthening our Gender Staff Network including encouraging routine career-development conversations, making sure staff know what pathways are open to them.
- Strengthening our culture and day-to-day behaviours through:
 - The introduction of a cultural awareness roll out programme starting with leaders
 - Continued emphasis on our anti-racist charter and commitments.
 - Further rollout of the Unprofessional Behaviours work and a refreshed Behaviours Framework to support a respectful working environment.

- Tracking improvement through:
 - Staff Survey and WDES/WRES indicators.
 - Appraisal data, training uptake and representation across pay bands.
 - Improvements in disclosure rates and reductions in pay gaps.
 - Qualitative engagement work with staff focus groups and a developed culture champions scheme

These steps will help us build a fairer and more supportive organisation where all colleagues can develop and progress.

Report prepared by:

Paul Taylor
Director of Organisational Development and Culture

On Behalf of:

Andrew McMenemy
Executive Chief People Officer

GPG, EPG and DPG Action Plan: 2025/26

Objective	Action	Timescale	Lead	Measure/Success
Increase LTC and Disability status and Data accuracy	Launch awareness to encourage voluntary sharing of LTC or Disability status for colleagues with LTC or disability.	Dec-26	EDI Lead, Workforce team	10% increase of reporting shared LTC or disability
	Embed the importance of sharing LTC or disability at recruitment stage.	Dec-26	Recruitment	5% increase from Applicant stage.
Implement and promote reasonable adjustments process	Promote and implement reasonable adjustment and flexible working process supporting managers and staff in having the conversations building psychological safety when disclosing LTC or a disability.	Oct-26	Wellbeing lead	WDES and NHS National Survey results
Advance representation of gender, global majority and LTC of staff in senior roles	Promote career development programmes to medical staff, with the aim of increasing the appointment of a senior workforce which is diverse, representative of the workforce, including those with protected characteristics.	Nov-26	OD Lead	NHS National Survey results
	To improve representation and reduce disparities the Trust needs to develop and promote the career development programmes: MDP, LDP, RISE, Edward Jenner, Mary Seacole and Women in Leadership.	Nov-26	OD Lead	NHS National Survey results
	To continue to build representation within the Trust embed and facilitate career development conversations with staff, informing them of relevant opportunities to develop within the Trust.	Oct-26	OD Lead	NHS National Survey results and monitor Appraisal
Culture change	To Continue to equip staff with inclusive, anti-racist and equitable training to build cultural competence	Continued	EDI Lead and OD lead	Mandatory training data
	Continue to roll our Unprofessional Behaviours and promote the behaviour framework Trust wide, to build on staff work ethic and civility.	Continued	OD Lead, Wellbeing and EDI lead	Evaluation and Attendees data

9. STRATEGIC INITIATIVES


9.1 TIME TO CARE CLOSURE REPORT

● Discussion Item

AG

REFERENCES

Only PDFs are attached

 Time To Care Closure Report 01.04.2026.pdf

SUMMARY REPORT		BOARD OF DIRECTORS PART 1			1 April 2026	
Report Title:		Time To Care Closure Report				
Executive/ Non-Executive Lead:		Alex Green, Executive Chief Operating Officer & Deputy CEO				
Report Author(s):		Emily Phillips, Project Manager				
Report discussed previously at:		Time to Care Steering Group				
Level of Assurance:		Level 1		Level 2	✓	Level 3

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR3 Finance and Resources Infrastructure	✓	
	SR4 Demand/ Capacity	✓	
	SR5 Statutory Public Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources	✓	
	SR9 Digital and Data		
	SR10 Workforce Sustainability	✓	
	SR11 Staff Retention	✓	
	SR12 Organisational Development	✓	
SR13 Quality Governance	✓		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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	Accountability Framework Meetings Urgent Care and Inpatient Steering Group		
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 outputs of the learning from the Time To Care Programme.	Approval	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to

1. Note the contents of the report
2. Note the transition of the programme to business as usual
3. Seek further information where required.

Summary of Key Issues

The Time to Care Programme was established to release significant, measurable time for direct patient care on inpatient mental health wards. Despite early delays caused by funding, recruitment and establishment control issues, substantial progress has been achieved. The programme has delivered a new engagement-led operating model, recruited the majority of the planned workforce, and initiated meaningful cultural change across services.

The 5-year programme of change was initiated with total funding of £21.1m and a goal to recruit 353 Whole Time Equivalents. Benefits expected to be realised in years 3-5.

Key Achievements

- Introduction of a new operating model built around Purposeful Admission, Therapeutic Care, Trauma-Informed Care, and Safe and Effective Discharge, now implemented across inpatient and urgent care services, with a focus now on embedding changes.
- Implementation of 16 priority staffing initiatives, focusing on safe staffing and enhancing therapeutic capacity.
- Enhanced collaboration and team culture, with high-performing multidisciplinary teams and stronger cross-professional working reported in several Care Units.
- Valued co-production, with Lived Experience Ambassadors contributing meaningfully to programme design and delivery and Peer Support embedded in the workforce model.
- Successful recruitment of 333.7 WTE roles against a 339 WTE target, significantly strengthening inpatient Multi-Disciplinary Team capacity and introducing new roles such as peer support workers, activity coordinators, clinical site managers and additional AHP input.

Key challenges experienced during the programme

- Approval to proceed at risk (May 2024) required two years of recruitment to be completed within a compressed time period.
- Delayed implementation impacting on delivery of financial and non-financial benefits within original timescale.

The completion of the programme and the challenges experienced have led to a number of areas of learning being identified and these have been included in the attached report.

The programme is now transitioning to business as usual with benefits reported via relevant sub-committees of the Board and contractual oversight meetings.

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

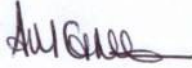
Acronyms/Terms Used in the Report

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Supporting Reports/ Appendices /or further reading

Time To Care Programme Closure Report

Executive Lead



Alex Green
Executive Chief Operating Officer & Deputy CEO



Essex Partnership University
NHS Foundation Trust

Time to Care Programme Closure Report

MARCH 2026

EPUT

CASE FOR CHANGE

The unprecedented challenges of recent years have had an adverse effect on EPUT and our staff's ability to deliver the safe, therapeutic care we aspire to provide.

SYSTEM



- **High rates** of Section 136, ED admission and long waiting lists
- **Variation** across Inpatient and Community resource availability
- Increased **demand** in areas of deprivation within EPUT's **geography**
- Increase in demand due to **population growth** and the socio-economic crisis
- Impact of the **Covid-19 Pandemic**
- Current trust **scrutiny** creating risk adverse practice across the Trust

STAFF









- Significant **recruitment** and **retention** challenges
- Delays to **patient admissions** and **discharges** due to limited **availability** of wider **MDT** staff
- **Capacity** challenges and a lack of clear oversight of **patient flow**
- Disjointed and inconsistent **therapeutic offer** due to resource pressures
- Core clinical staff undertaking administrative **activities outside of their remit**
- Lack of **clinical leadership** across a 24/7 period

PATIENTS



- People miss having a focus and **purposeful activity** in day to day life on the ward
- Some people don't know about or understand their **care plan** and the **support** in place for them
- Family and carers are not always **informed** and are not always effectively taking role in person's care
- Feeling that staff **don't have time** or are busy elsewhere
- Some people do not feel supported to make the **transition** to life after ward
- **Compassion fatigue**: patients sometimes feel dehumanised

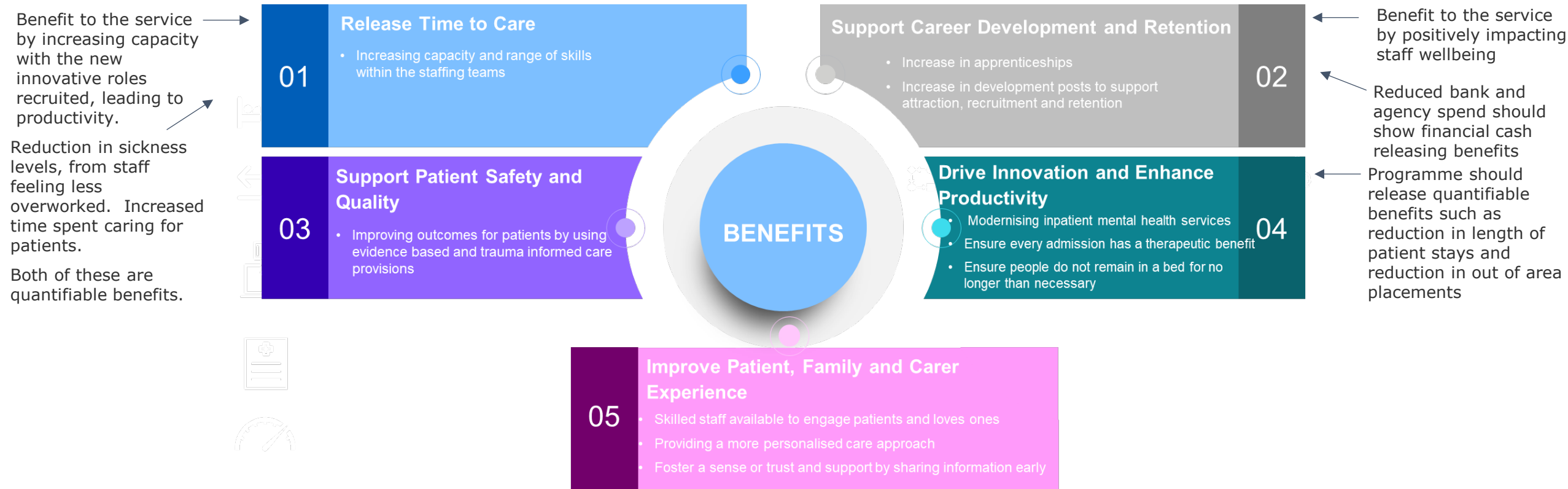
PROCESS IMPROVEMENT AIMS & BENEFITS

	Description	Estimated time to care saved	Dependencies	
	Ward Manager Development Programme	<ul style="list-style-type: none"> Co-develop a leadership & learning programme to upskill ward managers. Focused on developing consistent approaches and foundational skills 	<ul style="list-style-type: none"> Decrease non-value added time by streamlining ward manger responsibilities by approximately 4 hours per week 	<ul style="list-style-type: none"> EPUT co-facilitator capacity Ward manager protected time to attend the course
	SMART v2 Roll Out	<ul style="list-style-type: none"> Roll out SMART v2 bed management system 	<ul style="list-style-type: none"> c. 57 hours/week by updating SMART ahead of SitRep c. 7.5 hours/week by decreasing information requests via email 	<ul style="list-style-type: none"> Vendor engagement Clinical staff time to engage with TTC and willingness to adopt the new solution
	Improved SitRep and Handover Processes	<ul style="list-style-type: none"> Evaluate & standardise handovers & SitRep protocols to increase efficiency 	<ul style="list-style-type: none"> Up to 9 hours of clinical time/ week saved by reducing shift and MDT handover duration 	<ul style="list-style-type: none"> Clinical staff time to engage with TTC MDT appetite for change Availability of solutions that enable meetings standardisation
	Digital System Optimisation and Compliance Assessment	<ul style="list-style-type: none"> Understand challenges and explore opportunities to optimise documentation processes between Paris and Mobius 	<ul style="list-style-type: none"> Optimisation of documentation on systems will save up to approx. 2-3hrs of daily time Reduced number of documents scanned by approx. 25% 	<ul style="list-style-type: none"> Clinical staff time to engage with TTC IT and clinical team capacity to develop new or modify existing capabilities in Paris/ Mobius Ward staff availability/capacity to input to compliance assessment visits
	Access to Shared Care Records (SCR)	<ul style="list-style-type: none"> Provide medics with access to the Shared Care Record 	<ul style="list-style-type: none"> Decrease non-value added time for pharmacy teams (c. 2-3 hours per day in some cases) 	<ul style="list-style-type: none"> Medical teams' capacity to facilitate SCR access and attend training
	Safe Staffing Dashboard	<ul style="list-style-type: none"> Develop a dashboard to increase visibility of recruitment & staffing information 	<ul style="list-style-type: none"> Reduced time spent on accessing multiple data sources to ascertain ward staffing levels At least 10 hours time spent producing performance reports 	<ul style="list-style-type: none"> Technical and functional limitations/capabilities of digital solutions when building dashboard

BENEFITS OF TIME TO CARE

Implementation of the programme will deliver a wide range of benefits including service benefits and quantifiable economic benefits.

Aim is to monitor and track progress against these by obtaining feedback from our service users about their experiences from the Trust adopting time to care. Tracking the inpatient journey before and then during implementation to show a revised therapeutic and trauma informed approach within inpatient care.



Critical success factors such as clinical impact, service and workforce impact, financial benefits and impact and readiness to deliver will determine the programmes' success.

PROJECT OVERVIEW

PURPOSE AND OBJECTIVES

The Trust recognised that its systems and ways of working could be more efficient, enabling staff to spend more time on direct patient care. In response, the Time to Care programme was launched to release significant, measurable time for care on inpatient mental health wards by transforming how we work to support high-quality care every day.

This included a review and redesign of the inpatient staffing model to better align with patient needs, enhance safety, increase capacity, and strengthen the workforce through existing and new roles.

Sixteen initiatives were prioritised in year one, focusing on safely staffed wards and a shift from observation-led to engagement-led care. This involved creation of new roles to expand the capacity and skills within our multi-disciplinary teams.

Implement a new therapeutic acute inpatient care operating model. Using local, national, and international best practice and guidance to deliver high quality care for patients in the right place and in the right way for their needs. Delivering safe, effective care and a better experience for our patients, their families and carers, and our staff:

- Our care is personalised, therapeutic and trauma-informed.
- Stronger communication and collaboration helps us make the right choices for our patients.
- People are only admitted to hospital when there is a clear purpose for admission, and for no longer than is necessary.

DESIRED OUTCOMES

Implement 16 High Priority Staffing Initiatives

5-Year Programme Overview

Total Funding: £21.120 million

Programme Duration: 5 years

Workforce Recruitment Goal: 353 WTE (Whole Time Equivalent) staff

Recruitment Timeline 2023/24:

Recruitment commenced in July 2023

183 WTE recruited by the end of March 2024

Recruitment Timeline 2024/25:

Remaining 170 WTE to be recruited by March 2025

This will bring the total number of positions filled to 353 WTE

The programme includes recruitment across a wide range of multidisciplinary roles to support service delivery, including:

Activity Coordinators
Allied Health Professionals (AHPs)
Clinical Site Managers
Dietitians
Family and Carer Ambassadors
Family Group Conferencing Leads
Psychological Services Staff
Peer Support Workers
Perinatal Nurse Specialists
Pharmacists
Professional Nurse Educators
Registered Practitioners
Speech and Language Therapists (SLTs)
Ward Clerks

WHAT WAS DELIVERED

Programme Delays and Initial Barriers

Despite initial delays significant progress has been made in delivering the programme's key components. The programme did not commence immediately following Board approval in July 2023. Although the business case proposed recruiting 11 WTEs immediately post-approval, this was not feasible due to revisions to job descriptions, job evaluation processes and establishment control and budget alignment. No funding was received for 2023/24, resulting in the programme being postponed for that financial year.

Approval to Proceed at Risk

In May 2024, the Board agreed the Operating Plan enabling the Executive Lead Steering Group to implement and recruit at risk, pending commissioner funding. The recruitment timeline was significantly condensed, requiring two years' worth of recruitment activity to be completed within 10 months.

Funding and Workforce Adjustments

In August 2025, funding was distributed, confirming a revised workforce target of 336.77 WTE, down from the original 337 WTE. This reduction was due to a skill mix identified by the services

A shortfall of 26.86 WTE was also identified in the calculation of registered professionals for Specialist Services.

In December 2024, an options paper was presented to address this: £1.18m was required to resolve the deficit.

Solutions totalling £1.42m (30.89 WTE) were identified, resulting in a £240k residual budget.

The closing WTE for 24/25 was 332.81 WTE following a skill mix review., Additionally, 6.26 WTE Peer Support Workers and Professional Nurse Educator roles were added for recruitment in 2025/26, adjusting the total WTE target to 339.07 WTE.

Recruitment Progress

The programme has recruited 333.7 WTE against a target of 339 WTE, leaving 5.4 WTE vacancies.

Operating Model Implementation

The Trust recognised the need for a cultural and operational shift alongside workforce expansion. A revised operating model was introduced, transitioning from observation-led care to engagement-led care, built on four pillars: Purposeful Admission, Therapeutic Care, Trauma-Informed Care and Safe and Effective Discharge. This model has been implemented across inpatient and urgent care services and is currently being embedded. Implementation for specialist service wards is scheduled to begin imminently.

BENEFITS REALISATION

Impact on Benefits Realisation Due to Deviation from Phased Approach

The original business case was underpinned by a phased approach to recruitment and implementation, which was critical to the realisation of the anticipated cash-releasing benefits. This included a staged introduction of staffing initiatives in Year 1, and full implementation from Year 2 onwards, with phased delivery of benefits expected over a 3 to 4-year period.

However, due to delays in securing funding and the absence of recruitment activity during 2023/24 (Year 1), the phased delivery approach was not achieved. Instead, approval to proceed was granted in May 2024, necessitating a compressed and accelerated recruitment programme through to March 2025. In recognition of the challenges posed by this revised timeline and the partial implementation of the operating model, a formal change request was approved in June 2025 to extend delivery through to September 2025.

This deviation from the original plan has directly impacted the timing and scale of benefits outlined in the business case. The financial modelling had assumed that cash-releasing benefits—primarily through reductions in agency and bank staff usage and out-of-area placements—would begin to accrue in Year 2, with a significant uplift from Year 3 onwards. Given the delays in implementation, these benefits are now expected to begin materialising later than planned, likely in the latter part of Year 3 or into Year 4 and remain contingent on the successful completion of recruitment and full adoption of the operating model.

Consequently, the overall value-for-money position, as originally presented, may be impacted, and this should be considered when evaluating the outcomes of the programme.

BENEFIT	OWNER	BASELINE VALUE	TARGET VALUE
Reduction in Bank & Agency Spend (Cash-Releasing benefit)	Nursing	This is assumed to be a Cash-Releasing Benefit, based on savings made in reducing spend on temporary bank and agency staff, directly as a result of permanent capacity supported by recruited establishment posts. Bank & Agency costs for the in-scope wards are significant and higher than the cost of substantive posts. The costs for 2022/23 were £31.9m for Bank & Agency costs, which has been taken as the baseline.	Assumed target reduction on the baseline is 40% as it focuses on registered professionals. These sums would be offset by cash-releasing benefits in Year 1 amounting to £1.769m rising to £18.871m by Year 5. Year 1: £1.769M, Year 2:£4.850M, Year 3: £9.314M, Year 4: £14.233M and Year 5: £18.871M
Reduction in Inappropriate Out of Area Placements (Cash-Releasing benefit)	Operations	This is assumed to be a Cash-Releasing Benefit, based on savings made in reducing 'spot purchases' of bed days from the independent sector to address capacity constraints related to out of area placements. The inpatient services team experiences a number of inappropriate out of area placements (OoAP) resulting from bed shortages. Recent trends show that this is a significant challenge compared to previous years. From data provided, for 2022/23, OoAPs were on average 590 bed days for the first 6 months and increased substantially over the second six months to over 1,000 per month. The corresponding baseline cost for OoAP is £15.566m per annum.	For each of the three options we assumed target reductions which vary under the Conservative, Moderate and Aggressive scenarios, and which also reflect the number and focus of initiatives in supporting capacity management. For option 2, the target benefit saving was identified by operational leads as 35% of OoAP spend.
Reduction in Sickness Levels (Non-Cash-Releasing benefit)	HR	This is assumed to be a Non-Cash-Releasing Benefit, reflecting the economic value of improved staffing presence and avoidance of costs to fill rostering gaps. Balance scorecard data was obtained to establish an average absence for the in-scope wards of 7.1% (April to October 2022), with a corresponding estimated cost equates to £1.525m annually.	Reduction of this by 15% to just over 6.0% would produce a target annual benefit of around £229k. The target reduction on average absence rates based on comparison of EPUT rates to NHS Model Hospital median national average. Estimated cost equivalent of 1% improvement aligns to moderate benefit.
Reduced Length of Stay (Non-Cash-Releasing benefit)	Performance	This is assumed to be a Non-Cash-Releasing Benefit, reflecting the economic value of improved capacity management. Length of Stay (LOS) and number of discharges in month were established for each type of inpatient ward from the balanced scorecard metrics, which were extrapolated to give an annualised figure for bed days and corresponding annualised baseline cost.	'Focus Wards': For two ward types (Older Adult acute and Low Secure beds for forensic mental health), the Trust's Length of Stay was shown to be higher than the Peer Average . We have separately estimated a deeper benefit for these wards compared to the other ward types. Other Wards: For the three other ward types (Adult acute, Psychiatric and Mother & Baby), the Trust's LOS for those bed types are slightly lower than the Peer Average (or there is not a Peer Average to provide comparison) therefore it is not reasonable to assume anything other than modest improvements for the target reduction.
Increased Time to Care (Non-Cash-Releasing benefit)	Nursing	This is assumed to be a Non-Cash-Releasing Benefit, reflecting the wider economic value of time spent with patients and driven by the established Care Hours per Patient Day metric. The rationale for this is that by introducing the High Priority initiatives there will be a benefit gained by having a greater number of Time to Care hours compared to the baseline and existing staff (and hence a quantifiable benefit).	We obtained data for the number of Whole Time Equivalents (WTEs) across the in-scope wards. Assuming a number of working hours per annum and a proportion currently used for Time to Care this produces a total number of hours for each Ward. Using the Care Hours Per Patient Day (CHPPD) and a range of target improvements this identifies the potential additional care hours for each ward type. Applying an hourly rate to this, based on a Band 5 Nurse, a total benefit has been calculated. Different target improvements were assumed for each Ward type and Conservative, Moderate, and Aggressive scenarios.

LESSONS IDENTIFIED

LESSON CATEGORY	LESSON DETAIL	IMPACT ON PROJECT DELIVERY	RECOMMENDATIONS	OWNER
Insufficient Funding for Digital Requirements	The business case did not include funding for essential IT resources such as laptops or software licences, only staffing costs were accounted for.	As a result, recruiting teams had to absorb these unexpected costs. Additionally, IT was not made aware of the need for extra licences, leading to unplanned expenditure on Microsoft and EPR systems.	During the project initiation phase, ensure comprehensive planning and early engagement with Digital/IT teams. All necessary digital requirements including hardware, software, and licence costs should be fully scoped and included in the business case before project approval.	Adam Whiting
Certificate of Sponsorship Funding	The business case did not include funding for Certificates of Sponsorship (CoS) for the staffing positions.	Whilst international recruitment did not occur, this impacted local recruitment where candidates required a visa, therefore limiting the candidate pipeline.	Future business cases for staffing positions should include a designated budget for Certificates of Sponsorship (CoS) to ensure flexibility in recruitment. This will enable the Trust to consider candidates who require visas, helping to widen the talent pool and minimise delays in filling critical roles.	Matt Gall
Resource Requirements	At the programme's initiation, comprehensive project planning did not fully assess the extent of resource needs across cross-functional teams within the Trust.	While the business case accounted for some resource costs related to Recruitment and Marketing, the programme also required significant subject matter expertise from Operations, Clinical, Finance, HR, Recruitment, Marketing, and Communications teams to ensure successful delivery. This sometimes proved challenging as individuals had competing priorities and ongoing business-as-usual duties to fulfil.	To ensure the successful initiation and delivery of future projects and programmes, it is essential to implement comprehensive resource planning during the pre-business case phase. This will enable the identification and allocation of necessary resources across all relevant departments, ensuring that resource requirements are accurately reflected and approved within the business case. The Trust can mitigate potential resource constraints, align departmental priorities, and plan for the success of projects from the outset.	Transformation Team
Recruitment Trajectory Plan	The recruitment plan outlined in the approved business case was unrealistic, as it proposed the immediate hiring of 11 WTEs upon approval. This was not feasible due to standard recruitment timelines and internal processes.	Following programme approval, it became necessary to revise the recruitment plan to account for actual hiring lead times. This included allowances for: <ul style="list-style-type: none"> Revisions to job descriptions Completion of job evaluation processes Establishment control procedures Alignment with available budgets The delay in addressing these factors impacted the programme's ability to initiate delivery as originally planned.	Future business cases should include a realistic recruitment plan that reflects actual hiring lead times, including the time required for job description revisions, job evaluation, establishment control, and budget alignment. Early engagement with HR and workforce planning teams is essential to ensure feasibility and alignment with recruitment processes. Additionally, a phased recruitment approach should be considered where appropriate, to allow for staged onboarding and reduced risk of programme delays.	Matt Gall
Transformation Programme Management	The transformation leads collaborated effectively throughout the duration of the programme, successfully building and sustaining high-performing teams.	Ensured programme maintained strong momentum by: <ul style="list-style-type: none"> Providing consistent support to operational services Proactively troubleshooting issues Leading meetings and driving key discussions Delivering timely and accurate reporting Fostering integrated working relationships across teams Recognising and promoting good practice and achievements 	Future transformation programmes should adopt a similar collaborative leadership model, ensuring that transformation leads work closely to build cohesive, high-performing teams.	Transformation Team
Embedding Change	A strong collaborative culture was observed in some areas, where multidisciplinary teams including pharmacy, consultants, psychology, and others worked cohesively rather than in isolated silos. This integrated approach fostered a positive work ethos and supported more holistic service delivery. Senior Leadership colleagues noted this, highlighting the value of cross-disciplinary collaboration in achieving shared goals.	This collaborative and integrated working culture contributed to more effective service delivery, improved communication between disciplines, and a shared sense of ownership and accountability. It also enhanced staff morale and created a more supportive working environment	Future programmes should seek to replicate the collaborative and multi-disciplinary approach as this has worked well in areas (North West)	Care unit teams
Staffing Model Deficit	Early and thorough validation of workforce modelling is essential to avoid discrepancies between planned and funded establishment levels.	The identification of a 26.87 WTE shortfall in registered professionals highlighted the need for robust checks, clear financial alignment, and flexibility to adjust roles to maintain both affordability and service delivery capacity.	Future programmes should build in an early review and sign-off process for workforce assumptions, ensuring that financial, operational, and clinical leads jointly validate staffing models before funding allocations are finalised. Regular reconciliation between budgeted and actual workforce figures should be maintained throughout implementation to identify and address variances promptly.	
Value of Co-production	The involvement of our Lived Experience Ambassadors (LEAs) throughout the programme proved invaluable.	Their ongoing participation enhanced the relevance, quality, and impact of the work.	Future programmes should continue to embed and highlight co-production as a core principle to ensure services are shaped by those with lived experience.	
Evolution of the Occupational Therapy Role	The transformation of inpatient care within EPUT has provided a valuable opportunity for Occupational Therapy to modernise its role and clearly demonstrate its unique contribution across four strategic priorities: purposeful admission, therapeutic inpatient care, trauma-informed practice, and proactive discharge planning.	This highlights the importance of aligning professional development and role design with wider service transformation to maximise impact and sustainability.	Future service developments should continue to embed and promote the modernised OT model across pathways. Sustaining investment in professional development, shared learning, and outcome evaluation will help maintain the momentum of change and ensure that OT continues to contribute strategically to service transformation.	Ellen van den Hoven
Occupational therapy	There is no occupational therapy provision in Grangewaters.	Due to the absence of occupational therapy provision, patients at Grangewaters are missing out on essential therapeutic support.	Conduct a comprehensive review of patient needs for occupational therapy at Grangewaters. Explore options to assign an occupational therapist to Grangewaters.	Ellen van den Hoven


10.1 EPUT CONSTITUTION

● Decision Item

👤 DG

REFERENCES

Only PDFs are attached

 EPUT Constitution 01.04.2026.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1			1 April 2026		
Report Title:	EPUT Constitution					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Executive Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors 11 March 2026					
Level of Assurance:	Level 1	✓	Level 2		Level 3	

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A – this is a corporate document providing the legal and governance framework for the organisation.		
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? <i>Note: Strategic risks are underpinned by a Strategy and are longer-term</i>	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 reviewed EPUT Constitution for approval.	Approval	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Approve the reviewed EPUT Constitution

Summary of Key Issues

The Trust is required to undertake a review its Constitution on an annual basis. The last review of the Constitution took place in March 2025.

The review of the Constitution requires approval from the Council of Governors and the Board of Directors.

The Constitution has been reviewed and no amendments are recommended. The Constitution was circulated to the Council of Governors and the Board of Directors, with any comments provided at the Council of Governors meeting on the 11 March 2026. The Council of Governors approved the reviewed Constitution at this meeting.

The Board of Directors are asked to approve the reviewed EPUT Constitution which is attached as Appendix 1.

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:	<table border="0"> <tr> <td style="text-align: right;">Capital £</td> <td></td> </tr> <tr> <td style="text-align: right;">Revenue £</td> <td></td> </tr> <tr> <td style="text-align: right;">Non Recurrent £</td> <td></td> </tr> </table>	Capital £		Revenue £		Non Recurrent £	
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

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Supporting Reports/ Appendices /or further reading

EPUT Constitution (Appendix 1)

Lead



Denver Greenhalgh
Executive Director of Governance

20260401

Essex Partnership University NHS Foundation Trust
Constitution

**Approved by Council of Governors 11 March 2026 and
Board of Directors 1 April 2026
Next Review Date: 30 April 2027**

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1. Interpretation and Definitions

- 1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the 2022 Act.
- 1.2 Words importing the plural shall import the singular and vice-versa.
- 1.3 The **2006 Act** is the National Health Service Act 2006
- 1.4 The **2012 Act** is the Health and Social Care Act 2012
- 1.5 The **2022 Act** is the Health and Care Act 2022
- 1.6 **Annual Members' Meeting** is defined in paragraph 13 of the Constitution
- 1.7 **Board of Directors** or **Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with this Constitution
- 1.8 **Board of Directors Nominations Committee** means a committee of the Board described in paragraph 30.4 of the Constitution
- 1.9 **Constitution** means this constitution which has effect in accordance with Section 37(1) of the 2006 Act
- 1.10 **Council of Governors or Council** means the Council of Governors of the Trust as described in paragraph 14 of this Constitution
- 1.11 **Chair** is the person appointed as Chair of the Board of Directors (and Chair of the Council of Governors) under paragraph 28 of this Constitution
- 1.12 **Chief Executive** is the person appointed as the Chief Executive Officer of the Trust under paragraph 31 of this Constitution
- 1.13 **Directors** means the Executive and Non-Executive members of the Board of Directors
- 1.14 **Executive Director** means a member of the Board of Directors appointed under paragraph 25 of the Constitution
- 1.15 **Member** means a person registered as a member of one of the constituencies set out in paragraph 5 of this Constitution
- 1.16 **Model Election Rules** means the Model Election Rules published by Department of Health and/or NHS Providers
- 1.17 **NHS England** is the body corporate as provided by Section 1H of the 2012 Act

- 1.18 Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the Constitution
- 1.19 Officer** means an employee of the Trust or any person holding a paid appointment or office with the Trust
- 1.20 Regulated Activities Regulations** means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended
- 1.21 The Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act
- 1.22 The Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary
- 1.23 Vice-Chair** means the Non-Executive Director appointed under paragraph 30.1 and 30.3 of this Constitution
- 1.24 Acting Chair** means the Non-Executive Director appointed under paragraph 30.2 and 30.3 of this Constitution.
- 1.25 Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried out for profit
- 1.26 Working Day** means a day of the week which is not a Saturday, Sunday or public holiday in England.

2. Name

- 2.1** The name of the foundation trust is Essex Partnership University NHS Foundation Trust (the Trust).

3. Principal Purpose

- 3.1** The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England
- 3.2** The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes
- 3.3** The Trust may provide goods and services for any purposes related to:
- 3.3.1** the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
 - 3.3.2** the promotion and protection of public health

- 3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

- 4.1 The powers of the Trust are set out in the 2006 Act
- 4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust
- 4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.
- 4.4 In accordance with section 65Z5 of the 2006 Act the Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following—
- (a) A relevant body as defined under section 65Z5(2) of the 2006 Act;
 - (b) A local authority (within the meaning of section 2B of the 2006 Act);
 - (c) A combined authority.
- 4.5 Where the Trust arranges for any functions exercisable by it to be exercised jointly the bodies by whom the function is exercisable jointly may—
- (a) Arrange for the function to be exercised by a joint committee of theirs;
 - (b) Arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.

5. Membership and Constituencies

- 5.1 The Trust shall have members, each of whom shall be a member of one of the constituencies in paragraph 5.2
- 5.2 The constituencies of the Trust shall be:
- 5.2.1 a Public Constituency
 - 5.2.2 A Staff Constituency.

6. Application for Membership

- 6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust subject to paragraphs 8 and 12 below

- 6.2** An applicant will become a member when the Trust has received and accepted the application, and the name of the applicant has been entered in the Trust's Register of Members (see Annex 9: Further Provisions paragraph 2).

7. Public Constituency

- 7.1** An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the Trust
- 7.2** Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency
- 7.3** The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

- 8.1** Individuals who are employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:
- 8.1.1** they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 8.1.2** they have been continuously employed by the Trust under a contract of employment for at least 12 months
 - 8.1.3** For the avoidance of doubt permanent staff are eligible to be members of the staff constituency. Temporary Staff can be a member of a Public Constituency if the criteria are met.
- 8.2** Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis
- 8.3** Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency
- 8.4** The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency; each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency
- 8.5** The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default – Staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10. NOT USED

11. NOT USED

12. Restriction on Membership

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency

12.3 An individual must be at least 12 years old to become a member of the Trust

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9: Further Provisions paragraph 2.

13. Annual Members' Meeting

13.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public

13.2 Annual Members' Meetings shall be conducted in accordance with paragraph 27A of Schedule 7 of the 2006 Act (and as set out in paragraph 46 of this constitution) and the standing orders for the practice and procedure of Annual Members' Meetings as set out in Annex 10: Annual Members' Meeting.

14. Council of Governors – Composition

14.1 The Trust is to have a Council of Governors, which shall comprise both

elected and appointed Governors

- 14.2** The composition of the Council of Governors is specified in Annex 4
- 14.3** The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

15. Council of Governors – Election of Governors

- 15.1** Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules adopting Single Transferable Vote (STV)
- 15.2** The Model Election Rules are referenced at Annex 5 but they do not form part of this constitution
- 15.3** A variation of the Model Election Rules by the Department of Health or NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution)
- 15.4** An election, if contested, shall be by secret ballot
- 15.5** Where a vacancy arises from amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the most recent election for that post the opportunity to assume the vacancy for the unexpired balance of the former member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.
- 15.6** Governors must be at least 16 years of age at the date they are nominated for election or appointment

16. Council of Governors – Tenure

- 16.1** An elected Governor may hold office for a period of up to three Years. The period of office shall be known as the 'term'
- 16.2** Elected Governors shall cease to hold office if they cease to be a member of the constituency or class by which they were elected
- 16.3** Elected Governors shall be eligible for re-election at the end of their term
- 16.4** Appointed Governors may hold office for a period of up to three Years

- 16.5** Appointed Governors shall cease to hold office if the appointing organisation withdraws its sponsorship of them or if the appointing organisation ceases to exist and there is no successor in title to its business
- 16.6** Appointed Governors shall be eligible for re-appointment at the end of their term
- 16.7** A Governor may serve a maximum of three terms of each up to three years in office and shall be eligible to stand for election or appointment as a Governor again following a break of at least a Year
- 16.8** “Year’ in this clause 16 means the period commencing on the date of election or appointment (as the case may be) and ending 12 months after such election or appointment.

17. Council of Governors – Disqualification and Removal

- 17.1** The following may not become or continue as a member of the Council of Governors:
- 17.1.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged
 - 17.1.2** a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)
 - 17.1.3** people who have made a composition or arrangement with, or granted a Trust deed for their creditors and have not been discharged in respect of it
 - 17.1.4** people who within the preceding five years have been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them
- 17.2** Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and for the removal of Governors are set out in Annex 6 paragraphs 4 and 5.

18. Council of Governors – Duties of Governors

- 18.1** The general duties of the Council of Governors are:
- 18.1.1** to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
 - 18.1.2** to represent the interests of the members of the Trust as a whole and the interests of the public

- 18.2** Further provision as to the roles and responsibilities of the Council of Governors is set out in Annex 6
- 18.3** The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – Meetings of Governors

- 19.1** The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 of this constitution) or, in their absence the Vice-Chair or Acting Chair (appointed in accordance with the provisions of paragraph 30 of this constitution), shall preside at meetings of the Council of Governors except as otherwise provided pursuant to the standing orders for the Council of Governors as at Annex 7
- 19.2** Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Council of Governors if that person is interfering with or preventing the proper conduct of the meeting
- 19.3** For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

20. Council of Governors – Standing Orders

- 20.1** The standing orders for the practice and procedure of the Council of Governors are referenced at Annex 7
- 20.2** The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of this constitution.

21. NOT USED

22. Council of Governors – Conflicts of Interest of Governors

- 22.1** If Governors have a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, Governors shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – Travel Expenses

- 23.1** The Trust may pay travelling and other expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust. These expenses are to be disclosed in the Trust's annual report
- 23.2** Governors do not receive remuneration when undertaking their duties and role as a Governor.

24. Council of Governors – Further Provisions

- 24.1** Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – Composition

- 25.1** The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors
- 25.2** The Board of Directors is to comprise:
- 25.2.1** a Non-Executive Chair
 - 25.2.2** not less than five and not more than eight other Non-Executive Directors; and
 - 25.2.3** not less than four and not more than eight Executive Directors,
- so that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive in a voting capacity.
- 25.3** One of the Executive Directors shall be the Chief Executive
- 25.4** The Chief Executive shall be the Accounting Officer
- 25.5** One of the Executive Directors shall be the Finance Director
- 25.6** One of the Executive Directors is to be a registered Medical Practitioner or a registered Dentist (within the meaning of the Dentists Act 1984)
- 25.7** One of the Executive Directors is to be a registered Nurse or a registered Midwife.

26. Board of Directors – General Duty

- 26.1** The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise

the benefits for the members of the Trust as a whole and for the public.

26.2 In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to—

- (a) The health and well-being of the people of England;
- (b) The quality of services provided to individuals—
 - (i) By relevant bodies, or
 - (ii) In pursuance of arrangements made by relevant bodies,

for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

(c) efficiency and sustainability regarding the use of resources by relevant bodies for the purposes of the health service in England.

27. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if:

- 27.1** they are a member of a Public Constituency, or
- 27.2** where any of the Trust’s hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and
- 27.3** They are not disqualified by virtue of paragraph 33 of this constitution.

28. Board of Directors – Appointment and Removal of Chair and Other Non-Executive Directors
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- 28.1** The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors
- 28.2** Appointment of the Chair or another Non-Executive Director shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors
- 28.3** Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors
- 28.4** The Council of Governors shall adopt a procedure for appointing/removing the Chair and/or other Non-Executive Directors in accordance with any

guidance issued by NHS England.

29. NOT USED

30. Board of Directors – Appointment of Vice-Chair, Acting Chair, Senior Independent Director and Deputy Chief Executive

- 30.1** The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as the Vice-Chair
- 30.2** When the absence of the Chair has or will exceed a period of 3 months the Council of Governors at a meeting shall appoint one of the Non-Executive Directors as the Acting Chair.
- 30.3** Before a resolution for such appointments is passed, the Chair shall be entitled to advise the Council of Governors of the Non-Executive Director who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision.
- 30.4** The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors as the Senior Independent Director to act in accordance with NHS England's *Code of Governance for NHS Provider Trusts* (as may be amended and replaced from time to time) and the Trust's standing orders.
- 30.5** The Board of Directors Remuneration and Nominations Committee, which comprises of all the Non-Executive Directors, shall appoint an Executive Director as the Deputy Chief Executive in line with agreed procedure.

31. Board of Directors – Appointment and Removal of the Chief Executive and Other Executive Directors
--

- 31.1** The Non-Executive Directors shall appoint or remove the Chief Executive
- 31.2** A committee consisting of the Chair and Non-Executive Directors shall appoint the Chief Executive.
- 31.3** The appointment of the Chief Executive shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors in accordance with the procedure agreed by the Council of Governors from time to time
- 31.4** A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors
- 31.5** An Executive Director's post may be held by two individuals on a job share basis (save that the Executive positions of registered Medical Practitioner or

registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions). Where such an arrangement is in force, the two individuals may only exercise one vote between them at any meeting of the Board of Directors as in the standing orders.

32. NOT USED

33. Board of Directors – Disqualification
--

The following may not become or continue as a member of the Board of Directors:

- 33.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged
- 33.2** a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)
- 33.3** people who have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it
- 33.4** a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them
- 33.5** a person who is subject of a disqualification order made under the Company Directors Disqualification Act 1986 and/or who is disqualified from being a trustee of a charity under the Charities Act 2011
- 33.6** people where disclosures revealed by a Disclosure & Barring Service check against such people are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute
- 33.7** people whose tenure of office as Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest
- 33.8** a person who has within the preceding two years been dismissed: otherwise than by reason of redundancy or for ill health, from any paid employment with;
 - 33.8.1** a health service body or a local authority;
 - 33.8.2** any other public body; or
 - 33.8.3** a private provider or health or social care services;

unless approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

- 33.9** a person who is the subject of a Sexual Offenders Order under the Sexual Offences Act 2003
- 33.10** a person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland
- 33.11** a person who is a Director or Governor or Governing Body member or equivalent of another NHS body, unless any conflict of interest has been reviewed and approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors
- 33.12** a person who is a member of the Council of Governors
- 33.13** in the case of Non-Executive Directors, a person who is no longer a member of one of the public constituencies
- 33.14** in the case of Non-Executive Directors, a person who has refused without any reasonable cause to fulfil any training requirement established by the Board of Directors
- 33.15** a person who is a member of a Local Authority's Overview & Scrutiny Committee covering health matters or of a Local Health watch Board or of a Health & Wellbeing Board
- 33.16** a person who is the spouse, partner, parent or child of a member of the Trust's Board of Directors
- 33.17** a person who has displayed aggressive or violent behavior at any NHS establishment or against any of the Trust's staff or persons exercising functions for the Trust
- 33.18** a person who fails to satisfy the requirements of the Regulated Activities Regulations
- 33.19** a person who has failed to sign and return to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for the Board of Directors
- 33.20** a person who has acted in a manner inconsistent with or who has failed to comply with the Trust's terms of authorisation, standing orders, standing financial instructions and/ or the code of conduct for the Board of Directors.

34. Board of Directors – Meetings
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- 34.1** Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair

may exclude any person from a meeting of the Board of Directors if that person is interfering with or preventing the proper conduct of the meeting

- 34.2** Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the Part 1 minutes of the meeting to the Council of Governors. A summary of Part 2 minutes will be provided to the Council of Governors.

35. Board of Directors – Standing Orders

- 35.1** The Board of Directors has adopted the standing orders for the practice and procedure of the Board of Directors referred to at Annex 8.
- 35.2** The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of the constitution.

36. Board of Directors – Conflicts of Interest of Directors

- 36.1** The duties that a Director of the Trust has by virtue of being a Director include in particular:
- 36.1.1** a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust
 - 36.1.2** a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity
- 36.2** The duty referred to in sub-paragraph 36.1.1 is not infringed if:
- 36.2.1** the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
 - 36.2.2** the matter has been authorised in accordance with the constitution if it has been considered and approved by the Board of Directors
- 36.3** The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest
- 36.4** In sub-paragraph 36.1.2, “third party” means a person other than:
- 36.4.1** the Trust, or
 - 36.4.2** a person acting on its behalf
- 36.5** If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must

declare the nature and extent of that interest to the other Directors

- 36.6** If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made
- 36.7** Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement
- 36.8** This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question
- 36.9** A Director need not declare an interest:
- 36.9.1** if it cannot reasonably be regarded as likely to give rise to a conflict of interest
 - 36.9.2** if, or to the extent that, the Directors are already aware of it
 - 36.9.3** if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:
 - 36.9.3.1 by a meeting of the Board of Directors, or
 - 36.9.3.2 by a committee of the Directors appointed for the purpose under the constitution
- 36.10** The standing orders for the Board of Directors make further provision for the disclosure of interests.

37. Board of Directors – Remuneration and Terms of Office

- 37.1** The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors
- 37.2** The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

38. Registers

The Trust shall have:

- 38.1** a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong
- 38.2** a register of members of the Council of Governors

- 38.3 a register of interests of Governors
- 38.4 a register of Directors, and
- 38.5 a register of interests of the Directors.

39. Admission to and Removal from the Registers

- 39.1 The Trust Secretary shall be responsible for fulfilling the obligations of the Trust in relation to the maintenance of, admission to and removal from the registers under the provisions of this constitution and as set out in paragraph 38.
- 39.2 Directors and Governors shall advise the Trust Secretary as soon as practicable of anything which comes to their attention or of which they are aware and which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 38.

40. Registers – Inspection and Copies

- 40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances prescribed below or as otherwise prescribed
- 40.2 The Trust may withhold all or part of the registers from inspection where disclosure of information could give rise to a real risk of harm or is prohibited by law.
- 40.3 So far as the registers are required to be made available:
 - 40.3.1 they are to be available for inspection free of charge at all reasonable times, and
 - 40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract
- 40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. Documents Available for Public Inspection

- 41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
 - 41.1.1 a copy of the current constitution,
 - 41.1.2 a copy of the latest annual accounts and of any report of the auditor

on them, and

41.1.3 a copy of the latest annual report

41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

41.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act

41.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

41.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act

41.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

41.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy

- 41.4** If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. Auditor

- 42.1** The Trust shall have an auditor
- 42.2** The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors
- 42.3** The auditor shall comply with Schedule 10 of the 2006 Act in auditing the accounts of the Trust.

43. Audit Committee

- 43.1** The Board of Directors shall establish a committee comprising Non-Executive Directors (at least one of whom has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate
- 43.2** The Audit Committee as a whole shall have competence relevant to the NHS sector.

44. Accounts

- 44.1** The Trust must keep proper accounts and proper records in relation to the accounts
- 44.2** NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts
- 44.3** The accounts are to be audited by the Trust's auditor
- 44.4** The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct
- 44.5** The functions of the Trust with respect to the preparation of the annual accounts, as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

45. Annual Report, Forward Plans and Non-NHS Work

- 45.1** The Trust shall prepare an annual report and send it to NHS England
- 45.2** The Trust shall give information as to its forward planning in respect of each financial year to NHS England

- 45.3** The forward plan shall be prepared by the Directors
- 45.4** In preparing the forward plan, the Directors shall have regard to the views of the Council of Governors
- 45.5** Each forward plan must include information about:
- 45.5.1** the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
 - 45.5.2** the income it expects to receive from doing so
- 45.6** Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:
- 45.6.1** determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and
 - 45.6.2** notify the Directors of the Trust of its determination
- 45.7** A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

46. Presentation of the Annual Accounts and Reports to the Governors and Members

- 46.1** The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
- 46.1.1** the annual accounts
 - 46.1.2** any report of the auditor on them
 - 46.1.3** the annual report
- 46.2** The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one Board Director in attendance
- 46.3** The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

- 47.1** The Trust shall have a seal
- 47.2** The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the Constitution

- 48.1** The Trust may make amendments of its constitution only if:
- 48.1.1** more than half of the members of the Council of Governors of the Trust voting approve the amendments, and
 - 48.1.2** more than half of the members of the Board of Directors of the Trust voting approve the amendments
- 48.2** Amendments made under sub-paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act
- 48.3** Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):
- 48.3.1** at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and
 - 48.3.2** the Trust must give the members an opportunity to vote on whether they approve the amendment
- If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. Actions taken by the Trust under the amended constitution, prior to the amendment ceasing to have effect, remain valid
- 48.4** Amendments by the Trust of its constitution are to be notified to NHS England.

49. Mergers, etc., and Significant Transactions

- 49.1** The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors
- 49.2** The Trust may enter into a significant transaction unless it is a merger, acquisition, separation or dissolution only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction

49.3 The definition of “significant transaction” for the purposes of paragraph 49.2 and section 51A of the 2006 Act is set out in Annex 9 paragraph 1.

50. Indemnities

50.1 Members of the Board of Directors, members of the Council of Governors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust

50.2 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Board of Directors, the Council of Governors and the Trust Secretary.

ANNEX 1: THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

THE PUBLIC CONSTITUENCIES			
Constituency Name	Area of the Constituency	No of Governors to be Elected	Minimum No of Members
Essex Mid & South	The electoral wards covered by: <ul style="list-style-type: none"> • Basildon Borough Council • Braintree District Council • Brentwood Borough Council • Castle Point Borough Council • Chelmsford Borough Council • Maldon District Council • Rochford District Council • Southend on Sea Borough Council • Thurrock Borough Council 	9	60
North East Essex & Suffolk	<ul style="list-style-type: none"> • Colchester Borough Council • Suffolk County Council • Tendring District Council 	3	60
West Essex & Herts and Rest of England	<ul style="list-style-type: none"> • Bedford Borough Council • Borough of Broxbourne Council • Central Bedfordshire Council • East Herts District Council • Epping Forest District Council • Harlow Council • Luton Borough Council • Milton Keynes Council • North Herts District Council • Stevenage Borough Council • Uttlesford District Council • Welwyn Hatfield Borough Council • Any other Council in England unless named in Annex 1 to the Trust's Constitution 	7	60

ANNEX 2: THE STAFF CONSTITUENCY

(Paragraph 8.4 and 8.5)

THE STAFF CONSTITUENCIES			
Constituency Name	Area of the Constituency	No of Governors to be Elected	Minimum No of Members
Clinical (Mental Health)	<ul style="list-style-type: none"> • Registered medical practitioners and registered dentists • Registered nurses and registered midwives • Healthcare professionals • Social workers 	3	60
Clinical (Physical Health)		1	60
Non-Clinical	<ul style="list-style-type: none"> • Support staff • Corporate Staff 	2	60

ANNEX 4: COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

Public Governors		19
Essex Mid & South	9	
North East Essex & Suffolk	3	
West Essex, Herts and Rest of England	7	
Staff Governors		6
Clinical (Mental Health)	3	
Clinical (Physical Health)	1	
Non-Clinical	2	
Appointed and Partnership Governors		5
Essex County Council	1	
Southend Borough Council	1	
Thurrock Council	1	
Anglian Ruskin and Essex Universities (joint appointment)	1	
Third Sector / Voluntary Sector	1	
Total Council of Governors		30

ANNEX 4.1: NOT USED

ANNEX 5: THE MODEL ELECTION RULES

(Paragraph 15.2)

The Model Election Rules 2014 are included as a separate document to this constitution. (<https://nhsproviders.org/resources/briefings/model-election-rules>)

ANNEX 6: ADDITIONAL PROVISION – COUNCIL OF GOVERNORS

(Paragraphs 17.3, 18.2 and 24.1)

1. Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution, the Trust's license and NHS England's *Code of Governance for NHS Provider Trusts* include

1.1 General Duties

- 1.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts so that the Trust does not breach the terms of its license. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so
- 1.1.2 to represent the interests of the members of the Trust and the interests of the public

2.1 Non-Executive Directors, Chief Executive and Auditor

- 2.1.1 to approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council of Governors
- 2.1.2 to appoint the Chair and Non-Executive Directors
- 2.1.3 to remove the Chair and the Non-Executive Directors. However, the Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of

engagement with the Board

- 2.1.4** to approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the remuneration committee of the Council of Governors. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors
- 2.1.5** to decide the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors having regard to the recommendations of the Remuneration Committee of the Council of Governors
- 2.1.6** to approve the appointment of the Chief Executive of the Trust
- 2.1.7** to approve the criteria for the appointment, removal and reappointment of the auditor
- 2.1.8** to appoint, remove and reappoint the auditor, having regards to the recommendation of the Audit Committee

3.1 Strategy Planning

- 3.1.1** to provide feedback to the Board of Directors on the development of the strategic direction of the Trust, as appropriate
- 3.1.2** to collaborate with the Board of Directors in the development of the forward plan
- 3.1.3** where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purposes of the NHS in England, to determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and notify its determination to the Board of Directors
- 3.1.4** where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England, approve such a proposal
- 3.1.5** to approve the entering into of any significant transaction (as

defined in this constitution) in accordance with the 2006 Act and the constitution

- 3.1.6** to approve proposals from the Board of Directors for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution
- 3.1.7** when appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution
- 3.1.8** to receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors

3.2 Representing Members and the Public

- 3.2.1** to prepare and from time to time review the Trust's membership engagement strategy and policy
- 3.2.2** to notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its license, and if these concerns cannot be resolved at local level
- 3.2.3** to report to the members annually on the performance of the Council of Governors
- 3.2.4** to promote membership of the Trust and contribute to opportunities to recruit members in accordance the membership strategy
- 3.2.5** to seek the views of stakeholders and feed back to the Board of Directors.

(Paragraphs 17.3 and 24.1)

4. Eligibility to be a Governor

- 4.1** A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:
 - 4.1.1** they are a Director of the Trust, or a director of another health service body
 - 4.1.2** they are the spouse, partner, parent or child of a member of the Board of Directors for the Trust

- 4.1.3 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986
- 4.1.4 they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003
- 4.1.5 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland
- 4.1.6 they are undergoing a period of disqualification from a statutory health or social care register
- 4.1.7 they have been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000
- 4.1.8 they have been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body
- 4.1.9 they are a vexatious complainant as determined in accordance with the Trust's complaints procedure
- 4.1.10 within 5 years prior to their nomination for election or appointment to the Council of Governors, they have had their office of Governor terminated for the reasons set out in paragraphs 5.1.4 – 5.1.9 of this Annex 6.
- 4.1.11 they have been expelled from another NHS Body and /or demonstrably hold views / act in ways that are inconsistent with Trust [vision, objectives and values](#).

(Paragraph 17)

5. Termination of Office and Removal of Governors

- 5.1 People holding office as a Governor shall cease to do so if:
 - 5.1.1. they resign by notice in writing to the Trust Secretary
 - 5.1.2 in the case of elected Governors, they cease to be member of the area of the constituency or class of the constituency by which they were elected
 - 5.1.3. in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

- 5.1.4. they consistently and unjustifiably fail to attend the meetings of the Council of Governors in line with the Governor Attendance policy as agreed by the Council of Governors
 - 5.1.5. they have refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake
 - 5.1.6. they have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors
 - 5.1.7. they have failed to complete a submission identifying any conflict of interest or they have knowingly provided false or misleading information in this regard.
 - 5.1.8. they have committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders
 - 5.1.9. they have acted in a manner detrimental to the interests of the Trust
 - 5.1.10. they have expressed opinions which are incompatible with the vision, objectives and / or values of the Trust
 - 5.1.11. they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs
- 5.2 Governors who are to be removed under any of the grounds set out in paragraph 5.1 above (with the exception of sub-paragraph 5.1.1 – 5.1.3) above shall be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present and voting
- 5.3 There shall be a working group/committee of the Council of Governors whose function shall be to:
- 5.3.1 receive and consider concerns about the conduct of any governor and/or
 - 5.3.2 consider whether there are grounds to remove a Governor from office and to make recommendations to the Council of Governors. Membership of the working group/committee shall be determined from time to time
- 5.4 If the Council of Governors receives a complaint in writing about any Governor or is asked to consider whether an individual is eligible to

become or remain a Governor, the working group shall investigate the matter and make a recommendation to the Council of Governors, which may include a recommendation that a Governor is removed from office pursuant to paragraph 5.2 above

- 5.5 The Council of Governors may decide that whilst the working group is carrying out its investigation, the Governor concerned shall be suspended from office. Suspension is a neutral act and any decision to suspend the Governor concerned shall not be seen as an indicator of, or have any bearing on, the eventual recommendation of the working group
- 5.6 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until seven (7) days after the date of decision
- 5.7 The Governor shall be suspended from office (if they have not already been suspended from office pursuant to paragraph 5.5 above) with effect from the date of the Council of Governors' decision until the date set out in paragraph 5.5 above

ANNEX 7: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 19.1 and 20)

Standing Orders For The Practice And Procedure Of The Council Of Governors are included as a separate document to this constitution.

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ANNEX 8: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 35)

Standing Orders For The Practice And Procedure Of The Board Of Directors are included as a separate document to this constitution.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph 49)

1. SIGNIFICANT TRANSACTIONS

- 1.1 In accordance with section 51A of the National Health Service Act 2006, the Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction
- 1.2 For the purpose of this paragraph 1 and subject to paragraph 1.4 below, “Significant Transaction” means a “transaction” as defined in paragraph 1.3 below which meets any one of the following tests:
 - 1.2.1 the assets which are the subject of the transaction exceed 25% of the total fixed assets of the Trust (Asset Test); or
 - 1.2.2 the income of the Trust will increase or decrease by more than 25% following the completion of the relevant transaction (Income Test); or
 - 1.2.3 the gross capital of the company or business being acquired or divested represents more than 25% of the total capital of the trust following completion (where “gross capital” is the market value of the relevant company or business’s shares and debt securities plus the excess of current liabilities over current assets, and the Trust’s capital is determined by reference to its balance sheet) (Gross Capital Test); or
 - 1.2.4 the Asset Test, the Income Test and the Gross Capital Test are not satisfied but the transaction, in the reasonable opinion of the Board of Directors:
 - (a) would impact on the manner in which health services are delivered by the Trust and/or the range of health services the Trust delivers; or
 - (b) exceeds a total value of £10,000,000 (£10 million) and has an overall risk rating which in the reasonable opinion of the Board of Directors is considered to be significant. The Board of Directors will assess the significance of the overall risk of the transaction against the applicable Trust’s own risk management framework in force at the time the risk assessment is conducted by the Board of Directors
- 1.3 “Transaction” means any agreement (including an amendment to an agreement) entered into by the Trust in respect of a merger, demerger, joint venture, divestment, or any other arrangement for the acquisition, disposal or delivery of health services, but, for the avoidance of doubt, it does not include:

- 1.3.1 an agreement entered into or changes to the health services carried out by the Trust following a reconfiguration of the health services led by the commissioners of such health services; or
- 1.3.2 a grant of public dividend capital or the entering into a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust
- 1.3.3 For the purpose of this paragraph 1.3 the following definitions apply:
 - (a) “merger” means a transaction that involves one organisation acquiring / transferring the assets and liabilities of another, either wholly or in part;
 - (b) “demerger” means a transaction that involves the disaggregation of a single corporate body into two or more new corporate bodies;
 - (c) “joint venture” means a transaction involving an agreement between two or more parties to undertake economic activity together which establishes a separate legal entity.; and
 - (d) “divestment” means a transaction that involves the disposal, in whole or in part, of an organisation’s business, services or assets and liabilities where the Board of Directors has made a decision to do so.

1.4 A transaction is not a Significant Transaction if it is:

- 1.4.1 a transaction which is a statutory merger, acquisition, separation or dissolution under sections 56, 56A, 56B or 57A of the National Health Service Act 2006; or
- 1.4.2 a transaction in the ordinary course of current business from time to time (including the expiry, termination, renewal, extension of, or the entering into an agreement in respect of the health services carried out by the Trust).
- 1.4.3 a transaction that involves the disposal, in whole or in part, of an organisation’s business services or assets and liabilities where the Board of Directors has not made a decision and therefore is outside Trust control.

(Paragraphs 6.2 and 12.4)

2. TERMINATION OF MEMBERSHIP

2.1 A member shall not become or continue to be a member if:

- 2.1.1 it is reasonably suspected by the Board that in the five years prior to the individual’s application for membership of the Trust or during the

period of their membership of the Trust, they have been involved as a perpetrator in what the Board reasonably considers to be a sufficiently serious incident of intimidation, threat, harassment, assault or violence against:

- a) any of the Trust's employees or other persons who exercise functions for the purpose of the Trust, or against any volunteers; or
- b) any employee of another health service body or any person who exercises functions for the purposes of another health service body or against any person who volunteers with another health service body; or
- c) any service user, carer or visitor to the Trust or any service user, carer or visitor to any other health service body

2.1.2 they have been excluded from the Trust's premises within the previous five years

2.1.3 they are expelled from membership by resolution of the Council of Governors

2.1.4 they cease to be eligible under this Constitution to be a member

2.1.5 they die

2.1.6 they have been expelled from another NHS Body and /or demonstrably hold views / act in ways that are inconsistent with Trust [vision, objectives and values](#).

2.2 It is the responsibility of members to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. Members who become aware of their ineligibility shall inform the Trust as soon as practicable and their names shall be removed from the Register of Members

2.3 Where the Trust has reason to believe that members cease to be eligible for membership or their membership can be terminated under this constitution, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

ANNEX 10: ANNUAL MEMBERS' MEETING

(Paragraphs 13 and 46)

1. Interpretation

- 1.1. Save as permitted by law, the Chair shall be the final authority on the interpretation of these standing orders (on which the Chair shall be advised by the Chief Executive and the Trust Secretary)

2. General Information

- 2.1. The purpose of the standing orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings
- 2.2. All business shall be conducted in the name of the Trust

3. Attendance

- 3.1. Each member shall be entitled to attend an Annual Members' Meeting

4. Meetings in Public

- 4.1. Meetings of the Annual Members' Meetings must be open to the public subject to the provisions of paragraph 4.2 below
- 4.2. The Chair may exclude members of the public from an Annual Members' Meeting if they are interfering with or preventing the reasonable conduct of the meeting
- 4.3. Annual Members' Meetings shall be held annually at such times and places as the Chair may determine

5. Notice of Meetings

- 5.1. Before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an officer of the Trust authorised by the Chair to sign on their behalf, shall be served upon every member at least 10 clear days before the meeting and posted on the Trust's website and displayed at its headquarters
- 5.2. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the Trust Secretary and shall be available for inspection by a member free of charge at the place of the meeting

6. Setting the Agenda

- 6.1. The Chair shall determine the agenda for Annual Members' Meetings which must include the business required by the Act

7. Chair of Annual Members' Meetings

- 7.1. The Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or Acting Chair shall preside. If neither the Chair, Vice-Chair nor Acting Chair is present the Directors and Governors shall elect one of their number to act as Chair

8. Chair's Ruling

- 8.1. Statements of members made at Annual Members' Meetings shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final

9. Voting

- 9.1. Decisions at meetings shall be determined by a majority of the votes of the members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote subject to the Act
- 9.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands
- 9.3. In no circumstances may an absent member vote by proxy

10. Suspension of Standing Orders

- 10.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of suspension
- 10.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting
- 10.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members
- 10.4. No formal business may be transacted while the standing orders are suspended
- 10.5. The Trust's Audit Committee shall review every decision to suspend the standing orders

11. Variation and Amendment of Standing Orders

11.1. These standing orders may be amended in accordance with paragraph 48 of the constitution

12. Record of Attendance

12.1. The Trust Secretary shall keep a record of the names of the members present at an Annual Members' Meeting

13. Minutes

13.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it

13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting

13.3. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 members are present.

11. OTHER

12. ANY OTHER BUSINESS

Information Item

ALL

12.1 REFLECTION ON RISKS, ISSUES OR CONCERNS INCLUDING

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

13. QUESTION THE DIRECTORS SESSION

14. DATE AND TIME OF NEXT MEETING: 3RD JUNE 2026 AT 10:00, THE
LODGE TRAINING ROOM 1